PRIMARY PROVIDER MANAGEMENT COMPANY, INC.'S REPORT TO THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE AND THE CALIFORNIA DEPARTMENT OF HEALTH CARE SERVICES REGARDING UTILIZATION MANAGEMENT DEPARTMENT PRACTICES

June 25, 2018

I. Introduction

Primary Provider Management Company, Inc. ("PPMC" or the "Company") provides management services, including utilization management, claims adjudication, and provider dispute resolution, to a network of California independent physician associations, including Vantage Medical Group, Inc. ("Vantage"), First Choice Medical Group ("FCMG"), Los Angeles Medical Center IPA ("LAMC"), and Cal Care IPA (collectively, "The IPAs"). On May 17, 2018, PPMC submitted an Interim Report on behalf of The IPAs regarding the self-disclosure letter sent to the California Department of Managed Health Care ("DMHC") on February 15, 2018 and captioned "RBO No. 10488: Examination of Vantage Medical Group, Inc. Claims Settlement Practices and Provider Dispute Resolution Mechanism Claims." The Interim Report addressed PPMC's Claims Department practices. At that time, PPMC had just learned from DMHC and the health plans of an anonymous letter that contained allegations of improper conduct regarding PPMC's Utilization Management ("UM") Department. Although PPMC was not able to obtain a copy of the letter from DMHC or the health plans at that time, it nevertheless commenced a comprehensive investigation of its UM Department processes and practices. The internal investigation was conducted by PPMC's outside counsel, Sheppard, Mullin, Richter & Hampton LLP ("Sheppard Mullin"), and Navigant Consulting, Inc. ("Navigant").

The facts in this Report are based on PPMC's internal investigation conducted to date. Related external audits and investigations conducted by DMHC and various health plans are ongoing and may cause PPMC to discover additional facts through the course of responding to various requests for information. In addition, certain new facts recently came to light and will require further investigation by Sheppard Mullin and Navigant. Accordingly, PPMC reserves the right to supplement this Report with additional facts as they may become available.

This Report is being simultaneously distributed to DMHC, the California Department of Health Care Services ("DHCS"), the various health plans that are contracted with The IPAs, and the Compliance Committee of the Board of Directors of PPMC's corporate parent, agilon health, inc. ("agilon health").

II. Executive Summary

In May 2018, PPMC commenced an intensive and compressed internal investigation regarding its UM Department functions. The investigation was undertaken in direct response to serious concerns expressed by DMHC and various health plans, including their receipt of an anonymous letter that was critical of PPMC's senior management, processes, and practices relating to UM and Claims functions. Sheppard Mullin and Navigant performed the investigation on an expedited basis in order to provide factual findings to DMHC and the health plans by the end of June 2018. The investigation team promptly commenced work by conducting more than 50 interviews of PPMC personnel and analyzing significant amounts of data and documents, including tens of thousands of emails. The investigation team also took into account the subjects raised and responses provided during the health plans' on-site audits, reviews, and interviews of PPMC personnel, as well as the corrective action plans that were subsequently issued to PPMC. This Report identifies factual findings that were confirmed during this compressed and

aggressive schedule. Some significant findings were identified just recently during the week of June 18th, and there is additional investigative work to be performed. To date, the investigation team identified the following primary findings:

1. There were no findings of fact that confirmed or corroborated allegations that PPMC engaged in systemic deletion, denial, or delayed disposition of requests for authorization for services. No facts supported allegations that PPMC abandoned or "dumped" patients.

2. A number of control weaknesses were found within the UM Department. Some of the control weaknesses affected organizations across PPMC. Corrective actions for many of these weaknesses have already been implemented or are in the process of being implemented. Weaknesses included inadequate management and supervision, lack of sufficient personnel given the volume of work, underdeveloped or inflexible technology systems that did not control access to sensitive data fields, and reliance on "tribal knowledge" rather than written policies and procedures, training, and education.

3. Several deficient UM practices were developed over time against a backdrop of limited controls. These practices generally involved processing and disposition of UM requests for authorization outside of industry norms and/or regulatory framework. Examples of deficient practices include partially documented and undocumented changes to UM data, display of financial information that could potentially and improperly bias UM determinations, and various shortcuts, such as semi-automated approvals, to compensate for apparent inadequate staffing resources.

4. The investigation detected three areas of improper conduct related to UM denials that involved the same UM Denial Nurse. First, there was a finding of certain UM medical necessity denials made by a UM Denial Nurse rather than a Medical Director. An analysis (that complies with Mandate Nos. 3 and 5 of DHCS's June 5, 2018 Corrective Action Plan to Vantage) to determine whether these denials resulted in the provision of substandard care to the members impacted has been initiated. Second, there was a practice of back-dating denial-related letters to members by the same UM Denial Nurse. Third, there was a related practice of failing to send such letters to providers. The vast majority of improper conduct occurred prior to the acquisition of PPMC by agilon health. Corrective actions to address each of these findings have already been completed (or are underway with respect to the first finding noted in this paragraph), including suspension of the UM Denial Nurse.

5. One additional area of potential improper conduct was recently identified, and is subject to further investigation and analysis. Last week, the investigation team discovered documents suggesting that certain UM audit files were altered for the purpose of obtaining a favorable score on an audit conducted in 2014. Interviews confirmed that UM audit file alteration occurred on at least one occasion in 2014. The same UM Denial Nurse described above participated in the alteration.

PPMC has already taken significant steps to implement corrective action to address these findings. These steps include appointment of new leadership and UM management, retention of

independent subject matter consultants, replacement of systems to enhance the UM and Claims processes, corrective actions to implement rigorous oversight, monitoring, and auditing functions, among many others described more completely in the corrective action section of this Report.

III. Investigation Overview

A. Sheppard Mullin Investigation Tasks

1. Witness interviews

The following witnesses were interviewed by Sheppard Mullin and Navigant:[1]

Aldrin Espinoza – UM Nurse	John Avila – Senior Director of Information Services
Amy Trinh – UM Coordinator	Jordon Tuckerman – UM Coordinator
Angela Jeong – UM Pharmacy Consultant	Josie Marquez – Medical Claims Review Coordinator
Annette Cuevas – UM Coordinator Lead	Juanita Escobar – CSS Lead Specialist
Anthony Sanchez – UM Coordinator	Karissa Summersgill – UM Coordinator
Araceli Gonzalez – UM Coordinator	Kelly Wilson – UM Nurse
Betsy Ha – (former) VP of Clinical Transformation (agilon health)	Kensley Beyler – UM Coordinator
Brinda Uribe – UM Coordinator	Khaliq Siddiq, MD – Senior Medical Director
Carolynn Cervantes – UM Nurse	Leticia Vasquez – UM Coordinator
Catherine Pearson – Denial Coordinator	Lilliana Serrano-Cruz – UM Coordinator
Chandai Pride – UM Nurse	Manoj Mathew, M.D. – Interim President of California Market (agilon health)
Christine Watson – UM Coordinator	Marcela Villa – UM Denial Nurse
Dyana Galvan – UM Nurse	Maria Torres – Director of Provider Relations
Jacqueline Salcido – UM Coordinator	Maribel Melchor – UM Coordinator
Jason Valenzuela – UM Coordinator	
Jennifer Paez – UM Nurse	

[1] Several witnesses were interviewed on more than one occasion.

Joanna Gomez – UM Coordinator Johanna Mendibles – UM Coordinator Max Baroi – (former) Database Analyst Michael Click – UM Nurse Missy Reed – VP, Provider Engagement Molly Anderson – Director of UM (Anaheim), (former) QM Manager (Corona) Natasha Navarro – UM Coordinator Norma Macias – UM Coordinator Rebecca Poras – UM Coordinator Reuel Gaskins, MD – Medical Director Richelle Castro – UM Nurse Rita Anthony – Medical Claims Review Robin Lopez – Medical Claims Review Rosalinda Plascencia – UM Coordinator	Mary Peck – Director of UM (Corona) Scott Tsai – UM Nurse Serena Atkins-Low – UM Nurse Shannon Richardson – UM Nurse Sheena Viste – UM Data Entry Siresh Paul – UM Supervisor Sonia Martinez – Provider Relations Manager Sophia Mani – UM Manager Stacie Oakley – (former) VP of Health Services Tanya Hires – UM Nurse Tanya Lewis – UM Coordinator Vanessa Weinberg – UM Nurse

In addition, Sheppard Mullin reviewed notes of interviews of PPMC personnel conducted by health plan auditors during their recent on-site audits of PPMC's Claims and UM functions.

