# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** CN04

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 07/11/2008

**Element Release Date:** 09/09/2008

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**08/23/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

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

**Deficiencies:**

Neighborhood Health Providers (NHP)does not meet the CMS compliance standard because CMS audited 20 cases from a universe of 420 and found out of the 20 cases reviewed 20 did not contain the 10 years requirements for file retention. All contracts still contain the 6 years retention provision and there were no amendmends to any of the contracts reviewed updating the new requirements as stated in 42 CFR 422.504 of the regulations.

**Corrective Action Required:**

Neighborhood Health Providers (NHP) must ensure that all the contracts are amended to reflect the 10 years record retention requirements as states in the regulation 42 CFR 422.504. A copy of the amendment to the contracts, must be sent to CMS for review and NHP must ensure that all the network providers are aware of that 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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** ER01

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 07/17/2008

**Element Release Date:** 09/09/2008

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/27/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Correct Enrollment Election - Elections must be completed by the beneficiary or representative, authorized under laws of the state.

**Deficiencies:**

Neighborhood Health Plan (NHP) does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 184 and found 11 cases in which multiple Medicare products were selected on the application. Also the application date was scratched on 2 of the 11 cases.

**Corrective Action Required:**

Neighborhood Health Plan (NHP) must conduct training of appropriate marketing and enrollment staff on enrollment election procedures such as making corrections to an individual enrollment form, documenting the reason for corrections and the individual making the corrections. NHP must also submit documentation to the regional office that details the nature of this training including the materials used in the training, the individuals conducting the training, and the individuals being trained.

# *CMS Medicare Managed Care Auditing Report*

## Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

**Findings:** NOT MET

**Review ID:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5
**Auditing Element:** GV03
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**
**Element Accepted Date:** 06/19/2008
**Element Release Date:** 09/09/2008
**CAP Released Date:**

**Visit Start Date:** 3/3/2008
**Exit Conference Date:** 04/03/2008
**Date Report Issued:** 05/13/2008
**Date Report Due:** 05/18/2008
**CAP Accepted Date:**
**Audit Closed Date:**
**Element Projected Completion Date:**06/19/2008
**MCO Response Due Date:** 06/27/2008

**Requirement:**

Grievance Decision Notification (Timeliness) - The MAO must notify the member of its decision 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 complaint involves an MAO"s decision to invoke an extension relating to an organization determination or reconsideration, or the complaint 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 a 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:**

Neighborhood Health Providers (NHP) does not meet the CMS compliance standard because CMS audited 14 cases (12 cases for NHP and 2 cases for delegated entity 3) from a universe of 14 and found that out of the 12 cases reviewed for NHP, 2 cases included notices which were not sent within the required 30 day timeframe.

**Corrective Action Required:**

Neighborhood Health Providers (NHP) must conduct training of appropriate staff on the CMS requirements to send member notices within the established timeframe. NHP 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 individuals being trained.

# *CMS Medicare Managed Care Auditing Report*

## Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

**Findings:** NOT MET

**Review ID:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** MR01

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/09/2008

**Element Release Date:** 09/09/2008

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/23/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

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

**Deficiencies:**

Neighborhood Health Plan (NHP) does not meet the CMS compliance standard because CMS audited 35 cases and found 19 cases that did not follow the requirements contained in the regulations and Medicare Marketing Guidelines for submission and distribution of File and Use materials. 17 of the 19 cases were model enrollment notices that were submitted with modifications, 1 case was a provider directory submitted without the contract number and material ID and 1 case was a promotional flyer submitted without the contracting statement.

**Corrective Action Required:**

Neighborhood Health Plan (NHP) must develop and implement policies and procedures that incorporate the regulations and marketing guidelines for submission and distribution of File and Use materials. NHP must conduct training of 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.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5
**Auditing Element:** MR08
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**
**Element Accepted Date:**
**Element Release Date:**
**CAP Released Date:**

**Visit Start Date:** 3/3/2008
**Exit Conference Date:** 04/03/2008
**Date Report Issued:** 05/13/2008
**Date Report Due:** 05/18/2008
**CAP Accepted Date:**
**Audit Closed Date:**
**Element Projected Completion Date:** 06/27/2008
**MCO Response Due Date:** 06/27/2008

