CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date:

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Submission and Distribution of Marketing Materials - For "non-model" documents and for ¿model¿ documents that the Part D sponsor modifies: The Part D sponsor must certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 45 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved. For "model" documents that the Part D sponsor uses without modification: The Part D sponsor must submit and certify that Medicare marketing materials use the CMS specified format and acceptable terminology, and submit them for a 10 day review period by CMS. The Part D sponsor must not distribute or make such materials available until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the Part D sponsor has not received notice from CMS that the materials have not been approved.

Reference:

42 CFR § 423.50(a)(1); § 423.50(a)(3); MA-PD Solicitation; Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

Medica does not meet this requirement. CMS requested Part D notice templates that Medica uses in the following situations: - informing enrollees about inquiries involving excluded drugs consistent with CMS-issued model notice, Notice of Inquiry Regarding an Excluded Drug, - informing enrollees of grievance deadline extension consistent with CMS-issued model notice, Notice of Plan's Decision to Extended the Deadline for Making a Decision Regarding a Grievance, - notification of grievance disposition consistent with CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance, - enrollee notification when a request is forwarded to the IRE consistent with CMS issued model notice, Notice of Case Status, - for notifying enrollees when a request for an expedited coverage determination is denied consistent with CMS issued model notice, Notice of Right to an Expedited Grievance, - requesting additional information from the enrollee's prescribing physician consistent with CMS issued model notice, Request for Additional Information, - for notifying enrollees of an adverse standard redetermination consistent with CMS issued model notice, Notice of Redetermination, and - for requesting a reconsideration consistent with CMS issued model notice, Request for Reconsideration. Medica submitted these notice templates, and they did display the contract number and CMS approval date in the lower left-hand corner as required in the CMS Marketing Guidelines. However, the approval date was after the audit period.

Corrective Action Required:

Medica submitted notice templates that had been approved after the audit period. Therefore, no corrective action is required for this element.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: MR06
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/10/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Plan Responsibility for Persons Employed or Contracted to Perform Marketing - The Part D sponsor must have a compensation structure that meets CMS requirements for any person directly employed or contracted to market the plan. The Part D sponsor must utilize only state licensed, certified, or registered individuals to perform marketing on behalf of the Part D sponsor, whether as an employee or under contract directly or downstream, if a state has such a marketing requirement, and it must conduct monitoring activities to ensure that individuals marketing on behalf of the Part D sponsor comply with all applicable Part D laws, all other Federal health care laws, and CMS policies, including CMS marketing guidelines, to ensure that beneficiaries receive truthful and accurate information.

Reference:

Medicare Marketing Guidelines for MAs, MA-PDs, PDPs, and 1876 Cost Plans

Deficiencies:

Medica does not meet this requirement because CMS reviewed Medica's policies and procedures (MAR 031 Benefit Advisors Field Observations and MAR 020 Benefit Advisors Employment files) regarding its responsibility for and oversight of persons employed or contracted to perform marketing and found they do not include a requirement that any person directly employed or contracted to market on behalf of Medica provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. CMS reviewed 10 sample contracts/compensation structures for individuals who perform marketing from a universe of 20 and found that 10 out of 10 samples were noncompliant. Specifically, the 10 sample contracts/compensation structures did not contain - a provision requiring any person employed to perform marketing on behalf of Medica provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment, and - a provision stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws).

Corrective Action Required:

Medica must revise its policies and procedures (MAR 031 Benefit Advisors Field Observations and MAR 020 Benefit Advisors Employment files) regarding its responsibility for and oversight of persons employed or contracted to perform marketing to include a requirement that any person directly employed or contracted to market on behalf of the Part D sponsor provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Medica. The person may be compensated based on your enrollment in a plan'. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Medica must include provisions within its marketing contracts/compensation structure requiring any person employed to perform marketing on behalf of Medica provide a written disclosure statement to all potential enrollees prior to enrollment or at the time of enrollment. The written disclosure statement must state the following: 'The person that is discussing plan options with you is either employed by or contracted with Medica. The person may be compensated based on your enrollment in a plan'. Additionally, Medica must include a provision within its marketing contracts/compensation structure stating that any coordinated marketing must be done in accordance with all applicable Part D laws, CMS policies, including CMS marketing guidelines and prohibited activities, and all Federal healthcare laws (including civil monetary penalty laws).