2. Document Review

Sheppard Mullin reviewed the following documents:

- All PPMC-related documents collected from Ion Baroi's personal laptop
- All Corrective Action Plans ("CAPs") issued to PPMC following UM audits conducted from 2014 to 2018[2]
- Findings from an internally-conducted policies and procedures audit of PPMC's UM Department (December 2017 and January 2018)

[2] Navigant also reviewed this information.

- Approximately 35,000 emails

B. Navigant Investigation Tasks

1. Witness interviews

Navigant participated in the witness interviews with Sheppard Mullin that are identified above. Additionally, Navigant conducted a walk-through of the UM Department that consisted of sitting with individuals at every stage of the process to watch and learn the process PPMC used to collect, validate, review, and disposition the Authorizations received. Navigant also met with an individual in Provider Relations to examine the process a provider used to submit an Authorization.

2. Data Analytics

Navigant obtained a copy of the PPMC Authorizations and Claims system (Xpress) back end data tables and performed many analyses surrounding Authorization distributions by status, timeliness, auto-approval, medical necessity determination (by user initials), and Authorization receipt processes.

3. Computer Script Analysis

Navigant reviewed the SQL scripts that were used by the Xpress system to process Authorization auto approvals.

4. Audit Documentation

Navigant reviewed the audit documentation of two IEHP audits, one from December 2014 and the other a focused audit from April/May 2017. Navigant compared the documents submitted to IEHP against the versions stored in the Document Center linked to Xpress.

5. Policy and Procedure Review

Navigant reviewed 64 UM Policies and Procedures for compliance with Medicare Advantage, Medi-Cal, and Knox Keene Act requirements.

6. Grievance Reviews

Navigant reviewed the case files of seventeen grievances. These grievances were selected from PPMC's 2017 logs of grievances forwarded to The IPAs by health plans using the following methodology. First, grievances identified as related to Delays in Referrals or as submitted against Vantage or FCMG were isolated as the potential review set. Second, the potential review set was further segregated by removing grievances that were identified as related to provider services, eligibility, access, and claims. The focus of the review was to determine whether there was member harm due to lack of quality of care.

7. Authorization Case File Reviews

Navigant reviewed the case files of forty prior and concurrent authorization requests processed by the UM Department. These authorization requests were selected from the UM data Navigant aggregated for 2017 and for January 2018 and consisted of cases with approved, denied, and cancelled disposition statuses.

IV. Findings

A. UM Department Overview & Process Flow

The health plans delegated to PPMC, through The IPAs, certain UM functions relating to Medicare Advantage, Medi-Cal, and Commercial lines of business. UM functions delegated to PPMC were performed by its UM Department personnel, which processed provider requests for authorization for members to receive certain medical services, including consultations and procedures performed by specialist providers, prescription medication, and access to certain treatment facilities (collectively, "Authorizations"). The UM Department dispositioned Authorizations that resulted in the following outcomes: approved, approved with modification, denied, and cancelled. Various regulatory and contractual provisions governed the timelines in which Authorization dispositions had to be made. These timelines were commonly referred to as turn-around-times or "TATs."

The UM Department's general process flow for dispositioning Authorizations is described below. Detailed descriptions of certain processes and related findings are provided in Section IV.B.

1. UM Department Personnel

As of May 17, 2018, the UM Department consisted of the following personnel (excluding Medical Directors):

- Director of UM: Mary Peck
- UM Manager: Sophia Mani
- UM Nurse LVN 15 FTEs
- UM Coordinator Lead 1 FTE
- UM Coordinator 19 FTEs
- UM Supervisor 1 FTE
- Medical Claims Review 1 FTE
- Health Services Coordinator 1 FTE
- Data Entry Clerk 1 FTE

- Denial Nurse LVN 1 FTE
- Denial Coordinator 1 FTE
- CCS Specialist Lead 1 FTE
- CCS Specialist 1 FTE

2. Authorization In-Take

Nearly all Authorizations received by PPMC were transmitted via PPMC's Internet portal (the "Portal") or by fax. Approximately 80% of Authorizations came in through the Portal, which enabled providers to electronically prepare and submit Authorizations and upload any supporting documents, such as clinical notes. Approximately 20% of Authorizations came in by fax. A *de minimis* number of Authorizations were also submitted by telephone and mail.

All Authorization data was stored in a PPMC-maintained SQL database, which PPMC personnel accessed and processed primarily using a medical management software application called "Xpress."[3] The Portal was connected to a separate "Advantage" database, which copied Authorization data and related documents submitted by providers into Xpress using an automated process. Copies of the original Portal submissions were also stored in the Advantage database.[4] Authorizations received by PPMC via fax, telephone, and mail were manually entered into Xpress.

3. Automatic and Supplemental Approval

The UM Department implemented a computer-run script to automatically approve certain Authorizations within Xpress. In addition, Mary Peck utilized a supplemental approval protocol to approve certain other Authorizations, which were not automatically approved by the computer script. Both of these practices are discussed in detail in Section IV.B. below.

4. UM Coordinator Responsibilities

Each business day morning, a UM Nurse prepared an Authorizations status report from the Xpress report generator (the "Status Report"). The Status Report was exported into Excel and gave priority to Authorizations with the shortest amount of TAT remaining. A UM Lead Coordinator would then assign Authorizations from the Status Report to UM Coordinators, who generally worked on specific, pre-determined categories of Authorizations. These categories were based on several factors, including the type medical service requested (*e.g.*, Oncology, DME, OB/GYN, Urgent), geographic location (*e.g.*, Fresno), member age (*e.g.*, adults and pediatrics), and whether the Authorizations were missing information related to the member or receiving provider. The Status Report was updated and rerun at approximately 12 pm and 4 pm

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[3] As further discussed herein, Authorization data can be accessed directly in the database, outside of the Xpress application. However, it appears that only a small group of PPMC employees and consultants (primarily Information Services personnel) have the requisite skills and software tools to do so.

[4] PPMC does not have ready access to the data stored in the Advantage database because the personnel who installed it are no longer with the Company and apparently did not adequately document the data architecture.

to monitor the Department's progress. As needed, a UM Nurse reassigned Authorizations to balance the work load and ensure timely disposition of all Authorizations.

UM Coordinators were primarily responsible for ensuring that Authorizations contained all information necessary for clinical evaluation by a UM Nurse. As such, UM Coordinators performed the following tasks (listed in approximate order of priority):

- Ensured that the Authorization identified a specific member;
- Validated member eligibility;
- Ensured that the Authorization included necessary clinical notes;
- Ensured that the Authorization included necessary diagnosis and CPT codes; and
- Ensured that the Authorization identified a receiving provider either by specific reference or by area practice.[5]

Where necessary data was missing from an Authorization, UM Coordinators attempted to collect and add it into Xpress. To collect missing data, UM Coordinators contacted providers, collaborated with sister Departments within PPMC, researched PPMC's internal records and files, and researched other relevant sources of information (*e.g.*, Medi-Cal and health plan websites).

One piece of necessary data that was frequently omitted from Authorizations was the identity of the receiving provider. UM Department personnel estimated that one-third of all Authorizations were received with the receiving provider "to be determined," which meant that the requesting provider did not select a receiving provider when preparing an Authorization in the Portal.[6] To fill-in this information, the UM Coordinator reviewed the notes submitted with the Authorization for references to a specific receiving provider. If the notes contained such a reference, and the receiving provider was in-network, the UM Coordinator added the receiving provider to the Authorization in Xpress. If the notes identified a specific receiving provider who was not in-network, the UM Coordinator escalated the issue to a UM Nurse for further action. If a receiving provider could not be identified, the UM Coordinator looked up potential providers on the relevant plan sponsor's website and selected the preferred provider (if available) or in-network provider located closest to the member.

During interviews, UM Coordinators generally stated that they were not permitted to, and did not, *add* diagnosis or CPT codes to an Authorization unless specifically authorized by a provider's office to do so, and that they documented such additions in Xpress diary notes.

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[5] Xpress was configured to facilitate some of these tasks by, for example, attempting to validate member and provider information.

[6] UM Department personnel stated that a potential cause for this behavior was that, until approximately 6 months ago, only the names of preferred providers were presented in the Portal's list of receiving providers. As a result, referring providers would leave that field blank and write in the name of the receiving provider in the notes section of the Authorization. The Portal has been updated to include the names of all in-network providers. According to UM Department personnel, however, providers have continued to submit Authorizations with the receiving provider "to be determined."

