# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** MR01
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/29/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.

**Reference:**

42 CFR § 423.50(a)(1); § 423.50(a)(3); MA-PD Solicitation; Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS requested Part D notice templates that United uses in the following situations: - informing enrollees about inquiries involving excluded drugs (i.e., a notice consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug), - informing enrollees of grievance deadline extension (i.e., a notice consistent with Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance), and - enrollee notification that a request for an expedited coverage determination is denied (i.e., a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance). These notice templates did not display the contract/MRT number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed a sample of 15 standard grievances from a universe of 281 and found that 14 samples were noncompliant as UnitedHealth notified enrollees of the grievance resolution with notices that were not CMS compliant. Specifically, in 14 out of 15 samples the notice did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines. CMS reviewed a sample of 10 standard redetermination requests for drug benefit from a universe of 228 and found that 6 out of 10 samples were noncompliant. Six out of 6 samples did not demonstrate the use of a CMS-approved Request for Reconsideration notice, specifically it did not display the contract numbers (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guidelines and of these, 4 samples also did not demonstrate the use of a CMS - approved Notice of Redetermination. CMS reviewed a sample of 10 standard redetermination requests for payment from a universe of 71 and found that 8 out of 10 samples were noncompliant. Seven out of 8 samples did not demonstrate the use of CMS-approved notices, Request for Reconsideration notice and Notice of Redetermination, specifically they did not display the contract numbers (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left-hand corner in accordance with CMS Marketing guideline. One out of the 8 samples did not demonstrate the use of a CMS-approved Notice of Redetermination and a Notice of Redetermination was not provided. CMS reviewed a sample of 10 requests for expedited redeterminations from a universe of 88 and found that 7 out of 10 samples were noncompliant. Specifically, 7 out of 7 samples did not demonstrate that UnitedHealth used CMS-approved notices when informing the enrollee of an adverse decision. UnitedHealth did not provide a CMS-approved Notice of Redetermination and the Request for Reconsideration notice. The notice did not display the contract number (and CMS approval date if it was filed under the normal marketing review submission process) in the lower left -hand corner in accordance with CMS Marketing guidelines.

**Corrective Action Required:**

UnitedHealth must provide CMS with a CMS-approved or accepted notice for the following model notices: - Notice of Inquiry Regarding an Excluded Drug, - Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, and - Notice of Right to an Expedited Grievance. UnitedHealth must notify enrollees of the grievance resolution using CMS compliant notices. Specifically, the notice must display the contract number if it was accepted under File and Use, or the contract number and CMS approval date if it was submitted through the normal marketing review submission process in the lower left-hand corner. UnitedHealth must conduct training of appropriate staff on the use of this notice template and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When a standard redetermination concerning drug benefit decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide notices that are CMS compliant. Specifically, UnitedHealth must provide CMS approved Request for Reconsideration and Notice of Redetermination and provide documentation demonstrating this to CMS. When a standard redetermination concerning payment decision is adverse, UnitedHealth must notify the enrollee using CMS-approved notices. Specifically, the notices provided should be consistent with the Notice of Redetermination and Request for Reconsideration. UnitedHealth must provide documentation demonstrating this to CMS.

# *CMS Part D Audit Report*
## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Audit ID:** 3563
**Contract Number:** H2949
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** MR06
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 12/1/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.

**Reference:**

Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS requested documentation demonstrating that UnitedHealth conducts ongoing monitoring of the marketing activities of internal and external marketing representatives. UnitedHealth did not provide documentation confirming that the UnitedHealth's marketing representatives are providing the required written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. CMS reviewed 10 sample contracts for individuals who perform marketing from a universe of 13,963 and found that 8 out of 10 samples were not compliant. Specifically, 7 out of 10 did not demonstrate the individual performing marketing was state licensed, certified or registered. Additionally, 1 out of 10 samples did not demonstrate the following: - a provision prohibiting payments by person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan.' - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws).

