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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

Requirement:

Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.

Deficiencies:

The sample of this area was 15. Six (30%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met. In order to provide technical assistance to the MAO, the reviewer reviewed the remaining cases and determined 7 out of 9 remaining cases did not meet CMS requirements. The case files were not categorized correctly or the reviewer was unable to determine if the MAO appropriately resolved the members grievance. This determination was based due to lack of case file documentation and interviews conducted with the MAO staff responsible for grievances. There is not a consistent formal communication process between the appeals and grievance staff or customer service staff, responsible for intake and screening of member inquiries. The grievance policies and procedure do not provide specific guidance to staff who are responsible for processing grievances through specific Medicare grievance phases (e.g. quality of care grievances). The MAO does not have a process to ensure the provider quality of care complaints are shared with its credentialing department and included as part of the provider recredentialing process. See element PR03).

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures that detail how the MAO staff and its delegates identify and appropriately address and resolve complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately tracking all grievances, correctly distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes that adhere to the Medicare grievance requirements, for the MAO and its delegates. 6. Develop processes to ensure that grievances are categorized appropriately in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that will allow the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issues raised by its beneficiarys. 8. Develop a comprehensive management report that will allow senior management to evaluate member complaints and identify and address potential areas of improvement, additional staff education, and improve member and provider satisfaction over time

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Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

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:

The review of case files submitted for grievances indicates the MAO is not compliant in this area. The sample of this area was 15. Six (30%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures outlining how the MAO staff and its delegates identify and appropriately address all complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately tracking all grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure grievances are accurately categorized in the MAOs system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based, on the nature of the issue or complaint raised by members. 8. Develop comprehensive management reports allowing senior management the ability to evaluate member complaints and identify and address potential areas of improvement, additional staff education, that would improve member and provider satisfaction.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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 review of case files submitted for grievances indicates the MAO is not compliant in this area. The sample of this area was 15. Six (30%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of the grievance process, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of the grievance requirements. 2. Develop grievance policies and procedures that outline how the MAO staff and its delegates identify and appropriately resolve complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, to include quality of care complaints, appropriately track grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure that grievances are accurately categorized in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issue or complaint raised by members. 8. Develop a comprehensive management report that allows senior management to evaluate member complaints and identify and resolve potential areas of improvement, additional staff education, and improve member and provider satisfaction.

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

Requirement:

Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.

Deficiencies:

The review of case files submitted for grievances indicates the MAO is not compliant in this area. The sample of this area was 15. Six (30%) of the case files in this sample were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of case files in a sample are misclassified and mark the elements associated with the worksheet as not met.

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for grievances per the RO Plan Manager's instructions. In addition the organization must also: 1. Develop grievance polices and procedures that demonstrate coordination between member services and other departments in a consistent manner. Polices and procedures must clearly map the workflow of grievance staff, including but not limited to the identification of each specific step, grievance task, responsibility, and day-to-day oversight of grievance requirements. 2. Develop grievance policies and procedures that outline how the MAO staff and its delegates identify and appropriately address complaints related to quality of care. 3. Develop a process to ensure provider and facility, quality of care complaint information is shared with provider relation and credentialing staff 4. Develop efficient oversight and management of grievance responsibilities by: appropriate and consistent documentation of grievances, including quality of care complaints, appropriately tracking grievances, accurately distinguishing a grievance from an appeal, and promptly and consistently transferring appeal issues to the appeals department staff. 5. Develop internal monthly audit processes of Medicare grievance requirements for the MAO and its delegates. 6. Develop processes to ensure that grievances are accurately categorized in the MAO's system and tracked until they are appropriately resolved. 7. Develop a process that allows the MAO to maintain, aggregate, and analyze grievance data based on the nature of the issues or complaint raised by members. 8. Develop a comprehensive management report that allows senior management to evaluate member complaints and identify and resolve potential areas of improvement, additional staff education, and improve member and provider satisfaction.

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
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CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

Requirement:

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

Deficiencies:

The MAO failed to revise notices generated after 11/16/06 to the beneficiary with the correct Customer Service hours of 8 am to 8 pm, 7 days a week.

Corrective Action Required:

The MAO must identify and update marketing materials with the correct Customer Service hours of 8am to 8pm, 7 days a week. The MAO must provide the RO with a list of documents revised.

