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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/15/2008
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Date Report Due: 11/18/2007
CAP Accepted Date: 08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date: 12/18/2007
MCO Response Due Date: 01/02/2008

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:

Desktop Procedure, SAI Policy MS701MA, incorrectly state the process for quality of care complaints that the plan receives directly from members is to refer them to QIO, HSAG. While CMS requires MA Organizations to cooperate with the QIO for complaints that their members file directly with the QIO, quality of care complaints received directly by the plan from members may be sent by the plan's quality review committee for peer review and dealt with internally within its own quality committees.

Corrective Action Required:

Mercy Care needs to revise its desktop procedure to correctly describe processing of quality of care complaints that it receives directly.

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Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
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Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 01/02/2008

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:

CMS sampled 15 grievances from a universe of 147. Two grievances were misclassified. They involved Part D rather than Part C issues. In 4 of the remaining 13 cases, the reviewer was unable to determine whether plan staff had adequately informed members of the grievance dispositions. All grievances in the sample were received and resolved by phone. In 2 of the 4 cases, notes on member grievance forms were insufficient. In a third case, the completed grievance form indicated that the member was not notified, and in a fourth, notes indicated that the provider, rather than the plan was to contact the member, but did not indicate whether that had been done.

Corrective Action Required:

Mercy Care must describe the steps it is taking to ensure that member service staff provides adequate grievance resolution notice to members, particularly when they receive and resolve complaints/grievances by phone. Documentation of complaints, actions taken and resolution notice needs to be strengthened. Corrective action should also include training if deemed necessary, and plans for monitoring compliance.

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Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR04
Review Type: Routine
Review Status: Confirmed
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CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:12/31/2007
MCO Response Due Date: 01/02/2008

Requirement:

Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.

Deficiencies:

Mercy Care did not submit documentation to show that it has information prepared to respond to member requests for the following information: (1) Summary description of methods of compensating physicians. This is a simple description of the various payment methodologies Mercy Care uses to compensate its physicians, such as capitation, Medicare fee schedule, reduced fee for service, risk pools, etc. It is part of the Physician Incentive regulations. (2) Number and disposition in aggregate of appeals and grievances in the manner and form required by CMS. Refer to Chapter 13 of the Medicare Managed Care Manual, Appendix 2 for the OMB format for this information, and the corresponding instructions in Sections 170 through 170.5.1.

Corrective Action Required:

Mercy Care must develop and submit as part of its CAP, materials for use in responding to requested disclosures of (1) Mercy Care's physician compensation methodologies, and (2) appeals and grievance data (Part C) in the format specified in Chapter 13 of the Medicare Managed Care Manual, Appendix 2.

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Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
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Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:04/01/2008
MCO Response Due Date: 01/02/2008

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:

Mercy Cares does not provide sufficient oversight over the sales representatives that are employed by Schaller Anderson and those with whom it contracts through Inspiris. CMS reviewed files of 8 sales representatives. One case was misclassified, as the sales agent was terminated prior to the beginning of the audit period. CMS found the following: (1) Three of the 7 sales representatives were not licensed. (2) Files of 4 sales representatives did not include performance data. (3) Files for the other 3 sales representatives contained performance evaluations but these evaluations did not incorporate feedback or results of other monitoring data available, such as data from Welcome Calls and unannounced presentation audits. (4) Files did not indicate whether sales representatives who had completed Mercy Care's annual training on federal and state regulatory requirements, had done so successfully.

Corrective Action Required:

Mercy Care must describe the actions it is taking to strengthen its oversight of sales representatives. Mercy Care's corrective action should describe measures for, (1) ensuring that all of its sales representatives are licensed by the State, including internal sales agents, (2)(3) conducting annual performance evaluations for all internal and external sales representatives. Evaluations should incorporate results of presentation evaluations (ride along reports), feedback from welcome calls and member complaint/disenrollment/retention logs, as well as any other reports that Mercy Care has developed to evaluate the performance of the sales representative. (4) setting internal performance standards for completion of training, ensuring that all sales representatives meet these standards and for documenting successful completion.

