CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0011, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: AA201
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 02/12/2008
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. Although SHMD providers have adequate access to its terms and conditions, many providers continue to report that they are unable to discuss the factors involved in becoming a deemed provider with someone at the plan. Providers report that they are unable to discuss payment amounts with a knowledgeable person at the plan and that requesting a supervisor or other contact is usually unsuccessful. CMS requires that PFFS organizations be able to demonstrate sufficient access to providers, by evidencing an efficient claims processing system capable of calculating proper reimbursement for covered services, recognizing when services are covered by Medicare and by establishing a provider dispute process that is capable of analyzing the Medicare guidelines and taking appropriate action to make revised decisions when plan systems are incorrect. Over the course of 2006 and 2007, providers have made numerous complaints to CMS about the disparity in payment amounts determined by SHMD when compared to Medicare payment rates. During the months of March, April and May 2007, CMS brought to SHMD attention numerous instances where providers had been unable to navigate through SHMD customer service. These providers could not get satisfactory resolution to their disputes, despite providing evidence of differing payments from Medicare. Frustrated providers have advised CMS that they may consider terminating deemed relationships with SHMD in the future. Additional evidence indicates that SHMD does not have an effective process in place to identify and maintain information relative to National Coverage Decisions (NCD) and Local Medical Review Policy (LMRP), critical elements of an effective claims processing system. Several complaints were determined to be related to this failure. Providers report that they are unable to discuss these issues or communicate with anyone at SHMD to resolve their problems.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: GV01

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date: 11/20/2007

Element Accepted Date: 04/02/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 08/07/2007

Exit Conference Date: 08/29/2007

Date Report Issued: 10/09/2007

Date Report Due: 10/13/2007

CAP Accepted Date: 04/07/2008

Audit Closed Date:

Element Projected Completion Date: 09/30/2008

MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. SHMD has been providing weekly reports to CMS since late 2006 which detail the numbers of grievances received by the organization. The reports reflect both verbal and formal grievances. Given the high number of complaints that have been raised to CMS regional offices and through CTM, the numbers reflected on those reports do not appear to be representative of the true number of grievances brought to the organization. Additionally, in preparation for this audit, SHMD was asked to provide a universe of grievances which involved access issues. SHMD was unable to produce a valid universe of this category of grievances that was representative of the range of complaints that had been brought to the plan¿s attention. CMS reviewers identified additional access grievances which should have been included in the sample through its own records. Many of these complaints or grievances had already been received through customer service. This indicates that verbal complaints are not being coded properly by customer service staff.

Corrective Action Required:

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.

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MRT Number: M0011, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: GV02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 02/15/2008
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. CMS reviewed 3 categories of grievances for this review; verbal grievances submitted through Customer Service, written or formal grievances, and grievances filed by members who have encountered difficulty in finding a provider willing to accept the plan. The formal grievances reviewed were consistent with the plan¿s process and provided a timely resolution and adequate notification. Review of verbal grievances indicated that customer service representatives failed to document that issues were forwarded to appropriate operational components for follow up actions. For example, 5 verbal grievances included complaints about the beneficiary¿s interaction with a sales agent, but only 1 case documented that the complaint was forwarded for agent investigation. It was also apparent that some of the resolutions provided to beneficiaries were incomplete or incorrect. When members brought sales complaints to the attention of the customer service representative, the beneficiary was advised that they were locked in and could not disenroll. CMS has advised SHMD that any allegation of misinformation should be treated as a request for retroactive disenrollment and should be forwarded to CMS for action. Additionally, insufficient action was evident in all of the complaints involving access issues. CMS reviewed complaints from beneficiaries which alleged that their provider refused to accept the plan or that they were unable to locate a provider willing to accept the plan¿s terms and conditions. The SHMD resolution for the member was a form letter that reminded the beneficiary about their ability to obtain care from any provider willing to accept the plan¿s terms and conditions. While technically accurate, this was certainly not a reasonable response to a complaint from a member who was unable to find a provider willing to work with the plan.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 12/20/2007
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 12/31/2007
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. Secure Horizon Medicare Direct (SHMD) was asked by CMS in August of 2006 to implement an outbound verification program for newly enrolled Medicare beneficiaries. This request was made in response to numerous complaints from beneficiaries who had been enrolled into these plans without their full knowledge and consent. Newly enrolled beneficiaries were to receive an outbound verification call to ensure that the agent accurately presented the PFFS plan, did not pressure the beneficiary to enroll and to provide an opportunity for the beneficiary to request disenrollment or cancellation as appropriate. Guidelines were established to select members for outbound calls based upon several factors including agent performance, complaint data, and service area specific criteria. Due to lower than anticipated enrollment volume, SHMD agreed to select 100% of newly enrolled beneficiaries for outbound calling, providing certain criteria was present. It was subsequently discovered that as a result of an administrative error that only 53% of the newly enrolled members actually were selected for outbound verification. Although the plan knew of the reduced numbers of outbound calls being performed, this information was not shared with CMS who was monitoring the performance and outcomes of the outbound verification call process. Additionally, the plan took no immediate action to rectify the administrative error that deselected almost half of the newly enrolled members from the verification process until CMS was made aware of the issue.

