# *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:** 04 Atlanta
**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Review ID:** 9057

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** MR08
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 01/16/2008
**Element Release Date:** 03/26/2008
**CAP Released Date:** 03/26/2008

**Visit Start Date:** 9/18/2007
**Exit Conference Date:** 09/20/2007
**Date Report Issued:** 11/02/2007
**Date Report Due:** 11/04/2007
**CAP Accepted Date:** 03/26/2008
**Audit Closed Date:** 03/26/2008
**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not 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; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C 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); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to-door solicitation of Medicare beneficiaries.

**Deficiencies:**

WHP does not meet the CMS 95% compliance standard because CMS reviewed 7 cases from the universe of 7 and found 4 cases where WHP did not document the ride-along with supervisory staff training nor the results of the shadowing process per WHP policies and procedures (WHP-SM-SAL-010). Additionally, each sales rep was given a Medicare Basics exam, however in a significant number of cases, the test results were not provided to determine if the rep met the minimum passing score of 70 percent (WHP-SM-SAL-005).

**Corrective Action Required:**

WHP must establish a mechanism for reporting the results for all individuals tested on their understanding of the Medicare program. Per WHP policies and procedures, CMS will look to see if test results are available for each sales representative. If the test results are not available, the plan must show how each rep was trained, and track the effectiveness of the training. These results are important in determining the representatives level of understanding of the Medicare program.

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**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OC01
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/07/2008
**Element Release Date:** 03/21/2008
**CAP Released Date:** 03/26/2008

**Visit Start Date:** 9/18/2007
**Exit Conference Date:** 09/20/2007
**Date Report Issued:** 11/02/2007
**Date Report Due:** 11/04/2007
**CAP Accepted Date:** 03/26/2008
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**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

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

**Deficiencies:**

Based on the review of worksheet OC2 The Managed Care Organization failed to make correct claim determinations which include developing the claim for additional information when necessary. Refer to 42 C.F.R. 422.100(a) and (b)(1) 422.132 422.504(g)(1) and Manual Chapter 4 Section 10.2. Of the 17 cases reviewed only case # 9 was denied properly, however after further review cases # 2, # 10, # 11, # 12, # 13, # 14 and # 17 were correctly processed and paid.

**Corrective Action Required:**

Windsor Health Plan (WHP) must submit a monitoring review process which will ensure that all claims are being paid or denied properly. The monitoring review process must include, but not be limited to, the date of implementation, staff responsible for the approval of the review process, how the review process will be monitored and the frequency of the review process. WHP must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff and include current Medicare Private Fee For Service regulations.

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Date Report Generated: 9/30/2008

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

**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OC04
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/07/2008
**Element Release Date:** 03/26/2008
**CAP Released Date:** 03/26/2008

**Visit Start Date:** 9/18/2007
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**Date Report Issued:** 11/02/2007
**Date Report Due:** 11/04/2007
**CAP Accepted Date:** 03/26/2008
**Audit Closed Date:** 03/26/2008
**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

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

**Deficiencies:**

Based on the review of Worksheet OC1. If the Managed Care Organization (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). Refer to 42 C.F.R. 422.520(a)(2)and Manual Ch.11 Section 100.2. Findings include:Of the 30 cases reviewed case #6 was paid in 33 days and case #15 was paid in 31 days and, according to the information contained in the files it was not possible to determine if interest was paid.

**Corrective Action Required:**

The MAO must provide training for its staff regarding element OC04. The MAO must submit a copy of the training provided along with a copy of the sign in sheet indicating who attended the training. The MAO must implement a monitoring review system or process to ensure all clean claims are being paid within 30 days to include, but not be limited to, who will conduct the monitoring, a schedule as to when the monitoring will be conducted, the frequency of the monitoring, and staff responsible for the approval of the review process. The MAO must implement a monitoring review system or process to ensure interest is paid on all clean claims not processed with in 30 days to include, but not be limited to, who will conduct the monitoring, a schedule as to when the monitoring will be conducted, the frequency of the monitoring and staff responsible for the approval of the review process. The MAO must The MAO must submit a copy of the monitoring review system or process. Windsor Health Plan must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff, and include all current Medicare Private Fee For Service regulations.

