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
Review ID: 8617
Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 08/15/2007
CAP Released Date: 04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 04/30/2007
MCO Response Due Date: 07/07/2007

Requirement:

Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.

Deficiencies:

Universal Health Plan does not meet the CMS 95% compliance standard because CMS reviewed 29 cases from a universe of 1765 and found 8 cases where the disenrollment notice was not sent timely. The cases identified were #1, #2, #4, #5, #7, #8, #9, #12 from worksheet DN01.

Corrective Action Required:

Universal Health Plan must follow their own disenrollment policy and procedure (DER-4) which states that a copy of the request for disenrollment and a disenrollment letter will be provided to the beneficiary within seven days of receipt of the request to disenroll. Universal Health Plan must provide training to the appropriate staff on this procedure and submit training material and attendance log to the Atlanta regional office. The training must be completed and the information sent to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/27/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.

Deficiencies:

Universal Health Plan (UHC) does not meet the CMS 95% compliance standard because CMS reviewed 10 cases from a universe of 40 and found 9 cases that were incorrectly classifed as involuntary disenrollments. Based on the case file documentation, the CMS reveiwer was unable to determine if a refund was due.

Corrective Action Required:

Universal Health Plan must adhere to their policy and procedure DER 11 and ensure that members are refunded any premiums collected incorrectly. Universal Health Plan must review each sample case and provide evidence to CMS that a refund was sent to the member. This information must be sent to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option. Member notice is required prior to transmission of the disenrollment to CMS.

Deficiencies:

Universal Health Plan (UHC) does not meet the CMS 95% compliance standard because CMS reviewed 10 cases from a universe of 40 and found 9 cases that were incorrectly classifed as involuntary disenrollments. In all cases reviewed, the member moved out of the service area, but requested disenrollment either before or after the move. Therefore, these cases were actually voluntary disenrollments. The cases identified were case #1, #2, #3, #4, #5, #6, #7, #9, and #10. All cases were voluntary disenrollment. In the remaining case #8, the CMS reviewer was unable to determine if the disenrollment was voluntary or involuntary, because there was no documentation that indicated that the member requested disenrollment or no evidence of the documentation required for involuntary disenrollment.

Corrective Action Required:

Universal Health Plan (UHC) must conduct training to appropriate staff on their own internal policies and procedures (DER 8 and DER 14) which stipulate how to correctly identify voluntary and involuntary disenrollments. UHC must submit documentation to the regional office that details the nature of the training, including the materials used, the individuals conducting the training, and the individuals being trained. This information is due to CMS by the end of May 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:07/20/2007
MCO Response Due Date: 07/07/2007

Requirement:

Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.

Deficiencies:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found 20 cases which failed to correctly ensure that the Enrollment Election Receipt-Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that the Enrollment Election Receipt-Dated Elections are appropriately dated as of the date they are received by the MAO. UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:07/20/2007
MCO Response Due Date: 07/07/2007

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:

No Data available and No Samples reviewed. Reviewed Policies and Procedures and determined that incorrect Enrollment Processes were identified. Specifically, language did not comply with timeframes specified by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found 19 cases which failed to comply with the Enrollment Acknowledgement (Timeliness) element. Specifically, the MAO failed to notify the beneficiary of receipt of the enrollment election within timeframes specified by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that the Enrollment Acknowledgement(timeliness) element is accurately depicted. UHC must modify it's current practices to make certain that it notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS. UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found that all 30 cases were non-compliant in the Enrollment Acknowledgement (Notice Content) element. Specifically, the written acknowledgement notice sent in response to the beneficiary's enrollment election did not meet CMS's requirements and failed to specify the correct effective date of enrollment.

Corrective Action Required:

UHC must revise its "Notice to Acknowledge Receipt of Completed Enrollment Election" and revise its current policies and procedures to ensure that the Enrollment Acknowledgement (Notice Content) element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER07
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.

