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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
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Visit Start Date: 5/21/2007
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice did not meet the CMS 95% compliance standard for this element. CMS reviewed 15 grievances from a universe of 17 and found that in all but one case, notices were deficient because they did not include a specific grievance disposition. The notices contained language stating that the plan was "not permitted by law to share or disclose the outcome of the investigation," which is not the case for most of the grievances in this sample. This language applies to specific quality of care grievances only, where laws and/or regulations prohibit such disclosure, as with peer reviewed quality of care complaints.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that the notices it sends members after investigating complaints, include descriptions of the disposition, as appropriate. Additionally, until further notice, Health Choice must send CMS (Regional Office, copies of all grievances it receives, along with copies of the letters it sends members notifying them of the grievance disposition. Copies of grievances and corresponding notices are due to CMS on the 15th of each month following the month in which they were closed.

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

Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Information Provided to Beneficiaries Upon Request - An MAO must provide the information required by CMS upon the request of a beneficiary.

Deficiencies:

Health Choice did not provide documentation demonstrating that it had information prepared about the number and disposition of appeals and grievances in the aggregate, and in the form required by CMS, to provide beneficiaries upon request. Refer to Chapter 13 of the Medicare Managed Care Manual, Section 170 - 170.5.2 and Appendix 2.

Corrective Action Required:

Health Choice must develop and submit a report of aggregated appeal and grievance data for the latest report period and continuing that meets CMS guidelines in Chapter 13 of the Medicare Managed Care Manual, Sections 170-170.5.2.

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Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
Element Release Date: 06/27/2008
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

No Engagement in Activities which Mislead, Confuse or Misrepresent the MAO - The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; · Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; · Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAO's involved and unless the materials have received prior approval from CMS; · Accept plan applications in provider offices or other places where health care is delivered;· Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000);· Offer gifts or payment as an inducement to enroll in the organization;·Engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; or · Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

CMS reviewed a sample of 10 marketing agent files and found little evidence of oversight by either Health Choice or its delegated broker/owner. Files did not include any performance data such as write-ups of "ride-alongs" or presentations, or data about number of sales and rapid disenrollments. The plan had no policy in place during the review period for tracking rapid disenrollments and for charge-backs when a new enrollee leaves the plan within the first 90-120 days. Health Choice forwarded several complaints to the owner/broker during the review period which were in files, but did not seem to have the full cooperation the broker/owner when it asked the broker about counseling one of his agents.

Corrective Action Required:

Health Choice must describe the steps that it is taking to strengthen its oversight over the marketing activities of delegated contracted sales brokers and agents, should it decide to continue that relationship. It should also describe the actions it is taking to develop and implement an oversight program for its in-house direct contracted or employed sales force.

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

Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 09/24/2007
Element Release Date: 09/24/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Good Faith Effort to Provide Written Notice of the Termination of a Contracted Provider - The MAO makes a good faith effort to provide written notice of the termination of a PCP to all members who are patients of that PCP, or for termination of a non-PDP provider to all patients seen on a regular basis, at least 30 days prior to the termination effective date.

Deficiencies:

Health Choice was unable to demonstrate that Medicare members are given written notice at least 30 days prior to primary care physician (PCP) terminations. Based on a review of a PCP termination letter, the reviewer found that the PCP termination letter was dated 04/27/2007 with a PCP termination effective date of 04/30/2007. The PCP termination letter demonstrated that Health Choice is not giving its Medicare members the CMS required 30-day notice of PCP or other provider terminations.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that it provides written notice to Medicare members 30 days prior to PCP or other provider terminations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits to ensure compliance with CMS requirements.

