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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 05/15/2008
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CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed a sample of seven grievances processed by one of their delegated entities, out of a universe of seven. Of these seven grievances, it was not possible to determine whether the delegated entity had correctly categorized them as grievances because there was no documentation of the grievance in the file, and the CMS reviewers therefore didn't know what the members' complaints were.

Corrective Action Required:

Develop a process to ensure that your delegated entity that processes CareAdvantage grievances from its patients maintains a copy of the member's written grievance. Or, if the grievance is filed orally, that internal systems notes are maintained and available for review.

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed a sample of eight grievances processed by the health plan, out of a universe of eight. CMS also reviewed a sample of seven grievances processed by one of their delegated entities, out of a universe of seven. Of the grievances processed by the health plan, two of the eight grievances were not processed timely. In one case, the member was notified of the grievance resolution 33 days after receipt of the grievance at the health plan. In the other case, no resolution letter was ever sent to the member. Of the grievances processed by the delegated entity, four of the seven grievances were not processed timely. One case was resolved in 56 days, one in 54 days, one in 62 days, and for the fourth case there was no documentation of the grievance in the file so it was not possible to determine when the grievance was received. It was therefore not possible to determine whether the grievance was processed timely.

Corrective Action Required:

Develop a process to ensure that grievances, both those processed by the health plan as well as entities delegated for grievance processing, are processed timely and all documentation is kept in the file.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
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CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

Grievance Decision Notification (Notice Content) The MAO must inform the member of the disposition of the grievance. For quality of care issues, the MAO must also include a description of the member's right to file a written compliant with the QIO.

Deficiencies:

Of the eight grievances processed by the health plan, in two cases the notice content was incorrect, or no notice was sent to the member. In one case, the member had filed a quality of care complaint but the resolution notice did not include a description of the member's right to file a written compliant with the QIO. In the other case, no resolution letter was sent to the member. Of the seven grievances processed by the delegated entity, in three cases the notice content was incorrect. In one case, the member had filed a quality of care complaint but the resolution notice did not include a description of the member's right to file a written compliant with the QIO. In the other two cases, there was no documentation of the grievance in the file. Therefore, the CMS reviewers could not determine the nature of the grievance and therefore were unable to determine if the notice content was correct (i.e., if there should have been a description of the member's right to file a written compliant with the QIO).

Corrective Action Required:

Revise grievance resolution notices to ensure they meet CMS requirements and submit them for review through HPMS. Develop a process to ensure that all relevant documentation of the grievance is maintained in the file.

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/26/2008
Element Release Date: 05/15/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

Requirement:

Method of Grievance Decision Notification The MAO just respond to written grievances in writing. The MAO must respond to oral grievances either orally or in writing, unless the member requests a written response. The MAO must respond to all grievances related to quality of care in writing, regardless of how the grievance was submitted.

Deficiencies:

Of the eight grievances processed by the health plan, in one case no notification of the grievance resolution was provided to the member.

Corrective Action Required:

Develop a process to ensure that all members who file grievance receive a grievance resolution notice.

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 02/20/2008
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CAP Released Date: 09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date: 05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date: 04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed a sample of 30 denied claims processed by the health plan, out of a universe of 7,358. CMS also reviewed a sample of eight denied claims processed by one of their delegated entities, out of a universe of 112. Of the thirty denied claims processed by the health plan, for 23 of them it was not possible to determine whether they made correct claims determinations. For thirteen of these 23 claims, the health plan was unable to provide a copy of the denial notice to the member. The CMS reviewers therefore couldn't determine whether the decision to deny the claim was correct. In one case, the denied services were for room and board care, which is not a Medicare-covered benefit, but the denial reason in the notice to the member was "no authorization." If these services were going to be covered by Medicaid, then no Medicare denial notice should go to the member. If the services were not going to be covered by Medicaid, then the denial notice should have gone to the member but the denial reason should have been that the services were not a Medicare-covered benefit. In X cases, the description of the denied services is unclear, and therefore the CMS reviewers could not determine if the denial was appropriate since it wasn't clear what the denied services were. For example, the services in one denial notice were listed as "Enteral formulae, Category I, Semi Shield Healthcare Ctr". In another they were listed as "Central Services and Supplies." In two others they were listed as "12 Lead Ecg." Of the eight denied claims processed by one of the delegated entities, for one of them no denial notice was sent to the member so it was possible for the CMS reviewers to determine if the denial was appropriate. Note: The health plan's policies and procedures indicate that a notice is sent to the member for lack of eligibility, lack of authorization, or a non-covered benefit. This section should be revised to include other reasons for which a member has financial liability of a denied claim (e.g., not urgent or emergent, benefit exceeded annual limit, etc.)

