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: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:04/13/2007
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MCO Response Due Date: 04/27/2007

Requirement:

Adequate and Appropriate Provider Network - The MAO maintains and monitors a network of appropriate providers that is sufficient to provide adequate access to and availability of covered services.

Deficiencies:

AHC failed to demonstrate that it maintains a network of appropriate providers to ensure geographically acceptable access to services that meet community standards of care. CMS reviewed the HSD tables, Provider Directory, internal CMS reports, and conducted staff interviews, and determined the following: 1) The number and/or names of providers listed on HSD-2 conflicted with the number and/or names of the providers listed in the October 2006 Provider Directory. Examples include, but are not limited to: HSD-2 lists seven Mental Health professionals for Martin County, but the Provider Directory lists only one. Mental Health facilities listed in the Provider Directory are not listed on HSD-3. 2) Gaps in the network were evident. Examples include, but are not limited to: No contracted Geriatricians in Broward County, no OB/GYNs, Pulmonologists, Rheumatologists, or Urologists in Indian River County, no Geriatricians, Nephrologists, or Psychiatrists in Martin County and no Orthopedists in St. Lucie County. 3) The HSD tables contained conflicting information, which compromises the integrity of the data. Examples include but are not limited to: a) The number of physicians listed on HSD-1 showed that there were no Rheumatologists in Brevard County, yet HSD-2 list two Rheumatologists. HSD-1 for Indian River County shows there are three Pain Management Specialists, yet HSD-2 lists the names of two physicians for that specialty. HSD-1 for Palm Beach County shows 59 Psychiatrists and other Behavioral/Mental Health disciplines, yet HSD-2 shows that there are 24 Licensed Clinical Social Workers, 4 Licensed Mental Health Clinicians, 11 PhD/ PSD and 22 Psychiatrists. b) HSD-2 indicated that numerous physicians do not have hospital affiliations. AHC indicated during an interview that they have contracted with two separate services to provide hospitalists for Broward, Palm Beach and Martin Counties. HSD-1 and HSD-2 did not reflect this information. c) There is no contracted hospital in Brevard County, although the community pattern of care for members residing in Melbourne is to use Wuesthoff Medical Center in Melbourne. d) AHC misclassified Community Mental Health Centers (CMHCs) in all counties on HSD-3. A comparison with CMS reports show there are no Medicare CMHCs in the network. AHC lists Psychiatric Hospitals, Acute Care Hospitals, and outpatient psychiatric providers as CMHCs. HSD-3 lists two mental health facilities that were not Medicare participating providers. One of these terminated their contract in 2005. Psychcare indicated during an interview that AHC had opted to include the non-participating hospital in their network as they were having recruitment difficulties. e) A 70-bed Psychiatric Hospital listed on HSD-3 voluntarily closed their doors in 2005 due to extensive hurricane damage but the contract was terminated in September 2006. f) A number of mammography facilities are not FDA-approved and as such are not entitled to reimbursement using Medicare monies. g) A hearing aide supplier was listed on HSD-3 as providing durable medical equipment. During a staff interview, AHC indicated there is no formal process in place to continually assess network access and admitted the HSD tables were 'a mess.' CMS reviewed AHC's policies and procedures to determine that services are geographically accessible and consistent with local patterns of care. CMS found that there is no contracted hospital in Brevard County, although AHC indicated that the community pattern of care for members residing in Melbourne is to use Wuesthoff Medical Center in Brevard County. In addition, AHC's policy standard for drive time to a network specialist is 60 miles or 60 minutes. This is well above the 30 minutes drive time standard for a populated area. AHC stated they will revise their policy to reflect CMS's guidelines.

Corrective Action Required:

AHC must submit a plan detailing how it will correct the HSD tables to illustrate their actual provider network and submit this plan to CMS. The plan should contain an implementation timeline and a strategy for monitoring accuracy. Once the plan is approved by CMS and implemented, AHC must submit the new HSD tables to the regional office for review and approval. AHC must also submit their plan for securing a contract with Wuesthoff Medical Center and submit a copy of the cover and signature pages when a contract is obtained. AHC needs to submit their revised policy for standard drive time to network specialists.

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Date Report Generated: 9/30/2008

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

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Review ID: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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CAP Accepted Date:09/12/2007
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Requirement:

PCP Panel Established and Maintained - The MAO establishes, maintains, and monitors a panel of primary care providers from which the member may select a personal primary care provider.

Deficiencies:

AHC did not meet this requirement because CMS was unable to determine AHC's actual panel of primary care providers. CMS reviwed policies and procedures, HSD tables, and the Provider Directory, and conducted staff interviews, and found conflicting information about who may serve as a Primary Care Provider (PCP), as described below: - AHC's policy states that Family Practitioners, Internists and General Practitioners may serve as PCPs. However, the Provider Manual does not include General Practitioners as part of the primary care network. - HSD-2 and the October 2006 Provider Directory included physicians identified only as Doctor of Medical Dentistry, MD ER Medicine, three Advance Registered Nurse Practitioners (ARNPs), and a Physician's Assistant (PA) as part of the PCP network. However, AHC provided documentation stating NPs and PAs may see patients secondary to a physician but do not have their own panels of patients. This contradicts a QI Report that tracked PCP panels and included a Nurse Practitioner having a panel of patients. In addition, PAs are not considered independent practitioners by CMS and therefore may not function as PCPs. It should be noted that this information is also included on HSD-2, but under a different first name published in the Provider Directory. - AHC indicated that they provided the auditor with documentation saying Medical Resources is their Preferred Provider network of primary and some specialty care, and that they provided a roster of a physicians. However, the roster did not include the physicians' specialties. - The documentation provided by AHC listed two physicians not included in the provider directory.

Corrective Action Required:

AHC must provide CMS with corrected HSD tables, a current provider directory, and communication sent to members notifying them of changes to the PCP panel (additions and deletions). Once this information is received, CMS will determine the adequacy of the PCP panel. AHC must provide a corrective action for listing a PA as a PCP in the provider directory. AHC must provide the provider manual and revise its policies and procedures to specify who may serve as a PCP. Additionally, AHC must address instances in which ARNPs are included in the PCP panel.