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

Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 09/17/2008
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CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:08/20/2008
MCO Response Due Date: 09/01/2007

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:

Health Choice did not meet the CMS 95% compliance standard for this element. CMS reviewed a sample of 30 denied claims from an initial universe of 5230. Eight of the cases were misclassified because they were claims from contracting rather than non-contracting providers. Of the remaining 22 cases, Health Choice denied 5 (radiology, lab, or anesthesia services) for failure to obtain prior certification or authorization, without attempting development. At the time of denials, claims were between 19 and 25 days old, and could have been pended as non-clean claims while Health Choice requested additional development. In case #7, Health Choice denied services for repositioning a venous catheter and a fluoroscope examination while its member was hospitalized. In case #8, a non-contracted hospital filed a claim for outpatient lab and radiology services for an individual with multiple diagnosis, which upon resubmission, turned out to be incident to emergency room care. In case # 21, Health Choice denied a claim from an out-of-area Medical Center for radiology services. The diagnosis code on the claim was for shortness of breath. There was no documentation in file to suggest that the plan considered the possibility that services were for out-of-area urgent care. In case #27, anesthesiology services were denied a hospitalized member. Health Choice later paid the claim when it was resubmitted. In case #30, the plan erroneously denied payment of a pre-admission chest x-ray.

Corrective Action Required:

Health Choice must describe the steps that it is taking to identify claims that may be related to an episode of emergent, urgent, post-stabilization or authorized care, and to ensure that it screens them against its claims data and if necessary, attempts development before denying them.

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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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
Element Release Date: 10/01/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

(A) Health Choice does not meet the CMS 95% compliance standard for this element. CMS reviewed 19 of the 30 cases selected for the sample from an initial universe of 27,334 claims and found that 9 of the 19 cases were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 9 cases were considered misclassified because these claims were from contracting, rather than non-contracting providers. (B) The Health Choice policy and procedure for timely claims payment M2 . 001 . 02 does not accurately state CMS policy. It mixes policy requirements with performance standards. CMS expects plans to identify and pay (or deny) clean claims from non-contracted providers within 30 days from receipt, and non-clean claims within 60 days. CMS applies a 95% performance standard to determine a plan's compliance with these requirements. Further, in order to monitor its own performance, a plan must be able to generate reports separately for claims from contracting and non-contracting providers, even though Health Choice's policy states that it applies the same timeframes for contracted providers unless contracts state otherwise. Reports mentioned in the policy and procedure would provide a plan with an overall picture of its claims performance, but not with respect to its performance of CMS requirements.

Corrective Action Required:

(A) Health Choice must generate and submit a new universe that includes only non-contracted providers. Enclosure IV to the March 19, 2007 letter confirming the site visit includes details about what Health Choice should include in the universe for WSOC1 and the required format for submission. The review period for this universe is the original - September 1, 2006 through February 28, 2007. (B) Health Choice must revise its policy and procedure to incorporate the comments noted in the audit deficiency (B) above.

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

Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:07/31/2008
MCO Response Due Date: 09/01/2007

Requirement:

Interest on Clean Claims Paid Late - If the MAO pays clean claims from non-contracting providers in over 30 calendar days, it must pay interest in accordance with § 1816 (c)(2)(B) and § 1842 (c)(2)(B).

Deficiencies:

(A) Refer to finding (A) for element OC03. (B) The Health Choice policy and procedure dealing with interest payments is not entirely accurate. First, the policy statement inter-mixes policy requirements and performance standards, and consequently the statement -"whenever HC Generations does not meet these requirements, the provider will be paid interest" - is unclear. CMS expects plans to pay interest on all clean claims from non-contracted providers that it does not pay within the required 30 days. Secondly, interest payment to contracted providers is not regulated by CMS. If the State requires that plans pay interest, then the plan must comply with State requirements. Interest rates and rules may differ. Policy may need to break them out. Third, interest rates to satisfy the CMS prompt payment requirement change every six months and can be found at the following url www.treasurydirect.gov/govt/rates/tcir/tcir_opdprmt2.htm

Corrective Action Required:

(A) Refer to the corrective action required for element OC03. (B) Health Choice must revise its policy and procedure (M2.005.02) to reflect the provisions noted in the deficiency above.

