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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: AA01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 08/15/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/08/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of HSD tables 2-4, provider directories, and interviews with staff, Universal Health Plan, Inc. did not provide adequate documentation to enable the reviewer to analyze whether or not the organization maintains and monitors an appropriate provider network. In addition, the Florida Agency for Health Care Administration (AHCA) provided the Atlanta regional office with several contract termination letters dating from October 2006 to the present. These terminations include hospitals, independent provider associations(IPAs)with large numbers of providers, as well as groups of specialists. The Quality Improvement Organization in Florida, Florida Medical Quality Assurance, Inc. (FMQAI), and a representative of the Agency for Health Care Administration (AHCA) were present during the interviews. Findings include: 1. HSD 2 issues include: a. Several cities appear in more than one county. b. There were several specialists,such as surgeons,that did not have hospital privileges at a contracted provider. This was verified during the credentialing review. UHC's internal policy stated that the provider will have hospital admitting privileges in a facility listed for admission, but there was no hospital listed on the HSD table. In addition, several specialists such as general surgeons, plastic surgeons, thoracic surgeons and others who require hospital privileges to perform procedures were listed without hospital privileges or had privileges at non-contracted facilities. c. Specialists such as thoracic and cardiac surgeons are repeated and counted as duplicate FTEs in more than one county under different specialties. This is confusing since it can lead the reviewer to count an incorrect number of FTEs in the county. d. Providers inappropriate to the Medicare population, such pediatricians or specialty groups that only have pediatricians on their panel, were included in the network. 2. UHC also failed to notify or inform CMS of the termination of large provider groups and independent provider organizations. In response to this activity, UHC was issued a letter of concern by CMS in March 2006. UHC submitted a CAP which was approved by the regional office. Large provider networks continue to terminate their contracts with UHC, oftentimes resulting in high member liability and a large number of complaints from multiple sources, including AHCA. Some of these terminations include (but are not limited to): a. Morton Plant Mease (Pinellas County) affecting the following hospitals and IPAs, terminated 11/14/2006: 1) Morton Plant Mease Primary Care, Inc. 2) MPM Specialists , LLC 3) MPM Immediate Care Centers 4) St. Anthony Primary Care 5) St. Anthony's Specialists, LLC b. Florida Eye Associates terminated 10/2006 affected the following providers and surgical center: 1) 8 providers 2) Ophthalmology Center of Brevard/ASC of Brevard c. Medical Associates of Brevard, LLC notified 11/17/2006 terminated the agreement 01/19/2007 which affects the following providers in Brevard county: 1) Allergy and Asthma 2) Cardiology 3) Endocrinology 4) Family Medicine 5) Gastroenterology 6) Gynecology 7) Internal Medicine 8) Nephrology 9) Neurology 10) OB/GYN 11) Pulmonology/Critical Care Sleep Medicine 12) Surgery d. Tallahassee Memorial Hospital is still in contract negotiations with UHC for their Medicare product. e. West Florida Urology, P.L.C. in Pinellas county notified the state agency 10/25/2006 that the contract would terminate 12/31/2006. There are three providers affected. f. Florida Arrhythmia Consultants in Fort Lauderdale notified UHC on 12/12/2006 that they would terminate their contract in February, 2007. g. Lakeland Regional Medical Hospital (Polk County) notified UHC that their contract would terminate on 01/27/2007. h. Bartow Regional Medical Center notified UHC on January 1, 2007 that the their contract would terminate March 15, 2007.

Corrective Action Required:

UHC must implement the following: 1. Construct a process which will provide for the development of accurate HSD tables. CMS recommends including subject matter experts from various departments within the agency in this process. Suggeted participants/departments include but are not limited to: a. Clinical staff from UM and Quality Management b. MIS c. Provider Relations 2. Provide to CMS the policies, procedures, and guidelines for the following: a. Accessibility and Availability guidelines for urban and rural network development. b. Strategies for network development and payment when specialists are available but refuse to contract with the Medicare Advantage Organization. c. Guidelines for analyzing the population for geographical penetration of Medicare eligibles, provider panels, and high referral specialists related to provider and population needs. These should also be based on local practice patterns of the population. 3. Create policies and procedures for the development of narratives to explain issues that cannot be addressed on the HSD tables. These include but are not limited to: a. Out of area services based upon practice patterns of the population. b. How services will be made available when providers cannot be contracted within an approved service area. c. Services provided in rural areas outside of CMS access standards, but which are consistent with practice patterns of care. d. Service gaps within a county. 4. Create internal systems which allow for the review of information for accuracy and relevancy before it is sent to CMS. These systems should target but not be limited to, consistency between HSD tables, contract types, and contract signature pages. 5. Submit a sample of HSD tables 1, 2, and 4 which have been created utilizing this new process for building HSD tables to the regional office. These should be submitted to CMS by the end of April 2007. 6. Submit revised HSD 3 tables to the regional office by the end of April 2007. Address whether UHC will seek to obtain contracts for the gaps in the network and specify how enrollees will have access to those services. 7. Submit a quarterly Medicare Provider Network Analysis Reports to the regional office for all counties in the approved service area. The first report will be due to CMS at the end of June 2007. 8. A contingency action plan which addresses: a. Strategies of how the remaining contracted providers will provide inpatient and outpatient services in the network. b. Additional Contracting c. Payment for claims to contracting and non-contracting providers d. Member notification letter addressing how services are to be obtained e. Expected timeframes of completion of each task f. How the MAO will transition: (1) Members who have prior authorizations and scheduled outpatient procedures with providers who have terminated their contract with UHC. (2) Procedures for members who are currently hospitalized, currently under case management, or receiving specialized service such as dialysis recipients, chemotherapy recipients, and other identified chronically ill members whose providers have terminated their contract with UHC. The action plan should include short and long term goals of how these services will be obtained immediately as well as how UHC is working toward permanently correcting the network issues. Documentation supporting the implementation of the above processes must be submitted to the regional office by the end of April 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 08/15/2007
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Visit Start Date: 2/5/2007
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Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/08/2007
MCO Response Due Date: 05/15/2007

Requirement:

Required Contract Provisions: Privacy and ConfidentialityThe MAO's written contracts with first tier and downstream entities must contain the provisions that contracting providers agree to safeguard beneficiary privacy and confidentiality and ensure accuracy of beneficiary medical, health, and enrollment information and records.

Deficiencies:

Based on the review of WS CN1-Provider Contracts and staff interviews, Universal Health Care failed to provide contracts with Privacy and Confidentiality provisions consistent with Federal and State Laws which ensure that the medical, health, and enrollment information of the member is not compromised. Findings include: The contract with Harbor Behavioral Health did not contain CMS's required language. The contracts with the 13 Field Marketing Organization does not contain the required language in Chapter 11, Section 100.5.

Corrective Action Required:

UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 08/15/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/08/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS CN1-Provider Contracts and staff interviews, Universal Health Care failed to provide first tier and downstream contracts with the required CMS provisions. Findings include: Two contracts did not have the necessary language. The two contracts were the East Pasco Medical Center and the Harbor Behavioral Health Care Institute.

Corrective Action Required:

UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: CN06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 08/15/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:08/08/2007
MCO Response Due Date: 05/15/2007

Requirement:

Required Contract Provisions: Compliance with MAO's Policies and ProceduresThe 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:

Based on the review of WS CN1-Provider Contracts and staff interviews, Universal Health Care failed to provide contracts with language that complies with the MAO policies and procedures. Findings include: Two contracts did not have the necessary language. The two contracts were the East Pasco Medical Center and the Harbor Behavioral Health Care Institute.

Corrective Action Required:

UHC will review all contracts and templates and modify these if they do not contain CMS's required language. UHC must send contract amendments to the providers whose contracts lack the required language. UHC will submit an attestation to CMS which states that all UHC contracts have been updated to contain the required CMS language. This attestation is due to CMS by the end of May 2007.

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Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/22/2007
Element Accepted Date: 05/22/2007
Element Release Date: 08/15/2007
CAP Released Date: 04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Universal Health Plan does not meet the CMS 95% compliance standard because CMS reviewed 29 cases from a universe of 1765 and found 8 cases where the disenrollment notice was not sent timely. The cases identified were #1, #2, #4, #5, #7, #8, #9, #12 from worksheet DN01.

Corrective Action Required:

Universal Health Plan must follow their own disenrollment policy and procedure (DER-4) which states that a copy of the request for disenrollment and a disenrollment letter will be provided to the beneficiary within seven days of receipt of the request to disenroll. Universal Health Plan must provide training to the appropriate staff on this procedure and submit training material and attendance log to the Atlanta regional office. The training must be completed and the information sent to CMS by the end of May 2007.

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 05/22/2007
Element Release Date: 08/15/2007
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/26/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Universal Health Plan (UHC) does not meet the CMS 95% compliance standard because CMS reviewed 10 cases from a universe of 40 and found 9 cases that were incorrectly classifed as involuntary disenrollments. Based on the case file documentation, the CMS reveiwer was unable to determine if a refund was due.

Corrective Action Required:

Universal Health Plan must adhere to their policy and procedure DER 11 and ensure that members are refunded any premiums collected incorrectly. Universal Health Plan must review each sample case and provide evidence to CMS that a refund was sent to the member. This information must be sent to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: DN06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 05/22/2007
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Visit Start Date: 2/5/2007
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Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

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. Member notice is required prior to transmission of the disenrollment to CMS.

Deficiencies:

Universal Health Plan (UHC) does not meet the CMS 95% compliance standard because CMS reviewed 10 cases from a universe of 40 and found 9 cases that were incorrectly classifed as involuntary disenrollments. In all cases reviewed, the member moved out of the service area, but requested disenrollment either before or after the move. Therefore, these cases were actually voluntary disenrollments. The cases identified were case #1, #2, #3, #4, #5, #6, #7, #9, and #10. All cases were voluntary disenrollment. In the remaining case #8, the CMS reviewer was unable to determine if the disenrollment was voluntary or involuntary, because there was no documentation that indicated that the member requested disenrollment or no evidence of the documentation required for involuntary disenrollment.

Corrective Action Required:

Universal Health Plan (UHC) must conduct training to appropriate staff on their own internal policies and procedures (DER 8 and DER 14) which stipulates how to correctly identify voluntary and involuntary disenrollments. UHC must submit documentation to the regional office that details the nature of the training, including the materials used, the individuals conducting the training, and the individuals being trained. This information is due to CMS by the end of May 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 04 Atlanta
Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Review ID: 8117

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/22/2007
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CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

Enrollment Election Receipt - Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.

Deficiencies:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found 20 cases which failed to correctly ensure that the Enrollment Election Receipt-Dated Elections (and required documentation) are dated as of the date they are received by the MAO in a manner acceptable to CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that the Enrollment Election Receipt-Dated Elections are appropriately dated as of the date they are received by the MAO. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/22/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

No Data available and No Samples reviewed. Reviewed Policies and Procedures and determined that incorrect Enrollment Processes were identified. Specifically, language did not comply with timeframes specified by CMS.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 05/31/2007
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CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

Enrollment Acknowledgement (Timeliness) - The MAO notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS.

Deficiencies:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found 19 cases which failed to comply with the Enrollment Acknowledgement (Timeliness) element. Specifically, the MAO failed to notify the beneficiary of receipt of the enrollment election within timeframes specified by CMS.

Corrective Action Required:

UHC must modify it's current practices to make certain that it notifies the beneficiary of receipt of the enrollment election within timeframes specified by CMS. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER06
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 05/31/2007
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CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER1-Application and Enrollment, UHC does not meet the CMS 95% compliance standard because CMS audited 30 cases from a universe of 2745 and found that all 30 cases were non-compliant in the Enrollment Acknowledgement (Notice Content) element. Specifically, the written acknowledgement notice sent in response to the beneficiary's enrollment election did not meet CMS's requirements and failed to specify the correct effective date of enrollment.

Corrective Action Required:

UHC must revise its "Notice to Acknowledge Receipt of Completed Enrollment Election" and revise its current policies and procedures to ensure that the Enrollment Acknowledgement (Notice Content) element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER07
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
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Visit Start Date: 2/5/2007
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Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

No Data available and No Samples reviewed. Reviewed policies and procedures and determined that the language within the policies did not comply with timeframes specified by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure that this element is accurately represented. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
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CAP Released Date:04/22/2008

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Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe includes a list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER10
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/22/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER11
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/22/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER12
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/22/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER3 - CMS Enrollment Rejections, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 753 and found 30% or more of the cases selected for the sample were misclassified. Thus, the universe, as well as the sample selected, are deemed inadequate and cannot be used to determine findings for the elements associated with this universe.

Corrective Action Required:

UHC is required to revise its current policies and procedures to ensure compliance with the regulatory requirements of this element. Please include in these policies and procedures how the MAO will provide the CMS Regional Office with a universe listing for the requested sample for this element. Because 30% or more of the cases selected for the sample were misclassified, the universe was deemed inadequate and could not be used to determine findings for the elements associated with that universe. Therefore, please provide a revised universe list for WS ER3 - CMS Enrollment Rejections no later than April 30, 2007. This universe is the complete list of all Medicare beneficiary transactions that took place during the selected review period. In addition, UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by no later than April 30, 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: ER15
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date: 05/22/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date: 04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS ER6 - State and County Code Change - Monthly Activity Report, UHC does not meet the CMS 95% compliance standard because CMS audited 15 cases from a universe of 327 and found 6 cases where the MAO did not appropriately follow-up on changes in State and County Codes. Specifically, the MAO should review the CMS Monthly Transaction Reply/Monthly Activity Report listings and the Maintenance Records upon receipt and appropriately follow-up on any change in residence for its members reported to it by CMS.

Corrective Action Required:

UHC must revise its current policies and procedures to ensure compliance with this element. UHC must conduct training of appropriate staff on these policies and procedures and submit documentation to the regional office that details the nature of this training, including: the materials used in the training, the individuals conducting the training, and the individuals being trained. This information must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

Organization Determinations and Reconsiderations Not Categorized as Grievances - The MAO must correctly distinguish between organization determinations, reconsiderations, and grievances and process them through the appropriate mechanisms.

Deficiencies:

Based on the review of 10 samples in WS GV1-Grievances, UHC failed to correctly distinguish between reconsiderations and grievances and failed to process the cases within the required timeframes. Seven out of 10 cases (2,3,4,5,6,7,and 11) were misclassified which is over 30% of the sample. As a result, the reconsiderations and/or grievances were not processed according to regulatory statute. In addition, members from case numbers 8 and 9 had called their Congressional offices and the Atlanta regional office because they had not received resolution to their problems. These specific cases were CTM cases residing in HPMS and required MAO intervention.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's grievance process. 2. A training program for the appeal and grievance staff. Please provide to CMS the training manual, the individuals conducting the training and a list of the individuals trained. 3. An internal audit system designed to evaluate whether or not grievances are resolved within the timeframes specified in the organization's policies and procedures. 4. A process which requires the appeals/grievance committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: MR08
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/30/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

The MAO does not have adequate oversight or management over its marketing representatives. The MAO has contracted with 13 Field Marketing Organizations (FMOs). These FMOs employ 10,000 Agents to market Universal's Private-Fee-For-Service (PFFS) product. The service area for the PFFS is eight states. The MAO has 3 Marketing Directors for these eight states. The MAO does not have any written policies and procedures for the oversight of these FMOs and/or the brokers. In reviewing the MAO's inquiry log, there were a large number of marketing complaints, and no indication of any follow up or resolution. In reviewing the marketing representatives personnel files, the reviewer found that there was inadequate documentation of training, there was no performance data, and in three files there was no state license for the representatives.

Corrective Action Required:

The MAO must provide to CMS a written plan on how it will provide oversight of the 13 FMOs and its brokers. The plan must detail how the MAO will investigate and document marketing allegations and what actions the MAO will take. The MAO must provide training to all of its marketing representatives and this training must be documented in their personnel files. The MAO must investigate all marketing complaints on their inquiry log and provide CMS with their resolution. The MAO's management must provide assurances to CMS that they will provide oversight of their marketing staff to ensure future compliance in this area. The MAO must provide to CMS, for the next 12 months, a report of all marketing allegations they receive directly and through CTM with the results of their investigations and the resolutions. All requested documentation and the first report are due to the Regional Office by the end of April 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 05/31/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:04/27/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

The sample reviewed by CMS consisted of 30 paid claims. Two of these claims (#14 and #26) were not paid within the required 30 days and interest was not paid.

