Medi-Cal Policy Institute

Medi-Cal Treatment Authorizations and Claims Processing: Improving Efficiency and Access to Care

Prepared by Outlook Associates, Inc.

July 2003

Report

The Medi-Cal Policy Institute, established in 1997 by the California HealthCare Foundation, is an independent source of information on the Medi-Cal and Healthy Families programs. The Institute seeks to facilitate and enhance the development of effective policy solutions guided by the interests of the programs' consumers. The Institute conducts and commissions research, distributes information about the programs and the people they serve, highlights the programs' successes, and identifies the challenges ahead. It collaborates with a broad spectrum of policymakers, researchers, providers, consumer representatives, and other stakeholders who are working to create higher-quality, more efficient Medi-Cal and Healthy Families programs.

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Additional copies of this and other publications can be obtained by calling the Medi-Cal Policy Institute at (510) 286-8976 or by visiting the Web site (www.medi-cal.org).

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Executive Summary

Background and Methodology

The medical provider community in California perceives that the Treatment Authorization Request (TAR) and claims processes for the state of California's Medicaid (Medi-Cal) program are overly burdensome and deter providers from serving Medi-Cal patients.[1, 2] In addition, physicians believe it is more difficult to obtain tests or specialty consultations for their Medi-Cal patients.[3] Because of concerns about these perceptions and the low level of provider participation in the Medi-Cal program, the Medi-Cal Policy Institute (MCPI) commissioned this study to assess the speed and ease-of-use of Medi-Cal's TAR and claims processes.

The Medi-Cal program is administered by the Department of Health Services (DHS). DHS contracts with Electronic Data Systems (EDS) to process Medi-Cal claims and to perform data management for the state's Medi-Cal TAR process. Outlook Associates (Outlook) met on-site with representatives of the DHS Medi-Cal core services field offices and those from the pharmacy field offices. Outlook also met with DHS claims personnel and representatives of the EDS Claims Center. Outlook made multiple site visits to some of the offices, and all offices were subject to follow-up and clarification of processes via email and telephone conversations. The findings were reviewed with each entity involved in the study.

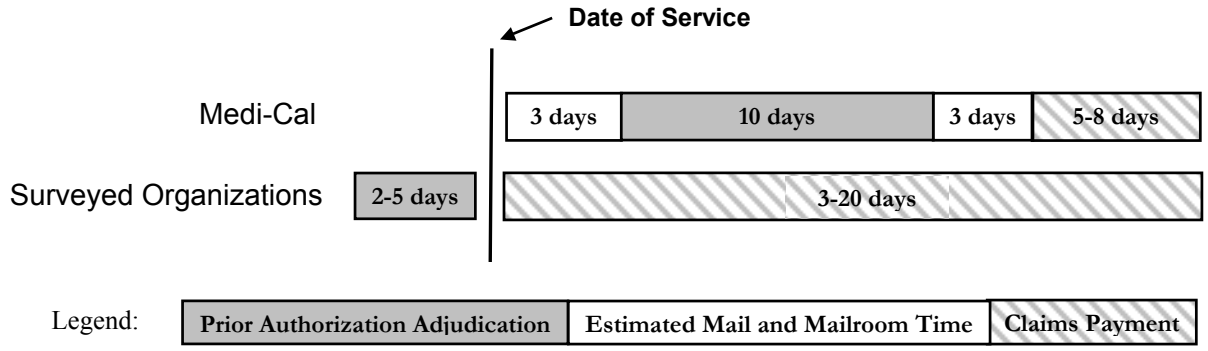
In addition, Outlook interviewed more than 200 individuals at approximately 125 California Medi-Cal provider organizations to assess their satisfaction level with the TAR and claims processes. Finally, Outlook evaluated prior authorization and claims processes at a wide range of health care organizations, including four state Medicaid programs, three California commercial health plans, and four California Medi-Cal managed care plans.

Overall Findings

Medi-Cal is one of the fastest payers of clean claims. However, for services that require prior authorizations or TARs, Medi-Cal takes either the same amount of time or longer than other

organizations to pay its providers as measured from the date of service. This is primarily due to the fact that TAR adjudications are usually performed after the date of service (or retroactively).

Figure 1. Treatment Authorization Processing Time for Medi-Cal Versus Other Surveyed Organizations



Overall, providers are satisfied with the claims process, but dissatisfied and frustrated with the TAR process. As a result of delays in TAR evaluation, Medi-Cal providers may place themselves at financial risk and Medi-Cal beneficiaries may be placed at medical risk, thereby compounding the issue of access to medical care. Throughout the study, the issue of Medi-Cal's trust in its providers was prevalent. Providers believed that in addition to the inefficiencies in the system, there was a planned "hassle factor" to specifically delay authorizations or claims payments due to potential fraudulent activities.

TAR Assessment

Objectives of a Typical Prior Authorization Program

Most prior authorization programs ascribe to three key objectives.

1. ***Review medical necessity and quality.*** Ensures that patients receive appropriate medical care in a timely manner and that patients do not receive inappropriate treatment.
2. ***Ensure cost control.*** Assists in controlling costs by allowing treatment at and directing treatment to facilities with previously contracted/approved rates, and by disallowing the overutilization of services.
3. ***Detect fraud.*** Minimizes and detects potential fraud by monitoring providers requesting an unusual quantity of services and patients receiving unusual services or an unusual quantity of services.

The Medi-Cal TAR Process

California state laws related to Medicaid require Medi-Cal providers to obtain prior authorization for specific procedures and services before reimbursement can be approved. To file a TAR, providers must fill out one of several types of paper TAR forms and forward the TAR, usually by

mail, to the appropriate field office where the TAR is adjudicated, resulting in one of four decisions:

- approve (original request is approved);
- modify (original request is modified for a variety of factors, such as dates of service or quantity);
- defer (request is returned to the provider requesting additional medical justification); or
- deny (original request is denied).

As described in Table 1, in calendar year 2001, 9 percent of claims (which represent 46 percent of the total claims dollars submitted) required a TAR. A total of 2.7 million TARs were processed in the year ending December 31, 2001. Of these, 77 percent were approved, 7 percent were modified, 8 percent were deferred, and 8 percent were denied.

Table 1. Volume of Claims Associated with TARs

Category	Claims Associated with TARs	Percentage of all Claims	Dollar Value	Percentage of all Claims
Pharmacy	4,447,054	10%	$565,403,408	14%
Long-term Care	2,014,476	100%	$3,168,112,086	100%
Inpatient	369,402	62%	$8,580,250,764	66%
Outpatient	161,901	1%	$59,550,586	3%
Home Health	603,688	81%	$220,881,490	88%
Physician	89,627	0%	$77,668,655	3%
Other	3,724,099	9%	$428,740,507	13%
TOTAL	**11,410,247**	**9%**	**$13,100,607,496**	**46%**

Source: Special query of calendar year 2001 claims data provided by EDS in May 2002.

Medi-Cal takes longer than other organizations to process a TAR. Most of the surveyed health care organizations use the National Committee on Quality Assurance (NCQA) standard of two days turnaround time. In comparison, processing time at Medi-Cal field offices averages between 9 and 12 working days, excluding mail-in, mail-out, and mailroom processing time.

TAR Findings

The findings from this study indicate that the Medi-Cal TAR program does not achieve the three objectives of a typical TAR program.

1. ***Review medical necessity and quality.*** The role of the TAR has changed significantly since July 2000, when AB 2877 was passed. This bill allowed for the submission of retroactive TARs (for example, TARs submitted after the date of service). As a result,

Medi-Cal has no opportunity to affect the care of patients on the estimated 84 percent of non-on-site TARs, which are submitted retroactively. This practice may place Medi-Cal patients at risk since they may be receiving unnecessary procedures or inappropriate care. Although the process was problematic prior to AB 2877, the current process remains cumbersome and outdated.

Hospital TARs are of particular concern. Approximately 99 percent of non-on-site hospital stay TARs and 40 percent of on-site hospital stay TARs are submitted retroactively, suggesting that very few admissions that require TARs are reviewed for medical necessity and quality prior to hospitalization. To compound this issue, Medi-Cal evaluates hospital stay TARs on a "per diem" basis, and each day of a hospital stay must be adjudicated individually. This leads to lengthier adjudication times, since a five-day hospital stay is adjudicated as if it were five separate TARs. This practice is also subject to inconsistent adjudication and increased appeal rates. Other payers surveyed for this study used "per discharge" rates based on diagnosis codes (thereby forcing hospitals to manage their own utilization review) and required approval of all nonemergency hospital stays.

Finally, unlike most of the other organizations surveyed for this study, Medi-Cal does not use formal criteria or guidelines to adjudicate prior authorizations. As a result, medical necessity and quality are impacted due to significant inconsistency in adjudication decisions, which results in increased provider confusion and higher appeal rates.

2. ***Ensure cost control.*** One component of implementing cost control measures involves analyzing and understanding the costs of the TAR program and each of its services. The other organizations surveyed for this study routinely reevaluate the necessity of prior authorizations by service based on financial and medical measures. However, Medi-Cal does not perform routine cost-benefit analyses to identify whether a particular service warrants a TAR. In addition, there are no established routine, integrated TAR and claims management reports, making difficult any integrated analysis, such as tracking whether an authorization ultimately results in a claim or understanding the cost-benefit by TAR type or drug.

3. ***Detect fraud.*** DHS has indicated that TARs are used as a means of deterring and identifying fraudulent providers. In contrast, other surveyed organizations indicate that they are moving away from using prior authorization as a means of fraud detection. Instead, they are implementing sophisticated claims algorithms to identify fraudulent behavior before payments are made, thereby enabling the elimination of a prior authorization program for the specific purpose of detecting fraud. The new Medi-Cal fiscal intermediary contract includes a provision for strengthening fraudulent identification in the claims area, but to be fully effective, it should also require some relief on the TAR side.

TAR Recommendations—Refining the Current TAR System

The following recommendations focus on incremental change and can be implemented within the current context of the TAR system.

1. Perform cost-benefit analyses for each TAR and reduce the number of TARs required.

Cost-benefit analyses by service or drug will help identify costs, retroactive levels, approval/denial rates, and trends by TAR type. Such analysis would help guide policy to decrease TAR volumes by establishing guidelines and cost thresholds. Ultimately, TARs should be required for only those services with a tendency towards overutilization, a high level of fraudulent activity, and/or a demonstrated cost-benefit gain. Reducing the types of TARs required will also help to demonstrate trust in Medi-Cal providers. In conjunction with the reduction of TAR services, it is helpful to implement automated preclaims payment reviews that can identify unexplained peaks in claims to identify potential fraud. Through similar exercises, organizations surveyed have been able to reduce the number and level of personnel required for specific prior authorization types.

2. Consider a change in the pharmacy 6Rx drug limit and operations/staffing.

A large number of drugs require a TAR, and the pharmacy volume is increasing due to both an increase in nonformulary drugs and a requirement that TARs be submitted for all drugs once a beneficiary exceeds six prescriptions per month. The six prescription limit results in dramatically increased volumes beginning midmonth and causes a significant variation in processing times between the beginning of the month and midmonth. In addition, TARs are not reported at the drug level (for example, the name of the drug and the dosage), which makes it even more difficult to evaluate pharmacy TAR trends. Most other organizations evaluated for this study perform prior authorizations on a limited drug list, thereby limiting the number of staff members involved. Medi-Cal is currently struggling to fill pharmacist positions and may wish to reevaluate the cost-benefit of the 6Rx guideline, as well as the staffing structure required to adjudicate the additional TARs.

3. Develop standard turnaround times and a standard set of adjudication guidelines, or use a standard computer program for all adjudicated TAR services.

In order to standardize adjudication methodology, to ensure more timely and consistent adjudication decisions, and to help providers better understand the criteria used in adjudication decisions, uniform turnaround time and adjudication guidelines should be established. Staff should be adequately trained in the new guidelines and internal quality control audits (by service, adjudicator, and/or office) should be conducted. This will help to improve patient care by providing timely authorizations and will reduce the number of providers placed at financial risk. Medi-Cal should consider using the NCQA standard of two-days turnaround time and triaging TARs by urgency level.

4. Improve analytic capacity for meaningful policy development.

Findings from this study show that although data is claimed to be available, it is not often analyzed meaningfully. A staff comprised of skilled analysts knowledgeable in the TAR program, as well as in sophisticated data analysis techniques should be hired to be responsible for analyzing data and forecast trends. These analysts could perform multiple functions,

including working with the field office administrators to enhance operations, performing analysis to support policy decisions, and supporting and facilitating an annual TAR review process. This will help ensure that staff can craft analyses and interpret data appropriately in order to support effective, timely decision-making efforts, perform ad-hoc analyses, and recommend improved TAR policies.

5. Accelerate *e*-TAR (SURGE) implementation.

e-TAR can support some of the recommendations outlined above, but only if a majority of TARs are submitted electronically using this new Internet-based TAR system. Expanding *e*-TAR to all providers as soon as possible will:

- increase analytical features for enhanced management reporting;
- ensure consistent data validation at the point of data entry;
- provide meaningful data for timely analysis;
- create immediate provider education opportunities;
- provide faster turnaround times for TAR decisions; and
- reduce personnel needed for data entry.

It took Medi-Cal approximately ten years to reach an online claims submission rate of 81 percent. A ten-year implementation of *e*-TAR will not benefit the currently archaic TAR process. Several of the issues identified in this report need to be resolved more quickly to ensure Medi-Cal beneficiaries and providers are not placed at risk.

TAR Recommendations—Considering New Approaches

Findings from this study reveal that the TAR process is not effectively accomplishing its goals. Serious thought should be given to the identification of new approaches for accomplishing the same goals. These new approaches will require significant interaction between departments to ensure meaningful change.

1. Develop alternative review processes for fraud and abuse detection.

Through sophisticated and targeted analysis, Medi-Cal can create baselines for each drug, service, or provider to enable trending and forecasting of both TARs and claims, which could identify potential anomalies. Such a process would help to identify and focus detection efforts on fraudulent providers and to ensure that legitimate providers submitting appropriate claims are paid more quickly. In addition, through this analysis, a portion of current services requiring TARs may be eliminated from adjudication and remaining TAR services may be adjudicated more quickly.

2. Change the way in which providers are paid and establish standard hospital contract rates based on diagnosis codes.

Convert hospital payments from a "per-diem" to a "per-discharge" basis. This will eliminate the time consuming adjudication of each day of a hospital stay, ensure that a standard rate is paid based on the diagnosis, and return the responsibility for appropriate utilization management to the hospital. Each day does not need to be authorized separately to meet the goals of AB 2877, which requires evaluation based only on medical necessity. This implementation will require coordination of various Medi-Cal entities to ensure success. It will also be critical to make certain that quality of care and access to care are not compromised and that rates are set appropriately.

Claims Assessment

The Medi-Cal Claims Process

Providers may submit claims electronically through the Internet, a clearinghouse, point-to-point (for example, modem-to-modem), tapes, and point-of-service (POS) devices, or via hard copy on standard paper forms which are mailed to the EDS Claims Center. The adjudicated process results in one of four decisions:

- paid (claim is paid);
- denied (claim is denied);
- suspended (EDS staff perform further research); or
- additional information requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

Approximately 223 million claims, which is equivalent to 27 percent of the national Medicare volume, were processed in the year ending December 31, 2001.[4] Overall, 81 percent were submitted electronically, representing 71 percent of the dollar value billed. Of the total submitted, 63 percent were paid, 22 percent denied, 16 percent suspended, and 0.5 percent returned to the provider.

Claims Findings

EDS does an excellent job of processing and paying clean electronic claims. A clean claim is one that is submitted properly and is timely and appropriate. These claims can be adjudicated in as little as one day and sent for financial processing the next working day. If providers choose electronic deposits, payments can be received in less than one week after claims are submitted. Compared to other organizations surveyed, Medi-Cal is among the fastest payers of clean claims.

In addition, electronic claims submission rates are high. In 2001, 81 percent of adjudicated paid claims were submitted electronically via Computer Media Claims (CMC) or POS, which represents 71 percent of the total dollars billed. As expected, the submission rates varied significantly by provider with pharmacy claims having the highest submission rate (94 percent)

and home health (49 percent) and physicians (61 percent) the lowest. California is comparable to other surveyed states, which reported submission rates between 81 percent and 97 percent of claims.

However, providers are frustrated with the claims corrections and appeals processes and identified these as their primary concerns. Correcting claims requires a lengthy process, and providers have difficulty using the Claims Inquiry Form (CIF). The appeals process is also lengthy and requires significant documentation. Standard and professional appeals are at, or slightly exceed, the contractual cycle time requirement of 45 days and 75 days, respectively.

Claims Recommendations

1. Implement a streamlined correction process, similar to Medicare's online correction process.

Eliminate the need for a Resubmission Transmittal Document (RTD) or CIF by allowing corrections to be made on suspended or denied claims through the original online submission method. Many providers are already familiar with Medicare's system, are trained in making these types of corrections, and would welcome this type of system from Medi-Cal.

2. Redesign the Claim Inquiry Form (CIF) and retrain providers.

If implementing a streamlined correction process is not feasible, the CIF form should be redesigned. Currently, the form must be completed with a typewriter or neatly printed in black ink. It would be more efficient to make an electronic form available for submission through the Internet. This will reduce the number of claims staff required to "touch" a particular claim.

3. Perform a quality assurance analysis regarding claim resolution.

Identify the number of claims requiring CIFs that later become appeals and evaluate the length of time from initial submission or date of service until a claim is fully resolved. This type of analysis would enable management to refine the CIF and appeals processes by providing an understanding of why claims become CIFs, or why CIFs become appeals, and an understanding of why and when in the process claims decisions are overturned. Ultimately, it is hoped that these types of analyses can be used to improve the claims corrections and appeals processes, and to assist in identifying where providers need to be trained.