However, as further discussed in Section V.B., UM Coordinators sometimes changed certain Authorization data in Xpress, and sometimes did so without documenting their changes.

UM Coordinators eventually handed off most Authorizations, including related documentation, to a UM Nurse for further processing and disposition. This hand-off was accomplished by applying a combination of pend and reason codes to the Authorization within Xpress. Accordingly, UM Department personnel commonly used the verb *to pend* when referring to the process of transferring an Authorization from one UM employee to another (*e.g.*, the Authorization was *pended* from the UM Coordinator to the UM Nurse). Thus, to pend an Authorization to a UM Nurse, a UM Coordinator selected the pend code "pend" and a reason code that corresponded with the category of the Authorization, such as DME, oncology, pediatrics, etc.

However, under the following limited circumstances, UM Coordinators dispositioned Authorizations themselves:

- Several UM Coordinators stated that they were permitted to approve Authorizations for a limited set of procedures to in-network providers, provided that member eligibility was validated.

- If the identity and/or eligibility of the member associated with an Authorization could not be ascertained, the UM Coordinator canceled the Authorization.

During interviews, UM Coordinators generally stated that they contacted provider offices to notify them of cancellations made pursuant to the above practices, and documented such notices in Xpress diary notes.

5. UM Nurse Responsibilities

UM Nurses processed Authorizations pended to them by UM Coordinators. According to witness interviews, UM Nurses processed on average between 120-200 Authorizations per day on Monday through Thursday. On Fridays, a UM Nurse's workload could exceed 200 Authorizations.[7] Similar to UM Coordinators, UM Nurses were also assigned to work on specific categories of Authorizations. UM Nurses had the following options to process Authorizations: approve, pend for second-level review, pend for denial, and cancel.

UM Nurses evaluated Authorizations pended to them utilizing all necessary information included for approval or potential denial. They reviewed the Authorization and accompanying notes to understand the service being requested, and compared that information against a hierarchy of evidenced-based clinical guidelines in accordance with line of business and health plan requirements. Generally, they relied on Medicare NCD/LCD, Medi-Cal, Encoder Pro, Milliman Care Guidelines ("MCG"), Apollo, or health plan specific criteria.

Assuming that the UM Nurse determined that an Authorization should be approved, then the Nurse determined the status of the receiving provider. If the receiving provider was in-network,

[7] UM Department personnel generally did not work on weekends. Accordingly, Authorizations whose TATs were set to expire over the weekend were dispositioned on Fridays.

the UM Nurse either approved the Authorization (by changing the Xpress pend code to "approve" and the reason code to "approved") or pended the Authorization for second-level review with a recommendation to approve. This latter option was selected if the estimated value of the services requested in the Authorization, as calculated and displayed in Xpress, exceeded the UM Nurse's approval threshold. If the services were valued above that threshold, which varied between UM Nurses from approximately $1,299 to $4,999, the Authorization was pended to Ms. Peck using the pend code "pend" and the reason code "MP" or "DO." During interviews, UM Nurses generally stated that they did not consider the estimated value of the services requested in the Authorization (even though that information was displayed in Xpress) when determining whether to approve an Authorization. As of June 4, 2018, a software "overlay" was installed to prevent Xpress from displaying the estimated value of services requested in an Authorization, and UM Nurses' monetary approval thresholds were discontinued.

In contrast, if the receiving provider was not in-network, the UM Nurse researched whether there was an in-network provider in the same region available to provide the service requested in the Authorization. If an in-network provider was available, the UM Nurse took the following steps:

- The UM Nurse first contacted the referring provider and sought permission to redirect the Authorization to the in-network receiving provider. If the referring provider agreed, the UM Nurse changed the Authorization's receiving provider data in Xpress, and approved or pended the Authorization for second-level review with a recommendation to approve pursuant to the practices described above. UM Nurses generally stated that they documented such changes, including the referring provider's consent thereto, in Xpress diary notes.

- If the referring provider did not agree to the proposed redirection, the UM Nurse pended the Authorization to the medical director with a recommendation to approve it with modification (*i.e.*, redirection to the in-network provider).

Another possibility could be that the receiving provider was not in-network, and there was not an in-network alternative. In that case, the UM Nurse approved the Authorization pending execution of a Letter of Agreement ("LOA"). PPMC's Provider Relations Department would then contact the receiving provider to enter into an LOA applicable to the Authorization.

UM Nurses also pended Authorizations for denial (or approval with modification) if they determined that any of the following conditions was met: (1) the requested service was subject to a carveout (*i.e.*, PPMC did not have financial responsibility for the service); (2) the requested service was not a covered benefit; or (3) medical necessity for the requested service had not been established.

Lastly, UM Nurses cancelled Authorizations under the following circumstances:

- Authorizations were cancelled if the referring provider failed to submit necessary information prior to the expiration of the applicable TAT. During interviews, UM Nurses generally stated that this sort of cancellation was permitted only after 3 unsuccessful attempts to obtain the missing information form the referring provider, although one

claimed to be aware of cancellations made after fewer than 3 attempts. All such attempts were supposed to be documented in Xpress diary notes.

- Authorizations were cancelled at the request of the referring provider. Providers sometimes made these requests at the UM Nurse's recommendation where it appeared unlikely that the provider would be able to submit documents necessary for clinical determination before the applicable TAT expired or that the Authorization was submitted in error or contained erroneous data. Providers' cancellation requests were supposed to be documented in Xpress diary notes.

- Authorizations were cancelled if they were created erroneously by PPMC.

- Authorizations were cancelled if they were determined to be duplicative of other Authorizations.

6. Denial Nurse Responsibilities

The Denial Nurse[8] reviewed Authorizations pended for denial by UM Nurses. To conduct this review, the Denial Nurse reviewed the Authorization, its related medical notes and other documents, and the applicable clinical guidelines for medical necessity determinations (i.e., Medicare NCD/LCD, Medi-Cal, Encoder Pro, MCG, Apollo, and/or health plan specific criteria).[9] This review had 3 possible outcomes. First, if the Denial Nurse disagreed with the UM Nurse's recommendation for denial, the Denial Nurse pended the subject Authorization back to the UM Nurse for further processing. Second, if the Denial Nurse agreed that the Authorization should be denied because of a carveout or a non-covered benefit, the Denial Nurse would add her administrative rationale for denial into the "limitations" field of the Authorization in Xpress and deny the Authorization by changing its pend code to "deny" and selecting the appropriate reason code (*i.e.*, carveout or non-covered benefit). Third, if the Denial Nurse agreed that the Authorization should be denied for lack of medical necessity or determined that it should be approved with a modification, the Denial Nurse would add her clinical rationale for denial or approval with modification in the Xpress limitations field and/or diary notes and pend the Authorization to the medical director for further review by changing its pend code to "pend" and its reason code to "RG."

To facilitate the denial process, the Denial Nurse maintained a Word document that contained boilerplate statements of clinical rationale for denial. When denying an Authorization, the Denial Nurse attempted to draw from these boilerplate statements, tailored to reflect the member's specific circumstances, rather than compose wholly original statements of clinical rationale.

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[8] Since approximately 2014, PPMC has had only one Denial Nurse, Marcela Villa, LVN.

[9] PPMC was without access to complete MCG criteria for approximately ten months (June 2016 – April 2017) due to a license issue that arose when PPMC was transferred from its previous owner to its current owner. During this period, PPMC retained complete access to Medicare NCD/LCD, Medi-Cal, Encoder Pro, Apollo, and health plan specific criteria.

7. Medical Director Responsibilities

As a general practice, the Medical Director reviewed Authorizations pended for denial for lack of medical necessity and Authorizations pended for approval with modification. To conduct this review, the Medical Director typically reviewed the Authorization, the notes submitted with it, and the Denial Nurse's clinical rationale for denial or approval with modification, which incorporated the clinical guidelines for medical necessity applicable to the requested service. If he determined that an Authorization should be denied, he denied the Authorization by changing its Xpress pend code to "deny" and reason code to "Z1" (the code for medical necessity denial). Similarly, if he determined that an Authorization should be approved with modification, he so indicated by changing its Xpress pend code to "approve" and selecting the appropriate reason code.

8. Denial Coordinator Responsibilities

The Denial Coordinators received Authorizations that had been denied by the Denial Nurse or Medical Director (pursuant to the processes outlined above) and prepared letters to members notifying them of the denials ("Denial Letters"). The Denial Letters were based on templates obtained from the health plans. Generally, to prepare a Denial Letter, the Denial Coordinator pasted into the appropriate template the administrative or clinical rationale for denial appearing in the Authorization limitations field and/or diary notes in Xpress. The Denial Nurse and Denial Coordinator[10] interviewed stated that the Denial Nurse reviewed Denial Letters before they were mailed.