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Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO did not meet the 95% compliance standard because CMS reviewed 30 WS OC01 (Denial Proper) sample case files from a universe of 129 and found that 14 case files were not adjudicated correctly. None of the 30 case files had been developed for missing, or incorrect information and the beneficiary was liable for payment. The MAO was unable to provide a policy or procedure to support that the MAO develops for missing information, prior to issuing a denial. Based on CMS interview conducted with the MAO during the site visit, no development process in place.

Corrective Action Required:

1. The MAO must revise/develop policies and procedures to instruct claims processing staff to develop for missing or incorrect claim information when a beneficiary is held liable. The MAO must conduct training of the appropriate staff on the policies and procedures 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. 2. The MAO must conduct an internal audit each month of a denied claim sample. The audit should evaluate whether the claims processor is developing for missing information, prior to issuing a denial. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 3. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 4. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The CMS Reviewer was unable to make a determination regarding the MAOs compliance with the requirement to pay interest in accordance with the Medicare guidelines, since 0 sample case files reviewed were adjudicated within 60 days. The policy and procedure provided by the MAO was incomplete in identifying and adjudicating "clean claims". Based on CMS Reviewers interview with the MAO staff, the MAO does not have the ability to identify, track or report clean claims activity.

Corrective Action Required:

1. The MAO must revise the following policies and procedures: a) Identifying and adjudicating clean claims and b) Interest payment calculation. 2. The MAO must conduct training of the appropriate staff on these policies and procedures 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. 3. The MAO must conduct an internal audit each month of claims paid within 60 days. This audit should evaluate whether the claims processor calculated interest correctly. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, the results of the audit, and any recommendations or resolutions implemented to correct deficiencies identified. 4. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 5. The MAO must establish a mechanism for identifying, tracking and reporting clean claims activity.

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO did not meet the 95% standard because CMS reviewed 30 WS OC06 (Notice Compliant) sample case files from a universe of 129 and found that 12 case files were not denied appropriately. In 12 case files the denial was not clearly stated on the member denial letter. The denial notice did not include the denied service or specific reason for the denial which would be clear and not confusing or misleading to the beneficiary. In addition, 7 of 12 case files denial letters generated after 11/16/06 did not contain the correct Customer Service hours of 8 am - 8 pm, 7 days a week.

Corrective Action Required:

1. The MAO must conduct training of appropriate staff on applying the appropriate denial message, to ensure the beneficiary has a clear understanding of the service denied and the specific reason for the denial. The MAO must 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 individual being trained. 2. The MAO must conduct an internal audit each month of denied claims and the denial messages generated on the denial letter. This must evaluate whether the appropriate denial message was provided to the beneficiary was clear and not misleading. The MAO must submit a summary report monthly to the regional office of its findings until further notified. The summary report should include: name and title of the auditor(s), the audit methodology, and the results. 3. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full compliance with CMS requirements. 4. The MAO must provide the regional office with a complete listing of denial codes generated on the member denial letters as well as the denial code messages generated on the provider payment vouchers. 5. The MAO must provide the regional office a sample denial letter, reflecting the correct customer service hours and days as 8am - 8pm, 7 days a week. 6. The MAO must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

Requirement:

Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.

Deficiencies:

The CMS Reviewer was not able to determine based on the policy and procedure provided by the MAO that this requirement is met. The policy and procedure does not include or reference the Medicare Secondary Payer guidelines. The policy and procedure is incomplete in instructing the claims processing staff on how to coordinate benefits/payment.

Corrective Action Required:

1. The MAO must revise or develop a policy and procedure that includes the Medicare Secondary Payer guidelines.
2. The MAO must conduct training of the appropriate staff on this policy and procedure 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.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO does not meet the regulatory requirements in this area. Review of 9 case files determined that 2 were not sent timely and 3 of the notices sent to members did not contain the appropriate denial language or appropriate notices. No cases in this sample were misclassified. The reviewer also noted the MAO's appeals policies and procedures are general in nature and do not outline specific steps, tasks, or responsibilities of Member Services or other involved departments. There appears to be no internal day-to-day oversight or connectivity between departments or the MAO's delegates to ensure members receive timely and appropriate notices. There is not a process in place to ensure member denial notices contain denial language that is member friendly (language that members understand).