Corrective Action Required:

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.

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MRT Number: M0011, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR08
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 12/20/2007
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 12/31/2007
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. Beginning in early 2006 CMS brought to SHMD numerous instances of allegations of inappropriate sales and marketing activities conducted by employed and contracted sales representatives. The allegations covered a wide range of inappropriate sales methods, many of which were designed to confuse and mislead beneficiaries. In response to those allegations, throughout 2006 SHMD worked to enhance and improve its oversight of sales agents, establish acceptable guidelines for agent performance, implement a more effective investigative process to analyze sales complaints and to take appropriate action in response to those investigations. Unfortunately, complaints continue to be received by CMS and other regulatory bodies that indicate the problems persist. CMS reviewed and analyzed a sample of 20 complaints involving allegations that agents misled or failed to provide accurate information to Medicare beneficiaries during the election process. CMS evaluated whether the plan followed its own guidelines for incident investigation and took corresponding corrective action with agents as appropriate. Of the 20 cases reviewed, CMS found that SHMD did not always take timely or appropriate action in response to the performance demonstrated by the agents involved in the complaint. Delays were noted when agents were asked to provide SHMD with information relative to the incident. Plan guidelines in existence at the time were not always followed which allowed the agents in question to continue to represent SHMD and enroll additional Medicare beneficiaries. In some samples where re-training was recommended as corrective action, evidence of the training was unavailable. CMS found that the time involved in the investigation process and ultimate decision making was too long. These delays resulted in additional complaints from beneficiaries. In 10 of the sales incident samples reviewed, the agent involved had already been terminated based upon previous complaints. CMS reviewed the 20 sales agent files representing the agents involved in the complaints referenced above, to verify that SHMD has an effective process in place to document all required data elements such as sales agent¿s licensure, specific Medicare and product training provided, performance on tests, pertinent information on sales complaints, commissions paid, chargeback data, rapid disenrollment and that SHMD has a documented process for recording information appropriately in sales rep files relative to agent performance and corrective actions required. The results of this review determined that most of the files reviewed did not consistently reflect all required documentation.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 04/02/2008
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 01/01/2009
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. CMS reviewed 30 denied claims. In 5 of the samples reviewed, SHMD failed to make the proper determination on the original claim. For 3 of the 5 cases referenced, SHMD communicated the denial using an incorrect or unclear denial reason to the provider. The Provider Remittance Advice (PRA) conveys denial information to the provider. This notice provides the reason for the denial and also whether there is member liability for the services rendered. SHMD does not pend claims and relies on its denial communications to inform providers of the correct reason for denial and what may be needed to re-process claims. For this reason it is critical that denial notices, the PRA and other forms of correspondence, convey accurate information. Additionally, throughout 2006 and 2007 CMS has received numerous complaints from providers stating that services that are routinely paid for by Original Medicare are denied by SHMD. Many of the complaints raised to CMS attention have resulted in corrected claim determination and additional payments. Systemic issues have been identified and for which SHMD has made changes to its coverage guidelines. These continued complaints are further demonstration that despite the lessening of the number of complaints received by CMS, that problems continue to exist.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 04/02/2008
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 01/01/2009
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. The Explanation of Benefits (EOB) is the document used by SHMD to convey all determinations related to claims payment to beneficiaries. This review examined 30 EOBs generated for denied claims and also looked at 28 EOBs while reviewing provider disputes. SHMD does not consistently reflect services denied to providers as member denials. In some cases, the amount denied to the provider is reflected as not-covered, but other times it is not. In most instances, the amount reflected as not covered is not reflected as member liability, but the denial reason is silent with respect to whether the member is in fact liable. Additionally, many of the reasons used to convey denial information to the member are not understandable and not useful to the member. Members are not clear on what has been denied, what they may be liable for and not enough information is provided for the member to successfully appeal the determination.

