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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:08/31/2008
MCO Response Due Date: 02/23/2008

Requirement:

Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.

Deficiencies:

42 CFR 422.112(a)(1) Manual Ch. 4 - section 120.2 Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services. Method of Evaluation: Determine if the MAO: 1. Ensures that services are geographically accessible and consistent with local community patterns of care the MAO must ensure that providers are distributed so that no member residing in the service area must travel an unreasonable distance to obtain covered services. In general, commonly used services must be available within 30 minutes driving time. Longer travel times are permissible based on location and established routine patterns of care such as in rural areas. 2. Has provider network standards that define the types of providers to be used when more than one type of provider can furnish a particular item or service. Identify the types of mental health and substance abuse providers in their network and Specify the types of providers who may serve as a member's primary care physician. 3. Assess other means of transportation that members rely on such as public transportation. Required Documentation: All HSD Tables. Documentation Examples: HEDIS practitioner turnover measure· Maps identifying the location of providers· Policies and procedures for identifying out of network providers for infrequently used or unusual services· Provider directories· MAO analysis of transportation alternatives available to members and location of providers along these routes· CAHPS survey results Element Not Met. CMS identified areas of concern in the provider network, where providers are available, the MAO did not contract with providers. MCS failed to indicate where members could access services for which there were no specialists located in their municipality of residence. 1. HSD 2, Column 10 (Contracted Hospital) is blank. 2. HSD 2, Column 14 (Does MCO Delegate Credentialing?) is annotated as N, even when credentialing is performed by FHC. 3. There are numerous group practice corporate names listed on HSD 2 and counted as a practitioner on HSD1, thus inflating the count for that specialty. 4. Physicians with different addresses on HSD 2 are counted twice on HSD 1 thus inflating the count for that specialty.

Corrective Action Required:

Information was provided to the MAO during the onsite review reflecting the review of the HSD tables and areas identified by CMS that required intervention by the MAO to pursue a contract with providers in the identified areas. The MAO will contact providers and provide narratives of success with contracting or declination of contract with narrative explanations. The MAO will submit monthly reports to the Regional Office for six months with a work plan for determining network capacity, network outreach and successful contract with providers.

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/23/2008

Requirement:

Services Provided with Cultural Competence - The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds.

Deficiencies:

42 CFR 422.112(a)(8) Manual Ch. 4 Section 120.2 MCS did not provider services with cultural competence. Services Provided with Cultural Competence - The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds. Method of Evaluation: Determine if the MAO:1. Has developed appropriate policies and administrative systems to address access barriers likely to be encountered by individual members. 2. Ensures that translator services are available for non-English speaking members. Ensures that interpreter services and other accommodations (such as teletypewriter or TTY connections for member services) are made available to the hearing-impaired MPCT requests that this be placed back into the Manual Documentation Examples: Policies and procedures· Provider manual · List of employees who serve as translators· Translator service agreements· List of interpretive accommodations available to the hearing-impaired· Non-English medical pamphlets and instructions· Braille publications, audio tapes, readers, or other appropriate means of communication for the visually impaired · List of continuing education classes which enhance the knowledge of cultural competence Element not met. MCS failed to have formal translator services available or interpreter services identified and no formal policy available for review.

Corrective Action Required:

MCS will develop a corrective action plan to address the issue identified. MCS will develop a policy and procedure, provider manual, and develop a hearing impaired policy, implement a TTY/TDD line, and develop a policy on Interpreter services and will forward policies to Regional Office for review. MCS will post all revisions to provider manual on MCS physician intranet. MCS will train all employees on policies and provide evidence of training to CMS Regional Office.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CF01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 04/16/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/28/2008
MCO Response Due Date: 02/23/2008

Requirement:

Confidentiality of Member Information - The MAO implements procedures to ensure the confidentiality of member medical records and other member information.

Deficiencies:

42 CFR 422.118 Manual Ch. 4 Section 140.1 Confidentiality of Member Information - The MAO implements procedures to ensure the confidentiality of member medical records and other member information. Method of Evaluation: Determine if the MAO: 1. Has policies and procedures regarding confidentiality of medical records or other health and enrolment information it maintains with respect to enrollees. 2. Has policies and procedures that protect against unauthorized or inadvertent disclosure of information to any individual, including the MAO¿s own employees or contractors, who do not have an identifiable need for the information 3. Releases original medical records only in accordance with Federal and State laws, court orders, or subpoenas which includes release of medical records to a member when requested by that member. Documentation Examples: Policies and procedures· Signed employee confidentiality forms· Employee ethics statement Element not met. MCS does not have a fully developed policy that incorporates elements listed above. MCS does not have signed employee confidentiality statements, which include all members of any committee, external physician providers, delegated vendors etc.