Conclusion

Throughout this study, the California Department of Health Services has been very responsive in addressing the findings identified for their departments. The Medi-Cal Operations Division (MCOD) of DHS formed two task forces to address issues after receiving a copy of the TAR assessment report in April 2001. DHS's Payment Systems Division (PSD), which is responsible for the Medi-Cal claims process, has also begun to implement some of the recommendations from the quality analyses on claims corrections. DHS's activities are outlined in more detail in Appendix A.

However, these laudable efforts only address a portion of the issues presented in this report. Many issues dealt with throughout this study will require the integral participation of various

DHS departments to ensure a common goal. However, these interdepartmental issues are likely to yield the greatest achievements and ensure significant progress. For example, performing a cost-benefit analysis on each TAR service or drug will require thorough and capable analysis, as well as involvement and cooperation from the TAR, policy, claims and contracting departments to ensure that the analysis is appropriately incorporated into policy.

The sheer number of departments involved makes ownership of issues difficult and adds a level of complexity to any efforts to address the issues. This obstacle alone is significant enough to table issues in order to address critical operational "fires"; yet, the effects leave providers and beneficiaries disgruntled and ultimately burden the system with unnecessary costs.

In light of the budget constraints California is currently experiencing, there are significant opportunities to be considered to streamline and reduce administrative and medical costs in TAR and claims management while improving customer satisfaction. Such an endeavor will require a concerted effort on the part of many departments and individuals, along with a willingness to examine the entire system from a fresh perspective.

I. Introduction

Previous studies indicate that the medical provider community in California perceives the processes for Medi-Cal Treatment Authorization Requests (TARs) and claims payment to be overly burdensome, thereby deterring providers from serving Medi-Cal patients.[5],[6] In addition, physicians believe it is more difficult to obtain tests or specialty consults for their Medi-Cal patients.[7] Because of concerns about the level of provider participation in the Medi-Cal program, the Medi-Cal Policy Institute (MCPI) commissioned this project to assess the speed and ease-of-use of Medi-Cal's TAR and claims payment processes. Specialty programs such as California Children's Services (CCS), Child Health and Disability Prevention Program (CHDP), and Genetically Handicapped Person Program (GHPP) were excluded from this assessment.

Objectives

The objectives of this study are to:

- describe the Medi-Cal TAR and claims payment processes, including a discussion of the roles and structure of the Department of Health Services (DHS) and its field offices and the state's Medicaid Management Information System (CA-MMIS) contractor, which is currently Electronic Data Systems (EDS);
- assess the Medi-Cal TAR and claims processes in a comparable context by evaluating other health care organizations, identifying best practices, and surveying a representative sample of the provider community; and
- recommend solutions for improving the structure and operations of Medi-Cal TAR and claims processing.

Methodology

To achieve the study objectives, Outlook Associates (Outlook) met on-site with representatives of the six core service offices (Fresno, Los Angeles, Sacramento, San Bernardino, San Diego, San Francisco) and the two pharmacy offices (Northern California in Stockton [with a satellite in Sacramento] and Southern California in Los Angeles).[8] In addition, Outlook met with DHS claims personnel and representatives of the EDS Claims Center. Outlook made multiple site visits to some of the offices, and all offices were subject to follow-up and clarification of processes via email and telephone conversations.

Following the on-site meetings and subsequent follow-up, Outlook prepared a summary report of its findings and diagrams of the workflows for TARs and claims-related processes. These were presented to and validated by each office.[9] Outlook presented the TAR assessment findings at a meeting with the field office administrators and Medi-Cal Operations Department (MCOD) management. In response to the study, DHS has taken steps to address some of the problems raised in this study, including establishment of two workgroups to address some of the issues presented (see Appendix A).

Outlook also interviewed more than 200 individuals at approximately 125 California Medi-Cal provider organizations to assess their satisfaction level with the Medi-Cal TAR and claims processes. As a part of this survey, each provider was asked to rate certain processes related to TARs and claims.[10] Finally, Outlook evaluated prior authorization and claims processes at a wide range of health care organizations, including four state Medicaid programs, three California commercial health plans, and four California Medi-Cal managed care plans. The organizations were chosen using the following guidelines:

- organizations similar to California's Medi-Cal program in size and complexity of prior authorizations and claims; and
- organizations with innovative practices with respect to prior authorizations and claims, including practices that could be transferable to California's Medi-Cal program.

A description of characteristics of the providers who were interviewed is provided in Appendix D, and a description of the surveyed health care and state organizations is provided in Appendix E. The best practices of surveyed health care organizations are included in Appendix F.

II. Background

Roles of DHS and EDS

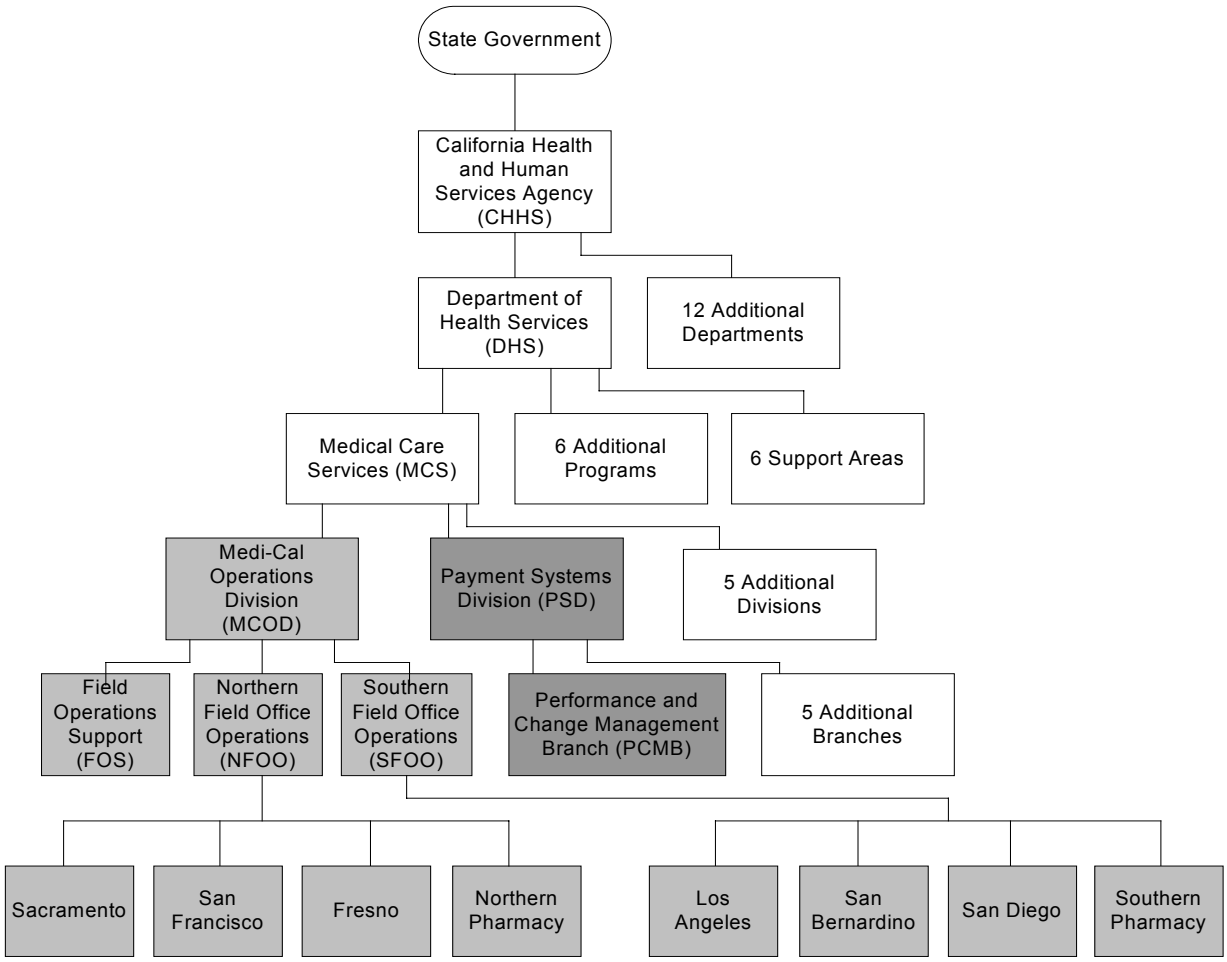
The Department of Health Services is one of the largest departments in California government and has more than 5,000 employees. It is one of 13 departments that make up the the California Health and Human Services (CHHS) agency.

Medical Care Services (MCS), a component of DHS, is responsible for the overall coordination and direction of health care delivery systems supported by the department. MCS directly operates the Medi-Cal program, including prior authorization and reimbursement for Medi-Cal fee-for-service (FFS) beneficiaries, and eligibility and scope of benefits for all Medi-Cal beneficiaries. Among others, MCS's divisions include:

- the Medi-Cal Operations Division (MCOD), which runs field operations branches that administer TARs; and
- the Payment Systems Division (PSD), which administers the claims system and oversees the fiscal intermediary contract (currently held by EDS).

Figure 2 highlights the divisions within DHS that administer the TAR and claims processes.

Figure 2. DHS Organization Chart



Source: DHS Web site.

Note: The San Jose field office, which closed on July 1, 2002, used to report to Northern Field Office Operations.

EDS is DHS's fiscal intermediary contractor and performs data management for both the state's Medi-Cal TAR and claims data processes. Under the oversight of PSD, EDS operates the CA-MMIS. Of specific relevance to this assessment, EDS processes Medi-Cal fee-for-service claims and all supporting processes related to claims, such as appeals, inquiries, and customer service.

In addition, EDS provides data entry personnel at each of the Medi-Cal field offices through the EDS Field Office Administrative Group (FOAG). Upon receipt of a TAR at the field office, the data entry staff initially enter the TAR into CA-MMIS. After field office personnel have adjudicated the TAR, staff confirm the adjudication decision and enter comments. The EDS contract has been amended to allow EDS to provide professional staff, notably pharmacists and clerical staff, to some of the field offices. A more detailed listing of the services that EDS provides to DHS is listed in Appendix G.

Procurement for Fiscal Intermediary

During the course of this project, the California Department of Health Services underwent a procurement process for the CA-MMIS fiscal intermediary. The contract was awarded to the incumbent, EDS, in October 2002, after an 18-month competitive process.

The current contract renewal requests seven system enhancements:

- develop fraud detection and prevention;
- redesign provider enrollment;
- replace the Surveillance and Utilization Management Subsystem (SURS);
- enhance provider relations operations (PRO);
- add presumptive eligibility functionality for pregnant women;
- append health care plan and primary care physician information to eligibility messages; and
- create a CA-MMIS data element dictionary (DED).

Treatment Authorization Request (TAR) Process

State laws related to Medi-Cal require prior authorization for specific procedures and services before reimbursement can be approved.[11] When the prior authorization program was established, the program imposed timeliness restrictions requiring that TARs be received within ten days of the inception of services, except in extreme cases. Assembly Bill 2877, passed on July 7, 2000, modified these restrictions by removing the ten-day timeliness clause. As will be discussed later in this report, the removal of the timeliness clause has significantly impacted the number of retroactive TARs, and the role of the TAR.

Only a small proportion of all services require a TAR, although these services account for a relatively large proportion of total spending. Some 9 percent of claims require a TAR, accounting for 46 percent of the dollars submitted.

Table 2. Claims Requiring a TAR, 2001

Category	Number of Claims Associated with TARs	Percent of Claims Requiring a TAR	Dollars Submitted Requiring a TAR	Percent of Dollars Submitted Requiring a TAR
Pharmacy	4,447,054	10.0%	$565,403,408	14%
Long-term Care	2,014,476	100.0%	$3,168,112,086	100%
Inpatient	369,402	62.0%	$8,580,250,764	66%
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TOTAL	11,410,247	9.0%	$13,100,607,496	46%

Source: Special query of calendar year 2001 claims data provided by EDS in May 2002.

Providers complete one of several types of paper TAR forms, depending on the type of service requested, and then forward the TAR to the appropriate field office.[12] Pharmacy TARs are processed by fax, and hospital stay on-sites are completed by a DHS nurse who is physically on-site at the hospital. All other TARs are processed by mail. DHS staff, supported by EDS FOAG staff, process the TARs and make one of four decisions:

- approve (original request is approved);
- modify (original request is modified for a variety of factors, such as dates of service or quantity);
- defer (request is returned to the provider requesting additional medical justification); or
- deny (original request is denied).

This decision is then communicated to the provider in the same manner in which it was sent to the office (for example, if a provider mailed in a TAR, the decision is returned by mail). Providers may also call into the Provider Telephone Network (PTN) to retrieve decisions.

More than 2.7 million TARs were processed in the year ending December 31, 2001. Of the total submitted, the overall adjudication rates were:

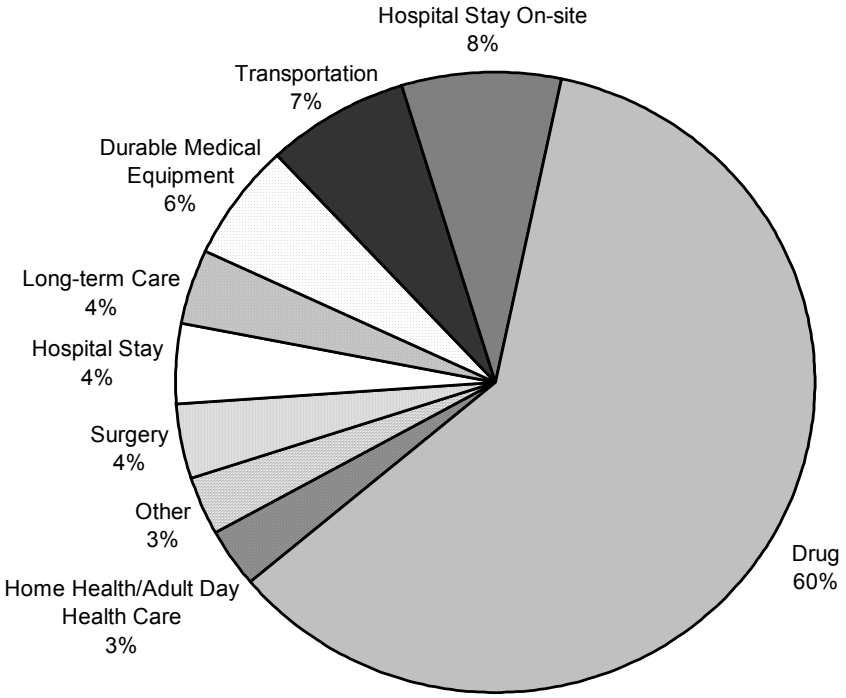
Table 3. TAR Adjudication Rates, 2001

Received	Adjudicated	Approved	Modified	Deferred	Denied
2,733,229	98%	77%	7%	8%	8%

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

Note: Approved, modified, deferred, and denied TARs are calculated as a percent of adjudicated TARs.

Figure 3. 2001 TARs by Category



Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

Note: Durable Medical Equipment TARs include all durable medical equipment, such as hearing aids, and prosthetic and orthotic equipment; Long-term Care TARs include Skilled Nursing Facilities (SNF), subacute care, and hospice care; surgery TARs includes inpatient and outpatient surgeries; "Other" includes detoxification, hemodialysis, office visits, therapies (speech, physical, and occupational), intermediate care, transitional care, and other services.

Six of the field offices adjudicate TARs for core services and specialized regional services, and two offices (Northern Pharmacy and Southern Pharmacy) adjudicate the pharmacy TARs. Each service is evaluated on a case-by-case basis, patient by patient, and, in the cases of hospital stays, on a day-by-day basis for per diem rate hospitals.

Core services consist of:

- hemodialysis;
- home health;
- elective hospital admissions;
- elective hospital surgeries;
- extension of hospital stay;
- dental hospitalizations;
- office visits;
- excluded mental health diagnoses;
- other outpatient;
- outpatient surgeries;
- intermediate care facility / developmentally disabled (ICF/DD);
- intermediate care facility / developmentally disabled habilitative (ICF/DDH);
- intermediate care facility / developmentally disabled nursing (ICF/DDN);
- psychiatry;
- hospice care;
- adult day health care; and
- kidney transplants.

Although core service TARs are sent to a local field office, specialized service TARs (such as regionalized or special services) are centralized and sent to one or, in some cases, two offices for the entire state. Table 4 provides an overview of the core, regionalized, and special services provided by each field office. Figure 4 reflects the counties served by each field office for core services.

