CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Review ID: 8817

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/20/2008
Element Release Date: 03/19/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

Requirement:

Required Contract Provisions: Abide by Federal RequirementsThe MAO's written contracts with first tier and downstream entities must contain a provision to show that the contracting entity will: comply with Medicare laws, regulations, reporting requirements, and CMS instructions; agree to audits and inspection by CMS and/or its designees; cooperate, assist, and provide information as requested; and maintain records a minimum of 10 years.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 20 cases from a universe of 2650 whereby 17 cases (#2-9, 11-15, 17-20) failed to meet federal requirements for the required contract language for first tier and downstream provider contracts. Also, 2 cases (#10, 16) were submitted for non-contracted providers and were included in the universe of contracted providers. The documentation submitted for case #4 was a letter of intent, which is not considered an acceptable contract by CMS.

Corrective Action Required:

Freedom Health must amend its provider contracts to ensure that all contracts include the required contract language, specifically, the accuracy of enrollee records, the right for HHS and its designees to audit extends for a period of 10 years rather than 6 years and complying with and abiding by all federal regulations as mandated by 42 CFR 422.504. The corrective action must include a timeline for amending all deficient provider contracts and submit copies of the amended contracts to the regional office for the cases identified above. Additionally, Freedom must execute a legal and binding contract and/or agreement with the provider identified in case #4 and submit a copy of this document as part of the corrective action plan.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 01/25/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

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:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 15 cases from a universe of 25 in which 5 cases were untimely and 2 cases were misclassified as follows. Cases 4, 12, 13, 14 and 15 were processed beyond the 30 day timeframe for standard grievances and no extensions were taken. Cases 8 and 11 were processed in error as grievances: #8: the enrollee requested reimbursement for dental services by a non-par dental provider. #11: the enrollee questioned the denial of a free service that was provided by the plan which constituted an adverse organization determination and is appealable.

Corrective Action Required:

Freedom Health must process grievances according to the timelines mandated by 42 CFR 422.564. Additionally, Freedom Health must correctly distinguish grievances from organization determinations and appeals. In complying with this corrective action, Freedom Health must develop and implement correct policies and conduct training of appropriate staff on these policies and procedures. Freedom Health must also submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/07/2008
Element Release Date: 02/07/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

Requirement:

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

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 30 cases from a universe of 5725 whereby 10 cases (#2, 4, 5, 9, 11, 13, 14, 19, 24, 25) failed to meet federal requirements for timely payment of non-contracting provider clean claims. During the discussion, the claims manager stated that the claims processing function is shared by Freedom and a delegated entity, USHH. Pursuant to 42 CFR 422.500 and 422.520(a) (1), Freedom must pay 95 percent of clean claims from non-contracting providers within 30 calendar days of receipt.

Corrective Action Required:

1.)Freedom must submit a copy of revised procedures for oversight of USHH. Oversight procedures must ensure that USHH meets CMS requirements for timely processing of clean claims. Oversight procedures should cover training of USHH staff, review of USHH's claims processing system, and review of USHH's policies and procedures. 2.)Freedom must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. 3.)Beginning with October 2007, Freedom must send the regional office a list of all clean unaffiliated provider claims (not line items) paid (not received) during the quarter. The listing should provide the claim number, date of receipt (which may be a date from an earlier quarter), paid date, and number of days it took to process. The report should provide a total of claims paid in 1-30 days, in 31-60 days, and over 60 days. This report is due to the regional office within 15 days of the close of the quarter. Freedom will be required to submit this quarterly report until further notice.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/08/2008
Element Release Date: 02/08/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

