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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/12/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/01/2008
MCO Response Due Date: 12/24/2007

Requirement:

Voluntary Disenrollment (Timeliness) - The MAO sends the disenrollment notice to the member within timeframes specified by CMS.

Deficiencies:

PMC does not meet the CMS 95% compliance standard because CMS audited 15 cases and found 14 cases were the disenrollment notice were not sent within the CMS defined timeframes.

Corrective Action Required:

CMS auditor notes that this was a deficiency in the 2005 post contract audit. PMC must provide a description of the new process developed to download, audit and process transaction reply codes received from CMS. PMC is also required to conduct training of appropriate staff responsible for this process. PMC must also submit documentation of the training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. To ascertain the effectiveness of the new process and training PMC must conduct internal audits on a monthly basis. PMC should submit a summary report once a quarter to the regional office of its monthly findings until futher notice beginning the fourth quarter of 2007. This report is due to the regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/12/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Voluntary Disenrollment (Notice Content) - The MAO sends the disenrollment notice to the member in a format specified by CMS, providing the correct effective date of disenrollment.

Deficiencies:

PMC does not meet the CMS 95% compliance standard because CMS audited 29 and found 14 cases were the disenrollment notice content was missing required language.

Corrective Action Required:

PMC must ensure that appropriate language is included in the disenrollment letters sent to members. Please ensure that all notices to be used are approved through CMS Marketing system in HPMS.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/01/2008
Element Release Date: 05/15/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Correct Enrollment Election - Elections must be completed by the beneficiary or representative.

Deficiencies:

In 4 out of 30 records reviewed, PMC did not provide evidence of a signed/completed appropriately election.

Corrective Action Required:

In order to be compliant with CMS guidelines, PMC must ensure that all elections are properly signed and completed appropriately. This is inclusive to proper training of sales representatives, enrollment department and all other PMC employees who accept elections.

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/01/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Enrollment Election Completion Process - The MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete.

Deficiencies:

The requirement is not met. Four of fifteen cases for this sample were misclassified (more than 30%). In addition, in three of the remaining eleven cases, the plan failed to follow the correct procedure to request information to complete the election in accordance with 42 CFR 422.60(e), Medicare Managed Care Manual Chapter 2, Section 40.2.2. The enrollment elections were incorrectly denied because: 1) "No Part B" and "individual attempted to enroll outside of enrollment period" - when the election form shows ICEP, 2) an app was accepted in March with OEP checked on the enrollment election (stil in the OEP) and 3) election form taken at home by sales representative in May 2007 for an effective date of June 1, 2007 when the beneficiary was not entitled to Medicare Part B until July 2007. All of these scenarios could have been resolved if the staff was knowledgeable of the enrollment election periods or verified the information on the form prior to submission to CMS. Sales, Membership and accounting and customer service policies and procedures lack information on the election periods. Staff in the various department lack the knowledge of the complete enrollment process, specifically the election periods.

Corrective Action Required:

PMC staff must be provided with refresher training on the enrollment process. In addition, staff from all departments involved in the sales and processing of enrollments, must be trained on the Medicare Advantage enrollment election periods. Policies and procedures for all departments involved must be revised to include the complete enrollment election periods and process in accordance with 42 CFR 422.60(e) and the Medicare Managed Care Manual, Chapter 2, Section 40.2.2. They must be submitted to the CMS Regional Office for review and approval.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/22/2008
Element Release Date: 04/22/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Denial of Enrollment Prior to Transmission to CMS (Timeliness) - The MAO correctly notifies beneficiaries of denial of enrollment within timeframes specified by CMS.

Deficiencies:

The requirement is not met. Eight of fifteen (more than 30%) enrollment denials sampled were misclassified. Incorrect denials included: 1) "No Part B" and "attempting to enroll outside of enrollment period" when the election form clearly indicated ICEP, 2) denial because beneficiary tried to enroll outside of open enrollment period when the representative that accepted the election indicated OEP, and 3) election form accepted by sales representative at individual's home in May 2007 for June 1, 2007 effective date when the beneficiary was not entitled to Part B until July 1, 2007. Policies and procedures from Membership and accounting were found to be incomplete. They lacked election period information.