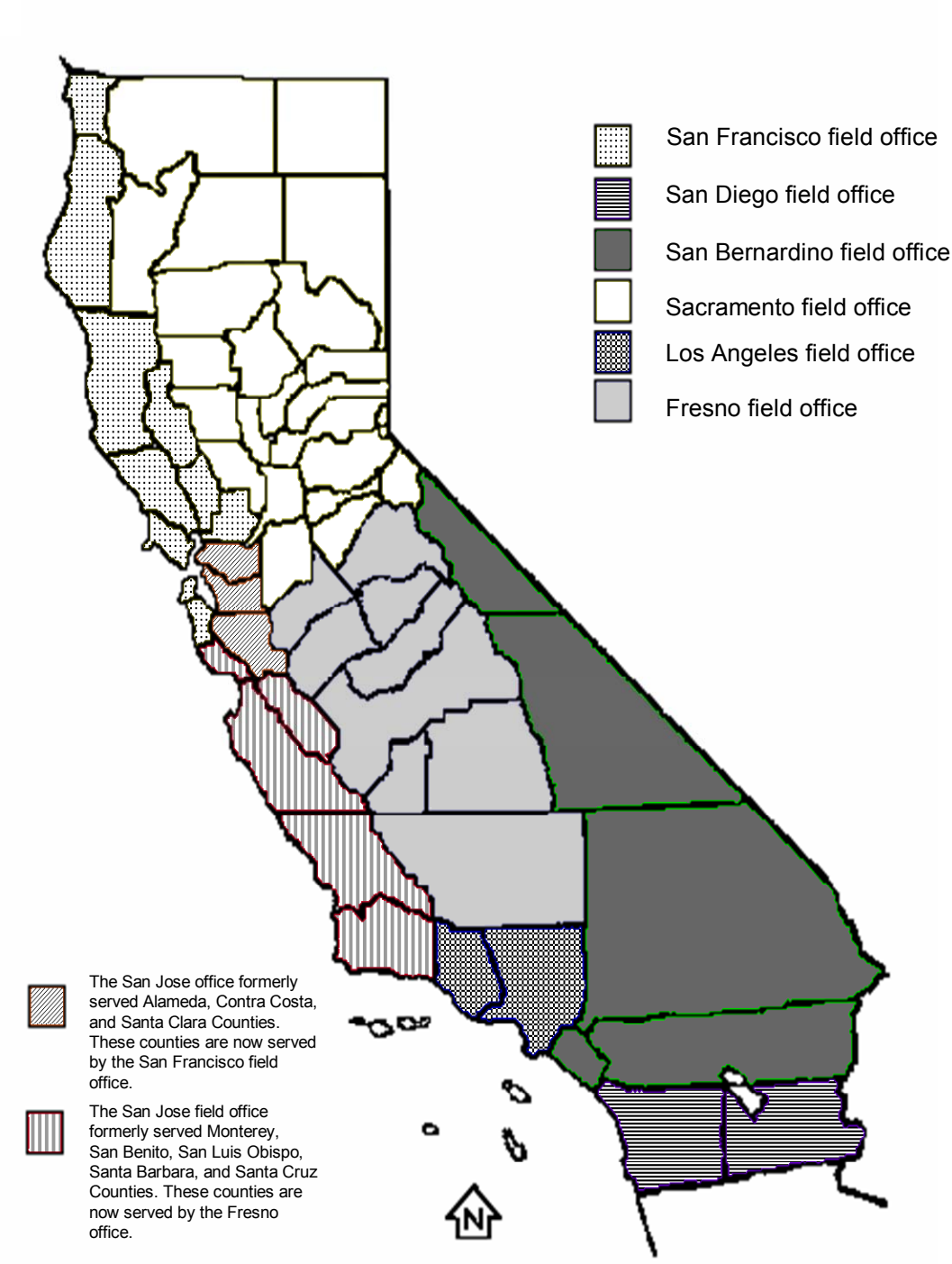
Table 4. TAR Services by Medi-Cal Field Office

Services Provided by Medi-Cal Field Offices								
Services	**Fresno**	**Los Angeles**	**Sacramento**	**San Bernardino**	**San Diego**	**San Francisco**	**S. Pharmacy Los Angeles**	**N. Pharmacy Stockton**
Core Services	■	■	■	■	■	■		
Regionalized Services:								
Hearing Aids	■							
Oxygen and Respiratory Equipment	■							
Orthotics and Prosthetics	■							
Respiratory Care Services	■							
Nonemergency Medical Transport			■		■			
Nursing Facilities (Levels A and B)				■				
Durable Medical Equipment						■		
Occupational Therapy						■		
Physical Therapy						■		
Podiatry						■		
Speech Therapy						■		
Subacute						■		
Incontinence Supplies			■					
Intravenous Equipment	■							
Medical Supplies	■							
Suction Pumps	■							
Breast Pumps	■							
Special Services:								
Detoxification		■				■		
Pharmacy							■	■
Organ Transplants						■		
EPSDT Nutritional Services						■		
Out-of-State						■		

Source: Medi-Cal Medical Services Provider Manual and Medi-Cal Staff, August 2002.

Note: The San Jose field office serviced incontinence supplies, intravenous equipment, medical supplies, suction pumps, and breast pumps through July 1, 2002.

Figure 4. TAR Core Services by Field Office

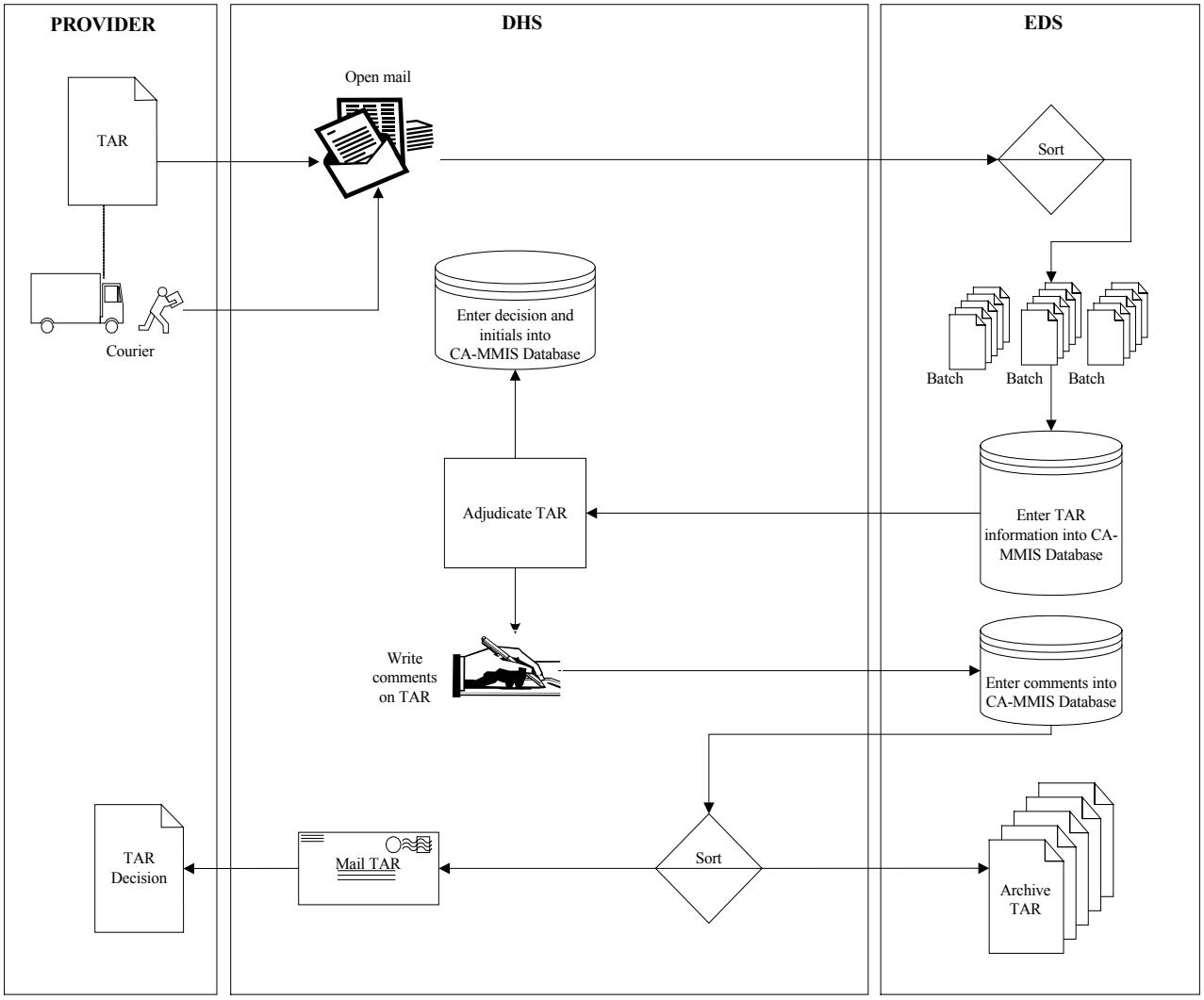


TAR data are captured and processed in CA-MMIS.[13] The six local field offices perform up to seven different processes related to TAR management, including processing of:

- non-on-site (mail-in) TARs (TAR is mailed from the provider to the local or regional field office for adjudication);
- on-site TARs (DHS nurse will physically go on-site to a hospital, SNF, Adult Day Health Care (ADHC) facility, transportation provider, home health provider, or to an ICF/DDH or ICF/DDN provider to perform concurrent and retroactive reviews of stays or services);
- fax TARs (hospital staff will fax TAR into field office at specified times for concurrent and retrospective reviews of hospital stays; for noncontracting or rural hospitals that are unable to have on-site nurses perform reviews due to remote locations);
- Medical Case Management (MCM) of complex patients (MCM evaluates the case management need of the beneficiary, and, if approved, creates case management goals and manages the TAR process for that beneficiary until the case management goals are met; beneficiaries meeting specific criteria (such as being in and out of the emergency room repeatedly, or in need of a coordinated package of services) are referred to case management;[14]
- TAR Update Transmittal (TUT) (allows for the correction of a previously adjudicated TAR);
- first-level appeals (allows provider to appeal for a "better" decision when a TAR has been denied or modified); and
- fair hearing requests (allows Medi-Cal members whose providers' TARs were modified or denied to appeal for a "better" decision).

The generalized TAR process flow is diagramed in Figure 5.

Figure 5. TAR Process Flow



The two pharmacy offices adjudicate two types of TARs—those for prescription drugs that are not on the formulary, and those for the seventh or greater request for any prescription for a beneficiary in a month (called 6Rx TARs). The offices primarily perform five different processes related to TAR adjudication:

- pharmacy fax review TARs (TAR is faxed from the pharmacy to one of the two pharmacy field offices for adjudication);
- non-on-site (mail-in) TARs (TAR is mailed from the provider to the pharmacy field office for adjudication; less than 1,000 pharmacy TARs per year are processed in this manner)
- TAR Update Transmittal (TUT) (allows for the correction of a previously adjudicated TAR);
- first level appeals; and

- fair hearing requests.[15]

In addition, the field office staff at all offices, often in conjunction with EDS, provide education to provider staff on TAR preparation, understanding denial rates, and identifying additional documentation needed for deferred TARs.

e-TAR

The Medi-Cal Operations Division and the Payment Services Division, in conjunction with EDS, have designed a new internet-based TAR system called Service Utilization Review Guidance and Evaluation system (SURGE). Over the past three years, this system, also called *e*-TAR, was designed with the involvement of field office staff and providers. It was developed to respond to the needs of users and for management of the current CA-MMIS TAR system. A more detailed description of *e*-TAR is included in Appendix K.

The SURGE application allows providers to input and submit TAR information via the Internet. TAR data are directed to the appropriate field office for adjudication and then decisions are posted online. Thus, providers are able to access TAR decisions online.

The SURGE application is being implemented as a pilot application. It was rolled out to field offices between April 22 and July 10, 2002, beginning with the Sacramento field office and ending with the Los Angeles field office. The pilot was targeted to 200 providers who originally expressed interest in the system. The results of the pilot will be used to refine the application before it is made available to all providers. Full availability of the system to all providers is dependent on feedback received during the pilot period.

Once *e*-TAR is fully implemented, it will enable, among other things, faster turnaround on TARs, prioritization of TARs at a local level, electronic exchange of work between offices, and enhanced management reporting. This application is in its infancy and will require adoption by the wider provider community before its benefits are fully realized.

As of December 2002, the SURGE application was still in the pilot phase. Nearly 6,000 *e*-TARs were submitted statewide by approximately 60 providers. The *e*-TAR submission rates, as a percentage of the total number of TARs submitted, ranged significantly from 0 to 100 percent, averaging at about 26 percent. Since each provider implemented the SURGE application at different points in time during the pilot, it is difficult to compare the experience of providers; however, analysis can be performed after more time has passed.

In the limited experience of the pilot, providers have required a significant amount of assistance and education with the application. DHS and EDS field office staff are performing targeted sessions with providers to assist them with the successful implementation of the application. Providers will need to reexamine their internal processes when moving from the paper TAR-based system to the electronic application.

With the exception of the Los Angeles field office, all field offices adjudicated significant numbers of *e*-TARs during the pilot time period. The group accessing the application for adjudication or inquiry purposes has grown from a handful of individuals in each office to

approximately 25 percent of the adjudicating staff. Medi-Cal and its contractor are currently revising training materials to ensure consistent use of the application.

Approximately 100 changes were identified as necessary prior to the statewide implementation. These changes, which are currently in progress, are expected to improve system stability, response time, and overall ease-of-use of the application. Once changes are complete, DHS will evaluate an appropriate timetable to roll out the application to the entire provider community.

Claims Process

PSD has overall responsibility for Medi-Cal claims payments. Under the oversight of PSD, EDS staff process claims at a centralized location in Rancho Cordova, California.

Providers may submit claims through several electronic means, including the Internet, a clearinghouse, point-to-point (such as modem-to-modem), and tapes. These electronic submission methods are referred to as Computer Media Claims, or CMC. In addition, pharmacy providers may submit through point-of-service (POS) devices. Alternatively, one of several paper forms can be used to submit paper claims, depending on the type of service provided. These claims are mailed to the EDS Claims Center.[16] Adjudicated claims result in one of four decisions:

- paid (claim is paid);
- denied (claim is denied);
- suspended (EDS staff perform further research); or
- additional information requested (a Resubmission Transmittal Document (RTD) is sent to the provider requesting additional information).

More than 222 million claims were processed in the year ending December 31, 2001. Overall, 80 percent of claims were submitted electronically, accounting for 71 percent of the dollars paid. Of the total submitted, the overall adjudication rates were:

Table 5. Claims by Decision, 2001

Received	Adjudicated	Paid	Denied	Suspended	Returned to Provider
222,772,729	102%	63%	22%	16%	.5%

Source: MR-O-709 Report for calendar year 2001.

Note: The total of adjudicated claims may add up to more than 100 percent as it includes claims received in 2000, but adjudicated in 2001. The total adjudicated may not add up to the individual percentages of paid, denied, suspended, and returned to provider totals due to rounding.

These numbers varied by provider as shown in Table 6.

Table 6. Claims by Provider Type, 2001

Provider Type	Adjudicated	Paid	Denied	Suspended	Returned to Provider
Pharmacy	80,023,848	63%	29%	4%	0.06%
Long-term Care	3,087,778	84%	9%	11%	0.24%
Inpatient	945,964	65%	14%	28%	1.58%
Outpatient	53,497,182	64%	17%	21%	0.47%
Physician	76,494,339	60%	21%	26%	1.02%
Vision	1,514,020	71%	15%	20%	0.15%
Crossover	7,209,598	71%	12%	24%	2.29%
Total	222,772,729	63%	22%	16%	0.52%

Source: MR-O-709 Report for calendar year 2001.

Note: The total number of claims paid, denied, suspended, and returned to the provider may add up to more than 100 percent, as numbers represent an addition of monthly snapshots in time. For example, a suspended claim in January may become a denied claim in February.

Some 81 percent of the adjudicated paid claims are submitted electronically via CMC and POS submission. Although many providers submitted electronically, 84 percent of the providers still submitted at least one claim on paper, since not all claim types may be submitted electronically.

As shown in Table 7, there is significant variation in the types of providers who submit electronically, with pharmacies showing the highest electronic submission rate, and physicians the lowest.

Table 7. Electronic Submission Rates, 2001

Category	Number of Providers	Percent of Providers	Number of Claims	Percent of Claims	Claim Dollars	Percent of Claims Dollars
Pharmacy	5,030	96%	42,946,801	94%	$3,629,241,197	92%
Long-term Care	1,820	74%	1,525,500	76%	$2,156,567,269	67%
Inpatient	695	55%	468,992	79%	$9,265,029,864	72%
Outpatient	470	44%	9,571237	78%	$1,630,952,469	75%
Home Health	229	46%	363,879	49%	$126,808,737	51%
Physician	8,068	30%	14,152,134	61%	$1,377,398,086	47%

Source: Special query of calendar year 2001 claims data provided by EDS in May 2002.

In addition to adjudicating claims, the EDS Claims Center performs additional functions related to claims management. These are to:

- process Claims Inquiry Forms (CIF) (an automated process that allows providers to perform a wide range of functions, including tracing the status of a claim, correcting a claim or adjusting a claim; most appropriate for correcting straightforward errors, or claim tracing);

- process claims appeal (provider may appeal a decision for a reversal or an adjustment of payment; manually intensive, requires that the most seasoned claims staff address each appeal individually);

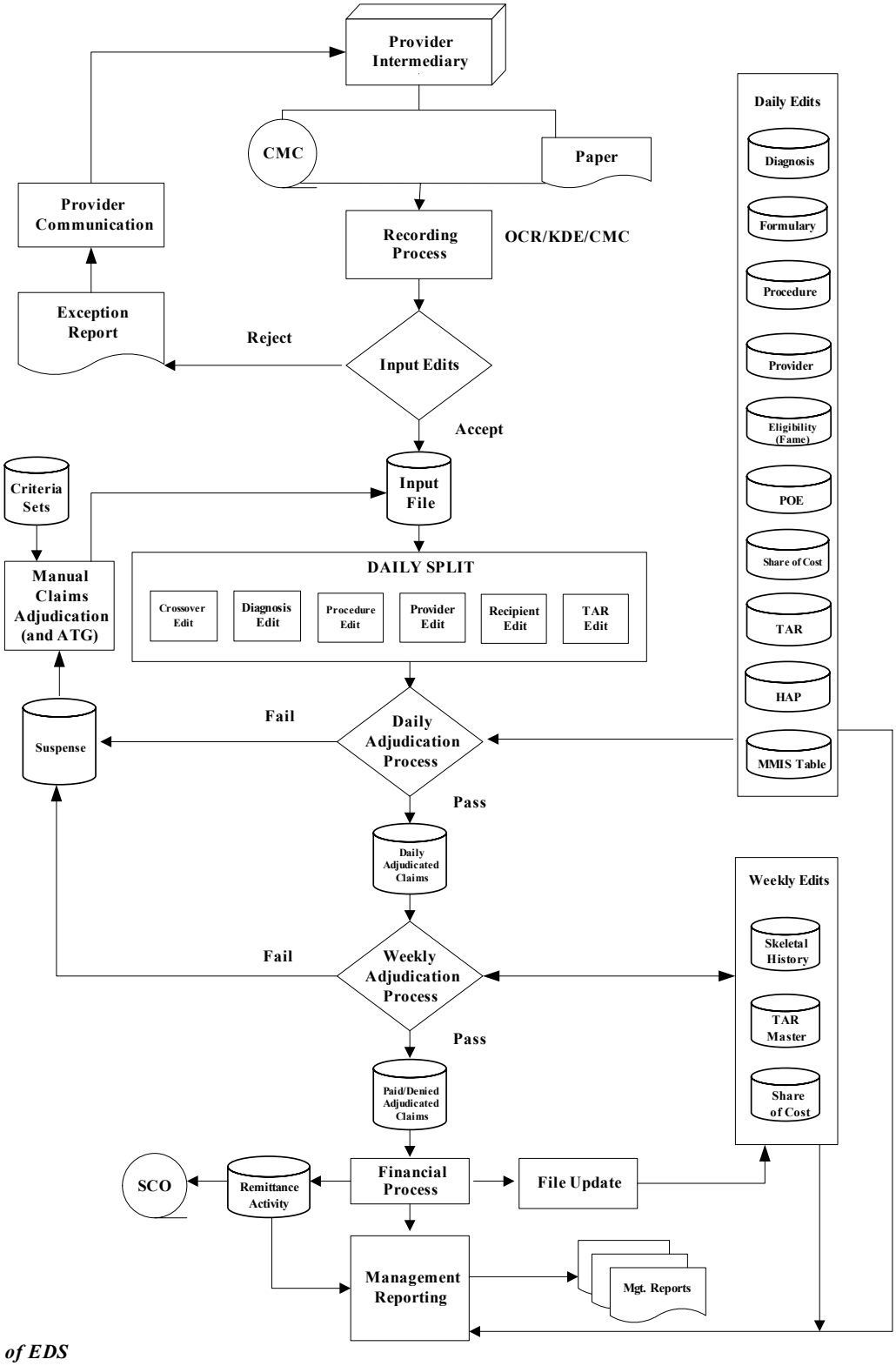
- process Resubmission Transmittal Document (RTDs) (providers are sent RTDs on some suspended claims, which are completed and returned to EDS);

- manage the EDS Help Desk (EDS assists providers with a wide range of issues, from provider applications to claims inquiries); and

- maintain provider communication (EDS produces and updates the provider manual and manages other communications to providers).[17]

The claims process diagram in Figure 6 demonstrates how both paper and electronic claims are received and processed through the CA-MMIS system.