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Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
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Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice does not meet the CMS 95% compliance standard for this element. CMS reviewed 30 denied claims from an initial universe of 5230. Eight of the 30 cases were misclassified because claims were from contracted rather than non-contracted providers. In the remaining 22 cases, Health Choice had not sent claim denial notices to members.

Corrective Action Required:

Health Choice must start sending CMS compliant notices (the standardized Notice of Denial of Payment) to members when it denies claims from non-contracted providers. The description of denied services and the denial reasons used with the notice must be clear and understandable. As part of the required corrective action, Health Choice must describe how it plans to implement this requirement as well as its plans for monitoring to ensure ongoing compliance.

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Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

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

Deficiencies:

CMS reviewed 10 standard pre-service organization determinations from a universe of 51 and found that 5 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 5 misclassified cases were expedited organization determinations.

Corrective Action Required:

Health Choice must submit a new universe for WSOP1 (Standard Pre-Service Denials) for the review period September 1, 2006 through February 28, 2007. See Enclosure IV from the CMS letter to Health Choice dated March 19, 2007 for a description of the universe and the format for submission.

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

Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 09/25/2007
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Visit Start Date: 5/21/2007
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS reviewed 10 standard pre-service organization determinations from a universe of 51 and found that 5 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 5 misclassified cases were expedited organization determinations.

Corrective Action Required:

Health Choice must submit a new universe for WSOP1 (Standard Pre-Service Denials) for the review period September 1, 2006 through February 28, 2007. See Enclosure IV from the CMS letter to Health Choice dated March 19, 2007 for a description of the universe and the format for submission.

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Findings: NOT MET

Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 09/26/2007
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Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice does not meet the CMS 95% compliance standard for this element. CMS reviewed a sample of 10 expedited organization determinations from a universe of 874 and found 1 case misclassified, and the remaining 9 cases non-compliant because Health Choice had not notified members of the decisions either orally or in writing. (Decisions had been made within the required 72 hour time-frame.)

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that it is meeting the member notification requirements for expedited organization determinations in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight audits.

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Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
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Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS evaluated compliance with this requirement based on Notices of Denial of Medicare Coverage (NDMCs) included in the misclassified sample WSOP1 since the misclassified cases in that sample were expedited pre-service organization determinations, and the sample for WSOP2 - generally used to determine compliance with this requirement - did not include any denials. CMS found that the NDMCs were noncompliant because denial reasons were vague. They lacked the CMS required specificity that facilitates beneficiary understanding of what is being denied and the reason for the denial.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that the NDMC contains denial reasons that are specific, clear and easily understood by the beneficiary in accordance with CMS policy and regulations. Corrective action must include internal health plan oversight.

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Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS determined that Health Choice does not meet the 95% compliance standard for this element. CMS reviewed 20 credentialing files. Two were misclassified. Of the remaining 18, CMS found 13 files non-compliant with CMS requirements for the following reasons: (A) 11 files credentialed/ recredentialed by Health Choice were missing verification of hospital privileges and were not reviewed for Medicare opt-out, (B) recredentialing in 3 cases was not completed timely. In one case, Health Choice completed recredentialing on 3/08/07 but the previous recredentialing had been completed 2/03/04. In a second case, Health Choice recredentialed the physician 12/04/06, yet the previous recredentialing was 7/29/03. In the third case, Health Choice recredentialed the physician 1/06/04 and recredentialing was not scheduled until 6/14/07. (C) 1 file from delegated credentialing entity (1) was missing primary source verification of board certification and was not reviewed for Medicare opt-out, and (D) 1 file from delegated credentialing entity (2) was not reviewed for Medicare opt-out.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that it and its delegated entities credential/recredential contracted providers in accordance with CMS requirements, on a timely basis. Corrective action must include policy and procedure revisions for the health plan as well as its delegated entities. It must also include internal health plan audits as well as delegation oversight audits of credentialing files to ensure compliance.