Corrective Action Required:

MCS will develop confidentiality policy and procedure incorporating required elements and identifies persons necessary to be in compliance with policy, i.e. all committee members, external providers who have access to member information, applicable staff, and delegated vendors. MCS will forward policy to Regional Office for review. MCS will have all employees, committee members, delegated affiliates sign confidentiality statements. MCS will develop policy statement determining length of time that signed statement is valid, i.e. staff members length of employment, committee members 1 year, UM providers 2 years delegated vendors etc. MCS will retain copy of signed statements. Committee members will sign statements per developed policy. Delegated affiliates will sign statements per developed policy. MCS will submit copies of signed statements to CMS Regional Office for review. Information to be submitted to the Regional Office by March 2008.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DG01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/01/2008
MCO Response Due Date: 02/23/2008

Requirement:

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

Deficiencies:

42 CFR 422.502(i) Manual Ch. 11 section 100.2 Oversight of Delegated Entities with Chapter 4 Responsibilities - If any of the activities or responsibilities for the above elements in Chapter 4 are delegated to other parties, the MAO must oversee them per CMS standards. Method of Evaluation: Determine if the MAO:1. Has a written agreement with the delegated entity/entities which specifies the delegated activities and reporting responsibilities of the entity and includes the revocation of the delegated activities and/or other remedies for inadequate performance. 2. Evaluates an entity¿s ability to perform the delegated activities prior to delegation. 3. Monitors an entity on an ongoing basis and formally reviews that entity at least once annually. Documentation Examples: Contracts/written agreements with delegated groups· Initial assessment criteria for delegated entities· Delegated entity monitoring reports· Delegated services manual Element not met. MCS failed to perform a pre delegation audit on its behavioral health vendor.

Corrective Action Required:

The MAO organization will develop an audit tool that will assist them in performing oversight of the delegated entity. Audit tool will encompass the following: review of contract, credentialing review of initial credentialing files and recredentialing files following CMS's guidelines. Facility credentialing should following CMS's guidelines, on review of quality of care issues, utilization issues and concerns, delegated vendors policies and procedures, delegated organizations board meeting minutes, noting information applicable to contract with MCS, application of Medicare coverage guidelines and member complaints, grievances, appeals. MCS will forward a copy of audit tool to the CMS Regional office by March 1, 2008.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/03/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 02/23/2008

Requirement:

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

Deficiencies:

42 CFR 422.66(b)(3) Manual Ch. 2 - section 50.1.4 Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS. This requirement is not Met. In five out of 15 files reviewed the plan failed to send out a disenrollment letter to beneficiaries who voluntarily disenrolled through other sources other than MAO. Plan began sending out disenrollment letters to members who were voluntarily disenrolled through other sources other than MAO, on March 8th, 2007.

Corrective Action Required:

The Plan had identified this problem back in March 2007, and immediately implemented a correction action plan. The MAO began issuing disenrollment noticies to members disenrolled through sources other than the MAO in March, 2007. The Plan must closely monitor this process to ensure that letters are issued in a timely manner in accordance to 42 CFR 422.66(b)(3) and Medicare Managed Care Manual Chapter 2, Section 50.1.4.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/03/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 02/23/2008

Requirement:

Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.

Deficiencies:

Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment. This requirement is not Met. Please refer to DN02, In five out of 15 cases reviewed the Plan failed to send notification to enrollees voluntarily disenrolled through other sources other than the MAO.

Corrective Action Required:

The MAO must ensure that this element is met per 42 CFR 422.66(b)(3)(ii)-(iii) and the Medicare Managed Care Manual, Chapter 2, Section 50.1.4.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/03/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

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:

The requirement is not met. In nine out of 14 case files reviewed, the Plan failed to send out timely enrollment rejection notification letters to Medicare beneficiaries according to CMS timelines.

Corrective Action Required:

The MAO must ensure that it correctly notifies beneficiaries of enrollment denials in accordance to timeframes specified at 42 CFR 422.60(e)(3) and Medicare Managed Care Manual, Chapter 2, Section 40.2.3.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER10
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/03/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:08/09/2007
MCO Response Due Date: 02/23/2008

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:

42CFR 422.60(e)(3) Manual Ch. 2- section 40.4.2 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. 11 of the 15 samples reviewed did not meet CMS' requirements. AEP date on rejection letters were not accurate.

Corrective Action Required:

MCS must revise the final notice of Enrollment Rejection letter. They must describe CMS' acceptance or rejection of enrollment in accordance with 42 CFR 422.60(e)(3) and Medicare Managed Care Manual, Chapter 2, Section 40.4.2. The Plan must submit a revised letter to the Regional Office for review and approval no later then 10 days after receipt of this 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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

Requirement:

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

Deficiencies:

In 7 out of 15 cases the organization failed to notify the beneficiary timely of Plan's resolution of the case.