Figure 6. Claims Process



Courtesy of EDS

III. Findings

Overall Findings

This section presents overall findings while the following sections present more specific findings related to TARs, claims, and provider communication.

1. Medi-Cal TARs take significantly longer to process than other payers.

Medi-Cal's TAR process is significantly more time-consuming than other payers. Medi-Cal does not measure the total time that a TAR spends in its offices; rather, it measures only the DHS working days from which a TAR is logged into the system through the time the adjudication decision is confirmed in the system. This includes the adjudication decision time, but it excludes mail-in and mail-out times, as well as any transfers between the mailroom and the data entry area. The processing time for nonpharmacy TARs ranges from 8.63 working days at the San Bernardino field office to 11.93 working days at the Fresno field office, as shown in Table 8 below. Working days include each state working day, thereby excluding state holidays and weekends. Providers confirm the processing times and indicate that Medi-Cal TARs range from two days on average for pharmacies to 30 days for subspecialist physicians. One home health provider stated, "It takes too long for TARs to get approved. We sent in a batch on March 26, 2002, and they were returned on April 30, 2002."

Table 8. TAR Field Office Processing Times and Approval Rates, 2001

Field Office	Number of TARs Adjudicated	Processing Time (in days)	Approved	Modified	Deferred	Denied
Fresno	100,712	11.93	72%	10%	14%	4%
Los Angeles	221,629	9.40	68%	18%	7%	8%
Sacramento	142,337	11.02	71%	11%	13%	5%
San Bernardino	169,070	8.63	82%	6%	10%	2%
San Diego	167,302	9.76	75%	8%	11%	6%
San Francisco	174,765	9.51	59%	19%	15%	7%

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

Note: Totals may not add up to 100 percent due to rounding. The processing time is calculated from the time the TAR is first entered into CA-MMIS through the time that the TAR is post-data-entered into CA-MMIS, and is calculated in state working days. Processing time excludes time used for the field office's mail intake procedures and mailing of the TAR to the provider; therefore, providers will accurately report additional time due to the unaccounted U.S. mail transit time, and the field office's mailroom time for both the receipt and return of the TAR. Processing time is probably lower than actual processing time, since all on-site hospital TARs are entered as a one-day turnaround time, when in reality they may have been waiting several weeks for adjudication at the provider site.

Table 9. Pharmacy Field Office Processing Times and Approval Rates, 2001

Field Office	Number of Faxed TARs Adjudicated	Processing Time (in days)	Approved	Modified	Deferred	Denied
Northern Pharmacy	325,786	2.75	79%	1%	11%	9%
Northern Pharmacy 6Rx	467,948	2.94	89%	3%	3%	5%
Southern Pharmacy	253,212	4.39	66%	2%	11%	20%
Southern Pharmacy 6Rx	564,214	4.52	84%	5%	4%	7%

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

Note: Totals may not add up to 100 percent due to rounding. The processing time is calculated from the time the TAR is first entered into CA-MMIS through the time that the TAR is post-data-entered into CA-MMIS, and is calculated in state working days. "6Rx" refers to the seventh or greater request for a formulary prescription for a beneficiary in a monthly period, which requires a TAR.

Outlook found that the four surveyed Medicaid programs manage their prior authorizations via either fax or mail, which is similar to Medi-Cal. One state Medicaid program responds to all prior authorizations within 24 hours, while the other three state Medicaid programs report turnaround times ranging from one to three weeks for most prior authorizations.

The providers surveyed state that prior authorizations for Health Maintenance Organizations (HMOs) and other payers are simpler and faster than Medi-Cal, and they are usually conducted via telephone or fax with answers received on the phone. Providers also indicate that HMOs and other payers usually adjudicate their authorizations using the National Committee on Quality Assurance (NCQA) standard of less than two days, although most are adjudicated in less than four hours. The organizations surveyed confirmed this by indicating that their turnaround times range from 15 minutes (via telephone) to five days (via fax)—although most strive for the NCQA standard of two days.

> One large health plan provides almost immediate authorization to its providers via telephone. The plan relys extensively on a utilization management program and receives faxed information justifying medical necessity. For claim authorization, the provider telephones in to a call center. The intake representative collects demographic information, verifies eligibility, and enters the provider and patient information into the system. The call is then forwarded to a nurse who creates a prior authorization, adjudicates it telephonically, and enters the result into the claims system. Average turnaround time is 15 minutes.

Medi-Cal states standard turnaround times only for its pharmacy TARs; for all other TAR types, there are no standards for turnaround times, and, therefore, there are no expected turnaround times to communicate to the provider population. In comparison, all other organizations surveyed had stated requirements for TARs that were clearly communicated to all constituents. One state Medicaid program's prior authorization turnaround times were stated in the legislation and ranged from one to three weeks, depending on the type of TAR.

2. Medi-Cal is one of the fastest payers of clean claims.

Medi-Cal's processing of clean claims, which are electronic claims that require no special handling, is excellent. Claims are adjudicated both daily and weekly. If a provider submits a claim at the appropriate time in the cycle (Thursday), the claim can be adjudicated in one day and sent for financial processing the next working day. If the provider chooses electronic deposits, the payment can be received in less than a week after claim submission. State organizations are at the leading edge of these processes. One state Medicaid program has a very similar process and turnaround time, while another state Medicaid program adjudicates and confirms the payment at the POS for three claim types: pharmacy, inpatient and nursing home. In comparison, providers believe that Medicare and other payers may adjudicate their claims quickly, but hold the payments for 30 days.

> "The payment download on the Internet site is terrific."
> [Nursing Home]
>
> "We processed 500 claims [in a zipped file] in 108 seconds using a 56K modem."
> [Billing Company]

EDS has developed good monitoring tools to evaluate its claims cycle time. The Medi-Cal Cycle Time Analysis Report is shared with DHS management on a monthly basis. The report details 43 categories that are evaluated, the report source referenced, and the specific contract standards measured within each category. Each month is listed and evaluated against the individual measurements, and instances in which EDS is not meeting the standard are identified. Examples of a few categories are listed in Table 10.

Table 10. EDS Cycle Time Standards

Category	Contract Standard	Range of Performance	Comments
Claims Overall	90% in 25 days	11–19 days	Significantly better than the required standard.
	99% in 75 days	24–33 days	Significantly better than the required standard.
Long-term Care	90% in 8 days	5–8 days	Meeting the required standard
Appeals Professionally Reviewed	99% in 50 days	12–16 days	Significantly better than the required standard.

Source: Medi-Cal Cycle Time Analysis Report, 2000–2001.

With one exception in the appeals area (discussed later in the report, see Table 21), EDS is performing well by meeting or exceeding its cycle time in the areas evaluated by this report.

3. Strategic and policy decisions are difficult due to a lack of easily accessible management-reporting tools at Medi-Cal.

CA-MMIS contains a significant amount of data, and there are sophisticated reporting tools associated with it. However, it can be problematic to obtain and analyze appropriate data for various decision making efforts in a timely manner. There are no routine, integrated TAR and claims management reports; therefore, tracking items, such as whether an authorization ultimately results in a claim or the average dollars paid for a certain service, can be difficult and requires special reporting. The current TAR management reports do not include certain TAR categories (such as deferred TARs for on-site visits and state hospital "paperless" TARs), and deferred TARs are not monitored to resolution so it is difficult to evaluate the ultimate decision made. In addition, lack of adequate reporting capabilities at the pharmacy level makes it difficult to evaluate TAR drug management (for example, how many drugs are always approved, how often is a requested drug replaced with another drug, and/or which drugs are requested and approved together?).

The SURGE application (*e*-TAR) is expected to enable streamlined management reporting and provide access to TAR data with a Business Objects querying tool. However, this tool will not be fully functional until a majority of TARs are processed through the *e*-TAR system, and it will require skilled analysts, who understand both the business and the data, to craft analyses and interpret the data.

4. As a rule, Medi-Cal agencies work independently of each other to accomplish their particular function.

Although Claims, TARs and Audits and Investigation have interrelated activities, their physical locations, lack of integrated management reports, and inefficient communication at all levels make it difficult to coordinate activities. In addition, the day-to-day priorities of each functional unit may not be the same. One notable exception is the adjudication of the Adult Day Health Care (ADHC) TARs in the Los Angeles and San Diego offices.

> The innovative pilot for ADHC in the Los Angeles and San Diego field offices allows various state agencies to work in concert to evaluate an area that is becoming increasingly fraudulent. Medi-Cal field office nurses go to the ADHC site, along with staff from Credentialing and Audits and Investigation, to evaluate TARs and ensure a plan of care is in place for each patient.

5. Medi-Cal patients may be placed at medical risk.

Approximately one-third of the physicians interviewed for this study indicated that their Medi-Cal patients have been put at medical risk because of preauthorization delays. This is a particularly important issue among specialty physicians, as more than half of the cardiologists and neurologists interviewed indicated they have been forced to delay necessary care due to lack of timely authorization from Medi-Cal. The most common reasons cited for delays in the TAR process were:

- the Medi-Cal medical reviewers' inability to evaluate urgent medical situations in a timely manner;
- the Medi-Cal medical reviewers' difficulty in determining whether or not certain procedures are medically necessary; and
- additional requests for documentation and justification.

Through *e*-TAR, each office will be able to determine criteria for prioritizing TARs, and the urgency of each medical situation could be included in the criteria.

6. Providers may be placed at financial risk.

While Medi-Cal field office adjudicator may approve a TAR for a service, the claim associated with that TAR could later be suspended or denied. Although the claim may be appropriately denied for reasons such as eligibility or benefit limitations, there are instances when the claim is denied for medical necessity. This requires the provider to submit a correction or an appeal, which can take months to process and which ultimately may or may not be approved. In contrast, while other payers may take longer to pay, after a prior authorization is given, the claim is always paid.

The two most common reasons that providers are placed at financial risk include TAR decisions and eligibility processing. For example, when TARs are submitted, the decision may not be approved until after the procedure requested has occurred. Also, providers are often must wait for a patient's eligibility to be processed retroactively before they are able to submit a TAR or a claim.

Of the providers interviewed, one-third reported financial loss on Medi-Cal patients due to Medi-Cal TARs and claims processing issues. Specialty physicians (such as orthopedists and neurologists) reported particularly high financial loss rates, which could lead to difficulty in attracting specialty physicians to Medi-Cal. In most cases, loss occurs when physicians attempt to place the patient's medical needs ahead of their own financial needs. For example, a beneficiary may enter a pharmacy on a Friday evening with a prescription refill for a cardiac maintenance drug. Based on the standard turnaround time expectations, the TAR is expected to be approved by Tuesday at 5 p.m.; however, pharmacists are keenly aware that a patient without this type of medication for four days could land in the hospital with an acute episode. For this reason, they will usually dispense the medication and assume the financial risk.

7. Providers are restricting access to Medi-Cal patients or reducing patient care due to TAR and certain claims processes.

Some surveyed providers indicated that they are reducing the services they are willing to provide to Medi-Cal patients. Several physician subspecialists indicated they are phasing out their Medi-Cal fee-for-service program but are willing to take Medi-Cal managed care patients. Some providers are categorically excluding all Medi-Cal patients due to their concerns over the problematic TAR process. Other providers expressed difficulty with claims resolution.

8. Providers often refer to the "hassle factor" of dealing with Medi-Cal.

More than 30 percent of the providers surveyed indicated that there is a "hassle factor" in dealing with Medi-Cal. Some of the reasons include:

- voluminous paperwork (examples include provider enrollment and TAR processing);
- extensive follow-up and delays in approval (such as provider enrollment, TARs, and claims);
- patient noncompliance (for example, patients not showing up for appointments or not following medical instructions correctly); and
- more frequent patient office visits.

One diagnostic company, an established Medi-Cal provider, continually struggles with enrollment of new physicians at existing provider sites. "The process can take several months." Medi-Cal states that the average turnaround time to process a completed provider application is 60 days, with 95 percent of the applications processed in that time frame.

9. Some providers cite low Medi-Cal payment rates.

Home health agencies, specialty physicians, ambulance companies, podiatrists, and SNFs cite Medi-Cal rates as significantly lower than the actual costs of the services provided. Physicians surveyed reported particularly high financial loss rates, and a majority of them write off unreimbursed services to Medi-Cal beneficiaries. This is particularly true with physician specialties such as orthopedics, neurology, dermatology, and pediatric subspecialties, which could lead to difficulties in attracting specialty physicians to Medi-Cal. Pharmacies, in contrast, indicated they may receive a higher reimbursement from Medi-Cal than from other payers.

10. Streamlined prior authorization and fraud tracking is a focus in surveyed health plans and Medicaid programs.

Four of the health care organizations surveyed have developed new methods of addressing prior authorizations and fraud tracking through the use of extensive data analysis and skilled analyst personnel. Two additional organizations indicated that they are attempting to do the same. Through the use of technology, these organizations have been able to create baselines using claims data that are specific to both the provider and the service. Using these baselines and skilled research personnel, they are able to monitor appropriate usage of prior authorizations and opportunities for fraud. This has allowed for reduction in restrictions, including the elimination of referral notifications to an approved group of specialists and elimination of prior authorizations for various services. Staff are redeployed on targeted opportunities to reduce fraud and overutilization by working on highly fraudulent services or by working directly with specific providers.

Medi-Cal has developed similar programs around fraud tracking, such as the "pre-check-write" process, but few programs have been developed for improving TAR processing. EDS implemented the "pre-check-write" process for Medi-Cal in 1999 to identify providers who may be billing inappropriately and to stop payments within a quick timeframe. EDS generates weekly reports that analyze providers within provider types and variances to the norm. A list of suspicious providers is provided to Audits and Investigation, which requests case summary or standard reports for selected providers. Beneficiary random samples for those providers are sent to field office investigators for on-site reviews the following week. Based on findings in the field, the state controller's office may withhold payments to the provider.

Findings Specific to Medi-Cal TARs

Core Service TARs

1. The TAR process is manual and paper intensive.

All adjudication on a TAR is performed on paper, although in most cases the adjudicator accesses certain key information from CA-MMIS (such as eligibility, TAR history, and patient profile). Because there is no electronic auto-adjudication process, each TAR is evaluated by a staff person. In addition, since most hospitals are paid on a "per diem" basis, each day of a hospital stay is examined separately. In contrast, two of the organizations surveyed process all prior authorizations electronically. While these organizations report that they currently receive only 20 to 30 percent of their prior authorizations electronically, they are hoping to increase this number through targeted provider education.

2. *e*-TAR has been rolled out to pilot providers, yet the system is still in its infancy.

e-TAR was rolled out to pilot providers between April and July 2002, and approximately 300 *e*-TARs have been received statewide. EDS and DHS field office personnel are in the process of providing updated *e*-TAR training. The results of the pilot will be used to refine the system before it is expanded to all providers. As with any system implementation, providers will need to make changes to the way they do business in order to implement *e*-TAR successfully. The goal is to utilize *e*-TAR to address many of the problematic issues associated with TARs (for example,

to improve the speed of adjudication, improve management reporting, and prioritize workload). However, the benefits of *e*-TAR will not be fully realized until the system is used by a large percentage of providers.

3. The TAR process is consistent among field offices.

With few exceptions (which are addressed in the operational findings in Appendix L), the flow of paper at Medi-Cal field offices is very similar, and a TAR is processed consistently regardless of the type of TAR, the service requested, or the field office location where the TAR is processed.

4. The TAR process is complex.

Medi-Cal requires extensive documentation substantiating the TAR. For some retroactive hospital inpatient stay TARs, Medi-Cal asks for the entire chart to be photocopied to ascertain medical necessity. In contrast, Medicare does not have a prior authorization process but, instead, uses published criteria that determine if the claim is payable. Providers surveyed indicated that most other payers require very little documentation, all of which can be communicated via telephone or fax.

