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: 8197

Region: 06 Dallas

Contract Number / Name: H3208 HCSC INSURANCE SERVICES COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/01/2007
Element Accepted Date: 11/21/2007
Element Release Date: 07/31/2008
CAP Released Date: 07/31/2008

Visit Start Date: 7/9/2007
Exit Conference Date: 07/13/2007
Date Report Issued: 08/16/2007
Date Report Due: 08/27/2007
CAP Accepted Date: 11/21/2007
Audit Closed Date: 07/31/2008
Element Projected Completion Date:
MCO Response Due Date: 09/30/2007

Requirement:

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

Deficiencies:

This requirement is not met. HCSC Insurance Services Company (HISC) denial notices for claims submitted by non-contracting providers contain neither sufficient descriptions of the denied services nor adequate explanations of the reasons for denial. The words, "non covered services", are shown as either the description of the service, the reason for denial, or both, for over 25 percent of the sample cases. As a Preferred Provider Organization, HISC must provide reimbursement for all Part A and Part B services covered under the Original Medicare program regardless of whether the services are furnished by a contracting provider. The organization must comply with CMS national coverage determinations, general coverage guidelines included in Original Medicare manuals and, written coverage decisions of local Medicare contractors in the same geographic service area. To the extent that services furnished by non-contracting providers do not conform to Original Medicare coverage criteria, the claim denial notice must include a description of the actual service as well as a specific statement which includes a detailed explanation of the reason for the denial.

Corrective Action Required:

HISC must revise, effectuate and audit internal procedures to ensure compliance with 42 CFR 422.568(e). HISC must take appropriate steps to correct denial notices for noncontracting provider claims to ensure that notices provide a description of the actual service as well as a specific denial reason. The CAP response should include a timetable for correction and implementation of revised policies, procedures or processes, and any other actions necessary to correct this deficiency. HISC must also provide the format and content of revised policies and procedures for our approval and the CAP should include a provision for ongoing monitoring of this delegated function. Following corrective actions taken, HISC should conduct an internal audit, on a monthly basis, of claim denials issued by the organization to ensure ongoing compliance with this requirement. The CAP should, at a minimum, provide for the submission of a quarterly summary report to the Regional Office of the monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. HISC must continue to provide a quarterly update of internal audit results until CMS determines that HISC meets regulatory requirements

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Region: 06 Dallas

Contract Number / Name: H3208 HCSC INSURANCE SERVICES COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP12
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/01/2007
Element Accepted Date: 10/26/2007
Element Release Date: 03/26/2008
CAP Released Date: 07/31/2008

Visit Start Date: 7/9/2007
Exit Conference Date: 07/13/2007
Date Report Issued: 08/16/2007
Date Report Due: 08/27/2007
CAP Accepted Date: 11/21/2007
Audit Closed Date: 07/31/2008
Element Projected Completion Date:
MCO Response Due Date: 09/30/2007

Requirement:

Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.

Deficiencies:

This requirement is not met. CMS could not determine if HCSC Insurance Services Company (HISC) is in compliance with this requirement. A universe did not exist for worksheet OP05 (QIO Review of Termination of Services-SNF, HHA, CORF Provider Services). Based on the findings for elements OP10 and OP11 we conclude that HISC deprived enrollees of the opportunity to file a QIO appeal due to the organization's failure to properly notify its enrollees of their due process rights following a decision to terminate provider services. The findings for elements OP10 and OP11 are contributory factors to the absence of a universe as HISC could not demonstrate that its enrollees were notified of their right to request a fast track appeal by the QIO following a termination decision by the organization.

Corrective Action Required:

The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, timeliness information for all notices (Detailed Explanation of Non-Coverage CMS 10095-B) issued by the organization at the request of the QIO. This information should be included in the organization's summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the necessary actions required to furnish the CMS -10095-B on a timely basis following notification by the QIO.