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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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
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Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:
MCO Response Due Date: 01/02/2008

Requirement:

Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.

Deficiencies:

Mercy Care Advantage was unable to demonstrate that Medicare members are given written notice at least 30 days prior to primary care physician (PCP) terminations. Based on a review of a PCP termination letter, the reviewer found that the PCP termination letter was dated 05/28/07 with a PCP termination date "effective immediately". The PCP termination letter demonstrated that Mercy Care Advantage is not giving its Medicare members the CMS required 30-day notice of PCP or other provider terminations.

Corrective Action Required:

Mercy Care Advantage must describe the actions it is taking to ensure that it provides written notice to Medicare members 30 days prior to PCP or other provider terminations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits to ensure compliance with CMS requirements.

CMS Medicare Managed Care Auditing Report

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Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:02/27/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed a sample of 30 denied claims from a universe of 2629 that were received from non-contracted providers. Two claims were misclassified - one because it was a duplicate claim, and the other because it was submitted by a contracted provider (DOS 2/27/2007 and contract effective date with Mercy Care Advantage 1/1/2007). Of the remaining 28, 6 claims were not properly denied for the following reasons: (1) In 3 cases, claims were electronically submitted from a laboratory. Mercy Care's EDI look-up screen does not contain information about the referring physician although that information should be part of the electronic claims submission. It is unlikely that members walk into labs without orders or referrals, and file documentation does not show that claims processors attempted to determine identities of referring physicians in order to their establish contracting status. If referrals are from contracting physicians, then Mercy Care should be paying the claims, as members can not be expected to know that these services would not be covered. CMS requires plans to attempt development of missing information needed to appropriately adjudicate a claim before denying. (2)In a fourth case, again for lab services, the referring physician was contracted with the plan. Mercy Care should have paid the non-contracted provider since the member has no reason to expect that he was being sent to a non-contracted provider and that services would not be covered. (3)Two other claims were denied without Mercy Care attempting to develop claims for additional missing medical documentation needed to reach a decision. These claims should have been considered non-clean claims, pended and developed, but were instead denied within 27 and 15 days respectively. (The reason why this is important is that non-contracted providers, once an MA Organization has denied a claim, may bill members.)

Corrective Action Required:

Mercy Care must describe the steps that it is taking to address the identified deficiencies. Corrective action should include at a minimum, the following: (1) Analysis and a correction of its EDI claims look-up to permit processors to view referring physicians, and an interim solution for claims development when services are from non-contracted providers such as laboratories, where it is unreasonable to expect that members would have walked into on there own without orders or a referral from a physician. (2) Changes in policy to pay non-contracted providers when members were referred to them from contracted providers. Mercy Care must also work with such identified referring physicians to ensure that they either changer referral patters and refer only to contracting providers, or obtain proper plan authorization prior to referring out of network. (3) Changes in claims processing and any necessary training, to include reasonable attempts to develop claims prior to denying them.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:02/01/2008
MCO Response Due Date: 01/02/2008

Requirement:

Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement 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, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.

Deficiencies:

Mercy Care policy and procedures call for paying non-contracted providers according to Original Medicare rates, however the reviewer noted problems with 5 of the 30 paid claims (#5, #9, #10, #12, #17) sampled. CMS used the Physician Fee Schedule Look-up on the CMS website to roughly check the amount of plan payments in these cases, and found that Mercy Care had underpaid providers. Two of the procedures were for ER visits (99285). Others were for an inpatient consultation (99252), initial hospital visit (99223), and a US exam/abdom (76700). In each case, the amount allowed appeared to be close to the conversion factor showing up in the Physician Fee Schedule Look-up, rather than the price. The paid claims reconsideration reviewer also noted a case in the favorable claims reconsideration sample (#6) in which the non-contracted provider appealed the amount he had been paid for an ER visit (code 99285). In this case, Mercy Care reversed its initial decision and paid an amount roughly equivalent to that in the Physician Fee Schedule Look-up for AZ physicians.