5. Medi-Cal does not use formal criteria, guidelines, or a standard utilization management program to adjudicate TARs.

All but one of the organizations surveyed have established TAR criteria, either through computer programs such as Milliman and Robertson (M&R), InterQual or an internally developed set of guidelines. Some of these organizations share guidelines with their providers and provide assistance to ensure the receipt of appropriate documentation to justify medical necessity. Medi-Cal has created a limited set of guidelines for certain services, but attempts to create additional guidelines in the past have failed because of budget constrainst. The lack of guidelines makes it difficult for internal staff to adhere to standards. As a result, providers have difficulty understanding why a particular TAR receives one decision in a given case, and a different decision in another case.

> "Milliman and Robertson (M&R) is integrated into our system, and providers have access to M&R online. A provider can look at M&R before filling out the authorization to determine if the patient will qualify." [Health Plan of San Joaquin]

6. The TAR adjudication decision is inconsistent from one adjudicator to another.

TARs are adjudicated in the field office based on medical necessity. However, each adjudicator determines medical necessity differently and requires a different amount of information to evaluate medical necessity. As a result, a range of decisions may be made based on the same medical facts. Providers surveyed repeatedly complained about the difficulty in obtaining a consistent decision, as well as the difficulty in understanding the information an adjudicator might need to make a decision.

7. The hospital "per diem" contract rate increases adjudication staff time.

Medi-Cal personnel must adjudicate every day of a hospital stay. This leads to lengthier adjudication times as each day of the hospital stay is adjudicated independently. In addition, this process allows for inconsistency from one adjudicator to the next, as two adjudicators may

approve different lengths of stay for the same case. Such inconsistency leads to appeals as providers attempt to understand the rationale behind Medi-Cal's decisions.

8. There is significant variation in processing time for non-on-site hospital extension-of-stay TARs.

The hospital extension-of-stay is usually retroactive and mailed into the field office. As shown in Table 11, the processing time varies from 10.32 days in the San Diego field office to 20.64 days in the Los Angeles field office. MCOD is now planning to adjudicate these TARs on-site at those hospitals where they have on-sites nurses. However, most reviews will continue to be retrospective.

Table 11. Processing Time and Approval Rates for Hospital Extension-of-stay, Non-on-site TARs in 2001

Field Office	Number of TARs Adjudicated	Processing Time (in days)	Approved	Modified	Deferred	Denied
Fresno	18,676	14.37	86%	6%	5%	4%
Los Angeles	37,320	20.64	78%	13%	5%	4%
Sacramento	8,870	12.60	79%	6%	12%	4%
San Bernardino	16,672	11.86	86%	4%	5%	5%
San Diego	5,402	10.32	76%	14%	5%	5%
San Francisco	4,152	12.92	76%	7%	12%	5%

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001, Service R7.

Note: Totals may not add up to 100 percent due to rounding. The processing time is calculated from the time the TAR is first entered into CA-MMIS through the time that the TAR is post-data-entered into CA-MMIS, and is calculated in state working days. Processing time excludes time used for the field office's mail intake procedures and mailing of the TAR to the provider; therefore, providers will accurately report additional time due to the unaccounted U.S. mail transit time, and the field office's mailroom time for both the receipt and return of the TAR.

9. Staffing ratios vary across field offices.

Tables 12 and 13 compare staffing ratios for adjudicated TARs across field offices. Table 12 compares an entire office's staffing profile, roughly assuming that all individuals adjudicate all TARs and that each TAR is equivalent. As Table 12 is a simplification of the staffing profile of each office, Table 13 looks specifically at services that nurses are supposed to adjudicate and uses an adjusted TAR number. This adjusted TAR number counts each day of a hospital stay TAR as one TAR (for example, a hospital stay TAR of 5 days is counted as 5 TARs) because each day is evaluated individually. All non-hospital-stay TARs are counted only once.

Table 12. Staffing Ratios, 2001

Field Office	Number of TARs Received	Number of TARs Adjudicated	Modified/ Denied TARs	Number of Adjudicators	Annual Number of Adjudicated TARs per Adjudicator
Fresno	104,016	100,712	13,867	18	5,595
Los Angeles	251,083	247,479	61,029	37	6,689
Sacramento	143,836	142,337	21,884	25.8	5,517
San Bernardino	176,061	169,070	13,677	23.3	7,256
San Diego	167,705	167,302	23,287	23.5	7,119
San Francisco	181,026	174,765	46,811	26.5	6,595
Total	1,023,726	1,001,665	180,555	154.1	6,500

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

Note: TAR adjudicators include nurse evaluators, medical technicians, medical consultants, podiatric and physical therapy consultants. Medical Case Management staff and dedicated appeal staff are not included.

Table 13. Adjusted Nurse Staffing Ratios, 2001

Field Office	Number of TARs Adjudicated	Adjusted Number of TARs Adjudicated	Average Number of Nurse Adjudicators	Adjusted Annual Number of Adjudicated TARs per Adjudicator	Nurse Adjudicator Workload Assessment
Fresno	100,712	177,092	15.58	11,367	Low
Los Angeles	247,479	919,366	37.00	24,848	High
Sacramento	142,337	252,070	18.47	13,648	Low
San Bernardino	169,070	324,333	19.33	16,779	Average
San Diego	167,302	260,871	16.21	16,093	Average
San Francisco	174,765	222,662	16.92	13,160	Low
Total	1,001,665	2,156,394	123.51	17,459	N/A

Source: RF-O-029 Medical Operations Division Treatment Authorizations Request Volume Report for calendar year 2001. Information on 2001 Medi-Cal field office personnel provided by the field office administrators, May 2002.

Note: Adjusted TARs adjudicated include hospital stay extension TARs multiplied by the number of days of the hospital stay (since each day is adjudicated independently), and all additional TARs that nurses are supposed to adjudicate. For example, if there are 30 hospital stay TARs with an average length of stay of 5.5 days and 25 additional TARs, the2001 TARs adjudicated is 55 TARs, but the adjusted adjudicated TARs is 190.

Table 12 reflects a tight range of adjudication ranging from 5,517 to 7,256 TARs per adjudicator per year. However, Table 13 shows a more accurate nurse workload picture with several offices showing low workloads and the Los Angeles office showing a very high workload for nurse adjudicators.

It is important to note that if hospital stay TARs were adjudicated on a "contract" rate instead of a per diem rate, the workload represented in Table 12 would be appropriate.

Table 13 only highlights nurse staffing, even though all adjudicators (including, physicians, medical technicians, and other nurses) assist in TAR adjudication. For example, in Los Angeles, appeal nurses or physicians assist nurses in their adjudication because, as the numbers above show, the workload is high.

10. Nurses could adjudicate some TARs currently adjudicated by physicians.

As listed in Table 14 below, Medi-Cal physicians adjudicate certain TARs, such as those for Magnetic Resonance Imaging (MRI) or elective surgeries. All other organizations surveyed indicated that nurses adjudicate most services, using medical guidelines, and physicians are only consulted for denials or complex cases.

> One organization's clerical authorization coordinators receive prior authorization requests via fax and use InterQual to determine whether the request meets guidelines. The coordinators have authority to approve certain types of prior authorizations; others are referred to nurses for adjudication. Responses are faxed to the provider. The process is usually completed in less than four hours.

Table 14. Adjudication Practices at Medi-Cal Field Offices

Category	TAR Service	Physician Consultant	Nurse	Medical Technician	Other
Home Health	Home Health		P		
Hospital	Hospital Stay (Extension)		P		
Hospital	Hospital Stay (Extension On-Site)		P		
Hospital	Hospital Admission	P	S		
Hospital	Hospital Surgery	P			
Hospital	Organ Transplant	P			
Hospital	Outpatient	P			
Long-term Care	Hospice Care		P		
Long-term Care	SNF Initial Authorization		P		
Long-term Care	SNF Reauthorization		S	P	
Long-term Care	Subacute	S	P		S
Physician	Office Visit	P		S	
Physician	Psychiatry	P			
Other	Adult Day Health Care		P	S	
Other	Detoxification			P	
Other	Durable Medical Equipment		P	P	
Other	Hearing Aids		S	P	
Other	Hemodialysis		S	P	
Other	ICF DD/DDH/DDN		P		

Category	TAR Service	Physician Consultant	Nurse	Medical Technician	Other
Other	Occupational Therapy				P
Other	Other				
Other	Physical Therapy		S		P
Other	Prosthetic/Orthotic	P			P
Other	Speech Therapy		P		
Other	Transitional Care		P		
Other	Transportation		P	S	

Source: Medi-Cal TAR field offices May 2002.

Note: P = Primary Adjudicator; S = Secondary Adjudicator; "Other" includes physical therapist, occupational therapist, and so on.

11. Non-on-site (mail-in) TARs are generally retroactive for date of service.

From the data available, it is estimated that overall, approximately 84 percent of non-on-site (mail-in) TARs are retroactive for date of service. As shown in Table 15, this number differs by service adjudicated. Typically, by the time the field office receives the TAR, the beneficiary has already received services from a provider. This eliminates the possibility for the Medi-Cal field office adjudicator to assist the provider in determining the beneficiary's most appropriate care. Assembly Bill 2877, which passed on July 7, 2000, allowed for retroactive adjudication of TARs by repealing the "10 day timeliness clause." This has significantly changed the role of the TAR. As a result of the legislation, a TAR is no longer considered a prior authorization of services since, at the time of adjudication, services have already been rendered. Rather a TAR is only a preapproval for the billing of services already rendered.

In comparison, among the other organizations surveyed, providers submit prior authorizations before the service is rendered more than 90 percent of the time, since the prior authorization response is received on average in less than two days.

Table 15. Retroactive TARs by Provider Category

Category	TAR Service	Submission Method	TAR Volume	Percent Retroactive (based on volume)
Home Health	Home Health	Mail	33,210	81%
Hospital	Hospital Stay (extension non-on-site)	Mail	110,304	99%
Hospital	Hospital Admission	Mail	23,607	79%
Hospital	Hospital Surgery	Mail	12,909	78%
Hospital	Organ Transplant	Mail	2,081	50%
Hospital	Outpatient	Mail	80,525	80%
Long-term Care	Hospice Care	Mail	650	93%

Category	TAR Service	Submission Method	TAR Volume	Percent Retroactive (based on volume)
Long-term Care	SNF Initial Authorization	Mail	83,980	100%
Long-term Care	SNF Reauthorization	Mail	24,046	99%
Long-term Care	Subacute	Mail	6,055	0%
Physician	Office Visit	Mail	3,482	85%
Physician	Psychiatry	Mail	19	47%
Other	Adult Day Health Care	Mail	49,507	96%
Other	Detoxification	Mail	4,252	58%
Other	Durable Medical Equipment	Mail	114,545	51%
Other	Hearing Aids	Mail	27,843	50%
Other	Hemodialysis	Mail	11,445	79%
Other	ICF DD/DDH/DDN	Mail	8,631	100%
Other	Occupational Therapy	Mail	4,382	48%
Other	Other	Mail	4,932	15%
Other	Physical Therapy	Mail	30,285	73%
Other	Prosthetic/Orthotic	Mail	8,514	74%
Other	Speech Therapy	Mail	2,722	49%
Other	Transitional Care	Mail	10,298	50%
Other	Transportation	Mail	196,649	99%
TOTAL		Mail	854,873	84%

Source: RF-O-029 Medical Operations Division Treatment Authorizations Request Volume Report for calendar year 2001; Medi-Cal TAR field offices May 2002.

Note: TAR volume includes number of TARs processed through the seven core field offices in 2001 (including San Jose). TARs processed through the pharmacy field offices are excluded. Hospital stay TARs processed on-site are also excluded.

Although Medi-Cal field office personnel adjudicate TARs based on medical necessity, the TAR is often a "prebilling authorization" for services that have already been rendered, rather than a treatment authorization. Providers indicate that since most other payers adjudicate the TAR in two days or less, they usually submit prior authorizations for those payers before the service is rendered.

12. TAR services are evaluated infrequently.

Medi-Cal's TAR workload group spent four months in 2001 reviewing and evaluating 16 services using criteria such as current practice patterns and potential for overutilization and fraud. Through these efforts, a recommendation was made to reduce the yearly TAR volume

statewide by 50,000 TARs, or 1.9 percent of total TARs.[18] Some 85 percent of the surveyed health care organizations routinely evaluate their prior authorization list through an established process. Evaluations are usually done annually, although some occur monthly or semiannually.

13. TAR field office processes are neither provider nor beneficiary focused.

Several services are often required to complete appropriate treatment for a beneficiary. For example, a beneficiary requiring hemodialysis could also require transportation to the hemodialysis center. However, TARs for such related services are not necessarily coordinated, and the TAR requests are sent to two different TAR offices. The hemodialysis TAR is sent to the local field office, since it is a core service, and the nonemergency medical transportation TAR, which is a regionalized TAR, is sent to the San Diego or Sacramento office. The lack of coordination leads to differing adjudication times and, in some cases, different decisions for TARs. Another similar example is oxygen services and oxygen equipment.

14. Cumbersome state hiring practices make recruiting staff difficult for Medi-Cal.

The state is unable to respond quickly to needed staff shortages and has imposed a hiring freeze statewide. Currently, MCOD has a 5 percent vacancy rate statewide. Several Medi-Cal field offices expressed difficulty identifying, attracting, and hiring qualified candidates, although few offices have difficulty retaining personnel once hired. Recruitment of pharmacy personnel, in particular, is a continuous struggle, and DHS has outsourced the responsibility for recruiting pharmacists to EDS.

In response to the state's difficulty with recruiting, the State Personnel Board (SPB) completed a needs assessment evaluation in October 1993 for MCOD.[19] In light of SPB's recommendations, MCOD has implemented an expedited hiring process of three of its health professional classifications (nurse evaluators, medical consultants, and pharmacists). In addition, field office staff have been trained by SPB to conduct their own Qualification Appraisal Interview Panels (QAIP), which has expedited the hiring process. Lastly, MCOD headquarters personnel staff, in conjunction with the field office administrators and supervisors, have developed a customized supplemental application for the selection of nurses, doctors, and pharmacists.

MCOD has attempted to work as responsively as possible within the state's constraints. MCOD management continually reviews the hiring and staffing needs of each office and, when a vacancy occurs, determines the best usage of that position. Therefore, when appropriate, vacant positions are moved among the field offices and headquarters as dictated by workload and other factors.

15. The fiscal intermediary contract is used as a means to address staffing issues.

Additional staff are needed in certain offices to address the TAR workload. DHS has used the flexibility of the fiscal intermediary contract to hire additional staff through EDS. This has occurred most notably in both pharmacy field offices and the Los Angeles field office. This practice creates challenging management-reporting structures, and requires supervisors from both DHS and EDS. In some cases, EDS staff outnumber DHS staff in a given position. For example, in the Southern Pharmacy field office, 27 of the 47 pharmacists are EDS employees.

16. Correction of TARs is labor intensive and time consuming.

Most field offices receive and manage corrections via mail, and some allow fax and telephone corrections in extreme cases. Some offices require supervisory approval of all corrections. Some require that all corrections, including data entry errors, go through the TUT process, while others do not.

CA-MMIS does not allow the adjudicator to quickly view the last update to a TAR, nor does it compile a history and date of all updates to the TAR. All corrections should be, but are not necessarily, listed in the comment section of the TAR.

Provider satisfaction ratings for Medi-Cal TAR corrections averaged 3.2 out of 5. Reasons given include:

- The correction process is noted to be inconsistent even within the same office, depending on the individual field office representative.

- Providers consider the process to be overly bureaucratic and slow, and there is little collaboration to quickly resolve corrections. Providers are asked to resubmit TARs or written documentation to correct even minor corrections (such as correcting a "2" to a "20," marking "male" rather than "female," or correcting an incorrect number of cc's of a drug). In some cases, when TAR handwriting is illegible, providers have been asked to mail in a written request to have the handwriting deciphered. From the providers' perspective, corrections appear to be Medi-Cal's last priority and, in some offices, can take as long as 120 days to resolve.

In response to problems, MCOD has begun to address this issue throughout the field offices.

17. Lack of local management-reporting tools at field offices make day-to-day operational management difficult.

The standard Batch Entry Log System (BELS) report generated through CA-MMIS provides limited value as a management-reporting tool. Various offices create their own management-reporting tools and some hand-count items in order to track office performance. While these efforts are laudable, they underscore the need for standard robust management-reporting tools, which could be used to evaluate and track TAR receipts and staff productivity on a real-time basis, and to identify and predict problem areas. It is anticipated that *e*-TAR, when fully implemented, will be able to alleviate problems associated with management reporting.

18. Incomplete TAR tracking does not account for the full workload of the field offices.

Several practices lead to an inaccurate count of TARs. Deleted TARs are removed from the system and the paper trail on those TARs is lost; yet, the number of deleted TARs is accurately counted. However, misdirected or incomplete TARs may be counted twice in some offices and not counted at all in others, depending on each office's particular practice. Duplicate TARs are addressed in a variety of ways in field offices, which leads to an inaccurate reporting of the number of TARs. No report exists to track all potential duplicate TARs in the system. "Paperless" TARs (TARs sent from state hospitals to the field offices) are not entered into the system but do represent work performed by the adjudicators. DHS tracks TAR volume and activity on a monthly and annual basis through the RF-O-029 Medi-Cal Operations Division

Treatment Authorization Requests Report. However, the report does not include TARs for certain services (for example, deferred TARs for on-site visits, and state hospital "paperless" TARs).

19. Deferred TARs are inadequately monitored.

Approximately 8 percent of Medi-Cal TARs are deferred statewide, yet there is no knowledge of the outcome of the deferrals. Once a TAR is deferred, it is not tracked through the Medi-Cal system, and its ultimate disposition is unknown. Providers view a deferred TAR as a "live" TAR awaiting a decision; yet, to the field office, the TAR has been adjudicated and a decision has been made. This discrepancy leads to misunderstandings as providers attempt to obtain a decision on a deferred TAR through additional documentation. Some deferred TARs may come back into the system as new TARs; others come back into the system with additional information to complete the original TAR; and others may never come back into the system at all. In addition, there is no process in place to identify how often a TAR is "touched" prior to completion, which leads to inaccurate volume statistics. The lack of tracking of deferred TARs tdoes not allow field offices to identify common reasons for TAR deferrals or to address those reasons through streamlined processes or provider education.

