DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard
Baltimore, Maryland 21244-1850

PROGRAM COMPLIANCE AND OVERSIGHT GROUP

December 14, 2012

VIA:
EMAIL (mtsattaur@pupcorp.com)
AND FACSIMILE (407-226-1951)

Imtiaz Sattaur
Chief Executive Officer
Physician's United Plan, Inc.
9102 Southpark Center Loop
Suite 200
Orlando, FL 32819
Phone: 407-718-2087

Re: Notice of Imposition of Civil Money Penalty for Medicare Advantage - Prescription Drug Plan Contract Number: H5696

Dear Mr. Sattaur:

Pursuant to 42 C.F.R. § 422.752(c)(1), the Centers for Medicare & Medicaid Services (CMS) is providing notice to Physician's United Plan, Inc. (PUP), a company owned by IDJB Investments, LLC (IDJB), that CMS has made a determination to impose a civil money penalty (CMP) in the amount of $50,000 for Medicare Advantage - Prescription Drug (MA-PD) Plan Contract Number: H5696.

CMS has determined that PUP failed to provide its enrollees with services and benefits in accordance with CMS requirements. An MA-PD sponsor's central mission is to provide Medicare enrollees with medical services and prescription drug benefits within a framework of Medicare requirements that provide enrollees with a number of protections.

Summary of Noncompliance

CMS conducted an audit at PUP's Orlando, Florida offices from July 23 through July 27, 2012. During the audit, CMS conducted reviews of PUP's operational areas to determine if PUP is following CMS rules, regulations and guidelines. After conducting an extensive review, CMS auditors concluded that PUP failed to comply with CMS requirements governing the processing of Part C grievances, organization determinations, and appeals set forth in 42 C.F.R. Part 422,

Subpart M. Violations in these areas can result in enrollees experiencing delays or denials in receiving covered services and increased out-of-pocket costs. These violations directly adversely affected (or had the substantial likelihood of adversely affecting) PUP's enrollees.

Part C Grievance, Organization Determination, and Appeal Relevant Requirements

Medicare enrollees have the right to contact their plan sponsor to express general dissatisfaction with the operations, activities, or behavior of the plan sponsor or to make a specific complaint about the denial of coverage for services to which the enrollee believes he or she is entitled. Sponsors are required to classify general complaints about services, benefits, or the sponsor's operations or activities as grievances. 42 C.F.R. § 422.564 (a) and (b). Sponsors are required to classify complaints about coverage for services as a request for an organization determination. 42 C.F.R. §§ 422.564 (b) and 422.566(b). Sponsors are also required to determine whether a grievance qualifies as a quality of care complaint. When an enrollee makes a quality of care complaint, sponsors must address the nature of the complaint and provide a written response with information on the enrollee's right to file a complaint with a quality improvement organization (QIO). 42 C.F.R. § 422.564 (c), (d)(3)(iii). It is critical for a sponsor to properly classify each complaint as a grievance, quality of care complaint, and/or an organization determination. Failure to properly classify an organization determination request denies an enrollee their due process and appeal rights and may delay an enrollee's access to medically necessary or life-sustaining services.

The enrollee, the enrollee's representative, or the enrollee's treating physician or prescriber may make a request for an organization determination. 42 C.F.R. § 422.566(c). The first level review is the organization determination, which is conducted by the plan sponsor, and the point at which beneficiaries or their physicians submit justification for the service or benefit 42 C.F.R. § 422.566. If the organization determination is adverse (not in favor of the enrollee), the enrollee has the right to file an appeal. 42 C.F.R. § 422.580. There are different decision making timeframes for the review of organization determinations and appeals. 42 C.F.R. §§ 422.568, 422.572 and 422.590.

Deficiencies Related to Grievances, Organization Determinations, and Appeals

CMS identified serious violations of Part C requirements in PUP's grievances, organization determinations, and appeals operations. PUP's violations include:

- Failure to process expedited organization determinations under the required 72 hour timeframe. This is in violation of 42 C.F.R. §§ 422.572(a) and 422.570(c)(2)(ii).

- Failure to properly identify and address quality of care issues and inform beneficiaries of their rights to file a quality of care complaint with the quality improvement organization (QIO). This is in violation of 42 C.F.R. §422.564(e)(3)(iii).

Basis for Civil Money Penalty

Pursuant to 42 C.F.R. § 422.752(c), CMS has determined that PUP's violations of Medicare Part C are significant enough to warrant the imposition of a CMP. PUP failed substantially to carry out the terms of its contract with CMS, and failed to carry out its contract with CMS in a manner that is consistent with the effective and efficient implementation of the program. 42 C.F.R. § 422.510(a)(1) and (2).

Right to Request a Hearing

PUP may request a hearing to appeal CMS's determination in accordance with the procedures outlined in § 42 C.F.R. Part 422 Subpart T. PUP must send a written request for a hearing to the Departmental Appeals Board office listed below within 60 calendar days from receipt of this notice, or by February 13, 2013. 42 C.F.R. § 422.1006. The request for hearing must identify the specific issues and the findings of fact and conclusions of law with which PUP disagrees. PUP must also specify the basis for each contention that the finding or conclusion of law is incorrect. The request should be sent to:

Civil Remedies Division
Department of Health and Human Services
Departmental Appeals Board
Medicare Appeals Council, MS 6132
330 Independence Ave., S.W.
Cohen Building Room G-644
Washington, D.C. 20201

A copy of the hearing request should also be sent to CMS at the following address:

Patricia Axt, Director, Division of Compliance Enforcement
Centers for Medicare & Medicaid Services
7500 Security Boulevard
MAIL STOP: C1-22-06
Baltimore, MD 21244
Email: Trish.Axt@cms.hhs.gov
FAX: 410-786-6301

If PUP does not request an appeal in the manner and timeframe described above, the initial determination by CMS to impose a CMP will become final and due on February 14, 2013. PUP may choose to have the penalty deducted from its monthly payment, transfer the funds electronically, or mail a check to CMS.

Please note that any further failures by PUP to comply with these or any other CMS requirements may subject your organization to other applicable remedies available under law, including the imposition of intermediate sanctions, penalties, or other enforcement actions as described in 42 C.F.R. Parts 422 and 423, Subparts K and O.

If PUP has any questions about this notice, please call or email the enforcement contact provided in the email notification.

Sincerely,

/s/

Gerard J. Mulcahy
Acting Director
Program Compliance and Oversight Group

cc: Ms. Colleen Carpenter, CMS/CMHPO/Region IV
Ms. Teresa Kries, CMS/CMHPO/Region IV
Mr. Michael Taylor, CMS/CMHPO/Region IV