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
Region: 04 Atlanta
Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Review ID: 8777

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 01/03/2008
Element Release Date: 06/12/2008
CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/09/2007

Requirement:

Required Contract Provision: Hold Harmless - The MAO's written contracts with first tier and downstream entities must contain a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO.

Deficiencies:

University Health Care does not meet the CMS compliance standard because CMS audited 20 cases from a universe of 7,399 and found 20 cases where the contracts contained the following state language "Provider agrees that in the event of HMO's insolvency or other cessation of operations, services to the MA members will continue through the period for which the premium has been paid to HMO" This language is contrary to the CMS guidance provided in Chapter 11 of the Medicare Managed Care Manual that states "the MA organization must provide for continuation of enrollee health care benefits for all enrollees, for the duration of the contract period for which CMS payments have been made, and enrollees who are hospitalized on the date its contract with CMS terminates, or, in the event of an insolvency, through discharge."

Corrective Action Required:

University Health Care must revise all contracts to include hold harmless language that is consistent with Chapter 11, Section 100.3 of the Medicare Managed Care Manual. Documentation must be submitted to CMS that the contracts have been revised appropriately.

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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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
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Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/09/2007

Requirement:

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

Deficiencies:

University Health Care does not meet the CMS compliance standard because CMS audited 20 cases from a universe of 7,399 and found 8 contracts erroneously required the provider to maintain records for six years instead of ten years.

Corrective Action Required:

University Health Care must revise all contracts to include record retention requirements that are consistent with Chapter 11, Section 100.4 of the Medicare Managed Care Manual. Documentation must be submitted to CMS that the contracts have been revised appropriately.

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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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
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Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/09/2007

Requirement:

Adequate Compliance PlanThe MAO must have a formalized compliance plan that contains the requirements specified by CMS

Deficiencies:

University Health Care does not meet the CMS compliance standard because no detailed monitoring strategy exists for internal plan activities or for the delegated entities. In addition, no corrective action initiatives exist to respond to findings from audit activities.

Corrective Action Required:

University Health Care must establish a formal mechanism for ongoing internal monitoring as well as monitoring of any delegated entities to ensure continued compliance. Findings should be reviewed regularly and corrective action initiatives implemented to resolve any findings.

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
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Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 02/15/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 15 cases from a universe of 1,751 and found that 10 cases were misclassified. The misclassified cases were either Part D complaints, inquiries, or provider complaints.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
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Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 02/15/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 15 cases from a universe of 1,751 and found that 10 cases were misclassified. The misclassified cases were either Part D complaints, inquiries, or provider complaints.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
Element Release Date: 06/12/2008
CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
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Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 02/15/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 15 cases from a universe of 1,751 and found that 10 cases were misclassified. The misclassified cases were either Part D complaints, inquiries, or provider complaints.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
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CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 02/15/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 15 cases from a universe of 1,751 and found that 10 cases were misclassified. The misclassified cases were either Part D complaints, inquiries, or provider complaints.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C grievances received during the audit period. The term grievances must include all member concerns that do not fall within the purview of the Medicare organization determination or reconsideration processes regardless of whether other words are used to describe them. This includes issues received telephonically as well as in writing.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/04/2008
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CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the CMS compliance standard because CMS audited 24 cases from a universe of 32,642 and found 17 cases in which the denial was not proper. Some cases had multiple deficiencies. The following problematic areas were identified for this element: 1) Fifteen cases of the seventeen cases were not developed nor was there any attempt to develop the cases. These cases were denied because there was no pre-certification or authorization on file yet all the claims were paid by Passport Health Plan or Kentucky Medicaid. Both the members and providers received notice that the claims were denied and the member was responsible for the billed amount. Since these were non-contracted providers, there was nothing to prevent them from billing the member even though the EOB states that they are being sent to Passport Health Plan for review. 2) One case erroneously denied claims for out of area renal dialysis. 3) Another case was denied for outside the timely filing limits however, the Medicaid time limits were being applied rather than the Medicare time limits. 4) Three of the fifteen cases referenced above had additional errors that made the denial improper. Two cases were denied and the non-contracted provider was instructed to resubmit the claim to the delegated entity responsible for processing the vision claims. Another case was denied for outside the timely filing limits however, the Medicaid time limits were being applied rather than the Medicare time limits.

