CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: CN02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Required Contract Provision: Prompt Payment - The MAO"s written contracts with first tier and downstream entities must contain a prompt payment provision.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 20 sample case files from a universe of 5065 and found 3 cases that the reviewer was unable to locate the prompt payment provision. The sample case files were case #9, #10, and #19. MD Medicare Choice was unable to locate case files 9 and 10. Case file #19 was a MSO contract that did not contain the provision.

Corrective Action Required:

MD Medicare Choice must audit all of its contracts to ensure they contain all of the contract provisions specified in Chapter 11, section 100.4 of the Managed Care Manual. MD Medicare Choice must conduct an audit of its contracts and ensure a valid contract exists for all providers listed in their provider directory. MD Medicare Choice must remove providers from their directory if a valid contract is not located. After completion of the audit, a report must be submitted to CMS that shows a contract exists for each provider listed in your directory. This report is due to CMS Atlanta Regional Office by September 30, 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: CN03
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 20 sample cases file from a universe of 5065 and found 3 cases that the reviewer was unable to locate the hold harmless provision. The sample case files were case #9, #10, and #19. MD Medicare Choice was unable to locate case files 9 and 10. Case file #19 was an MSO contract that did not contain the provision.

Corrective Action Required:

Refer to CN02.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN04

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 20 sample case files from a universe of 5065 and found 3 cases that the reviewer was unable to locate the abide by federal requirements provision. The sample case files were case #9, #10, and #19. MD Medicare Choice was unable to locate case files 9 and 10.. Case file #19 was an MSO contract that did not contain the provision.

Corrective Action Required:

Refer to CN02.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN06

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

Required Contract Provisions: Compliance with MAO"s Policies and Procedures - The MAO"s written contracts with first tier and downstream entities must specify that providers agree to comply with the MAO"s policies and procedures.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 20 sample case files from a universe of 5065 and found 3 cases that the reviewer was unable to locate the comply with MAO policies and procedures provision. The sample case files were case #9, #10, and #19. MD Medicare Choice was unable to locate case 9 and 10. Case file #19 was an MSO contract that did not contain the provision.

Corrective Action Required:

Refer to CN02.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN02

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

The CMS reviewer reviewed 15 cases in the Voluntary Disenrollment Other category. Of the 15 cases, 5 were cases where the MAO could not demonstrate that the notice had been sent. These cases are #s 3, 4, 5, 10 and 11. CMS reviewer also found that for case #14, there was no signature on the application (Refer ER01).

Corrective Action Required:

The MAO must provide documentation that notices were sent to members and that they were timely. The MAO must provide training to its staff and put in place processes to ensure that notices are sent and that documentation is readily available to CMS. The MAO must submit training materials and attendance log to CMS. The training must be completed and by the end of September 2008. The MAO must provide explanation for the application that did not have a signature (refer to ER01).

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN03

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

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:

The CMS reviewer reviewed 15 cases in the Voluntary Disenrollment Other category. Of the 15 cases, 5 involved cases where the MAO could not demonstrate that the notice had been sent. These cases are #s 3,4,5, 10 and 11.

Corrective Action Required:

The MAO must provide documentation that notices were sent to members and that they were timely. The MAO must provide training to its staff and put in place processes to ensure that notices are sent and that documentation is readily available to CMS. The MAO must submit training mateials and attendance logs to CMS. The training must bee completed by September 2008.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN04

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

Refund of Premium - The MAO must refund all amounts incorrectly collected from its Medicare members or from others on their behalf.

Deficiencies:

The CMS Reviewer reviewed the Involuntary Disenrollment (Move out or service area) cases. The sample included 10 cases. Of the ten (10) cases, the MAO was not able to provide all the necessary documentation for any of the cases.

Corrective Action Required:

The MAO must be able to provide documentation that all CMS' requirements being met. The MAO must provide training to its staff and put in place processes to ensure that documentation is maintained and is readily available to CMS. The MAO must submit training materials and an attendance log to CMS. The training must be completed by September 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Involuntary Disenrollment for Move Out of Service Area - The MAO must disenroll Medicare members who permanently leave the approved plan service area, or who reside outside the approved plan service area for more than six (6) months, unless they move into an approved plan continuation area and the member has elected the continuation of enrollment option, or the plan offers a visitor/traveler program. Member notice is required prior to transmission of the disenrollment to CMS.