Corrective Action Required:

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.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: OC201

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date: 11/20/2007

Element Accepted Date: 02/15/2008

Element Release Date: 07/24/2008

CAP Released Date:

Visit Start Date: 08/07/2007

Exit Conference Date: 08/29/2007

Date Report Issued: 10/09/2007

Date Report Due: 10/13/2007

CAP Accepted Date: 04/07/2008

Audit Closed Date:

Element Projected Completion Date: 06/30/2008

MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. See findings for AA201 and PR206.

Corrective Action Required:

See CAR for AA201 and PR206.

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Findings: NOT MET

Review ID: 8797

Region: 09 San Francisco

MRT Number / Name: M0011 MRT United Healthcare

Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: PR03

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date: 11/20/2007

Element Accepted Date: 12/20/2007

Element Release Date: 07/24/2008

CAP Released Date:

Visit Start Date: 08/07/2007

Exit Conference Date: 08/29/2007

Date Report Issued: 10/09/2007

Date Report Due: 10/13/2007

CAP Accepted Date: 04/07/2008

Audit Closed Date:

Element Projected Completion Date: 09/30/2007

MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. SHMD does not have an effective process in place to identify physicians who have opted out of the Medicare program. At the time of this review, SHMD shared with CMS that it would implement a process to review the Medicare Opt Out list quarterly, identify providers who may have submitted claims for reimbursement and flag those providers for future claims received. These activities will ensure that providers who have opted out will be identified and prohibited from receiving payment for services provided. These processes were to be in place by the close of Q3 2007.

Corrective Action Required:

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

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Contract Number / Name: H5435 UNITED HEALTHCARE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: PR206
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 11/20/2007
Element Accepted Date: 04/07/2008
Element Release Date: 07/24/2008
CAP Released Date:

Visit Start Date: 08/07/2007
Exit Conference Date: 08/29/2007
Date Report Issued: 10/09/2007
Date Report Due: 10/13/2007
CAP Accepted Date: 04/07/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 11/23/2007

Requirement:

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.

Deficiencies:

The requirement is not met. CMS reviewed 28 provider appeals to assess the plan¿s process in resolving these disputes. Overall, this review finds that SHMD is not able to demonstrate an effective process for the resolution of provider disputes related to payment or coverage of Medicare services. The specific issues identified in the review of disputed cases are as follows: 1) The SHMD provider dispute process allows a 30 day timeframe for the processing of provider disputes at either the reconsideration or appeal levels. 4 of the case files reviewed could not provide evidence of the actual request for review or the date received. 9 additional sample cases were not processed within the 30 day timeframe as required by plan guidelines. 2) 3 cases reviewed did not follow the SHMD provider dispute process by eliminating the reconsideration phase. Instead, the provider¿s dispute was elevated to the appeal level without provision of the reconsideration phase of review. 3) SHMD failed to appropriately develop issues presented by providers in their disputes. This was especially true of the reconsideration phase of the appeal process. In several cases, evidence of Medicare payments or additional documentation regarding payment amount or coverage was provided, but SHMD took no action to review or analyze the additional information prior to making its revised decision. In some samples, providers requested that they discuss the issue under dispute and in no case was there any evidence that the plan made contact with the provider. Additionally, as stated in element AA201, SHMD does not have an automated system in place to incorporate the review of NCD and LMRP in its coverage determination process. One sample case reviewed contained evidence of a demonstration project in place that provided coverage for the service in question. Despite that evidence from the provider, the appeal was upheld by SHMD in error. Other instances of similar situations have been brought to CMS attention throughout 2007. 4) Reconsideration determinations to providers are frequently not clear. Some of the notices provided no useful information to the provider about what might be necessary to make a revised decision. Denial reasons were frequently changed from one level of appeal to the next, making it extremely difficult for providers to successfully rebut the determination. In none of these cases was the appeal process extended to allow additional levels of appeal given the change in denial reasons. Rather, the final appeal letter explains to the provider that the decision is final, no further appeal is possible. None of the correspondence to providers contains information about the opportunity to submit evidence from Medicare demonstrating a different payment amount.

Corrective Action Required:

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.