Corrective Action Required:

PMC must ensure that elections are denied in accordance with 42 CFR 422.60(e)(3)and Chapter 2 of the Medicare Managed Care Manual Section 40.2.3. Staff must be provided with refresher training and policies and procedures must be revised to include the complete denial process. Proof of training must be provided. Revised policies and procedures must be submitted to the CMS Regional Office for review and approval.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 04/22/2008
Element Release Date: 04/22/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Denial of Enrollment Prior to Transmission to CMS (Notice Content) - The denial notice meets CMS requirements. If the MA plan is currently enrolled to capacity, the notice explains the procedures that will be followed when vacancies occur.

Deficiencies:

The requirement is not met. Eight enrollment denials were misclassified. Notices for two of the seven "true" enrollment denials left in the sample, contained the incorrect denial reason. Although the other five left in the sample indicated the actual reason why the plan had denied them-they were the wrong reasons for denial and not in accordance with federal regulations or the CMS Medicare Manual. Denial notices were found to be outdated. Policies and procedures were incomplete. Changes were recommended while onsite. Refer to ER07.

Corrective Action Required:

PMC must ensure that it follows the correct procedure for denial of enrollment prior to transmission to CMS and that the notices it issues to the affected beneficiaries meet CMS requriements. Please refer ER07 for CAR.

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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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER09
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/01/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Final Notice of Enrollment/CMS Rejection (Timeliness) - When the MAO receives information from CMS, it promptly (within timeframes specified by CMS) notifies beneficiaries in writing of CMS's acceptance or rejection of enrollment.

Deficiencies:

The requirement is not met. For thirteen of the thirty enrollment rejections sampled, the plan failed to issue its rejection notice within the timeframes specified by CMS in accordance with 42 CFR 422.60(e)(3) and Medicare Managed Care Manual, Chapter 2, Section 40.4.2.

Corrective Action Required:

PMC must promptly (and within the timeframes specified by CMS) notify beneficiaries in writing of CMS' acceptance or rejection of enrollment in accordance with 42 CFR 422.60(e)(3) and Medicare Managed Care Manual Section 40.4.2.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER10
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/08/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Final Notice of Enrollment/CMS Rejection (Notice Content) - The final notice of enrollment sent to the beneficiary, which describes CMS' acceptance or rejection of enrollment, meets CMS requirements.

Deficiencies:

Notices for five of fifteen cases sampled did not accurately describe CMS' acceptance or rejection of enrollment and therefore, did not meet CMS requirements as required by 42 CFR, Section 422.60(e)(3) and Medicare Managed Care Manual Section 40.4.2. Notices were found to be outdated. Policies and procedures were not complete. Changes were recommended onsite.

Corrective Action Required:

PMC must revise ensure that the final notice of enrollment sent to the beneficiary, describing CMS' rejection of enrollment, meets CMS requirements in accordance with 42 CFR, Section 422.60(e)(3) and Medicare Managed Care Manual, Section 40.4.2. Final Notice of rejection and revised policies and procedures must be revised and submitted to CMS Regional Office for review and approval.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

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:

Sample is misclassified because more than 30% of the cases are marked as Misclassified. CMS auditor notes this element was deficient in the 2005 audit

Corrective Action Required:

Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must conduct training of appropriate staff on appropriate identification of grievances, appeals and organization determinations. PMC 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, the individuals being trained, and methods of evaluation. CMS acknowledges PMC has begun implementing this process and has stated a completion date of 10/2007 Auditor notes that PMC has created a unit Quality and Production Scoring System (QPSS) to closely monitor grievance staff performance. The MCO should conduct monthly internal audits QPSS .The MCO should submit a summary report once a quarter to the regional office of its monthly findings until further notified beginning the fourth quarter of 2007. This report is due to the Regional Office within 15 days of th close of the quarter. The summary report should include: title of the auditor(s), the audit methodology, and the results of the audit.¿ In addition, PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

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:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

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:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Findings: NOT MET

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Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 04/28/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

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:

Sample is misclassified because more than 30% of the cases are marked as Misclassified.