Corrective Action Required:

MCS must revise its policy and procedure to ensure that all members are notified of the organization's decisions as expeditiously as the case requires based on the member's health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves the Plan's decision to invoke an extension relating to an organization determination or reconsideration, or the compliant involves Plan's refusal to grant an enrollee's request for an expedited organization determination or expedited reconsideration, then MCS must respond to an enrollee's grievance within 24 hours. MCS must also train all applicable staff members of the revised policy and procedures.

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 02/23/2008

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:

In 11 out of 15 cases MCS failed to issue the proper notice of resolution to the beneficiary.

Corrective Action Required:

MCS must revise its policy and procedures so that it issues notification of investigation results to all concerned parties as expeditiously as the enrollee's case requires, based on the enrollee's health status, but no later than 30 calendar days from the date the oral or written grievance is filed with the health plan.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/17/2008
MCO Response Due Date: 02/23/2008

Requirement:

Appropriate Submission and Distribution of Marketing Materials -The MAO follows the requirements contained in the regulations and the Medicare Guidelines for submission and distribution of marketing materials, including appropriate timelines and content of model, non-model, and File & Use materials.

Deficiencies:

The MAO an has failed to submit marketing materials through HPMS in English prior to submitting Spanish versions as outlined in the Managed Care Marketing Guidelines. Plan has submitted materials in Spanish without CMS required attestation. Required marketing materials such as Summary of Benefits, Evidence of Coverage and others have been disapproved and resubmitted without addressing Regional Office's recommendations. Final approved versions of CMS required pre and post enrollment materials have had an alarming amount of revisions, some ranging over 5 or 6 disapprovals. Plan Manager and Analyst have had calls with Plan to address recurrent disapprovals. Grievances from beneficiaries have led to detection of inaccurate File and Use materials in HPMS. In addition, the 2007 Annual Notification Materials (Annual Notice of Change Letter, Summary of Benefits), etc., did not meet CMS mandated mailing timelines as well as the 2008 notification materials.

Corrective Action Required:

Plan must demonstrate recurrent use of attestation for all non-English pieces of submitted marketing materials per CMS Managed Care Marketing Guidelines. Plan must monitor File and Use materials to ensure accuracy of said materials prior to printing and to ensure that they meet CMS Marketing Guidelines. Plan must ensure materials are reviewed for accuracy prior to submitting to CMS. Plan must have process in place for receiving recommendations and or comments from CMS reviewer and incorporate said changes into materials prior to re-submission. Plan must establish a process to ensure CMS that all future Annual Notification materials will meet CMS mailing timelines.

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
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Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/07/2008
MCO Response Due Date: 02/23/2008

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:

Based on sample review of sales representative files, half did not possess a valid Commonwealth license to sell MA products. Most were provisional licenses without proof of status update or action on behalf of the MAO in accordance to their policy and procedures. There was no policy and procedure to address who, when and how sales representative files would be audited to ensure accuracy of contents and updates. Performance data was lacking, there were no marketing statistics to demonstrate rapid disenrollment rates or chargeback's. The Plan failed to demonstrate oversight of the individuals contracted to sell their products. Although some representative files contained marketing allegations, there was no evidence in the file to demonstrate feedback or disciplinary action. In addition, one case contained marketing allegations that were not considered for investigation by corporate compliance. The MAO alleged that complaints of a legal nature are handled through corporate processes and not through the CMS required compliance investigation procedure.

Corrective Action Required:

MAO must provide policies and procedures to address maintenance of sales representive files to ensure contents are consistent throughout, contain all necessary documentation and are updated and monitored regularly. Plan must demonstrate via policy and procedures how it will address sales representative's who have provisional Commonwealth licenses and what will happen to these individuals after this period expires. Policies and procedures need to be implemented to address handling of marketing allegation by including evidence of an investigation in accordance to CMS regulations. Feedback and disciplinary action need to be addressed at the compliance level and documented within the sales representative file. Performance data needs to be gathered regularly and documented in the sales representative file as well.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

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:

Eleven out of 30 cases submitted by MCS were not processed correctly. In nine of 11 cases the Plan inappropriately denied claims due to non-provider participation. However the providers in the nine cases sampled, are listed on both provider directory and HSD tables. In all cases Plan failed to follow up with provider to secure additional information and develop cases accordingly. In our review of the cases provided to us by the delegated entity, four out of the 15 cases were duplicates of cases already listed in sample and therefore labeled misclassified. Of the remaining 11 cases in six cases the delegated entity failed to secure additional information and develop cases accordingly.

Corrective Action Required:

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

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

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:

In three out of 30 cases Plan failed to process clean claims within 30 days of receipt. Of the three clean claims not processed within 30 days, in two claims MCS failed to pay the correct interest amounts.