Corrective Action Required:

University Health Care must restructure the claims processing system to pend all claims that do not have a prior authorization on file rather than immediately denying the claim. While the claim is pended by Passport Advantage, it should be sent to Passport Health Plan for review and payment. If PHP pays the claim, no EOB would have needed to be issued to the member thus eliminating any member liability. However, if the claim is denied by PHP, the EOB should be issued indicating the member is indeed liable for the cost of the services. The same process should be utilized for the SNF and behavioral health services paid by Kentucky Medicaid. It is possible that PHP or KY Medicaid may not make a determination by PAD's 60th day. In these situations, PAD may deny the claim, but a denial reason code should be included stating the claim is pending a decision by Medicaid. Furthermore, University Health Care must revise it's marketing materials to clearly explain that when members seek care from non-contracted providers, it is their responsibility to obtain any necessary pre-authorizations. Second, revise all internal processes and systems to pay for out of area renal dialysis in all circumstances. Third, UHC must review all policies and procedures as well as systems programs to correct the timeframes for non-contracted providers to submit claims to follow the Medicare timely filing requirements not the Medicaid timeframes. Finally, UHC must institute a process by which vision claims that are not submitted correctly to the delegated entity are transferred in a manner that is transparent to both the beneficiary and the provider. Documentation must be submitted to confirm that all necessary steps were taken to correct these issues including the training of staff, when necessary. When training is conducted UHC should document the nature of the training including: materials used in the training, 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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
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Visit Start Date: 9/10/2007
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Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the CMS compliance standard because CMS audited 24 cases from a universe of 32,642 and found that none of the twenty-four cases included the full OMB-approved language of the Notice of Denial of Payment. Furthermore, seventeen cases in which the written denial notice did not clearly state the service and/or the denial reason. In fourteen cases, the description of the service was not clear. Terms such as medical care or medication were used that did not clearly indicate to the member what was being denied. Second, thirteen of the cases used denial reason codes that were either unclear or inconsistent with each other. Some commonly used denial reason codes that were unclear were payment denied/reduced for absence of or exceeded precertification/authorization, Medicare fee schedule paid, if these services were performed by an out of network provider, you may be responsible for the difference between the amount charged and the allowed amount. Lastly, the denial notice was compliant with the OMB approved form, but the term HCFA was used rather than CMS.

Corrective Action Required:

University Health Care must revise it's Explanation of Benefits to comply with the requirements set forth in Chapter 13 of the Medicare Managed Care Manual which states Medicare health plans that use system-generated notifications regarding payment denials must ensure that the notification contains the OMB-approved language of the NDP in its entirety, and meets the content requirements listed in the NDP's form instructions. The standardized denial notice forms have been written in a manner that is understandable to the enrollee and must provide 1) The specific reason for the denial that takes into account the enrollee's presenting medical condition, disabilities, and special language requirements, if any, 2) Information regarding the enrollee's right to a standard or expedited reconsideration and the right to appoint a representative to file an appeal on the enrollee's behalf (as mandated by 42 CFR 422.570 and 422.566(b)(3), 3) For service denials, (see Notice of Denial of Medical Coverage (NDMC), Appendix 1), a description of both the standard and expedited reconsideration processes and time frames, including conditions for obtaining an expedited reconsideration, and the other elements of the appeals process, 4) For payment denials, (see Notice of Denial of Payment (NDP), Appendix 1) a description of the standard reconsideration process and time frames, and the rest of the appeals process and, the beneficiary's right to submit additional evidence in writing or in person. Second, UHC must review all of its service descriptions to ensure they clearly state the service that is being denied particularly since a beneficiary commonly receives multiple services during a visit. In addition, all denial reason codes must be reviewed and revised so that they clearly indicate the reason the service is denied as well as ensure that none of the reason codes conflict with one another. All system auto-generated denial codes should be included in this review to verify that they are clear and being used appropriately. Pay particular attention to the following codes BC1, BD4, and P13 since they appeared consistently throughout the sample case files. Training should be conducted for staff on any changes made as a result of this CAP as well as the use of the manual code P73 (Medicare fee schedule paid) since this code was erroneously used for denied claims. When training is conducted UHC should document the nature of the training including materials used in the training, individuals conducting the training, and the individuals being trained. Lastly, CMS recommends that UHC revise its standard denial notice to correct the name of our agency from HCFA to CMS. The marketing material should be submitted through the marketing review process.