Corrective Action Required:

The MAO must pay the interest on the 2 identified claims were interest was not paid. Documentation of this action must be provided to CMS. The MAO must monitor their claims payment processes to ensure that all clean claims are processed within required time frames. The MAO must routinely perform internal audits to ensure future compliance in this area. An outline of the audit process and the results of the audits must be provided to CMS on a quaterly basis until further notice. The first report must be submitted to the Regional Office by April 30, 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of WS OP1-Standard Pre-Service Denials and staff interviews, UHC failed notify members in writing as expeditiously as the member's health condition requires. Findings include: Nine out of the ten denials reviewed were not issued in a timely manner. As a result, the denial process time did not meet regulatory requirements.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the effectiveness and adequacy of the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of 10 samples for WS OP1-Standard Pre-Service Denials, UHC failed to clearly state why services were being denied on the written CMS 100003-NDMC. All notices included a generic statement that the service was not medically necessary and failed to state the specific reason for the denial.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and statement of denial reasons for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP04
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of 10 samples for WS OP2-Requests for Expedited Determinations, UHC failed to notify the members in writing as expeditiously as the member's health requires. This requires UHC to notify the members of the expedited requests orally and in writing within 3 calendar days of the oral notification. Nine of ten cases reviewed in the sample did not send the decision notice within the required timeframe.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP09
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of 15 samples for WS OP3-Favorable Standard Pre-Service Organization Determinations, UHC failed to expedite approval and provide notification to the member within 14 calendar days after receiving the request. One case (#15) did not have the service approved in a timely manner. One case (#8) was an potential emergent care service and was misclassified. Findings include: 1. Case #15 was a surgical request for a total thyroidectomy which would include an acute inpatient stay. This service was not approved until 60 days after receipt. There was no documentation to support an approval extension. 2. Case #8 was a request for an inpatient stay for respiratory failure with pleural effusion. There was no documentation to support an approval extension. Also, respiratory failure is an emergent situation requiring critical measures and should not be placed in the pre-service authorization process. Emergent care including stabilization is covered as a necessary service and does not require pre-authorization.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for the MAO's pre-service authorization process. 2. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. 3. An internal audit system designed to evaluate whether or not pre-service authorizations are are completed within the required 14 calendar days. 4. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
Element Accepted Date: 07/20/2007
Element Release Date: 04/22/2008
CAP Released Date:04/22/2008

Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of a sample of 20 of WS PR1-Physician credentialing and recredentialing files and staff interviews, CMS determined Universal Health Care failed to consistently follow their documented policies and procedures for credentialing providers. UHC does not have a formal process for reviewing performance indicators which incorporates information from necessary reports such as utilization management, grievances, appeals, and quality of care issues. This process is a vital component of the recredentialing process. As a result, there were significant findings found in the Medical Advisory Committee (MAC) minutes that were not incorporated into the files of the providers during recredentialing. (Please refer to item 2a). The Quality Improvement Organization (QIO) and the Agency for Health Care Administration (AHCA) were present for the interviews and assisted in the review of the Medical Advisory minutes and samples. The reviewers found that fourteen of the credentialing files were incomplete. The findings include: 1. Five out of twenty providers did not have hospital privileges at a contracted hospital and these included an oncologist, a rheumatologist, and a urologist. 2. The Medical Advisory Committee (MAC) did not follow-up on quality issues identified in the files. UHC does not have a formal peer review group which is required by state law and outlined in their policy. Findings include: a. Quality nurse did not request entire medical records for review when quality of care issues were identified. The entire medical record is required to review the medical history and events that led to the incident. b. The peer review file is not consistently signed by the medical director. c. When quality of care issues are identified, there is no process to track the issues though the MAC meetings to the Board of Directors for action. The MAC committee minutes did not reflect the final severity levels as written in the UHC Quality Management Policy Q 4.4. In addition, there was no documentation to support the presence of a formal provider remediation process when high severity cases are identified. Examples of high risk medical issues identified during this review are: 1) Five members had sternal infections following cardiac arterial bypass surgery. The procedures were performed at the same hospital and three of the five had the same surgeon. 2) Four members had orthopedic surgery without recommended deep vein thrombosis prophylactic therapy. As a result, all five had blood clots post surgery. Two members were patients at the same hospital and three members were transferred to the same skilled nursing facility. 3) Two unexpected deaths were identified post urological surgery. One case involved both the urologist and the cardiologist who evaluated the member prior to surgery. The member died in the recovery room immediately after surgery apparently from a heart related condition.