Corrective Action Required:

In accordance with Medicare Guidelines, MCS and/or its delegated entity must pay 95 percent of clean claims from non-contracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the date of request. MCS must ensure that all clean claims exceeding 30 days are paid accordingly with interest.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

Requirement:

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

Deficiencies:

This element is met for MCS, however, in our review of the cases provided to us by the delegated entity, four out of the 15 cases were duplicates of cases already listed in sample and therefore labeled misclassified. Of the remaining 11, delegated entity failed to process two claims within the 60 day time frame.

Corrective Action Required:

In accordance with Medicare Guidelines, MCS and/or its delegated entity must make correct claim determinations for services not payable and issue proper denials within 60 days of receipt. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. Failure to issue a determination within the 60 day timeframe constitutes an adverse determination and the organization is obligated to send the case to the IRE for review.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/21/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

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:

This element is met for MCS, however, in our review of the cases provided to us by the delegated entity, four out of the 15 cases were duplicates of cases already listed in sample and therefore labeled misclassified. Of the remaining 11, in six cases the delegated entity failed to issue proper denial notices to the beneficiaries.

Corrective Action Required:

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

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:04/30/2008
MCO Response Due Date: 02/23/2008

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:

Two out of 10 cases were misclassified. In seven of the remaining eight cases, MCS failed to issue a timely decision.

Corrective Action Required:

MCS must ensure that when an enrollee has made a request for a service, that they notify the enrollee of its determination as expeditiously as the enrollee's health condition requires, but no later than 14 calendar days after the date the organization receives the request for a standard organization determination.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
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CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

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:

In 2 out 10 cases were misclassified. 7 of the remaining 8 cases MCS failed to issue a timely decision. In all 8 cases MCS failed to issue to member a denial notice in writing which provided the service denied and the basis for denial. As such we could assess plans ability to send out notices as required.

Corrective Action Required:

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

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

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:

In five out 10 cases MCS failed to issue a timely decision verbally or in writing to the member. As such we could not assess Plans ability to send out notices as required.

Corrective Action Required:

MCS must ensure that when an enrollee has made a request for a service, they notify the enrollee of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after the organization receives the request for an expedited organization determination.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/23/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

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:

In five out of 10 cases MCS failed to issue a timely decision verbally or in writing to the member. As such we could assess Plan's ability to send out notices as required

Corrective Action Required:

MCS must establish and maintain procedures that establish efficient and convenient means for enrollees to submit oral/written requests for expedited organization determinations. MCS must document all oral requests in writing and maintain the documentation in the case file. MCS must promptly decide whether to expedite a determination based on whether applying the standard time frame for making a determination could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function. Provide written notice of denials of requests for expedited determinations and instructions on how to file an expedited grievance when enrollees dispute the managed care denial or extension decision, and develop a meaningful process for receiving requests for expedited reviews. These procedures should include designating an office and/or department to receive both oral or written requests and a telephone number for oral requests, and may include a facsimile number to facilitate receipt of requests for expedited organization determinations. The procedures must be clearly explained in member materials. In addition, Medicare health plans will be accountable for educating staff and provider networks to ensure that requests for expedited review received by medical groups or other health plan offices are referred immediately to the Medicare health plan's designated office or department. The 72-hour period begins when the request is received by the appropriate office or department designated by the Medicare health plan regardless of whether the provider is under contract to the Medicare health plan. If the Medicare health plan requires medical information from non-contracted providers to make a decision, the Medicare health plan must request the necessary information from the non-contracted provider within 24 hours of the initial request for an expedited organization determination.

CMS Medicare Managed Care Auditing Report

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/28/2008
MCO Response Due Date: 02/23/2008

Requirement:

Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions.

Deficiencies:

42 CFR 422.202(a)(d) Participation and Termination Procedures - The MAO must have written policies and procedures and a process for rules of physician participation and adverse participation decisions. CMS reviewed MCS's written policies and procedures for rules of physician participation and adverse participation decisions. We attempted to determine if the MAO: 1) has written rules of participation, including: terms of payment, credentialing, and other rules, such as those found in the provider manual, that directly relate to participation decisions. 2)gives written notice, before the rules are put into effect, of material rule changes. 3) ensures that physicians receive a notice of adverse participation decisions, 4) has a process for appealing adverse participation decisions, including a written notice of an adverse decision (an action to suspend or terminate an agreement), which explains the appeal rights and contains, the reasons for the action (including, if relevant, the standards and profiling data used to evaluate the physician and the numbers and mix of physicians needed by the MAO), and, the process and timing for this appeal, 5) notifies contracting physicians of the timeframes for terminating the contract without cause within at least 60 days of the termination, 6) ensures that the hearing panels' composition consists of a majority of its members who are peers of the affected physician, 7) if a quality deficiency exists, sends a notice to the licensing and disciplinary bodies and other appropriate authorities when a provider is suspended or terminated, 8) has policies and procedures to determine if the provider opted out of Medicare and acts on the results if he/she has opted out, 9) ensures that all the above items apply equally to physicians in subcontracting groups (Documentation Example's: policies and procedures, credentialing committee minutes, Model Termination/Suspension Notice, provider manual, selection and retention criteria, list of terminated or suspended providers and case file(s) of terminated/suspended physician(s), criteria for composition of the hearing panel, hearing panel minutes.) This element is not met as evidenced by MCS's current credentialing committees' failure to have representation of members of the participating physician community. The only providers on the credentialing committee are physicians employed by the MAO. MCS failed to ensure that the hearing panels' composition consists of a majority of its members who are peers of the affected physician. The reviewer was unable to determine if delegated providers are submitted to the committee for review. MCS's committee minutes are lacking in the following areas definition of the chairperson, define a quorum, signature of committee chair, review of previous minutes and approval at next credentialing committee meeting, approval of credentialed physicians, also there was no list of physicians credentialed or recredentialed attached to the minutes therefore the reviewer was unable to determine who had been credentialed and approved for that month. There was no list of disputed physician applications or recredentialing applications. MCS's committee minutes do not follow a recognized committee format, and there is failure to follow industry format for minutes. MCS's policies and procedures do not depict the composition of the credentialing committee, or describe the number of external community based physicians who are members of the committee or of the appeals committee. There is no evidence of external physician participation or committee members/physicians who are not employees of the MAO. The credentialing committee meets minimally once a month and the only physicians present at many of the meetings are Medical Directors for the MAO. Committee members do not sign a confidentiality agreement.

Corrective Action Required:

MCS must actively recruit community based participating physicians to be members of the credentialing committee and a distinct group of physicians for the appeals committee who are not employees of the MAO. The committee participants should actively participate in the Peer Review Process. Documentation in committee minutes should reflect participation of all members of the credentialing committee. Committee minutes documentation to follow industry standards, quorum, chairperson, list of providers to be credentialed attached, confidentiality statements signed by all committee members, open items addressed at the next meeting, improved description of quality review for recredentialing. Documentation should also include minutes of review and approval/disapproval of delegated providers. MCS must submit revised policies to the Regional Office that describe the composition of the credentialing committee, the appeals committee etc., and the number of committee members who are external to the MAO. MCS will submit to the Regional Office a list of external providers who have agreed to be members of the credentialing committee along with signed statements of confidentiality. This list is to be submitted with the minutes of the credentialing committee for six (6) committee meetings beginning the first quarter of 2008.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
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CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

Requirement:

Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's: medical policy, quality assurance programs, and medical management procedures.

Deficiencies:

42 CFR 422.202(b) and (c) Manual Ch. 6 - Section 20.1 Consultation with Physicians and Subcontracted Physician Groups - The MAO must establish a formal mechanism to consult with the physicians and subcontracted groups that have agreed to provide services regarding the organization's medical policy, quality assurance programs, and medical management procedures. Method of Evaluation: Determine if the MAO:1) has a process for adoption of practice guidelines, 2) approves and periodically reviews clinical criteria based on scientific advances or changes in customary practice (Relevant health care professionals should perform the approval and periodic review), 3) makes clinical criteria for specific procedures available upon a request from a provider, 4) includes new practice guidelines based on the needs of its population or identified variations in practice patterns within the MAO, 5) hHas a formal mechanism for consulting affiliated physicians as it periodically reevaluates guidelines, 6) disseminates Practice guidelines to physicians (including those physicians in subcontracted groups) and selected relevant guidelines, such as preventive and self care, to the members, 7) conducts consultation with affiliated physicians and outside experts and communicates coverage decisions to providers, 8) adopts coverage policies that are consistent with national Medicare coverage determinations. 9) Has a process for communicating practice guidelines, upon request, to all providers and enrollees, including: discharge criteria, continued stay, and admission practice guidelines. (Documentation Examples: Provider manuals and newsletters· Documentation to evaluate if the MAO conducts consultations with affiliated physicians and outside experts, Coverage decision process for communicating information to physicians),Examples of the MAO's clinical practice guidelines · QA Minutes Element not met MCS failed to have external providers on credentialing committee. Providers need to sign confidentiality statements. Develop a formal policy for consulting with groups.