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Review ID: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA05
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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

Requirement:

Services Provided with Cultural Competence - The MAO ensures that all services, both clinical and non-clinical, are accessible to all members and are provided in a culturally competent manner, including those with limited English proficiency or reading skills, and those with diverse cultural and ethnic backgrounds.

Deficiencies:

AHC does not meet this requirement because AHC was unable to provide documentation of translator service agreements. CMS reviewed policies and procedures, the provider manual, and the 2005 QAPI study done on Culturally and Linguistically Appropriate Services. When asked to provide documentation of their translator service agreements, AHC presented CMS with the 2006 Quality Improvement Evaluation that states the plan has contracted with Alpha Translator Services and Deaf Communication Specialists since 2004, and websites for theses services. However, these are not adequate documentation to show that AHC has translator services available for non-English speaking members and that interpreter services and other accommodations are made available to the hearing impaired.

Corrective Action Required:

AHC must obtain agreements for translator services and submit copies of those agreements to CMS.

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Review ID: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CC04
Review Type: Routine
Review Status: Confirmed
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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

Requirement:

Member Health Record Uses Established StandardsAll MAOs that offer CCPs must ensure that each provider furnishing services to members maintains member health records in accordance with standards established by the MAO, which take into account professional standards.

Deficiencies:

AHC did not meet this requirement because AHC lacked key components outlined in the method of evaluation for medical record content and monitoring medical records. CMS reviewed policies and procedures for medical record content and examples of medical record audits and determined that they did not include: - Addressing psychological conditions in the problem list, - Presenting complaints, diagnoses and treatment plans, - Dosages and dates of initial or refill prescriptions, and - Possible risk factors for the member relevant to the particular treatment. In addition, monitoring procedures did not address assessing and improving medical record content or completeness of the member¿s records.

Corrective Action Required:

Pursuant to 42 CFR 422.112 (b)(4)(ii), AHC must ensure member health records are complete and information is current. The corrective action must include submitting revised policies and procedures and establishing a monitoring tool for assessing and improving the content and completeness of the members¿ records. AHC must submit its plan for ongoing monitoring of this area to CMS. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Additionally, AHC must provide CMS with a copy of the notification to physicians of these changes and the date that physicians are made aware of the changes.

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

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Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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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:

AHC does not meet the CMS compliance standard. CMS audited 20 executed provider and delegated entity contracts and determined that none of the contracts contain the required audit and inspection provision. This provision calls for the contracting party to agree to audits and inspection by CMS and/or its designees and maintain records for a minimum of 10 years. While AHC's contracts did contain a similar provision, that provision required the contracting party to maintain records only for a minimum of six years. The outside counsel who prepares and updates AHCs contracts to ensure that AHC is in compliance with federal and state requirements had prepared an amendment to the existing contract that captured the 10-year provision. Unfortunately, AHC¿s Network Development staff did not ensure that this amendment was executed for many of its existing contracts. Discussions with the Director of Network Development revealed that AHC did not have written policies and procedures that communicated how AHC should address contracts requiring amendment. The actual process that was in place permitted only new network providers and existing providers who had a change in their group to receive updated or amended contracts with the required provision.

Corrective Action Required:

AHC must revise all existing contracts with providers and delegated entities to add the 10-year record retention contract provision. In addition, AHC must develop and implement policies and procedures which detail how it will ensure that it amends new and existing contracts with any new CMS and Federal requirements. AHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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CAP Accepted Date:09/12/2007
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Requirement:

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

Deficiencies:

AHC does not meet the CMS requirement because its Corporate Compliance Program dated September 2005 does not describe a risk assessment process associated with its internal auditing and monitoring process. By risk assessment, we mean a method for determining areas at risk for noncompliance which AHC should therefore target for internal auditing and monitoring.

Corrective Action Required:

AHC must provide a revised compliance program which includes methods for assessing areas at risk for noncompliance which AHC will subsequently target for internal auditing and monitoring.

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Requirement:

Compliant Disenrollment Process - The MAO disenrolls Medicare members, when appropriate, upon receipt of a request for disenrollment. The MAO annotates its own system and the CMS system with the correct disenrollment effective date.

Deficiencies:

AHC does not meet the CMS compliance standard because CMS reviewed 15 cases from a universe of 83 and found that four cases did not contain evidence that members were eligible to disenroll at the time (cases 2, 3, 13, and 15).

Corrective Action Required:

AHC must develop and implement policies and procedures that clearly describe steps to determine whether an enrollee is eligible to disenroll. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals conducting the training, and the individuals being trained.

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Requirement:

Involuntary Disenrollment for Disruptive Behavior - The MAO may disenroll Medicare members for disruptive behavior only when their behavior is disruptive, unruly, abusive, or uncooperative to the extent that continuing membership seriously impairs the MAO's ability to furnish services to the member or other members. Disruptive behavior includes threats of violence by the member to employees of the MAO. The MAO disenrolls Medicare members for disruptive behavior only after serious efforts to resolve the problem, including the use of internal grievance procedures, consideration of extenuating circumstances, and CMS's advance approval of the proposed disenrollment, have been made. Disenrollment of a member is effective the first day of the calendar month after the month in which notice is provided to the member of the intended action, unless otherwise determined by CMS.