**Corrective Action Required:**

UnitedHealth must provide CMS with documentation that its marketing program monitoring activities confirm that UnitedHealth's marketing representatives are providing the written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. An example of acceptable documentation for this is completed copies of the field evaluation tool/sample form used by sales managers/directors in conducting evaluations of sales agents. UnitedHealth must develop a process for ensuring that the persons conducting marketing for its 'Part D' plans are state licensed, certified, or registered and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement. UnitedHealth must amend its contracts for persons conducting marketing for its Part D plans to include the following: - a provision prohibiting payment by the person performing marketing to beneficiaries, - a provision to withhold or withdraw payment if an enrollee disenrolls in an unreasonably short timeframe, - a provision requiring any person directly employed or contracted to market on behalf of UnitedHealth provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and states that the written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with UnitedHealth. The person may be compensated based on your enrollment in a plan,' and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal health care laws (including civil monetary penalty laws). UnitedHealth must provide CMS with a copy of the language in the amendments and inform CMS when all amendments are issued and in effect.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CN05
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/25/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Required Contract Provisions: Long-Term Care Pharmacies - The Part D sponsor¿s written contracts with network long-term care pharmacies must include the CMS-specified performance and service criteria for long-term care pharmacies. Note: This element is waived for MA-PFFS organizations that offer a Part D Benefit if they (i) provide plan enrollees access to covered Part D drugs dispensed at all pharmacies without regard to whether they are contracted network pharmacies, and (ii) do not charge cost-sharing in excess of that required for qualified prescription drug coverage.

**Reference:**

42 CFR § 423.120(a)(5); MA-PD Solicitation; Long Term Care Guidance

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed 5 contracts with network long term care pharmacies, from a universe of 459 and found two of the 5 samples did not demonstrate that written contracts with network long-term care pharmacies included the CMS-specified performance and service criteria for long-term care pharmacies. Specifically the contracts did not include the provisions for: Comprehensive inventory, Operations and Prescriptions Orders, Special Packaging, IV Medication, Drug composition, Pharmacist on Call, Delivery of Service, Emergency Boxes, Emergency Log Books, Ordering Supplies, and Pharmacy Contract Compliance. Upon re-request, UnitedHealth provided a cross-walk indicating the performance and service criteria were located in Exhibit 1.3. However, the Exhibit 1.3 submitted for two samples (Minimum Qualifications for Participation in Pharmacy Network) did not contain the required provisions.

**Corrective Action Required:**

UnitedHealth must provide CMS with documentation demonstrating that it has executed written contracts with network long-term care pharmacies which include the CMS-specified performance and service criteria for long-term care pharmacies. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD01
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 5/9/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Notices in Network Pharmacies - The Part D sponsor must arrange with its network pharmacies to post or distribute notices instructing enrollees to contact their plans to obtain a coverage determination or request an exception if they disagree with the information provided by the pharmacist.

**Reference:**

42 CFR § 423.562(a)(3); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception (Medicare Part D-Formulary Management: Policy Number CPS-026) and found it did not include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. Additionally, CMS reviewed UnitedHealth's documentation demonstrating that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception and found it did not demonstrate that UnitedHealth's network pharmacies meet the requirement for posting or distributing notices.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures (Medicare Part D-Formulary Management: Policy Number CPS-026) regarding notices in network pharmacies that provide instructions for obtaining a coverage determination or requesting an exception to include a provision for sending the 'Medicare Prescription Drug Coverage and Your Rights' notice to the location in the LTC facility designated to accept such notices or, if the network or preferred pharmacy is on-site, it must deliver the notice described above to the location in the LTC facility designated to accept such notices. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, UnitedHealth must demonstrate that it conducts ongoing monitoring of network pharmacies to ensure they are posting or distributing notices regarding procedures for obtaining a coverage determination or requesting an exception. Examples of acceptable documentation include pharmacy audits.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD02
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/28/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Coverage Determination Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for coverage determinations (expedited and standard) regarding basic coverage and supplemental benefits, and the amount, including cost sharing, if any, that the enrollee is required to pay for a drug. These procedures must address unplanned transitions, and actions that are coverage determinations as defined in § 423.566(b). The Part D sponsor must establish and maintain efficient and convenient means for individuals (including enrollees, their appointed representatives, or their prescribing physicians) to submit oral or written requests for coverage determinations, document all oral requests in writing, and maintain the documentation in a case file. The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely review and resolution of all enrollee requests for re-determinations, reconsiderations by the Independent Review Entity (IRE), and reviews by the Administrative Law Judge (ALJ) received both orally and in writing.