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD03
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/12/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Timely Notification of Coverage Determination Concerning Drug Benefit - In response to a drug benefit request, the Part D sponsor must notify the enrollee (and the prescribing physician involved, as appropriate) of its determination as expeditiously as the enrollee¿s health condition requires, but no later than 72 hours after receipt of the request, or, for an exceptions request, the physician¿s supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse coverage determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.568(a); § 423.568(e); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because CMS reviewed a sample of 10 requests for standard coverage determinations concerning drug benefits from a universe of 520 and found 6 out of 10 samples were noncompliant. Specifically, 6 out of 10 samples did not demonstrate that Medica provided timely notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of Medica's decision within a timeframe that is CMS compliant constitutes an adverse coverage determination requiring Medica to forward the enrollee's case file to the IRE and provide notification to the enrollee within 24 hours of the adjudication timeframe. Medica did not demonstrate that the six case files were forwarded to the IRE or that the enrollee was notified.

Corrective Action Required:

Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning drug benefit decision in a timeframe that is CMS compliant and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD04
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/12/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Coverage Determinations Concerning Payment - The Part D sponsor must notify the enrollee of its determination no later than 72 hours after receipt of the payment request, or, for an exceptions request, after receiving the physician's supporting statement. If the coverage determination was denied and the initial notification was provided orally, the Part D sponsor must send the written notice to the enrollee within 3 calendar days of the oral notice. For favorable determinations, the Part D sponsor must authorize payment and notify the enrollee within 72 hours after receiving the request, or, for an exceptions request, after receiving the physician's supporting statement. The Part D sponsor must also make payment (i.e., mail the payment) within 30 calendar days of the request, or, for an exceptions request, after receiving the physician's supporting statement. Failure to notify the enrollee within the 72 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE. Note: This element also applies to out-of-network (OON) paper claims submitted by beneficiaries or their appointed representatives.

Reference:

42 CFR § 423.568(b); § 423.568(e); MA-PD Solicitation; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because CMS reviewed a sample of 5 requests for standard coverage determinations concerning payment from a universe of 5 and found that 1 out of 5 samples was noncompliant. Specifically, 1 out of 5 samples did not demonstrate that Medica provided timely notification of the coverage determination decision to the enrollee. Failure to notify the enrollee of Medica's decision within a timeframe that is CMS compliant constitutes an adverse coverage determination requiring Medica to forward the enrollee's case file to the IRE and notify the enrollee within 24 hours of the adjudication timeframe. Medica did not demonstrate that the sample file was forwarded to the IRE or that the enrollee was notified.

Corrective Action Required:

Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its coverage determination concerning payment decisions and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CD09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/12/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Timely Notification of Expedited Coverage Determination - The Part D sponsor must make its expedited coverage determination and notify the enrollee of its decision (adverse or favorable), as expeditiously as the enrollee¿s health condition requires, but no later than 24 hours after receiving the request, or, for an exceptions request, the physician¿s supporting statement. If the decision is adverse and the Part D sponsor first notifies the enrollee of the determination orally, the Part D sponsor must mail written confirmation to the enrollee within 3 calendar days of the oral notification. Failure to notify the enrollee within the 24 hour timeframe constitutes an adverse determination requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.570(e); § 423.572(a-b); § 423.572(d); § 423.578(c)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because CMS reviewed a sample of 4 requests for expedited coverage determinations from a universe of 4 and found that in 4 out of 4 samples Medica did not demonstrate timely notification of the decision to the enrollee. Failure to notify the enrollee of Medica's decision within a timeframe that is CMS compliant constitutes an adverse determination requiring Medica to forward the enrollee's case file to the IRE and notify the enrollee within 24 hours of the adjudication timeframe. Medica did not demonstrate that four of the case files were forwarded to the IRE.