Deficiencies:

AHC's is not in compliance with this requirement because the auditor reviewed policies and procedures and interviewed management and found the following: AHC provided three policies from four different departments related to this element. The policies are not consistent with each other, do not as a whole contain provisions for all of the requirements in Section 50.3.2 of the MA Enrollment and Disenrollment Guidance, and in once case is in violation of this guidance. - AHC's Customer Service Department Policy CS50-0009 effective January 2, 2007 and approved January 12, 2007 says that AHC may disenroll a member for continual refusal to follow a physician's treatment plan and/or medical advice. It also says that if after a third Primary Care Physician complains of the member's behavior, termination will take effect within 30 days or immediately if required. - AHC's Utilization Management (UM) Department Policy UM-P035 says that the UM Department will forward documentation of disruptive behavior to the Enrollment Department. The corresponding Enrollment Department policy, however, does not reflect that or explain what the Enrollment Department would do with the documentation. - AHC's Network Development Policy ND60-0023 provides for attempts to resolve the problem, advance notice to the member, and forwarding documentation to CMS. However, the documentation described does not include all of the documentation required by CMS. In addition, the policy does not explain what happens after AHC submits documentation to CMS, or that the Enrollment Department is involved in this process. - AHC's Enrollment/Disenrollment Department Policy ER110-0015 is very incomplete on its own. It neither explains that specific responsibilities for disenrollment for disruptive behavior are shared with other departments, nor refers to the related policies of those other departments. During interview, AHC described its process as a medical center making a formal, written complaint to AHC, and thereafter AHC's Enrollment Department sending the case to the CMS Regional Office. The interviewee was not aware of additional steps in the process.

Corrective Action Required:

AHC must revise its policies and procedures to clearly distinguish the responsibilities of each department in the process for involuntary disenrollment for disruptive behavior. Each policy must reference any other department and/or other policies related to this process. As a whole, all applicable policies must include all of the steps required by CMS prior to disenrollment for disruptive behavior. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and 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

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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:

AHC does not meet the CMS compliance standard. CMS audited cases from Worksheets WS-ER1 and WS-ER2 and found no applicable cases in the samples. Therefore, the auditor reviewed AHC's policies and procedures. The auditor determined that AHC does not have written policies or procedures to identify incomplete enrollment elections, nor do they have a process for requesting additional information from beneficiaries to ensure that elections are complete. During an interview with the Marketing Director, the auditor determined that AHC does not have a clear and concise process in place to request information from members that it needs to complete elections.

Corrective Action Required:

AHC must develop and implement policies and procedures for identifying incomplete enrollment elections and requesting additional information to complete elections. AHC must also conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the training that it conducted, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. AHC must submit its plan for ongoing monitoring of this area to CMS.

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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:

AHC does not meet the CMS compliance standard. CMS reviewed 15 cases from a universe of 19 determined that 13 did not fit the criteria for inclusion in the universe. The auditor considered those cases misclassified and requested AHC to provide a correct universe. The new universe contained only two cases. The auditor determined that of the two cases, one case revealed that AHC did not send a denial notice within the required timeframe. AHC's policy ER 110-0016, which reflects CMS requirements, says that AHC will send denial notices no later than seven business days from receipt of the application.

Corrective Action Required:

AHC must submit to CMS a plan that will ensure that any denial letters will be sent within required timeframes.

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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:

AHC does not meet the CMS compliance standard because CMS audited 9 cases from a universe of 9 and found 8 cases in which AHC did not notify beneficiaries in writing of CMS' rejection of enrollment. These cases involved CMS rejections due to coverage by a subsidized employer plan.

Corrective Action Required:

AHC must revise its policies and procedures to describe steps to be taken when CMS rejects enrollment due to coverage by a subsidized employer plan. Policies must reflect that all of the requirements in The Medicare Managed Care Manual Chapter 2 related to this deficiency will be met. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. AHC must submit its plan for ongoing monitoring of this area to CMS.

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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:

AHC does not meet the CMS compliance standard because CMS reviewed 15 cases from a universe of 305 and found 3 cases that were not processed timely. - Case 5: the Customer Service call notes which are entered at the time the member calls did not show a call corresponding to the grievance record. Therefore, the auditor could not determine the actual receipt date or calculate timeliness of resolution. - Cases 14 and 15: documentation in the case files shows that AHC did not notify the members of the resolution of their grievances. AHC's Compliance Department 2006 Audit Log shows that AHC completed an audit of this area in January 2006 and found that cases lacked information about resolutions. The cases that the CMS auditor found deficient originated from May through July 2006. Therefore, AHC still had not corrected deficiencies six months after its initial audit.

Corrective Action Required:

AHC must conduct training of appropriate staff on processes related to documenting all incoming grievances and notifying members about grievance resolutions. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

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Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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Auditing Element: GV04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:04/13/2007
Element Accepted Date: 09/12/2007
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CAP Released Date:09/26/2007

Visit Start Date: 1/29/2007
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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
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Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard because CMS reviewed 15 cases from a universe of 305 and found 5 cases in which AHC did not inform the member of the disposition of the grievance as required. - Two cases contained quality of care complaints, but AHC's responses did not include a description of the member's right to file a written complaint with the QIO (cases 4 and 7). - In one case AHC should have advised the member of his right to receive a detailed written notice of his practitioner's decision not to provide a health service (case 5). This would have triggered the correct process for requests for service, formal denial, and appeal rights. Instead, AHC advised the member to call to appeal, when no formal denial was ever issued. - In two cases AHC did not provide documentation to show that they notified the members of the resolution of their grievances (cases 14 and 15).

Corrective Action Required:

AHC must conduct training of appropriate staff on the following topics: 1) When it is appropriate to advise the member of his or her right to receive a detailed written notice of a practitioner's decision not to provide a health service, and 2) Notifying members of the resolution of their grievances. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must submit a grievance resolution notice template that includes the member's right to file a written complaint with the QIO if their grievance involves a quality of care complaint. AHC must submit the template through tne normal CMS marketing review process and provide evidence that it has done so for the purpose of this corrective action.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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Findings: NOT MET

Review ID: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
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Element Release Date: 09/12/2007
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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC did not meet the CMS compliance standard because CMS audited 15 cases from a universe of 305 and found the following: - Three cases were misclassified because they did not contain expressions of dissatisfaction (cases 11, 12, and 13). This did not meet the CMS threshold for misclassified cases of 30%, and therefore, the auditor disregarded these cases. - Two cases did not contain resolution notices to the members (cases 14 and 15). Therefore, the auditor was unable to determine that AHC used the required method of grievance decision notification. AHC's Compliance Department 2006 Audit Log shows that AHC completed an audit of this area in January 2006 and found that cases lacked information about resolutions. The cases that the CMS auditor found deficient originated from May through July 2006. Therefore, AHC still had not corrected deficiencies six months after its initial audit.