**Reference:**

42 CFR § 423.566(a); § 423.566(b); § 423.566(c); § 423.570(c)(1-2); MA-PD Solicitation; Reporting Requirements Section VII: Appeals Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process', CW MM-AP-109 `Medicare Part D Prescription Drug Appeals': CPS 028 `Medicare Part D Transition Process') and found that the policies did not include a provision defining coverage determinations in accordance with § 423.566(b)(1-5). Only a brief description was provided in policy CPS 027. Additionally, UnitedHealth's policies and procedures regarding reporting requirements for appeals data elements did not contain a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals. During Staff Discussions, UnitedHealth stated that its Prior Authorization System (PAS) tracks and maintains data required for CMS's quarterly reporting. In order to demonstrate compliance with CMS requirements this provision must be included in written policies and procedures.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures for receiving, tracking, addressing, and maintaining records of coverage determinations(CPS 027- 'Medicare Part D - Coverage Determination and Exceptions Process': CW 'MM-AP-109 'Medicare Part D Prescription Drug Appeals': CPS 028 'Medicare Part D - Transition Process') to include provisions that fully incorporate the definition of a coverage determination as defined in § 423.566(b)(1-5). Additionally, UnitedHealth must revise its policies and procedures regarding reporting requirements for appeals data elements to include a provision for quarterly reporting of all data requested in Reporting Requirements: Appeals.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Audit ID:** 3563
**Contract Number:** H2949
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD03
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 3/7/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

**Reference:**

42 CFR § 423.568(a); § 423.568(e); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 'Medicare Part D - Coverage Determination and Exceptions Process', CPS 028 'Medicare Part D Transition Process') and did not find provisions stating that: - failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. - UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in the quotation marks was not found. CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefit from a universe of 13,201 and found 4 out of 10 samples were noncompliant. Specifically, 4 out of 10 samples did not demonstrate that UnitedHealth provided timely notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of UnitedHealth's decision within a timeframe that is CMS compliant constitutes an adverse coverage determination requiring UnitedHealth to forward the enrollee's case file to the IRE within 24 hours of the adjudication timeframe. UnitedHealth did not demonstrate that the four case files were forwarded to the IRE. Furthermore, during Staff Discussions, UnitedHealth staff stated that they respond to ALL coverage determination requests as exceptions requests, and that the timeframe does not begin until receipt of the physician's supporting statement. Per Chapter 18 of the Prescription Drug Benefit Manual, only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding enrollee notification of coverage determinations concerning drug benefit (CPS 027 'Medicare Part D Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe 'constitutes an adverse coverage determination' requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination `as expeditiously as the enrollee's health condition requires', but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks must be added. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS. UnitedHealth must process coverage determination requests in accordance with Chapter 18 of the Prescription Drug Benefit Manual. UnitedHealth must ensure that only for exceptions requests does the timeframe for processing a coverage determination begin upon receipt of the physician's supporting statement. For all other coverage determination requests, the timeframe begins when the request is received by the plan. UnitedHealth must conduct training of appropriate staff on this process and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*
# Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD04
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.

**Reference:**

42 CFR § 423.568(b); § 423.568(e); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policy and procedure regarding enrollee notification of coverage determinations concerning payments (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') and did not find provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. CMS reviewed a sample of 10 requests for standard coverage determinations concerning payment from a universe of 2303 and found that 10 out of 10 samples were noncompliant. Specifically, 10 out of 10 samples did not demonstrate that UnitedHealth provided timely notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of UnitedHealth's decision within a timeframe that is CMS compliant constitutes an adverse coverage determination requiring UnitedHealth to forward the enrollee's case file to the IRE within 24 hours of the adjudication timeframe. UnitedHealth did not demonstrate that the ten case files were forwarded to the IRE.