Deficiencies:

No Data available and No Samples reviewed. Reviewed policies and procedures and determined that the language within the policies did not comply with timeframes specified by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER09
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/15/2007
MCO Response Due Date: 07/07/2007

Requirement:

Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER10
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/15/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER11
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/15/2007
MCO Response Due Date: 07/07/2007

Requirement:

Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER12
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/15/2007
MCO Response Due Date: 07/07/2007

Requirement:

Retroactive Enrollment Requests - The MAO requests retroactive enrollments when required, due to CMS enrollment rejection error, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. As a result of having 30 % or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. The universe listing is the complete list of all Medicare beneficiary transactions that took place during the selected review period, from which CMS will randomly choose cases to review for compliance. In addition, UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER15
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
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CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:
MCO Response Due Date: 07/07/2007

Requirement:

Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any change in residence for its members reported to it by CMS.

Deficiencies:

Based on the review of WS ER6 - State and County Code Change - Monthly Activity Report, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 327 and found 6 cases where the MAO did not appropriately follow-up on changes in State and County Codes. Specifically, the MAO should review the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follow-up on any change in residence for its members reported to it by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure compliance with this element.UHC must conduct training of appropriate staff on these policies and procedures and 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, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
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Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of 10 samples in WS GV1-Grievances, UHC failed to correctly distinguish between reconsiderations and grievances and failed to process the cases within the required timeframes. Seven out of 10 cases (2,3,4,5,6,7,and 11) were misclassified which is over 30% of the sample. As a result, the reconsiderations and/or grievances were not processed according to regulatory statute. In addition, members from case numbers 8 and 9 had called their Congressional offices and the Atlanta regional office because they had not received resolution to their problems. These specific cases were CTM cases residing in HPMS and required MAO intervention.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's grievance process. 2. A training program for the appeal and grievance staff. Please provide to CMS the training manual, the individuals conducting the training and a list of the individuals trained. 3. An internal audit system designed to evaluate whether or not grievances are resolved within the timeframes specified in the organization's policies and procedures. 4. A process which requires the appeals/grievance committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
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Visit Start Date: 2/5/2007
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Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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 MAO does not have adequate oversight or management over its marketing representatives. The MAO has contracted with 13 Field Marketing Organizations (FMOs). These FMOs employ 10,000 Agents to market Universal's Private-Fee-For-Service (PFFS) product. The service area for the PFFS is eight states. The MAO has 3 Marketing Directors for these eight states. The MAO does not have any written policies and procedures for the oversight of these FMOs and/or the brokers. In reviewing the MAO's inquiry log, there were a large number of marketing complaints, and no indication of any follow up or resolution. In reviewing the marketing representatives personnel files, the reviewer found that there was inadequate documentation of training, there was no performance data, and in three files there was no state license for the representatives.

Corrective Action Required:

The MAO must provide to CMS a written plan on how it will provide oversight of the 13 FMOs and its brokers. The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The MAO must provide training to all of its marketing representatives and this training must be documented in their personnel files. The MAO must investigate all marketing complaints on their inquiry log and provide CMS with their resolution. The MAO's management must provide assurances to CMS that they will provide oversight of their marketing staff to ensure future compliance in this area. The MAO must provide to CMS, for the next 12 months, a report of all marketing allegations they receive directly and through CTM with the results of their investigations and the resolutions. All requested documentation and the first report are due to the Regional Office by the end of April 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

The sample reviewed by CMS consisted of 30 paid claims. Two of these claims (#14 and #26) were not paid within the required 30 days and interest was not paid.

Corrective Action Required:

The MAO must pay the interest on the 2 identified claims were interest was not paid. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by April 30, 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

Standard Pre-Service Denials (Timeliness) - If the MAO makes an adverse standard pre-service organization determination, it must notify the member in writing using the CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, of its decision as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).

Deficiencies:

Based on the review of WS OP1-Standard Pre-Service Denials and staff interviews, UHC failed notify members in writing as expeditiously as the member's health condition requires. Findings include: Nine out of the ten denials reviewed were not issued in a timely manner. As a result, the denial process time did not meet regulatory requirements.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
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Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:07/20/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of 10 samples for WS OP2-Requests for Expedited Determinations, UHC failed to notify the members in writing as expeditiously as the member's health requires. This requires UHC to notify the members of the expedited requests orally and in writing within 3 calendar days of the oral notification. Nine of ten cases reviewed in the sample did not send the decision notice within the required timeframe.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP09
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

Requirement:

OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).