Deficiencies:

The CMS reviewer reviewed 10 sample Involuntary Disenrollment (Move Out of the Service Area) cases. Of the 10 cases, 9 of the cases MAO did not provide adequate documentation to determine if the disenrollment was appropriate. The MAO did not provide any documentation regarding a disenrollment transaction.

Corrective Action Required:

The MAO must be able provide documentation to CMS when requested. The MAO must provide training to its staff and put in place processes to ensure that documentation is maintained and readily available to CMS. The MAO must provide training matial and attendance logs to CMS. The training must be completed by the end of September 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice is not in compliance with this requirement because CMS reviewed 30 cases from a universe of 5210 and 5 cases were incorrect (cases 1,12,28,26 and 29). Case # 1 shows a POA on record. However, MD Medicare Choice was not able to provide documentation to show a POA on file. Therefore, the reviewer was unable to determine if the election was signed and completed appropriately. Additionally, case numbers 12, 26, and 29 did not include signatures on the application. The reviewer was unable to determine if an election was completed by the beneficiaries. During the site visit, MD Medicare Choice did not provide supporting documenation or other media to verify an election was made by the beneficiary or representative, authorized under laws of the state as required by Chapter 2 of the Managed Care manual. MD Medicare Choice has a policy and procedure in place for telephonic enrollments, yet they were unable to produce evidence that this procedure was followed. Case # 28 was incorrect because several fields on the application were not completed. MD Medicare Choice did not provide supporting documentation to show the application was complete and an election was made by the beneficiary or a representative, authorized under laws of the state.

Corrective Action Required:

MD Medicare Choice must submit supporting documentation to show the elections were completed by the beneficiaries and or representatives, authorized under laws of the state, or other media that supports an election for cases 12, 26 and 29. MD Medicare Choice must conduct an audit of all telephonic enrollments completed during the review period and provide evidence that these enrollment elections were completed at the request of the beneficiaries enrolled. The evidence must include all of the requirements specified in Chapter 2 of the Medicare Managed Care Manual. MD Medicare Choice must adhere to its own policy and procedure EN 10.6 and ensure all applications are complete prior to submission to CMS as outlined in Medicare Managed Manual Chapter 2 and 42 CFR 422.60c.1. MD Medicare Choice 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 trained. This information must be submitted to CMS reviewer by September 30, 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER03
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 11/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Enrollment Effective Date (Timeliness) - The MAO enrolls Medicare beneficiaries with a correct effective date and election period type based on the appropriate election period.

Deficiencies:

MD Medicare Choice does not meet this requirement. MD Medicare Choice does not meet this requirement because CMS reviewed 30 cases out of a universe of 5210 and 9 cases (6,7,8,21,24,25,26,27,30) did not include the correct effective date and election period type based on the applicable election period. Additionally, the reviewer was unable to determine the correct effective date of enrollment and election period for cases 7, 8, 21, 25, 26 and 27 because the applications had multiple date stamps. MD Medicare Choice was not able to confirm the correct date stamp on the appications during the site visit. Case 6 showed the completed election was received on 3/4/2008. However, the effective date of enrollment was 3/1/2008 instead of 4/1/2008. MD Medicare was not able to provide supporting documentation to show the reason an effective date of enrollment was before the application was received.

Corrective Action Required:

MD Medicare Choice must ahere to its own policies and procedures (EN10.16, EN10.17, EN10.18, and EN10.21) and ensure applications are processed with the correct effective dates during the applicable election period. MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. MD Medicare Choice must conduct a monthly audit of their enrollment process for three months beginning September 1, 2008 through November 30, 2008 and provide a monthly report to the CMS Regional Office to include the following information: a. Copies of all applications received for the period September 1, 2008 through November 30, 2008. b. Provide supporting documentation if a POA is identified. c. Enrollment period used d. Effective date of enrollment.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

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:

MD Medicare Choice does not meet the requirements for this element. MD Medicare Choice does not meet the requirements for this element because CMS reviewed 30 cases from worksheets WS-ER1 and WS-ER2 and found only two applicable cases in worksheet WS-ER1. Therefore, the auditor reviewed MD Medicare Choice's policies and procedures for their enrollment election completion process. The CMS reviewer determined MD Medicare Choice does not have appropriate written policies and procedures to identify incomplete enrollment elections, nor does MD Medicare Choice have a process for ensuring additional information is requested when the application is incomplete. Additionally, the CMS reviewer identified three applications (12, 26 and 29) that were incomplete. However, these applications were processed with effective enrollment dates.