Corrective Action Required:

UHC must develop and implement the following: 1. Updated policies and procedures to incorporate the functions of a formal peer review committee. 2. Submit to CMS minutes of the peer review committee to verify that the following are implemented: a. Tracking and trending of quality of care issues. b. Reporting of variances and violations to the appropriate agencies for investigation (i.e. wound infection frequency in surgical patients. c. Any remedial action taken for severe cases or cases which have a large scope. These issues should be forwarded to the Board of Directors for appropriate action. d. Organize and annotate minutes for both the MAC and peer review committees to provide detailed minutes for distribution to the Quality Management Steering Committee. e. Coordinate a formal provider remedial system for actions pertaining to quality of care cases. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR05
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
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Date Report Issued: 03/31/2007
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CAP Accepted Date:08/15/2007
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Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of a sample of 20 of WS PR1-Physician credentialing and recredentialing files and staff interviews, CMS determined Universal Health Care failed to consistently follow their documented policies and procedures for credentialing ancillary providers. Eight ancillary facilities did not have a completed application for provider selection.

Corrective Action Required:

UHC must develop and implement the following: 1. A corrective action plan which will outline the process that UHC will develop to ensure compliance with this element. 2. Adherence to the credentialing process as outlined in UHC's policy and procedures which require all ancillary providers to fill out an application for processing. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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

Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY03
Review Type: Focused
Review Status: Confirmed
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CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

Appropriate Utilization Management Program - If the MAO offers a coordinated care plan, or a local PPO that is licensed as an HMO, the MAO must employ a utilization management program that meets CMS requirements for each plan.

Deficiencies:

Based on the review of 15 samples for WS OP3-Favorable Pre-service Reconsiderations, UHC failed to follow written polices and procedures which reflect medical coverage rules, required practice guidelines and regulatory guidelines for emergent care. Findings include but are not limited to: 1. Case #15 was a surgical request for a total thyroidectomy which would include an acute inpatient stay. This service was not approved until 60 days after receipt. There was no documentation to support an approval extension. 2. Case #8 was a request for an inpatient stay for respiratory failure with pleural effusion. There was no documentation to support an approval extension. Also, respiratory failure is an emergent situation requiring critical measures and should not be placed in the pre-service authorization process. Emergent care including stabilization is covered as a necessary service and does not require pre-authorization. 3. Case #7 included claims for services delivered in an emergency department relating to a potential heart problem. The services included an echo cardiogram of the heart as well as a stress test. The claim was denied for out-of-network. In addition, the member stated she had gone to the emergency room because she believed she was having a "heart attack". This meets the criteria for emergent treatment which should not be denied. This case has been sent to the IRE for review.

Corrective Action Required:

UHC must develop and implement the following: 1. Implement the UM plan and program as outlined in the MAO's policies and procedures. 2. Develop a process for sharing relevant information with all departments, providers, and committees such as QA, UM, claims, appeals, grievances, and peer review. 3. Develop a committee structure which expands and incorporates members of the relevant departments into the QA, UM, and Peer Review committees. 4. Develop a process to evaluate the current UM reports and add new relevant reports to the Information System. 5. Audit the denial on retrospective review process of claims to identfy the denial of emergent/urgent care. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC01
Review Type: Focused
Review Status: Confirmed
MCO Response Received Date:05/22/2007
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Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of 10 samples for WS RC1-Favorable Claims Reconsiderations, UHC failed to provide documentation in eight of the cases (#1, 2, 3, 4, 5, 7, 8, and 10) which verified that the claim was paid within 30 calendar days. The checks were copied but the date sent to the provider was not provided, therefore the reveiwer was unable to determine if the provider was paid within the required time frames. In addition, one case (#1) did not send the notice to the member within the required timeframes.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for favorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office when requested. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RC02
Review Type: Focused
Review Status: Confirmed
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Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on review of 10 samples for WS RC2-Unfavorable Claims Reconsiderations, UHC failed to forward cases to the Independent Review Entity (IRE), and provide notification to the member within 60 days of receipt of the request. Two cases in the sample (#9 and #10) did not notify the member timely. One case (#1) in the sample was not sent to the IRE timely. In addition, there was insufficient documentation to verify when the claim was effectuated after UHC received the notification of the overturn.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

