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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/12/2008

Element Release Date: 08/14/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/10/2008

MCO Response Due Date: 05/22/2008

Requirement:

Required Contract Provisions: Privacy and Confidentiality - The MAO"s written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality, consistent with all Federal and State laws, and ensure accuracy of beneficiary medical, health, and enrollment information and records.

Deficiencies:

42 CFR 422.118 The MAO's written contracts with first tier and downstream entities must contain specific required provisions to be in compliance with all state and federal laws, statutes and regulations. The sample submitted reflects three misclassified and five incorrect for those submitted to CMS. The contracts were vague, inconsistent and did not clearly identify the contracting parties and who is responsible for safeguarding beneficary privacy and confidentiality. Plan does not have adequate policies and procedures to demonstrate that their contracts meet the requirements of this element.

Corrective Action Required:

The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for safeguarding beneficiary privacy and confidentiality. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN02

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/12/2008

Element Release Date: 08/14/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/10/2008

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

42 CFR 422.118 The MAO's written contracts with first tier and downstream entities must contain specific required provisions to be in compliance with all state and federal laws, statutes and regulations. The sample submitted reflects three misclassified and five incorrect for those submitted to CMS. The contracts were vague, inconsistent and did not clearly identify the contracting parties or who is responsible for providing for a prompt payment provision. Plan does not have adequate policies and procedures to demonstrate that their contracts meet the requirements of this element.

Corrective Action Required:

The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for a prompt payment provision. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/12/2008

Element Release Date: 08/14/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/10/2008

MCO Response Due Date: 05/22/2008

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:

42 CFR 422.118 The MAO's written contracts with first tier and downstream entities must contain specific required provisions to be in compliance with all state and federal laws, statutes and regulations. The sample submitted reflects three misclassified and five incorrect for those submitted to CMS. The contracts were vague, inconsistent and did not clearly identify the contracting parties or who is responsible for including a hold harmless clause. Plan does not have adequate policies and procedures to demonstrate that their contracts meet the requirements of this element.

Corrective Action Required:

The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for a provision that Medicare members are held harmless for payment of fees that are the legal obligation of the MAO. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/12/2008

Element Release Date: 08/14/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 05/22/2008

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:

42 CFR 422.118 The MAO's written contracts with first tier and downstream entities must contain specific required provisions to be in compliance with all state and federal laws, statutes and regulations. The sample submitted reflects three misclassified and five incorrect for those submitted to CMS. The contracts were vague, inconsistent and did not clearly identify the contracting parties and who is responsible for maintaining the records for a minimum of 10 years. Plan does not have adequate policies and procedures to demonstrate that their contracts meet the requirements of this element.

Corrective Action Required:

The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for reporting, audits, inspection by CMS or its designees, cooperation, and maintainence of records for a minimum of 10 years. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: CN06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/12/2008

Element Release Date: 08/14/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/30/2008

MCO Response Due Date: 05/22/2008

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:

42 CFR 422.118 The MAO's written contracts with first tier and downstream entities must contain specific required provisions to be in compliance with all state and federal laws, statutes and regulations. The sample submitted reflects three misclassified and five incorrect for those submitted to CMS. The contracts were vague, inconsistent and did not clearly identify the contracting parties and who is responsible for specifying that providers agree to comply with the MAO's policies and procedures. Plan does not have adequate policies and procedures to demonstrate that their contracts meet the requirements of this element.

Corrective Action Required:

The MAO must submit a written plan and a sample contract demonstrating that their contracts specifically identify the name of the contracting parties and whether they are first tier or downstream entities. The plan must include specific details that include compliance with the Federal requirement for providers to comply with the MAO's policies and procedures. The MAO must submit a plan to provide oversight of the contracting process and that all executed contracts are in compliance with all Federal laws, statutes and regulations. The MAO should submit the name of the individual or parties who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: DN02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 06/16/2008
Element Release Date: 08/08/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/01/2008
MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

In 1 out of the 15 files reviewed the confirmation letter was not sent out timely. Per Chp. 2 Section 50.1.4 - confirmation letters must be sent out within 7 business days following receipt the Transaction Reply Reports from CMS.

Corrective Action Required:

As stated in Chp. 2 Section 50.1.4 - If the MA organization learns of the voluntary disenrollment from the CMS transaction reply report (as opposed to through written request from the member), the MA organization must send a written confirmation notice of the disenrollment to the member within seven business days of the availability of the transaction reply report. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/18/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:05/01/2008

MCO Response Due Date: 05/22/2008

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:

Entire sample (4 out of 4) - was misclassified.