Corrective Action Required:

Mercy Care must investigate and determine root cause(s) of identified underpayments/incorrect payments to non-contracting physicians (whether caused by Mercy Care's claims system or by processor errors). Corrective action should include a description of Mercy Care's analysis, the breadth of the problem, the steps Mercy Care is taking to resolve identified problems (including time-frames for completion of each step), and its ongoing monitoring plans to ensure that it pays non-contracted physicians and other providers appropriately at Original Medicare rates, when required.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

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MCO Response Received Date:01/15/2008
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Date Report Issued: 11/18/2007
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CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:07/13/2008
MCO Response Due Date: 01/02/2008

Requirement:

Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.

Deficiencies:

Mercy Care did not meet the 95% compliance standard for this element. CMS reviewed a sample of 30 non-contracted provider claims from a universe of 36,320 and found that Mercy Care had not paid 4 clean claims within the required 30-day time frame.

Corrective Action Required:

Mercy Care must describe the actions that it is taking to ensure that it pays clean claims to non-contracted providers within 30 days of receipt. Corrective action should include an analysis of the non-compliant cases (#5, #6, #11, and #13) to determine why payment was late. It should also include a description of the steps Mercy Care is taking to address identified causes of delay as well as a description of Mercy Care's plans for monitoring its own performance for compliance on an ongoing basis.

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Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

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Review Type: Routine
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MCO Response Received Date:01/15/2008
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Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:07/13/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 30 denied claims from non-contracted providers. Two of the 30 were misclassified. Of the remaining 28 claims, 22 were for attendant care services. Mercy Care processed these cases through its Medicare system for a denial since the services could, when provided by Medicare certified home health agencies to members in a Medicare covered home health period, could be primary to AHCCCS/ALTCS. All of these 22 were from AHCCCS/ALTCS only services and Mercy Care suppressed member notification. The CMS reviewer had the following findings: (1) Mercy Care did not issue denial notification to members in the remaining 6 cases sampled. Some files included screen prints of both remittance and EOB messaging but no evidence that EOBs were issued to members. Documentation submitted for this element did not include a copy of the EOB. EOBs must include standardized appeal language as well as clear denial reasons. There is nothing to prevent non-contracted providers who have received denials from the plan from billing members for the Medicare covered services they provided. The only time Mercy Care, as a SNP, may suppress denial notices from provider that does not contract for Mercy Care Advantage is when members are also in Mercy Care's AHCCCS or ALTCS contracts and the organization is going to pay claims under one of those contracts. (2) The messaging on remittance notices used to notify providers of the denials is not clear, and does not meet CMS requirements as specified in section 40.2.3 of Chapter 13. It includes two sets of instructions for providers who want to protest plan decisions, but the instructions do not specify which process should be used by contracting providers, and which by non-contracting providers. (3) Mercy Care has an accepted notice - H5580_054 filed under file and use certification procedures - for denying claims, however, it is incorrect. The transmittal and first page says that it is for denial of payment, yet the appeal rights included in the notice are for denial of services. (4) Reasons for denials, as well as other messaging for non-contracted providers on remittance advices are clear and in some cases misleading, e.g., paid at 80% of contract rate. The header labeled "penalty" is actually for payment of interest.

Corrective Action Required:

Mercy Care must describe the actions that it is taking to ensure that it meets the requirements for this element. Corrective action must include at a minimum, the following: (1) Mercy Care must begin issuing denial notices that meet CMS requirements to members who receive services from non-contracted providers, when Mercy Care is not going to pay for the services in full (less Medicaid cost-sharing) under its AHCCCS or ALTCS contracts. (2) Revise the remittance advice appeal messaging so that non-contracted providers who want to appeal (request reconsideration) know which instructions to follow. Submit the EOB language to CMS for review and approval. (3) Submit a new claims denial notice that meets CMS requirements for review and approval ¿ not under the file and use certification process. (4) Review and revise the remittance advice format and develop additional messaging applicable for use with non-contracted providers. (5) Conduct training for all staff involved.

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Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
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CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:02/08/2008
MCO Response Due Date: 01/02/2008

Requirement:

Standard Pre-Service Denials (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.