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:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 30 cases from a universe of 1168 where all 30 cases failed to meet federal requirements for the notice content of non-contracted denied claims. None of the thirty (30) notices stated the member's financial responsibility. All Explanation of Benefits (EOBs) notices indicated a $0 member liability. During the discussion, Freedom Health, Inc. claims staff stated that their internal system does not correctly state the member's financial liability for obtaining services/items from a non-contracted provider. In all thirty (30) cases, the EOB notices contained non-specific denial reasons and service codes. The EOBs contained codes rather than descriptions of the services rendered and denied in all of the sample cases. Pursuant to 42 CFR 422.568(d) (e), Freedom Health, Inc. must clearly state the reason that a particular service is being denied in a language that can be understood by the enrollee. For example, in cases #2-#30, the EOB denial reason states "Deny-No Auth on File". The reviewer noted that many cases stated that services were not authorized rather than selecting from an available list of more specific denial code reasons.

Corrective Action Required:

Freedom Health, Inc. must develop and implement a process for generating EOBs that show the member's financial liability and which allows the MAO to maintain the actual EOB mailed to members. The beneficiary should be able to read the EOB and clearly determine the medical service rendered or items provided to the enrollee that the MAO will not pay for. Furthermore, the beneficiary should be able to determine the extent of his or her financial liability. Additionally, Freedom must submit a list of denial reasons and codes to CMS for review and approval. Freedom must conduct training of claims analysts or specialists on determining the appropriate denial code which will be entered for the claim and denial notice and submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/08/2008
Element Release Date: 02/08/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

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:

Freedom does not meet the CMS 95% compliance standard because CMS reviewed 3 cases from a universe of 3 and found that in all 3 sample cases the Notice of Denial of Medicare Coverage (NDMC) is non-specific and not written in a manner that a beneficiary can understand. The reviewer identified the following additional deficiencies: -The NDMC omitted a detailed explanation of why the medical services/items are being denied with the description of any appliable Medicare coverage rule or any other appliable MAO policy on which the denial decision was based. -Examples of denial reasons include: Case #1, "No history of Tachy-Arrythmia/No symptoms/ejection fraction" Case #2, "Documentation does not support a medical condition requiring an electric bed. Bathroom rails are not a covered benefit." - CMS reviewers were unable to identify if the notices were sent to the beneficiaries due to no addresses on the NDMC. Additionally, in 3 out of the 3 sample cases, the OMB-approval code was omitted from Freedom's template notice.

Corrective Action Required:

The Notice of Denial of Medical Coverage (NDMC) is a standardized written notice to be issued when the MAO denies a MAO enrollee's request for medical service. This is a standard form. MAOs may not deviate from the content of the form and the OMB control number must be displayed on the notice. The NDMC must list the denied medical services or items that were requested by the enrollee or physician. Additionally, the MAO must provide a specific and detailed explanation why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable MAO policy upon which the denial decision was based. Freedom must revise their policies and procedures to reflect the requirements outlined in section 40.2.2 of Chapter 13 of the Medicare Managed Care Manual. Freedom must conduct training of appropriate staff on thoroughly completing the Notice of Denial of Medical Coverage as outlined in the Medicare Managed Care Manual, Chapter 13, Section 40.2.2. We highly suggest that the MAO refer to examples of acceptable language in Chapter 13. Freedom must submit documentation which includes the following information: The nature of the training, The date(s) that training occurred, The individuals conducting the training, The names of staff that were trained, and Written training materials used. Last, Freedom must submit a denial reason matrix with clear denial reasons to CMS for review and 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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/08/2008
Element Release Date: 02/08/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

Requirement:

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

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. The sample consisted of 10 cases from a universe of 20 and all 10 cases were processed timely, however, the CMS reviewer was unable to locate documentation confirming the beneficiary was notified of the MAO's decision within the 72-hour time frame. Pursuant to 42 CFR 422.570 and 422.572, the MAO must notify the member in writing within 72 hours of the MAO's decision. During the discussion with the UM department, it was stated that Freedom does not contact the beneficiary if a service is approved. The UM director/manager was not aware of the regulation in the CFR or guidance in Chapter 13 for this requirement.