Corrective Action Required:

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. Please submit the universe for the last six months.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN07

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Compliant Retroactive Disenrollment Requests - The MAO correctly submits requests to the CMS Regional Office, or Program Safeguard Contractor, for retroactive disenrollments that are permitted by the CMS policy in the MA Enrollment Guidelines, Section 60.5. Supporting information is included in accordance with CMS policy.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN08

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Involuntary Disenrollment for Disruptive Behavior - The MAO may request disenrollment of a Medicare member for disruptive behavior only when the behavior substantially impairs the MAO"s ability to furnish services to the member or other members. The MAO may only disenroll a member for disruptive behavior if it has MET the requirements of Section 50.3.2 of the MA Enrollment Guidelines and with CMS approval. 42 C.F.R. § 422.74(d)(2); Manual Ch. 2 " Section 50.3.2

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN09

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Involuntary Disenrollment for Fraud or Abuse - The MAO may disenroll Medicare members when they commit fraud or permit abuse of their enrollment cards. Fraud is limited to knowingly providing, during the election process, fraudulent information that materially affects the determination of the members" eligibility to enroll in an MA plan. Abuse of members" enrollment cards includes intentionally permitting others to use their enrollment cards to obtain services under the MA plan. The MAO disenrolls Medicare members for fraud or abuse only after the MAO mails the members a written notice that includes an explanation of the members" right to a hearing under the MAO"s grievance procedures. The MAO disenrolls members effective the first day of the calendar month after the month in which notice is sent to the members of the intended action. When an MAO disenrolls a member for this reason, it must immediately notify the CMS RO.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: DN10

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Inappropriate Encouragement to Disenroll - The MAO does not, orally or in writing, or by any action or inaction, request or encourage a Medicare member to disenroll.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/01/2008

MCO Response Due Date: 05/22/2008

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:

There were 5 out of the 15 files reviewed that did not met CMS requirements. 4 of the 5 files - no letter requesting additional information was sent to out to the member. In 5th file - the beneficiary was wrongfully denied enrollment. Beneficiary was eligible for enrollment into the plan under ICEP.

Corrective Action Required:

MAO must correctly identify incomplete enrollment elections and follow CMS requirements for requesting information from the beneficiaries to make the elections complete. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:05/05/2008

MCO Response Due Date: 05/22/2008

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:

Acknowledgement letter, Annual Election Period dates are inaccurate - letter currently states Nov. 15th to Decemeber 31st 2006.

Corrective Action Required:

AEP info needs to be updated to reflect current year (letter currently states 2006).

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 06/17/2008
Element Release Date: 08/08/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/01/2008
MCO Response Due Date: 05/22/2008

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:

13 out of the 15 files reviewed were not met. In 4 of the 15 files reviewed the MAO did not notify beneficiaries of the denied enrollment. In the remaining 11 files the MAO did not provide accurate timeframes to the beneficiaries to submit the additonal information requested, as specified by CMS.

Corrective Action Required:

The MAO must correctly notify beneficiaries of denial of enrollment within timeframes specified by CMS. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER08

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:09/01/2008

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

In 14 out of the 15 files reviewed the Annual Election Period dates in the Denial notice were inaccurate - letter stated AEP: Nov. 15th to Decemeber 31st 2006.

Corrective Action Required:

Denial letter AEP dates needs to be updated to reflect current year (letter currently states 2006) - to meet CMS requirements. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER12

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Retroactive Enrollment Requests - The MAO requests retroactive enrollments, when appropriate, and adheres to CMS requirements in requesting retroactive enrollments from the Regional Office or Program Safeguard Contractor.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER15
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 06/17/2008
Element Release Date: 08/14/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:05/01/2008
MCO Response Due Date: 05/22/2008

Requirement:

Appropriate Follow-Up on Changes in State and County Code - The MAO reviews the CMS Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follows-up on any notification of a potential change in residence for its members reported to it by CMS.

Deficiencies:

10 out of the 15 files reviewed were not met. MAO would attempt to contact member via phone, if unable to reach the member, no further action was taken by MAO.

Corrective Action Required:

The MAO must review the CMS Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follow-up on any notification of a potential change in residence for its members reported to it by CMS. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Please submit a CAP for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER16

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Prohibition of Health Screening - The MAO does not deny or discourage enrollment on the basis of health status, except for ESRD, as provided in CMS guidance (including exceptions). SNPs may limit enrollment to individuals who meet the additional eligibility requirements.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: ER17

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 08/08/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:03/04/2008

MCO Response Due Date: 05/22/2008

Requirement:

Working Aged Survey - The MAO must conduct an annual working aged survey. It must submit one Excel file for both members who were working aged in the annual survey for those members who did not respond to the survey. The name and HIC# for each member must be included in this file.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: ER502
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 06/18/2008
Element Release Date: 08/08/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:05/04/2008
MCO Response Due Date: 05/22/2008

Requirement:

Dual Eligible Enrollment (Note: This element is only applicable if auditing a Dual Eligible SNP) - The MAO must designate the type of dual eligible population it will serve and ensure that its enrollment practices are consistent with this designation.