Deficiencies:

Based on a review of 10 files for adverse standard pre-service organization determinations from a universe of 606, the reviewer found all 10 Notices of Denial of Medical Coverage (NDMCs) non-compliant because Mercy Care Advantage was not using the CMS required NDMC, or an RO-approved modification of the NDMC.

Corrective Action Required:

Mercy Care Advantage must describe the actions it is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. Corrective action must include internal health plan audits to ensure compliance with CMS requirements.

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Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
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Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:
MCO Response Due Date: 01/02/2008

Requirement:

Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, 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 organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.

Deficiencies:

CMS reviewed a sample of 10 expedited organization determinations from a universe of 299 and found 1 case misclassified, and the remaining 9 cases non-compliant because Mercy Care Advantage had not notified members of the decisions either orally or in writing. (Decisions for 8 of the cases had been made within the required 72 hour time-frame.)

Corrective Action Required:

Mercy Care Advantage must describe the actions it is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.

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Requirement:

Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.

Deficiencies:

There were no cases in the sample (WS-OP2) to evaluate compliance with this element. Evaluation of this element was based on the Notice of Denial of Medical Coverage (NDMC) issued to the beneficiary for standard pre-service denials (WS-OP1). The WS-OP1 sample demonstrated that the NDMC was noncompliant. The reviewer found that in all 10 cases that Mercy Care Advantage was not using the CMS required NDMC, or an RO-approved modification of the NDMC.

Corrective Action Required:

Mercy Care Advantage must describe the actions it is taking to ensure that it issues the CMS required NDMC or an RO-approved modification of the NDMC for adverse standard or expedited pre-service organization determinations. Corrective action must include internal health plan audits to ensure compliance with CMS requirements.

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Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

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CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 20 credentialing files. CMS found 17 files non-compliant with CMS requirements for the following reasons: (1) 3 files from a non-delegated credentialing entity (PCN) were not credentialed by Mercy Care Advantage. Credentialing interviews revealed that all Medicare contracted physicians in the non-delegated entity had not been initially credentialed by Mercy Care Advantage nor was there a credentialing delegation agreement with the entity (PCN). Mercy Care Advantage developed a report to identify how many Medicare physicians in this entity were contracted and not credentialed. The report identified 143 non-credentialed Medicare contracted physicians. There are 50 contracted PCPs with membership panels totaling 844 and 93 contracted specialists with 1420 open authorizations, who have not been credentialed by the health plan. (2) 1 file credentialed/recredentialed by Mercy Care Advantage was missing the year on the dated DEA certificate. (3) 2 files credentialed/recredentialed by Mercy Care Advantage and delegated credentialing entity (ACP) were missing primary source verification of board certification. (4) 9 files credentialed/recredentialed by Mercy Care Advantage and delegated credentialing entity (ACP) were missing the consideration of quality of care information in the recredentialing process. (5) 17 files credentialed/recredentialed by Mercy Care and delegated credentialing entity (ACP) were not reviewed for Medicare Opt Out.

Corrective Action Required:

Mercy Care must initially credential all the non-credentialed Medicare contracted (PCN) physicians as soon as possible but no later than the end of 2007 (Mercy Care states that the PCPs will be credentialed at the November Credentialing Committee meeting). Mercy Care must credential the PCN specialists, both those with open authorizations and those without. In addition, Mercy Care must not assign any new members to the non-credentialed PCP panels and no new referrals to the non-credentialed specialists until credentialing is complete. Mercy Care must submit to CMS a list of all its Medicare contracted physicians (MDs, DOs, chiropractors and podiatrists) with the initial credentialing/recredentialing dates for each physician. Mercy Care Advantage must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 05/20/2008
Element Release Date: 08/11/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 01/02/2008

Requirement:

Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.

