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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: AA05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 10/18/2006
Element Release Date: 10/01/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Services Provided with Cultural Competence - The M+CO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. Does not apply to non-network PFFS plans.

Deficiencies:

The requirement to provide all services with cultural competence is not met. The MAO provided one sample case file for Access and Availability complaints. The beneficiary called and complained about quality of care and cost sharing issues. The customer service representative documented the beneficiary's inability to write. However, the appeal department staff told the member that "Members cannot file appeals verbally." The appeals department staff did not provide the beneficiary with an alternative process to ensure the enrollee's right to appeal.

Corrective Action Required:

To meet this requirement the MAO must: 1. Provide the MAO's revised policies and procedures to ensure that all MAO services are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. 2. Conduct training of MAO staff on these policies and procedures and submit documentation that details the nature of the training, the materials used, the dates of training, individuals conducting the training and the individuals trained.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/05/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Required Contract Provisions: Abide by Federal Requirements - The M+CO's written contracts, service agreements or terms and conditions of payment with first tier and downstream entities must: 1) contain a provision to show that the contracting entity will comply with Medicare laws, regulations, reporting requirements, and CMS instructions; 2) agree to audits and inspection by CMS and/or its designees; 3) cooperate, assist, and provide information as requested; and 4) maintain records a minimum of 6 years.

Deficiencies:

Sterling provided 9 administrative service agreements and one provider agreement. Of those, 7 agreements did not contain the language to maintain records a minimum of 10 years. The reviewer notes that the MAO recently conducted an internal audit of contracts using the 2004 PFFS Monitoring Guide. The guide was released prior to the January 28, 2005 release Medicare Program; Establishment of the Medicare Advantage Program; Final Rule. Therefore, this finding was not identified in the internal audit. Inconsistencies in contract language related to record retention led the reviewer to believe that the MAO does not have adequate oversight over the area responsible for contract maintenance. There was no evidence of oversight of MA contract language requirement changes.

Corrective Action Required:

To comply with the requirement the MAO must: 1. Establish a mechanism for ongoing oversight of the area responsible for contracting and provide the RO with a description of established oversight mechanisms. 2. Provide CMS with a plan for revising MAO contracts and agreements including, revised language, timing of contract revision and responsible party. 3. Provide CMS with revised contracts.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: CN09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/05/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Adequate Compliance Plan - The M+CO must have a formalized compliance plan that contains the requirements specified by CMS.

Deficiencies:

This requirement is not met based on the review of the MAO's written Compliance Plan, internal reports, and interviews with the Compliance Officer and staff. The compliance plan provided by the MAO appeared to be a high -level planning document, rather than an actual detail of processes conducted (i.e., a work plan). The reviewer did not find evidence of a risk assessment being conducted by the MAO to respond promptly to detected problems with the MA program. During interviews, the reviewer requested a detailed compliance plan and schedules of compliance activities for 2006. The MAO then stated that they are in the process of developing the workplan.

Corrective Action Required:

To meet this requirement the MAO must: 1. Provide a written compliance plan that includes policies and procedures that describe specific activities to ensure compliance, frequency at which the activities are to be conducted, methodologies to be used for internal audits and the method of documenting and reporting the results to appropriate management staff. 2. Develop and provide the MAO's detailed work plan, including all of the activities to be undertaken and/or overseen by the Compliance Officer and related support staff, timeframes for completion and staff responsible for internal audits.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: DG01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/09/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Oversight of Delegated Entities with Chapter 4 Responsibilities - If any of the activities or responsibilities for the above elements in Chapter 4 are delegated to other parties, the M+CO must oversee them per CMS standards.

Deficiencies:

This requirement is not met. The MAO did not provide evidence that it has effective oversight processes to comply with this requirement. The MAO delegates all operations to a TPA. The reviewers interviewed TPA staff in each of the non-compliant operational areas. The reviewers determined that internal audits are conducted and findings are identified. However, the reviewers were unable to determine, whether the findings are reported to management and whether anyone monitors corrective actions to ensure that identified deficiencies are corrected and the MA requirements are met.