9. UM Statistics

Table 1 below provides statistics regarding the UM Department's disposition of Authorizations from 2014 through mid-June 2018.

Table 1

Year	**2014**	**2015**	**2016**	**2017**	**2018[11]**
All Authorizations[12]	**325,043**	**378,232**	**415,944**	**495,596**	**288,516**
Total Approvals	**295,996**	**339,782**	**379,453**	**460,180**	**261,728**
(%) all Authorizations	91.06%	89.83%	91.23%	92.85%	90.72%
Auto Approved	**122,742**	**137,688**	**84,567**	**29,860**	**15,909**
(%) all Approvals	41.47%	40.52%	22.29%	6.49%	6.08%
Peck (Supplemental)	**-**	**-**	**46,824**	**139,539**	**73,544**
	0.00%	0.00%	12.34%	30.32%	28.10%

[10] For the majority of the period from 2014 to the date of this Report, the UM Department had one Denial Coordinator, Catherine Pearson.

[11] Period covered: January 1, 2018 through June 16, 2018.

[12] Total Authorizations include pended Authorizations that are not separately identified in Table 1. Pended Authorizations represent less than 0.5% of all Authorizations for 2014-2017. Pended Authorizations from 2018 contain current activity that had not been dispositioned when the data was captured.

Year	2014	2015	2016	2017	2018[11]
Approved Manually	**173,254**	**202,094**	**248,062**	**290,781**	**172,275**
	58.53%	59.48%	65.37%	63.19%	65.82%
Approved Modified	**521**	**430**	**301**	**331**	**252**
	0.18%	0.13%	0.08%	0.07%	0.10%
Total Denials	**7,650**	**10,772**	**7,236**	**5,059**	**3,266**
(%) all Authorizations	2.35%	2.85%	1.74%	1.02%	1.13%
Carveout	**959**	**1,309**	**1,340**	**955**	**692**
(%) all Denials	12.54%	12.15%	18.52%	18.88%	21.19%
Not covered benefit	**556**	**722**	**773**	**652**	**511**
	7.27%	6.70%	10.68%	12.89%	15.65%
No Medical Necessity	**5,166**	**6,867**	**2,793**	**2,043**	**1,482**
	67.53%	63.75%	38.60%	40.38%	45.38%
Others	**969**	**1,874**	**2,330**	**1,409**	**581**
	12.67%	17.40%	32.20%	27.85%	17.79%
Total Cancellations	**20,890**	**26,876**	**27,174**	**29,415**	**15,034**
(%) all Authorizations	6.43%	7.11%	6.53%	5.94%	5.21%
Duplicate	**5,443**	**9,934**	**12,144**	**12,451**	**6,168**
(%) all Cancellations	26.06%	36.96%	44.69%	42.33%	41.03%
Entry Error	**6,711**	**5,435**	**4,995**	**3,712**	**1,484**
	32.13%	20.22%	18.38%	12.62%	9.87%
By Provider	**1,415**	**1,182**	**1,336**	**3,305**	**2,000**
	6.77%	4.40%	4.92%	11.24%	13.30%
Incomplete	**4,401**	**4,850**	**3,282**	**2,169**	**533**
	21.07%	18.05%	12.08%	7.37%	3.55%
Invalid Member	**2,385**	**5,224**	**4,437**	**5,044**	**2,833**
	11.42%	19.44%	16.33%	17.15%	18.84%
Others[13]	**535**	**251**	**980**	**2,734**	**2,016**
	2.56%	0.93%	3.61%	9.29%	13.41%

Table 2 below presents statistics related to the UM Department's compliance with TATs applicable to Authorization *decisions*, with reference to regulatory and policy guidance as well as the Industry Collaboration Effort ("ICE") timeliness grids. These statistics were derived from data stored in Xpress, the accuracy of which was not independently validated. These statistics do not account for the impact of extensions or deferral letters on applicable TATs, if any, because Xpress does not have a field or set of fields to reliably calculate that information. These statistics

[13] **Appendix A** provides a schedule of the of denials and cancellations that respectively comprise the categories of Other denials and Other cancellations presented in Table 1.

do not address timeliness with TATs applicable to *letter issuance* because, for the majority of the time period reflected in **Table 2**, PPMC did not capture data evidencing the dates on which letters were mailed.

Table 2

Status and Line of Business	2014	2015	2016	2017	2018
Referral - Routine Approvals					
Commercial	89.7%	96.1%	97.6%	94.2%	94.2%
Medi-Cal	89.8%	95.3%	97.5%	93.1%	93.1%
Medicare	96.6%	99.6%	99.8%	99.3%	99.3%
Referral - Routine Cancellations					
Commercial	89.5%	95.3%	96.7%	94.3%	94.3%
Medi-Cal	87.0%	94.0%	96.6%	94.0%	94.0%
Medicare	97.2%	99.3%	99.5%	99.4%	99.4%
Referral - Routine Denials					
Commercial	89.8%	80.6%	95.5%	91.7%	91.7%
Medi-Cal	85.8%	85.1%	85.3%	87.4%	87.4%
Medicare	99.2%	100.0%	100.0%	100.0%	100.0%
Referral - Urgent Approvals					
Commercial	91.6%	97.6%	97.4%	95.2%	95.2%
Medi-Cal	92.8%	98.1%	97.7%	93.9%	93.9%
Medicare	94.2%	98.7%	97.7%	96.1%	96.1%
Referral - Urgent Cancellations					
Commercial	85.2%	92.9%	96.7%	97.3%	97.3%
Medi-Cal	84.9%	91.4%	95.9%	94.2%	94.2%
Medicare	85.2%	94.5%	97.4%	92.5%	92.5%
Referral - Urgent Denials					
Commercial	100.0%	100.0%	100.0%	100.0%	100.0%
Medi-Cal	97.0%	96.4%	95.3%	96.6%	96.6%
Medicare	96.9%	93.3%	88.2%	80.0%	80.0%

B. Details Regarding Certain UM Department Practices

This section of the Report provides additional details related to certain UM Department practices and related findings.

1. Auto- and Supplemental-Approval of Authorizations

The UM Department implemented two practices to facilitate the approval of certain Authorizations. Those practices were (1) a computer-run "script" to automatically approve

Authorizations that met certain criteria (the "Auto-Approval Script") and (2) a supplemental approval protocol performed by Ms. Peck.

a. Auto-Approval of Authorizations

UM Department personnel confirmed that Max Baroi, a former member of PPMC's Information Services Department and the son of PPMC's former Senior Vice President, Ion Baroi, wrote and implemented the Auto-Approval Script in approximately 2013. The Script was still in use as of the date of this Report.

The Auto-Approval Script appears to have been implemented for the purpose of expediting the UM process by automating the approval of Authorizations that met certain criteria. Generally, the Script approved initial and follow-up consultations that, prior to the Script's implementation, were seldom, if ever, denied by the UM Department. The pre-authorized consultations were identified through analysis of the UM Department's historical approval data taking into account experiences with health plans.

The Auto-Approval Script ran daily, reviewing all Authorizations received since its last run. The Script approved Authorizations that satisfied at least all of the following criteria: (1) the patient had then-current eligibility; (2) the receiving provider was in-network; and (3) the service requested was suitable for auto-approval.[14] The Auto-Approval Script was designed to recognize services suitable for auto-approval with reference to their specific combinations of diagnosis and procedure codes.[15] Auto-approved Authorizations were marked with specific data codes within Xpress.

PPMC personnel did not review auto-approved Authorizations. Further, approvals made by the Auto-Approval Script triggered automated fax notices of decision that were transmitted to providers immediately following the system approval. As a result, the Auto-Approval Script reduced the UM Department's workload, expedited the approval of certain Authorizations, and facilitated the timely transmission of notices of approval decisions.[16]

Authorizations that did not satisfy all of the Auto-Approval Script's criteria were left in the UM work queue for review and disposition by UM Department personnel. No facts have been identified suggesting that the Auto-Approval Script or any other computer-run script denied any Authorization. No facts have been identified suggesting that the Auto-Approval Script or any other computer-run script improperly removed Authorizations from the UM work queue.

b. Supplemental Approvals by Ms. Peck

Ms. Peck developed a supplemental approval protocol to further expedite the approval of Authorizations. Data indicate that she implemented this protocol in mid-2016. Ms. Peck observed that the daily UM Department work load continued to stress the capacity of her staff despite the launch of the Auto-Approval Script. Accordingly, with the knowledge and support of

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[14] This is not intended to be an exhaustive list of the criteria applied by the Auto-Approval Script.