Deficiencies:

CMS reviewed 20 credentialing files, 8 files were reviewed from three (3) delegated credentialing entities. CMS found 6 files non-compliant with CMS requirements for the following reasons: (1) 1 file credentialed/recredentialed by delegated credentialing entity (ACP) was missing primary source verification of board certification, (2) 5 files credentialed/recredentialed by delegated credentialing entity (ACP) were missing the consideration of quality of care information in the recredentialing process, and (3) 6 files credentialed/recredentialed by delegated credentialing entity (ACP) were not reviewed for Medicare Opt Out.

Corrective Action Required:

Mercy Care Advantage must describe the actions it is taking to ensure that its delegated entities credential/recredential contracted providers in accordance with CMS requirements. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 04/14/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:04/01/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 10 favorable claims reconsiderations from a universe of 274. Two cases were misclassified. Six of the 8 remaining reconsiderations were not timely because Mercy Care did not issue payments for on overturned cases within 60 calendar days after receipt, as required.

Corrective Action Required:

Mercy Care must describe the actions that it is taking to ensure that it issues payments to effectuate its own overturn decisions within 60 days after it receives claim reconsideration requests, as required. Corrective action should also include a description of Mercy Care's plans for monitoring its own performance to ensure ongoing compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 06/06/2008
Element Release Date: 06/06/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:10/15/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 10 unfavorable claims reconsiderations in sample for WSRC2 out of a universe of 153, and found that 6 of the 10 cases were misclassified. They had actually been reversed by the plan and paid, and belonged in the WSRC1 sample of favorable claim reconsiderations. When 30% or more of cases sampled are misclassified, CMS considers any requirement based on review of that sample as NOT MET. During the review, CMS noted the following other processing deficiencies in the remaining cases: (1) Mercy Care did not forward 3 of the 4 remaining cases to the IRE as required when it could not fully reverse its own initial organization determinations. (2) In 3 of 4 cases, file documentation did not show that Mercy Care notified members that it had transferred their requests to the IRE for final decisions, and in the one case in which it issued a notice, language was incorrect.

Corrective Action Required:

CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, CMS is requesting that Mercy Care generate a new universe for a later audit period - 6 months after CMS accepts the corrective action plan for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 06/06/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:10/01/2008
MCO Response Due Date: 01/02/2008

Requirement:

Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization 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.

Deficiencies:

CMS reviewed 10 unfavorable claims reconsiderations in sample for WSRC2 out of a universe of 153, and found that 6 of the 10 cases were misclassified. They had actually been reversed by the plan and paid, and therefore belonged in the WSRC1 sample of favorable claim reconsiderations. When 30% or more of cases sampled are misclassified, CMS considers any requirement based on review of that sample as NOT MET.

Corrective Action Required:

CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, CMS is requesting that Mercy Care generate a new universe for a later audit period - 6 months after CMS accepts the corrective action plan for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 04/14/2008
Element Release Date: 04/14/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:01/31/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 10 favorable standard pre-service reconsiderations out of a universe of 20 and noted the following deficiencies: (1) In 3 of the 10 cases, Mercy Care did not notify members of the decision within the required 30 days - in 2 of the cases, notice was late, and in the third, the date the member was notified was not documented. (2) In 3 of the 10 cases, Mercy care did not provide authorizations for services within the required 30 days.

Corrective Action Required:

Mercy Care must describe the steps that it is taking to ensure that it (1) notifies members of favorable standard pre-service reconsideration decisions it makes, and (2) authorizes these services, both within 30 days of receipt of standard pre-service reconsideration requests.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 06/06/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:10/01/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 10 unfavorable claims reconsiderations in sample for WSRP2 out of a universe of 42, and found that 3 of the 10 cases were misclassified. They had actually been resolved in favor of the member, so should have been included in the WSRP1 sample of favorable standard pre-service reconsiderations. When 30% or more of cases sampled are misclassified, CMS considers any requirement based on review of that sample as NOT MET. CMS noted the following processing deficiencies in the sample: (1) In cases when a plan accepts an oral request for a standard pre-service reconsideration, it must obtain a signed copy of the oral complaint from the member. In three cases, a copy of the reconsideration request sent to the member for signature was missing. (2) Documention to show when the plan sent cases to the IRE were missing in 5 cases. (3) Mercy Care did not solicit good cause for one of the reconsiderations that was later than 60 days from the initial decision.