Corrective Action Required:

Policies and procedures must be revised to map the workflow in a clear, detailed manner, with identification of each specific step, task, and responsibility, including those of other departments (e.g. Claims, UM, Member Services, Provider Relations, and Medical Director). Polices and procedures should be revised to be more consistent with Medicare regulations with regard to the initial determination or pre-service denials. The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals 2. Develop a process to audit its delegate monthly to ensure that Medicare appeals requirements are meet, 3. Develop internal controls to ensure that member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure that Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure that members received correct notices in the appropriate time frame(s) as required by CMS

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO does not meet the regulatory requirements in this area. Review of 10 case files determined that 3 case files contained letters that were sent to members that were not compliant. No cases in this sample were misclassified. The reviewer noted the MAO's appeals policies and procedures are general in nature and do not outline specific steps, tasks, or responsibilities of Member Services or other involved departments. There is not an internal day-to-day oversight or connectivity between departments or the MAO's delegates to ensure members receive timely and appropriate notices. There is not a process in place to ensure that member denial notices contain denial language that is member friendly (language that members understand).

Corrective Action Required:

The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals, 2. Develop a process to conduct monthly audits of delegates to ensure Medicare appeals requirements are met, 3. Develop internal controls to ensure member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure member Medicare model letters are updated in a timely manner and updated materials are disturbed to the MAO's delegates 5. Develop a process to ensure members receive correct notices in the appropriate time frame(s) as required by CMS

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

Findings: NOT MET

Review ID: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
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Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO does not meet the regulatory requirements in this area. Review of 10 case files determined that 6 expedited determinations were either not process timely or were process incorrectly. No cases in this sample were misclassified.

Corrective Action Required:

The MAO must: 1. Develop a formal process to conduct monthly internal audits of Medicare appeals 2. Develop a process to audit its delegate to ensure Medicare appeals requirements are meet in a consistent manner, 3. Develop internal controls to ensure member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure members received correct notices in the appropriate time frame(s) as required by CMS

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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO did not have case files in the sample that would allow the reviewer to evaluate the MAO's ability to accurately send members an appropriate expedited denial notice content. Review of the MAO's policies and procedures clearly indicates the MAO does not have policies and procedures or formal workflow processes that support CMS requirements in this area.

Corrective Action Required:

1. Develop a formal process to conduct internal audits of Medicare appeals 2. Develop a process to audit its delegate to ensure Medicare appeals requirements are meet in a consistent manner, 3. Develop internal controls to ensure that member denial notices are appropriate, member friendly, and contain appropriate denial reasons, 4. Establish a formal process to ensure that Medicare model letters are updated in a timely manner and that updated materials are disturbed to its delegates 5. Develop a process to ensure that members received correct notices in the appropriate time frame(s) as required by CMS

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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

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:

The reviewer determined the MAO's credentialing process does not include quality of care information, including performance indicators from its utilization management system, grievance system, enrollee satisfaction surveys, or other activities in the MAO which have been developed but are not currently being considered during the recredentialing process.

Corrective Action Required:

The MAO must develop a process to ensure that provider quality of care complaints are incorporated into the MAO's recredentialing process. Polices and procedures in this area must clearly map workflow and assigned responsibilities between departments in order to ensure that provider quality of care complaints and their completed resolution are incorporated in the provider recredentialing process and provided to the appropriate committee official prior to final 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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 04/01/2008
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

Requirement:

Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.

Deficiencies:

The reviewer determined the MAO does not have appropriate mechanisms in place that will allow the MAO to monitor delegated entities on an ongoing basis and formally review the entity at least once annually. The reviewer determined that the MAO does not require its delegates to provide reports that would allow the MAO an opportunity to determine the entitys ability to perform Medicare functions per CMS requirements or provide the MAO with data analysis for future strategic planning.