Corrective Action Required:

1) MD Medicare Choice must revise its policies and procedures for identifying incomplete enrollment elections and requesting additional information to complete elections. 2) MD Medicare Choice must conduct training of appropriate staff on these policiesand procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training to include the policies and procedures, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 30, 2008.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER05

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

Required Enrollment Notice (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election and confirmation of enrollment acceptance within timeframes specified by CMS. This may be done with two separate notices or one combined notice as specified by CMS.

Deficiencies:

MD Medicare choice does not meet the requirements for this element. MD Medicare Choice does not meet the requirements for this element because CMS reviewed 30 samples out of a universe of 5210 and 23 cases (1,2,3,4,5,7,10,11,12,13,14,15,16,18,20,21,22,23,24,25,27,28,29 and 30) did not include timely notices to the beneficiaries. Case 1 included notices where the acknowledgement letter was sent to the beneficiary on 3/20/2008 and the confirmation notice was sent to the beneficiary on 3/11/2008. Additionally, cases 3, 22, 23, did not include acknowledgement notices for these beneficiaries and cases 7, and 29 did not include confirmation notices for these beneficiaries. MD Medicare Choice was not able to provide supporting documentation to meet this requirement during the site visit.

Corrective Action Required:

MD Medicare Choice must revise its policies and procedures to ensure beneficiaries receive appropriate notices within the required timeframes specified by CMS. Policies and procedures must be revised to include the following: 1) Revise its policy and procedures to ensure notices are processed within the specified timeframes outlined in the Medicare Managed Care Manual Chapter 2 Enrollment and Disenrollment and in accordance with CMS guidelines and 42 C.F.R., section 422.60e.3. 2) MD Medicare Choice must conduct training of appropriate staff on this policy and procedure 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. This information must be submitted to the CMS reviewer by September 30, 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Required Enrollment Notice (Notice Content) - The written acknowledgement notice and confirmation of enrollment acceptance, sent in response to the beneficiary"s enrollment election, meets CMS requirements and specifies the correct effective date of enrollment.

Deficiencies:

MD Medicare Choice does not meet this requirement. MD Medicare Choice is not compliant with this element because CMS reviewed 30 cases out of a universe of 5210 and 17 were incorrect. MD Medicare choice did not provide the correct information in the notices to their members according to CMS guidelines. MD Medicare Choice was unable to provide the notices during the site visit.

Corrective Action Required:

MD Medicare Choice must revise its policies and procedures to ensure beneficiaries receive the correct information according to CMS regulations and guidelines. Policies and procedures must be revised to include the following: 1) Revise its policy and procedures to ensure notices include the correct information in accordance with CMS regulations and guidelines and the Medicare Managed Care Manual Chapter 2 Enrollment and Disenrollment sections Section 40.4, 40.4.2, and in accordance with 42 C.F.R., section 422.60e,3. 2) MD Medicare Choice must conduct training of appropriate staff on this policy and procedure 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. This information must be submitted to the CMS reviewer by September 30, 2008.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER07

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

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:

In reviewing the MAO Enrollment Denials, the CMS Reviewer found that of the 15 cases 10 were not sent denial notices timely. These cases are #s 2,3,5,6,8,9, 10, 11 and 12.

Corrective Action Required:

The MAO must provide training to its staff and put in place processes to ensure that notices are sent to members timely. The MAO must provide training to its staff. The MAO must provide CMS with the training materials and attendance log. The MAO must complete this training by the end of September 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER11
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/25/2008

Requirement:

Submission of Enrollment Transactions to CMS - The MAO follows CMS guidelines for submitting enrollment transactions to CMS.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 cases from a universe of 796 and found 5 cases that did not contain information to indicate when the transactions were submitted to CMS. The sample case files were case #4, #5, #6, #7, and #8. In addition, MDMC's policies and procedures for enrollment and disenrollment do not contain a policy or procedure for all instances when CMS rejects a file.

Corrective Action Required:

MD Medicare Choice must develop a policy and procedure for all CMS enrollment or disenrollment rejections identified on the transaction reply report to include the appropriate action that must be taken in all instances. MD Medicare Choice must submit the policy and procedure to CMS for review and approval. Once approved, MD Medicare Choice must implement the procedure and provide training to appropriate staff. MD Medicare Choice must submit to CMS the training outline, the staff attending the staff, and the training date.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/25/2008

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:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 sample cases from a universe of 42 cases and found 4 cases that were incorrectly classified as grievances when they were actually appeals for denial of claims or denial of services. The sample case files in question are #2, #4, #8, and #14.

