CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: MR01

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date:09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 05/07/2008

CAP Released Date:07/08/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date:10/30/2007

Audit Closed Date: 07/08/2008

Element Projected Completion Date:11/01/2007

MCO Response Due Date: 09/13/2007

Requirement:

Appropriate Submission and Distribution of Marketing Materials - For "non-model" documents and for "model" documents that the M+CO modifies: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 45 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 45 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.For "model" documents that the M+CO uses without modification: The M+CO submits Medicare marketing materials in a format and using acceptable terminology as directed by CMS at least 10 days before intended distribution. The M+CO does not distribute such materials until it receives notice from CMS that CMS has approved the materials, or until 10 days have expired and the M+CO has not received notice from CMS that the materials have not been approved.

Deficiencies:

Part D Audit Finding:CMS requested Part D notice templates that Humana uses in the following situations: - notification of Part D grievance disposition (i.e., a notice consistent with CMS-issued model notice, Notice of Plan's Decision Regarding a Grievance), - enrollee notification when a Part D request is forwarded to the IRE (i.e., a notice consistent with the CMS-issued model notice, Notice of Case Status), - enrollee notification that a request for an expedited coverage determination is denied (i.e., a notice consistent with CMS-issued model notice, Notice of Right to an Expedited Grievance), and - when requesting additional information from the enrollee¿s prescribing physician (i.e., a notice consistent with the CMS-issued model notice, Request for Additional Information). These notice templates did not display the contract/MRT number in the lower left-hand corner in accordance with CMS Marketing guidelines. Additionally, CMS requested Humana¿s standard Part D notice templates (i.e. Medicare Prescription Drug Coverage and Your Rights, and Notice of Denial of Medicare Prescription Drug Coverage) and the notices supplied by Humana did not display the OMB control number in the upper right-hand corner in accordance with CMS Marketing guidelines.

Corrective Action Required:

Humana must use Part D notice templates that have been CMS approved and display the contract/MRT number with the approval date in the lower left-hand corner for the following model notices: - Notice of Plan¿s Decision Regarding a Grievance, - Notice of Case Status, - Notice of Right to an Expedited Grievance, and - Request for Additional Information. Humana must use Part D standard notices that display the OMB control number in the upper right-hand corner for the following standard notices: - Medicare Prescription Drug Coverage and Your Rights, and - Notice of Denial of Medicare Prescription Drug Coverage.

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
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Element Projected Completion Date: 11/01/2007
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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
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Element Projected Completion Date: 11/01/2007
MCO Response Due Date: 09/13/2007

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 03/12/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 12/15/2007
MCO Response Due Date: 09/13/2007

Requirement:

Marketing Materials: Enrollment and Understanding of Plan Rules - The M+CO establishes and maintains a marketing system for confirming that enrolled members understand that they are enrolled in the M+C plan, and understand the rules applicable under the plan.

Deficiencies:

Both Humana and CMS continue to receive complaints from enrolled beneficiaries which demonstrate that they did not understand their election. Humana's present verification process is only used on agent assisted enrollments, and Humana reports in their present Corrective Action Plan that many times the verification process is not completed. The verification process is done while the agent in still in the home or with the enrollee. CMS believes this process should be completed after the representative leaves the enrollee. Many complaints received by CMS are from beneficiaries who believe that they were enrolling in a prescription drug plan, but then find themselves in an MA-PD plan. This demonstrates that enrollees are not fully educated on understanding their enrollment choice. Humana should implement a better process to educate the beneficiary on the choices they made.

Corrective Action Required:

Humana should implement a more rigorus verification call process separate from the sales process. Humana should demonstrate that it has oversight over the verification process and therefore, should submit to CMS verification call audit results. Humana should also implement processes to better educate all enrollees about their plan choice, such as new member orientation sessions, outbound calls to enrollees to educate the member on how to use their plan, etc.

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 03/12/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
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MCO Response Due Date: 09/13/2007

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 03/12/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
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MCO Response Due Date: 09/13/2007

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date:07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date:10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date:11/01/2007
MCO Response Due Date: 09/13/2007

Requirement:

No Engagement in Activities which Mislead, Confuse or Misrepresent M+CO - The M+CO does not engage in activities which materially mislead, confuse, or misrepresent the M+CO and: ·May not claim recommendation or endorsement by CMS or that CMS recommends that beneficiaries enroll in the plan; ·May not 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; ·May not use providers or provider groups to distribute printed information comparing benefits of different health plans, unless the materials have the concurrence of all M+CO's involved and unless the materials have received prior approval from CMS; ·May not accept plan applications in provider offices or other places where health care is delivered; ·May not employ M+C 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); ·May not offer gifts or payment as an inducement to enroll in the organization; ·May not engage in any discriminatory marketing practice, such as attempting to enroll individuals from higher income areas, without a similar effort in lower income areas; and ·May not conduct door-to -door solicitation of Medicare beneficiaries.