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008. However, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures showing the effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: GV03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 06/16/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:08/01/2008

MCO Response Due Date: 05/22/2008

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:

In 5 of 12 records reviewed, Liberty failed to provide the members with a notification of the Plan's decision within required timeframes.

Corrective Action Required:

Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members within required timeframes. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: GV04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 06/16/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:08/01/2008

MCO Response Due Date: 05/22/2008

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:

In 6 of 12 records, Liberty failed to provide the members with a notification of the plan's decision and any appeal rights.

Corrective Action Required:

Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: GV05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 06/16/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:08/01/2008

MCO Response Due Date: 05/22/2008

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:

In 4 of 12 cases, Liberty failed to use the correct method to provide members with a notification of its decision.

Corrective Action Required:

Liberty must conduct training of appropriate staff to ensure required grievance notifications are sent to members when appropriate. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. In addition, Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: MR05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date: 06/19/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:05/20/2008

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008 however they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 06/16/2008
Element Release Date: 06/19/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:05/20/2008
MCO Response Due Date: 05/22/2008

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:

MAO did not have sufficient policies and procedures in place for the audit review period.

Corrective Action Required:

MAO has constructed new policies and procedures for 2008 however, they have not been reviewed by the committee and have not received approval. Please submit scanned signature page, along with the policies and procedures effective date, to us electronically for our review.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

In 29 of 30 records reviewed, the claim for service was denied for failure to obtain authorization. Reviewer was unable to determine if the claim development was correct as there was little if any documentation maintained by the plan. Further, the MAO did not follow its own policy and procedure for this area. Also, Liberty's policy and procedure did not include a definition for urgently needed services.

Corrective Action Required:

In accordance with Medicare Guidelines, Liberty must make correct claim determinations for services obtained from non-contracting providers. The organization must also make at minimum, one attempt to obtain additional information from non-contracted providers when necessary, especially in situations where member liability exists, prior to denying the claim. This may be in the form of a phone call, fax, letter, etc. In the event the organization is unable to secure the necessary information from the provider, within the 30/60 day timeframe, it may utilize the 14 day extension provision with proper documentation. Liberty must conduct appropriate training of its staff in the correct method for processing and documenting these claims. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Liberty needs to revise policy and procedure to include a definition for urgently needed services. Liberty must conduct monthly monitoring audits of this area submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/05/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

For samples reviewed for the two delegated entities for the timely payment of timely, 15 of 15 claims were paid timely and 14 of 15 claims were paid timely (claim 710040588500001 was not paid timely). However, for claims paid by Liberty, 11 out of 30 claims were not paid timely. In the interview with the Claims Staff, the auditors were informed that the Plan is currently not differentiating between clean and unclean claim. However, the claims system will be upgraded and tweaked to capture this information. Documentation provided for the delegated entity also did not identify clean and non-clean claims. Policies and procedures G108 and G110 provided included information on monitoring of aging reports, management, standards and goals for timely processing of claims. However, these policies did not provide a step by step process on how non-contracting provider clean claims are handled and processed from the time of receipt to ensure they are paid timely. These policies are not approved and signed.

Corrective Action Required:

Liberty must update its existing policies to include information on identifying handling clean and non-clean claims. The policy must include a step by step procedure for handling and processing received claims from non-contracted providers and the required timeframes. These policies must be approved and signed by appropriate officials. Liberty must conduct training for the appropriate staff and departments on these updated policies and procedures to ensure there is coordination of these processes within the plan. Documentation must be provided to the Regional Office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individual being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance. Liberty should conduct a monthly internal audit of its claims determination. This audit should evaluate whether Liberty is paying its non-contracting provider clean claims timely. Liberty should submit a summary report once a quarter to the regional office of its monthly findings until further notice. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

Of the thirty cases reviewed for element OCO4, eleven cases were not paid within 30 days and interest was never paid for claims 2007081006500051 and 2007090406800005. Of the remainding nine claims for which interest was paid, the interest amount paid for 2007112706800041 was incorrect. Also, for the 15 cases from the delegated entity, claim 710040588500001 was more than 30 days and interest was never paid. Policy and Proccedure (P and P) GI09 provided for this element does not have a step by step process on how Liberty handles all type of claims and ensures that all claims over 30 days are processed with interest and within the required timeframe. Also, the submitted P and P G109 is not approved and signed.

Corrective Action Required:

Liberty must update its existing policies to include information on identifying and how to handle clean and non-clean claims and to ensure that payment of interest is done for all claims over 30 days . The policy must include a step by step procedure for handling and, include information on processing those claims from non-contracted providers over 30 days within the required timeframes. Liberty must conduct training for the appropriate staff and departments on these updated policies and procedures to ensure there is coordination of these processes within the plan. Liberty will be required to submit Documentation to the Regional Office that details the nature of this training, including: the materials used in the training, the individual conducting the training and the individual being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure continued compliance, and Liberty should conduct a monthly internal audit to ensure interest is being paid on all late claims. This audit should evaluate whether Liberty is paying its non-contracting provider interest on late claims timely and the correct amount. Liberty should submit a summary report once a quarter to the regional office of its monthly findings until further notice. The summary report should include: title of the auditor(s), the audit methodology, and the result of the audit.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OC06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

In all 30 cases reviewed, Liberty failed to issue to members a denial notice that provided a description of the services being denied. In all 10 cases reviewed for Heritage (Healthcare Partners), one of the MAO's delegated entities, Heritage failed to issue to the members a denial notice that provided appeal rights and the services being denied.