Corrective Action Required:

AHC must conduct training of appropriate staff on notifying members of the resolution of their grievances and thoroughly documenting this activity. AHC must submit documentation to CMS that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS 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: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: HA01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:04/13/2007
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Element Release Date: 09/12/2007
CAP Released Date:09/26/2007

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Initial Health Assessment ConductedThe MAO makes a good faith effort to conduct an initial health assessment of all new members within 90 days of the effective date of enrollment.

Deficiencies:

AHC did not meet this requirement because it failed to conduct any initial health assessments. CMS reviewed policies and procedures, the Health Assessment questionnaire, and phone script. In addition, the auditor requested examples of completed health assessments and unsuccessful attempts to the complete health assessments. In response, AHC advised CMS that it did not conduct initial health assessments during the period in which they were allowed to enroll new members.

Corrective Action Required:

AHC must begin immediately to conduct health assessments for new enrollees. AHC must provide CMS with a report of the new enrollees, the number of health assessments conducted and the number of unsuccessful attempts per month. AHC must submit this report on a quarterly basis for a minimum of two quarters.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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Auditing Element: MR08
Review Type: Routine
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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard. CMS reviewed AHC's Marketing policies and marketing representative personnel files and determined that AHC has employed only minimal oversight over individuals who sell its plans to ensure that they do not engage in activities which mislead, confuse or misrepresent. For example, - AHC does not have procedures in place to monitor the activities of individuals who sell its plans - AHC does not conduct personnel evaluations - AHC does not have effective training for individuals who sell its plans None of the 10 marketing representative personnel files that the auditor reviewed contained evidence that the representatives received any training since June 6, 2006. Appropriate training would have included changes to CMS requirements and 2007 plan benefits. In addition, AHC stated that it inadvertently delayed informing sales staff about CMS enrollment and marketing sanctions, resulting in four new enrollments during the sanction period. The auditor discovered these enrollments during review of enrollment case files (worksheet WS-ER1). In addition, there is evidence that beneficiaries were not enabled to make an informed decision regarding enrollment into AHC. Member letters reviewed as part of the claims reconsideration cases (worksheets WS-RC1 and WS-RC2) revealed that a substantial number of members requested reconsiderations of their copayments. Members stated in their letters that AHC did not inform them about certain copayments at the time they enrolled.

Corrective Action Required:

AHC must revise its policies and procedures to monitor the marketing activities of its agents/brokers to ensure compliance with CMS requirements. These policies must include, at a minimum, procedures that detail how AHC will accomplish the following: -monitor the activities of individuals who sell its plans, -conduct regularly-scheduled personnel evaluations, -conduct ongoing training for individuals who sell its plans, and -withhold or withdraw payment if a beneficiary disenrolls shortly after enrolling in the plan AHC must submit these policies to CMS.

CMS Medicare Managed Care Auditing Report

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
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Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard because CMS audited 30 cases from a universe of 22,459 and found in 14 cases that AHC did not appropriately develop the claims prior to denying them. All 14 claims were for services obtained outside of AHC¿s service area and AHC denied all 14 for no authorization. However, authorization is not required for urgently needed services received outside of an MAO¿s service area. Therefore, AHC should have provided documentation as evidence that it determined that the services were not urgently needed. The cases did not contain that documentation. The only documentation in many of these cases reflected only that there was no authorization on file. There was therefore no way to ascertain whether AHC made correct claims determinations. It is clear that AHC recognized for much of the time period under review that it was making incorrect claim determinations. In fact, AHC paid four of the sample cases under different claim numbers when the plan either through an internal audit or resubmissions further developed the claims and determined that they should have paid them. In addition, the claims manager acknowledged during interview that AHC should have further developed a large percentage of the claims in the sample as required by their own policies and procedures. He also acknowledged that claims reviewers should have assessed whether the services provided were urgently needed. On or around June 19, 2006, AHC trained staff on the correct procedure for processing claims without authorization from out-of-area providers. However, AHC's internal audits log shows that AHC audited claims denied for no authorization in June 2006 and found that some claims were possibly denied incorrectly and may have been urgent care. As a result, AHC decided to perform daily audits beginning June 26, 2006. Yet, seven of the deficient claims in the sample were denied after this date.

Corrective Action Required:

AHC must conduct additional training of appropriate staff on how to develop claims from non-participating providers for which no authorization is on file. AHC must submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. AHC must continue to conduct an internal audit each month of this area to evaluate whether claims are being developed correctly. AHC must submit a summary report of its monthly findings to CMS once a quarter until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit.

CMS Medicare Managed Care Auditing Report

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Review Type: Routine
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CAP Accepted Date:09/12/2007
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MCO Response Due Date: 04/27/2007

Requirement:

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

Deficiencies:

AHC does not meet the CMS compliance standard because its written policies and procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits are not followed. The claim system and the enrollment system on which these policies are based do not have the capability to record and store secondary payer information. The Claims Department learns of secondary payer information only when it receives a claim with an Explanation of Benefits from a primary payer because secondary payer information recorded or captured by the Enrollment Department isn't shared with claims.

Corrective Action Required:

AHC must implement changes to its enrollment and claim systems which will enable them to capture coordination of benefits information and Medicare secondary payer information that can be utilized by both the Claims and Enrollment Departments. AHC must also develop and implement policies and procedures for this area based upon any new system or updates of its existing claims and enriollment systems. AHC must conduct training of appropriate staff on the system enhancement and policies, and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training and the individuals being trained.