Deficiencies:

Based on the review of 15 samples for WS OP3-Favorable Standard Pre-Service Organization Determinations, UHC failed to expedite approval and provide notification to the member within 14 calendar days after receiving the request. One case (#15) did not have the service approved in a timely manner. One case (#8) was an potential emergent care service and was misclassified. Findings include: 1. Case #15 was a surgical request for a total thyroidectomy which would include an acute inpatient stay. This service was not approved until 60 days after receipt. There was no documentation to support an approval extension. 2. Case #8 was a request for an inpatient stay for respiratory failure with pleural effusion. There was no documentation to support an approval extension. Also, respiratory failure is an emergent situation requiring critical measures and should not be placed in the pre-service authorization process. Emergent care including stabilization is covered as a necessary service and does not require pre-authorization.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date: 04/22/2008

Visit Start Date: 2/5/2007
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Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of 10 samples for WS RC1-Favorable Claims Reconsiderations, UHC failed to provide documentation in eight of the cases (#1, 2, 3, 4, 5, 7, 8, and 10) which verified that the claim was paid within 30 calendar days. The checks were copied but the date sent to the provider was not provided, therefore the reveiwer was unable to determine if the provider was paid within the required time frames. In addition, one case (#1) did not send the notice to the member within the required timeframes.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for favorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date: 04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on review of 10 samples for WS RC2-Unfavorable Claims Reconsiderations, UHC failed to forward cases to the Independent Review Entity (IRE), and provide notification to the member within 60 days of receipt of the request. Two cases in the sample (#9 and #10) did not notify the member timely. One case (#1) in the sample was not sent to the IRE timely. In addition, there was insufficient documentation to verify when the claim was effectuated after UHC received the notification of the overturn.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
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CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on review of 10 samples for WS RC2-Unfavorable Claims Reconsiderations, UHC failed to have complete documentation that Maximus-CHDR (IRE) had been notified of the effectuation of the decision. Three cases in the sample (#2, 4, and 10) did not have adequate documentation that the notice has been sent to the IRE. One sample case (#7) was for emergent care and should not have gone through the pre-authorization or approval process. Findings include: 1. Case #7 included claims for services delivered in an emergency department relating to a potential heart problem. The services included an echo cardiogram of the heart as well as a stress test. The claim was denied for out-of-network. In addition, the member stated she had gone to the emergency room because she believed she was having a "heart attack". This meets the criteria for emergent treatment which should not be denied. This case has been sent to the IRE for review. 2. Cases 2, 4, and 10 contained a generic form which did not provide verification that the notice of the effectuation of the overturn had been sent to the IRE.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. 4. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
Element Accepted Date: 08/15/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 05/23/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review 10 samples for WS RP1-Favorable Standard Pre-Service Reconsiderations, UHC failed to notify the member timely of the adjudication of the reconsideration and/or authorize timely the overturn of the denial. Three cases (#3, 5, and 6) were not authorized within the timeframes for a favorable standard pre-service reconsideration.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the favorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not overturns are authorized within the timeframes in the organization's policies and procedures. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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

Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/30/2007
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CAP Released Date: 04/22/2008

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Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of 10 samples for WS RP2-Unfavorable Standard Pre-Service Reconsiderations, UHC failed to consistently send the denied reconsideration to the independent review entity (IRE) as expeditiously as the member's health requires but no later than 30 calendar days after receiving the reconsideration request. Two cases (#2 and 8) were not sent to the IRE within the timeframes for unfavorable pre-service reconsiderations.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the unfavorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not denied cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 8617

Region: 04 Atlanta

Contract Number / Name: H5820 UNIVERSAL HEALTH CARE INSURANCE COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/30/2007
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Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 07/07/2007

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:

Based on the review of eight samples on WS RP3-Requests for Expedited Reconsiderations, UHC failed to consistently decide whether to expedite a reconsideration and failed to send the required notices to the members based on regulatory requirements. This includes notifying the member timely of the decision not to expedite and sending the case to the IRE. The findings include: 1. Case #2 was not sent to the IRE timely. 2. In cases #3, 4, and 8 the notice advising the member that the case would not be expedited was not sent timely.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the requests for expedited reconsideration process. 2. An internal audit system designed to evaluate whether or not cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.