Corrective Action Required:

MCS must actively recruit community based participating physicians to be members of the various committees who are not employees of the MAO. The committee participants should actively participate in the Peer Review Process, medical policy, quality assurance program and medical management committee. Documentation in various committee minutes should reflect participation of all members of the committee. Committee minutes documentation to follow industry standards, quorum, chairperson, problem identified, corrective action, resolution, confidentiality statements signed by all committee members, open items addressed at the next meeting, improved description of activities of each committee. MCS must submit revised policies to the Regional Office that describe the composition of the various committees, the appeals committee etc., and the number of committee members who are external to the MAO. MCS will submit to the Regional Office a list of external providers who have agreed to be members of the various committees along with signed statements of confidentiality.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/28/2008
MCO Response Due Date: 02/23/2008

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:

42 CFR 422.204(b)(2) Manual Ch. 6 - Section 60.3 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. Method of Evaluation: Complete the sample review of WS-PR1. Determine if the result from column 17 meets the compliance standard. Element not met. 10 of 10 files reviewed were incomplete, missing information, not timely, or out of compliance with regulatory requirements. Difficult to determine on recredentialing files what Quality Improvement Oversight is performed. Credentialing committee minutes are lacking in who is being credentialing, approval of delegated entities credentialed providers, discussion of providers under review, outcome of providers under review, facility credentialing and approval. MCS was permitting provisional credentialing which CMS does not permit. MCS policies and procedures require updating.

Corrective Action Required:

MCS will develop a corrective action plan that depict the oversight of the credentialing department, oversight of delegated entities for credentialing and recredentialing, development of formal credentialing requirements for facility credentialing. MCS will submit CAP to the Regional Office for review. MCS will improve committee minutes by following format listed below. MCS will attach list of providers who are to be approved or disapproved to all committee minutes. MCS will identify providers with unique ID number in all credentialing committee minutes. This unique number will also be included on all credentialing files. MCS will submit credentialing committee minutes for six (6) committee meetings starting with December 2007. MCS will develop a self audit tool to monitor credentialing files. Random sample of 10-20 files monthly for compliance with regulatory requirements. MCS will submit results of 2 quarters of results of internal audit of credentialing files.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:08/30/2008
MCO Response Due Date: 02/23/2008

Requirement:

Process for Consultation with Health Care Professionals Regarding CredentialingThe MAO must have a process for health care professionals' input in the credentialing process.

Deficiencies:

The MAO must have a process for health care professionals' input in the credentialing process. 43 CFR 422.204(b)(2)(iii) CMS reviewed MCS's policies and procedures to determine if the MAO established a consistent process for receiving advice fro contracting health professionals with respect to criteria for credentialing and recredential of individual health care professionals. The element is not met. The scope for the committee is not adequate to offer sufficient peer review. There are no external physicians or participating providers who are members of the credentialing committee. Often the only physician review is the chairperson of the Committee who is also a Medical Director for MCS. There is no evidence of external participation of contracted providers.

Corrective Action Required:

MCS must actively recruit participating providers to be members of the credentialing committee who are not employees of MCS. The committee participants need to actively participate in the Peer Review Process. Documentation in committee minutes needs to reflect participation of all members of the credentialing committee. MCS must submit revised credentialing policies to the Regional Office for review. MCS must submit credentialing committee minutes for six (6) months with attendance sheets reflecting committee members with title and affiliations.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Element Release Date: 04/16/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 02/23/2008

Requirement:

Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.

Deficiencies:

42 CFR 422.204(b)(1) Manual Ch. 6 - Section 70 Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing. Method of Evaluation: Determine if the MAO:· Requires determination, and re-determination at specified intervals that each facility is:· Licensed to operate in the State· In compliance with any applicable State or Federal requirements including the requirement to be Medicare certified· Reviewed and approved by an accrediting body or meets the standards established by the organization itself. Documentation Examples: Policies and Procedures· State Licensure information· Accrediting Information· Files the MAO keeps on its contracting facilities· Medicare Provider number documentation· Credentialing committee minutes Element Not met, Based on the review of a sample of 10 (ten) facility credentialing not in compliance. At time of review CMS determined that 6 (six) of 10 (ten) files reviewed did not meet established criteria, i.e. contract not fully executed, no license, Medicare number, CLIA certificate, lack of malpractice information in the files for review. The facilities under HSD table 3 had stated that all radiology information would be located on HSD table 1 when the files were pulled for reveiw the providers had not been credentialed as individual providers or as facilities. Therefore the files were incomplete under both designations. The plan needs to define under which category radiology providers would be listed and credential accordingly. In review of mammography facilities 3 of 15 listed were not FDA approved facilities, members cannot be referred to these facilities.