Corrective Action Required:

Medica must always provide notification to the enrollee, or the appointed representative, as applicable, of its expedited coverage determination decisions within the CMS approved timeframes and provide documentation demonstrating this to CMS. If Medica fails to notify the enrollee, or the appointed representative, as applicable, of its decision in a timely manner, Medica must forward the case file to the IRE and notify the enrollee within 24 hours of the expiration of the adjudication timeframe and provide documentation demonstrating this to CMS.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: CE01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/8/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Exceptions Procedures and Criteria (Tiered Cost-Sharing) - The Part D sponsor must establish and maintain reasonable and complete exceptions procedures, subject to CMS¿ approval, for exceptions requests to the Part D sponsor¿s tiered cost-sharing structure. The exceptions procedures must address situations where a formulary¿s tiering structure changes during the year, and an enrollee is using a drug affected by the change. The Part D sponsor must grant an exception for non-preferred drugs when medically necessary and consistent with the prescribing physician¿s statement that meets CMS criteria. The Part D sponsor¿s tiered cost-sharing exceptions process and exception criteria must meet CMS requirements including for unplanned transitions.

Reference:

42 CFR § 423.578(a)(1-2); § 423.578(a)(4); MA-PD Solicitation and EP Attestation Addendum; Reporting Requirements for Section VI: Prior Authorization, Step Edits, Non-Formulary Exceptions, and Tier Exceptions; Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals; Information for Part D Sponsors on Requirements for a Transition Process

Deficiencies:

Medica does not meet this requirement because CMS reviewed Medica's policies and procedures (PHR 440 Formulary Exceptions, Exceptions Request: Tracking, Timely Review and Resolution) regarding processing requests for exceptions to its tiered cost-sharing structure and found it did not include a provision stating that Medica must grant a tiering exception when it determinates that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects.

Corrective Action Required:

Medica must revise its policies and procedures (PHR 440 Formulary Exceptions, Exceptions Request: Tracking, Timely Review and Resolution) regarding processing requests for exceptions to its tiered cost-sharing structure to include a provision stating that a Part D sponsor `must grant' a tiering exception when it determinates that the preferred drug for treatment of the enrollee's condition would not be as effective for the enrollee as the requested drug and/or would have adverse effects. Specifically, the language in quotation marks must be added. Medica must conduct training of its staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Part D Audit Report

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Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE05
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Timely Notification and Effectuation of Standard Redetermination Concerning Covered Drug Benefit - If the Part D sponsor makes a redetermination that is favorable for the enrollee, or affirms in whole or in part its original adverse coverage determination, it must notify the enrollee in writing of its redetermination as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it received the request for a standard redetermination, meeting CMS requirements. For favorable redeterminations for the enrollee, the Part D sponsor must effectuate it as expeditiously as the enrollee¿s health condition requires, but no later than 7 calendar days from the date it receives the request. Failure to notify the enrollee within the timeframe constitutes an adverse redetermination decision requiring the Part D sponsor to forward the enrollee¿s request to the Independent Review Entity (IRE) within 24 hours of the expiration of the adjudication timeframe. The Part D sponsor must also inform the enrollee, within 24 hours of the expiration of the adjudication timeframe, when the case is forwarded to the IRE.

Reference:

42 CFR § 423.590(a)(1-2); § 423.590(c); § 423.590(g)(1-4); § 423.636(a)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because over 30% of the cases provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Benefits, were misclassified. Specifically, 1 sample was a request for an expedited redetermination and 1 sample was a coverage determination request. The universe provided by Medica is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Medica must provided CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS the root cause as well as a detailed corrective action plan.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE09
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Review of Adverse Coverage Determinations - The Part D sponsor must ensure that a person or persons who were not involved in making the coverage determination conducts the redetermination. When the issue is a denial based on lack of medical necessity, the Part D sponsor must ensure the redetermination is made by a physician with the expertise in the field of medicine that is appropriate for the services at issue. The physician making the redetermination need not, in all cases, be of the same specialty or subspecialty as the prescribing physician.