CMS Medicare Managed Care Auditing Report

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Review Type: Routine
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CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard because CMS reviewed 10 cases from a universe of 125 and found in 10 cases that AHC did not provide sufficient documentation to substantiate the receipt date. Therefore, the auditor could not determine whether AHC provided notices timely. AHC provided screen prints from its referral system as evidence of receipt of a request for service. However, AHC's Compliance Department 2006 Audits Log revised December 15, 2006 shows that AHC performed two audits of referral entry backlogs and found that as of December 14, 2006, several centers had backlogs and inconsistent entry of the field "Date Physician Ordered Service." Therefore, the referral system screen prints are not sufficient evidence to show the actual date that a physician or member requested a service. While onsite, the auditor requested additional documentation such as member correspondence or screen prints of phone logs showing the date that AHC received the request for service. However, in response to this request, AHC provided the same referral system screen prints.

Corrective Action Required:

AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on 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.

CMS Medicare Managed Care Auditing Report

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
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MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard because CMS reviewed 10 cases from a universe of 125 and found that in 10 cases, notices did not clearly state the service denied and denial reason. Deficiencies include but are not limited to the following: - Incomplete denial reasons, e.g., "Does not meet criteria" (case 1), - Unclear denial reasons that do not follow examples of language provided in the Medicare Managed Care Manual Chapter 13, Section 40.2.2. Examples of insufficient language include, "suggest first baer/aber test prior to mri (case 2), and "need to follow with urologist prior to u/s test" (case 5), and - Unclear descriptions of the denied service, e.g., "mri of iac" (case 2), "renal u/s and bladder u/s" (case 5), and "liver imaging with flow 99m technetium red blood cells" (case 8).

Corrective Action Required:

AHC must revise its policies and procedures to include steps and/or examples of service descriptions and denial reasons which meet CMS requirements. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Medicare Managed Care Auditing Report

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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Requirement:

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

Deficiencies:

AHC's Compliance Department 2006 Audits Log revised December 15, 2006 shows that AHC performed two audits of referral entry backlogs and found that as of December 14, 2006, several centers had backlogs and inconsistent entry of the field "Date Physician Ordered Service." Therefore, AHC has not been properly documenting all oral requests in writing because they have not accurately documented the receipt date. While onsite, the auditor requested additional documentation such as member correspondence or screen prints of phone logs showing the date that AHC received the request for service. However, in response to this request, AHC provided screen prints from the same referral system. Interview of the QI and UM managers confirmed a history of delayed data entry of referral requests, which causes entry of inaccurate receipt dates. In addition, AHC's policy UM P024FL does not include a timeframe for notifying members of approval or disapproval.

Corrective Action Required:

AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on 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.

CMS Medicare Managed Care Auditing Report

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CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

Requirement:

Requests for Expedited Organization Determinations (Timeliness) - The MAO must promptly decide whether to expedite an organization determination based on regulatory requirements. If the MAO decides not to expedite an organization determination, it must automatically transfer the request to the standard timeframe, provide oral notice to the member of the decision not to expedite within 72 hours of receipt of the request for an expedited organization determination, and provide written notice within 3 calendar days of the oral notice. If the MAO makes an expedited organization determination (favorable or adverse), it must notify the member in writing as expeditiously as the member's health requires, but no later than 72 hours after receiving the request (or an additional 14 calendar days if an extension is justified). If the MAO first notifies the member of its expedited determination orally, it must mail written confirmation to the member within 3 calendar days of the oral notification.

Deficiencies:

AHC does not meet the CMS compliance standard because CMS reviewed 10 cases from a universe of 551 cases and found in 10 cases that AHC did not provide sufficient documentation to substantiate the receipt date of expedited requests for service. Therefore, the auditor could not determine whether AHC provided timely notice to the member. In addition, nine cases did not contain clear documentation of verbal notice to the member. AHC provided screen prints from its referral system as evidence of receipt of an expedited request for service. However, AHC's Compliance Department 2006 Audits Log revised December 15, 2006 shows that AHC performed two audits of referral entry backlogs and found that as of December 14, 2006, several centers had backlogs and inconsistent entry of the field "Date Physician Ordered Service." Therefore, the referral system screen prints are not sufficient evidence to show the actual date that a physician or member requested a service. While onsite, the auditor requested additional documentation such as member correspondence or screen prints of phone logs showing the date that AHC received the expedited request for service. However, in response to this request, AHC provided the same referral system screen prints.

Corrective Action Required:

AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on 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.

CMS Medicare Managed Care Auditing Report

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Requirement:

Expedited Denials (Notice Content) - If the MAO makes an adverse expedited organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and denial reason.

Deficiencies:

AHC does not meet the CMS compliance standard. The auditor reviewed 10 requests for expedited organization determinations and in 2 cases the case files did not contain documentation to show whether the standard applies because there was no evidence showing whether the service was approved or denied (cases 2 and 5). AHC's policy UM P024FL contains procedures for sending NDMCs which clearly state the service denied, the denial reason, the clinical criteria or rationale used to make the decision, and the member's appeal rights. The policy does not expand on or provide examples of how to do this to ensure compliance with guidance provided in the Medicare Managed Care Manual Chapter 13, Section 4.2.2. Evidence that this expansion is needed was found in 10 adverse standard pre-service organization determinations from sample WS-OP1 for which the auditor determined that in all 10 cases, the NDMCs did not clearly state the service denied and/or denial reason as required by the Chapter 13 manual guidance. For example, - Denial reasons included vague language such as "Does not meet criteria" (case 1), or technical language such as "suggest first baer/aber test prior to mri (case 2). - Description of services denied included technical terms and abbreviations such as "MRI of IAC" (case 2) and "renal u/s and bladder u/s" (case 5).

Corrective Action Required:

AHC must revise its policies and procedures to include steps and/or examples of service descriptions and denial reasons which meet CMS requirements. AHC must conduct training of appropriate staff on these policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Medicare Managed Care Auditing Report

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MCO Response Due Date: 04/27/2007

Requirement:

OPTIONAL: Favorable Standard Pre-Service Approvals (Timeliness) - If the MAO makes a favorable standard pre-service organization determination, it must notify the member of its determination as expeditiously as the member's health condition requires, but no later than 14 calendar days after receiving the request (or an additional 14 days if an extension is justified).