**Corrective Action Required:**

UnitedHealth must revise its policy and procedure regarding enrollee notification of coverage determinations concerning payment (CW MM-AP-109 `Medicare Part D Prescription Drug Appeals') to include the following provisions stating that: - UnitedHealth must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement, - UnitedHealth must make payment (i.e. mail the payment) within 30 calendar days of the request or, for an exceptions request, after receiving the physician's supporting statement, and - failure to notify the enrollee within the timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. UnitedHealth must conduct training of appropriate staff on this policy and procedure and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

# *CMS Part D Audit Report*
## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD09
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 3/7/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

**Reference:**

42 CFR § 423.570(e); § 423.572(a-b); § 423.572(d); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D Transition Process') and found that the policies did not include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), `as expeditiously as the enrollee's health condition requires', but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. Specifically, the language in quotation marks was not found. CMS reviewed a sample of 10 requests for expedited coverage determinations from a universe of 749 and found that in 3 out of 10 samples UnitedHealth did not demonstrate timely notification of the decision to the enrollee. Failure to notify the enrollee of UnitedHealth's decision within a timeframe that is CMS compliant constitutes an adverse determination requiring UnitedHealth to forward the enrollee's case file to the IRE within 24 hours of the adjudication timeframe. UnitedHealth did not demonstrate that two of the case files were forwarded to the IRE.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 `Medicare Part D Coverage Determination and Exceptions Process': CPS 028 `Medicare Part D Transition Process') to include provisions stating that: -failure to notify the enrollee within the timeframe constitutes an adverse determination requiring UnitedHealth to forward the enrollee's request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe, and -UnitedHealth must make its expedited coverage determination and notify the enrollee (and/or other applicable party) of its decision (adverse or favorable), as expeditiously as the enrollee's health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician's supporting statement. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must always notify the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If UnitedHealth fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, UnitedHealth must forward the case file to the IRE within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CD10
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 3/7/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Notice Content Requirements for Expedited Coverage Determination - The notice of any expedited coverage determination must state the specific reasons for the determination in understandable language. If the determination is not completely favorable, the notice must also: (i) include information concerning the enrollee¿s right to a redetermination; (ii) describe both the standard and expedited redetermination processes, including the enrollee¿s right to request, and conditions for obtaining, an expedited redetermination, and the rest of the appeals process; and (iii) comply with any other requirements specified by CMS.

**Reference:**

42 CFR § 423.572(c); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D- Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') and found that the policies did not include a provision stating that if oral notice is provided for adverse decisions, then the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. The above noted provisions were found in policy 'CPS 027 'Medicare Part D-Coverage Determination and Exception Process', page 5, § 1.5 but were only applicable to written notices.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited coverage determination (CPS 027 - 'Medicare Part D- Coverage Determination and Exceptions Process': CPS 028 'Medicare Part D - Transition Process') to include a provision stating that if oral notice is provided for adverse decision, the notices must satisfy the following requirements: - states the specific reason for the denial and take into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any. - provides information regarding the right to appoint a representative to file an appeal on the enrollee's behalf. - provides a description of both the standard and expedited redetermination processes and timeframes, including conditions for obtaining an expedited redetermination, and the rest of the appeals process. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CE01
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 3/7/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

**Reference:**

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D-Coverage Determination and Exceptions Process') and found the policy did not include a provision stating that if the Plan Sponsor requires a written statement from the enrollee's prescribing physician, the request must be done immediately.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding processing requests for exceptions to its tiered cost-sharing structure (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that if the Sponsor requires a written statement from the enrollee's prescribing physician, the Plan Sponsor must request a written statement immediately. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Audit ID:** 3563
**Contract Number:** H2949
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** CE02
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 3/7/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Exceptions Procedures and Criteria (Non-Formulary Drugs) - The Part D sponsor must establish and maintain exceptions procedures, subject to CMS¿ approval, for receipt of an off-formulary drug. The Part D sponsor must grant an exception for a non-formulary Part D drug whenever it determines that the drug is medically necessary, consistent with the prescribing physicians¿ statement that meets CMS criteria, and that the drug would be covered but for the fact that it is an off-formulary drug. The Part D sponsor¿s formulary exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

**Reference:**

42 CFR § 423.578(b); § 423.578(b)(1); § 423.578(b)(2); § 423.578(b)(5); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') and found it did not include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors listed below has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug: (1) All covered Part D drugs on any tier of a Part D sponsor's formulary would not be as effective for the enrollee as the non-formulary drug, and/or would have adverse effects: (2) The number of doses available under a dose restriction for the prescription drug: (a) Has been ineffective in the treatment of the enrollee's disease or medical condition or, (b) Based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (3) The prescription drug alternative(s) listed on the formulary or required to be used in accordance with step therapy requirements: (a) Has been ineffective in the treatment of the enrollee¿s disease or medical condition or, based on both sound clinical evidence and medical and scientific evidence, the known relevant physical or mental characteristics of the enrollee, and known characteristics of the drug regimen, is likely to be ineffective or adversely affect the drug's effectiveness or patient compliance: or (b) Has caused or, based on sound clinical evidence and medical and scientific evidence, is likely to cause an adverse reaction or other harm to the enrollee. Section 3.3.1.1 of CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process' states that to determine medical necessity all of the above criteria must be met: this is more stringent for the enrollee than CMS requires.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding processing requests for exceptions for non-formulary drugs (CPS-027 'Medicare Part D - Coverage Determination and Exceptions Process') to include a provision stating that the Part D sponsor must grant a formulary exception when it determines that one of the three factors stated above has been demonstrated, and the drug would be covered but for the fact that it is an off-formulary drug. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** GV01
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Complaint Categorization (Grievances vs. Coverage Determinations) - The Part D sponsor must promptly and correctly determine and inform the enrollee whether a complaint is subject to its grievance procedures or its coverage determination procedures.

**Reference:**

42 CFR § 423.564(b); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed a sample of 15 standard grievances from a universe of 281 and found 5 samples were noncompliant. Specifically, in 5 out of 15 samples, the samples were incorrectly categorized as they were not Part D standard grievances. The incorrectly categorized samples were: an inquiry (1), reimbursement requests (2), a redetermination request (1), and a coverage determination request (1).

**Corrective Action Required:**

UnitedHealth must correctly categorize all requests that are specific to its Part D benefit as inquiries, grievances, coverage determinations or appeals and submit documentation demonstrating this to CMS

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** GV02
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/27/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Grievance Policies and Procedures - The Part D sponsor must establish and maintain policies and procedures for tracking and addressing the timely hearing and resolution of all oral and written enrollee grievances including but not limited to the following: fraud and abuse, enrollment/disenrollment, benefit package, pharmacy access/network, marketing, customer service, confidentiality/privacy, and quality of care. The Part D sponsor must also maintain records of such grievances.

**Reference:**

42 CFR § 423.562(a)(1)(i); § 423.564(a-b); § 423.564(g); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Reporting Requirements for Section V: Grievances

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) and found it did not include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding reporting requirements for grievances data elements (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision for quarterly reporting of all data requested in Reporting Requirements: Grievances. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** GV03
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 1/1/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Grievance Process Training - The Part D sponsor will train relevant staff and subcontractors on its grievance policies and procedures.

**Reference:**

MA-PD Solicitation

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth¿s policies and procedures regarding grievance process training ('Ovations Appeals and Grievances Training Process Summary') and found it was dated December 2007 which is outside of the audit period. UnitedHealth was unable to provide the auditors with a policy regarding grievance process training which contained the required provisions and was in effect during the audit period.

**Corrective Action Required:**

UnitedHealth submitted to the audit team a policy and procedure entitled 'Ovations Appeals and Grievances Training Process Summary', dated post-audit period (12/2007) that includes the required provisions. Therefore, no corrective action is required for this element.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** GV04
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification of Grievance Disposition - The Part D sponsor must notify the enrollee of its decision as expeditiously as the case requires, based on the enrollee¿s health status, but no later than 30 days after the date the Part D sponsor receives the oral or written grievance (or an additional 14 days if an extension is requested by the enrollee or justified by the Part D sponsor). If the Part D sponsor extends the deadline, it must immediately notify the enrollee in writing of the reason(s) for the delay.

**Reference:**

42 CFR § 423.564(e)(1-2); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth¿s policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) and found it did not include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. CMS reviewed a sample of 15 standard grievances from a universe of 281 and found that 3 were noncompliant. Specifically, in 2 of the 15 samples UnitedHealth did not demonstrate that the enrollee was notified within CMS compliant timeframes. Additionally, in 1 out of 15 samples UnitedHealth did not demonstrate that the issue was resolved or that the enrollee was notified within CMS compliant timeframes of the grievance resolution.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding enrollee notification of grievance disposition (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132 (approved 5-9-07)) to include a provision stating that the enrollee must immediately be notified in writing when UnitedHealth extends the deadline. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. UnitedHealth must provide documentation to CMS that demonstrates it notifies enrollees of its standard grievance decisions within the CMS compliant timeframes, and that it documents the resolutions to enrollees' grievances.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** GV07
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Response to Expedited Grievances - The Part D sponsor must respond to an enrollee¿s grievance within 24 hours if the complaint involves a refusal by the Part D sponsor to grant an enrollee¿s request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

**Reference:**

42 CFR § 423.564(f); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) and found it did not include the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding timely response to expedited grievances (Ovations Medicare Part D Prescription Grievance Process, policy number: CW-MM-AP-132) to include a provision stating the 24-hour timeframe for responding to an enrollee's expedited grievance if the complaint involves a refusal by the Part D sponsor to grant an enrollee's request for an expedited coverage determination or an expedited redetermination, and the enrollee has not yet purchased or received the drug that is in dispute. UnitedHealth must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE03
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Decision to Accept or Deny Request for Expedited Redetermination - The Part D sponsor must promptly decide whether to expedite the redetermination if it determines, based on the enrollee¿s request, or as indicated in the prescribing physician¿s request, that applying the standard timeframe for making a redetermination may seriously jeopardize the enrollee¿s life, health, or ability to regain maximum function.

**Reference:**

42 CFR § 423.584(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and found it did not include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding decisions to accept or deny requests for expedited redeterminations (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating that any additional medical information UnitedHealth requires, must be requested within 24 hours of receiving the initial request for an expedited redetermination. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Audit ID:** 3563
**Contract Number:** H2949
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE05
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

**Reference:**

42 CFR § 423.590(a)(1-2); § 423.590(c); § 423.590(g)(1-4); § 423.636(a)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') and found it did not include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CMS reviewed a sample of 10 standard redetermination requests for drug benefit from a universe of 228 and found that 2 out of 10 samples were noncompliant. Specifically 1 sample did not demonstrate that the enrollee was provided with a Request for Reconsideration notice. Additionally, 1 sample did not demonstrate that the enrollee was notified of the redetermination decision in a timeframe that is CMS compliant, nor did it demonstrate that the case file was forwarded to the IRE.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning covered drug benefit (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning drug benefit decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE06
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification and Effectuation of Standard Redetermination Concerning Payment - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its adverse coverage determination, it must issue its redetermination (in writing for the adverse redeterminations) no later than 7 calendar days from the date it received the request, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must authorize the payment within 7 calendar days from the date it receives the request for redetermination. It must then make the payment no later than 30 calendar days after the date it receives the request for redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

**Reference:**

42 CFR § 423.590(b-c); § 423.590(g)(1-4); § 423.636(a)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') and found it did not include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. CMS reviewed a sample of 10 standard redetermination requests for payment from a universe of 71 and found that 3 out of 10 samples were noncompliant. Two out of the 10 samples did not demonstrate that the enrollee was notified of the redetermination decision in a timeframe that is CMS compliant, nor did documentation demonstrate that case files were forwarded to the IRE. One out of the 10 samples did not demonstrate that payment was provided in a timeframe consistent with CMS requirements.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding timely notification and effectuation of standard redeterminations concerning payment (CW-MM-AP-109 'Medicare Part D Prescription Drug Appeals') to include a provision stating that the Part D sponsor must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making a standard redetermination concerning payment decision, UnitedHealth must notify the enrollee in a timeframe that is CMS compliant. When a decision is not made within the CMS timeframes, UnitedHealth must forward the enrollee's case file to the IRE as CMS requires. For favorable standard redetermination concerning payment decisions, UnitedHealth must make the payment within 30 calendar days and provide documentation demonstrating this to CMS. Additionally, UnitedHealth must submit a new sample upon request from CMS to verify compliance with this requirement.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE07
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Notification of Expedited Redetermination and Request for Medical Information - If a Part D sponsor grants a request for expedited redetermination, it must complete its redetermination and give the enrollee (and the prescribing physician involved, as appropriate), notice of its decision as expeditiously as the enrollee¿s health condition requires but no later than 72 hours after receiving the request. If medical information is necessary, the Part D sponsor must make the request within 24 hours of receiving the initial request for an expedited redetermination. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

**Reference:**

42 CFR § 423.584(e); § 423.590(d-e); § 423.638(a); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and found it did not include provisions stating that: - medical information must be requested within 24 hours of the enrollee's initial request, and - UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures regarding enrollee notification following decision on expedited redeterminations and requesting medical information required for making a decision on an expedited redetermination (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and to include provisions stating that: - medical information must be requested within 24 hours of the enrollee's initial request, and - UnitedHealth must inform the enrollee, within 24 hours, when the case is forwarded to the IRE. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. When making an adverse expedited redetermination decision, UnitedHealth must always notify the enrollee of its decision and provide the enrollee with a request for reconsideration notice when applicable.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE09
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

**Reference:**

42 CFR § 423.590(f)(1-2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed a sample of 10 requests for standard redeterminations concerning drug benefits from a universe of 228 and found that 1 sample did not demonstrate that UnitedHealth uses appropriate personnel to conduct redeterminations. Specifically, in the sample the initial denial was based on lack of medical necessity and the redetermination was conducted by a pharmacist and not a physician with expertise in the field of medicine that was appropriate for the services at issue.

**Corrective Action Required:**

UnitedHealth must ensure that if the issue is a denial based on lack of medical necessity the redetermination must be made by a physician with expertise in the field of medicine that is appropriate for the services at issue and provide documentation to CMS demonstrating this.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RE10
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:**
**Element Release Date:**
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.

**Reference:**

Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) and found it did not include a provision stating that case files must be sent the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. During Staff Discussions, UnitedHealth stated that it faxes the IRE within a timeframe consistent with CMS requirements: however, this must be included in the written policies and procedures.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures for forwarding case files to the IRE upon the IRE's request in a timely manner (CW-MM-AP-109, Medicare Part D Prescription Drug Appeals) to include a provision stating case files must be sent to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time the IRE requests the case file. Additionally, UnitedHealth must revise its policies and procedures to include a provision stating that a hard copy of the case file must be delivered to the IRE by overnight delivery at its designated address, or by fax at its designated fax number. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Part D Audit Report*

## Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

**Findings:** Not Met
**Contract Number:** H2949
**Audit ID:** 3563
**Part D Sponsor Name:** HUMANA HEALTH PLAN, INC.

**Audit Guide Version:** MA-PD Sponsor Part D Audit Guide Version 1
**Auditing Element:** RV03
**Audit Type:** Routine
**Audit Location:** Desk Review
**Date Report Issued:** 1/28/2008
**Date Report Due:** 3/13/2008
**Element Accepted Date:** 4/14/2008
**Element Release Date:** 4/14/2008
**Element Projected Completion Date:** 2/26/2008

**3 Year Reporting Cycle:** 1/1/2006 - 12/31/2008
**Estimated Visit Start Date:** 12/10/2007
**Estimated Visit Start Date:** 12/14/2007
**Actual Visit Start Date:** 12/10/2007
**Actual Visit End Date:** 12/14/2007
**Part D Sponsor Response Received Date:**
**Part D Sponsor Response Due Date:** 3/13/2008
**CAP Release Date:**
**CAP Accepted Date:**

**Requirement:**

Effectuation of Third Party Reversals ¿ Benefits (Expedited) - If the expedited determination or expedited redetermination for benefits by the Part D sponsor is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 24 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

**Reference:**

42 CFR § 423.638(b); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

**Deficiencies:**

UnitedHealth does not meet this requirement because CMS reviewed UnitedHealth's policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit (Ovations Health Services Policy and Procedures Medicare D Prescriptions Drug Appeals, Policy number CW-MM-AP-109) and did not find a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision.

**Corrective Action Required:**

UnitedHealth must revise its policies and procedures for effectuating third party reversals on an appeal of an expedited request for a benefit, (Ovations Health Services Policy and Procedures Medicare D, Prescriptions Drug Appeals, Policy number CW-MM-AP-109) to include a provision stating that the benefit under dispute must be authorized or provided as expeditiously as the enrollee's health requires but no later than 24 hours after the date it receives notice reversing the decision. UnitedHealth must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.