Corrective Action Required:

MD Medicare Choice must conduct training of appropriate staff on their policy and procedure (MDMC-GA-13.004) and submit documentation to CMS that details the nature of the training, the materials used in the training, the individuals conducting the training, and the individuals being trained. MD Medicare Choice must audit all 42 grievances listed in the universe to ensure they are correctly categorized. Cases involving claims payment or service denials must be processed as an appeal as outlined in Chapter 13 of the Medicare Managed Care Manual. Cases must not be denied for not meeting the 60 day timeframe. Cases that are unfavorable to the member must be forwarded to the independent review entity for review. A detailed report of the audit must be sent to the CMS Regional Office. The report must include the denial, reason for the denial and the date the case was forwarded to the independent review entity. The report must include the date the claim was paid or the service provided in cases that are favorable to the member. MD Medicare Choice must perform a quarterly audit of all grievances received and provide a report to the CMS Regional Office the disposition of the grievances.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV03
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date: 09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Grievance Decision Notification (Timeliness) - The MAO must notify the member of its decision as expeditiously as the case requires based on the member"s health status but no later than 30 days after the receipt date of the oral or written grievance. If the complaint involves an MAO"s decision to invoke an extension relating to an organization determination or reconsideration, or the complaint involves an MAO"s refusal to grant an enrollee"s request for an expedited organization determination or expedited reconsideration, the MAO must respond to an enrollee"s grievance within 24 hours. Exception: If the member requests an extension, or if the MAO justifies a need for information and documents that the delay is in the interest of the member, the MAO may extend the 30-day timeframe up to an additional 14 days. In this case, the MAO must immediately notify the member in writing of the reasons for the delay.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 sample cases from a universe of 42 cases and found 5 cases that exceeded the 30 day timeframe. The sample case files in question are #1, #12, #13, #14, and #15.

Corrective Action Required:

MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.003) and provide acknowledgement of grievance within 7 days, and send notification of results to all parties within 30 calendar days from the date the grievance is filed. MD Medicare Choice must conduct training of appropriate staff regarding their policy and procedure 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

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

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 complaint with the QIO.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 sample cases from a universe of 42 cases and found 4 cases in which the member was not informed of the disposition of the grievance. In two of these cases, a letter was not mailed to the member. In one of the cases, both the husband and wife were complaining, but the plan only provided a resolution for the husband and the wife's complaint was not addressed. The remaining case, the beneficiary's issue with their diabetic supplies was not addressed. The sample case files in question are #2, #13, #14, and #15.

Corrective Action Required:

MD Medicare Choice must follow to its own policy and procedure (MDMC-GA-13.003) and inform members of the grievance disposition. MDMC must audit the 42 grievances contained in the universe, and provide the grievance resolution to members in all instances where this was not done. MDMC must submit a report to the CMS Regional Office when this is accomplished. The report should include, the date the audit was done, the number of members affect, the number of resolution letters sent, and the date the letters were sent. MD Medicare Choice must conduct training of appropriate staff on their policy and procedure (MDMC-GA-13.003) 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

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: GV05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Method of Grievance Decision Notification - The MAO must 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:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 sample cases from a universe of 42 and found 3 cases in which the MAO was unable to provide evidence the grievance was responded to either in writing or orally. The sample cases in question are #13, #14, and #15.

Corrective Action Required:

MD Medicare Choice must follow its own policy and procedure (MDMC-GA-13.003) and inform members (both written and oral) of the grievance disposition. MDMC must audit the 42 grievances contained in the universe, and provide the grievance resolution to members in all instances where this was not done. MDMC must submit a report to the CMS Regional Office when this is accomplished. The report should include, the date the audit was done, the number of members affected, the number of resolution letters sent, and the date the letters were sent. MD Medicare Choice must conduct training of appropriate staff on its policy and procedure 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

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

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

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/25/2008

Requirement:

No Engagement in Activities Which Mislead, Confuse, or Misrepresent the MAO The MAO does not engage in activities which materially mislead, confuse, or misrepresent the MAO. The MAO may not: " Claim recommendation or endorsement by CMS or Medicare or the Department of Health and Human Services, or that CMS, Medicare, or the Department of Health and Human Services recommend that beneficiaries enroll in the plan; " Make erroneous written or oral statements including any statement, claim, or promise that conflicts with, materially alters, or erroneously expands upon the information contained in CMS-approved materials; " Use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all MAOs involved and unless the materials have received prior approval from CMS; " Use providers to accept enrollment applications or offer inducement to persuade beneficiaries to join plans; " Use providers to offer anything of value to induce plan enrollees to select them as a provider; " Accept plan applications in provider offices or other places where health care is delivered; " Employ MA plan names which suggest that a plan is not available to all Medicare beneficiaries (Does not apply to plan names in effect on or before July 31, 2000); " Offer gifts or payment as an inducement to enroll in the organization; " Offer cash gifts, including charitable contributions made on behalf of people attending a marketing presentation, and including gift certificates and gift cards that can be readily converted to cash; " Engage in any discriminatory marketing practice, such as targeted marketing to Medicare beneficiaries from higher income areas, without making comparable efforts to enroll Medicare beneficiaries from lower income areas; " Use high pressure sales tactics to enroll a beneficiary into a plan or require an in-home appointment; " Send unsolicited e-mails unless the Medicare beneficiary agrees to receive e-mails; " Buy or rent e-mail lists to distribute information about MA plans " Conduct door-to-door solicitation of Medicare beneficiaries.

Deficiencies:

During the review of the 10 sales agent files, the CMS reviewer found that the MAO did not provide documentation of performance measures for any of the files reviewed. Additionally, the reviewer found that all licensure documentation was dated 6/20/2008. The reviewer also found, upon further investigation, that 8 of the representatives had not received an appointment (that is required by state law) until 6/20/08. The MAO was not able to provide any documentation prior to that date, that the agents in fact were licensed to sell MD Medicare Choice products. The MAO submitted a universe of 722 agents to CMS for the Audit, as of 7/17/08 the State of Florida shows 452 appointmented agents for MD Medicare Choice. The majority of the agents that have appointments received them on or after 6/20/08. In reviewing applications submitted with samples, CMS reviewer found that a majority of the applications, were taken by agents that did not have the appointment from the State at the time. This is a violation of Florida State law 641.386. Additionally, the CMS Reviewer found that the MAO does follow its own policy and procedures. PP # MK016 the MAO states "MD Medicare Choice is contracted with state licensed agents throughout Florida to sell the MD Medicare Choice plans. MD Medicare Choice will maintain separate contracts and accurate licensing records of all contracted agents (brokers)." PP #MK001 states that "MD Medicare Choice implements a policy to ensure that agents representing the plan have appropriate state health agent licensing, and remain in good standing with the state. MD Medicare Choice also expects it employee agents to sell health policies strictly for MD Medicare Choice." PP #MK009 states that "MD Medicare Choice performs performance reviews and random audits to ensure that sales agents(brokers) ar following MDMC policies and procedures, and State/Federal guidelines as outlined in the Sales Training Manual provided upon employment (or assignment), annually, and/or as changes are made to the Sales Training Manual as required by new or modified State and/or Federal regulations."

Corrective Action Required:

The MAO must provide to CMS the enrollments for each sales agent/broker in the sample. The MAO must ensure that all state licensure requirements are met for its sales agents/brokers. The MAO must establish processes to ensure that they are submitting timely requests for appointments to the state. The MAO must provide CMS with a bi-weekly report on the status of all existing sales agent/broker appointments. The MAO must report to CMS, on monthly basis, when a sales agent/broker has been hired and appointment requested. The MAO will continue this reporting until CMS determines it is no longer necessary.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC01

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the compliance standards for this element because CMS reviewed 30 cases out of a universe of 5103 and found 5 (cases 1, 2, 3, 4, 5) that were misclassified. The remaining 25 cases, 25 out of 25 (cases 6 through 30), MD Medicare Choice did not provide documentation on the denial codes and reason for denial. Therefore, the CMS reviewer was unable to determine if the claims were properly denied. MD Medicare Choice was not able to provide evidence on how its claims payment system distinguishes between a contracted provider and a non contracted provider. The CMS Reviewer was unable to determine when beneficiary liability was appropriate. MD Medicare Choice was not able to show were appropriate records were being maintained for its members for denied claims. Therefore, the reviewer was unable to determine if the claims were processed appropriately. Additionally, MD Medicare Choice was not able to produce sufficient documentation from its third party contracted provider for claims.