Deficiencies:

AHC does not meet the CMS compliance standard because CMS reviewed 15 cases from a universe of 575 and found the following: - 1 case was misclassified because it was not member-initiated, and - 14 cases did not contain sufficient documentation to substantiate the receipt date. Therefore, the auditor could not determine whether AHC provided notices timely. AHC provided screen prints from its referral system as evidence of receipt of a request for service. However, AHC's Compliance Department 2006 Audits Log revised December 15, 2006 shows that AHC performed two audits of referral entry backlogs and found that as of December 14, 2006, several centers had backlogs and inconsistent entry of the field "Date Physician Ordered Service." Therefore, the referral system screen prints are not sufficient evidence to show the actual date that a physician or member requested a service. While onsite, the auditor requested additional documentation such as member correspondence or screen prints of phone logs showing the date that AHC received the request for service. However, in response to this request, AHC provided the same referral system screen prints.

Corrective Action Required:

AHC must establish a means for accurately documenting the receipt date of referral requests. Adequate documentation could include date-stamped correspondence, hand-written logs of referral requests that are recorded at the time a verbal request is made, or screen prints of phone logs showing the date that AHC received the request for service. AHC must revise its policies and procedures to reflect this means of documentation. AHC must conduct monthly audits to ensure appropriate documentation of the date of referral requests and the entry of this information into the data system. AHC must provide CMS with quarterly summary reports of its monthly audit results until further notice. The summary report should include: the title of the auditor(s), the audit methodology, and the results of the audit. AHC must conduct training of appropriate staff on 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.

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: 7977

Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:04/13/2007
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CAP Released Date:09/26/2007

Visit Start Date: 1/29/2007
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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Credentialing Requirements for FacilitiesThe MAO must have written policies and procedures for selection and evaluation of providers and follow a documented process for facilities regarding initial credentialing and recredentialing.

Deficiencies:

AHC did not meet this requirement because it lacked effective policies and procedures for the credentialing and recredentialing of ancillary providers. CMS reviewed Credentialing Committee minutes, policies and procedures, a total of twelve ancillary provider credentialing files, and conducted staff interviews, and determined that AHC's facility credentialing and recredentialing policies and procedures were not specific to the type of ancillary provider being credentialed or recredentialed. The paragraph addressing recredentialing did not include ancillary provider types such as freestanding dialysis facilities. The delegated entity policies and procedures were tailored for physician and other health care professional credentialing and did not address requirements for ancillary credentialing. Review of the twelve provider files led the auditor to conclude the following: - In eight of ten cases it was difficult to ascertain whether the file was an initial credentialing or a recredentialing file, - Seven files did not meet credentialing criteria based on the following: a) One Psychcare provider terminated its contract in 2005, b) One Psychcare provider was not a Medicare participating provider, c) One Psychcare provider voluntarily closed its doors in 2005 and the contract was terminated in September 2006, d) Only one file contained an application, e) AHC did not address quality of care issues for recredentialed providers, and f) State licenses were missing from three files, and although they were current in other AHC files, interview revealed these were not obtained as part of a credentialing or recredentialing effort. Staff interview revealed that AHC did not have the resources to credential or recredential ancillary facilities, but anticipated hiring additional personnel. The facilities credentialed and recredentialed by Psychcare were not put before the credentialing committee for approval, even though their policy for delegated credentialing and recredentialing states that AHC must retain the right to final approval of all practitioners, providers and sites of care.

Corrective Action Required:

AHC must submit revised ancillary provider policies and procedures, including the policy and procedure for delegated entities, to CMS for approval. Specifically, AHC must develop and submit an action plan for credentialing and recredentialing ancillary providers currently in the network, including a timeline for completion. Once the delegated entity policies and procedures are approved by CMS and AHC, AHC must provide them to Psychcare. AHC must also develop an appropriate audit tool and use it to monitor procedures. AHC must submit the plan and timeline to CMS and provide quarterly reports outlining the number of facilities credentialed and or recredentialed. AHC provide CMS with a description of how it will monitor compliance and the person/position responsible.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY01
Review Type: Routine
Review Status: Confirmed
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CAP Released Date:09/26/2007

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CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

QI Program That Is Evaluated Annually - The MAO must have an ongoing quality improvement (QI) program that is formally evaluated at least annually.

Deficiencies:

AHC did not meet this requirement because it failed to demonstrate that it has an ongoing quality improvement program that meets CMS requirements. CMS reviewed AHC's 2006 and 2007 Quality Improvement (QI) programs and work plans, the 2006 QI program evaluation, the 2006 Utilization Management (UM) program, work plan and evaluation, the 2006 Health and Wellness QI work plan, the QI Committee Meeting Minutes, the Board of Director Meeting Minutes, and conducted staff interviews, and determined the following: - Each department has a separate QI program, work plan and evaluation that is not incorporated into a corporate-wide QI program. There is no corporate-wide QI program, work plan or evaluation that incorporates all departments. This was confirmed by AHC staff who indicated that this is something that is being changed. In addition, AHC's QI program did not include representatives from sales and marketing. - The Board of Directors Meeting minutes showed that the 2005 work plan evaluation was not presented to the Board. The 2006 work plan for the QI department and the Health and Wellness work plan were presented and approved at the June 21, 2006 Board meeting, but the QI program was not presented, nor were the 2005 QI evaluations, Programs or work Plans from other departments presented for approval. - There was no evidence in the Board minutes that the overall QI plans from any of the departments were actively monitored by the Board. - The 2006 evaluation reflected quantifiable goals and whether they had been reached, but these goals/measurements were not documented in the 2006 work plan and are not present in the 2007 work plan.