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Region: 09 San Francisco

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Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
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Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice does not have a process or written policies and procedures for the initial credentialing and recredentialing of its contracted facilities.

Corrective Action Required:

Health Choice must develop and implement a process to initially credential and recredential its contracted facilities. The process must include internal plan audits to assure compliance with CMS requirements.

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

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Review ID: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 11/06/2007
Element Release Date: 11/06/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice could not produce Board of Director's minutes demonstrating that Health Choice's policy making body has oversight and accountability for the Quality Improvement (QI) Program. The submitted Board of Director's minutes were redacted and did not contain meaningful evidence of the Board's oversight of the Health Choice QI Program.

Corrective Action Required:

Health Choice must submit to CMS evidence that it has a Board of Directors that is accountable and responsible for the plan's QI Program. Health Choice must submit to CMS a copy of the 2007 QI Program that has been reviewed, approved and signed by the appropriate chairpersons, e.g., Board of Director's chairperson, QI Committee chairperson, along with the supporting Board of Director minutes reflecting review and approval of the QI program.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 09/25/2007
Element Release Date: 09/25/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Deficiencies:

Health Choice does not have a policy and procedure for identifying and correcting quality of care issues that come to its attention through internal surveillance, complaints, or other mechanisms.

Corrective Action Required:

Health Choice must develop a process (policy and procedure) to identify and correct quality of care issues that come to its attention through internal surveillance, complaints, or other mechanisms. The process must include internal plan audits to ensure compliance with CMS requirements.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
Element Release Date: 06/27/2008
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS reviewed 1 favorable payment reconsideration case. Health Choice had only one in its universe. The case file did not include documentation to show that the plan had notified the member of its reconsideration decision as required.

Corrective Action Required:

Health Choice must describe the measures it is taking to ensure that it notifies members of favorable claim reconsideration decisions within CMS required timeframes. Corrective action should include provisions for internal monitoring to ensure ongoing compliance.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
Element Release Date: 10/01/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

Health Choice had only one case in the WSRC2 (adverse claim reconsideration) universe. CMS found that this case was actually a pre-service request that went to the IRE for dismissal because the member had already received the services. Health Choice also included it in the universe for WSRP2. CMS determined that the case (and the universe for WSRC2) was misclassified and consequently, the requirement is NOT MET.

Corrective Action Required:

Health Choice must submit a new universe for WSRC2 (unfavorable claims reconsiderations) but for an extended review period, 9/1/2006 through 6/30/2007, rather than the original review period. Refer to Enclosure IV of the 3/19/2007 letter from CMS confirming the site visit for details about the universe and submission format.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
Element Release Date: 10/01/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS reviewed 3 favorable standard pre-service reconsiderations from a universe of 3. One was misclassified, and should have been part of the universe for WSRP2 (unfavorable standard pre-service reconsiderations) since Health Choice had only partially reversed its prior denial. When 30% or more of a sample are misclassified, CMS must consider any element based on that sample review as NOT MET.

Corrective Action Required:

Health Choice must generate a new universe for WSRP1 (favorable standard pre-service reconsiderations), but for an extended review period, 9/1/2007 through 6/30/2007, rather than the initial review period only. Refer to Enclosure IV for the 3/19/2007 letter from CMS confirming the site visit for details about the universe and submission format.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
Element Release Date: 06/27/2008
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.

Deficiencies:

Health Choice does not meet the CMS 95% compliance standard. CMS reviewed 5 cases from a universe of 5 and found that 1 case was misclassified. In 1 of the 4 remaining cases, Health Choice was late forwarding the case to the IRE. In 2 others, file documentation was inadequate to determine when Health Choice forwarded the cases to the IRE and therefore, whether Health Choice sent them within the CMS required timeframe. As for member notification, Health Choice was late informing the member in 1 case that it had forwarded the case to the IRE. In a second, file documentation was insufficient to determine when Health Choice notified the member.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that it 1)forwards adverse standard pre-service reconsiderations to the IRE within the CMS required timeframe when it is unable to fully reverse its own decisions, and 2)notifies effected members concurrently that it is forwarding their cases to the IRE for a final reconsideration decision. Corrective action must include internal monitoring to ensure ongoing compliance.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
Element Release Date: 06/27/2008
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.