Corrective Action Required:

1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for properly denying a claim. 2) MD Medicare Choice must revise its current claims process to ensure claims are being developed for additional information. 3) MD Medicare Choice must develop a system for distinguishing contracted providers from non contracted providers. 4) MD Medicare Choice must develop a system for processing claims within CMS timeframes in accordance with 42 C.F.R., 422.100 a and b, 1, 422.132, 422.504 g 1 and Medicare Managed Care Ch. 4 Manual, section 10.2. 5) MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 6) MD Medicare Choice must conduct an audit of their delegated claims provider within 30 days of receiving this report. The audit will be conducted for the period July through August 2008 on all denied claims. Provide a copy of the report to the CMS reviewer by September 30, 2008.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC03

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 09/25/2008

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:

The CMS Reviewer reviewed 30 Non-contracted provider paid claims samples cases. Of the 30 samples cases, 21 were not paid within 30 days, 17 interest payment was incorrect or not paid, and 9 were paid within 60 days.

Corrective Action Required:

The MAO must monitor its claims payment processes to ensure that all clean claims are processed within the required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and results of the audits must be provided to CMS on a quarterly basis until further notice. The first report must be submitted to CMS by September 30, 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 09/25/2008

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:

The CMS Reviewer reviewed 30 Non-contracted provider paid claims samples cases. In 17 of the 30 sample cases, the interest payment was incorrect or not paid as required. During the discussion with MAO staff, it was determined that there is delay in checks being sent to the providers, the MAO indicates that the delay is 24 to 48 hours, however the CMS Reviewer was not able to verify this information.

Corrective Action Required:

The MAO must put into place processes to ensure that the interest is paid on claims and the correct amount of interest is paid. The MAO must provide CMS with policies and processes outlining these processes. The MAO must incorporate in these policies and procedures the process for mailing of checks on date issued.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OC05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

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:

MD Medicare Choice does not meet the requirements for this element. MD Medicare Choice does not meet the requirements for this element because CMS reviewed 30 cases out of a universe of 5103 and 5 cases (1, 2, 3, 4, 5) were misclassified and 6 out of 25 cases (6, 7, 12, 28, 29, 20) were not adjudicated within the required CMS specified timeframe.

Corrective Action Required:

1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for properly adjudicating a claim. 2) MD Medicare Choice must revise its current claims process to ensure claims are being processed within CMS specified timeframes and in accordance with 42 C.F.R., 422.520 a, 3 and Medicare Managed Care Ch. 11 Manual sections 100.2 and Medicare Managed Care Ch. 13 Manual section 40.1 3) MD Medicare Choice must conduct training of appropriate staff on these policies and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 4) MD Medicare Choice must conduct an audit of their delegated claims provider within 30 days of receiving this report. The audit will be conducted for the period July through August 2008 on denied claims. Provide a copy of the report to the CMS reviewer by September 30, 2008.

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: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC06

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

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 specific denial reason. The notice must also inform the enrollee of his or her right to a standard reconsideration and describe the appeal process.

Deficiencies:

MD Medicare Choice does not meet the requirements for this element. MD Medicare Choice does not meet the requirements for this element because CMS reviewed 30 cases out of a universe of 5103 and 5 (cases 1, 2, 3, 4, 5) were misclassified, 25 out of 25 cases (6 through 30) were incorrect. In all 25 cases the notices were non compliant. MD Medicare Choice did not include the reason for denial in any of the notices. Additionally, MD Medicare Choice did not include a current approved notice of denial of payment in any of the cases. The notice that was provided in all 25 cases was not accurate and included limited information about the reason for denial of the claim.

Corrective Action Required:

1) MD Medicare Choice must develop and implement policies and procedures that clearly describe the steps for including the appropriate information in the notices for denied claims. 2) MD Medicare Choice must revise its current claims process to ensure notices include the correct denial code and reason for denial. 3) MD Medicare Choice must develop a system for ensuring compliance in accordance with 42 C.F.R., section 422.568d and e, and Medicare Managed Care Ch. 13 Manual section 40.2.2. 4) MD Medicare Choice must conduct training of appropriate staff on these policies\and procedures and submit documentation to CMS that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be provided to the CMS reviewer by September 15, 2008. 5) MD Medicare Choice must provide a copy of the CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP CMS notice to the CMS reviewer by September 1, 2008.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Adverse Standard Pre-Service Organization Determinations (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:

MD Medicare Choice does not meet CMS compliance standard because CMS audited 8 cases from a universe of 8 and found 1 case that was not processed timely. The sample case file identified was case #6. Policy and Procedure MDMC-UM-602 states notification is sent within the timeframes established by CMS.