Corrective Action Required:

The health plan must revise its policies and procedures to ensure that denial notices sent to members are maintained in the file and available for review. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. The health plan should conduct an internal audit each month of CareAdvantage denied claims. This audit should evaluate whether claims are being properly denied, processed timely, and whether proper denial language is included in the notices. Please submit a summary report once a quarter to the regional office of your monthly findings until further notified. The summary report should include the title of the auditor, the audit methodology, and the results of the audit. Upon receipt of the quarterly audit findings, if it is determined that HPSM is in compliance for three consecutive months, CMS will permit quarterly internal auditing. If, upon review of the quarterly audits, it is determined that HPSM has fallen out of compliance, HPSM must revert to the monthly audit schedule until the health plan can demonstrate three consecutive months of compliance.)

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Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 05/15/2008
Element Release Date: 05/15/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

Reasonable Reimbursement for Covered Services - The MAO must provide reasonable reimbursement 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, Renal dialysis services that Medicare members obtain while temporarily out of the service area, and Services for which coverage has been denied by the MAO but found to be services the member was entitled to upon appeal.

Deficiencies:

The health plan indicated in pre-site visit materials that the delegated entity responsible for mental health services pays some claims above the Medicare amount and other claims below the Medicare amounts.

Corrective Action Required:

Develop a process to ensure that delegated entities are aware of and are implementing Medicare payment amounts when processing non-contracted CareAdvantage claims.

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed 10 non-contracted provider paid claims from one of the two delegated entities selected for review, out of a universe of 125. Of these 10 claims, seven were not paid within 30 days of receipt.

Corrective Action Required:

HPSM must revise its oversight policies and procedures to ensure that claims processed by delegated entities are processed timely. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. HPSM must establish and maintain effective oversight controls over its delegated entities to ensure that CareAdvantage claims are processed according to CMS requirements for timeliness. HPMS must submit a policy and procedure that describes the types of oversight activities it will implement over its delegated entities. HPSM should conduct regularly scheduled audits of CareAdvantage clean claims processed by its delegated entities that have claims processing responsibilities for CareAdvantage claims. This audit should evaluate whether claims are being processed timely. Please submit a summary report once every six months to the regional office of your audit findings until further notice. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Element Release Date: 05/15/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/25/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed 30 non-contracted provider paid claims processed by the health plan. Of these, two clean claims were not paid within 30 days of receipt. Of these two claims paid late, no interest was paid on one of them. However, this claim was paid only one day late, and the required interest payment was $.03. CMS reviewed 10 non-contracted provider paid claims processed by one of the delegated entities. Of these 10 claims, seven were not paid within 30 days of receipt. Interest was not paid on these seven claims.

Corrective Action Required:

Develop a process to ensure that HPSM and its entities delegated for claims processing responsibilities of CareAdvantage claims pay interest at the correct amount on clean claims paid more than 30 days after receipt.

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Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 05/15/2008
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CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

Of the 60 paid and denied claims processed by the health plan that CMS reviewed, 16 of them were not processed within 60 days. Of the 18 paid and denied claims processed by one of the two delegated entities reviewed, eight of them were not processed within 60 days.

Corrective Action Required:

HPSM must revise its policies and procedures to ensure that non-contracted, non-clean claims are processed timely. Conduct training of appropriate staff on the revised P and P and submit documentation to the regional office that details the nature of this training, include the materials used in the training, the individuals conducting the training, and the individuals being trained. HPSM should conduct an internal audit on a regular basis of CareAdvantage non-contracted, non-clean claims. This audit should evaluate whether claims are being properly and timely developed and processed timely. Please submit a summary report once every six months to the regional office of your audit findings until further notice. The summary report should include the title of the auditor, the audit methodology, and the results of the audit.