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
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MCO Response Received Date: 12/12/2007
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Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the CMS compliance standard because CMS audited 10 samples from a universe of 147 and found in all 10 cases that the plan did not use the standard Form No. CMS-10003-NDMC (Notice of Denial of Medical Coverage) to inform members of adverse standard pre-service organization determinations. In all 10 samples, University Health Plan failed to provide appeal rights to members and did not use clear and understandable language to inform the member of the reason for the denial. There was no marketing material ID and approval date and no OMB control number on the denial notices issued by University Health Care

Corrective Action Required:

University Health Care must revise its policies and procedures to ensure that it uses the standard Form No. CMS-10003-NDMC (Notice of Denial of Medical Coverage) which includes enrollee appeal rights. The plan must provide a specific and detailed explanation of why the medical services or items are being denied using clear and understandable language. University must submit the standard Form No. CMS-10003-NDMC to CMS for review and approval. Once approved by the regional office, University must include a marketing material ID and approval date on the Notice of Denial of Medical Coverage. The OMB control number must also be displayed on the notice. University Health Care must conduct training of appropriate staff on these revised 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.

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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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP12
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
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Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/28/2008
MCO Response Due Date: 12/09/2007

Requirement:

Detailed Explanation of Non-Coverage of Provider Services (Timeliness) -- The MAO (upon notification by the QIO that an enrollee has filed a request for a fast-track appeal) must send a detailed notice to the enrollee by the close of business of the day the QIO notification is received.

Deficiencies:

University Health Care does not meet the CMS compliance standard. University Health Care notified CMS that there was no universe for termination of provider services for members in SNF, HHA or CORF. During the on-site discussions at the plan, University Health Care indicated that its providers were issuing the required CMS notices and provided a copy of a notice issued. University is required to provide a completed copy of the Detailed Explanation of Non-Coverage (CMS 10095-B) to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings.

Corrective Action Required:

University Health Care must develop and implement a process to ensure that it provides a Detailed Explanation of Non-Coverage (CMS 10095-B) to members receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. The notice must be provided no later than close of business of the day of the QIO's notification, or close of business the day before discharge, whichever is later. University Health Plan must conduct training of appropriate staff on these revised 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.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/28/2008
MCO Response Due Date: 12/09/2007

Requirement:

Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.

Deficiencies:

University Health Care does not meet the CMS compliance standard. University Health Care notified CMS that there was no universe for termination of provider services for members in SNF, HHA or CORF. During the on-site discussions at the plan, University Health Care indicated that its providers were issuing the required CMS notices and provided a copy of a notice issued. University is required to provide a completed copy of the Detailed Explanation of Non-Coverage (CMS 10095-B) to enrollees receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings.

Corrective Action Required:

University Health Care must develop and implement a process to ensure that it provides a Detailed Explanation of Non-Coverage (CMS 10095-B) to members receiving skilled nursing, home health or comprehensive outpatient rehabilitation facility services upon notice from the Quality Improvement Organization (QIO) that the enrollee has appealed the termination of services in these settings. University is required to use the standard notice. University is required to use the standard notice, CMS Form No. 10095-B, OMB No. 0938-0910 and must submit it to the regional office for review and approval. Once approved by the regional office, University must include the marketing material ID and approval as well as the OMB control number on the Detailed Explanation of Non-Coverage. University Health Plan must conduct training of appropriate staff on these revised 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.

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Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

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CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/18/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 3 cases from a universe of 3 and found that 1 sample was misclassified. The misclassified case was a Part D claims reconsideration.

Corrective Action Required:

University Health Care must produce produce a representative universe of all Part C adverse claims reconsiderations received during the audit period.

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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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
Element Release Date: 06/12/2008
CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/18/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 3 cases from a universe of 3 and found that 1 sample was misclassified. The misclassified case was a Part D claims reconsideration.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C effectuation of third party claims reconsideration reversals received during the audit period.

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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
Element Release Date: 06/12/2008
CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/18/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 10 cases from a universe of 11 and found 8 cases which were misclassified. 7 of the misclassified cases were Part D complaints and 1 was a duplicate Part C case.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C favorable standard pre-service reconsiderations received during the audit period.

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: 8777

Region: 04 Atlanta

Contract Number / Name: H1807 UNIVERSITY HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 12/12/2007
Element Accepted Date: 03/06/2008
Element Release Date: 06/12/2008
CAP Released Date: 06/12/2008

Visit Start Date: 9/10/2007
Exit Conference Date: 09/12/2007
Date Report Issued: 10/25/2007
Date Report Due: 10/27/2007
CAP Accepted Date: 06/12/2008
Audit Closed Date: 06/12/2008
Element Projected Completion Date: 01/18/2008
MCO Response Due Date: 12/09/2007

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:

University Health Care does not meet the compliance standard because CMS audited 10 cases from a universe of 13 and found 8 cases which were misclassified Part D reconsiderations.

Corrective Action Required:

University Health Care must produce a representative universe of all Part C adverse standard pre-service reconsiderations received during the audit period.