Deficiencies:

CMS reviewed the policy and procedure submitted by Health Choice to support this requirement (M8.002.02). The policy and procedure does not address processing of expedited reconsideration requests, only expedited organization determinations.

Corrective Action Required:

Health Choice must revise its policy and procedure on appeals (M8.002.02) to include provisions for receiving, identifying, processing, and tracking expedited reconsideration requests.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 06/27/2008
Element Release Date: 07/17/2008
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS reviewed 1 expedited reconsideration request from a universe of 1 and found that Health Choice had not notified the member or authorized representative orally of its decision not to process the request using expedited procedures within the required 72 hour timeframe. The only notification it provided was a written notice dated 5 days after the date the reconsideration request was received.

Corrective Action Required:

Health Choice must describe the actions it is taking to ensure that it processes expedited reconsideration requests correctly within the required timeframes.

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
Element Release Date: 10/01/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

Requirement:

Decision Not to Expedite a Reconsideration (Notice Content) - If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician's support, and provide instructions about the MAO grievance process and its timeframes.

Deficiencies:

CMS determined that Health Choice does not meet the notice requirement for this element based on review of the single sample case for WSRP3, and the "Notice of Right to an Expedited Grievance" that it submitted as supporting audit documentation. (A) The notice in the case file is non-compliant because it does not include all of the required CMS information, i.e., 1) that the member has a right to file an expedited grievance if he disagrees with Health Choice's decision to process his reconsideration request using standard rather than expedited timeframes, 2) that he may resubmit his request with a physician¿s support, and 3) instructions about Health Choice's grievance process. (B) Health Choice had a CMS accepted "Notice of Right to an Expedited Grievance"(H5587_2006_103) available for staff use when transferring expedited reconsideration cases to the standard process, but failed to use that version. Please see the note for OP06. There are discrepancies between the version of this notice submitted by Health Choice through HPMS and as audit documentation. The latter is non -compliant because it is missing spaces for staff to check to designate the reason it is sending the notice.

Corrective Action Required:

(A) Health Choice must describe the actions it is taking to ensure that staff send the appropriate version of the "Notice of Right to an Expedited Grievance" when advising members that it will be processing their reconsiderations using standard rather than expedited appeal timeframes. (B) Health Choice must ensure that it has destroyed incorrect versions of the "Notice of Right to an Expedited Grievance."

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: 8099

Region: 09 San Francisco

Contract Number / Name: H5587 HEALTH CHOICE ARIZONA, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/29/2007
Element Accepted Date: 10/01/2007
Element Release Date: 10/01/2007
CAP Released Date:09/17/2008

Visit Start Date: 5/21/2007
Exit Conference Date: 05/22/2007
Date Report Issued: 07/18/2007
Date Report Due: 07/06/2007
CAP Accepted Date:09/17/2008
Audit Closed Date: 09/17/2008
Element Projected Completion Date:
MCO Response Due Date: 09/01/2007

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:

CMS has determined that Health Choice does not meet the requirements for this element. The plan had no expedited reconsideration cases in its WSRP3 sample that went to the IRE for a determination. Therefore, CMS determined compliance based on a review of policy and procedures (8002.02) and found that they did not include 1) plan timeframes for effectuating decisions made by an ALJ or higher, and 2) a provision to notify the IRE when it effectuates decisions made by an ALJ or higher.

Corrective Action Required:

Health Choice must revise its policy and procedures to include the provisions noted in the deficiency above.