Corrective Action Required:

AHC must provide CMS with the following: - A 2007 QI Program and work plan that integrates all departments within the organization. The department responsible for each objective must be identified and quantifiable goals/measurements need to be documented. The QI Program also needs to identify why topics were selected and how goals/measurements were determined. - Signature pages showing the evaluation and work plan were approved by the COO and Medical Director - Copies of the QI Committee minutes, for a minimum of three quarters, that reflect implementation and progress of the 2006 work plan - Copies of the Board of Director Minutes that show when the program was reviewed and approved. - Copies of the Board of Director Minutes, for a minimum of two quarters, showing Board oversight of the QI program.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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Auditing Element: QY02
Review Type: Routine
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CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

Requirement:

Adequate Health Information System - The MAO must maintain a health information system that collects, integrates, analyzes, and reports data necessary to implement its QI program.

Deficiencies:

AHC did not meet this requirement because it failed to demonstrate that it maintains a health information system that provides accurate data and integrates, analyzes, and reports data necessary to implement its QI program. CMS considered the Information Systems Overview, staff interviews, review of QI committee Meeting minutes, and internal reports, and determined the following: - AHC failed to maintain a system that ensures that information and data received from providers is accurate, - AHC did not have a formalized process to analyze data, - AHC could not identify and address deficiencies through provider education or corrective action because physician profiling is currently not done, - Basic claims processing edits such as validating gender/procedure and conflicting diagnoses codes were not in place, which has an impact on the accuracy of provider data, - The QI Department obtains most of its data by manually reviewing data rather than through system-generated reports, - AHC does not track, trend, or benchmark, and therefore AHC cannot identify potential problems or determine baseline norms in order to do comparisons to spot aberrancies, and - AHC does not generate reports that identify over or underutilization, and therefore, AHC neither identifies nor corrects aberrant practice patterns.

Corrective Action Required:

AHC must analyze their current claims processing system to identify and correct any areas that allow providers to submit inaccurate data. AHC must submit the results of this analysis along with the corrective action taken to CMS. AHC must develop a plan to identify and analyze reports to enable the QI and UM departments to track trends and benchmark data. The plan must include a timeline for implementation and a copy of all reports developed as part of the plan. AHC must submit a copy of this plan to CMS and indicate the individual responsible for data analysis. In addition, AHC must develop a plan to generate reports that identify over and underutilization, including a timeline for implementation. AHC must submit the plan to CMS with copies of the reports that are developed.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Auditing Element: QY05
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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Significant Problems Corrected - The MAO corrects significant systemic problems that come to its attention through internal surveillance, complaints, or other mechanisms.

Deficiencies:

AHC does not meet this requirement because it failed to correct identified problems in a timely manner. CMS reviewed policies and procedures, 2006 Compliance Department Audit Logs, sample cases, and conducted interviews with staff, and determined that there was no evidence that AHC took timely and specific actions to correct identified problems. This is evidenced by the following: - The 2006 Compliance Department Audit Logs showed that AHC completed an audit of grievances in January 2006 and found that cases lacked information about resolutions. CMS reviewed a sample of AHC¿s grievances and found that two cases from a sample of 15 lacked information about resolutions. These cases originated from May through July 2006. AHC had not corrected this problem six months after its internal audit. - AHC conducted an audit in June 2006 and found that claims were not appropriately developed and as result some claims may have been incorrectly denied. AHC planned to perform daily audits of this function beginning June 26, 2006. Despite these daily audits, CMS found seven claims in a sample of 30 that were insufficiently developed after daily audits were to begin. Refer to GV03 and OC01.

Corrective Action Required:

AHC must develop a plan to ensure that that it corrects problems that it identifies during internal surveillance. The plan must include documentation showing the corrective action to be taken, the individual responsible for implementing and monitoring the corrective action, and the date the problem is corrected. The plan must describe how AHC will address the problems identified in the deficiency described above. AHC must submit this plan to CMS.

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

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Auditing Element: QY08
Review Type: Routine
Review Status: Confirmed
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CAP Released Date:09/26/2007

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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Chronic Care Improvement Program The MAO must have a chronic care improvement program (CCIP).

Deficiencies:

The Medicare Advantage Quality Review Organizations (MAQROs) performed a review of AHC's CCIP and reported that AHC did not meet the following two of four requirements: 1) The MAO must establish criteria for participation in the program Multiple discrepancies in AHC's reporting makes it unclear whether AHC has established criteria for identifying MA enrollees who are eligible to participate in their CCIP program. See the attached report from the MAQROs for specific discrepancies. 2) There must be quantitative measures of improvement that are assessed at least annually for CCIP The reported quantitative measures of improvement are problematic and it is questionable whether they can be expected to be valid measures for assessing the CCIP program. While AHC describes their CCIP program as having two major components - the disease management and the Health and Wellness programs, there does not appear to be methodology in place to do quantitative measurement and analysis of the Health and Wellness program aspect of the CCIP. In addition, AHC indicated that the number of enrollees eligible for the CCIP is 18372. However, that number exceeds AHC's total enrollment by over 6,000 enrollees.

Corrective Action Required:

AHC must provide CMS with evidence that it has included in its written program an explanation about whether an ICD-9 code (or other data sources) are used as evidence of a comorbid condition versus a primary reason for CCIP eligibility. Documentation of this would enable reviewers to determine whether identification criteria are established and systematically utilized. In addition, AHC notes that using a broad criteria based on ICD-9 codes may result in false positives in diagnoses. As AHC further defines CCIP eligibility criteria, it must provide evidence that it prevents or at least accounts for the impact of false positives on outcomes measures, especially in regard to any future determination of cost outcomes. AHC must provide CMS with design processes for outcome measures that have been revised to reflect all aspects of the CCIP (both disease management and the Health and Wellness program). AHC must also provide evidence that it has sought out educational offerings and reports on strategies for evaluating outcomes. In addition, AHC must provide clarification about why the number of enrollees it says are eligible for the CCIP exceeds AHC's total enrollment by over 6,000 enrollees.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Auditing Element: QY09
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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Quality Improvement Projects The MAO must successfully complete annual QI projects that focus on both clinical and non-clinical areas and submit the project reports to the evaluation entity.