> Health Plan of San Joaquin has implemented a system for addressing "open" deferrals. If the provider has not returned a response to the deferral after three phone calls or four weeks (whichever comes first), an automatic denial letter from the medical director is sent to the provider.

Most other organizations surveyed indicated that they do not defer prior authorizations; in fact, these organizations stated that they prefer to deny a prior authorization rather then defer it. Of the organizations that do defer TARs, the deferral on the TAR is "closed" after a period of time of actively trying to complete the TAR. These organzations also reported that they actively monitor the volume of "open" prior authorizations.

20. The Los Angeles Medi-Cal field office has a significantly different profile than other offices.

As the largest Medi-Cal field office, Los Angeles has the highest volumes in the state, including:

- 25 percent of all adjudicated TARs;
- 48 percent of hospital stay on-site TARs;
- 36 percent of hospital stay non-on-site TARs; and
- 43 percent of first-level appeals (see Tables 16 and 19).

In addition, 61 percent of the Los Angeles field office's TAR volume consists of the more complex hospital stay TARs (see Table 17). These volumes, coupled with the above average workload and lengthy processing times discussed earlier, result in significant provider frustration. It is the intent of Medi-Cal to increase staffing in the Los Angeles field office. This will be achieved by making first-level appeal nurses available to adjudicate TARs and by hiring additional staff through hiring freeze exemptions.

Table 16. Hospital On-site and Non-on-site Extension-of-stay TARs by Field Office

Field Office	Hospital Stay On-site TARs	Percent of Total Hospital On-site TARs	Hospital Stay Non-on-site TARs	Percent of Total Hospital Non-on-site TARs
Fresno	12,333	5%	19,986	18%
Los Angeles	108,836	48%	39,955	36%
Sacramento	23,210	10%	11,152	10%
San Bernardino	25,519	11%	17,092	15%
San Diego	17,419	8%	6,067	6%
San Francisco	18,731	8%	6,429	6%
San Jose	20,303	9%	9,385	9%
TOTAL	226,372	100%	110,304	100%

Source: 2001 RF-O-029 Report.

Note: Total includes a small number of TARs processed through the two pharmacy offices. The San Jose field office is included since it operated throughout 2001.

Table 17. Hospital Extension-of-stay TARs as a Percentage of Total TARs by Field Office

Field Office	Hospital Stays TARs	All Other TARs	Total Number of TARs	Percent of Total TARs	Hospital TARs as a Percentage of Total TARs
Fresno	32,319	71,697	104,016	10%	31%
Los Angeles	148,791	96,016	244,807	23%	61%
Sacramento	34,362	109,474	143,836	13%	24%
San Bernardino	42,611	133,450	176,061	16%	24%
San Diego	23,486	144,219	167,705	16%	14%
San Francisco	25,160	155,866	181,026	17%	14%
San Jose	29,688	29,275	587,963	5%	50%
TOTAL	336,676	739,997	1,076,414	100%	31%

Source: 2001 RF-O-029 Report.

Note: Total includes a small number of TARs processed through the two pharmacy offices. The San Jose field office is included since it operated throughout 2001.

Pharmacy TARs

1. A large number of drugs require TARs.

All drugs not included on the Medi-Cal pharmacy formulary, and all requests for drugs above the 6Rx limit, require a TAR. This includes maintenance drugs for chronic conditions and other drugs that are routinely approved. One of the health care organizations surveyed evaluates only "A-rated" generic drugs, biotech drugs, or new drugs. This limited evaluation drastically reduces

the volume of prior authorizations for drugs. Other states surveyed limit their benefits to a certain number of drug prescriptions per month (for example, three drugs maximum) and do not approve any drugs beyond the limit.

2. Pharmacy TAR volume is increasing.

The Medi-Cal drug benefit is one of the most heavily utilized benefits. Since the inception of the 6Rx limit, the volume of drug-related TARs has increased significantly and now accounts for approximately 60 percent of the entire TAR volume. It is estimated that more beneficiaries will take advantage of this benefit in the future.

3. Pharmacy TAR processing times vary significantly between the beginning and the end of the month.

Regular pharmacy TARs are distributed relatively evenly throughout the month. However, the 6Rx TARs, which account for 60 percent of the drug TAR volume, begin to increase linearly starting midmonth. This leads to an ever-increasing TAR volume throughout the month resulting in a very heavy TAR volume at the end of the month. At the beginning of the month, TARs are adjudicated consistently by the next working day; however, by the end of the month, with the significant increase in volume, it becomes very difficult for staff to adjudicate the TARs in that same time frame. Providers routinely complain that TAR turnaround times are usually one to two days at the beginning of the month, but—by the end of the month—the turnaround time can increase to five or six days.

In addition to changes throughout the month, pharmacy processing times vary by two days between the Northern Pharmacy field office and the Southern Pharmacy field office (see Table 9). The increased adjudication time at the Southern Pharmacy field office is most likely the result of the office faxing the TAR back to the provider and then entering the TAR into CA-MMIS. Although the stated goal for the pharmacy offices is a 24-hour processing time, the departmental goal for processing is the next working day after receipt. Both pharmacy offices are required to return an authorization to providers in 24 hours. However, due to a provision in the EDS contract with DHS allowing 72 hours for data entry into the system, the authorization may not be entered into the system for another three days. Although EDS strives to meet the needs of DHS, they are not always able to do so. As a result, when there are delays in EDS processing, providers are unable to bill against authorizations. This is of particular issue in the Southern Pharmacy office. The provision in the EDS contract has been addressed in the current procurement for the fiscal intermediary and will be reduced to a 24-hour processing time to better meet the needs of the Pharmacy field offices.

> One state Medicaid program has both a voice response unit and a help desk for pharmacy authorizations. Through a series of prompts, a provider can obtain immediate approval or denial of prior authorizations. The help desk processes prior authorizations within 24 hours.

In comparison, unlike Medi-Cal, three of the four state Medicaid programs surveyed have Pharmacy Benefits Management (PBM) vendors, and one has a state-administered program. Each of these Medicaid programs report a 24-hour turnaround on pharmacy prior authorizations.

4. Pharmacy staffing ratios are consistent across the two field offices.

Table 18 compares the staffing ratios for 2001 adjudicated TARs in the pharmacy field offices. Both pharmacy field offices are relatively consistent in the number of TARs received and adjudicated. Each office has approximately the same number of consultants, although that number increased sharply in 2002. For example, the Southern Pharmacy office now has 47 adjudicators and is still looking to hire additional staff.

Table 18. Pharmacy Field Office Staffing Ratios for Adjudicated TARs, 2001

Field Office	2001 TARs Received	2001 TARs Adjudicated	Modified/ Denied TARs	Pharmacist Adjudicators	Yearly Adjudicated TARs per Adjudicator
Northern Pharmacy	809,648	798,362	65,818	31	25,754
Southern Pharmacy	834,964	819,511	126,536	30	27,317
Total	1,644,612	1,617,873	192,354	61	26,523

Source: RF-O-029 Medical Operations Division Treatment Authorization Requests Volume Report for calendar year 2001.

The volume of TARs adjudicated in the pharmacy offices is significantly higher than the regional offices, averaging 26,523 TARs per year. Between 60 and 70 percent of pharmacy TARs are the 6RxTARs, or TARs for members who have exceeded the sixth instance of a contract drug in that monthly period. These TARs can be adjudicated relatively quickly as they are evaluated solely on medical necessity.

5. The Pharmacy field offices do not match their client's work hours.

Both pharmacy offices are available to providers from 8:00 a.m. to 5:00 p.m., Monday through Friday. In contrast, pharmacies operate from early morning to late evening, on weekends, and some on a 24-hour basis seven days a week.

TAR Appeals and Fair Hearings

1. The TAR appeals processes and decisions vary significantly across field offices.

Although the appeal process is supposed to require an independent review, in two of the offices the reviewer who initially adjudicates the TAR also evaluates the appeal, and in another office the field office administrator evaluates all appeals. This process is very time consuming, as a significant amount of research is required to evaluate the appeal. It is also manually intensive in that many of the reviewers handwrite the appeal decision, which is then forwarded through a three-level approval process and typed by clerical staff.

The current decentralized approach for processing first-level appeals, in which appeals are performed in each office, does not necessarily lead to either independent or standardized appeal decisions. Some believe that the appeals process seemed to work best when individual staff members specialized in performing appeals. The difficulty of appeals ranges significantly. Some appeals are overturned because the provider did not submit the proper documentation with the

original TARs (but did submit the documentation with the appeal). Others are more complex, requiring several individuals to collaborate and evaluate the appeal.

Providers expressed frustration with trying to guess at the additional information Medi-Cal needs to justify medical necessity for an appeal. In addition, providers stated that requests for backup information are often extensive, and sometimes physicians are unable to obtain the requested information from hospitals. For example, a retroactive TAR for an angioplasty was returned with a request for the following: information on when the patient was first seen; a copy of the discharge summary; and information on all studies, including EKGs, echocardiograms, chest x-rays, and cardiac enzyme tests. The provider stated it was not always possible to get the requested documents from the hospital. In this particular case, the results were instead dictated in the enclosed consultation report, including the fact that the patient had a 90 percent blockage at the time of the procedure.

Provider satisfaction ratings with the appeal process averaged about 2.5 out of 5. An appeal can take several months to a year to be resolved. Providers that are not successful in having decisions overturned durin the first-level appeals process may appeal again through the second-level appeals process, which is centralized in Sacramento. Providers appear to fall into one of the following three categories:

- providers that never appeal because the process is considered to be too lengthy and they do not know why the decision was denied or understand what information Medi-Cal is attempting to obtain to make its decision;

- providers that automatically appeal at the first level, and, if denied, at the second level to "see if they can squeeze any money out of Medi-Cal"; these providers tend to send "any and all documentation" to the field office; and

- providers that appeal those cases where they feel they should and can win the appeal.

2. There are too many appeal levels.

A provider can request a first-level appeal at the Medi-Cal field office from an independent adjudicator. If the appeal is denied at the field office level, a second-level appeal can be requested from a centralized appeal department in Sacramento. In contrast, most organizations surveyed have only one appeal level performed in a central location. As of this report, DHS has submitted regulations to consolidate appeals to one level in Sacramento.

3. Appeals ratios vary significantly by Medi-Cal field office.

Table 19 compares the 2001 appeals volume and activity across field offices. The Los Angeles, Sacramento, and San Diego field offices have higher first-level appeal rates (as a percentage of modified/denied appeals), demonstrating the propensity of southern California hospitals and nonemergency transportation providers to appeal more readily. These appeals do not necessarily yield higher overturn rates, as both the San Diego and Los Angeles offices have high denial rates, but they do cause significant work for those field offices.

Table 19. Appeals Ratios

	First-level Appeals							Second-level Appeals				
Field Office	First-level Appeals	Appeals as a Percent of Adjudicated TARs	Appeals as a Percent of Modified /Denied TARs	Approved (Overturned)	Modified	Deferred	Denied	Second-level Appeals	Second-level Appeals as a Percent of First Level Appeals	Approved (Overturned)	Modified	Denied
Fresno	897	.89%	6.5%	28%	7%	N/A	65%	301	34%	37%	7%	47%
Los Angeles	6,861	2.8%	11.2%	16%	8%	N/A	76%	2,360	34%	34%	17%	35%
Sacramento	2,270	1.59%	10.4%	36%	52%	N/A	12%	255	11%	26%	10%	32%
San Bernardino	854	.50%	6.2%	65%	6%	N/A	29%	79	9%	20%	7%	71%
San Diego	1,986	1.19%	8.5%	22%	5%	1%	72%	1,091	55%	39%	14%	46%
San Francisco	2,899	1.66%	6.2%	16%	9%	9%	66%	1,375	47%	6%	3%	88%
Northern Pharmacy	162	.02%	.24%	47%	1%	5%	45%	N/A	N/A	N/A	N/A	N/A
Southern Pharmacy	12	.001%	.009%	0%	0%	0%	100%	N/A	N/A	N/A	N/A	N/A
Total	15,941	.60%	4.3%	N/A	N/A	N/A	N/A	5,461	N/A	28%	12%	49%

Source: Information provided through primary interviews at each Medi-Cal field office.

Note: Southern Pharmacy only tracks denied appeals. The remainder of second-level appeals was litigated or no decision was made. N/A indicates data are not available.

The overturn rate of appeals varies significantly among field offices, ranging from a low of none (0 percent) in the Southern Pharmacy field office to a high of 65 percent in the San Bernardino field office. This variance appears to be due to differences in processes and procedures within the various field offices. For example, the Southern Pharmacy field office only tracks denied appeals, thereby making it difficult to evaluate the true number of appeals being performed in that office. Also, the San Bernardino office will frequently deny an initial TAR that does not have sufficient documentation. This TAR returns as an appeal with the proper documentation, and is then overturned.

4. Fair hearings processing differs significantly across field offices.

In some Medi-Cal field offices, only one person completes all fair hearings, and the fair hearing processor may be a nurse or a medical technician (Med-Tech), depending upon the office. In

other offices, the work is distributed among various staff members. The process is very time consuming, as a significant amount of research is required to evaluate each fair hearing. It is also manually intensive, in that many of the reviewers handwrite the decision, which is then forwarded through a three-level approval process and then typed by clerical staff. Some believe that the fair hearing process worked best when individual staff members specialized in performing fair hearings processing.

The state Department of Social Services (DSS) works with beneficiaries to create fair hearing requests. However, incorrect fair hearing requests are often submitted or a request is submitted to the wrong field office. These errors suggests that the DSS staff may not have a clear understanding of the purpose of the fair hearing request or the procedures required to process them.

5. Fair hearing statistics vary across Medi-Cal field offices.

Table 20 compares the 2001 fair hearings volume and activity across field offices. The San Diego field office demonstrates a significantly higher rate of fair hearing requests (2 percent of all modified or denied TARs), as compared to the other field offices, which are all less than 1 percent. One provider in the San Diego service area is currently acting as the representative for Medi-Cal beneficiaries for fair hearing requests and is submitting a large number of requests.

Table 20. Fair Hearing Statistics

Field Office	Fair Hearing Requests	TARs Received	TARs Adjudicated	Modified or Denied TARs	Fair Hearings as a Percent of TARs	Fair Hearings as a Percent of Modified or Denied	Withdrawn/ Dismissed/ Rescinded	Position Statements	Percent with Position Statements
Fresno	102	104,016	100,712	13,867	.10%	0.74%	5	97	95%
Los Angeles	191	251,083	247,479	61,029	.07%	0.31%	31	92	75%
Sacramento	58	143,836	142,337	21,884	.04%	0.27%	42	13	24%
San Bernardino	37	176,061	169,070	13,697	.02%	0.27%	33	3	3%
San Diego	472	167,705	167,302	23,287	.28%	2.00%	340	132	28%
San Francisco	135	181,026	174,765	46,811	.08%	0.28%	69	60	47%
Northern Pharmacy	117	809,648	798,362	65,818	.01%	0.17%	110	23	18%
Southern Pharmacy	404	834,964	819,511	126,536	.05%	0.32%	94	77	45%
Total	1,516	2,668,339	2,619,538	372,929	.06%	.41%	724	497	41%

Source: Information provided through primary interviews at each Medi-Cal field office.

Note: Totals may not add up to 100 percent due to rounding errors. Some TARs are still in progress and some were deleted from the system. The Southern Pharmacy number may be artificially high, as fair hearings not addressed one month are added to the next month's total.

Many of the offices do not write a position statement explaining the department's rationale for a decision for the fair hearings they receive. Most offices attempt to resolve fair hearings, to the degree they can, before creating a position statement.

Findings Specific to Medi-Cal Claims

1. Overall, EDS does an excellent job of processing "clean" electronic claims.

EDS has an efficient process for validating, processing, and paying claims submitted electronically. In most cases, payment is available in less than seven days. Providers are satisfied with how efficiently and quickly EDS processes "clean" electronic claims (electronic claims that require no special handling). Many providers surveyed stated that they have perfected their techniques in submitting electronic claims and use paper claims only as needed. As a result, Medi-Cal claims processing times compare very favorably to Medicare and other payers.

In addition, EDS is able to meet claims cycle times well. EDS has created a cycle time report, which is shared with DHS. This cycle time report shows the standards required for the claim category and EDS's performance in each category. With one exception in the appeals area, EDS is meeting or exceeding its cycle time in the areas evaluated by this report.

2. A high percentage of claims are submitted electronically.

Some 80 percent of Medi-Cal claims are submitted electronically. This percentage is similar to that in other surveyed Medicaid programs, as two states Medicaid programs submit the same percentage electronically, while two others have electronic submission rates of 93 and 97 percent. All states seem to be limited by claims that require attachments, as these are always submitted on paper.

3. Paper claims and complex claims cause more difficulty.

Claims submitted on paper (due to attachments, inability of a program to bill electronically, or provider preference) are processed more slowly and have higher suspense ratios. Providers consider the most problem-inducing claims and issues to be:

- split billing (occurs when a length of stay is billed in multiple pieces; for example, the 1st day of the month through the 15th is on one bill, and the 16th through the 31st of the same month is on a separate bill);
- share of cost (when an individual pays a portion of their medical care);
- claims pending eligibility;
- other coverage (a service is billed to multiple entities, such as Medicare);
- coding and systems issues/errors;
- additional documentation/justification; and
- corrections.