**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 MAOs involved and unless the materials have received prior approval from CMS; " Use providers to accept enrollment applications or offer inducement to persuade beneficiaries to join plans; " Use providers to offer anything of value to induce plan enrollees to select them as a provider; " 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; " Offer cash gifts, including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates and gift cards that can be readily converted to cash; " Engage in any discriminatory marketing practice, such as targeted marketing to Medicare beneficiaries from higher income areas, without making comparable efforts to enroll Medicare beneficiaries from lower income areas; " Use high pressure sales tactics to enroll a beneficiary into a plan or require an in-home appointment; " Send unsolicited e-mails unless the Medicare beneficiary agrees to receive e-mails; " Buy or rent e-mail lists to distribute information about MA plans " Conduct door-to-door solicitation of Medicare beneficiaries.

**Deficiencies:**

Neighborhood Health Plan (NHP) does not meet the CMS compliance standard because CMS audited 10 cases from a universe of 24 and found 8 cases in which the marketing representatives did not have proof on file of being licensed by the State of NY. CMS found that 6 of these representatives did not have a State license pursuant to New York Insurance Law Section 2101. 2 of the 8 marketing representatives had expired state licenses on file. We found that 1 representative with an expired license received commissions after his license expiration date.

**Corrective Action Required:**

Neighborhood Health Plan (NHP) must establish and maintain effective oversight controls over its marketing department to ensure that State laws regarding license agents are followed. NHP must comply with NY State Insurance Law which states that an unlicensed employee of a licensed insurance broker that sells, solicits or negotiates insurance would be acting as an insurance broker and would need to be licensed as such. NHP must also maintain oversight control to prevent that an unlicensed employee to solicit, sell or negotiate insurance for a commission or other compensation directly dependent on the amount of business done. The MCO must submit a policy and procedure which describes the types of oversight activities it will implement over its delegated entities. NHP must also establish a mechanism for ongoing monitoring of this area to ensure continued compliance. While onsite the plan supplied and updated state license for one marketing representative who had an expired license on file. This was satisfactory.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OC01

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/09/2008

**Element Release Date:** 09/09/2008

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/20/2008

**MCO Response Due Date:** 06/27/2008

**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:**

Neighborhood Health Providers (NHP)does not meet the CMS compliance standard because CMS audited 65 cases (30 cases NHP, 30 cases for delegated entity 2, and 5 cases for delegated entity 3) from a universe of 1142 and found out of the 30 cases reviewed for delegated entity 2, 22 did not contain evidence of appropriate claim development. The term "soft denial" was associated with the denial of these cases by the entity, which means no attempts were made to obtain additional information from the non-contracted provider prior to the denial, however, an opportunity for the provider to submit additional information is given in the denial notice.

**Corrective Action Required:**

Neighborhood Health Providers (NHP) must revise its oversight of its delegated entities by ensuring that the delegated entities are following appropriate plan's policies and procedures. Policies and procedures should be updated to reflect guidelines on appropriate claims development associated with non-contracted providers. NHP must also establish a mechanism for ongoing monitoring of this area to ensure continued 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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP02

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:**

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/20/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Adverse Standard Pre-Service Organization Determinations (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 the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process

**Deficiencies:**

NHP does not meet the CMS compliance standard for this element. A universe of 22 from a delegated entity was submitted to CMS. Of this universe, 10 records were selected for review. Of the 10 records, 9 were not untimely and one record was misclassified. The 9 records did not have documentation that the members were notified verbally or in writing and one was misclassified. The notice used by the plan was not approved by CMS.

**Corrective Action Required:**

NHP must develop a system for processing and notifying their member timely regarding adverse pre-service organization determinations. The Plan must use CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC. The notices must be sent to the member in a timely manner and must clearly state the service denied and the specific denial reasons. The notices should inform the members of their rights. NHP must document all oral and written requests. Member services and the staff involved in this process should be trained in policies and procedures.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP03

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/20/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Receipt and Documentation of Expedited Organization Determination Requests - The MAO must establish an efficient and convenient means for individuals (including members, their applicable representatives, or their physicians) to submit oral or written requests for expedited organization determinations, document all oral requests in writing, and maintain the documentation in a case file.

**Deficiencies:**

NHP does not meet the CMS compliance standard for this element. CMS audited 15 cases from a universe of 52 cases was submitted by delegated entity 2. CMS found 7 cases which were not processed timely for the element standard pre-service organization determination. Seven cases were not processed timely and one case was misclassified. The dates the services were requested were not indicated in NHP administrative notes or MIS print outs.