Corrective Action Required:

Due to the severity of the issues identified during the audit PMC is required to implement an aggressive corrective action plan that includes revaluating processes, training, oversight and auditing. CMS notes that PMC has implemented an internal corrective action plan. PMC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. PMC is required to submit to CMS a new universe in order for new cases to be selected for review. Once these cases are selected by CMS, PMC will be required to send to the Regional Office the selected cases and the documentation for a desk audit to occur. PMC should review the universe description to ensure that the proper cases are selected. CMS has determined that time period will be from January - June 2008. PMC should submit the Universe to CMS no later than July 18, 2007 for sample selection.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/01/2008
Element Release Date: 05/15/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Marketing Materials: Enrollment and Understanding of Plan Rules - The MAO establishes and maintains a system for confirming that enrolled members are enrolled in an MA plan and that they understand the rules applicable under the plan.

Deficiencies:

"Marketing Materials: Enrollment and Understanding of Plan Rules" is NOT MET. PMC does not meet the Method of Evaluation for the following: 1. Ensures that plan rules are completely explained during the enrollment process. Based on a review of performance data (inclusive in 1 out of 10 samples of Marketing Representatives Information) there is not sufficient proof that PMC has equipped their Marketing Representatives with the proper tools required to ensure that beneficiaries are receiving the complete rules of PMC during the enrollment process. This is due to improper filing and undisclosed information concerning performance data in the 1 out of 10 samples. 2. Ensures that beneficiary election decisions are based on complete and accurate information/documentation. On further review of 'Actions for Perceived Abuse'(inclusive in 9 out of 10 samples of Marketing Representatives Information) there is not sufficient proof that PMC takes inventory concerning Marketing Audit Results including rapid disenrollment rates and volume of retroactive disenrollments made and/or requested. In addition, in 9 out of 10 files sampled, Member Grievance Cases against Marketing Representatives and Actions for Perceived Abuse were not recorded properly. 9 out of 10 records included improper Member Grievance and Perceived Abuse Action information.

Corrective Action Required:

PMC must supply in all Marketing Representatives files the proper information relaying to adherence to the Elements of MR05. PMC must provide a Corrective Action Plan (CAP) establishing the following: Marketing Representatives files must include performance data consisting of extensive information regarding PMC's system and maintenance of said system, which confirms that enrolled members are enrolled into PMC's MA/MAPD plan and comprehend the rules applicable under that plan. PMC must also provide a CAP establishing a process and maintenance of the said process, which outlines a procedure to monitor Marketing Representative information concerning rapid disenrollment rates and request and/or completion of retroactive disenrollments to CMS.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/06/2008
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CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

The Element is NOT MET. This is a REPEAT FINDING. In 1 out of 10 records sampled, PMC has not provided sufficient proof and validation of testing and comprehension of the Medicare Program by individuals who sell and/or market for PMC. In 1 out of 10 records sampled, PMC has not provided sufficient proof and validation that evaluation and testing was completed. For the 1 case, there is no performance data or training noted. In addition, there is no record of quota adherence and accuracy of enrollments. In 5 out of 10 cases PMC did not provide accurate information concerning recording of rapid disenrollment rates and charge-back to marketing and/or sales representatives who enrolled beneficiaries that subsequently disenrolled within 3 months or less. In addition, recording of supervisory review or disciplinary action taken for these agents with high disenrollment rates was not evident. In 9 out of 10 cases PMC failed to note actions for perceived abuse. Files are scarce concerning adherence data and 7 out of the 10 include information classified as 'unknown' due to unclear/missing information. In addition, 9 out of 10 marketing representative files sampled include either expired or non existing licensure. This deficiency exists with contractors as well as direct employees.