Corrective Action Required:

MD Medicare Choice must follow its own policy and procedure and ensure that denial of services notices are sent timely. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must sent to the CMS Regional Office, the date of the training, the materials used, and the staff trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Adverse Standard Pre-Service Organization Determinations (Notice Content) - If the MAO makes an adverse standard pre-service organization determination, the written CMS-10003-NDMC (Notice of Denial of Medical Coverage), or an RO-approved modification of the NDMC, must be sent to the member and must clearly state the service denied and the specific denial reason. The notice must also inform the enrollee of his or her right to a standard or expedited reconsideration, including the rights to, and conditions for, obtaining an expedited reconsideration, as well as describe the appeal process

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 8 cases from a universe of 8 and found 6 cases in which the denial notice did not clearly state the service denied and the specific denial reason.

Corrective Action Required:

MD Medicare Choice must revised the standard denial letter language contained in MDMC-UM-602C. The standard denial language is vague and does not provide the specific denial reason. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must send to the CMS Regional Office, the date of the training, the materials used, and the staff trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: OP09
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 6/23/2008
Exit Conference Date: 06/27/2008
Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 15 sample cases from a universe of 11236 and found 12 cases in which the favorable standard pre service determination was not processed timely and the member was not notified timely. The sample case files were cases #2, 3, 4, 5, 6, 8, 10, 11, 12, 13, 14, and 15. In all 12 cases, MD Medicare Choice did not provide documentation of when the service was requested and if an extension was taken. Policy and procedure MDMC-GA-13.004 states appeals documents and correspondence are maintained.

Corrective Action Required:

MD Medicare Choice must follow its own policy and procedure and ensure favorable standard preservice determinations are appropriately documented and the documentation is easily retrievable. MD Medicare Choice must provide training on these procedures to appropriate staff. MD Medicare Choice must sent to the CMS Regional Office, the date of the training, the materials used, and the staff trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: PR03

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date:

Element Release Date:

CAP Released Date:

Visit Start Date: 6/23/2008

Exit Conference Date: 06/27/2008

Date Report Issued: 08/11/2008

Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/13/2008

MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 20 sample case files from a universe of 5065 and found 5 cases that did not meet CMS requirements. The sample cases are case #8, #10, #11, #13, and #17. Case file #8 did not contain a license, Case files #10, 11, and 13 did not contain malpractice insurance, case file #17 did not contain information on board certification. Additionally, 13 of the sample case files did not contain clinical privileges information. A review of the policies and procedures MDMC-CR-203 Credential Renewal and MDMC-CR-301 Initial Application, both require a current license, malpractice insurance and board certification for specialists.

Corrective Action Required:

Medicare Choice must adhere to its own policies and procedures and ensure all providers are properly credentialed. MD Medicare Choice must audit provider files all 5,065 and send CMS a detailed report on its progress. The report must contain all of the CMS required elements contain in Chapter 6 of the Medicare Managed Care Manual section 60.3. Once the audit is complete, MD Medicare Choice must send CMS Regional Office updated HSD tables listing all providers within its network that are contracted, credentialed and are providing services to its members

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RC01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
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Visit Start Date: 6/23/2008
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Date Report Issued: 08/11/2008
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CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

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

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 10 sample case files out of an universe of 78 and found 9 cases, where the reconsideration was not processed timely and 1 case that was misclassified. The 9 sample case files are cases #1, #2, #3, #4, #5, #6, #7, #9, and #10. Cases #1, #2, #3, #5, #6, #7, #9, and #10, the case files did not contain documentation when the claim was originally denied and when the member was notified of the decision. Cases #3, #4, #5, #6, #7, #9, and #10, the file did not contain documentation when the claim was paid.

Corrective Action Required:

MD Medicare Choice must adhere to its own policy and procedure MDMC-GA-13.004 concerning the steps taken when an initial decision is overturned. MD Medicare Choice must conduct training on this procedure to appropriate staff and notify CMS Regional Office when this is accomplished. Training is toinclude, the date of the training, materials used, and staff trained. MD Medicare Choice must conduct an audit of the 78 cases contained in the universe and ensure members are notified of the decision and the claim is paid. MD Medicare Choice must send a report to CMS regional office when this is completed. The report should include the member's name, type of service denied, date member was notified, and the date the claim was paid. This should be accomplished by September 30, 2008.