Corrective Action Required:

Freedom Health, Inc. must adhere to federal regulations that require MAOs to notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request. 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. In addition, Freedom must develop and implement policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/08/2008
Element Release Date: 02/08/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

Requirement:

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

Deficiencies:

There were no sample cases to review for this element, however, CMS used Freedom's written policies and procedures as documentation examples to evaluate this element. The Notice of Medical Non Coverage was deficient for OP02. The same issues applies for OP05.

Corrective Action Required:

The Notice of Denial of Medical Coverage (NDMC) is a standardized written notice to be issued when the MAO denies a MAO enrollee's request for medical service. This is a standard form. MAOs may not deviate from the content of the form and the OMB control number must be displayed on the notice. The NDMC must list the denied medical services or items that were requested by the enrollee or physician. Additionally, the MAO must provide a specific and detailed explanation why the medical services or items are being denied, with the description of any applicable Medicare coverage rule or any other applicable MAO policy upon which the denial decision was based. Freedom must revise their policies and procedures to reflect the requirements outlined in section 40.2.2 of Chapter 13 of the Medicare Managed Care Manual. Freedom must conduct training of appropriate staff on thoroughly completing the Notice of Denial of Medical Coverage as outlined in the Medicare Managed Care Manual, Chapter 13, Section 40.2.2. We highly suggest that the MAO refer to examples of acceptable language in Chapter 13. Freedom must submit documentation which includes the following information: The nature of the training, The date(s) that training occurred, The individuals conducting the training, The names of staff that were trained, and Written training materials used. Last, Freedom must submit a denial reason matrix with clear denial reasons to CMS for review and 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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 11/26/2007
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

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:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 20 cases (#s 1-2, 4-5, 7-16, 19) from a universe of 3005 and 15 cases failed to meet CMS' compliance standards for the following: -completed applications, -verification of the most recently issued Medicare Opt Out list at the time of credentialing or re-credentialing, and -maintaining current credentialing information as of the current credentialing cycle.

Corrective Action Required:

Pursuant to 42 CFR 422.204, Freedom Health must ensure that all credentialing and re-credentialing applications are complete and information is current. All items or questions in the application must be addressed with the appropriate response or indicated as not applicable. This requirement also applies to credentialing that is done by delegated entities. In addition, Freedom and its delegated entities must ensure compliance with the requirements mandated by 42 CFR 422.220 regarding physicians and practitioners who opt out of Medicare by reviewing the most recently issued Medicare Opt Out list and include this documentation in each credentialing file.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 01/25/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

Requirement:

Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 10 cases from a universe of 22 and all 10 cases were processed without the appropriate waiver of liability form that would allow the non-contracted providers to act as an "assignee" of the enrollee. Pursuant to 42 CFR 422.574, 422.578 and 422.582, a non-contracted provider can request a standard reconsideration only if a completed waiver of liability form is submitted that waives the right to payment for the services provided. Therefore, these cases were not valid appeals or reconsiderations according to federal regulations and should have been forwarded to CMS' independent review entity for dismissal.

Corrective Action Required:

Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. In addition, Freedom Health must develop and implement policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/20/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

Requirement:

Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS' independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS' independent review entity.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 2 cases from a universe of 2 whereby the providers refused to submit a completed waiver of liability form in order to appeal the denied claims. Based on the documentation included in both cases, Freedom Health conducted reconsiderations and informed the Medicare enrollees that the cases were being forwarded to CMS' independent review entity for reconsideration. Pursuant to 42 CFR 422.574, 422.578 and 422.582, a non-contracted provider can request a standard reconsideration only if a completed waiver of liability form is submitted that waives the right to payment for the services provided. Therefore, these cases were not valid appeals or reconsiderations according to federal regulations. Although the cases were forwarded to CMS' independent review entity for dismissal, Freedom Health conducted a reconsideration in each case which was inappropriate.