Corrective Action Required:

In order to comply with CMS guidelines, PMC must provide and adhere to a process which confirms that marketing and sales representatives do not engage in activities which mislead, confuse or misrepresent the organization. The process should also include documented, effective training intended to equip representatives, and in tern, beneficiaries, with the tools to make educated decisions regarding enrollment. PMC must keep consistent records regarding the following: 1. Trainings and employee examinations. 2. Performance data, including adherence to quotas, etc. 3. Rapid disenrollments and cancellations, including request for retro disenrollments. 4. Supervisory warnings and/or disciplinary actions. In addition, PMC must contractually comply with CMS guidelines to employ sales and marketing representatives who are licensed. No representative should be allowed to carry out sales and marketing duties for PMC without a current, validated and non-expired license.

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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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Correct Claim Determinations - The MAO must make correct claim determinations, which include developing the claim for additional information when necessary, for: Services obtained from a non-contracting provider when the services were authorized by a contracted provider or the MAO, Ambulance services dispatched through 911, Emergency services, Urgently needed services, Post-stabilization care services; and Renal dialysis services that Medicare members obtain while temporarily out of the service area.

Deficiencies:

The element is not met for PMC nor its delegated entities MDN and FHC. In 30 out of 30 cases PMC failed to secure additional information and develop cases accordingly. In 6 out of 6 cases FHC failed to secure additional information and develop cases accordingly. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN's ability to receive and process claims within 60 days.

Corrective Action Required:

In accordance with Medicare Guidelines, PMC and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. MDN must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent 2.Non-urgent 3.Out of area care, 4. Not a covered service 5.Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). PMC must ensure that MDN submits this information in accordance with the aforementioned instructions.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/06/2008
Element Release Date: 05/15/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Timely Payment of Non-Contracting Provider Clean Claims - The MAO must pay 95 percent of "clean" claims from non-contracting providers within 30 calendar days of receipt.

Deficiencies:

In 4 out of 30 cases plan failed to process clean claims within 30days of receipt. PMC did not provide a sample for delegated entity FHC. File was misclassified.

Corrective Action Required:

In accordance with Medicare Guidelines, PMC and/or its delegated entity must pay 95 percent of clean claims from non-contracted providers within 30 calendar days of the request. All other claims must be paid or denied within 60 calendar days from the the date of request. PMC must also ensure that this process is followed when requesting and securing universe information from its delegated entities.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/08/2008
Element Release Date: 05/15/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

In 2 out of 4 cases not processed within 30days, PMC failed to pay, or show proof of proper interest payment made to non-contracted providers. There were no cases where PMC's delegated entity, FHC, was deliquent concerning payment to non-contracted provider claims.

Corrective Action Required:

In order to be compliant with CMS guidelines, PMC must implement a process where interest payments made to non-contracted providers are calculated correctly. In addition, this process must include a plan for proper record keeping of interest amounts and payments made.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Timely Adjudication of Non-Clean Claims - The MAO must pay or deny all non-contracted claims that do not meet the definition of "clean claims" within 60 calendar days of receipt.

Deficiencies:

This element is not met for PMC and its delegated entities FHC and MDN. In 5 out of 30 cases reviewed in WSOC1 and in 2 out 4 cases submited for WSOC2 a total of 7 out of 34 cases PMC failed to process the claims within 60 days. FHC failed to process 1 out 6 cases within 60 days. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN's ability to receive and process claims within 60 days.

Corrective Action Required:

In accordance with Medicare Guidelines, PMC and/or its delegated entity must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation MDN must submit a new universe consisting of all non-contracted provider claims submitted during the review period which were denied for the following reasons: 1. Non-emergent 2.Non-urgent 3.Out of area care, 4. Not a covered service 5.Unauthorized services. Exclude duplicate claims, adjustments to claims that were previously processed, and claims denied because the beneficiary was not enrolled in the MA/Cost Plan on the date of service. A claim consists of one or more services/line items with a unique bill date and a unique paid date. If one line item in the claim is denied, the claim belongs in this universe. There should be only one record in the universe for each entire claim (line items should be rolled up). PMC must ensure that MDN submits this information in accordance with the aforementioned instructions.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
Element Release Date: 07/16/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 12/24/2007

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:

This element is not met for PMC and its delegated entities FHC and MDN. Of the 30 case files reviewed none of the cases contained denial notices. As such we could not assess plans ability to send out notices as required. In 6 out of 6 cases case files FHC failed to provide the member with the appropriate denial notice. Of the 15 cases submitted by Medicare Dental Network (MDN), all 15 were declared misclassified. As a result we were unable to measure MDN's ability to issue proper denial notices.