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

Findings: NOT MET

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Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
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CAP Released Date: 09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date: 05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date: 06/30/2008
MCO Response Due Date: 02/25/2008

Requirement:

Claim Denials (Notice Content) - If an MAO denies payment, the written denial notice (CMS-10003-Notice of Denial of Payment (NDP)), or an RO-approved modification of the NDP, must be sent to the member. The written denial must clearly state the service denied and the denial reason.

Deficiencies:

Of the 30 denied claims processed by the health plan that CMS reviewed, for 13 of them the health plan was unable to provide a copy of the denial notice to the reviewers so it was not possible to determine if the denial notice clearly stated the service denied and the denial reason. For the remaining 17 claims in which a denial notice was provided to the reviewers, 11 did not clearly state what the denied service was. In addition to the examples described in OC02, some other unclear descriptions of denied services were, "chiropractic manipulative treatment (CMT)-Spinal, three to four regions," "Durable Medical Equipment, Miscell.," and "Critical Care, Each Add'l. 30 Minutes Loc Lmt 3, 5, b." Of the eight denied claims processed by one of the delegated entities reviewed by CMS, no denial letters were sent to members for any of the denied claims. Note: The health plan was using a denial notice that had been approved by the regional office. However, the CMS reviewers for the audit found that the notice should not have been approved as it varied from the mandated OMB-issued Notice of Denial of Payment. Although this is not a finding at CMS should not have approved the notice, it is recommended that the health plan submit a notice compliant with OMB's most recent version of the Notice of Denial of Payment so that it may be in compliance with this requirement going forward.

Corrective Action Required:

Develop a process to ensure that for both HPSM as well as delegated entities, copies of the denial notice for denied claims is maintained in the file and available for review. Revise the language describing the denied benefits in denial notices so that it is clearer and more meaningful to the member. Ensure that it does not contain medical or clinical jargon, and that the member will know what services are being denied (and hence what services they may appeal) based on the description in the letter. You may want to consult or use the ICE denial reason matrix, approved by CMS. For your delegated entities, develop a process to ensure that denial notices are sent to members when the member has financial liability for the claim.

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Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

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:

CMS reviewed 10 standard pre-service organization determinations from a universe of 21 and found that 7 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 misclassified cases were 5 retro requests, 1 duplicate request, and 1 was for a beneficiary in a skilled nursing facility (SNF). Delegated Entity-CMS reviewed 10 standard pre-service organization determinations from a universe of 15 and found that 7 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 misclassified cases were 5 duplicate requests, 1 requested item was rented over an extended period of time thus being paid in full, and 1 case was not a denial.

Corrective Action Required:

Health Plan of San Mateo must submit a new universe for WS-OP1 (Standard Pre-Service Denials) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP1 universe from the health plan's delegated entity.

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Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
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Review Type: Routine
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CAP Accepted Date:05/16/2008
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Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

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:

CMS reviewed 10 standard pre-service organization determinations from a universe of 21 and found that 7 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 misclassified cases were 5 retro requests, 1 duplicate request, and 1 was for a beneficiary in a skilled nursing facility (SNF). Delegated Entity-CMS reviewed 10 standard pre-service organization determinations from a universe of 15 and found that 7 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 7 misclassified cases were 5 duplicate requests, 1 requested item was rented over an extended period of time thus being paid in full, and 1 case was not a denial.

Corrective Action Required:

Health Plan of San Mateo must submit a new universe for WS-OP1 (Standard Pre-Service Denials) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP1 universe from the health plan's delegated entity.

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Date Report Generated: 9/30/2008

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

Findings: NOT MET

Review ID: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

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Review Type: Routine
Review Status: Confirmed
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Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

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, 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:

CMS reviewed 10 expedited organization determinations from a universe of 120 and found that 4 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 4 misclassified cases were 2 retro requests, 1 was an automatic authorization approval, and 1 case was unable to be located. Delegated Entity-CMS reviewed 10 expedited organization determinations from a universe of 10 and found that 6 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 6 misclassified cases were 5 requests without evidence of expedited status and 1 case could not be located.

Corrective Action Required:

Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.

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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/07/2008
Element Release Date: 03/07/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed 10 expedited organization determinations from a universe of 120 and found that 4 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 4 misclassified cases were 2 retro requests, 1 was an automatic authorization approval, and 1 case was unable to be located. Delegated Entity-CMS reviewed 10 expedited organization determinations from a universe of 10 and found that 6 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 6 misclassified cases were 5 requests without evidence of expedited status and 1 case could not be located.