Corrective Action Required:

CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, Mercy Care must generate a new universe for a later audit period - 6 months after CMS' acceptance of corrective action for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 06/10/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:10/15/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 10 unfavorable claims reconsiderations in sample for WSRP2 out of a universe of 42, and found that 3 of the 10 cases were misclassified. They had actually been resolved in favor of the member, and therefore, should have been part of the WSRP1 sample of favorable standard pre-service reconsiderations. When 30% or more of cases sampled are misclassified, CMS considers any requirement based on review of that sample as NOT MET.

Corrective Action Required:

CMS usually requires organizations with misclassified samples to regenerate a new universe using the same audit period. However, in this case, because of other appeal processing deficiencies noted in this and other samples, Mercy Care must generate a new universe for a later audit period - 6 months after CMS' acceptance of corrective action for other identified appeal processing deficiencies. Review of the newly generated universe will be conducted as part of a focused visit.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 04/13/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:04/01/2008
MCO Response Due Date: 01/02/2008

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:

CMS reviewed 2 requests for expedited reconsiderations out of universe of 2. Mercy Care did not expedite review of either case and failed to notify members verbally, or to document verbal notice, of the transfer of the reconsiderations to the standard process. Consequently, this notice requirement is not met.

Corrective Action Required:

Mercy Care must describe the methods that it is taking to ensure that staff provide notice to members (oral followed up by written notice, or simply written notice) as required within the required 72 hour timeframe, when it transfers expedited requests to the standard pre-service reconsideration process. Corrective action should also include Mercy Care's plans for monitoring ongoing compliance with this requirement.

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: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 04/13/2008
Element Release Date: 06/12/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:01/31/2008
MCO Response Due Date: 01/02/2008

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:

The letter that Mercy Care used in one of the two cases in the sample from WSRP3 to notify the member that his request did not meet expedited criteria and would be processed under standard procedures was incorrect. It had not been approved by CMS, and did not include language offering the member the right to file an expedited grievance if he disagreed with the decision. The template letter submitted as part of the audit documentation, also did not meet CMS requirements. Although approved, it is for use in processing redeterminations for Medicare Part D.

Corrective Action Required:

Mercy Care must take the following actions: (1) Submit a corrected notice for review and approval through HPMS and once approved, ensure that old versions of any unapproved notices are destroyed. (2) Conduct training for those who use appeal notices. (3) Describe plans for monitoring ongoing compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8098

Region: 09 San Francisco

Contract Number / Name: H5580 SOUTHWEST CATHOLIC HEALTH NETWORK CORPORATION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/15/2008
Element Accepted Date: 04/13/2008
Element Release Date: 06/10/2008
CAP Released Date:08/11/2008

Visit Start Date: 10/3/2007
Exit Conference Date: 10/04/2007
Date Report Issued: 11/18/2007
Date Report Due: 11/18/2007
CAP Accepted Date:08/11/2008
Audit Closed Date: 08/11/2008
Element Projected Completion Date:01/31/2008
MCO Response Due Date: 01/02/2008

Requirement:

Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file a grievance if he or she disagrees with the decision to grant an extension.

Deficiencies:

Although Mercy Care's policy and procedure - 3100 . 75 -, page 9, reflects accurate processing, the letter Mercy Care used to notify a member in a sample case (#6) in the unfavorable standard pre-service sample (WSRP2)was incorrect. It did not include required expedited grievance provisions, and it had not been approved by CMS.

Corrective Action Required:

Mercy Care must take the following actions: (1) Develop and submit through HPMS, a notice to members that Mercy Care can use when it needs to extend its time-frame for making reconsideration decisions. Refer to the model notice in Appendix 5 of Chapter 13 in the Medicare Managed Care with the title, Notice of Right to an Expedited Grievance. (2) Conduct training for staff processing appeals. (3) Describe the plans that Mercy Care has for monitoring ongoing compliance of this requirement.