[15] **Appendix B** provides a list (current as of the date of this Report) of the CPT codes that were suitable for auto-approval by the Auto-Approval Script.

[16] Table 1 above provides statistical details regarding approval decisions made by the Auto-Approval Script.

PPMC's then-executive leadership, including Ion Baroi and Karen Hiteshi, Ms. Peck developed a protocol to supplement the Auto-Approval Script and further reduce the UM Department's work load.

Ms. Peck's supplemental approval protocol consisted of the following actions, which she personally carried out almost every day that she reported to work from the inception of the protocol through approximately mid-May 2018, when she was directed to discontinue it. First, each morning, Ms. Peck reviewed an Excel spreadsheet report of the Authorizations whose TATs were set to expire that day. The report listed the Authorizations, along with the related diagnosis and CPT codes related to the services requested (among other data). The number of Authorizations contained in the daily report varied, but was generally between 1,000 and 2,000.

Second, Ms. Peck sorted the report by specialty. For example, she grouped all ENT Authorizations together.

Third, working through one specialty at a time, Ms. Peck selected Authorizations to in-network providers for supplemental approval by highlighting them within the report. She identified supplemental approval Authorizations by recognizing combinations of diagnosis and CPT codes, which Ms. Peck learned through experience were seldom, if ever, denied.

Fourth, after completing her review, Ms. Peck sent the report containing her highlights to PPMC's Information Services Department. After receiving Ms. Peck's report, an Information Services Department staff member accessed the Authorizations in the Xpress database that corresponded with those highlighted (in the report) by Ms. Peck and approved them.[17] The Information Services Department also applied the code "MX Punch" in the Xpress database to each Authorization approved by Ms. Peck.

Ms. Peck did not formally document the combinations of diagnosis and CPT codes that she used for her supplemental approval protocol. However, it appears that the majority of the Authorizations she approved were for initial or follow-up consultations.[18] No facts were identified suggesting that Ms. Peck *denied* Authorizations using her supplemental approval protocol.

2. Changes to Authorization Data

The investigation found that some PPMC personnel made changes to data within Xpress related to Authorizations' CPT codes, dates, receiving provider, and urgent/routine status.

a. The "Gold List"

The UM Department's Authorization process required requesting providers to identify not only the service sought to be performed (*e.g.*, an initial consultation), but also the specific CPT or estimated code related to the service (*e.g.*, 99203). The UM Department approved not only the

[17] Table 1 above provides statistical details regarding approval decisions made by Ms. Peck's supplemental approval protocol.

[18] An analysis of the Authorizations Ms. Peck approved pursuant to her summary approval protocol has identified her frequently approved CPT codes, which are presented in **Appendix C**.

service to be performed, but also the estimated or presumptive CPT code to be used by the rendering provider when subsequently billing for the service performed. As of June 6, 2018, the UM Department had revised its authorization process so that it no longer required providers to specify CPT codes in Authorizations or incorporated specific CPT codes in resulting approvals.

Prior to June 1, 2018, however, the UM Department implemented certain screening practices related to approving the estimated or presumptive CPT codes. Its *default* practice was to approve prospective Authorizations for only CPT codes ending in 3 or lower. Under this practice, Authorizations seeking approval for estimated or presumptive CPT codes ending in a number larger than 3, when approved, were revised downward to reflect only CPT codes ending in a 3.

Subsequent to the above UM Department approval process, when providers submitted claims for reimbursement for actual services rendered to the Claims Department, they were permitted and expected to submit claims using whichever CPT code they believed was appropriate. "Clean" claims for reimbursement (*i.e.*, claims submitted in compliance with applicable rules and regulations) utilizing CPT codes that were equal to or below the levels approved by the UM Department were generally approved and paid by the Claims Department without further review. In contrast, claims utilizing CPT codes that exceeded the levels approved by the UM Department were preliminarily denied by the Claims Department pending the claimant provider's submission of medical records to support the claimed level of service. Medical records submitted in support of higher level CPT codes were routed to the UM Department's Medical Claims Review team for further evaluation. The Medical Claims Review team determined whether the code levels claimed were supported by the medical records (in which case the claim was approved and paid at the levels claimed).

UM Department personnel confirmed that some specialist providers objected to the UM Department's screening practice of capping prospective approvals at CPT code level 3 and subjecting later-submitted claims for CPT codes above that level to medical review. These specialist providers complained that reimbursements paid by the Claims Department at CPT code level 3 were insufficient, and that they were unwilling to have their claims subjected to a Medical Claims Review. Sometimes they refused or threatened to refuse to see PPMC's members unless their Authorizations were pre-approved at CPT codes level 4 or above.

To ensure appropriate network coverage, by approximately 2013 (and potentially earlier), the UM Department developed and implemented a practice sometimes referred to as the "Gold List" to exempt certain specialist providers from the above-described authorization practices. Providers added to the Gold List were permitted to submit claims for reimbursement for specifically enumerated initial and follow-up consultations using CPT code level 4 (and, in limited cases, level 5)[19] without supporting medical records. Gold List providers' clean claims were approved and paid. By way of comparison, a clean claim submitted by a non-Gold List specialist provider for a CPT 99204 (initial consultation) was denied pending Medical Claims Review, while the same claim submitted by a specialist provider on the Gold List was approved and paid with no Medical Claims Review required. The Gold List practice was terminated as of June 6, 2018.

[19] Gold List providers were generally permitted to submit claims for CPT 99204 and 99214.

According to some UM Department personnel interviewed, Ion Baroi held ultimate decision making authority with respect to adding or removing specialist providers to and from the Gold List. While the exact criteria he applied to control the composition of the Gold List is unknown, some employees stated that at least the following conditions appeared to be necessary for Gold List admission: (1) the provider was an in-network specialist;[20] (2) the provider was unwilling to treat PPMC's members for reimbursement below a CPT code level 4; and (3) there were no alternative providers located in the same region that both specialized in the same area of care as the putative Gold List provider and were willing to accept the non-Gold List rules.

b. Data Changes Made Pursuant to the Gold List

(1) UM Department Personnel

UM Department personnel, primarily UM Coordinators, changed the CPT codes on Authorizations within the Xpress database so that resulting approvals contained CPT codes at levels that were consistent with the Gold List. To illustrate, if an Authorization to a specialist on the Gold List sought authorization for a CPT 99203 (initial consultation), a UM Coordinator changed the last digit in the code from a "3" to a "4." This type of alteration was done as a prophylactic measure to prevent complaints from receiving providers who would object if approvals issued with only a CPT code level 3. Some employees stated that they were instructed to document such changes in Xpress diary notes, but did not always do so.

Conversely, UM Department personnel, primarily UM Coordinators, adjusted downward CPT codes within the Xpress database on Authorizations to non-Gold List specialists where the requested codes ended in 4 or 5. To illustrate, if an Authorization to a non-Gold List provider sought authorization for a CPT 99204 (initial consultation), a UM Coordinator changed the last digit of the code from a "4" to a "3." This change was made pursuant to the Department's default practice to approve Authorizations for services only at CPT code levels of 3 or lower. UM Department personnel generally stated that they were instructed to document this sort of change in the Xpress diary notes, but did not always do so.

Neither of these code-changing practices were documented in a formal, written policy.

(2) Auto-Approval Script

The Auto-Approval Script, as designed, also changed CPT codes within the Xpress database related to auto-approved Authorizations. The Script performed the same types of changes made by the UM Coordinators – adjusting upward CPT codes requested for Gold List providers at levels below 4 (*e.g.*, changing a 99203 to a 99204), and adjusting downward CPT codes requested for non-Gold List providers at levels above 3 (*e.g.*, changing a 99204 to a 99203). It appears that these changes were not recorded in Xpress diary notes.

[20] No facts have been identified suggesting that any primary care physician was added to the Gold List.

(3) Customer Service

UM Department personnel and documents confirmed that Customer Service Representatives changed CPT codes within the Xpress database on Authorizations. Representatives made these changes at the request and direction of the referring providers, who contacted them by telephone.

c. Data Changes Not Related to Gold List

Some data changes made by UM Department personnel appear to be unrelated to the Gold List.