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**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OC06
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/07/2008
**Element Release Date:** 03/26/2008
**CAP Released Date:** 03/26/2008

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**Date Report Issued:** 11/02/2007
**Date Report Due:** 11/04/2007
**CAP Accepted Date:** 03/26/2008
**Audit Closed Date:** 03/26/2008
**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

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

**Deficiencies:**

WHP is not using OMB Approved No. 0938-0829 Form No. CMS-10003-NDP (June 2001) Notice of Denial of Payment. The denial reasons listed on the Explaination of Benefits form (EOB) do not clearly state the denial reason making it difficult for the member to understand the reason the claim was denied. The EOB did not contain a date field.

**Corrective Action Required:**

WHP must immediately start using OMB Approval No. 0938-0829 Form No. CMS-1003-NDP (June2001). WHP must submit a monitoring review system or process ensuring they have implemented the correct OMB form, The monitoring review system or process must include, but not be limited to, the date of implementation, who approved the implementation, and how the implementation will be monitored. WHP must submit a revised list of denial reasons for this product. Each denial reason must clearly state the reason the claim was denied. WHP must implement a monitoring review system to ensure the correct denial reasons are displayed on all denied claims. The monitoring review system or process must include, but not be limited to who will conduct the monitoring, a schedule with the begin date and the frequency of the monitoring. WHP must submit a corrected EOB to include the date field. Windsor Health Plan (WHP) must develop policies and procedures (PP) for claim processing. The PPs must include the complete claim process from the receipt date by WHP to payment or denial. The PPs must be signed, approved by the appropriate WHP staff, and include all current Medicare Private Fee For Service regulations.

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**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OP04
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/21/2008
**Element Release Date:** 03/26/2008
**CAP Released Date:** 03/26/2008

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**CAP Accepted Date:** 03/26/2008
**Audit Closed Date:** 03/26/2008
**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

Requests for Expedited Organization Determinations (Timeliness) - The M+CO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the M+CO 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 M+CO 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 M+CO 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:**

The MAO did not submit samples for the requested expedited organizational determinations. During discussions with the MAO staff and the review of the submitted documentation, it was determined that the MAO was unable to produce a report that could provide the requested information. It was stated that the medical management support system used during the audit period did not have an indicator field to differentiate between expedited and standard organization requests. Therefore, CMS is unable to determine if the expedited requested were decided timely.

**Corrective Action Required:**

WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.

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**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OP05
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/21/2008
**Element Release Date:** 03/26/2008
**CAP Released Date:** 03/26/2008

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**Element Projected Completion Date:**
**MCO Response Due Date:** 12/17/2007

**Requirement:**

Expedited Denials (Notice Content) - If the M+CO 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:**

The MAO did not submit samples for the requested expedited organizational determinations. During discussions with the MAO staff and the review of the submitted documentation, it was determined that the MAO was unable to produce a report that could provide the requested information. It was stated that the medical management support system used during the audit period did not have an indicator field to indicate expedited or standard organization requests. Therefore, CMS is unable to determine if the expedited requested notices contained the required content.

**Corrective Action Required:**

WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.

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**Findings:** NOT MET

**Review ID:** 9057

**Region:** 04 Atlanta

**Contract Number / Name:** H1850 WINDSOR HEALTH PLAN, INC.

**Auditing Guide Version:** PFFS Monitoring Guide
**Auditing Element:** OP08
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:** 12/18/2007
**Element Accepted Date:** 03/21/2008
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**Requirement:**

Correctly Distinguishes Between Organization Determinations and Reconsiderations - The M+CO must correctly distinguish between organization determinations and reconsiderations.

**Deficiencies:**

The MAO did not submit samples for the requested expedited organizational determinations. During discussions with the MAO staff and the review of the submitted documentation, it was determined that the MAO was unable to produce a report that could provide the requested information. It was stated that the medical management support system used during the audit period did not have an indicator field to indicate expedited or standard organization requests. Therefore, CMS is unable to determine if the expedited requested notices contained the required content.

**Corrective Action Required:**

WHP is required to submit to CMS a new universe in order for the new cases to be selected for review. Once these cases are selected by CMS, WHP will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. CMS has determined the time period will be from December 2006 to May 2007. WHP should submit the Universe to CMS no later than December 17, 2007 for sample selection.