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
Region: 04 Atlanta
Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Review ID: 9137

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 04/25/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS

Deficiencies:

Although the MAO has a formalized compliance plan that includes the requirements specified by CMS, the MAO failed to implement all aspects of the plan. The MAO failed to conduct- internal monitoring and auditing activities of the various functions of the company. Therefore, the MAO had not identified areas that require corrective action. Data collection was documented. However, tracking, trending and evaluation of the data were not available. The approval dates for the compliance policies and procedures are 2005 (no day or month)and 6/14/2007. The first signature approval for the policy was dated 6/14/2007.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/11/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

Based on the samples reviewed, it was determined that the MAO did not always notify its members of its decisions within 30 days following the receipt date of an oral or written grievance. Three of 15 cases revealed untimely responses and/ or no evidence of a response to members. In addition, a Complaint Description and Resolution document contained date discrepancies when compared to the internal complaint log. Eight of 15 cases indicated that member grievances were actually resolved prior to the MAO receiving the complaint.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/16/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

WHP does not meet the CMS 95% compliance standard because CMS reviewed 10 cases from the universe of 10 and found 7 cases where WHP did not document the ride-along with supervisory staff training or the results of the shadowing process per WHP policies and procedures (WHP-SM-SAL-010). Additionally, each sales rep was given a Medicare Basics exam, however in cases #4, #6, #8, #9, the test results were not provided to determine if the rep met the minimum passing score of 70 percent (WHP-SM-SAL-005).

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 03/07/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

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:

WHP is not using OMB Approved No. 0938-0829 Form No. CMS-10003-NDP (June 2001) Notice of Denial of Payment. The denial reasons listed on the Explanation of Benefits form (EOB) do not clearly state the denial reason making it difficult for the member to understand the reason the claim was denied. The EOB did not include a date field.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/11/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

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:

The MAO did not submit a universe for this element. The MAO's rational for not submitting the universe was their interpretation that the universe addressed pre-service denial from members only. In addition, the MAO has stated that during the monitoring period, there were 135 request for services and 54 denials of services. Therefore, a universe could have been provided for a sample selection. After detailed discussions with the MAO staff, it was determined that the plan did have a universe of standard pre-service denials that could have been submitted for review.

Corrective Action Required:

The MAO must submit a universal of pre-service denials as directed in the original June 12, 2007.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/11/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

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:

The element is not met. The MAO did not submit a universe for this element. The MAO's rational for not submitting the universe was their interpretation that the universe addressed pre-service denial from members only. In addition, the MAO has stated that during the monitoring period, there were 135 request for services and 54 denials of services. Therefore, a universe could have been provided for a sample selection. After detailed discussions with the MAO staff, it was determined that the plan did have a universe of standard pre-service denials that could have been submitted for review.

Corrective Action Required:

The MAO must submit a universal of pre-service denials as directed in the original letter dated June 12, 2007.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 02/26/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

The MAO did not submit a universe for the requested expedited organizational determinations. During discussions with the MAO staff and the review of the submitted documentation, it was determined that the MAO was unable to produce a report that could provide the requested information. It was stated that the medical management support system used during the audit period did not have an indicator field to differentiate between expedited and standard organization requests. Therefore, CMS is unable to determine if the expedited requested were decided timely.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 02/26/2008
Element Release Date: 03/26/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date:
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

The MAO did not submit a universe for the requested expedited organizational determinations. During discussions with the MAO staff and the review of the submitted documentation, it was determined that the MAO was unable to produce a report that could provide the requested information. It was stated that the medical management support system used during the audit period did not have an indicator field to indicate expedited or standard organization requests. Therefore, CMS is unable to determine if the expedited requested notices contained the required content.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/11/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.

Deficiencies:

Due to the MAOs inability to submit a universe for organization determinations, CMS was unable to determine the MAO's ability to correctly identify cases. CMS could not assured that the MAO can correctly distinguish between organization determinations and reconsiderations as required.

Corrective Action Required:

The MAO must submit a universal of pre-service denials as directed in the orginal June 12, 2007.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/11/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.