Corrective Action Required:

To comply with this requirement the MAO must: 1. Establish and maintain effective oversight controls over delegated entities and ensure the MAO maintains compliance for MA operations. 2. Submit policies and procedures that describe the types of oversight activities the MAO will implement over its delegated entities. 2. Provide a schedule of the MAO's oversight activities for its delegated entities. 3. Develop reporting capabilities for oversight of each operational area that is being delegated. 4. Coordinate report format with the RO. 5. When the report format is finalized, implement reporting processes. 6. Beginning with the first month following the CAP acceptance provide the RO with oversight reports for 6 months or until the MAO reaches full compliance, with CMS requirements.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

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 reviewer determined the organization does not meet CMS' 95% required compliance in this area. The universe size was 1206. The Sample size was 15 (N=15). The reviewer determined that 7 of the 15 (47%) grievance sample case files indicate the organization does not appropriately resolve member concerns that do not fall within the purview of the Medicare appeal process. In addition, the reviewer determined the organization does not appropriately and in a consistent manner notify members of grievance resolutions. Twelve of 15 (80%) grievance sample files indicate the organization does not appropriately adjudicate grievances in a consistent manner according to its internal policies and procedures or the organization's member's Evidence of Coverage (EOC). In addition, the reviewer identified the following: 1.The organization does not disseminate grievance information to its other Medicare departments in a consistent manner, 2.The organization uses inconsistence internal practices and procedures in this area, 3.The use of inappropriate letters to members regarding their complaints that often contained inaccurate information, 4.Failure to support the effectuation of resolution due to lack of documentation, 5.Lack of internal oversight or internal auditing of this area which would allow the organization the opportunity to correct deficiencies in this area in an effective and consistent manner As a PFFS plan, the organization operates in several states. This may require the organization to have multiple state grievance processes which may be more complex or restrictive than federal requirements in order to comply with applicable state laws within the organization's approved service area. As such, PFFS plans may have multiple state grievance processes or requirements in place. The reviewer found no evidence that the inconsistencies notes during this review were a result of multiple state requirements. Nor did the organization offer multiple state requirements as a justification for the inconsistent process that was noted during this review. The organization does not delegate any functions in this area.

Corrective Action Required:

1. The organization must establish and maintain effective oversight controls of grievances. The organization must submit policies and procedures, which describes the type of oversight activities it will implement. Policies and procedures must include responsible staff members and time frames for completion of tasks. 2. The organization must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. 3. The organization must conduct routine internal audits of grievances and submit internal findings to the RO per the instructions of the RO plan manager. 4. The organization must: develop and implement policies and procedures that ensure the organization is also compliant with federal and state grievance requirements, train appropriate staff on these policies and procedures, submit documentation to the regional office that details the nature of this training, including; the materials used in the training, the individuals conducting the training, and the individuals being trained. 5. The organization must review and revise member correspondence in order to ensure that members receive accurate information in language that is clear and understandable to beneficiaries.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: GV02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date:10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date:04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date:02/19/2007
MCO Response Due Date: 09/28/2006

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 organization does not meet the CMS 95% compliance standard. Twelve of 15 (80%) grievance sample files indicate the organization does not appropriately adjudicate grievances in a consistent manner according to its internal policies and procedures or the organization's member's Evidence of Coverage (EOC). See additional comment under element GVO1.

Corrective Action Required:

1.The organization must establish and maintain effective oversight controls of grievances. The organization must submit policies and procedures which describes the type of oversight activities it will implement. Policies and procedures must include responsible staff members and time frames for completion of tasks. 2. The organization must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. 3. The organization should conduct routine internal audits of grievances. The organization should submit a summary report once a quarter to the RO of its monthly findings until further notice. See final report for submission guidance. 4. The organization must: develop and implement policies and procedures that ensure the organization is also complaint with federal and state grievance requirements, train appropriate staff on these policies and procedures, submit documentation to the RO that details the nature of this training, including; the materials used in the training, the individuals conducting the training, and the individuals being trained. 5. The organization must review and revise member correspondence in order to ensure that members receive accurate information in language that is clear and understandable to beneficiaries.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/05/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

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 MAO did not meet the 95% compliance standard. CMS reviewed 28 WS OC01 (Correct Claim Determinations) case files from a universe of 8669 and found that 7 claims cases were not adjudicated correctly. In 4 cases claims were not developed for missing or incorrect information and the beneficiary's EOB stated that the beneficiary would be financially responsible. In 2 cases the claims processor had selected an incorrect provider or pay to provider record, resulting in the claim adjudicating to the incorrect provider. In 1 case the claim denied in error for no CLIA#. The CLIA# had been provided on the claim. The provider filed a complaint with LA DOI, and Sterling eventually reprocessed the claim and paid the provider using the CLIA# originally provided.