Corrective Action Required:

Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed. For cases of this nature, CMS is requiring that Freedom Health develop a member letter or notification to inform members that a case is being forwarded to CMS' independent review entity for dismissal and submit this letter to the Regional Office Plan Manager 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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 02/20/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 10/29/2007

Requirement:

Effectuation of Third Party Claims Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 2 cases from a universe of 2 whereby the providers refused to submit a completed waiver of liability form in order to appeal the denied claims. Based on the documentation included in both cases, Freedom Health conducted reconsiderations and informed the Medicare enrollees that the cases were being forwarded to CMS' independent review entity for reconsideration. Pursuant to 42 CFR 422.574, 422.578 and 422.582, a non-contracted provider can request a standard reconsideration only if a completed waiver of liability form is submitted that waives the right to payment for the services provided. Therefore, these cases were not valid appeals or reconsiderations according to federal regulations. Although the cases were forwarded to CMS' independent review entity for dismissal, Freedom Health conducted a reconsideration in each case which was inappropriate.

Corrective Action Required:

Freedom Health, Inc. must adhere to federal regulations that require non-contracted providers to submit a completed waiver of liability form in order to appeal a denied claim. Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. As part of this corrective action, Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed. For cases of this nature, CMS is requiring that Freedom Health develop a member letter or notification to inform members that a case is being forwarded to CMS' independent review entity for dismissal and submit this letter to the Regional Office Plan Manager 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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 01/25/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

Requirement:

Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 1 case from a universe of 1 that was processed as an appeal without the appropriate appointment of representation. Pursuant to 42 CFR 422.574, 422.578 and 422.582(d), Freedom Health must comply with federal regulations and only process appeals or reconsiderations that have been requested by the appropriate parties.

Corrective Action Required:

Freedom Health must comply with this requirement by obtaining an appointment of representation form when a request is received from someone other than the enrollee, an assignee or legal representative. As part of this corrective action, Freedom must also develop and implement correct policies and procedures and conduct training of appropriate staff on these policies and procedures. Documentation must be submitted to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 01/25/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

Requirement:

Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 1 case from a universe of 1 and it was misclassified. This case included a reconsideration request for the termination of skilled nursing facility (SNF) services and should have been processed according to the fast-track appeals process.

Corrective Action Required:

Freedom Health must comply with the fast-track appeals process that is mandated by 42 CFR 422.264. As part of the corrective action, Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.

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: 8817

Region: 04 Atlanta

Contract Number / Name: H5427 FREEDOM HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 10/29/2007
Element Accepted Date: 01/25/2008
Element Release Date: 02/20/2008
CAP Released Date: 03/19/2008

Visit Start Date: 7/31/2007
Exit Conference Date: 08/02/2007
Date Report Issued: 09/14/2007
Date Report Due: 09/16/2007
CAP Accepted Date: 02/20/2008
Audit Closed Date: 03/19/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 10/29/2007

Requirement:

Effectuation of Third Party Expedited Reconsideration Reversals - If the MAO's determination is reversed in whole or in part by the independent review entity, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination. The MAO must also inform the independent review entity that the organization has effectuated the decision.If the MAO's determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member's health requires, but no later than 60 days from the date it received notice of the reversal. The MAO must also inform the independent outside entity that the organization has effectuated the decision.

Deficiencies:

Freedom Health, Inc. does not meet the CMS 95% compliance standard for this requirement. This sample consisted of 1 case from a universe of 1 and it was misclassified. This case included a reconsideration request for the termination of skilled nursing facility (SNF) services and should have been processed according to the fast-track appeals process.

Corrective Action Required:

Freedom Health must comply with the fast-track appeals process that is mandated by 42 CFR 422.264. As part of the corrective action, Freedom Health must develop and implement correct policies and procedures to ensure compliance with this requirement. Freedom must also conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the following: the nature of this training, the materials used in the training, the individuals conducting the training, the individuals being trained and the date(s) training was completed.