Corrective Action Required:

If the Medicare plan or it's designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/11/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

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

Deficiencies:

PMC does not meet the CMS 95% compliance standard because CMS audited 9 and found 2 cases were the denials was not processed timely.

Corrective Action Required:

CMS auditor notes that this was a deficiency in the 2005 post contract audit. Auditor notes that PMC has taken corrective action to address this issue however the following information must be submitted to asses the plan appropriately: (1) Flowchart of the revised process (2) Role, Function of the Health Services Quality Unit (3) Description and findings of the newly established internal audit program (4) Materials utilized for training, who conducted the training and list of staff that attended session. Also include method of evaluation utilized to determine staff understanding/comprehension. (5) Audit findings submitted on a quarterly basis of the monthly findings until futher notice beginning the fourth quarter of 2007. This report is due to the Regional office within 15 days of the close of the quarter. The summary report should include: title of the auditor(s), the audit methodolosgy, and the result of the audit.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/12/2008
Element Release Date:
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

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:

PMC does not meet the CMS 95% compliance standard because CMS audited nine and found 2 cases were the denial notice was not sent, therefore auditor could not determine if the notice was compliant.

Corrective Action Required:

PMC must establish a mechanism for ongoing monitoring of the department responsible for ensuring the required notices are disseminated within the appropriate time frames.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP15
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 04/17/2008
Element Release Date: 04/17/2008
CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 04/30/2008
MCO Response Due Date: 12/24/2007

Requirement:

Notice of Non-Coverage of Inpatient Hospital Care - The MAO must provide notice to the enrollee of its decision (or that of the delegated provider) of non-coverage of further hospital care no later than the day before hospital coverage ends when the enrollee disagrees with the discharge or noncoverage decision. Prior to issuance of this notice, the MAO secures concurrence from the physician responsible for the patient's care in the hospital. The MAO's notice of non-coverage of further inpatient hospital care must include the reason why further inpatient hospital care is no longer needed; the date and time of the enrollee's liability for continued impatient care; and the enrollee's appeal rights.

Deficiencies:

For element OP15 there was no evidence that PMC has a "Notice of Non-Coverage of Inpatient Hospital Care" and the process of when this notice will be provided to members.

Corrective Action Required:

PMC must develop guidelines or policy and procedures regarding how and whem the "Notice of Non-Coverge of Inpatient Hospital Care" is provided to member. This notice must include information why further inpatient hospital care is no longer needed, the date and time of the enrollee's liability for continued inpatient care, and the enrolee's appeal rights. Please ensure that this notice has been reviewed under CMS Marketing requirements in HPMS. This document must be submitted to the Regional Office along with documentation that the appropriate staff has been trained on these policies or guidelines when this notice must be provided to members. Please refer to Section 150.1 in Chapter 13 of the Medicare Managed Care Manual for guidance.

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: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/11/2008
Element Release Date: 05/27/2008
CAP Released Date:

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Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Credentialing Requirements for Physicians and Other Health Care Professionals - The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing and recredentialing.

Deficiencies:

Reference:42 CFR 422.204(b)(2) Manual Ch. 6 - Section 60.3 Method of Evaluation: Complete the sample review of WS-PR1. Determine if the result from column 17 meets the compliance standard. This element is not met. CMS reviewed PMC documents to determine if the credentialing process was consistent with the requirements for credentialing and recredentialing of physicians and other health care professionals. The documents reviewed included policies and procedures and provider credentialing files. CMS reviewed a sample of 20 credentialing files. The sample included 8 files from FHC, the entity to which PMC had delegated Behavioral Health Services. By the date of the review, FHC no longer provided Behavioral Health services for PMC. CMS determined that this element is not met based on the findings below. Nine of the 20 files reviewed lacked evidence of one or more of the required elements of the credentialing process. Detailed findings are as below: Six files did not contain evidence of verification of information from the National Practitioner Data Bank. One file lacked evidence of primary source verification of license. One file lacked evidence of primary source verification of education. Documentation in one file showed that all required information had not been obtained prior to the provider's acceptance into the network.