Corrective Action Required:

The MAO must revise the policies and procedures that instruct claims processing staff to develop a claim for missing or incorrect information. The MAO must conduct training of appropriate staff on these policies and procedures and submit documentation to the RO that details the nature of the training, including: the curriculum and materials used in training, the individuals who conducted the training, and the staff who attended the training. The MAO must conduct an audit of the denied claims. The audit should evaluate whether the claims processor developed the claims for missing information appropriately, prior to denying the services. In addition, the audit must include verifying the claims processor selected the correct provider of service record. The MAO must submit a summary report monthly to the RO of its findings beginning the first month following acceptance of the CAP. The summary report should include: title and name of the auditor(s), the audit methodology, and the results of the audit findings. The MAO must continue reporting this information to the RO for six consecutive months, or until compliance with CMS requirements is reached and sustained. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance with CMS requirements.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/05/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Interest on Clean Claims Paid Late - If the M+CO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and (C).

Deficiencies:

The MAO did not meet the 95% standard. CMS reviewed 1 case for WS 0C04 (Interest on Clean Claims Paid Late). The case was incorrectly controlled with the Claims Department receipt date of 2/8/06, in error. The correct Mailroom receipt date is 2/3/06, five days earlier. The claim paid in 34 days on 3/9/06, without an interest payment calculation.

Corrective Action Required:

The MAO must conduct training of appropriate staff on identifying and controlling claims with the correct receipt date. The MAO must submit documentation to the RO that details the nature of the training including: the materials and curriculum used in training, the individuals conducting the training, and the individuals trained. The MAO must establish and maintain effective oversight controls over its delegated entity ASI, to ensure that claims are controlled with the correct receipt date. The MAO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entity, to ensure this element is met.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/05/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

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 MAO did not meet the 95% standard. CMS reviewed 28 WS OC06 (Claim Denials, Notice Content) case files from a universe of 8669 and found that 25 cases were not denied appropriately. In 25 cases the denial was not clearly stated on the Explanation of Benefits (EOB). The denial notice did not include the denied service or specific reason for the denial which would be clear and not confusing or misleading to the beneficiary.

Corrective Action Required:

The MAO must conduct training of appropriate staff on applying the appropriate denial code messages on claims, to ensure the beneficiary has a clear understanding of the service denied and the specific reason for the denial. The MAO must submit documentation to the RO that details the nature of the training including: the materials and curriculum used in training, the individuals who are conducting the training, and the individuals trained. The MAO must conduct a monthly internal audit of the denied claims and the denial code messages generated, on the EOBs. This audit must evaluate whether the appropriate denial code message provided on the EOB to the beneficiary was clear and not misleading. The MAO must submit a summary report monthly to the RO of its audit findings, beginning the first month following acceptance of the CAP. The summary report should include: title and name of the auditor(s), the audit methodology, and the audit findings. The MAO must continue reporting this information to the RO for six consecutive months, or until compliance with CMS requirements is reached and sustained. The MAO must provide the RO with a complete listing of EOB and Explanation of Payment (EOP)denial message codes. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: PR203
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 04/06/2007
Element Release Date: 10/16/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 03/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Enforcement of Limit - The M+CO must enforce any balance billing limit established by the plan.

Deficiencies:

The requirement to enforce balance billing limits established by the plan is not met. The MAO provided 20 case files for worksheet AA10 from a universe of 262. Of these, one case was misclassified. This case was related to premium payment, not cost shares. In 10 cases, 52% of the cases reviewed, the reviewer could not determine that the billing issues presented were completely resolved and the limit was enforced. The MAO's MIS reports of "Open Issues" provided additional evidence that the MAO does not resolve billing issues presented timely or consistently, resulting in repeat inquiries by beneficiaries and providers. In addition, the case files indicated the MAO did not consistently follow its internal processes for appeals and grievances. Beneficiaries in two (2) cases reported they did not receive the services billed to the MAO. Both cases were handled by MAO staff as MA appeals. However, these cases should have been processed as grievances. The MAO did not have a fraud and abuse process for MA claims. The MAO also, did not provide evidence it addresses the issue of inappropriate beneficiary billing when providers refuse to bill Sterling.