4. Corrections of claims are frustrating and require a lengthy process to resolve.

If a claim is suspended or denied and a provider believes that the claim should have been paid, a correction may be necessary. Providers surveyed indicated corrections of claims as their primary problem, claiming significant difficulty obtaining resolution on corrections. Although few corrections claims are problematic, the effort and time required to track the claims in the system is extensive. Every provider interviewed indicated ongoing problems with corrections claims. Some claims remain "unresolved" one or two years after the date of service. One provider reported having a continous correction claim "bucket" that amounts to one-third of the monthly billings. Each month, some claims go in to and others come out of this bucket—but the dollar amount in the bucket remains constant.

Providers rated the correction process a 2.7 out of 5 and stated particular difficulties with the Claims Inquiry Form and appeals processes. Providers cited the Medicare corrections process, which allows online corrections, as a practice they would like to see implemented for Medi-Cal claims.

5. The Resubmission Transmittal Document (RTD) form is straightforward.

The RTD paper form enables providers to resubmit information for certain types of suspended claims. The form is used for a validation error (such as information the provider inadvertently overlooked or neglected to include on the form). The process was found to be relatively straightforward and expeditious.

6. The Claims Inquiry Form (CIF) is difficult to use and providers misunderstand the process.

The CIF form enables providers to inquire on a claim or make relatively straightforward corrections to a suspended claim. Providers are required to type or print this paper form and return it via mail. The CIF is then entered into the computer at the claims center, which allows for automated processing of inquiry forms. Suspended claims will pend again, and a claims examiner will manually attempt to correct the claim based on the CIF.

7. The appeal process is lengthy and requires significant documentation.

Based on Medi-Cal's cycle time reports, both standard and professional appeals are at, or slightly exceed, the contractual cycle time requirement of 45 and 75 days, respectively.[20] Providers expressed frustration with the length of time it takes to receive appeals decisions and the volume of documentation required for an appeal.

8. The Remittance Advice (RA) does not always clearly explain nonpayment reasons.

Although the reason code is stated on the Remittance Advice (RA) for denied claims, providers reported that it is often difficult to evaluate why the reason code is appropriate for that claim. For example, a claim may be listed as duplicate, but there will be no reference to the original paid claim. One provider indicated that, on a $5,000 claim, the RA informed them that $10.37 was paid, $50.00 was suspended, and the remainder of the claim was denie; yet, from the RA the provider was unable to determine the reasons for each of these adjudication decisions.

> One state Medicaid program lists the status of pended claims on their remittance advice. It shows a snapshot of where the claim is in the process, and the status is updated each time the RA is printed, usually weekly.

9. Coding updates are often delayed resulting in inaccurate payments.

Medi-Cal is often slow in updating its system with new codes for various procedures. Many of the issues related to coding updates are expected to be addressed with HIPAA (Health Insurance Portability and Accounting Act of 1996), which will standardize these transactions.

10. Overall, EDS does a good job of meeting the contract-specified cycle time requirements.

EDS has developed good monitoring tools to evaluate claims cycle times. The Medi-Cal Cycle Time Analysis Report is shared with DHS management on a monthly basis. The report details 43 categories that are evaluated, the report source referenced, and the specific contract standards measured within each category. Each month is listed and evaluated against the individual measurements, and instances where EDS is not meeting the standard are identified.

EDS is doing an excellent job of managing the claims that it receives and there are only three areas where EDS's performance is slightly outside the established standards, as shown below.

Table 21. EDS Cycle Time Standards

Category	Contract Standard	Performance Outside the Standard for Year 2001	Comments
Claims Inquiry Form	99% in 75 days	2 months (79–96 days)	
Appeals Examined	100% in 45 days	6 months (46–48 days)	The other 6 months are exactly at 45 days
Appeals Professionally Reviewed	100% in 75 days	1 month (76 days)	All other months are exactly at 75 days

Source: Medi-Cal Cycle Time Analysis Report, 2000–2001.

11. Claim resolution is not tracked.

Although EDS has mastered the ability to track the cycle time of a claim and ensure that it is processed in a timely manner, DHS does not require EDS to track of the resolution of a claim. For example, it is unknown how many claims become CIFs, and how many of these CIFs become appeals. Additionally, the total resolution time is not tracked, so when a problematic claim is finally resolved, there is no statistic identifying resolution time from the date of service, or the number of steps to which it was subjected (including, claim process, RTD, CIF, appeal, and professional appeal).

12. Duplicative archiving processes waste time and money.

EDS archives claims information in digital storage through their input process. However, DHS requires by conract that a permanent copy be saved on microfilm. DHS is working to change its process to digital archiving.

13. Inconsistent EDS Claims Help Desk service confuses providers.

To be useful, the EDS Claims Help Desk should be able to demonstrate versatility in addressing a variety of questions. All organizations surveyed indicated that this is a particularly difficult function for EDS to perform effectively. Providers rate the help desk service at 2.9 out of 5. Although the help desk staff are often able to answer the more straightforward questions, providers expressed frustration with the lack of knowledge for more specialized questions (for example, questions regarding split billing, share of cost, co-pays, durable medical equipment), and the unwillingness of the help desk staff to research the correct answer.

Providers also indicated that EDS staff do not appear knowledgeable about the questions posed. An EDS staff member may read from the provider manual, but at DHS's request, is unable to interpret the manual. In addition, providers reported that telephone calls to the the toll-free number are not answered for a long time, and then it takes a long time to get through the prompts—both problems result in frustration in obtaining resolution to questions. The lack of EDS staff continuity results in little opportunity for providers to build relationships with a particular staff member or to work with more experienced staff members. Providers reported spending additional time repeating and explaining prior requests to different EDS staff members. One provider states, "We can call three different staff members at the EDS Claims Help Desk and get three different answers to the same question."

The procurement for the fiscal intermediary contract currently under consideration calls for the enhancement of the provider relations operations, which should address some of these issues.

Provider Communication Findings

1. Providers are frustrated with ineffective communication with the Medi-Cal field offices.

The level and frequency of provider communication varies among field offices. Some offices have developed extensive education programs targeted at particular providers (for example, for those providers whose TAR denial rates have risen above 10 percent) and at provider associations (for example, a transportation association). With rare exceptions, providers cannot reach a specific staff member consistently through a direct phone number. Most offices are very protective of their staff members' time and accessibility, distancing them from direct interaction with providers. As a result, providers calling the field office with questions usually speak to a different individual on each call. Providers rate field office communications at 3.3 out of 5. This rating increased significantly to an average of 4.25 when providers were able to work directly and frequently with one individual, such as a case management nurse, which allows providers to build long-term partnerships in caring for patients. Providers are looking for an "advocate" in the field office who assists them in navigating the process so that their issue is resolved expeditiously.

2. All providers are treated in the same manner.

Medi-Cal TAR procedures treat all providers in the same manner, regardless of the particular provider's utilization management practices, adjudication history, fraudulent tendencies, or Medi-Cal knowledge. This "one size fits all" approach does not reward providers for good performance.

3. The provider manual is unwieldy.

The provider manual is the product of an attempt to synthesize the enormous amount of information that should be communicated to providers into one document. Medi-Cal has recently revised the manual, relying heavily on feedback from providers through focus groups. Many providers surveyed indicated that they like the comprehensive index, cross-referencing system, and table of contents; but some providers still find the manual confusing, and locating specific topics remains difficult.

4. Changes in the provider manual are paper intensive, often unclear, and time-consuming to manage.

Correction pages are sent to providers when changes are made to the manual. The provider then inserts these pages into the provider manual to keep it current. Often, there is no indication of what corrections were made on the pages or the relevance of the corrections. The numerous changes and/or bulletins are time consuming to manage, and it is not always possible to get clarification on the new policies from Medi-Cal staff.

5. The online provider manual is useful for experienced providers.

The online version of the provider manual duplicates the provider manual and is updated in a timely manner on the Web site. Some providers use the online manual exclusively. The online manual serves experienced providers well. However, some newer providers may have difficulty using the search engine to query information, as they must know exactly what they are trying to find.

6. Medi-Cal seminars have a variable impact.

EDS currently performs training seminars, but many providers prefer to speak directly to field office personnel regarding TAR issues. This creates a duplicative structure and can lead to conflicting information. Some providers consider the Medi-Cal seminars to be helpful while others find it difficult to obtain answers to their specific questions regarding expediting claims payments. The provider community has a poor understanding of the denied and suspended claims processes as well as the RTD, CIF, and appeal processes.

7. Providers are not familiar with the Provider Telephone Network.

Once a TAR is adjudicated and entered into CA-MMIS by EDS staff, the decision is available to providers via a telephone answering system. If the decision is approved, the provider may submit a claim against that TAR. However, many providers are unaware of the telephone service, or, if they are aware of the service, they are unaware that they can submit the claim without having the approved paper TAR.

> "We always call the provider with prior authorization denials. Sometimes it is to educate the provider that a certain benefit is not part of their contract (for example, mental health). Often, we receive additional information that will allow us to approve the prior authorization." [Small managed care health plan]

8. The Provider Telephone Network does not provide sufficient information on modified and denied TARs.

If a TAR is approved, the telephone system provides detailed information on the service, quantity, and other details of the TAR. However, modified and denied TARs are reported as "modified" or "denied," with no further details available. This

prompts many calls to the field office to ascertain the details of the decision. *e*-TAR should alleviate this problem, since providers will be able to check the status of TARs online.

IV. Recommendations

This section proposes recommendations to the above findings. A grid cross referencing recommendations to the findings outlined above is included in Appendix O.

Overall Recommendations

1. **Develop standardized criteria for monitoring and managing TARs and claims.**
   - ***Develop a comprehensive utilization management program.*** Using claims and TAR data, develop a baseline based on a variety of characteristics (such as provider, provider type, category, service, and geographic area). Create back-end processes to monitor potentially abusive utilization practices using reports and ticklers. Develop a cross-functional team composed of TAR, claims, and policy individuals who can work together to address issues that arise. This program could be similar to the "pre-check-write" process currently in place but would be more focused on utilization management. *e*-TAR may eventually facilitate this function once a majority of TARs are processed through *e*-TAR.

   - ***Align Audits and Investigation personnel with local field offices.*** Incorporate Audits and Investigation personnel as part of the local Medi-Cal field office staff, reporting through the field office administrator.

   - ***Use standard utilization management programs or create comprehensive guidelines for TAR adjudication.*** In comparison to the organizations surveyed, Medi-Cal is the only organization that does not use standardized criteria. This fact, coupled with the omnipresent comment that TARs were inconsistently adjudicated, requires a standard set of criteria to explain medical necessity. A clear set of guidelines will make it easier to communicate adjudication practices to providers, standardize documentation required for medical necessity, and explain denials. Given the Los Angeles office's higher-than-average workload, DHS should consider piloting standard guidelines in this office.

- ***Reduce the number of services that require TARs.*** After the above-mentioned recommendations have been implemented, DHS should identify services that could be managed in ways other than the TAR process.

- ***Develop different TAR sampling methodologies for providers.*** Using standard, objective criteria (based on the above-described utilization management program and comprehensive guidelines) develop appropriate TAR sampling guidelines by service and provider. For example, samples could range from 5 to 100 percent, depending upon the service and the provider's TAR and claim history. The same provider could be sampled at 100 percent for one service and 5 percent for another. Based upon provider TAR adjudication patterns and claim history, the field office could also develop targeted education.

2. Establish standard hospital contract rates.

- ***In the long term, establish standard hospital contract rates based on diagnosis code.*** In conjunction with California Medical Assistance Commission (CMAC), DHS should establish standard contract rates by hospital and by diagnosis code. Medicare has established standard payments based on diagnosis related groups (DRG), and other states have established standard rates for their state Medicaid programs. This will eliminate the need for routine TAR evaluation of hospital stays and extensions of stays, and will free up utilization management staff to work on the more complex hospitalizations.

- ***In the short term, consider establishing standard hospital contract rates for certain services or retroactive TARs.*** Establishing standard hospital contract rates for all hospitals based on diagnosis code may be a lengthy exercise. Therefore, in the short term, DHS should consider focusing on certain services, perhaps those that are consistently retroactive. (Retroactive TARs provide no opportunity to affect the beneficiary's care; thus, the only issue is how much the provider will receive in exchange for services already rendered.) Quality assurance should be ensured through a random sampling evaluation. These standard rates would standardize adjudication, increase productivity in TAR adjudication, and reduce the overall number of personnel needed for adjudication.

3. Enhance management-reporting tools.

Allow claims and TAR data to be accessed by managers so that routine analyses can be performed on a timely basis (for example, track TAR receipts and staff productivity on a real-time basis). In addition, managers should have the ability to design ad-hoc analyses to assess various management questions. One possible option is to create a data warehouse with a user-friendly front-end system. *e*-TAR will eventually facilitate this function, once a majority of TARs are processed through *e*-TAR.

Improving Medi-Cal TARs Processing

1. Create, implement, and communicate standard TAR turnaround-time guidelines.

Currently, there are no published TAR turnaround-time guidelines. Turnaround-time standards should be established and communicated, as well as actively monitored and managed. These turnaround times should be established from the point of view of the provider and should

incorporate mail and mailroom times—not just the processing time that is currently tracked by the field office. Turnaround-time standards could be customized by service (such as pharmacy, surgery, and so on) or medical urgency (for example, surgeries planned within the next two days should receive highest priority) or retroactive status (for instance, retroactive TARs should be returned more slowly than nonretroactive TARs). A customized system would require computer systems to monitor the TAR types and assess each category's performance.

2. Consider alternate methods of adjudication for retroactive TARs.

Given AB 2877, TARs will continue to be submitted retroactively. However, TARs that are routinely submitted retroactively by service or provider should undergo a different evaluation process.

3. Develop a methodology for assessing the processing time of on-site TARs.

Using *e*-TAR, DHS nurses should be able to identify the true processing time of TARs, as well as the number of times a particular TAR is "touched" by an adjudicator. This will help evaluate how many times a TAR is deferred and will assist with "midstream" transfers adjudication, as when a hospital stay is partially adjudicated in the hospital and partially evaluated non-on-site.

4. Implement *e*-TAR aggressively.

e-TAR will eventually assist with management reporting, but a meaningful picture will only begin to emerge once a majority of TARs are processed through *e*-TAR.

- Once the pilot is complete, the *e*-TAR application should be advertised and actively deployed within the provider community. Providers will need some targeted education and "handholding" to encourage them to use the application and appreciate its benefits.

- As an improvement to *e*-TAR, a standardized utilization management tool, such as Milliman and Robertson or InterQual, or a standard set of guidelines could be integrated into the application to assist with adjudication.

5. Perform a routine assessment of services that require a TAR.

Evaluate services that require a TAR on a yearly basis, including approval rates, potential for overutilization and fraud. Work with policy makers and other departments to identify what services can be removed from TAR authorization.

6. Reduce the number of services that physicians adjudicate.

Similar to the organizations surveyed, nurses—with well-defined criteria or guidelines—should adjudicate a significant number of the services that Medi-Cal physicians currently adjudicate. This would make the physicians available to consult with nurses on difficult TARs or to work with appeals.

7. Specialize staff members by TAR type or by provider.

Although cross training is important, staff should be encouraged to specialize by TAR type or provider. This will create more consistent adjudication decisions and increase efficiency. It is important to note that the offices that predominantly adjudicate one particular type of TAR are the most efficient at adjudication.

8. Consider auto-adjudication of certain TAR services.

Some services (such as hemodialysis services, some retroactive TAR services, or services that have very high approval rates) can be evaluated using very objective medical criteria. DHS should create a simple system to automatically adjudicate these TARs, with clinical personnel reviewing only those TARs that are suspended. Ensure quality assurance and fraud analysis through a random sampling evaluation. Auto-adjudication would standardize adjudication, increase productivity, and reduce the overall number of personnel needed for adjudication.

9. Enhance and communicate the TAR correction process.

This process should be performed consistently in a timely manner. A management report should be developed at the field office level to track the number of corrections received and their resolution time.

10. For the longer term, develop a strategy for the evaluation of pharmacy TARs.

Given the large number of drugs DHS is evaluating, the high number of 6Rx drugs, the distribution of 6Rx drugs throughout the month, and the heavy utilization of EDS to staff the pharmacy field offices, the department should develop a long-term strategy for pharmacy TARs. This strategy should include such options as:

- Place the pharmaceutical TAR management out to bid to various agencies, including Pharmacy Benefit Management (PBM) companies and the fiscal intermediary. Write a contract, impose and monitor performance criteria.
- Use the services of a mail-order pharmacy for routine drugs.
- Reevaluate the list of drugs that require a TAR. Remove maintenance drugs (such as cardiac conditions and diabetes) and drugs with high approval rates that are at a low risk for fraud.
- Evaluate whether the 6Rx drug limit is truly creating a cost savings. Based on the analysis, determine if a higher limit or no limit is more appropriate.
- Align the pharmacy turnaround time with the federal 24-hour turnaround time mandate. The state should model itself after the more stringent federal mandate and reduce provider confusion regarding the turnaround time.
- Ensure that the fiscal intermediary contract matches DHS's needs. The new fiscal intermediary contract requests 24-hour turnaround time, which should assist the pharmacy in performing post review in the stipulated 24-hour timeframe.

11. In the shorter term, address the hiring challenges of the pharmacy field offices.

Modify work schedules to better match the increasing TAR volume throughout the month:

- Consider placing pharmaceutical consultants on varied schedules (for example, seven hours a day the first two weeks and nine hours a day the last two weeks of the month).

- Consider having consultants work evening or Saturday hours to better match pharmacy hours.

- Use the EDS pharmaceutical consultants as variable staffing at the end of the month, instead of throughout the month, or for evening and weekend staffing. Hire two pharmaceutical consultants to work two weeks at the end of the month, instead of hiring one to work throughout the month.

12. Improve operational processes in the Medi-Cal field offices.

- Improve TAR tracking and turnaround times for the following:
  - on-site TARs;
  - deferred TARs; and
  - "paperless" TARs.
- Develop timely daily management tracking tools.
- Revise post-data-entry processes in the Southern Pharmacy field office by having EDS enter the TARs before faxing them back to the providers.

