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: 3193

Region: 02 New York

Contract Number / Name: H3351 EXCELLUS HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/18/2008
Element Accepted Date: 10/16/2007
Element Release Date: 05/22/2008
CAP Released Date:05/22/2008

Visit Start Date: 8/14/2006
Exit Conference Date: 08/19/2006
Date Report Issued: 01/12/2007
Date Report Due: 10/03/2006
CAP Accepted Date:03/07/2008
Audit Closed Date: 05/22/2008
Element Projected Completion Date:12/31/2007
MCO Response Due Date: 02/26/2007

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:

All of the contracts reviewed did not contain the new 10-year record retention provisions. Although this provision is relatively new, the federal 10-year record retention requirement provisions must still be specifically stated in contracts with Excellus/Univera (H3351) network providers.

Corrective Action Required:

Excellus must ensure that the federal 10-year record retention requirement provision is specified in all contracts with Excellus/Univera (H3351) network providers. The CAP must specify how and when this will be accomplished.

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: 3193

Region: 02 New York

Contract Number / Name: H3351 EXCELLUS HEALTH PLAN, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/18/2008
Element Accepted Date: 10/17/2007
Element Release Date: 05/22/2008
CAP Released Date:05/22/2008

Visit Start Date: 8/14/2006
Exit Conference Date: 08/19/2006
Date Report Issued: 01/12/2007
Date Report Due: 10/03/2006
CAP Accepted Date:03/07/2008
Audit Closed Date: 05/22/2008
Element Projected Completion Date:06/30/2007
MCO Response Due Date: 02/26/2007

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:

The requirement is not met. A sample of fifteen grievance cases were reviewed and also the plans's grievance policies and procedures. It was noted that the grievance acknowledgement template letter has two versions available to the MAO employee responding. The plan advised the complainant that the review would require either 30 days or 45 days to complete. This is contrary to federal requirements which require the plan to resolve and responf to the complainant within 30 days unless it formally justifies an extension, in which case, the response should be completed within 44 days. In addition to the basic response template letters being non-compliant, federal requirements specify that if a complaint involves a quality of care issue, the MAO is also required to advise the complainant of the right to file a written complaint with the QIO. In the sample reviewed, there were six cases which involved quality of care issues, but there was no reference to the QIO in any of the letters responding to the complainant.

Corrective Action Required:

Excellus must ensure that grievance acknowledgement letters follow the required federal timeframes. A revised template letter should be prepared and also a template letter providing for extensions when appropriate. Staff should also be reminded that when a quality of care issue is noted in a grievance, there should also be a notice to the complainant of the right to file a written complaint with the QIO.

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: 3193

Region: 02 New York

Contract Number / Name: H3351 EXCELLUS 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:01/18/2008
Element Accepted Date: 10/17/2007
Element Release Date: 05/22/2008
CAP Released Date:05/22/2008

Visit Start Date: 8/14/2006
Exit Conference Date: 08/19/2006
Date Report Issued: 01/12/2007
Date Report Due: 10/03/2006
CAP Accepted Date:03/07/2008
Audit Closed Date: 05/22/2008
Element Projected Completion Date:09/30/2007
MCO Response Due Date: 02/26/2007

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:

This requirement is not met. Twelve claims from a sample of 30 clean claims from non-participating providers were not paid within 30 days.

Corrective Action Required:

Excellus must ensure that non-contracting providers' clean claims are paid timely. 95% of clean claims are required to be paid within 30 days of receipt. Excellus must submit a corrective action plan that will ensure that it processes non-participating providers' claims on a timely basis. The plan must include how it will monitor that non -participating provider claims are paid timely. For the CAP to be released, Excellus must demonstrate that at least 95% of the non-participating provider claims are paid within 30 days for 2 consecutive quarters. It could use the the CMS worksheet for this element on a random sample of at least 20 non-participating provider claims per quarter until it is successful.