Deficiencies:

1.) The CMS and Humana continue to receive numerous complaints about Humana's sales and marketing practices during the seven months prior to the review. -Humana has implemented a detailed process to investigate each and every complaint received and to discipline agents and brokers who are found to be out of compliance, however, recently Humana reported that they have not been able to keep up with the number of complaints received. Humana states that the reason for the delay in entering all complaints into the investigaton process is due to moving the process to national oversight rather than regional. 2.)Many of the complaints that Humana has received indicate that an agent gave incorrect information to a beneficiary. CMS then questions the effectiveness of the training of these agents and the oversight that Humana has over these agents in the field. 3) One agent (refer to sample 1) was dismissed for a major Section A allegation, however appointment with the state still shows active. Humana policies and procedures indicate that when an agent/broker is dismissed for cause, that is reported to the appropriate state Department of Insurance. CMS recommends that Humana have a process in place to communicate such incidents to the appropriate state promply. 4.) Humana does not have a process to quickly be able to communicate to all of their agents and brokers when it is necessary to dispense information concerning CMS or Humana policy changes, etc. Indeed, the plan admits that many times their own agents do not respond to them on requests for details of an enrollment. 5.) For many of the agent allegations that Humana received and reported to CMS, there is no proof of a verification call being completed. Yet Humana's policies and procedures state that an agent is required to do a verification while still in the home. The policy and procedure also says that Humana will make three attempts to contact a beneficiary after a sale and then send a letter. But many of the allegations in the report show no verification of any kind.

Corrective Action Required:

Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly reports to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, but especially private-fee-for-service (PFFS) plans where the majority of the complaints are centered, (3) better oversee agent/broker licenses and appointments for the states where sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.

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Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: MR08
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
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Deficiencies:

1.) The CMS and Humana continue to receive numerous complaints about Humana's sales and marketing practices during the seven months prior to the review. -Humana has implemented a detailed process to investigate each and every complaint received and to discipline agents and brokers who are found to be out of compliance, however, recently Humana reported that they have not been able to keep up with the number of complaints received. Humana states that the reason for the delay in entering all complaints into the investigaton process is due to moving the process to national oversight rather than regional. 2.)Many of the complaints that Humana has received indicate that an agent gave incorrect information to a beneficiary. CMS then questions the effectiveness of the training of these agents and the oversight that Humana has over these agents in the field. 3) One agent (refer to sample 1) was dismissed for a major Section A allegation, however appointment with the state still shows active. Humana policies and procedures indicate that when an agent/broker is dismissed for cause, that is reported to the appropriate state Department of Insurance. CMS recommends that Humana have a process in place to communicate such incidents to the appropriate state promply. 4.) Humana does not have a process to quickly be able to communicate to all of their agents and brokers when it is necessary to dispense information concerning CMS or Humana policy changes, etc. Indeed, the plan admits that many times their own agents do not respond to them on requests for details of an enrollment. 5.) For many of the agent allegations that Humana received and reported to CMS, there is no proof of a verification call being completed. Yet Humana's policies and procedures state that an agent is required to do a verification while still in the home. The policy and procedure also says that Humana will make three attempts to contact a beneficiary after a sale and then send a letter. But many of the allegations in the report show no verification of any kind.

Corrective Action Required:

Since the July 2005 audit, CMS has been monitoring Humana on previous Corrective Actions for marketing activities that mislead, confuse or misrepresent the plan. Humana has been providing a bi-weekly reports to the lead region. This report demonstrates the investigation of each allegation that Humana receives whenever an agent or broker is indicated as out of compliance. The most recent report shows 350 allegations reported in the reporting period of June 8 through June 22, 2007. Humana reports that due to transitioning the process into their national headquarters, the plan fell behind in getting the initial investigation accomplished in order to be able to have enough information to get the allegation placed into the investigation process. Therefore, the CMS will require some new corrective actions, and will monitor the effectiveness of all corrective actions during the next two months. Humana should implement processes to (1)improve the entering of each allegation into the bi-weekly sales allegation report to the CMS in a more timely fashion (2) better educate agents/brokers and their managers on all aspects of Medicare products, but especially private-fee-for-service (PFFS) plans where the majority of the complaints are centered, (3) better oversee agent/broker licenses and appointments for the states where sell Humana Medicare products, (4) better track rapid disenrollments and cancellations with a process for personnel action for those agents with the largest offenses, (5) improve communication processes with all of your agents/brokers directly, especially delegated agents and (6)improve the process of ensuring verification calls are competed in a timely fashion with the recommendation that they be completed after the agent/broker has departed from the sale. The CMS may take further action based on complaints received during this time.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 07/08/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 12/31/2007
MCO Response Due Date: 09/13/2007