Corrective Action Required:

PMC needs to review its policies and procedures and revise them as necessary so that all of the required information is available to the Credentialing Committee at the time the provider is reviewed for acceptance into the network. PMC is to submit such revised policies and or procedures to CMS. PMC is to develop an action plan regarding the oversight process that PMC will implement to verify that all credentialing requirements are met by its delegated entities. PMC is to submit this action plan to CMS. PMC is to implement a program to educate personnel involved in the credentialing process of this corrective action plan.

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Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
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Visit Start Date: 9/10/2007
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Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Favorable Claims Reconsiderations (Timeliness) - If the MAO makes a reconsidered determination on a request for payment that is completely favorable to the member, it must issue written notice of its reconsidered determination to the member and pay the claim no later than 60 calendar days after receiving the reconsideration request.

Deficiencies:

In 2 out of 6 cases PMC failed to pay and issue written notification to the member within 60 days of receiving the reconsideration request.

Corrective Action Required:

PMC must ensure that if it overturns it adverse organization determination denying an enrollee's request for payment, the organization will issue its reconsidered determination and send payment for the service to the enrollee or provider. This must be mailed no later than 60 calendar days from the date the plan received the request for standard reconsiderations .

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 01/11/2008
Element Accepted Date: 02/14/2008
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Visit Start Date: 9/10/2007
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Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date: 05/02/2008
Audit Closed Date:
Element Projected Completion Date: 03/31/2008
MCO Response Due Date: 12/24/2007

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:

Of the 6 cases reviewed, in 2 cases PMC failed to notify the members in writing timely and in 3 cases PMC plan failed to authorize the requested service timely.

Corrective Action Required:

PMC must ensure that if it overturns it adverse organization determination denying an enrollee's request for a service, the organization will issue an authorization for the service and notify the enrollee no later than 30 calendar days from the date the plan received the request for standard reconsideration .

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 9657

Region: 02 New York

Contract Number / Name: H4004 PREFERRED MEDICARE CHOICE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:01/11/2008
Element Accepted Date: 02/14/2008
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CAP Released Date:

Visit Start Date: 9/10/2007
Exit Conference Date: 09/20/2007
Date Report Issued: 11/09/2007
Date Report Due: 11/04/2007
CAP Accepted Date:05/02/2008
Audit Closed Date:
Element Projected Completion Date:03/31/2008
MCO Response Due Date: 12/24/2007

Requirement:

Requests for Expedited Reconsiderations (Timeliness)The MAO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the MAO decides not to expedite a reconsideration, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.

Deficiencies:

In 3 out of 4 cases, PMC failed to issue the notification to the beneficary timely and forward the case to the IRE as required.

Corrective Action Required:

PMC must establish and maintain procedures for expediting reconsiderations. This includes establishing an efficient and convenient method for individuals to submit oral and/or written requests for expedited appeal, documenting oral requests, and maintaining said documentation in accordance with Medicare guidelines. If the MAO decides not to expedite a reconsideration request it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited reconsideration, and provide written notice within 3 calendar days of the oral notice. If the MAO decides to expedite the reconsideration, it must make a determination and notify the member as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO makes an expedited reconsideration determination that is fully favorable to the member, it must authorize or provide the service as expeditiously as the member's health requires, but no later than 72 hours from the time it receives the request for reconsideration (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its fully favorable expedited determination orally it must mail written confirmation to the member within 3 calendar days of the oral notification. If the MAO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the MAO fails to provide the member with the results of its reconsideration within the timeframes specified above (as expeditiously as the member's health condition requires or within 72 hours), this failure constitutes an adverse reconsideration determination and the MAO must submit the file to CMS' independent review entity within 24 hours. The MAO must concurrently notify the member in writing that it has forwarded the case file to CMS' independent review entity.