**Corrective Action Required:**

A system must be developed so that the notices are sent timely and the notices must clearly state the reasons for service denial. NHP must document all oral and written requests. They should document when they notify the member orally and in writing. The plan must also develop a log for expedited request and the documentation should be comprehensive. Member services and the staff involved in this process should be trained in the policies and procedures. Furthermore, NHP must establish and maintain effective oversight of its delegated entities in order to ascertain if they are adhering to the plan and CMS policies and procedures.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5
**Auditing Element:** OP05
**Review Type:** Routine
**Review Status:** Confirmed
**MCO Response Received Date:**
**Element Accepted Date:**
**Element Release Date:**
**CAP Released Date:**

**Visit Start Date:** 3/3/2008
**Exit Conference Date:** 04/03/2008
**Date Report Issued:** 05/13/2008
**Date Report Due:** 05/18/2008
**CAP Accepted Date:**
**Audit Closed Date:**
**Element Projected Completion Date:**06/19/2008
**MCO Response Due Date:** 06/27/2008

**Requirement:**

Adverse Expedited Organization Determinations (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 the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process.

**Deficiencies:**

There were no samples, notices or policies and procedures for this element.

**Corrective Action Required:**

Neighborhood Health Providers (NHP) must develop and implement policies and procedures for Adverse Expedited Organization Determinations. NHP must conduct training of 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. NHP must develop a template letter with a matrix clearly stating the reasons for denials. The notice must have complete appeals language.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

---

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP06

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 07/21/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**07/22/2008

**MCO Response Due Date:** 06/27/2008

---

**Requirement:**

Organization Determination Extensions (Notice Content) - If an extension is granted for an organization determination, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

**Deficiencies:**

There were no samples, notice or policies and procedures for this element.

**Corrective Action Required:**

NHP must develop and implement policies and procedures for Organizational Determination extensions. NHP must conduct training of 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. NHP must develop an Organization Determination Extensions Notice/Template. The notice/template must include reasons for the delay, and informs the member of their right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

---

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP07

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:**

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Decision Not to Expedite an Organization Determination (Notice Content) - If the MAO decides not to expedite an organization determination, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the 14-day standard timeframe, inform the member of the right to file an expedited 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 determination with any physician"s support, and provide instructions about the MAO grievance process and its timeframes.

**Deficiencies:**

There were no samples, notices or policies and procedures for this element.

**Corrective Action Required:**

NHP must develop a notice/template for a decision not to Expedite an Organization Determination. NHP must develop and implement policies and procedures for not expediting organizational determinations. NHP must conduct training of 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.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP09

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

OPTIONAL: Favorable Standard Pre-Service Organization Determinations (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination 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:**

NHP does not meet the CMS compliance standard for this element. CMS audited 15 cases related to this element (OP-3) favorable pre-service organization determination. CMS found 7 cases were not processed timely for the element standard pre-service organization determination. Seven cases were not processed timely and one case was misclassified. The dates the services were requested were not indicated in NHP administrative notes or MIS print outs.

**Corrective Action Required:**

NHP must develop and implement policies and procedures for notifying members about favorable standard pre-service organization determination. NHP must conduct training of 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.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** OP15

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Detailed Notice of Discharge of Inpatient Hospital Care - Prior to discharging the individual or lowering the level of care within the hospital setting, the MAO must secure concurrence from the physician responsible for the enrollee"s inpatient care. When the QIO has notified an MAO that an enrollee has requested an immediate review of an MAO or hospital"s determination that inpatient care is no longer necessary, the MAO must, directly or by delegation, provide the Detailed Notice of Discharge to the enrollee as soon as possible but no later than noon of the day after the QIO"s notification. The detailed notice must include a detailed explanation of why services are either no longer reasonable and necessary or are no longer covered in an inpatient hospital setting; a description of any applicable Medicare coverage rule, instruction, or other Medicare policy used in this determination, including information about how the enrollee may obtain a copy of the Medicare policy; any applicable MA organization policy, contract provision, or rationale upon which the discharge determination was based; and facts specific to the enrollee and relevant to the coverage determination sufficient to advise the enrollee of the applicability of the coverage rule or policy to the enrollee"s case. During the review process, the plan ensures that all information the QIO needs to make its determination is provided, either directly (with hospital cooperation) or by delegation, no later than noon of the day after the QIO notifies the MAO that a request for an immediate review has been received from the enrollee.