Corrective Action Required:

MCS must develop and implement the following: 1) a corrective action plan which will outline the process that MCS will develop to ensure compliance with this element, 2) revise policies and procedures to reflect CMS guidelines, 3) present completed files to credentialing committee for review and approval, 4) provider manual list FDA approved mammography centers under a separate heading. Submit revised manual to Regional Office for review, 5)develop audit tool and monitor on a monthly basis facility credentialing, 6) develop a recredentialing policy and audit tool, 7) revise policy to reflect FDA approved mammography facilities, 8) incorporate member complaints, UM, or provider issues into recredentialing. MCS must submit to the CMS Regional Office revised credentialing policies and credentialing manual for review by March 2008.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 04/16/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
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Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:03/01/2008
MCO Response Due Date: 02/23/2008

Requirement:

No Prohibition on Health Care Professional Advice to PatientsAn MAO may not prohibit a health care professional from advising or advocating on behalf of a patient.

Deficiencies:

42 CFR 422.206(a) and (b) Manual Ch. 6 - Section 40 No Prohibition on Health Care Professional Advice to Patients. An MAO may not prohibit a health care professional from advising or advocating on behalf of a patient. Method of Evaluation: Determine if the MAO:1. Allows health care providers to give information about:· The member's health status, medical care or treatment options (including alternative treatments that may be self-administered), including the provision of sufficient information to the individual to provide an opportunity to decide among all relevant treatment options· The risks, benefits, and consequences of treatment or non-treatment· The opportunity for the member to refuse treatment and to express preferences about future treatment decisions. Documentation Examples: Policies and procedures· Provider manual· Provider newsletter(s)· If complaint filed with CMS, documentation from the MAO· Member newsletters Element not met. In reviewing MCS's policy the following information was left out in provider information and member information the following statement "including alternative treatments that may be self administered." Policy review reflects following information left out of MCS's policy.

Corrective Action Required:

MCS must revise policy and procedure to reflect appropriate language in the regulation. Submit policy and procedure to Regional Office for review. Update member handbook, member materials, provider manual, provider materials. Forward updated material to Regional Office March 2008.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 06/04/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

Requirement:

QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.

Deficiencies:

42CFR 422.152 (a) and (f)(2): Manual Ch. 5-Section 20.1 QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually. Method of Evaluation: Determine if the MAO: 1) has a QI program that incorporates information from customer service, appeals and grievances, medical management, credentialing, provider relations, claims, sales, and marketing, 2) designates a senior official responsible for QI administration, 3)has a policy making body that evaluates the effectiveness of the QI program, 4)has an annual evaluation of its QI program which assesses both progress in implementing the QI strategy and the extent to which the strategy is in fact promoting the development of an effective QI program. Considers whether activities in the organization's work plan are being completed on a timely basis or whether commitment of additional resources is necessary. Includes recommendations for needed changes in program strategy or administration, 5) encourages its providers to participate in CMS and HHS quality improvement initiatives. Documentation Examples: quality improvement (QI) minutes, QI program and evaluation, board minutes, organizational charts· QI workplan Element not met. MCS failed to demonstrate that it has an ongoing quality improvement program that meets CMS requirements. Upon review of governing board meeting minutes for years 2005-2007 the board did not review the Quality Improvement Program, annual evaluation, yearly workplan and UM workplan, etc. as required by regulation. Governing Board of Director's minutes for 2005, 2006 and 2007 were reviewed, these minutes lacked documentation of oversight of the MAO QA/QI program for the three calendar years. For years 2005-2007 documentation supplied by MCS for review does not meet CMS requirements which include the following: the written program did not include the following: a. the purpose of the quality improvement program, b. written statement of the scope of responsibility which includes all aspects of Medicare care as well as administrative operational components such as claims adjudication, appeals and grievances and review of all departments, including oversight of delegated services.

Corrective Action Required:

MCS must incorporate the following elements in their QA program, work plan, narrative and evaluation. Customer service, appeals and grievances, credentialing including facility credentialing, provider relations, claims, sales and marketing. This documentation should also include oversight of delegated entities, member input etc., and incorporation of CCIP, HEDIS, CAHPS and individual studies designated by the plan. This documentation must then be submitted for review, discussion and approval by the Governing Board on an annual basis in the 1st quarter of the year in order for the plan to be implemented. MCS must submit to the Regional Office for review a revised 2007 QA Workplan, 2006 evaluations, 2007 QA Description that incorporates all required elements and individual departments quality improvement activities and this document to reflect oversight of delegated entities and member input into the quality program. MCS will submit to the Regional Office the 2008 QA workplan, 2007 evaluation and 2008 QA Description. MCS must submit copy of signed governing board minutes that document review of the Quality Improvement Program, yearly evaluation and annual workplan. MCS will submit governing board meeting minutes for 2007 and 2008 which reflect governing board approval.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 08/11/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 02/23/2008

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:

42 CFR 422.504(i) Manual Ch. 11 section 100.2 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. Method of Evaluation: Determine if the MAO: 1) Has a written agreement with the delegated entity/entities, which specifies the delegated activities and reporting responsibilities of the entity, and includes the revocation of the delegated activities and/or other remedies for inadequate performance. 2) Evaluates the entity¿s ability to perform the delegated activities prior to delegation. 3) Monitors the entity on an ongoing basis and formally reviews the entity at least once annually. Documentation Examples:· Contracts/written agreements with delegated groups· Initial assessment criteria for delegated entities· Delegated entity monitoring reports· Delegated services manual Element not met. MCS failed to perform a pre delegation audit on its behavioral health vendor. For calender year 2006 the Plan performed an annual review. The report documents that credentialing information will go to a CVO yet the CVO is not named or contract with CVO verified. This information should have been verified on an initial pre-delegation audit. The report discusses credentialing committee minutes, definition of quorum is not defined, number and types of providers listed as members of the committee is not provided. Review of information supplied regarding credentialing committee minutes does not state any discussion of quality issues, recredentialing issues or initial issues with providers being credentialed. The report states that a credentialing review was performed, yet list of files reviewed is not attached to report, unable to verify if files were reviewed. The report states that there are deficiencies with several policies, yet a corrective action is not required. The Plan identified deficiences with the Quality Improvement and Utilization Management Program yet did not require corrective action from the delegated entity.

Corrective Action Required:

The MAO will follow up on calendar year 2006 and request that issues identified with policies, and quality improvement and utilization management be addressed with a corrective action plan. The MAO will develop a audit check list which incorporates the following items. Credentialing: Perform a credentialing audit of delegated files, include both initial credentialing and recredentialing. Retain results of audit and attach to yearly review file. Review Member complaints, grievances and appeals. Review QI activity Review QI studies Review Policy and Procedure update Review of UM data Review of credentialing committee minutes Review of credentialing files with list attached to final report. Review of governing board activities pertaining to contract with MCS. The MAO will perform an in depth review of delegated vendors within first six (6)months of 2008. The MAO will forward results of oversight of delegated vendor to Regional Office for review. The MAO will issue a deficiency report to delegated vendor with request for corrective action plan for issues identified for calender year 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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/20/2008
Element Release Date: 05/02/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/23/2008

Requirement:

Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.

Deficiencies:

Quality Improvement Projects: The MAO must successfully complete annual QI projects that focus on clinical or non-clinical areas and submit the project reports to the evaluation entity.

Corrective Action Required:

Revise the 2006 Quality Improvement Project so that reported data for each measurement period follows HEDIS specifications for the defined quality indicator. HEDIS sampling methodology rather than a reduced sample size is required so that the project's impact on the target population can be evaluated. Implement interventions specifically focused on improving the QI project's quality indicator. Submit the revised report to the evaluation entity, MAQRO.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 03/20/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

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:

The requirement is not met. In one out of 10 unfavorable claims reconsiderations sampled, the MAO failed to process the reconsiderations timely. In addition, seven of the remaining nine were misclassified "appeals" not reconsiderations, leaving only two cases to meet the timeliness requirement for this element.

Corrective Action Required:

The MAO must ensure that it processes unfavorable claims reconsiderations timely. In addition, it must ensure that its staff receives refresher training in order to correctly identify what it is an appeal and what is a reconsideration.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/28/2008
MCO Response Due Date: 02/23/2008

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:

The requirement is not met. In one out of the six unfavorable claims reconsiderations sampled, the MAO failed to process the reconsideration timely per Code of Federal Regulations 422.590 (b)(2)(c) and (3). Four of the selected cases were misclassified.

Corrective Action Required:

The MAO must ensure that it processes all unfavorable claims reconsiderations within the specified timeframes. In addition, MAO staff must receive refresher training on the appeals process. Please provide CMS with training schedule(s) and implementation timelines.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
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CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:08/31/2008
MCO Response Due Date: 02/23/2008

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:

The requirement is not met. Six out of 10 unfavorable pre-service reconsiderations sampled, were not processed timely.

Corrective Action Required:

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.

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: 9837

Region: 02 New York

Contract Number / Name: H4006 MCS ADVANTAGE INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 08/12/2008
CAP Released Date:09/08/2008

Visit Start Date: 8/21/2007
Exit Conference Date: 12/04/2007
Date Report Issued: 01/09/2008
Date Report Due: 01/18/2008
CAP Accepted Date:03/20/2008
Audit Closed Date: 09/08/2008
Element Projected Completion Date:02/29/2008
MCO Response Due Date: 02/23/2008

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:

The requirement is not met. Two out of the 10 unfavorable standard pre-service reconsiderations were misclassified. In addition, two of the remaining eight cases, were not processed in accordance with CMS guidelines.

Corrective Action Required:

The MAO must ensure that it follows the correct 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.