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
Region: 04 Atlanta
Contract Number / Name: H5729 MD MEDICARE CHOICE

Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RC02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
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CAP Released Date:

Visit Start Date: 6/23/2008
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Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Adverse Claims Reconsiderations (Timeliness) - If the MAO affirms, in whole or in part, its adverse organization determination, or fails to provide the member with a reconsideration determination within 60 days of receipt of the request (which constitutes an affirmation of its adverse organization determination), it must forward the case to CMS" independent review entity no later than 60 calendar days after receiving the reconsideration request. The MAO concurrently notifies the member that it has forwarded the case to CMS" independent review entity.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 1 sample case from a universe of 1 and found this case was not processed timely. The case was partially overturned, but the file did not contain documentation that the case was forwarded to the Independent Review Entity.

Corrective Action Required:

MD Medicare Choice must adhere to their own policy and procedure (MDMC-GA-13.004) concerning the steps taken when an initial decision is overturned. MD Medicare Choice must conduct training on this procedure to appropriate staff and notify CMS Regional Office when this is accomplished. This is to include, the date of the training, materials used, and staff trained. MD Medicare Choice must research this case and forwarded the information to the Independent Review Entity for reconsideration and notify CMS regional office when this is accomplished but no later than September 30, 2008.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 12737

Region: 04 Atlanta

Contract Number / Name: H5729 MD MEDICARE CHOICE

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RC03

Review Type: Focused

Review Status: Confirmed

MCO Response Received Date:

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CAP Released Date:

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Date Report Due: 08/11/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 09/25/2008

Requirement:

Effectuation of Third-Party Claims Reconsideration Reversals - If the MAO"s determination is reversed in whole or in part by the independent review entity, the MAO must pay for the service no later than 30 calendar days from the date it receives the notice reversing the organization determination. The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO"s determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member"s health requires, but no later than 60 days from the date it received notice of the reversal.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 1 sample case from a universe of 1 and found this case was not processed timely. The case was partially overturned, but the file did not contain documentation that the case was forwarded to the Independent Review Entity and thus the file did not contain a decision from the Independent Review Entity.

Corrective Action Required:

MD Medicare Choice must adhere to its own policy and procedure MDMC-GA-13.005 and ensure cases are effectuated when an overturn is received from the Independent Review Entity (IRE). If the decision received from the IRE is overturned, MD Medicare Choice must ensure the decision is effectuated and notify CMS regional office when this occurs. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained.

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Region: 04 Atlanta
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Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:
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Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

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:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 1 sample case from a universe of 1 and found this case was not processed timely. The case file did not contain documentation that the case was sent to the IRE nor was the member notified.

Corrective Action Required:

MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.004) and ensure cases are forwarded to the the Independent Review Entity (IRE)when the reconsidered decision is not fully favorable to the member. MD Medicare Choice must forward this case to the IRE and notify the member and CMS regional office when this is accomplished. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET
Region: 04 Atlanta
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Review ID: 12737

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP03
Review Type: Focused
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Visit Start Date: 6/23/2008
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Date Report Issued: 08/11/2008
Date Report Due: 08/11/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/30/2008
MCO Response Due Date: 09/25/2008

Requirement:

Effectuation of Third-Party Standard Pre-Service Reconsideration Reversals - If the MAO"s determination is reversed in whole or in part by the independent review entity, the MAO must authorize the service within 72 hours from the date it receives the notice reversing the determination, or provide the service as quickly as the member"s health requires (but no later than 14 calendar days from that date). The MAO must also inform the independent review entity that the organization has effectuated the decision. If the MAO"s determination is reversed in whole or in part by an ALJ, or at a higher level of appeal, the MAO must authorize or provide the service under dispute as expeditiously as the member"s health requires, but no later than 60 days from the date it received notice of the reversal.

Deficiencies:

MD Medicare Choice does not meet the CMS compliance standard because CMS audited 1 sample case from a universe of 1 and found this case was not processed timely. The case file did not contain documentation of the outcome of the reconsideration of the denial nor did it contain documentation that the file was forwarded to the Independent Review Entity. Thus the file did not contain a decision from the Independent Review Entity.

Corrective Action Required:

MD Medicare Choice must adhere to its own policy and procedure (MDMC-GA-13.005) and ensure cases are effectuated when an overturn is received from the Independent Review Entity (IRE). If the decision received from the IRE is overturned, MD Medicare Choice must ensure the decision is effectuated and notify CMS regional office when this occurs. MD Medicare Choice must provide training on these procedures to appropriate staff. A report must be sent to the CMS Regional Office once the training is completed, which includes the date of the training, the materials used, and the staff trained