Corrective Action Required:

To meet the requirement to enforce the balance billing limit the MAO must: 1. Provide a description of processes that the MAO will use to ensure that the balance billing limit is enforced and revise applicable procedures and workflows including all steps in the process, timeframes and the individual responsible to ensure compliance. 2. Develop and implement oversight processes to ensure that issues submitted by beneficiaries are correctly identified and fully resolved. 3. Provide a description of processes to protect beneficiaries when providers refuse to bill Sterling, include timeframes for each step and the individuals responsible to ensure compliance. 4. Develop and implement reports on the MAO's timeliness of response and resolution of balance billing issues 5. Submit these reports to the RO monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the organization reaches full compliance with CMS requirements. 6. Develop and provide procedures for addressing potential fraud complaints under the MA plan.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: PR206
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 02/15/2007
Element Release Date: 10/09/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/18/2007
MCO Response Due Date: 09/28/2006

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 MAO did not meet the CMS 95% compliance standard for processing provider payment appeals. CMS reviewed 19 cases from a Universe of 295. In 5 of the 19 cases reviewed, the MAO did not process the disputes timely. In 6 of the 19 cases, the reviewer was unable to determine whether the dispute was completely resolved. In addition, when a dispute response was provided, the MAO did not consistently provide a clear explanation of actions taken by the MAO. Providers could not determine if further action was necessary on their part. In several of the cases reviewed, providers made multiple written requests to the MAO regarding a particular payment issue but received no written response from the MAO. One case was directed to the MAO's second level process and was forwarded to compliance for review. However, the case file was not processed until it was pulled for the CMS review. The provider payment appeal exceeded the MAO's established timeframe for processing by 147 days.

Corrective Action Required:

To comply with the requirement for a provider payment appeal system the MAO must: 1. Provide a description of processes the MAO will use to ensure that providers receive complete responses to all issues in their inquiries. 2. Develop a process for handling corrected claim submissions versus provider payment disputes and provide materials the MAO will use to educate providers on the process. 3. Develop a description of the process the MAO will use to ensure that provider disputes are processed within the MAO's timeliness standards. Include copies of any tools the MAO will use for oversight of the process. 4. Provide a copy of training materials the MAO will use to ensure the MAO's consistency in handling provider complaints including: documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained. 5. Develop reports on the timeliness of response and resolution of provider payment issues. 6. Submit compliance reports to the RO monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance, with CMS requirements.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: QY02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/17/2007
MCO Response Due Date: 09/28/2006

Requirement:

Adequate Health Information System - The M+C PFFS plan must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement and support the activities of the QAPI program.

Deficiencies:

The organization's health information system or data collection system is not able to collect, integrate, and analyze information and report data necessary to ensure: information and data received from providers is accurate, timely and complete; integrate data from various sources, including member concerns and complaints; formalize processes to analyze data, and address identified deficiencies in reported data through provider education or other corrective actions as noted above. The reviewer determined the organization was not compliant in this area by review of the organization's Information Systems (IS) and IS departmental integration (specifically the organization's call tracking system); policies and procedures, internal audit reports, and staff interviews.

Corrective Action Required:

The organization must enhance its health information system in order to ensure it is capable of collecting, integrating, analyzing and disseminating information throughout the organization and report data that will allow management to efficiently address identified deficiencies, and maintain and sustain compliance in this area.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: QY05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 01/17/2007
MCO Response Due Date: 09/28/2006

Requirement:

Significant Problems Corrected - The M+CO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Deficiencies:

The reviewer found no evidence that the organization has internal activities to correct or improve issue resolution processes or make improvements that address other system or administrative issues identified through complaints, internal audits or internal reports. As a result, management was unable to assess the organization's compliance with CMS' Medicare operational and administrative requirements on an on-going basis to ensure sustained compliance and to ensure it is reported to senior management. The lack of management oversight in this area contributed to deficiencies in the following Medicare operational areas: grievances, appeals, claims, and provider relations. Lack of compliance in these areas was further compounded by the recent growth of the organization's Medicare enrollment and the turnover of key staff positions.

