CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 11/02/2007
Element Release Date: 04/08/2008
CAP Released Date: 04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date: 01/15/2008
MCO Response Due Date: 09/02/2007

Requirement:

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.

Deficiencies:

In a review of 30 sample cases for the delegate CareOregon, 12 of 30 had improper denials. Most denied as not authorized and no evidence of development was provided in the case files. In two cases, the claim should have transferred to the mental health delegate for processing but instead incorrectly denied to the member as a non-covered service. The reviewer also noted one critical care and one out of area hospital service that incorrectly denied in this sample. The cases included information that the denials were per the MAO's policy for the service. In a review of 13 sample cases for the delegate, 13 of 13 were improperly denied. The reviewers did not find evidence of development in the case files provided. Several denials were for medical claims that the delegate is not contracted to pay, but the denial reason to the beneficiary indicated that services were not covered per the EOC. There was no evidence of a process to transfer medical claims from the delegate to the MAO for processing.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 01/11/2008
Element Release Date: 04/08/2008
CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:01/15/2008
MCO Response Due Date: 09/02/2007

Requirement:

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.

Deficiencies:

In a review of 30 case files processed by CareOregon, four of 30 were not paid within 30 days.

Corrective Action Required:

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.

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Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 10/26/2007
Element Release Date: 04/08/2008
CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:01/15/2008
MCO Response Due Date: 09/02/2007

Requirement:

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).

Deficiencies:

In 2 of the 4 cases that were not paid within 30 days, CareOregon did not pay the correct interest amount. The interest paid was calculated off the the run date of the check instead of the mail date, causing the interest payments to be less than the required amount.

Corrective Action Required:

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.

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Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 01/29/2008
Element Release Date: 01/29/2008
CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 09/02/2007

Requirement:

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.

Deficiencies:

Beneficiaries did not receive a denial notice with Medicare Appeal rights in the 30 sample case files provided by CareOregon. Of a review of 13 case files processed by the delegate, six did not have proper denial notices. Denial reasons were incorrect or did not provide enough information for the member regarding the denial reason.

Corrective Action Required:

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.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 10/26/2007
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CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
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Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:01/15/2008
MCO Response Due Date: 09/02/2007

Requirement:

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).

Deficiencies:

Two cases in the sample of 10 were misclassified. One was an approval and the other was a post service request. In the remaining sample cases, 2 of 8 denials were not processed timely.

Corrective Action Required:

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.

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Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 01/29/2008
Element Release Date: 01/29/2008
CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:10/01/2007
MCO Response Due Date: 09/02/2007

Requirement:

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.

Deficiencies:

Two cases in the sample of 10 were misclassified. One was an approval and the other was a post service request. In the remaining cases, 2 of 8 notices were incorrect because no denial notice was provided to the beneficiary as required.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8477

Region: 10 Seattle

Contract Number / Name: H5859 HEALTH PLAN OF CAREOREGON, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 10/24/2007
Element Release Date: 01/29/2008
CAP Released Date:04/09/2008

Visit Start Date: 6/14/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/19/2007
Date Report Due: 07/30/2007
CAP Accepted Date:02/14/2008
Audit Closed Date: 04/09/2008
Element Projected Completion Date:09/14/2007
MCO Response Due Date: 09/02/2007

Requirement:

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).

Deficiencies:

All cases submitted for this element were provider requests for service, instead of beneficiary requests. The universe was misclassified.

Corrective Action Required:

Provide a representative universe for this element. If a universe is not available, provide an explanation to the reviewer.