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: 8057

Region: 09 San Francisco

Contract Number / Name: H2931 HEALTH PLAN OF NEVADA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/15/2007
Element Accepted Date: 10/24/2007
Element Release Date: 10/24/2007
CAP Released Date: 01/29/2008

Visit Start Date: 7/17/2007
Exit Conference Date: 07/18/2007
Date Report Issued: 08/31/2007
Date Report Due: 09/01/2007
CAP Accepted Date: 11/09/2007
Audit Closed Date: 01/29/2008
Element Projected Completion Date:
MCO Response Due Date: 10/15/2007

Requirement:

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.

Deficiencies:

Based on a review of 20 provider contracts from a universe of 3850, the reviewer found 14 contracts non-compliant with the CMS requirement. The provider contracts have not been updated with 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."

Corrective Action Required:

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.

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Region: 09 San Francisco

Contract Number / Name: H2931 HEALTH PLAN OF NEVADA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/15/2007
Element Accepted Date: 11/04/2007
Element Release Date: 11/04/2007
CAP Released Date: 01/29/2008

Visit Start Date: 7/17/2007
Exit Conference Date: 07/18/2007
Date Report Issued: 08/31/2007
Date Report Due: 09/01/2007
CAP Accepted Date: 11/09/2007
Audit Closed Date: 01/29/2008
Element Projected Completion Date:
MCO Response Due Date: 10/15/2007

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:

Health Plan of Nevada/Sierra Health Services did not meet CMS 95% compliance standard for this element. CMS reviewed 15 grievances from a universe of 15 and found that in one case the notice was not issued within 30 days.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8057

Region: 09 San Francisco

Contract Number / Name: H2931 HEALTH PLAN OF NEVADA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/15/2007
Element Accepted Date: 11/04/2007
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CAP Released Date: 01/29/2008

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Audit Closed Date: 01/29/2008
Element Projected Completion Date:
MCO Response Due Date: 10/15/2007

Requirement:

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.

Deficiencies:

Health Plan of Nevada/Sierra Health Services did not meet the 95% compliance standard for this element. CMS reviewed 15 grievances from a universe of 15 and found that three notices did not address the members complaint.

Corrective Action Required:

Refer to the corrective action required for element GV03.

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Findings: NOT MET

Review ID: 8057

Region: 09 San Francisco

Contract Number / Name: H2931 HEALTH PLAN OF NEVADA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/15/2007
Element Accepted Date: 11/04/2007
Element Release Date: 11/04/2007
CAP Released Date: 01/29/2008

Visit Start Date: 7/17/2007
Exit Conference Date: 07/18/2007
Date Report Issued: 08/31/2007
Date Report Due: 09/01/2007
CAP Accepted Date: 11/09/2007
Audit Closed Date: 01/29/2008
Element Projected Completion Date:
MCO Response Due Date: 10/15/2007

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:

CMS originally reviewed 30 non-contracted provider denied claims processed by Health Plan of Nevada/Sierra Health Services. However, one of the cases was misclassified so the number of cases actually reviewed was 29 non-contracted provider denied claims. The denial notices used by Health Plan Nevada/Sierra Health Services comprise of an Explanation of Benefits (EOB) and the Important Information about a Member's Appeal Rights. All 29 of the EOBs reviewed contained truncated descriptions of the service being denied in a specified column. According to Health Plan Nevada\Sierra the truncation is due to system formatting issues because the column is limited to a specific amount of characters (i.e. when the description of Clinic Visit/Encounter Service is entered it gets truncated to read Clinic Visit/Enc¿ instead). Many of the truncated descriptions used did not clearly describe the medical services being denied. For 19 of the 29 denied claims, the CMS reviewer found the written denial notice should have clearly described the medical services denied or provide a clear and accurate reason to the member for denying the claim. It is important that a member understands what service is being denied and why it was denied so the member could make an informed decision to file an appeal if he/she disagrees with the claim denial. The two most common problems found with the descriptions were either they were truncated to the point in which the service being denied was not recognized or that they used complex medical service coding terminology that may not be recognized by the beneficiary. Both examples are provided below: Seven of the denial notices contain abbreviated descriptions of physician/provider visit that may not be recognized by the member. For example denied samples 2,12,14 describe services as New Outpt L4, Est Outpt L3E, New Outpt L2. Denied samples 6, 15, 16, 25 describe services as Tx, 1Area,15. These are all standardized descriptions for coding of medical services that would be understood by the provider but not necessarily so to the beneficiary. The beneficiary should be given a clear description of what services were denied. Twelve of the denial notices (cases 3, 4, 9, 10, 11, 17, 19, 23, 26, 27, 28, 29) used truncated descriptions that did not clearly describe the service being denied. For example case 3 states Health and B in the service column when it should state Health Behavioral and Assessment. Other examples such as in cases 9 and 11 state service as Extended Care when it should have noted that the extended care was for a wheelchair. The beneficiary was not given a clear description of what was denied. Since 19 claims out of a sample of 29 and a universe of 128 does not meet the compliance standard, the element is Not Met.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8057

Region: 09 San Francisco

Contract Number / Name: H2931 HEALTH PLAN OF NEVADA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/15/2007
Element Accepted Date: 10/26/2007
Element Release Date: 10/26/2007
CAP Released Date: 01/29/2008

Visit Start Date: 7/17/2007
Exit Conference Date: 07/18/2007
Date Report Issued: 08/31/2007
Date Report Due: 09/01/2007
CAP Accepted Date: 11/09/2007
Audit Closed Date: 01/29/2008
Element Projected Completion Date:
MCO Response Due Date: 10/15/2007

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:

Based on a review of 10 files for adverse standard pre-service organization determinations from a universe of 92, the reviewer found 3 cases non-compliant with the CMS requirement to process pre-service organization determinations within 14 calendar days. In one case, the decision was 1 day late. In a second case, the decision was 4 days late. In the third case, the decision was 11 days late.

Corrective Action Required:

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.