CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0009, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET
Region: 09 San Francisco
MRT Number / Name: M0009 MRT Pacificare
Contract Number / Name: H2949 HUMANA HEALTH PLAN, INC.

Review ID: 7297

Auditing Guide Version: MA Monitoring Review Guide, Version 3
Auditing Element: OC01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 07/06/2007
Element Accepted Date: 01/22/2007
Element Release Date: 10/11/2007
CAP Released Date: 10/11/2007

Visit Start Date: 04/10/2006
Exit Conference Date: 04/12/2006
Date Report Issued: 05/30/2006
Date Report Due: 05/27/2006
CAP Accepted Date: 01/22/2007
Audit Closed Date: 10/11/2007
Element Projected Completion Date:
MCO Response Due Date: 07/14/2006

Requirement:

Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, ambulance services dispatched through 911, emergency services, urgently needed services, post-stabilization care services and renal dialysis services that Medicare members obtain while temporarily out of the service area.

Deficiencies:

The requirement is not met. CMS reviewed 30 denied claims processed by the PCNV delegated claims processor from a universe of 305. Of the 30 claims reviewed, CMS found that 4 of the claims were either denied incorrectly or were not developed properly. CMS determined that 3 claims were denied improperly as the claims represented services provided out of the service area that would have met the criteria for urgent or emergent out of area care. The plan acknowledged that authorizations were in place for other services provided during the episode of care for 2 of the 3 incorrect determinations noted in this report. Subsequently these claims were overturned and paid. One claim was not developed properly and contained evidence that the requested medical documentation was not available from the billing company and that the plan would have to request such documentation from the provider. The plan failed to make that request and denied the claim without initiating the proper development.

Corrective Action Required:

PCNV must continue to monitor the accuracy of denial determinations made by its delegated claims processing entity. PCNV must implement a more comprehensive oversight program to address the delegate's failure to make appropriate determinations on non-contracted provider claims. Please submit evidence of the oversight process currently in place and the enhancements made to the program to specifically address the issue of incorrect denial determinations.