13. Consolidate related therapy TARs or similar services to the same field office.

- Medical services and related medical supply TARs (such as oxygen and oxygen equipment) should be sent to the same field office so that related TARs can be adjudicated together.
- Hemodialysis transportation should be approved at the same time the service is requested. Other similar examples should also be consolidated.

14. Enhance deferred TAR management.

Reduce the number of deferred TARs and evaluate the outcomes of TAR deferral.

- Encourage TAR adjudicators to call the provider to identify additional information that would allow the adjudicator to make a decision. Consider allowing the provider to fax in the additional information.
- Provide targeted education to providers on TAR deferral to reduce the number of future TAR deferrals.
- Close files on deferred TARs that are not returned to the office after a standard period of time (such as four weeks).

15. Eliminate the TAR appeal process from the Medi-Cal field offices and reduce the appeal levels to one appeal level.

Once consistent adjudication standards are established and communicated, the number of TAR appeals should decrease. The TAR appeal process in the field offices is inconsistent and

duplicative. DHS indicates they are in the process of eliminating the first-level appeal in the Medi-Cal field offices and consolidating all appeals to one level in Sacramento.

16. Enhance the fair hearing process.

- ***Remove the fair hearing process from the Medi-Cal field offices.*** Similar to the TAR appeal process, the fair hearing process is inconsistent across field offices. It should be centralized in the same department as the appeal department.

- ***Collaborate with DSS to streamline the fair hearing process.*** The Medi-Cal field offices and DSS should work together to develop better procedures for fair hearing cases, keeping the beneficiary's best interests in mind.

17. Manage staffing strategically.

- Discontinue hiring large numbers of staff through the fiscal intermediary contract.

- Reassess the staffing mix in the Medi-Cal field offices (for example, the Los Angeles field office).

- Evaluate the TARs to determine instances in which nurses could adjudicate instead of physicians.

18. Perform key systems improvements.

Some of these improvements will be made through *e*-TAR, although the impact may not be felt until a significant portion of TARs are processed through *e*-TAR.

- Allow the Provider Telephone Network to give detailed information on modified and denied TARs in the same manner that it gives information on approved TARs.

- Allow the completion of a TAR without "TUT-ing" it. Allow the last updated date to be visible, as well as a complete history of all updates performed on the TAR.

- Allow for TAR completion without deleting the TAR from the system. This will ensure that the paper trail and TAR history are not deleted.

Improving Medi-Cal Claims Processing

1. Track RTD, CIF, and appeal statistics.

Perform quality management to evaluate various statistics of problematic claims, including the average resolution time of problematic claims and the number of claims that become RTDs, then CIFs, then appeals, or any subset of the above.

2. Evaluate possible solutions to streamline problematic claim resolution.

Through the above analysis, enhance the RTD, CIF, appeal, and other related processes to speed up problematic claim resolution.

3. Perform targeted education regarding complex or problematic claims resolution.

Develop targeted education programs for providers to increase their understanding of reasons for denials. Clarify the appropriate uses and documentation required for the RTD, CIF, and appeals processes. The analysis described in the above recommendations will assist in identifying providers, provider types, or services that might require additional education.

4. Allow claims to be corrected through the online system in the same manner as the Medicare program.

Eliminate the need for an RTD or CIF by allowing corrections to a suspended or denied claim to be provided through the original online submission method.

5. Track problematic claims through their resolution on the Remittance Advice.

Indicate the "status" of the claim on the Remittance Advice. For example, a claim could be listed as "suspended" under review the first week, returned to provider with CIF, and list additional stages throughout the claim decision and payment process. This will eliminate the extensive manual tracking that providers currently undertake to determine the status of a claim.

6. Identify duplicate claims on the Remittance Advice.

A claim considered to be a duplicate should include identifying information, such as the paid claim check number, RA number, or date on the Remittance Advice so that the provider can verify the accuracy of the adjudication.

7. Create electronic versions of the RTD and CIF forms.

Currently, both RTDs and CIFs are paper forms mailed to the providers. These forms must be typed on a typewriter or neatly printed in black ink. Forms that do not conform often fall out of the electronic process. It would be more expeditious to make an electronic form available on the Internet and allow for electronic submission.

8. Reduce the number of claims submitted on paper.

- Identify claim categories, which are submitted on paper, and consider developing electronic submission capabilities.
- Develop a process for electronic submission of attachments so that claims can be submitted electronically.
- Perform targeted education and facilitation with providers who submit paper claims.

9. Ensure help desk personnel are knowledgeable and willing to resolve issues.

Help desks are a problematic issue throughout the health care industry. However, since the help desk is usually a provider's first, and sometimes only, interaction with EDS, the professionalism and knowledge base of help desk staff are critical to provider communication and education. It is hoped that the new fiscal intermediary contract will improve this function through the enhancements in the Provider Relations Operation (PRO).

10. Eliminate the microfilm archiving for paper claims.

Digital archiving is sufficient for paper claims.

Improving Provider Communication

1. Create a provider advisory board.

Medi-Cal does a good job of reaching out to provider organizations and associations, but a formal provider advisory board could assist with some of the outreach. A provider advisory board would assist Medi-Cal in reviewing documents sent to providers to ensure that they are clear and unambiguous. In addition, the provider advisory board could provide a conduit to the medical community for discussions regarding fraud issues, community practices, and other areas where collaboration is desired. In addition to addressing key provider issues, Medi-Cal would be seen as a partner in the provider community.

2. Create targeted account manager programs at the Medi-Cal field offices and at the EDS Claims Center.

Match providers with an individual account manager in each of the necessary locations (for example, DME providers would place all their phone calls to one individual). This individual should be intimately knowledgeable regarding TAR and claims requirements for this group of providers, should address all questions, and facilitate resolution on any issues a provider might experience. It is hoped that the new fiscal intermediary contract will improve this function through the enhancements in the PRO in the claims department. No similar plans exist for the Medi-Cal field offices.

3. Standardize and tighten policies and procedures.

Certain policies and procedures should be evaluated and rewritten with more specific explanations. The Medi-Cal field offices should be surveyed to determine the most frequent problems experienced with policies and procedures, and a task force should be created to prioritize and address these issues. This will reduce the potential for fraud and abuse, and it will create more standard adjudication practices across field offices. One example that could be addressed is the use of ADHC services, where many unclear areas exist in the policies and procedures, allowing opportunities for fraud and abuse.

4. Provide Continuing Medical Education (CME) credits to providers for attending Medi-Cal provider education sessions.

It is always difficult to capture a physician's attention. Granting CME credits for Medi-Cal courses could be an incentive to encourage physicians to participate, leading to a higher quality of TAR completion and fewer deferred TARs.

5. Enhance provider communication and education regarding deferred TARs.

Develop guidelines and educational programs regarding the TAR deferral process. Clearer communication regarding deferred TARs will lead to fewer "open" deferred TARs.

6. Provide standard appeal education to providers.

Develop an educational program delineating the appropriate reasons for an appeal and the required documentation. This will expedite appeal evaluation once it is received in the office and reduce the amount of clerical time spent on researching appeals.

7. Perform targeted education regarding the PTN.

Inform providers that they may bill for a service once a TAR is approved on the PTN, and that they do not need to wait for the paper copy of the TAR to be returned to them.

8. Develop targeted provider education to address specific issues.

In addition to the standard education programs, develop targeted education initiatives to assist providers. For example, the Los Angeles field office identifies providers whose denials rise above 10 percent and targets them for provider education. Similar analysis and targeted training will yield more promising results than blanketing providers or associations with various education initiatives.

9. Develop standard correspondence letters for use at all Medi-Cal field offices.

Standardize for all field offices letters or emails responding to or requesting specific information from providers. Standardized correspondence should be clear to the provider and easy for the adjudicator to produce. Some examples include standardized appeal letters or misdirected and incomplete TAR notifications. This would result in streamlined correspondence development and clearer provider communication.

10. Focus enhancements to the online provider manual.

The online provider manual could become the standard provider manual, although providers should always have the option to use a paper manual.

11. Eliminate sending replacement provider manual pages.

Paper revisions to the manual are costly, inefficient, and unanimously criticized by the providers.

- Providers should be segregated by category and should only receive updates that are pertinent to their provider category (such as DME providers, hospitals, specialty physicians, laboratories, and so on).
- Consider providing updates through email, highlighting the major changes to a policy with respect to the provider type, and including hyperlinks to the online provider manual. Providers who prefer to receive this communication on paper could receive a summary page highlighting the changes.
- Updated paper manuals could be released on a yearly basis to those providers that wish to receive them.

V. Conclusion

This TAR and claims assessment identifies several opportunities for improvement in the Medi-Cal program's TAR and claims processes. These improvements will ultimately benefit Medi-Cal's beneficiaries and its providers and will streamline and improve the timeliness of its processes. Medi-Cal is taking some steps to address these improvements through the *e*-TAR implementation and the procurement for its fiscal intermediary. However, some of the improvements offering the greatest impact will require changes in government policy and procedures and systemwide cooperation and change. These may be more difficult to implement but will have far-reaching results in terms of improving overall provider satisfaction and attracting a broader range of providers to the Medi-Cal program.

List of Appendices

The following appendices are available at www.medi-cal.org:

Appendix A: Letter from DHS

Appendix B: San Jose TAR Services Reassignment

Appendix C: Medi-Cal Field Office Best Practices

Appendix D: Providers

Appendix E: Health Care and State Organizations

Appendix F: Health Care Organizations' Best Practices

Appendix G: EDS Functions

Appendix H: Procedures Requiring TARs

Appendix I: TAR Forms

Appendix J: TAR and Claims Process Flow Charts and Descriptions

Appendix K: *e*-TAR

Appendix L: Medi-Cal Field Office Operational Findings

Appendix M: TAR Workload

Appendix N: Personnel Needs

Appendix O: Cross Reference of Recommendations and Findings

Glossary of Terms

Term	Definition
18-1 TAR Form	A TAR form requesting an extension of hospital stay
20-1 TAR Form	A TAR form requesting long term care services
50-1 TAR Form	A TAR form requesting medical or pharmacy services
55-1 TAR Form	A TAR form requesting multiple services at discharge
6Rx-TAR	Pharmacy TARs that are above the six prescription limit
ADHC	Adult Day Health Care
ALJ	Administrative Law Judge
AEVS	Automated Eligibility Verification System
ALOS	Average Length of Stay
Appeal	Appeals process wherein a provider TAR has been denied or modified and the provider appeals for a “better” decision
BELS	Batch Entry Log System
CA-MMIS	California Medicaid Management Information System
CCS	California Children's Services
CERTS	Claims and Eligibility Real Time System
Change Order 6 and 7 Staff	EDS staff (approved in the fiscal intermediary contract) to support the field office as a result of the 6Rx legislation
CHCF	California HealthCare Foundation
CHDP	Child Health and Disability Prevention Program; a state program under Childrens’ Medical Services branch of DHS
CIF	Claims Inquiry Form
Claim	A request for payment for medical services
Clean Claim	A claim that requires no special handling and processes without modification through the electronic claims system
CMAC	California Medical Assistance Commission
CMC	Computer Media Claims; EDS electronic claim system that uses HCFA 1500 and ANSI 837
CME	Continuing Medical Education

Term	Definition
COHS	County Organized Health Systems; a model of Medi-Cal managed care
COLD	Computer Output to Laser Disc
Contract Hospital	Contract hospitals have a contract with the DHS, and providers will direct Medi-Cal beneficiaries to those facilities for both elective and emergency services (noncontracted hospitals do not have a contract with DHS); beneficiaries may only be served on an emergency basis at noncontract hospitals
Co-pay	Patient's share of cost for medical services
CPT	Common Procedure Terminology; procedure coding scheme
CRN	Claims Reference Number
Crossover Claims	A Medicaid claim filed on behalf of a Medicare beneficiary who is also eligible for Medicaid
DCN	Document Control Number
DD	Developmentally Disabled
DDH	Developmentally Disabled Habilitative
DDN	Developmentally Disabled Nursing
DHS	Department of Health Services; the state agency that administers the Medi-Cal program
DME	Durable Medical Equipment
DMHC	Department of Managed Health Care
DOS	Date of Service
DRG	Diagnosis Related Group
DSS	Department of Social Services
EDS	Electronic Data Systems; Medi-Cal's current fiscal intermediary
EFT	Electronic Funds Transfer
EOB	Explanation of Benefits
EPSDT	Early and Periodic Screening, Diagnosis, and Treatment
ER	Emergency Room
e-TAR	Electronic Treatment Authorization Request; also known as SURGE.
Fair Hearing	Fair hearing requests are received by DHS for consideration from a Medi-Cal beneficiary who was denied service and wishes to appeal
FAQ	Frequently Asked Questions

Term	Definition
FFS	Fee-for-Service
FI	Fiscal Intermediary
FOA	Field Office Administrator
FOAG	EDS Field Office Administrative Group
FTP	File Transfer Protocol
GHPP	Genetically Handicapped Person Program
HCFA	Health Care Finance Administration
HCFA 1500	Claim form for professional services billing
Hemodialysis	Dialysis is a treatment for people in the later stage of chronic renal insufficiency
HGH	Human Growth Hormone
HIPAA	Health Insurance Portability and Accountability Act of 1996
ICD9	Diagnosis coding standard
ICF	Intermediate Care Facility
ICF/MR	Intermediate Care Facility/Mental Retardation
InterQual	A company that develops utilization review criteria for the health care industry
IS	Information System(s)
IVR	Interactive Voice Response
KDE	Key Data Entry
LAN	Local Area Network
LTC	Long-Term Care
M&R	Milliman and Robertson; a company that develops utilization review criteria for the health care industry.
MCM	Medical Case Management
MCMCD	Medi-Cal Managed Care Division of DHS
MCOD	Medi-Cal Operations Division; administers the TAR
MCPI	Medi-Cal Policy Institute
MCS	Medical Care Services; a division of DHS
Medicare DRG codes	Standard payment rates to hospitals based on patient diagnosis
Med-Tech	Medical Technician
Milliman and Robertson (M&R)	A company that develops utilization review criteria for the health care industry
MMIS	Medicaid Management Information System

Term	Definition
MRI	Magnetic Resonance Imaging
N/A	Not applicable
NCQA	National Committee for Quality Assurance
NDC	National Drug Code
NEMT	Non-Emergency Medical Transportation
OCR	Optical Character Recognition
P&O	Prosthetics and Orthotics
Payer	Health care organization that pays providers for services rendered on behalf of its members
PBM	Pharmacy Benefit Management
PCP	Primary Care Physician
Per Diem	By the day
Plan of Action	Plan developed to treat patient
PMPM	Per Member Per Month
Policy Letters	Clarify contract language; are legally enforceable; Contract Management Division of DHS issues contract amendment to plans
POS	Point of Service
Prior Authorization (PA)	A provider's request for permission to provide certain services to a Medi-Cal beneficiary
PRO	Provider Relations Operations
PSD	Payment System Division of DHS; administers claims and oversees fiscal intermediary contract
PTN	Provider Telephone Network
QAIP	Qualification Appraisal Interview Panel
RA	Remittance Advice
Retroactive Eligibility	Eligibility is approved after the date of service and inclusive of the date of service
Retroactive TAR	A TAR submitted for adjudication after the service has been rendered
RPA	Request for Personnel Actions
RTD	Resubmission Transmittal Document; used to correct errors on a suspended claim
Rx	Pharmacy prescription
SDN	Systems Development Notice
SNF	Skilled Nursing Facility
SPB	State Personnel Board

Term	Definition
Split Billing	When a service is apportioned and billed to different entities (e.g., Medicare and Medicaid and the beneficiary); when a length of stay is billed in multiple pieces (e.g., 1st through 15th is one bill, 16th through 31st is another bill)
SURGE (*e*-TAR)	Service Utilization Review Guidance and Evaluation system; the newly developed system for electronic TAR submission
SURS	Surveillance and Utilization Review Subsystem; a component of the claims system
TAR	Treatment Authorization Request
TCN	Total Control Number
TUT	TAR Update Transmittal
UB 92	Claim Form for Institutional Services
UR	Utilization Review

Endnotes

1. Little Hoover Commission. *A Prescription for Medi-Cal.* Sacramento, CA: November 1990.
2. Medi-Cal Policy Institute. *Physician Participation in Medi-Cal 1996–1998.* Oakland, CA: February 2002. (page 27)
3. Ibid.
4. Beacon Healthcare Solutions. *National Claims History File, Medicare.* 1998.
5. Little Hoover Commission. *A Prescription for Medi-Cal.* Sacramento, CA: November 1990.
6. Medi-Cal Policy Institute. *Physician Participation in Medi-Cal 1996–1998.* Oakland, CA: February 2002. (page 27)
7. Ibid.
8. During the course of this study, effective July 1, 2002, DHS closed the San Jose field office. The services provided by the San Jose field office have been reassigned to the Fresno, San Francisco, and Sacramento offices (see Appendix B).
9. All of the TARs and claims processes are more fully described in Appendix J, and Medi-Cal field office best practices are listed in Appendix C.
10. The ranking was based on a scale from one to five (with one being poor and five being excellent). The results of these ratings are included in the Findings section of this report.
11. A listing of procedures requiring prior authorization (as listed in the Manual of Criteria issued by DHS and as a part of Title 22, California Code of Regulations) is included in Appendix H.
12. See Appendix I for examples of the forms.
13. A more detailed narrative of the TAR flow is included in Appendix J.
14. The San Francisco field office currently does not perform this function, but it is anticipated that the MCM program will be expanded to the San Francisco field office in 2003.
15. Each of the processes is more fully described in Appendix J.
16. The paper claims forms include the standard HCFA 1500 for professional claims, UB92 for hospital claims, and the proprietary LTC for long-term claims.
17. The CIF and claims appeal processes are more fully described in Appendix J.
18. See Appendix M for more detail on the workload group.
19. See Appendix N for more detail on the needs assessment and hiring practices.
20. Standard review is preliminary review by a nonclinical staff member; professional review is review by a clinician to determine medical justification.

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