Corrective Action Required:

The MAO must conduct routine monthly audits of its delegates and provide senior management with reports that reflect the individual delegate's performance and ability to comply with CMS standards. The MAO must submit a summary of its monthly delegate audits and a list and description of the internal reports it will develop and submit to senior management that reflects the performance of its delegates to the Regional Office per the instructions of the Regional Office Plan Manager. Submit the summary report to the regional office monthly, beginning with the first month after the acceptance of the CAP for the next six months or until the MAO reaches full 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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

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:

The MAO does not meet the CMS 95% compliance standard. CMS reviewed 6 WS RC01 sample case files. 2 of the case files were adjudicated in more than 60 days and 2 of the case files had still not been adjudicated as of the conclusion of the site visit. Therefore, this requirement is not met.

Corrective Action Required:

Policies and procedures should be developed or revised to map the workflow in a clear, detailed manner, outlining each step, task, responsibility as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director) if those departments are involved in the process. The MAO must develop internal controls to ensure that favorable claim reconsiderations are adjudicated timely, by its delegate. The MAO must develop a formal process for auditing its delegate monthly, to ensure compliance with Medicare claims and appeals 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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

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:

Seven (more than 30%) of the sample case files were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of the cases in the sample are misclassified and mark the elements associated with the worksheet as not met. Based on the CMS interview with the MAO, provider disputes had been processed through the member appeal process. The IRE notified the MAO in January 2007 that the cases submitted to the IRE were being dismissed. The MAO stated in the interview with CMS that it had since developed a provider dispute policy and procedure to resolve these issues. The MAO also stated that all 7 case samples had been reprocessed to pay the provider.

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. The MAO must develop policies and procedures clearly outlinning the workflow of the appeals process, to include but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. The MAO must develop processes to ensure beneficiary claim reconsiderations are accurately categorized separately, from any provider dispute appeal process.

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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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:

Seven (more than 30%) of the sample case files were misclassified. CMS instructs its reviewers to stop reviewing a sample if 30% or more of the cases in the sample are misclassified and mark the elements associated with the worksheet as not met. Based on the CMS interview with the MAO, provider disputes had been processed through the member appeal process. The IRE notified the MAO in January 2007 that the cases submitted to the IRE were being dismissed. The MAO stated in the interview with CMS that it had since developed a provider dispute policy and procedure to resolve these issues. The MAO also stated that all 7 case samples had been reprocessed to pay the provider.

Corrective Action Required:

The MAO will be required to submit a new universe and sample case files for Unfavorable Claim Reconsiderations per the RO Plan Manager's instructions. The MAO must develop policies and procedures clearly outlinning the workflow of the appeals process, to include but not limited to the identification of each specific step, task, responsibility and day to day oversight of the reconsideration requirements. The MAO must develop processes to ensure beneficiary claim reconsiderations are correctly categorized separate from any provider dispute appeal process.

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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date:04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date:09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date:01/08/2008
MCO Response Due Date: 07/08/2007

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 8 sample case files from a universe of 8 and found 1 case file that was not compliant. The extension notice was mailed timely to the beneficiary, however the beneficiary was not notified timely of the favorable outcome.

Corrective Action Required:

Policies and procedures must be developed or revised to outline workflows in a clear, and detailed manner. The workflows must outline each step, task, responsibility, and timeline, to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director). The MAO must develop internal controls to ensure that favorable standard pre-service reconsideration notices are generated and mailed timely.

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: 8237

Region: 10 Seattle

Contract Number / Name: H5995 MARION POLK COMMUNITY HEALTH PLAN ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 08/17/2007
Element Accepted Date: 09/11/2007
Element Release Date: 09/14/2007
CAP Released Date: 04/01/2008

Visit Start Date: 5/1/2007
Exit Conference Date: 05/02/2007
Date Report Issued: 05/24/2007
Date Report Due: 06/16/2007
CAP Accepted Date: 09/14/2007
Audit Closed Date: 04/01/2008
Element Projected Completion Date: 01/08/2008
MCO Response Due Date: 07/08/2007

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:

CMS reviewed 3 WS RP02 (Reconsideration Timely) sample case files. 2 of the case files were adjudicated in more than 30 days.

Corrective Action Required:

Policies and procedures must be developed or revised to outline workflows in a clear, detailed manner. Workflows should outline each step, task, responsibility, as well as timeline to include other departments (e.g. Claims, UM, Customer Services, Provider Relations and the Medical Director). The MAO must develop internal controls to ensure that unfavorable pre-service reconsiderations are processed timely.