Corrective Action Required:

Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.

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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/07/2008
Element Release Date: 03/07/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

Requirement:

Correctly Distinguishes Between Organization Determinations and Reconsiderations - The MAO must correctly distinguish between organization determinations and reconsiderations.

Deficiencies:

CMS reviewed 10 expedited organization determinations from a universe of 120 and found that 4 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 4 misclassified cases were 2 retro requests, 1 was an automatic authorization approval, and 1 case was unable to be located. Delegated Entity-CMS reviewed 10 expedited organization determinations from a universe of 10 and found that 6 were misclassified. When 30% or more of sampled cases are misclassified, CMS must consider any element based on the sample as NOT MET. The 6 misclassified cases were 5 requests without evidence of expedited status and 1 case could not be located.

Corrective Action Required:

Health Plan of San Mateo must submit a new universe for WS-OP2 (Requests for Expedited Organization Determinations) for the review period March 1, 2007 through August 31, 2007. See Enclosure IV from the CMS letter to Health Plan of San Mateo dated September 20, 2007 for a description of the universe and the format for submission. Delegated Entity-Because Health Plan of San Mateo terminated the delegated entity's contract on November 28, 2007 effective February 1, 2008, CMS will not request another WS-OP2 universe from the health plan's delegated entity.

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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP13
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 09/16/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

Requirement:

Detailed Notice of Non-Coverage of Provider Services (Notice Content) - The MAO must include in the Detailed Notice of Non-Coverage of Provider Services an explanation as to why the provider services are no longer reasonable or necessary, or are no longer covered; the applicable Medicare rule, instruction or policy including citations, and how the enrollee may obtain copies of such documents; and other facts or information relevant to the non-coverage decision.

Deficiencies:

CMS reviewed 3 cases in WS-OP5, QIO Review of Terminations of Services-SNF, HHA, or CORF Providers, from a universe of 3. The reviewer found all 3 Detailed Explanation of Non-Coverage (DENC) notices non-compliant. The health plan is not using the CMS required DENC. In all 3 cases the beneficiary received a health plan modified DENC.

Corrective Action Required:

Describe actions Health Plan of San Mateo is taking to ensure that it is using the CMS required DENC when a beneficiary appeals to the Quality Improvement Organization (QIO)for Terminations of Services with SNF, HHA, or CORF Providers. Corrective action must include internal health plan audits to ensure 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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: PR03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 09/17/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:08/31/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

CMS reviewed 20 credentialing files and found 14 files non-compliant with CMS requirements for the following reasons: (A) 1 file (podiatrist) was not initially credentialed or recredentialed by the health plan or any delegated entity; (B) 2 health plan files were missing the inclusion of quality indicators in the recredentialing process; (C) 2 health plan files were not reviewed for Medicare opt-out, (D) recredentialing in 4 cases was not completed timely. In two cases, Health Plan of San Mateo completed recredentialing on 4/26/07 but the previous initial credentialing had been completed 6/04/03. In a third case, Health Plan of San Mateo recredentialed the physician 10/05/05, yet the recredentialing was 4/03/02. In the fourth case Health Plan of San Mateo recredentialed the physician 10/26/06, yet the previous recredentialing was 10/02/02. (E) 2 files from delegated credentialing entity, SMCMH, were reviewed. The physician files did not meet any of the credentialing sample review elements indicating that SMCMH does not have a credentialing/recredentialing process that meets CMS requirements. (F) 4 files from delegated credentialing entity, SMMC, were not reviewed for Medicare opt-out; and (G) 1 file from delegated credentialing entity, SMMC, did not have a completed reappointment application.

Corrective Action Required:

Describe the actions Health Plan of San Mateo is taking to ensure it and its delegated credentialing entities credential/recredential contracted providers in accordance with CMS requirements. This must include policy and procedure revisions for the health plan as well as its delegated entities. The corrective action must include internal health plan audits as well delegation oversight audits of credentialing files to ensure 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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 03/17/2008
Element Release Date: 09/17/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:08/31/2008
MCO Response Due Date: 02/25/2008

Requirement:

Oversight of Delegated Entities with Chapter 5 Responsibilities If any of the activities or responsibilities for the above elements, QY 01- QY05 or QY08-QY09, in Chapter 5 are delegated to other parties, the MAO must oversee them per CMS standards.