Requirement:

Correct Claim Determinations - The M+CO 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 M+CO, 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:

Humana does not meet the compliance standard for this element. The CMS reviewed 30 cases from a universe of 14,458 and found that 7 cases did not demonstrate compliance. All cases in this sample were processed by Humana. The denial was not appropriate for cases 1, 5, 10,16, 23, 25 and 26.

Corrective Action Required:

Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 07/08/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 12/31/2007
MCO Response Due Date: 09/13/2007

Requirement:

Correct Claim Determinations - The M+CO 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 M+CO, 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:

Humana does not meet the compliance standard for this element. The CMS reviewed 30 cases from a universe of 14,458 and found that 7 cases did not demonstrate compliance. All cases in this sample were processed by Humana. The denial was not appropriate for cases 1, 5, 10,16, 23, 25 and 26.

Corrective Action Required:

Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 07/08/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 12/31/2007
MCO Response Due Date: 09/13/2007

Requirement:

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Deficiencies:

Humana does not meet the compliance standard for this element. The CMS reviewed 30 cases from a universe of 14,458 and found that 7 cases did not demonstrate compliance. All cases in this sample were processed by Humana. The denial was not appropriate for cases 1, 5, 10,16, 23, 25 and 26.

Corrective Action Required:

Humana must provide documentation to enable CMS to determine that the necessary steps are taken to ensure that all claim determinations are appropriate.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: OC03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/22/2007
Element Release Date: 02/26/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 11/01/2007
MCO Response Due Date: 09/13/2007

Requirement:

Timely Payment of Non-Contracting Provider Clean Claims - The M+CO must pay 95 percent of "clean" claims from all providers within 30 calendar days of receipt.

Deficiencies:

Humana does not meet the CMS 95% compliance standard for processing clean claims within 30 days of receipt. The CMS reviewed 30 claims that were processed by their delegated entity, Palmetto Government Benefits Administrator (PGBA)from a universe of 2,523,726 and found 6 cases that were not processed timely. These were 5,16,19,23, 25 and 27.

Corrective Action Required:

Humana must provide documentation to support what steps are being taken to ensure that this CMS requirement is met. Since these claims were processed by PGBA, you should provide documentation of how you will maintain oversight of this delegated entity.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: OC03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/22/2007

Element Release Date: 02/26/2008

CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/30/2007

Audit Closed Date: 07/08/2008

Element Projected Completion Date: 11/01/2007

MCO Response Due Date: 09/13/2007

Requirement:

Timely Payment of Non-Contracting Provider Clean Claims - The M+CO must pay 95 percent of "clean" claims from all providers within 30 calendar days of receipt.

Deficiencies:

Humana does not meet the CMS 95% compliance standard for processing clean claims within 30 days of receipt. The CMS reviewed 30 claims that were processed by their delegated entity, Palmetto Government Benefits Administrator (PGBA)from a universe of 2,523,726 and found 6 cases that were not processed timely. These were 5,16,19,23, 25 and 27.

Corrective Action Required:

Humana must provide documentation to support what steps are being taken to ensure that this CMS requirement is met. Since these claims were processed by PGBA, you should provide documentation of how you will maintain oversight of this delegated entity.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: RP03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 05/07/2008

CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/30/2007

Audit Closed Date: 07/08/2008

Element Projected Completion Date: 09/12/2007

MCO Response Due Date: 09/13/2007

Requirement:

Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO 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, or pay the claim following the plan's normal claims processing procedures.

Deficiencies:

Two out of three cases reviewed were not authorized or paid timely.

Corrective Action Required:

Plan must implement a process to ensure that Third Part Standard Pre-Service Reconsiderations Reversals are effected timely.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide

Auditing Element: RP03

Review Type: Routine

Review Status: Confirmed

MCO Response Received Date: 09/14/2007

Element Accepted Date: 10/02/2007

Element Release Date: 05/07/2008

CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007

Exit Conference Date: 06/15/2007

Date Report Issued: 07/30/2007

Date Report Due: 07/30/2007

CAP Accepted Date: 10/30/2007

Audit Closed Date: 07/08/2008

Element Projected Completion Date: 09/12/2007

MCO Response Due Date: 09/13/2007

Requirement:

Effectuation of Third Party Standard Pre-Service Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize the service within 72 hours from the date it receives the notice reversing the determination, provide the service as quickly as the member's health requires (but no later than 14 calendar days from that date), or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO 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, or pay the claim following the plan's normal claims processing procedures.