(1) Addition of CPT Codes

During interviews, some UM Nurses stated that they sometimes added CPT codes in addition to those requested when approving an Authorization. The UM Nurses stated that generally the CPT codes they added related to follow-up consultations, and that they added them as a courtesy to the receiving provider where, based on the information provided in the Authorization and related notes, a follow-up consultation would have been approved if requested. As such, the purpose of approving the additional follow-up consultation was to prevent the receiving provider from submitting a separate Authorization for the that service.

At least one UM Nurse interviewed sometimes changed the number of follow-up consultations requested when approving an Authorization. The effect of this change was to approve more consultations than requested where it appear to the UM Nurse that the Authorization, as written, requested an insufficient number of consultations.

(2) Changed Dates

Certain UM Department personnel stated that they sometimes changed certain dates in the Xpress database related to Authorizations.[21] There were two types of date changes. First, UM Department personnel, primarily UM Coordinators, reviewed the "received date" and "received time" data in Xpress related to faxed Authorizations and compared the data with the corresponding data captured by the incoming fax application. If a discrepancy was observed, the reviewer changed the data in Xpress so that it was consistent with the data captured by the incoming fax application. It appears that such discrepancies were relatively rare.

Second, UM Department personnel, primarily UM Nurses, changed the "start date" of retroactive approvals so that it coincided with the date on which the service actually occurred, instead of the date on which the retroactive Authorization was received. This date change was made to ensure that the retroactive approval covered the appropriate period of service.

(3) Urgent-to-Routine Downgrades

UM Department personnel, primarily UM Nurses, sometimes changed data in Xpress related to the urgent/routine status of Authorizations. UM Department personnel generally stated that in

[21] The date changes discussed in this section were made to referral data in Xpress. These changes are separate and distinct from date changes discussed in Section IV.C., which appear to have involved UM audit files.

instances where the TAT for an urgent Authorization was close to expiration and the UM Department lacked sufficient information to support a disposition, a UM Nurse contacted the referring provider and requested permission to "downgrade" the Authorization from urgent to routine status. Also, on occasion, the UM Nurse believed there was a mistake made by the referring provider and the Nurse contacted the provider to seek clarification and potentially change the status of the Authorization. The requests were made for the purpose of extending the applicable TAT, which is longer for routine than for urgent Authorizations. UM Department personnel generally stated that UM Nurses downgraded Authorizations only if the referring provider authorized them to do so, and that such authorizations were documented in Xpress diary notes.

3. Denial Process

The investigation made several findings related to the UM Department's practices for processing denials, which are discussed below.

a. Medical Necessity Denials Not Made by a Medical Director

Data indicate that, since 2014, potentially 439 Authorizations were denied for lack of medical necessity by PPMC employees other than a Medical Director. Many of these denials appear to have been made by Xpress users with the title "Denial Nurse." The majority of the these denials were made during 2014 and 2015.

During her interview, Denial Nurse Villa confirmed that she denied Authorizations for lack of medical necessity on her own and was not directed to do so by anyone, including a Medical Director or licensed doctor of medicine. Denial Nurse Villa stated that she made these denials when an immediate disposition was necessary to comply with the applicable TAT and she determined that denial for lack of medical necessity was the proper disposition.

PPMC has commenced a member impact analysis to determine whether any medical necessity denial not made by a Medical Director resulted in the provision of substandard care to a member. This analysis includes case reviews and member out-reach activities consistent with Mandate Nos. 3 and 5 of DHCS's June 5, 2018 Corrective Action Plan to Vantage. PPMC will supplement this Report with the findings of the member impact analysis when they are completed.

b. Denial Letter Back-Dating

From potentially as early as 2006 through approximately mid-2016, Denial Letters were dated with the date on which the underlying denial determination was made. For example, if the decision to deny an Authorization was made on January 15, 2016, the corresponding Denial Letter was dated January 15, 2016 regardless of the actual date it was signed and mailed.

This practice may have resulted in back-dated Denial Letters to the extent that such Letters were mailed on dates subsequent to the dates of their respective underlying denial determinations. Denial Nurse Villa and Denial Coordinator Pearson stated that Denial Letters were generally mailed one or more days after the day of their underlying denial determination, and that this occurred both before and after mid-2016. These statements cannot be readily validated because,

prior to May 2018, PPMC did not capture data evidencing the date on which Denial Letters were actually mailed.[22]

In interviews, Denial Nurse Villa confirmed that she was trained on this Denial Letter dating practice when she joined PPMC in approximately 2006, and subsequently taught the practice to others. Although Denial Nurse Villa stated that she could not recall the name of the individual who trained her, she confirmed that the individual was no longer with the Company.

UM management observed and reported this practice to PPMC's executive leadership in March 2016. During interviews, UM Department personnel, including the individual responsible for reporting the practice to leadership, stated that the practice was discontinued by April or May 2016 with the support of Ion Baroi and Karen Hiteshi.

c. Denial Letter Distribution to Providers

From potentially as early as 2006 through approximately mid-2016, Denial Letters were sent only to members. This occurred even though many Denial Letters from this period identify the referring provider as a "cc" recipient. Over the same period, however, referring providers did receive faxed notification of the denial determination underlying the Denial Letter.

d. Medical Director Engagement

From approximately mid-2014 through approximately May 2018, PPMC's primary Medical Director responsible for making medical necessity determinations with respect to Authorizations was Reuel Gaskins, M.D. Dr. Gaskins performed this role, including the duties outlined in Section IV.A.6 above, from outside of PPMC's Corona, California facility, where the UM Department is located. While performing this role, Dr. Gaskins also maintained a full-time medical practice with offices in Riverside and Rancho Cucamonga, California. Dr. Gaskins estimated that he spent approximately 10 to 12 hours per day maintaining his medical practice, and performed his Medical Director duties during breaks throughout the day and after normal work hours.

Until early 2018, Dr. Gaskins did not review or physically sign Denial Letters sent on his behalf. Initially, his signature was applied by an ink stamp. More recently, his signature was electronically added to the templates used to prepare Denial Letters. Currently, Dr. Gaskins is required to physically sign Denial Letters.

Table 3 below presents the average and maximum number of Authorizations dispositioned by Dr. Gaskins per day over the period from 2014 to 2018.[23]

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[22] Since approximately mid-May 2018, PPMC's mailroom has captured data evidencing the date on which Denial Letters were mailed, including images of postmarked envelopes.

[23] Dr. Gaskins stated that he does not recall dispositioning more than 30-35 authorizations in a given day. However, no facts have been identified that anyone other than Dr. Gaskins made the determinations attributed to him in Xpress.

Table 3

	2014	2015	2016	2017	2018
Mean	22.2	28.6	12.8	9.7	16
Maximum	60	58	59	28	32

C. Recently Discovered Potential Finding Related to UM Audit

During the week of June 18, 2018, the investigation identified PPMC internal correspondence that suggested UM Department personnel altered certain UM audit files to change content that would potentially result in a negative audit finding. The correspondence reflects that on November 20, 2014, PPMC's former QM Manager, Analiza Santiago, notified UM Department personnel that IEHP was planning to perform a UM audit, and that it had sent PPMC a UM Approval Pull List of 20 approval files. It appears that the two primary UM Department personnel responsible for pulling the files were Denial Nurse Villa, and Ramiro Baeza, a former UM Denial Coordinator. On December 8, 2014, Denial Nurse Villa provided to Ms. Santiago, copying Mr. Baeza, PDF copies of the 20 files along with a Word document that summarized "the changes that were made." Analysis of the 20 approval files confirmed that several had some changes. Among the changes made to certain files were decision dates, reason codes, and approval status. It appeared that the changes were made using Adobe software.

Denial Nurse Villa was interviewed as soon as possible following the identification of the above-described correspondence. She acknowledged that she participated in altering some of the 20 audit files. She recalled that Mr. Baeza assisted with the alterations. Denial Nurse Villa stated that she performed the alterations under the supervision of Ms. Santiago and that she believed that Ms. Santiago was under pressure from Ion Baroi to achieve successful UM audit results. Denial Nurse Villa stated that this belief was based on statements made by Mr. Baroi to Ms. Santiago that she overheard in her work area. Denial Nurse Villa could not recall whether she or PPMC personnel had altered other UM audit files either before or after this incident. Following this interview, Denial Nurse Villa was suspended from PPMC until further notice.

An investigation to determine whether additional UM audit alteration occurred at PPMC is underway.

