CMS Medicare Managed Care Auditing Report

Auditing Review Results (Initial Report)-Public Website Version

Date Report Generated: 9/30/2008

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

Findings: NOT MET
Region: 09 San Francisco
Contract Number / Name: H0502 CONTRA COSTA HEALTH PLAN

Review ID: 8557

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: GV01
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 06/25/2007
Element Accepted Date: 07/24/2007
Element Release Date: 08/23/2007
CAP Released Date: 11/07/2007

Visit Start Date: 9/5/2006
Exit Conference Date: 09/07/2006
Date Report Issued: 06/05/2007
Date Report Due: 10/22/2006
CAP Accepted Date: 11/07/2007
Audit Closed Date: 11/07/2007
Element Projected Completion Date: 06/25/2007
MCO Response Due Date: 07/20/2007

Requirement:

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

Deficiencies:

One case from 6 grievances sampled was processed incorrectly. The member submitted a written request about being charged $136.00 for a dental office visit when the copayment should have been $10.00. The member's request should have been classified as an appeals instead of a grievance because the member disagrees with the copayment for dental services.

Corrective Action Required:

Contra Costa Health Plan must ensure it identifies and processes appeals and grievances appropriately.

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Review ID: 8557

Region: 09 San Francisco

Contract Number / Name: H0502 CONTRA COSTA HEALTH PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC04
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 06/25/2007
Element Accepted Date: 09/13/2007
Element Release Date: 09/13/2007
CAP Released Date: 11/07/2007

Visit Start Date: 9/5/2006
Exit Conference Date: 09/07/2006
Date Report Issued: 06/05/2007
Date Report Due: 10/22/2006
CAP Accepted Date: 11/07/2007
Audit Closed Date: 11/07/2007
Element Projected Completion Date: 12/13/2006
MCO Response Due Date: 07/20/2007

Requirement:

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

Deficiencies:

Contra Costa Health Plan does not meet CMS's 95% compliance standard. One clean non-contracting provider claim was paid within 40 days of receipt. CMS requirements require interest be paid to the provider for all clean non-contracting provider claims not paid within 30 days of receipt.

Corrective Action Required:

Contra Costa must update their policy and procedures to ensure interest is paid for clean non-contracting provider claims paid after 30 days of receipt. In addition, it appears the interest payment is a manual process, therefore, we require Contra Costa to conduct training to staff on its policy and procedure and to inform us of the date the training is completed.

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Review ID: 8557

Region: 09 San Francisco

Contract Number / Name: H0502 CONTRA COSTA HEALTH PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC06
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date:06/25/2007
Element Accepted Date: 11/07/2007
Element Release Date: 11/07/2007
CAP Released Date:11/07/2007

Visit Start Date: 9/5/2006
Exit Conference Date: 09/07/2006
Date Report Issued: 06/05/2007
Date Report Due: 10/22/2006
CAP Accepted Date:11/07/2007
Audit Closed Date: 11/07/2007
Element Projected Completion Date:
MCO Response Due Date: 07/20/2007

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:

Contra Costa does not meet CMS's 95% compliance standard. Of 30 provider claim denials randomly selected from a universe of 185 claims, 4 claims were misclassified. Three of the four misclassified claims were for Medicare FFS members receiving denials for CCHP's Medi-Cal program. One misclassified claim was for a contracted provider claim. Of the remaining 26 claims, Contra Costa did not send the CMS standard Notice of Payment Denial notice.

Corrective Action Required:

Contra Costa Health Plan must revise the Notice of Payment Denial to exclude additional language not found on the CMS standard notice. September 2005, CMS Regional Office received clarification from Central Office that the standardized notice must not be changed from the model except in limited circumstances. As a result of this clarification, we are requiring the health plan to revise this notice and if Medi-Cal appeal rights apply for a denied service, Contra Costa must issue a separate notice.

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Findings: NOT MET

Review ID: 8557

Region: 09 San Francisco

Contract Number / Name: H0502 CONTRA COSTA HEALTH PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OC07
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 06/25/2007
Element Accepted Date: 09/20/2007
Element Release Date: 09/20/2007
CAP Released Date: 11/07/2007

Visit Start Date: 9/5/2006
Exit Conference Date: 09/07/2006
Date Report Issued: 06/05/2007
Date Report Due: 10/22/2006
CAP Accepted Date: 11/07/2007
Audit Closed Date: 11/07/2007
Element Projected Completion Date: 06/25/2007
MCO Response Due Date: 07/20/2007

Requirement:

Medicare Secondary Payer (Claims) - The MAO must have procedures to identify payers that are primary to Medicare, determine the amounts payable, and coordinate benefits.

Deficiencies:

Contra Costa has Medicare Secondary Procedures for Medicare claims received with an Explanation of Medicare Benefit indicating Medicare Secondary Payer. Please describe the process Contra Costa uses to identify Medicare Secondary Payer situations for contracted providers.

Corrective Action Required:

Develop and submit Contra Costa Health Plan's policy and procedure for identifying Medicare Secondary Payer situations when Senior Health Plan members obtain medical services from contracted providers.

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Findings: NOT MET

Review ID: 8557

Region: 09 San Francisco

Contract Number / Name: H0502 CONTRA COSTA HEALTH PLAN

Auditing Guide Version: MA Audit Review Guide, Version 4
Auditing Element: OP02
Review Type: Routine
Review Status: Confirmed
MCO Response Received Date: 06/25/2007
Element Accepted Date: 08/27/2007
Element Release Date: 08/27/2007
CAP Released Date: 11/07/2007

Visit Start Date: 9/5/2006
Exit Conference Date: 09/07/2006
Date Report Issued: 06/05/2007
Date Report Due: 10/22/2006
CAP Accepted Date: 11/07/2007
Audit Closed Date: 11/07/2007
Element Projected Completion Date: 09/12/2006
MCO Response Due Date: 07/20/2007

Requirement:

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

Deficiencies:

Based on a sample of 7 denied standard pre-service organization determinations from a universe of 7, the reviewer found 1 non-compliant denial notice. The health plan used a commercial denial notice instead of the CMS required Notice of Denial of Medical Coverage (NDMC).

Corrective Action Required:

Describe the actions Contra Costa Health Plan is taking to assure that it issues the CMS required NDMC.