Corrective Action Required:

The organization must develop and maintain internal oversight of Medicare operations, specifically in the area of grievances. Oversight must include the development of internal audit reports that will allow management the ability to analyze on-going compliance and disseminate information throughout the organization. The organization must appropriately train staff and revise all policies and procedures that impact this area in order to ensure its ability to effectively identify and correct deficiencies and maintain and sustain compliance in this area.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 10/19/2006
Element Release Date: 10/12/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date:
MCO Response Due Date: 09/28/2006

Requirement:

Favorable Claims Reconsiderations (Timeliness) - If the M+CO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Deficiencies:

The CMS review determined this universe is misclassified. 4 of the 10 cases reviewed were misclassified as appeals.

Corrective Action Required:

Provide CMS with a representative Universe for this element.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RE01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/09/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date:
MCO Response Due Date: 09/28/2006

Requirement:

Acceptance of Standard Reconsideration Requests - The M+CO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).

Deficiencies:

This requirement for acceptance of standard reconsideration requests is not met. The MAO provided policies, procedures and workflows of the appeals process. However, the documentation for MAO staff was incomplete. This created problems in the identification and processing of appeal requests. The review of case files found inconsistency in MAO identification of appeals versus general complaints and their processing and resolution. Also, the reviewer found evidence of additional steps taken by the MAO that were not included in the documented process provided to CMS.

Corrective Action Required:

To meet the requirement for acceptance of standard reconsiderations the MAO must: 1. Revise policies and procedures to describe the actual appeal process the MAO uses. Include workflow of the process with timeframes for each step. 2. Develop a description of the process for accepting an appeal when the beneficiary is unable to write. 3. Develop staff training on the revised appeal process and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RE02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Appropriate Person(s) Conduct the Reconsideration - A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not, in all cases, be of the same specialty or subspecialty as the treating physician.

Deficiencies:

The reviewer did not find evidence that the MAO has a written process to meet this requirement. The MAO's case files provided evidence that 2 staff members review the reconsiderations prior to sending to the IRE. However, the process flow provided was incomplete and did not include information regarding this step of the reconsideration review.

Corrective Action Required:

To comply with the requirement to have appropriate persons conduct the reconsideration: Develop a description of the processes the MAO will use to ensure that persons who were not involved in the initial organization determination conduct the reconsideration. Include updated workflows and a description of staff training on the process.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the M+CO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The M+CO must concurrently notify the member of this action.

Deficiencies:

The MAO did not meet the 95% compliance standard. In 2 of the 9 cases provided, the MAO did not process the case timely and/or correctly. The cases contained requests from beneficiaries that were not processed and resolved correctly by the MAO.

Corrective Action Required:

To comply with the requirement the MAO must: 1. Develop a description of the process it will use to ensure the beneficiary's appeal requests are processed correctly. Include copies of revised procedures and workflows. 2. Develop a description of the oversight process the MAO will implement to ensure compliance in this area. 3. Develop training for MAO staff responsible for appeals and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.

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: 4942

Region: 10 Seattle

Contract Number / Name: H5006 STERLING LIFE INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/28/2006
Element Accepted Date: 12/19/2006
Element Release Date: 10/10/2007
CAP Released Date: 10/16/2007

Visit Start Date: 6/27/2006
Exit Conference Date: 06/30/2006
Date Report Issued: 08/14/2006
Date Report Due: 08/14/2006
CAP Accepted Date: 04/06/2007
Audit Closed Date: 10/16/2007
Element Projected Completion Date: 02/19/2007
MCO Response Due Date: 09/28/2006

Requirement:

Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal, or pay the claim following the plan's normal claims processing procedures.

Deficiencies:

The MAO did not meet the 95% compliance standard. Of the 9 cases reviewed, only 2 cases applied to this sample element. In 1 of the 2 cases that applied, the reviewer could not make a determination whether the effectuation was completed due to incomplete information contained in the sample case file. The reviewer checked the status of the case with the IRE and discovered that the case had actually been dismissed but there was no supporting documentation provided in the case file.

Corrective Action Required:

To meet the requirement to effectuate reversals the MAO must: 1. Provide a description of processes the MAO will use to assure that beneficiary's appeal requests are processed correctly and all steps are completed in the process. Include copies of revised procedures and workflows. 2. Develop a description of the oversight process the MAO will implement to ensure compliance in this area. 3. Develop staff training on these policies and procedures and submit documentation that details the nature of the training, dates training provided, the individuals conducting the training and the individuals trained.