Corrective Action Required:

If Liberty or its designee decides to deny, discontinue, or reduce service or payments, in whole or in part, then it must give the enrollee a written notice of its determination. If the enrollee has a representative, the representative must be sent a copy of the notice. The plan must use Medicare approved notice language as specified in Appendix 1 of Chapter 13 of the Medicare Managed Care Manual. The Standard denial notice must provide the specific reason for the denial and takes into account any the enrollee's presenting medical condition, disabilities, and special language requirements, if any. Liberty must conduct appropriate training of its staff in the correct method for processing and documenting how requests for services are processed. Liberty must submit documentation to the regional office that details the nature of this training including: the materials used in the training, the individuals conducting the training, and the individuals being trained. Liberty must conduct monthly monitoring audits of this area and submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OP04

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/05/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:07/18/2008

MCO Response Due Date: 05/22/2008

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, promptly provide oral notice to the member of the decision not to expedite, and provide written notice within 3 calendar days of the oral notice. If the MAO 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:

For element OP04, there were no samples,therefore Policy and Procedures 2008 UM Program, Section V111. Utilization review Methods, page 16, UM Policy and procedure - Section A-2 Pre-Service Review (2007), Page 6, UM Policy and Procedure- Section A-5 timeliness of Utilization Management Decision, page 19, UM Policy and Procedure Appendix A-Medicare Timeframes Standards Grid, page 144, and UM Policy and Procedure - Section E-1 - Denial Notices, page 100 were provided for review. These policies are not approved and signed off on and are noted as a draft. The individual policies provided do not include information of the complete process for handling an expedited organization request from receipt to the point of providing a decision. The document "Timeliness of Utilization Management decision" listed CMS timeframes. However, it was not clear how these timeframes will be met and by whom to ensure decisions are handled and notifications sent timely to members. Also, during the interview with the clinical sevices staff, it was not clear how this department coordinate with other departments or staff in addressing and completing a request for organization determinations.

Corrective Action Required:

Liberty must provide evidence of a formalized system for receiving and documenting expedited organization determinations requests from members. The policy must be updated to include the formalized system, a description of how the request is handled, and all departments and parties who are responsible for receiving, processing and expediting these requests to ensure requests are handled timely. This must also include copies of the notices approved through CMS process which will be sent to members. Policies must be approved and signed. Liberty must conduct training to staff on the updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OP05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date: 08/13/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:07/18/2008

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

For element OPO5 there were no samples, therefore, Policy and Procedures 2008 UM Program, Section V111. Utilization review Methods, page 16, UM Policy and procedure - Section A-2 Pre-Service Review, Page 6, UM Policy and Procedure- Appendix D-CMS MA Denial Templates and Template Instructions Form, page 154 and UM Policy and Procedure - Section E-1- Denial Notices, page 100 were provided for element OPO5. These policies are not approved and signed off on and are noted as a draft. The individual policies provided do not include information of the complete process for handling an organization requests from receipt to the point of providing a decision. Although the document provided included templates of the notices that will be sent, it was not clear how Liberty will ensure that these notifications will be sent timely to members. During the interview with the clinical sevices staff, it was not clear how this department coordinate with other departments or staff in addressing and completing a request for organization determinations.

Corrective Action Required:

Liberty must provide evidence of a formalized system for receiving, documenting and handling adverse expedited organization determinations requests from member to ensure denial notices with appeals rights etc. are sent timely to members. The updated policy must include a formalized process, timeframes to ensure that the request is handled, and all designated departments and parties involved in processing, expediting these requests and responsible for sending the notices timely to members. Policies must be approved and signed. Liberty must conduct training to staff on these updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: OP15

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/16/2008

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CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

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Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:05/19/2008

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

Auditor reviewed UM Policy Section: E, Procedure No: 1 The plan's policy did not contain a provision for obtaining the concurrence of the attending physician prior to discharging an inpatient to a lower level of care within the hospital setting. Nor did the policy contain any provision with respect to providing the QIO with all information needed to review the plan's determination.

Corrective Action Required:

The plan must revise its policy to meet the requirements of the Medicare Managed Care Manual, Chapter 13, with respect to the denial notice of discharge of inpatient hospital care. The policy must be approved and signed. Liberty must conduct training to staff on these updated guidelines and provide documentation to the regional office that details the nature of this training,the materials used in the training and the individual conducting the training.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: PR03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date: 08/13/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date: 10/31/2008

MCO Response Due Date: 05/22/2008

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:

42. CFR 42.204(b)(2) The MAO must follow a documented process for physicians and other health care professionals regarding initial credentialing or recredentialing. This element was not met as evidence by: 1. 11 of 20 Credentialing/Recredentialing files maintained by the MAO or delegated entities lacked one or more of the following: primary source verification of education, current license, current malpractice, current DEA or CDS certificate, quality of care issues, NPDB information, eligibility for Medicare participation, Medicare/Medicaid sanction list. 2. Oversight of delegated credentialing/recredentialing entities failed to ensure credentialing files were in compliance with MAO policies and federal regulations. 3. 6 of 10 Institutional and Supplier Credentialing/Recredentialing files maintained by the MAO or delegated entities lacked one or more of the following: signed contract, current state license/SOC, accreditation status, documentation of medicare participation.

Corrective Action Required:

The MAO must submit a plan to ensure credentialing and recredentialing files are in compliance with regulations and are maintained to ensure files remain current. The MAO must submit a plan to provide oversight of delegated credentialing entities and a plan to ensure delegated credentialing files are in compliance with federal regualtions. Submit title of person who will monitor for compliance.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RC01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/05/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

For this element RC01, there were no samples,therefore Liberty provide UM Policy and Procedure- Section E-4- Standard Service Appeals, page 114 and UM Policy and Procedure - Appendix B- Appeals Timeframe Standards, page 149 for review. Policies are not approved and signed. The policy provided did not have a complete process to handle favorable claims reconsiderations timely. For example on p.116(11), P.117 (111 and IV), it is not clear in some areas who are the responsible parties or department for completing the process and ensuring that timeframes are adhere to. The policy is too general in addressing appeals, and it is difficult to determine whether favorable claims reconsiderations or Favorable Standard Pre-Service Reconsiderations are being addressed. Also in the interview, the auditors were told that claims denial notices which also included appeals rights were not sent to members. On Page 115 under the process section (third bullet)it is stated that "the start time for an appeal should be considered to be the time when the Grievance and Appeals (G and A) department receives the request." This is incorrect. Although Appendix B provides timeframes it does not indicate who will be responsible for ensuring that these timeframes are met.

Corrective Action Required:

Liberty must update its policy so it is clear when a Favorable Claims Reconsideration is being addressed and when a Favorable Standard Pre-Service is being addressed. This policy must also include in its process all parties and department who are responsible for performing this functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether Favorable claims reconsiderations are received and handled appropriately and timely by the plan. Liberty should also determine whether it is correctly distinguishing between Favorable standard Pre-service reconsiderations and favorable claims reconsiderations. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RC02

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

For element RC02 there were no samples, therefore Liberty provided UM Policy and Procedure- Section E-4- Standard Service Appeals, Page 114, UM Policy and procedure- Section E-6- Processing member Appeals, page 125 and UM Policy and Procedure- Appendix B- Appeals Timeframe Standards, page 149 for review. These policies are not approved and signed. In the UM policy- Section E-4, the process was not complete for handling adverse claims reconsiderations timely. For example on p.116(11), P.117 (111 and IV), it is not clear for some areas this function is coordination within department to ensure the process is completed timely. The policy is too general in addressing appeals, and does not differentiate when favorable claims reconsiderations or Favorable Standard Pre-Service Reconsiderations is being addressed. UM policy E-6, process does not outline how and who will perform the tasks and the correct timeframes. Also in the interview, the auditors were told that claims denial notices which also included appeals rights were not sent to members. On Page 115 of UM Policy - Section E-4 under the process section (third bullet)states that "the start time for an appeal should be considered to be the time when the Grievance and Appeals (G and A) department receives the request." This is incorrect. Although Appendix B provides timeframes it does not indicate who will be responsible for ensuring that these timeframes are met.

Corrective Action Required:

Liberty must update its policy so it is clear on its process for addressing Adverse Claims reconsiderations timely. This policy must also include in its process all parties and department who are resposible for performing this functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed, and all notices must be approved through HPMS according to CMS guidelines. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether adverse claims reconsiderations are received and handled appropriately and timely by the plan. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RC03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date: 08/13/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:07/18/2008

MCO Response Due Date: 05/22/2008

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:

For element RC03 there were no samples, therefore Liberty submitted UM Policy and Procedure- Section E-4- Standard Service Appeals, Page 114, UM Policy and Procedure- Section E-6- Processing Member Appeals, Page 125 and UM Policy and Procedure- Appendix B- Appeals Timeframe Standards, Page 149 for review. The Policies submitted are not approved and signed. The Policy submitted is general and does not have a complete or developed process that outlines the Effectuation of Third Party Claims Reconsideration reversals with the responsible person (s) to ensure this function is completed timely.

Corrective Action Required:

Liberty must update its policy so it is clear on its process for addressing the Effectuation of Third- Party Claims Reconsideration reversals. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates sent to the independent review entity that it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RE01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

Requirement:

Acceptance of Standard Reconsideration Requests - The MAO must accept written requests for standard reconsiderations of requests for services or payment filed within 60 calendar days of the notice of the organization determination (or if good cause is shown, accepts written requests for standard reconsideration after 60 calendar days).

Deficiencies:

The auditors were told during the Appeals and Grievances interview that members services staff had little service training, were not consistent in logging all incoming complaints and logs were not pulled by the plan to caterogize those calls. Training was provided to member services staff on documenting all calls. Also,Liberty submitted 2008 UM Program- Section V111. Utilization review Methods, page 16, UM Policy and Procedure- Section E-4 Standard Service Appeals, page 114 and UM Policy and Procedure- Appendix B Medicare Appeal Time frames, page 149 for review for element RE01. These policies were not approved and signed. UM Policy and Procedure - Section E-4, page 114 states "that the start time for an appeal should be considered to be the time when the Grievance and Appeals (G and A) department receives the request. This is incorrect.

Corrective Action Required:

Liberty must update its policy so it is clear on its process for acceptance of standard reconsideration requests and must correct the information stated as being the start time for the appeal. This policy must also include in its process how it will handle oral requests, and all parties and department who are resposible for performing these functions and the required timeframes. Please see Chapter 13 of the Medicare Managed Care Manual- section 70 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty must conduct an internal audit each month of its incoming calls to ensure that they are properly categorized. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RE02

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 06/17/2008

Element Release Date: 06/19/2008

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:05/20/2008

MCO Response Due Date: 05/22/2008

Requirement:

Appropriate Person(s) Conduct the Reconsideration - A person or persons who were not involved in making the organization determination must conduct the reconsideration. When the issue is a denial based on lack of medical necessity, the reconsidered determination must be made by a physician with the expertise in the field of medicine that is appropriate for the service at issue. The physician making the reconsidered determination need not be, in all cases, of the same specialty or subspecialty as the treating physician.

Deficiencies:

During this review the Medical Director had started with Liberty about six weeks. Therefore, for the audit review period Liberty submitted policies 2008 UM Program- Section V111. Utilization review methods, page 16, UM Policy and Procedure- Section E-4 Standard Service Appeals, Page 114 and UM Policy and Procedure- Section E-5 Expedited Member Appeals, page 120 for element RE02. The policies provided are not approved and signed. Policy UM - E-4 p.117 addressing Appeal Determination is not clear on the process for getting the material to the person conducting the reconsideration, and the information provided regarding who conduct this review is confusing. Information on page 115 regarding the acceptance of the appeal timeframe is not correct.

Corrective Action Required:

Liberty must update its policy to outline its process for review of a reconsideration by the appropriate person (s). The information provided must be clear about who is conducting the review. The policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RP01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

Requirement:

Favorable Standard Pre-Service Reconsiderations (Timeliness) - If the MAO makes a fully favorable decision on a standard pre-service reconsideration, it must issue a decision to the member, and authorize or provide the service, as expeditiously as the member"s health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified).

Deficiencies:

For element RP01 there were no samples, therefore Liberty provided UM Policy and Procedure- Section E-4- Standard Service Appeals, page 114 and UM Policy and Procedure - Appendix B- Appeals Timeframe Standards, page 149 for review. These policies are not approved and signed. UM policy Section E-4 did not have a complete process on how it will handle favorable standard pre-service reconsiderations timely. For example on p.116(11), P.117 (111 and IV), it is not clear for some areas who are the parties or department responsible for moving the process along and corresponding timeframes. The policy is too general in addressing appeals and it is difficult to determine whether favorable standard Pre-Service Reconsiderations or favorable claims reconsiderations are being addressed. On Page 115 under the process section (third bullet) it is stated that "the start time for an appeal should be considered to be the time when the Grievance and Appeals (G and A) department receives the request." This is incorrect. Although Appendix B provides timeframes it does not indicate who will be responsible for ensuring that these timeframes are met.

Corrective Action Required:

Liberty must update its policy so it is clear when a Favorable Claims Reconsideration is being addressed and when a Favorable Standard Pre-Service reconsideration is being addressed. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes, information regarding a fourteen day extension if justified, and a template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether favorable standard pre-service reconsiderations are received and handled appropriately and timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RP02

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

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:

For element RP02, there were no samples, therefore Liberty provided UM Policy and Procedure- Section E-4- Standard Service Appeals, Page 114, and UM Policy and Procedure- Appendix B- Appeals Timeframe Standards, page 149 for review. These policies are not approved and signed. In UM policy- Section E-4, the process for accepting and handling adverse standard pre-service reconsideration was not complete. For example, on p.116(11), P.117 (111 and IV), it is not clear for some areas who are the parties or department responsible completing this process. The policy is too general in addressing appeals and it is difficult to determine whether Favorable claims reconsiderations or Favorable standard Pre-Service Reconsiderations are being addressed. Page 118. the information stated about fees for an external appeal in not allowable. On page 119, the timeframe for LHA to provide the service for an expedited service request over turned by CHDR is not correct. On Page 115 of UM Policy - Section E-4 under the process section (third bullet) it is stated that "the start time for an appeal should be considered to be the time when the Grievance and Appeals (G and A) department receives the request." This is incorrect. Although Appendix B provides timeframes it does not indicate who will be responsible for ensuring that these timeframes are met.

Corrective Action Required:

Liberty must clarify its policy for addressing Adverse Standard Pre-Service reconsiderations timely. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes and template of the written notice sent to members with notification of the result - Please see Chapter 13 of the Medicare Managed Care Manual- sections 70.7.1 and 70.7.3, 70.7.4 and 140 for guidance. The Policy must be approved and signed, and all notices must be approved through HPMS according to CMS guidelines. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on whether adverse standard pre-service reconsiderations are received and handled appropriately and timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/15/2008
MCO Response Due Date: 05/22/2008

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:

For element RP03, there was no sample, therefore Liberty submitted UM Policy and Procedure- Section E-4- Standard Pre-Service Appeals, Page 114, UM Policy and Procedure- Section E-6- Processing Member Appeals, Page 125, UM Policy and Procedure- Section E-7 -External Review of Final Determinations, page 128 and UM Policy and Procedure- Appendix B- Appeals Timeframe Standards, Page 149 for review. Policy UM - Section E-7. p.130 states that LHA may charge the enrollee up to $50.00 per external appeals. This is not allowed. The Policies submitted are not approved and signed. The Policy does not have a complete or developed process that outlines the Effectuation of Third Party Standard pre-Service Reconsideration reversals with the responsible person(s) to ensure this function is completed timely.

Corrective Action Required:

Liberty must clarify its policy for addressing the Effectuation of Third- Party Standard Pre-Service Reconsideration reversals under Medicare guidelines. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates which will be sent to the independent review entity when it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Please remove the information regarding charging the enrollee up to $50.00 per external appeal from the policy. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should conduct an internal audit each month on the Effectuation of Third - Party Standard Pre-Service Reconsideration reversals. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 08/13/2008
Element Release Date: 08/13/2008
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:
MCO Response Due Date: 05/22/2008

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:

The auditors were told during the Appeals and Grievances interview that members services staff were not consistent in logging all incoming calls. Also,the UM Policy and Procedure- Section E-5 Expedited Member Appeals, page 120 and UM Policy and Procedure- Appendix B Medicare Appeal Time frames, page 149 was reviewed for element RP04. These policies were not approved and signed. The policies do not outline a complete step by step process for handling an expedited appeal when it it written or oral. UM Policy Section E-5 Page 121 discussed routing the written appeal to the Appeal Desk for resolution and does not address documentation of the request.

Corrective Action Required:

Liberty must clarify its policy for receipt and documentation of Expedited reconsideration requests. This policy must also include in its process how it will handle all expedited reconsideration requests, and all parties and departments who are resposible for performing these functions and the required timeframes. Please see Chapter 13 of the Medicare Managed Care Manual- section 80.1 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RP05

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

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Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

For element RP05, there were no samples, therefore Liberty provided UM Policy and Procedure- Section E-5 Expedited Member Appeals, page 120 and UM Policy and Procedure- Appendix B Medicare Appeal Time frames, page 149 for review. These policies were not approved and signed. The policy does not outline a complete step by step process for handling an expedited appeal when it it written or oral to ensure that it is timely, Page 121 discussed routing the written appeal to the Appeal Desk for resolution and does not address documentation of the request. It is not clear from UM Policy and Procedure- Appendix B Medicare Appeal Time Frames how the Plan ensures the requests are handled in the required timeframe. The auditors were told during the Appeals and Grievances interview that members services staff were not consistent in logging all incoming calls, and these call logs were not pulled to categorize the complaints.

Corrective Action Required:

Liberty must update its policy so its process is clear how requests for expedited reconsiderations are handled timely. This process must include the responsible persons and departments who are responsible for performing the various functions with required timeframes, and the process if the MAO decides not to expedite a reconsideration - Please see Chapter 13 of the Medicare Managed Care Manual- section 80.1 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty must establish a mechanism for ongoing monitoring of this area to ensure compliance. Liberty should complete an internal audit each month of its incoming calls for grievances and appeals. This audit should evaluate whether all calls are correctly classified and handled appropriately within CMS designated time frames. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5

Auditing Element: RP06

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:

Element Accepted Date: 08/13/2008

Element Release Date:

CAP Released Date:

Visit Start Date: 2/19/2008

Exit Conference Date: 02/22/2008

Date Report Issued: 04/07/2008

Date Report Due: 04/07/2008

CAP Accepted Date:

Audit Closed Date:

Element Projected Completion Date:

MCO Response Due Date: 05/22/2008

Requirement:

Decisions Not to Expedite a Reconsideration (Notice Content) If the MAO decides not to expedite a reconsideration, the notice to the member of the decision not to expedite must explain that the MAO will process the request using the standard timeframe, inform the member of the right to file a grievance if he or she disagrees with the decision not to expedite, inform the member of the right to resubmit a request for an expedited reconsideration with any physician"s support, and provide instructions about the MAO grievance process and its timeframes.

Deficiencies:

UM Policy and Procedure- Section E-5 Expedited member Appeals, page 120 and UM Policy and Procedure- Appendix B Medicare Appeal Time Frames, page 149 were reviewed for element RP06. In the policy under process 11. C p.122 provided information on advising the member orally about the change to a standard appeal, but does not address giving information to the member on their appeal rights and sending a written letter within 3 days. A copy of the notice which will be sent because notify the member of the decision not to expedite a reconsideration was not included. The policy is not approved and signed. The policy is not clear on who does the verbal notification for the decision not to expedite the reconsideration, and who is responsible for performing many of the function described in the policy. The policy provided concerning the Medicare Appeal Time frames does not provide information on how Liberty will ensure that these timeframes will be met.

Corrective Action Required:

Liberty must clarify its policy to include a step by step process of how requests for expedited reconsiderations are handled, who makes the decisions, based on the decision how members are advised of their rights to resubmit a request for an expedited reconsideration, as well as, information concerning the grievance process and timeframes, and who is responsible for sending the notices to members. The templates for these notices must also be included. - Please see Chapter 13 of the Medicare Managed Care Manual- section 80 for guidance. The Policy must be approved and signed. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained. Liberty should complete an internal audit each month of how denied expedited reconsideration are handled when transfer to a standard reconsideration. This audit should evaluate whether members are informed of their appeals rights and if the written notices are sent timely. Liberty should submit a quarterly report of its monthly findings to the regional office after the CAP for this element is accepted. Liberty should submit these quarterly reports until further notified.

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: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date:
Element Release Date:
CAP Released Date:

Visit Start Date: 2/19/2008
Exit Conference Date: 02/22/2008
Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:09/15/2008
MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

For element RP07,there were no samples, therefore Liberty provided UM policy and procedure- Section E-7 External Review of Final Determinations, page 128, UM policy and procedure - Appendix B Medicare Appeal Time Frames, page 149 and UM Policy and Procedure- section E-5 Expedited Member Appeals, page 120 for review. The policy is not approved and signed. Page 130 in the policy states that LHA may charge the enrollee up to $50.00 per external appeals. The Policies submitted is general and does not have a complete or developed process that outlines the Effectuation of Third Party Expedited Reconsideration reversals with the responsible person(s) to ensure this function is completed timely.

Corrective Action Required:

Liberty must update its policy so it is clear on its process for addressing the Effectuation of Third- Party Expedited Reconsideration under Medicare guidelines. This policy must also include in its process all parties and department who are resposible for performing these functions and the required timeframes. This should include templates sent to the independent review entity that it has effectuated the decision - Please see Chapter 13 of the Medicare Managed Care Manual- section 140 for guidance. The Policy must be approved and signed. Please explain the information regarding charging the enrollee up to $50.00 per external appeal. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 10697

Region: 02 New York

Contract Number / Name: H3337 LIBERTY HEALTH ADVANTAGE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 5
Auditing Element: RP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:
Element Accepted Date: 08/13/2008
Element Release Date: 08/13/2008
CAP Released Date:

Visit Start Date: 2/19/2008
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Date Report Issued: 04/07/2008
Date Report Due: 04/07/2008
CAP Accepted Date:
Audit Closed Date:
Element Projected Completion Date:07/18/2008
MCO Response Due Date: 05/22/2008

Requirement:

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

Deficiencies:

For element RP08, Liberty submitted UM Policy and Procedure- Section E-6 Processing Member Appeals, page 125 and UM Policy and Procedure- Appendix B Medicare Appeal Time Frames, page 149 for review. The policy is not approved and signed. The policy provided did not provide information on granting extension for the different types of reconsiderations, must include information on the member appeals right if they disagree with the extension.

Corrective Action Required:

Liberty must update its policy to include a process on how extensions are granted for all types of reconsiderations, and must include information concerning the member's right to file an expedited grievance if he/she disagrees with the decision to grant an extension- See Chapter 13 of the Medicare Managed Care manual - 70.7.1. The policy must be signed and approved. Liberty must provide training for the appropriate staff on the updated policy and provide documentation to the regional office. This information must contain details on the nature of this training, the individual conducting the training and the individuals being trained.