Reference:

42 CFR § 423.590(f)(1-2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because over 30% of samples provided for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits were misclassified. Specifically, one sample was a request for an expedited redetermination and one sample was a coverage determination request. The universe provided by Medica is not representative of samples that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Medica must provide CMS with an analysis and explanation of why the universes submitted for WS-RE1_D, Requests for Standard Redetermination Concerning Drug Benefits, contain misclassified samples. Based on the analysis, Medica is to provide to CMS the root cause as well as a detailed corrective action plan.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RE10
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Timely Transfer to IRE Upon Reconsideration Request - In cases where an enrollee has filed a reconsideration request and the IRE has requested the enrollee's file, the Part D sponsor must transfer the case file to the IRE within 24 hours (expedited requests) or 48 hours (standard requests) from the time it receives the IRE¿s request for the case file.

Reference:

Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because over 30% of the cases provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Benefits were misclassified. Specifically, 1 sample was a request for an expedited redetermination and 1 sample was a coverage determination request. The universe provided by Medica is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Medica must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS, the root cause as well as a detailed corrective action plan.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV01
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Effectuation of Third Party Reversals ¿ Benefits (Standard) - If, on appeal of a request for benefit, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize or provide the benefit under dispute as expeditiously as the enrollee¿s health requires but no later than 72 hours after the date it receives notice reversing the determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(1); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because over 30% of the cases provided for WS-RE1_D, Requests for Standard Redeterminations Concerning Benefits were misclassified. Specifically, one sample was a request for an expedited redetermination and one sample was a coverage determination request. The universe provided by Medica is not representative of cases that CMS requested, and is therefore inadequate for determining compliance.

Corrective Action Required:

Medica must provide CMS with an analysis and explanation of why the universe submitted for WS-RE1_D contains misclassified cases. Based on the analysis, Medica is to provide to CMS, the root cause as well as a detailed corrective action plan.

CMS Part D Audit Report

Auditing Results (Public Website Version)

Date Report Generated: 9/30/2008

Contract Number: All, Chapter: All, Element: All, Finding: Not Met, Auditor: All

Findings: Not Met
Audit ID: 3481
Contract Number: H5420
Part D Sponsor Name: MEDICA HEALTHCARE PLANS, INC.

Audit Guide Version: MA-PD Sponsor Part D Audit Guide Version 1
Auditing Element: RV02
Audit Type: Routine
Audit Location: Desk Review
Date Report Issued: 3/3/2008
Date Report Due: 4/17/2008
Element Accepted Date: 5/9/2008
Element Release Date: 5/9/2008
Element Projected Completion Date: 4/11/2008

3 Year Reporting Cycle: 1/1/2006 - 12/31/2008
Estimated Visit Start Date: 1/14/2008
Estimated Visit Start Date: 1/17/2008
Actual Visit Start Date: 1/14/2008
Actual Visit End Date: 1/17/2008
Part D Sponsor Response Received Date:
Part D Sponsor Response Due Date: 4/17/2008
CAP Release Date: 5/9/2008
CAP Accepted Date: 5/9/2008

Requirement:

Effectuation of Third Party Reversals ¿ Payment (Standard) - If, on appeal of a request for payment, the Part D sponsor 's determination is reversed in whole or in part by the Independent Review Entity (IRE), or at a higher level of appeal, the Part D sponsor must authorize the payment within 72 hours, but make payment no later than 30 calendar days from the date it receives notice reversing the coverage determination. The Part D sponsor must also inform the IRE that the organization has effectuated the decision.

Reference:

42 CFR § 423.636(b)(2); Prescription Drug Benefit Manual; Chapter 18 ¿ Part D Enrollee Grievances, Coverage Determinations, and Appeals

Deficiencies:

Medica does not meet this requirement because CMS reviewed Medica's policies and procedures (AG 004 Part D Enrollee Appeals) for effectuating third party reversals on an appeal of a request for payment and it did not include a provision stating that payment must be authorized 'within 72 hours' from the date it receives notice reversing the decision.

Corrective Action Required:

Medica must revise its policies and procedure regarding effectuating third party reversals on an appeal of a request for payment to include a provision stating that payment must be authorized within 72 hours from the date it receives notice reversing the decision. Medica must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.