D. Forensic Analysis

1. Analysis of UM Department Policies and Procedures

Navigant reviewed 64 UM Policies and Procedures, including one from 2018 and 63 from 2016, for compliance with Medicare Advantage, Medi-Cal, and Knox Keene Act requirements.

a. UM 300: Referral Authorization Process

UM 300 is the one Policy and Procedure that is current as of 2018. This document is the primary resource for basic UM processing functions. It is twenty-four pages and includes information

that is duplicative within itself and with other Policies and Procedures, particularly the sections describing the timeliness requirements. The document shows it was last reviewed in January 2018 with authorized approval by Dr. Reuel Gaskins. It uses ICE as a source for timeframes instead of using regulatory requirements from DMHC, CMS, or Medi-Cal. The document does not include a definitions section and uses descriptions of different terms inconsistently throughout. Document formatting makes the requirements specific to different health plans difficult to differentiate. The description of allowable reasons for cancelling requests includes denial for a lack of documentation, which is not a generally recognized reason for cancelling a request.

b. UM 301 through 361 and UM Program 2016

The rest of the UM Department's Policies and Procedures that were accessible were from 2016. However, the dates on the documents show that most had not been reviewed or revised since 2013 to 2015. Many of the Policies and Procedures provide detail on the specifics of covered benefits that likely change year-to-year. Some Policies and Procedures, such as UM 308: Hospital Admission Authorization Process, UM 309: Inpatient Admission Review, and UM 310: Concurrent Review, separate related issues, causing duplication and confusion around the requirements. Overall, the Policies and Procedures do not adequately capture the procedural steps required, the quality assurance measures in place as controls, the regulatory references, or definitions for terminology.

c. Overall Gaps

Despite the extensive number of Policies and Procedures, Navigant found that the policies did not include adequate information on the use of Appointment of Representative forms or outreach to providers to obtain medical records.

2. (Preliminary) Forensic Analysis of Authorizations Data Stored in Xpress

Navigant professionals selected a sample of 40 Authorizations submitted through the Portal over the past 12 months and compared the "original" submissions (extracted from the Advantage database) against the corresponding data currently stored in Xpress. The sample included both outpatient and inpatient Authorizations of approved and denied status. The purpose of this analysis was to identify discrepancies between the data sets. Preliminary findings from this analysis are summarized below. Further analysis is necessary to validate these observations.

a. Date Variations

Of the 40 samples, three exhibited potential discrepancies with respect to the Authorization received date data. In these cases, the "original" received date pre-dated the received date reflected in Xpress. The discrepancies observed ranged from a single day to over two months.

b. Missing CPT Codes and Receiving Physicians

On multiple instances (21 out of 40 cases) "original" Authorizations received from physicians did not list either the CPT codes or the referred to physician, but that information was observed in the corresponding Xpress data.

c. CPT Code Variations

In three of the 40 cases, Navigant noted changes made to CPT codes. In two cases, discrepancies were observed between the CPT code(s) appearing in the "original" Authorizations and the corresponding codes stored in Xpress. In the third case, a discrepancy was observed between the number of office visits requested in the "original" Authorization (2 visits) and the corresponding number stored in Xpress (3 visits).

3. UM Grievances

Navigant reviewed the case files of seventeen grievances. These grievances were selected from PPMC's 2017 logs of grievances forwarded to The IPAs by health plans using the following methodology. First, grievances identified as related to Delays in Referrals or as submitted against Vantage or FCMG were isolated as the potential review set. Second, the potential review set was further segregated by removing grievances that were identified as related to provider services, eligibility, access, and claims. The focus of the review was to determine whether there was member harm based on lack of quality of care.

From these grievance files as well as the QM and UM Committee meeting minutes, Navigant determined the organization generally has the appropriate processes in place to investigate grievances, track, trend, and correct individual errors, and respond to the health plans for those grievances that are against the UM Department. Although the grievance files did not leave a clear trail of investigation for most of the samples reviewed, the response to the health plan fully reflected the documentation in Xpress and Doc Viewer in all but one grievance. In that grievance, the UM Department failed to inform health plan that the provider had called after making a prior authorization request to ask that the request be expedited and the UM Department instead continued to process the request as routine.

4. Case File Review

Navigant reviewed the case files of forty prior and concurrent Authorizations processed by the UM Department. These Authorizations were selected from the UM data Navigant aggregated for 2017 and for January 2018. Navigant selected this time period because earlier requests would not have had documentation readily available due to PPMC's archiving policy, and Navigant had access to a version of Xpress that was current as of January 2018. Navigant created a random sample and selected thirty samples from 2017, including all denials available in the random sampling (six), a total of ten pending and cancelled samples (two pending and eight cancelled), with the rest as approvals (sixteen). Navigant also selected ten samples from January 2018, including all denials (one), pending (two), and cancelled (two) samples available and the rest as approvals (five). Navigant reviewed these forty samples for compliance with Medicare Advantage, Medi-Cal, and Knox Keene requirements, as relevant, with the following results.

a. Documentation

In 38 of the forty Authorizations reviewed, the UM Department did not capture adequate documentation. The two remaining Authorizations were approved by the Auto-Approval Script. Inadequate documentation included: little to no notes by UM Coordinators, UM Nurses, and Medical Directors related to processing and clinical decision-making; notes on outreach that did not include the details of to whom staff spoke; no mail tracking; missing documents in Doc Viewer; and no confirmation for faxed notifications to providers. In two of these Authorizations, the documentation failed to show resolution that a disposition had been made. In two of the forty Authorizations reviewed, the referring provider requested a specific receiving provider that differed from the receiving provider approved. In those instances, the information available does not show whether UM Department personnel affirmatively chose to redirect the approved Authorization to a provider other than the one selected by the referring provider and, if so, why.

The UM Department should implement training for coordinators, nurses, and physician reviewers to ensure that all documentation is captured correctly.

b. Turnaround Time

In four of the forty Authorizations reviewed, the UM Department did not make a timely disposition determination. In one instance, an urgent Medi-Cal Authorization was decided one hour late. In another instance, the notification to the provider for the Medi-Cal member was not faxed until two days after the UM Department made its decision. In a third instance, the UM Department downgraded a Medi-Cal Authorization from urgent to routine with no documentation of the UM Department's decision-making process or approval by the provider. This request was decided on the sixth calendar day. In the fourth instance, the UM Department did not make timely notification of its denial of an urgent Medicare Advantage Authorization. The UM Department only captured an event code showing that written notification was sent to the member on the fourth day after the Authorization was received. The UM Department did not capture any notes regarding an oral notification.

The UM Department should create a process to track its notification timeliness more effectively and in real time.

c. Cancellations

Ten of the forty Authorizations were for cancellations.

In two of the ten cancellations, the Authorizations were for a service the UM Department delegates to RadNet. In both cases, the UM Department cancelled the Authorizations and did not perform further decision-making review. In one of those two cases, the notes show that the UM Department called the provider to ask them to submit the Authorization directly to RadNet.

In five of the ten cancellations, the UM Department cancelled the Authorizations as duplicates. Navigant verified that duplicate Authorizations were approved for all five of these cancellations.

In three of the ten cancellations, Navigant did not have access to sufficient documentation to verify appropriate decision-making.

d. Denial Letters

In one of the forty Authorizations reviewed, the UM Department sent a denial notification that was mostly in Spanish, but the denial rationale was in English.

In another of the forty Authorizations reviewed, the Denial Letter was dated on the same date as the underlying determination.

e. Use of Clinical Criteria

In one of the forty Authorizations reviewed, the UM Department notes show that the Denial Nurse reviewed the CPT code against Apollo Guidelines, with a recommendation to deny, and that the Medical Director noted that the CPT code was not medically necessary.

V. Corrective Actions

Based on internal investigation findings and information learned from health plan audits and CAPs, PPMC has implemented or is in the process of implementing numerous corrective actions. **Table 4** reflects the current draft in-progress of PPMC's comprehensive corrective action plan. Completion of the final version of the plan is targeted for the week of July 2, 2018. PPMC will distribute the final version of the corrective action plan when it is completed.