Deficiencies:

This element is not met. Although the MAO has written policies in place regarding physician participation, the MAO has not followed its procedures in a timely manner as evidenced by the findings in the sample review for worksheet PR1: Provider Credentialing. Forty percent of the samples reviewed did not meet CMS requirements for PR03. The eight provider samples were not credentialed although they were contracted and referenced as participating providers with the MAO at least six months prior to committee review of the pending credentialing files.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 02/27/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

This element is not met. Eight of the 20 samples reviewed did not meet CMS requirements. Those sample numbers are 6,12,13,14,15,16,18 and 20. The eight provider samples were not credentialed although they were contracted and referenced as participating providers with the MAO at least six months prior to review of the credentialing files. Six of the 8 samples, numbers 6,12,14,16,18, and 20 are also listed in the MAO's provider directory for enrollee selection. The 8 non-credentialed providers began participating with the MAO as early as 1/1/07. Upon review of their credentialing files, there is no evidence of any credentialing activity, i.e., OIG sanction list, verifying licensure, etc, for at least five months after provider participation. During the discussion with the credentialing staff, they indicated that they routinely reviewed the OIG sanction list and verified licensure prior to network participation. However, the staff stated that they reviewed these elements online, but did not retain hardcopy proof. Six additional provider samples reviewed reflected current credentialing, but according to MAO records, they were participating at least six months prior to credentialing committee approval. For samples 6 and 14, the reviewer was unable to determine the facilities where privileges are granted. The validation forms for hospital privileges in the credentialing files did not specify the names of the facilities. In January 2007, the MAO expanded to 24 additional counties which included Arkansas and Mississippi. In early 2007, the MAO identified their deficiency in provider credentialing. They implemented a corrective action plan to reach out to providers regarding submission of applications for credentialing, hired new staff and contracted with a CVO.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/16/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

Windsor Health Plan (WHP) did not meet the CMS 95% Compliance Standard because CMS reviewed 3 cases of a universe of 10 for favorable claims reconsideration and found WHP did not meet the compliance standard for timely payment. The cases were #3, #7, and #10. According to 42CFR 422.590(b)(1)and the Managed Care Manual Ch.13-Section 140.1.3, If the MAO completely reverses the initial adverse organization determination (i.e., initial claim denial), the organzation must pay for the service no later than 60 calendar days after the date it receives the request for reconsideration.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/16/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

Windsor Health Plan does not meet the CMS 95% Compliance Standard because CMS reviewed 2 cases from a universe of 2, and found that in case #1 of WS-RP3 WHP issued a notice of decision not to expedite a reconsideration. WHP's notice to the enrollee did not meet CMS requirements mandated in 42CFR 422.584(d)(2) Chapter 13 of the Medicare Managed Care Manual, Sect. 80.1. The notice failed to explain that the MAO will automatically tranfer and process the enrollees request using the 30-day time frame for standard reconsiderations. Also, the notice does not inform the enrollee of the right to resubmit a request for an expedited reconsideration.

Corrective Action Required:

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.

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: 9137

Region: 04 Atlanta

Contract Number / Name: H5698 WINDSOR HEALTH PLANS, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/18/2007
Element Accepted Date: 01/16/2008
Element Release Date: 04/29/2008
CAP Released Date: 04/29/2008

Visit Start Date: 9/18/2007
Exit Conference Date: 09/19/2007
Date Report Issued: 11/02/2007
Date Report Due: 11/03/2007
CAP Accepted Date: 04/29/2008
Audit Closed Date: 04/29/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/17/2007

Requirement:

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.

Deficiencies:

Windsor Health Plan does not meet the CMS 95% Compliance Standard because CMS reviewed 2 cases from a Universe of 2, and found that in case #1 of WS-RP3, the MAO granted an extension on a reconsideration. The written notice sent to the member did not include the reasons for the delay. Per 42CFR 422.590(a)(1),42CFR 422.590 (d)(2) and Chapter 13 of the Medicare Managed Care Manual Sect. 80.1, "When the Medicare Advantage Plan extends the time frame, it must notify the enrollee in writing of the reasons for the extension..."

Corrective Action Required:

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.