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Findings: NOT MET

Review ID: 8197

Region: 06 Dallas

Contract Number / Name: H3208 HCSC INSURANCE SERVICES COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP13
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/01/2007
Element Accepted Date: 10/26/2007
Element Release Date: 03/26/2008
CAP Released Date: 07/31/2008

Visit Start Date: 7/9/2007
Exit Conference Date: 07/13/2007
Date Report Issued: 08/16/2007
Date Report Due: 08/27/2007
CAP Accepted Date: 11/21/2007
Audit Closed Date: 07/31/2008
Element Projected Completion Date:
MCO Response Due Date: 09/30/2007

Requirement:

Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.

Deficiencies:

This requirement is not met. CMS could not determine if HCSC Insurance Services Company (HISC) is in compliance with this requirement. A universe did not exist for worksheet OP05 (QIO Review of Termination of Services-SNF, HHA, CORF Provider Services). Based on the findings for elements 0P10 and OP11 we conclude that HISC deprived enrollees of the opportunity to file a QIO appeal due to the organization's failure to adequately notify its enrollees of their due process rights following a decision to terminate provider services. The findings for elements OP10 and OP11 are contributory factors to the absence of a universe as HISC could not demonstrate that its enrollees were notified of their right to request a fast track appeal by the QIO following a termination decision by the organization.

Corrective Action Required:

The CAPs for elements OP10 and OP11 partially satisfy this request. In addition, HISC must capture, on a monthly basis, notice content information for all notices (Detailed Explanation of Non-Coverage of provider services CMS-10095-B) issued by the organization at the request of the QIO. This information should be included in the summary quarterly report to the Regional Office. Further, HISC must ensure that its policies and procedures accurately capture the actions necessary to furnish all required notice content elements of the CMS -10095-B.

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Region: 06 Dallas

Contract Number / Name: H3208 HCSC INSURANCE SERVICES COMPANY

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/01/2007
Element Accepted Date: 10/26/2007
Element Release Date: 05/09/2008
CAP Released Date: 07/31/2008

Visit Start Date: 7/9/2007
Exit Conference Date: 07/13/2007
Date Report Issued: 08/16/2007
Date Report Due: 08/27/2007
CAP Accepted Date: 11/21/2007
Audit Closed Date: 07/31/2008
Element Projected Completion Date:
MCO Response Due Date: 09/30/2007

Requirement:

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

Deficiencies:

HCSC Insurance Services Company (HISC) did not meet the CMS 95% compliance standard because CMS audited twenty (20) cases and found sixteen (16) cases without verification of the most recently issued Medicare opt out list for physicians and practitioners at the points of inital credentialing and recredentialing. Of the sixteen (16) non -compliant cases, thirteen (13)cases were performed by a delegated entity.

Corrective Action Required:

HISC must revise Policy # M-103-0320, Credentialing and Recredentialing Policy, to specify the Office of the Inspector General (OIG) website at www.oig.hhs.gov/fraud/exlusions/listofexcluded.html (Chptr 6, Sec 60.2) as the appropriate agency to verify Medicare excluded providers and entities. HISC must establish a mechanism for ongoing monitoring of Medicare opt out verification to ensure continued internal compliance. Policies and procedures should be updated to reflect these improvements. HISC must revise its oversight of its delegated entities to ensure that the most recent Medicare opt out list is reviewed at the points of initial credentialing and recredentialing. Policies and procedures should be updated to reflect these improvements. HISC must provide the regional office with the revised policies, procedures and mechanism(s) planned for continued internal and delegated entity compliance to the Medicare opt out credentialing requirement. In addition, HISC should conduct an internal audit of all delegated entities, on a monthly basis, to determine ongoing compliance. Your plan for corrective action should, at a minimum, provide for the submission of a quarterly summary report to the Regional Office of the monthly audit findings. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit. HISC must continue to provide a quarterly update of internal audit results until CMS determines that HISC meets regulatory requirements.