Deficiencies:

CMS reviewed 11 delegated credentialing files and found 6 files non-compliant with CMS requirements for the following reasons: (A) 2 files from delegated credentialing entity, SMCMH, were reviewed. The physician files did not meet any of the credentialing sample review elements indicating that SMCMH does not have a credentialing/recredentialing process that meets CMS requirements. (B) 4 files from delegated credentialing entity, SMMC, were not reviewed for Medicare opt-out; and (C) 1 file from delegated credentialing entity, SMMC, did not have a completed reappointment application.

Corrective Action Required:

Describe the actions Health Plan of San Mateo is taking to ensure its delegated credentialing entities credential/recredential contracted providers in accordance with CMS requirements. This must include policy and procedure revisions for the delegated entities. The corrective action must include delegation oversight audits of credentialing files to ensure 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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: QY08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 02/25/2008
Element Release Date: 05/19/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:02/22/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

Health Plan of San Mateo/H5428 submitted a letter summarizing a planned CCIP. Full implementation is anticipated at the end of Quarter 1 2008. The summary did not contain the required level of detail needed in order to score/validate the program.

Corrective Action Required:

Document the CCIP on the required reporting template. In particular, provide clarity and detail in the following areas: defining the targeted population, providing specific criteria for inclusion, describing how the conditions are relevant to the plan's own population, monitoring elements, and quantitative outcome measures.

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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 05/15/2008
Element Release Date: 05/15/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

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:

CMS reviewed five favorable standard pre-service reconsiderations processed by the health plan, of which one was misclassified. Of the remaining four cases, three of the cases were not processed timely. In one case, although the health plan had internal notes indicating that authorization for the service was provided, there was no copy of the letter to the member. Without a copy of the notice, CMS reviewers are unable to determine if a letter was sent. In the other two cases, an appeal was filed telephonically by a DME provider. The approval letter was sent to the DME company, not the member. It was noted in the review of these cases that when the health plan received a request for an appeal by someone other than the member, there was no evidence that the health plan attempted to obtain an Appointment of Representative (AOR) form. In such cases, the health plan should notify the member and their supposed representative in writing that until the AOR is obtained, the health plan will not consider the appeal request. The health plan should document its efforts to obtain the signed AOR, but must not undertake a review until the appropriate documentation is received. If the health plan does not obtain the correct documentation by the end of the appeal period (including extensions), it must forward the case to Maximus CHDR with a request for dismissal. See section 60.1.1 in chapter 13 of the Medicare Managed Care Manual.

Corrective Action Required:

Develop a process to ensure that appeals are processed according to CMS requirements and that copies of all relevant notices are maintained in the files and available for review. Revise your policy and procedure to indicate that when appeals are filed by a party other than the member, HPSM makes a documented effort to obtain the appropriate documentation (Appointment of Representative, waiver of payment liability, durable Power of Attorney, etc.) Include in the revision the correct process to follow according to CMS requirements when the appropriate documentation is not obtained from the third party.

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: 8079

Region: 09 San Francisco

Contract Number / Name: H5428 SAN MATEO HEALTH COMMISSION

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: RP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:02/20/2008
Element Accepted Date: 05/15/2008
Element Release Date: 05/15/2008
CAP Released Date:09/18/2008

Visit Start Date: 11/27/2007
Exit Conference Date: 11/28/2007
Date Report Issued: 01/11/2008
Date Report Due: 01/12/2008
CAP Accepted Date:05/16/2008
Audit Closed Date: 09/18/2008
Element Projected Completion Date:04/20/2008
MCO Response Due Date: 02/25/2008

Requirement:

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

Deficiencies:

The health plan provided one case in this universe. It was an appeal filed by a contracted provider. The health plan made two attempts to obtain a signed AOR from the provider, but did not receive the AOR within 60 days of when the provider filed the appeal. Because the appropriate AOR documentation was not obtained within the appeal timeframe, the health plan should have forwarded the case to Maximus CHDR with a request for a dismissal. The health plan did not do this; instead, they closed the case.

Corrective Action Required:

Revise your policy and procedure to indicate the correct procedure to follow when you do not obtain AOR documentation (or other representative documentation) with the appeals timeframe. Train appropriate staff on this revised process and provide documentation of the training in the Corrective Action Plan.