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Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on review of 10 samples for WS RC2-Unfavorable Claims Reconsiderations, UHC failed to have complete documentation that Maximus-CHDR (IRE) had been notified of the effectuation of the decision. Three cases in the sample (#2, 4, and 10) did not have adequate documentation that the notice has been sent to the IRE. One sample case (#7) was for emergent care and should not have gone through the pre-authorization or approval process. Findings include: 1. Case #7 included claims for services delivered in an emergency department relating to a potential heart problem. The services included an echo cardiogram of the heart as well as a stress test. The claim was denied for out-of-network. In addition, the member stated she had gone to the emergency room because she believed she was having a "heart attack". This meets the criteria for emergent treatment which should not be denied. This case has been sent to the IRE for review. 2. Cases 2, 4, and 10 contained a generic form which did not provide verification that the notice of the effectuation of the overturn had been sent to the IRE.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames for unfavorable claims effectuation. 2. An internal audit system designed to evaluate whether or not claims are effectuated within 30 calendar days from the date the CHDR notice is received reversing the organizational determination. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. 4. An assessment of the internal denial codes to ensure that emergent care is not reviewed for pre-authorization. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

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Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

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Review Type: Focused
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CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date: 05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review 10 samples for WS RP1-Favorable Standard Pre-Service Reconsiderations, UHC failed to notify the member timely of the adjudication of the reconsideration and/or authorize timely the overturn of the denial. Three cases (#3, 5, and 6) were not authorized within the timeframes for a favorable standard pre-service reconsideration.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the favorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not overturns are authorized within the timeframes in the organization's policies and procedures. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

CMS Medicare Managed Care Auditing Report

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Findings: NOT MET

Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Status: Confirmed
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CAP Accepted Date: 08/15/2007
Audit Closed Date: 04/22/2008
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MCO Response Due Date: 05/15/2007

Requirement:

Adverse Standard Pre-Service Reconsiderations (Timeliness) - If the MAO is unable to make a fully favorable decision on a standard pre-service reconsideration, it must forward the case to CMS' independent review entity as expeditiously as the member's health requires, but no later than 30 calendar days after receiving the reconsideration request (or an additional 14 calendar days if an extension is justified). The MAO must concurrently notify the member of this action.

Deficiencies:

Based on the review of 10 samples for WS RP2-Unfavorable Standard Pre-Service Reconsiderations, UHC failed to consistently send the denied reconsideration to the independent review entity (IRE) as expeditiously as the member's health requires but no later than 30 calendar days after receiving the reconsideration request. Two cases (#2 and 8) were not sent to the IRE within the timeframes for unfavorable pre-service reconsiderations.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the unfavorable standard pre-service reconsideration process. 2. An internal audit system designed to evaluate whether or not denied cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.

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

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Review ID: 8117

Region: 04 Atlanta

Contract Number / Name: H5404 UNIVERSAL HEALTH CARE, INC.

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Focused
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Visit Start Date: 2/5/2007
Exit Conference Date: 02/09/2007
Date Report Issued: 03/31/2007
Date Report Due: 03/26/2007
CAP Accepted Date:08/15/2007
Audit Closed Date: 04/22/2008
Element Projected Completion Date:05/31/2007
MCO Response Due Date: 05/15/2007

Requirement:

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

Deficiencies:

Based on the review of eight samples on WS RP3-Requests for Expedited Reconsiderations, UHC failed to consistently decide whether to expedite a reconsideration and failed to send the required notices to the members based on regulatory requirements. This includes notifying the member timely of the decision not to expedite and sending the case to the IRE. The findings include: 1. Case #2 was not sent to the IRE timely. 2. In cases #3, 4, and 8 the notice advising the member that the case would not be expedited was not sent timely.

Corrective Action Required:

UHC must develop and implement the following: 1. Policies and procedures which outline an internal system which evaluates the time frames and adequacy of the requests for expedited reconsideration process. 2. An internal audit system designed to evaluate whether or not cases are forwarded to the IRE within the required timeframes. 3. A process which requires the appeals committee to develop and submit periodic reports to the quality steering committee. These reports should be annotated in the committee minutes and submitted to the regional office upon request. Documentation supporting the implementation of the above processes must be submitted to CMS by the end of May 2007.