Deficiencies:

The Medicare Advantage Quality Review Organizations (MAQROs) reviewed AHC¿s three Quality Improvement Projects (QIPs) and determined that all three do not meet CMS¿s QIP requirements. The project documentation submitted by AHC demonstrates a lack of knowledge and understanding of basic quality improvement methods and terminology and the CMS requirements for Quality Assessment and Performance Improvement. The MAQROs made an overall interim assessment of Not Met for AHC's Disease Management project in process. The MAQROs assessed a rating of Noncompliance for four of six review elements, and a rating of Full Compliance for the remaining two elements. AHC could not appropriately describe topic relevance (CMS requirement) or the quality indicators (basic QI principles). In addition, project targets were not quantifiable and the selected indicators were not appropriate to measure the effectiveness of the interventions. AHC was unable to adequately explain the project topic selection rationale and process, the indicators, methodology, project results/measurements and presented a very general intervention strategy that did not address specific opportunities identified. The MAQROs made an overall interim assessment of Not Met for AHC's Advance Directives project in process. The MAQROs assessed a rating of Noncompliance on five of six review elements and a rating of Not Due on one element. Basic QI principles were missing from the submitted project. For example, the plan did not appropriately describe the indicator (including numerator and denominator) for the project. Baseline results were not clearly expressed. Under Results and Lessons Learned, AHC described less than one fourth of AHC¿s member population WITH advance directives in their existing medical records. Yet, an attached table and graph demonstrated that less than one fourth of the medical records are WITHOUT advance directives. The performance target ("all members") was described as being met. However, the baseline rate was described as 24 percent. AHC was unable to adequately explain the project topic and relevance, quality indicator, baseline study design, data collection and analysis, and study population and sampling. The MAQROs made an overall interim assessment of Not Met for AHC's Disease Management project in process. The MAQROs assessed a rating of Noncompliant for five of six review elements, and a rating of Partlal Compliance for the remaining element. AHC could not appropriately describe topic relevance (CMS requirement), or the quality indicators (basic QI principles). In addition, there are indications that AHC presented a review conducted by Pfizer as its QIP. AHC was unable to adequately explain the project topic selection rationale and process, the indicators, methodology, and project results/measurements, and presented a very general intervention strategy that did not address specific opportunities identified.

Corrective Action Required:

With regard to all three projects, AHC must: 1) Review the guides and manuals available on the CMS website health plans page, 2) Review the Medicare Managed Care Manual - Chapter 5: Quality Assessment and Improvement, 3) Review the HEDIS Technical Specifications, Volume 2 and indicators available from other national organizations, such as AHRQ, NQF, etc., 4) Seek training in quality improvement methods from the State QIO, NCQA, IHI or other local or national quality improvement organizations, and 5) Evaluate the documentation submitted for these projects and provide CMS with an action plan, including seeking technical assistance to reimplement the projects and submit a revised report. See the attached reports for each project from the MAQROs for additional comments and recommendations.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC does not meet the CMS compliance standard because the auditor reviewed three cases from a universe of three cases and one case did not contain either the denial notice or the reconsideration request (case 1). Therefore, the auditor could not determine whether AHC forwarded the case to the independent review entity within the required timeframes. The auditor requested these documents while onsite, but AHC indicated it could not provide them. AHC explained that the appeal was verbal, but did not provide documentation of the receipt of the appeal.

Corrective Action Required:

AHC must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. This plan must provide assurance that AHC staff will maintain proper documentation of both verbal and written appeals in member files. AHC must submit the plan to CMS.

CMS Medicare Managed Care Auditing Report

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

Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H1034 AMERICA'S HEALTH CHOICE MEDICAL PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:04/13/2007
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CAP Released Date:09/26/2007

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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

Requirement:

Receipt and Documentation of Expedited Reconsideration Requests - The MAO must establish an efficient and convenient means for individuals to submit oral or written requests for expedited reconsiderations, document all oral requests in writing, and maintain the documentation in a case file.

Deficiencies:

AHC's policy APP-0003 does not include a provision for documenting all oral expedited reconsideration requests in writing.

Corrective Action Required:

AHC must revise policies and procedures to add steps for documenting all oral expedited reconsideration requests in writing. AHC must also conduct training of appropriate staff on the revised policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Region: 04 Atlanta

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Date Report Issued: 03/13/2007
Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
Element Projected Completion Date:
MCO Response Due Date: 04/27/2007

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:

AHC did not meet this requirement. AHC's policy APP-0003 does not include a provision for forwarding reconsideration cases to the Independent Review Entity (IRE) when AHC makes an adverse decision. The policy addresses forwarding cases to the IRE only when AHC does not make a decision within the required timeframes. AHC has a policy APP-0004 which addresses sending cases to the IRE, however, it is not referenced in the earlier policy. In addition to reviewing policy, CMS reviewed one case from a universe of one case and determined that the requirement does not apply to the case because AHC's decision was favorable. Therefore, AHC would not have forwarded the case to the IRE.

Corrective Action Required:

AHC must revise policies and procedures to add a provision for forwarding reconsideration cases to the Independent Review Entity (IRE) when AHC makes an adverse decision. AHC should also reference its policy APP-0004 in this policy. AHC must also conduct training of appropriate staff on the revised policies and procedures. AHC must submit the policies to CMS with documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Date Report Due: 03/19/2007
CAP Accepted Date:09/12/2007
Audit Closed Date: 09/26/2007
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MCO Response Due Date: 04/27/2007

Requirement:

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

Deficiencies:

AHC did not meet the CMS compliance standard because the notice template AHC provided with policy APP-003 on Expedited Reconsideration Requests applies to an expedited initial organization determination rather than a reconsideration. AHC also provided as evidence of meeting this standard letter AHC APEXTN14r. This letter addresses an extension on a reconsideration of a request for service. However, the second to last paragraph contains language indicating it is meant to address AHC's denial of expediting a reconsideration.

Corrective Action Required:

AHC must submit a revised notice template which contains only language that is appropriate for this requirement. AHC must submit this template through the normal CMS marketing material review process, and provide evidence that this was done. AHC must also conduct training of appropriate staff on the revised template and submit documentation that details the nature of training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained.