CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET
Region: 02 New York
Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Review ID: 9637

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DG01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/11/2008
Element Release Date: 05/26/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

Reference: 42 CFR 422.502(i) Manual Ch. 11 section 100.2 Method of Evaluation: Determine if the MAO:1. Has a written agreement with the delegated entity/entities which specifies the delegated activities and reporting responsibilities of the entity and includes the revocation of the delegated activities and/or other remedies for inadequate performance2. Evaluates an entity¿s ability to perform the delegated activities prior to delegation3. Monitors an entity on an ongoing basis and formally reviews that entity at least once annuallyDocumentation Examples:· Contracts/written agreements with delegated groups· Initial assessment criteria for delegated entities· Delegated entity monitoring reports· Delegated services manual. This element is not met. CMS conducted interviews and reviewed documents in order to determine if MMM met the requirement of overseeing its delegated functions. CMS determined that MMM did not oversee the functions delegated to Medicare Dental Network (MDN). MDN provides dental services including oral surgery services to MMM members. Under terms of the agreement with MDN, all questions involving eligibility for benefits and interpretation of provisions of certain attached exhibits regarding benefits are determined by MDN. The agreement provided that the effective date for a dentist to participate in the network is the date of approval by the Credentialing Committee of MDN. The agreement also required MDN to engage in quality improvement activities. CMS found no evidence to show that MMM monitored the benefits related functions of MDN. CMS found no evidence to show that the credentialing function was monitored by MMM. CMS found no evidence to show that MMM monitored the quality improvement functions delegated to MDN. Based on the above, CMS determined that this requirement was not met.

Corrective Action Required:

MMM needs to review and revise its delegation policies as necessary to include oversight of all delegated entities. MMM is to submit a copy of such revised policies and procedures. MMM is to develop documentation form(s)that include all the elements that will be checked during the monitoring review. MMM is to submit the results of the initial monitoring. MMM is to provide a time table that shows how such monitoring will be continued and evaluated in the future.

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Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/08/2008
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CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.

Deficiencies:

The requirement is not met. In two of fifteen enrollment denials, the plan failed to correctly identify them as incomplete and failed to follow CMS requirements for requesting information from the beneficiaries to make the elections complete. Plan Policies and procedures were reviewed and found to be incomplete.

Corrective Action Required:

MMM must ensure that it correctly identifies incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete. Policies and procedures must be revised to include this process.

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Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
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Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.

Deficiencies:

The requirement is not met. The plan failed to issue an acknowledgment notices timely (required to be sent no later than 7 business days after receipt of the completed enrollment election) for three of thirty enrollment elections sampled.

Corrective Action Required:

MMM must ensure that it issues Acknowlegment notices timely in accordance with 42 CFR 422.60(e)(3) and Manual Chapter 2, Section 40.4.1.

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Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
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Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Enrollment Acknowledgement (Notice Content) - The written acknowledgement notice, sent in response to the beneficiary's enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.

Deficiencies:

The requirement is not met. Review of enrollment elections sampled revealed that the MMM acknowlegement notices are outdated and are missing required language per Chapter 2 of the Medicare Managed Care Manual, Section 40.4.1 and 42 Code of Federal Regulations 422.60(e)(3). Also refer to Exhibit 4: Model Notice to Acknowledge Receipt of Completed Enrollment.

Corrective Action Required:

While onsite, MMM staff made reference to new notices being entered into HPMS that included the updated language (i.e., OEP language. However, notices provided by Plan Manager, did not include the language and as a result, do not meet the CMS standards. Therefore, MMM must revise its Acknowledgement Notices in accordance with Chapter 2 of the Medicare Managed Care Manual. See Exhibit 4. The revised notice must be submitted to the Regional Office for review and approval.

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Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER10
Review Type: Routine
Review Status: Confirmed
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Element Accepted Date: 02/08/2008
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Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.

Deficiencies:

The requirement is not met. Notices for nine of fifteen CMS Enrollment Rejection sampled were found to have an incorrect reason for rejection. Some enrollments rejected because the wrong enrollment period was indicated on election form and subsequently submitted to CMS. Election periods for Dual eligible individuals were not submitted utilizing the Special Enrollment Period (SEP). Policies and procedures reviewed onsite (MBR002) did not include the IEP for Part D or the dual eligible SEP.

Corrective Action Required:

MMM must provide refresher training to its MA staff in the sales, membership and accounting, and customer service departments)on all Medicare Advatage election periods. Proof of such training must be submitted to the CMS Regional Office and must include: Attendance sheet and training course topics covered. Policies and procedures must be revised to include election period information as explained in Chapter 2 of the Medicare Managed Care Manual. MMM must pay particular attention to elections for dual eligible individuals which must be submitted utilizing the Special Enrollment Period (SEP) indicator for duals and the IEP for Part D. The revised policies and procedures must be submitted to the CMS Regional Office for review and approval.

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Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.

Deficiencies:

Sample is misclassified because more than 30% of the cases are marked as Misclassified. CMS auditor notes this element was deficient in the 2005 audit.

Corrective Action Required:

Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must conduct training of appropriate staff on appropriate identification of grievances, appeals and organization determinations. MMM must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, the individuals being trained, and methods of evaluation. CMS acknowledges MMM has begun implementing this process and has stated a completion date of 10/2007 Auditor notes that MMM has created a unit Quality and Production Scoring System (QPSS) to closely monitor grievance staff performance. The MCO should conduct monthly internal audits QPSS .The MCO should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the Regional Office within 15 days of th close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.¿ In addition, MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Grievance Decision Notification (Timeliness) The MAO must notify the member of its decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the compliant involves an MAO's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves an MAO's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee's grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies the need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.

Deficiencies:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
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CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.

Deficiencies:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
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Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
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MCO Response Due Date: 12/24/2007

Requirement:

Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.

Deficiencies:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit MMM is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that MMM has implemented an internal corrective action plan. MMM must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. MMM is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, MMM will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. MMM should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. MMM should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
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Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.

Deficiencies:

Element MR05 "Marketing Materials: Enrollment and Understanding of Plan Rules" is NOT MET. MMM does not meet the Method of Evaluation for the following: 1. Ensures that plan rules are completely explained during the enrollment process. Based on a review of performance data (inclusive in 8 out of 10 samples of Marketing Representatives Information) there is not sufficient proof that MMM has equipped their Marketing Representatives with the proper tools required to ensure that beneficiaries are receiving the complete rules of MMM during the enrollment process. This is due to improper filing and undisclosed information concerning performance data in the 2 out of 10 samples. 2. Ensures that beneficiary election decisions are based on complete and accurate information/documentation. On further review of performance data (inclusive in 8 out of 10 samples of Marketing Representatives Information) there is not sufficient proof that MMM takes inventory concerning Marketing Audit Results including rapid disenrollment rates and volume of retroactive disenrollments made and/or requested. In addition, in 10 files sampled, Member Grievance Cases against Marketing Representatives and Actions for Perceived Abuse were not recorded properly. 4 out of 10 records included improper Member Grievance and Perceived Abuse Action information.

Corrective Action Required:

MMM must supply in all Marketing Representatives files the proper information relaying to adherence to the Elements of MR05. MMM must provide a Corrective Action Plan (CAP) establishing the following: Marketing Representatives files must include performance data consisting of extensive information regarding MMM's system and maintenance of said system, which confirms that enrolled members are enrolled into MMM's MA/MAPD plan and comprehend the rules applicable under that plan. MMM must also provide a CAP establishing a process and maintenance of the said process, which outlines a procedure to monitor Marketing Representative information concerning rapid disenrollment rates and request and/or completion of retroactive disenrollments to CMS.

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Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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MCO Response Received Date:01/11/2008
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Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
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MCO Response Due Date: 12/24/2007

Requirement:

No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered;· Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000);· Offer gifts or payment as an inducement to enroll in the organization;·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

The Element is NOT MET. In 2 out of 10 records sampled, MMM has not provided sufficient proof and validation of testing and comprehension of the Medicare Program by individuals who sell/market. In 2 out of 10 records sampled, MMM has not provided sufficient proof and validation that evaluation and testing was completed. For the 2 cases there is no performance data and/or record of quota adherence and accuracy of enrollments. In 6 out of 10 cases MMM did not provide accurate information concerning recording of rapid disenrollment rates and charge-back to marketing/sales representatives who enrolled beneficiaries that subsequently disenrolled within 3 months or less. In addition, recording of supervisory review or disciplinary action taken for these agents with high disenrollment rates was not evident. In addition, 6 out of 10 marketing representative files sampled have either expired or no existing licensure to sell or market for MMM. This deficiency exist with contractors as well as direct employees.

Corrective Action Required:

In order to comply with CMS guidelines, MMM must provide and adhere to a process which confirms that marketing and sales representatives do not engage in activities which mislead, confuse or misrepresent the organization. The process should also include documented, effective training intended to equipt beneficiaries and/or their representative with the tools to make educated decisions regarding enrollment. MMM must keep consistant records regarding the following: 1. Trainings and employee examinations. 2. Performance data, including adherence to quotas, etc. 3. Rapid disenrollments and cancelations, including request for retro disenrollments. 4. Supervisory warnings and/or disciplinary actions. In addition, MMM must contractually comply with CMS guidelines to employ sales and marketing respresentatives who are licensed. All representatives should not be allowed to carry out sales and marketing duties for MMM without a current, validated and/or non-expired license.

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Auditing Element: OC01
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CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

This element is not met. In 14 out of 30 cases MMM failed to develop the claims for additional information as required. In the 1 case file submitted by APS, it was determined that APS failed to develop the claim for additional information as required. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN¿s ability to issue proper denials.

Corrective Action Required:

In accordance with Medicare Guidelines, MMM must make correct claim determinations for services obtained from non-contracting providers. MMM must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event MMM is unable to secure the necessary information MMM from the provider, within the 30/60 day timeframe, MMM may utilize the 14 day extension provision with proper documentation.

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Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
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Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).

Deficiencies:

Of the 2 claims not paid within 30 days APS failed to pay interest at the time of claim payment on both claims.

Corrective Action Required:

MMM must ensure that its delegated entities pay all clean claims exceeding 30 days are paid accordingly with interest.

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CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.

Deficiencies:

This element is met for MMM and the delegated entity APS, however it is not met for delegated entity MDN. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN's ability to receive and process claims within 60 days.

Corrective Action Required:

APS must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent, 2. Non-urgent, 3. Out of area care, 4. Not a covered service 5. Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). MMM must ensure that its delegated entity APS submits this information in accordance with the aforementioned instructions.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET
Region: 02 New York
Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Review ID: 9637

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/15/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.

Deficiencies:

In the case submitted by APS, the delegated entity failed to provide the member with the appropriate denial notice. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN's ability to issue proper denial notices.

Corrective Action Required:

If the Medicare plan or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any. MMM must ensure that it's delegated entities adhere to the aforementioned regulations.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP15
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 04/17/2008
Element Release Date: 04/17/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.

Deficiencies:

MMM is not using the current notice of non-coverage of Inpatient Hospital Care as required by CMS.

Corrective Action Required:

MMM is required to submit to CMS current notice of non-coverage of Inpatient Hospital Care for review and approval. Please ensure that the notice is approved through CMS Marketing process in HPMS.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/11/2008
Element Release Date: 05/27/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.

Deficiencies:

Reference:42 CFR 422.204(b)(2) Manual Ch. 6 - Section 60.3 Method of Evaluation: Complete the sample review of WS-PR1. Determine if the result from column 17 meets the compliance standard. This element is not met. CMS reviewed MMM documents to determine if the credentialing process used was consistent with the requirements for credentialing and recredentialing of physicians and other health care professionals. The documents reviewed included policies and procedures and provider credentialing files. CMS reviewed a sample of 20 credentialing files. The sample included 8 files from APS, the entity to which MMM delegated Behavioral Health Services. The sample also included two files from MDN, the delegated entity that provided dental and oral surgery services to MMM. CMS determined that this element is not met based on the findings below. Six of the reviewed files lacked evidence of at least one required element of the credentialing process. MMM did not consistently adhere to the requirement for recredentialing at least every three years. MMM did not monitor the credentialing performance of MDN, the delegated entity that credentials oral surgeons. The detailed findings from file review are noted below. Two oral surgeon files lacked evidence of primary source verification of education and license. These two files also lacked documentation of verification of whether the providers had been sanctioned or had opted out of Medicare. Two behavioral health provider files lacked evidence of primary source verification of education. In addition, one behavioral health provider's file lacked evidence of verification of opt-out status at the time of credentialing. Two delegated entity files lacked evidence that all credentialing elements had been obtained prior to acceptance into the network. One file showed that more than three years had elapsed between initial credentialing and recredentialing.

Corrective Action Required:

MMM needs to review and revise its policies and procedures as necessary so that all of the required information is available to the Credentialing Committee at the time the provider is reviewed for acceptance into the network. Submit such revised policies and or procedures to CMS. MMM is to submit a document that outlines the process it will implement to verify that recredentialing is done in a timely manner. MMM is also to submit a document that shows how it will monitor and evaluate the implementation of this process. MMM is to submit a document that describes the oversight process that MMM will implement to verify all credentialing requirements are met by its delegated entities. MMM is to implement a program to educate personnel involved in the credentialing process of this corrective action plan.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

In 6 out of 10 cases MMM failed to process favorable reconsiderations timely. In all 6 cases MMM did not notify the beneficiary nor pay the claim timely.

Corrective Action Required:

MMM must ensure that if it overturns it adverse organization determination denying an enrollee's request for payment, the organization will issue its reconsidered determination and send payment for the service to the enrollee or provider. This must be mailed no later than 60 calendar days from the date the plan received the request for standard reconsiderations .

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/15/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.

Deficiencies:

In all 10 cases the plan failed to process the reconsiderations timely and did not send the cases to the IRE as required. In 8 out 10 cases the plan failed to notify the beneficiary timely.

Corrective Action Required:

MMM must ensure that if it affirms, in whole or in part, its adverse organization determination (i.e., continues to deny payment in whole or in part), it must prepare a written explanation and send the complete case file to the independent review entity contracted by CMS. This must be completed no later than 60 calendar days from the date it receives the request for reconsideration. MMM must make reasonable and diligent efforts to gather and forward information to the independent review entity. MMM must also notify the enrollee that the case has been forwarded to the independent review entity. If CMS determines that MMM's has a pattern of not making a reasonable and diligent effort to gather and forward information to the independent review entity, MMM will be considered in breach of its Medicare contract.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

Deficiencies:

In 8 out 10 case files MMM failed to process the reconsideration timely. In 6 out 10 plan failed to notify the member timely. In 7 out of 10 plan failed to authorize the service timely.

Corrective Action Required:

MMM must ensure that if it overturns it adverse organization determination denying an enrollee's request for a service, the organization will issue an authorization for the service and notify the enrollee no later than 30 calendar days from the date the plan received the request for standard reconsideration.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

In 6 out 9 cases plan failed to process reconsideration timely. In all cases plan failed to notify the beneficiary and send the case to the IRE within the required timeframes.

Corrective Action Required:

MMM must ensure that if makes a reconsidered determination that affirms in whole or in part, its adverse organiztion determination, it must prepare a written explanation and send the complete case file to the independent review entitity contracted by CMS. This must be completed as expeditiously as rhe enrollee's health condition requires but no later than 30 calendar days from the date it receives the request for standard reconsideration, or no later than the end of any extension. MMM must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entitiy. MMM must also notify the enrollee that the case has been forwarded to the independent review entitiy. If CMS determines that MMM's has a pattern of not making a reasonable and dilegent effort to gather and forward information to the independent review entitiy, MMM will be considered in breach of its Medicare contract.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

In 6 out of 9 cases plan failed to process reconsideration timely. In all cases plan failed to notify the beneficiary and send the case to the IRE within the required timeframes. Based upon these deficiencies we could not measure MMM's ability to effectuate IRE decisions.

Corrective Action Required:

MMM must ensure that if makes a reconsidered determination that affirms in whole or in part, its adverse organiztion determination, it must prepare a written explanation and send the complete case file to the independent review entitity contracted by CMS. This must be completed as expeditiously as rhe enrollee's health condition requires but no later than 30 calendar days from the date it receives the request for standard reconsideration, or no later than the end of any extension. MMM must make reasonable and diligent efforts to gather and forward all pertinent information to the independent review entitiy. MMM must also notify the enrollee that the case has been forwarded to the independent review entitiy. If CMS determines that MMM's has a pattern of not making a reasonable and dilegent effort to gather and forward information to the independent review entitiy, MMM will be considered in breach of its Medicare contract.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/14/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.

Deficiencies:

8 out of the 10 submitted were prescription drug cases and therefore declared misclassified, exceeding the 30 % threshold. In 1 out of the 2 remaining cases, MMM failed to process reconsideration timely. As a result we could not assess MMM ability to process requests for expedited reconsiderations.

Corrective Action Required:

MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MMM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.

Deficiencies:

8 out of the 10 submitted were prescription drug cases and therefore declared misclassified, exceeding the 30 % threshold. In 1 out of the 2 remaining cases, MMM failed to process reconsideration timely. As a result we could not assess MMM ability to process requests for expedited reconsiderations.

Corrective Action Required:

MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 9637

Region: 02 New York

Contract Number / Name: H4003 MMM HEALTHCARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/11/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.

Deficiencies:

8 out of the 10 submitted were prescription drug cases and therefore declared misclassified, exceeding the 30 % threshold. In 1 out of the 2 remaining cases, MMM failed to process reconsideration timely. As a result we could not assess MMM ability to process requests for expedited reconsiderations.

Corrective Action Required:

MMM must establish a process to distinguish Part C and D requests. As such we are requesting that MM submit a new universe for sampling which contains all requests for expedited pre-service reconsiderations received during the review period, whether or not they were expedited, excluding requests for drugs covered under the Part D program.