**Deficiencies:**

There were no samples, notices or policies and procedures for this element.

**Corrective Action Required:**

NHP must use a CMS approved Detailed Notice of Discharge Inpatient Hospital Care notice/template. NHP must develop and implement policies and procedures for hospital discharges. NHP must conduct training of 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.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** PR03

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 07/17/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**02/01/2009

**MCO Response Due Date:** 06/27/2008

**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:**

This element was not met as evidenced by the following: one of 20 sampled provider files did not contain documentation of National Practitioner Data Bank information at the time of credentialing and four files did not contain evidence of verification of opt-out status at the time of credentialing.

**Corrective Action Required:**

NHP is to submit a corrective action plan that shows how it will monitor the credentialing process to ensure compliance with verification of these requirements at the time of credentialing.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RC01

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**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:**

There were no samples or notices for this element. Policies and procedures were reviewed and did not address all the requirements for this element.

**Corrective Action Required:**

Neighborhood Health Providers (NHP) must revise its policies and procedures for favorable claims reconsideration to include process to send written notice of its determination to member. NHP must conduct training of 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, they should also develop an approved Member notice template.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RP01

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**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:**

There were no samples or notices for this element. Policies and procedures were reviewed and did not address all the requirements for this element.

**Corrective Action Required:**

Neighborhood Health Providers must revise its policies and procedures for Favorable Standard Pre-Service Reconsiderations to include process to send written notice of its determination to member. Neighborhood Health Providers must conduct training of 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, they should also have an approved Member notice template.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RP05

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**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 prompt oral notice to the member of the decision not to expedite, 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:**

There were no samples or notices for this element. Policies and procedures were reviewed and did not address all the requirements for this element.

**Corrective Action Required:**

NHP must revise its policies and procedures for requests for Expedited Reconsiderations to address the process to foward its adverse expedited determination to CMS' independent review entity. NHP must conduct training of 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 NHP must develop a: Template of member notice about decision whether to expedite. Template of member notice of favorable decision. Template of member notice upholding denial. Template of cover letter/document used in forwarding case to CMS IRE. entity

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RP06

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Decisions 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:**

There were no samples or notices for this element. Policies and procedures were reviewed and did not address all the requirements for this element.

**Corrective Action Required:**

The plan must develop a written notice template. The notice must provide examples of reasons for the decision not to expedite the reconsideration.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RP07

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**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:**

There were no samples or notices for this element. Policies and procedures were reviewed and did not address all the requirements for this element.

**Corrective Action Required:**

The plan must contact IRE (Maximus-The Center for Health Disputes Resolution) for information on processing third party reconsideration reversals. The plan must develop policies and procedures for effectuating IRE expedited reconsiderations reversals. The plan must conduct training for 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.

# *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:** 10717

**Region:** 02 New York

**Contract Number / Name:** H3336 NEIGHBORHOOD HEALTH PROVIDERS LLC

**Auditing Guide Version:** MA Audit Review Guide, Version 5

**Auditing Element:** RP08

**Review Type:** Routine

**Review Status:** Confirmed

**MCO Response Received Date:**

**Element Accepted Date:** 09/12/2008

**Element Release Date:**

**CAP Released Date:**

**Visit Start Date:** 3/3/2008

**Exit Conference Date:** 04/03/2008

**Date Report Issued:** 05/13/2008

**Date Report Due:** 05/18/2008

**CAP Accepted Date:**

**Audit Closed Date:**

**Element Projected Completion Date:**06/19/2008

**MCO Response Due Date:** 06/27/2008

**Requirement:**

Reconsideration Extensions (Notice Content) - If the MAO grants an extension on a reconsideration, the written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.

**Deficiencies:**

There were no samples or notices for this element. Policies and procedures were reviewed and they did not address all the requirements for this element.

**Corrective Action Required:**

The plan must develop a notice template for this element. The plan must revise its policies and procedures for reconsideration extensions. The plan must conduct training of 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. The written notice to the member must include the reasons for the delay, and inform the member of the right to file an expedited grievance if he or she disagrees with the decision to grant an extension.