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CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP03
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
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CAP Accepted Date: 10/30/2007
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Element Projected Completion Date: 09/12/2007
MCO Response Due Date: 09/13/2007

Requirement:

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Deficiencies:

Two out of three cases reviewed were not authorized or paid timely.

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Plan must implement a process to ensure that Third Part Standard Pre-Service Reconsiderations Reversals are effected timely.

CMS Medicare Managed Care Auditing Report

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Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

Requirement:

Requests for Expedited Reconsiderations (Timeliness) - The M+CO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the M+CO 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 M+CO 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 M+CO 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), or pay the claim following the plan's normal claims processing procedures. If the M+CO 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 M+CO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the M+CO 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 M+CO must submit the file to CMS's independent review entity within 24 hours. The M+CO must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.

Deficiencies:

Of two cases reviewed, one was not sent timely notice and therefore did not meet compliance.

Corrective Action Required:

Humana must demonstrate that it authorizes and communicates on requests for expedited reconsiderations. Humana should provide a formal policy and procedure and proof of educated staff on the process to authorize and communicate on requests for expedited reconsiderations.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

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Requests for Expedited Reconsiderations (Timeliness) - The M+CO must promptly decide whether to expedite a reconsideration based on regulatory requirements. If the M+CO 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 M+CO 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 M+CO 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), or pay the claim following the plan's normal claims processing procedures. If the M+CO 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 M+CO affirms, in whole or in part, its adverse expedited organization determination, it must forward the case to CMS's independent review entity as expeditiously as the member's health requires, but not later than 24 hours after the decision. If the M+CO 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 M+CO must submit the file to CMS's independent review entity within 24 hours. The M+CO must concurrently notify the member in writing that it has forwarded the case file to CMS's independent review entity.

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Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP05
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
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Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

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Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1804 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

Requirement:

Effectuation of Third Party Expedited Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination, or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO 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, or pay the claim following the plan's normal claims processing procedures.

Deficiencies:

Effectuation of Third Party Expedited Reconsideration Reversals is not met. Only two cases were sampled and Humana could not give documentation indicated that the IRE was notified on one of the cases.

Corrective Action Required:

Plan must demonstrate that when a determination is reveresed in whole or in part by the independent review entity, that Humana authorizes and provides the service under dispute as expeditiously as the member's health rquired but no later than 72 hours after the date it recieves notice reversig the determination. Then Humana must inform the IRE that that Humana has effectuated the decision. Humana should provide proof of the correct implementation of these processes and evidence that the staff has been education to handle these cases correctly.

CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H5657 HUMANA INSURANCE COMPANY OF NEW YORK

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
Date Report Due: 07/30/2007
CAP Accepted Date: 10/30/2007
Audit Closed Date: 07/08/2008
Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

Requirement:

Effectuation of Third Party Expedited Reconsideration Reversals - If the M+CO's determination is reversed in whole or in part by the independent review entity, the M+CO must authorize or provide the service under dispute as expeditiously as the member's health requires but no later than 72 hours after the date it receives notice reversing the determination, or pay the claim following the plan's normal claims processing procedures. The M+CO must also inform the independent review entity that the organization has effectuated the decision. If the determination of the M+CO is reversed in whole or in part by an ALJ, or at a higher level of appeal, the M+CO 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, or pay the claim following the plan's normal claims processing procedures.

Deficiencies:

Effectuation of Third Party Expedited Reconsideration Reversals is not met. Only two cases were sampled and Humana could not give documentation indicated that the IRE was notified on one of the cases.

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CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

MRT Number: M0006, Contract Number: All, Category: All, Element: All, Finding:NOT MET, Reviewer:All

Findings: NOT MET

Review ID: 8657

Region: 07 Kansas City

MRT Number / Name: M0006 MRT Humana

Contract Number / Name: H1407 HUMANA INSURANCE COMPANY

Auditing Guide Version: PFFS Monitoring Guide
Auditing Element: RP07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 09/14/2007
Element Accepted Date: 10/02/2007
Element Release Date: 05/07/2008
CAP Released Date: 07/08/2008

Visit Start Date: 06/11/2007
Exit Conference Date: 06/15/2007
Date Report Issued: 07/30/2007
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Element Projected Completion Date: 01/01/2008
MCO Response Due Date: 09/13/2007

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