Table 4

Corrective Action	**Estimated Time to Complete**
1. Engage independent subject matter experts from Health Management Associates (Gertrude "Trudi" Carter, MD and Lynette Hutcherson, RN) to consult regarding corrective actions to UM Department	Completed
2. Implementation of system controls to remediate access to software functions a. Update the functionality and design of the current Xpress system to address and remediate access and control issues b. Testing and evaluation of remediation tools, and anticipate a full review of this proposed solution c. Contract consultant to address specific UM systems issues directly linked to the ability of UM staff to either edit certain fields or to review cost information related to the provider in the referral. d. Develop a replacement screen in the current Xpress referral system to prohibit unauthorized system changes, or review of	Completed

Corrective Action	Estimated Time to Complete
provider cost information in the referral, to demonstrate PPMC's commitment to addressing these issues, while providing a sustainable solution to both. Once implemented, the new screens will provide the ability to lock down the fields listed below from editing when the status of the referral is either "approved", "denied", or "cancelled". When the referral status is "pending", these fields will be editable. The list of fields identified for lock down are: "Received By", "Received Date", "Receive Time", "Reviewed By" , "Clean Date", "Clean Time", "Decision Date", "Decision Time", and "Limitations" e. The "Urgency" field will not be locked from editing; however, a report will be generated showing whenever a referral's urgency status is changed from "Urgent" to "Routine". f. Non-required fields can be removed from displaying (e.g., Estimated Cost). The estimated cost field will be hidden from both the "Referral" tab and from the "CPT Codes" tab. This will ensure that no financial information is explicitly, or implicitly, considered when making a referral decision. g. The UM overlay will be finalized by Monday, June 18, 2018. h. Development and implementation of daily field reporting of all fields in the Xpress system – including locked fields – capable of identifying any field modification, the date of the modification, and the associated User ID. The daily report will be distributed to the Claims and UM Department leadership and the President of MSO operations.	
3. Auditing and Process Controls a. Update the functionality and design of the current Xpress system to address and remediate access and control issues b. Testing and evaluation of remediation tools, and anticipate a full review of this proposed solution c. Contract consultant to address specific UM systems issues directly linked to the ability of UM staff to either edit certain	

Corrective Action	Estimated Time to Complete
fields or to review cost information related to the provider in the referral. d. Develop a replacement screen in the current Xpress referral system to prohibit unauthorized system changes, or review of provider cost information in the referral, to demonstrate PPMC's commitment to addressing these issues, while providing a sustainable solution to both. Once implemented, the new screens will provide the ability to lock down the fields listed below from editing when the status of the referral is either "approved", "denied", or "cancelled". When the referral status is "pending", these fields will be editable. The list of fields identified for lock down are: "Received By", "Received Date", "Receive Time", "Reviewed By" , "Clean Date", "Clean Time", "Decision Date", "Decision Time", and "Limitations" i. The "Urgency" field will not be locked from editing; however, a report will be generated showing whenever a referral's urgency status is changed from "Urgent" to "Routine". ii. Non-required fields can be removed from displaying (e.g., Estimated Cost). The estimated cost field will be hidden from both the "Referral" tab and from the "CPT Codes" tab. This will ensure that no financial information is explicitly, or implicitly, considered when making a referral decision. e. The UM overlay will be finalized by Monday, June 18, 2018. f. Development and implementation of daily field reporting of all fields in the Xpress system – including locked fields – capable of identifying any field modification, the date of the modification, and the associated User ID. The daily report will be distributed to the Claims and UM Department leadership and the President of MSO operations.	
4. Auditing and Process Controls a. Implementation of SQL auditing tool that will show when users are changing data elements within the databases for claims and UM. This auditing tool creates an audit log for the	

Corrective Action	Estimated Time to Complete
fields identified within the claims and UM system that were changed or attempted to be changed inappropriately. b. Implementation of controls and management oversight processes. If the SQL audit log has an entry for the key fields in the UM or Claims system, a copy of the audit log will forward to the following people: i. Claims Director of Claims (Wendy Magnacca) President of MSO Operations (Joan Danieley) Manager of Claims (Sylvia Lerma) ii. UM Director of UM (Mary Peck) Medical Director of UM (Dr. Khaliq Siddiq) Manager of UM (Sophia Mani) Director of UM Process Improvement (Randie Myers) c. The SQL auditing tool described above and corresponding reports will identify any inappropriate activity in the live data. As mentioned earlier, these reports will be escalated to the CSIO and department management for appropriate action.	
5. Analysis of UM and Claims Data for Impacted Providers and Members Retroactive to 2014 a. Review ALL Denials according to the following algorithm. The algorithm supports first and foremost, the involvement of the referring provider and, secondly, the appropriate decision-making process. Key is prioritization to ensure outreach is physician driven and based on member needs. Once sign-off is complete, PPMC will run a small sample to test the integrity of the logic. Once confirmed, a full report will be generated. The final reconciliation will account for all members in the universe. The data from the process will be used to do the impact analysis and be presented individual plan. b. Pull all UM denials for time period of 1/1/2014 through 5/31/2018.	

Corrective Action	Estimated Time to Complete
c. Denials will first be reviewed to ensure continued eligibility with PPMC. Members found to be no longer enrolled with PPMC will be removed from the universe and will be reported back in the final analysis. d. For eligible members, PPMC will complete a claims reconciliation to match the denied service codes which will assess if the members may have received the service after the denial. i. If the member received the service, this will be reported back in the final analysis. ii. If the member did not receive the service, the remaining UM denials will be categorized by line of business and type of denial - medical necessity, not a covered benefit or not a covered service (NCB/NCS). e. For NCB/NCS, the UM Denial files will be assessed to determine if the decision was appropriate based on the product benefit. i. If the assessment of the file indicates the determination was appropriate, the outcome will be reported back in the final analysis. ii. If the assessment of the file indicates the determination was inappropriate or inaccurate, PPMC will: 1. Contact the requesting provider to verify the service is still needed. a. If the requesting provider states the service is still needed, the provider can issue a new referral by verbal order and identify the referral status as routine/urgent. PPMC will contact the member to inform them of the approved service and generate a new approved referral to the requested provider.	

Corrective Action	Estimated Time to Complete
b. If the requesting provider states the service is no longer needed, the communication with the provider will be documented on the tracking log for reporting back in the final analysis. f. For denials based on medical necessity, the UM denial files will be reviewed by appropriate provider. i. If the assessment of the file indicates the determination was appropriate, the outcome will be reported back in the final analysis. ii. If the assessment of the file indicates the determination was inappropriate or inaccurate, PPMC will: 1. Contact the requesting provider to verify the service is still needed. a. If the requesting provider states the service is still needed, the provider can issue a new referral by verbal order and identify the referral status as routine/urgent. PPMC will: i. Process the new referral per UM protocol 1. Contact the member to inform them of the approved service 2. Generate a new approved referral to the requested provider. ii. If the requesting provider states the service is no longer needed, the communication with the provider will be documented on the tracking log for reporting back in the final analysis.	

Corrective Action	Estimated Time to Complete
g. To prioritize the outreach efforts, identified cases eligible for new referrals will be contacted in the following order: i. Priority 1 - Denials less than 6 months and to a specialty provider ii. Priority 2 - Denials less than 6 months and for an ancillary or DME service iii. Priority 3 - Denials greater than 6 months	
6. Update policies and procedures relating to provider/member letters, updated workflows relating to the processes for ensuring compliance with all applicable standards relating to their processing, and details relating to staff training on all the above.	
7. Implementation of documented internal quality audit processes by Compliance a. Oversee, review, update, and consolidation of UM and Claims departmental policies and procedures, including: b. Annual reviews to ensure business processes are updated to reflect regulatory requirements c. Internal audits by Compliance that will include a review of all departmental policies and procedures. i. Updated policies and procedures, as well as, the processes and approach to be used to conduct internal audits and a review of all departmental policies to be provided.	
8. Implementation of documented internal quality audit processes with oversight by designated individuals wholly separate from the claims and UM operations and outside independent certification a. Hire two new internal leaders of audit and payment integrity have to support the development of an internal claims department quality audit function. This function is the 3rd prong of a more comprehensive company- wide internal audit unit at PPMC for compliance with PPMC's internal policies and procedures, PPMC's code of conduct, and all applicable statutory, regulatory, and contractual rules and requirements.	

Corrective Action	Estimated Time to Complete
Three levels of audits are planned to be implemented by the fourth quarter of 2018: i. Corporate Internal Audit – including audits of internal control processes of claims processing and other key functions; ii. Compliance Audit – to test compliance with applicable contract and regulatory requirements; iii. Claims Department Audit – with attention to departmental quality control. b. Engage outside experts to support the UM operations and retain additional resources to ensure that PPMC has the appropriate internal quality audit functions in place to oversee UM. c. Engage external, experienced and industry-recognized auditing firm to provide the independent certification of PPMC's performance.	
9. Implementation of a documented process to evidence physician reviewing of UM cases for medical necessity (including claims) a. Redefine roles and responsibilities of clinical decision-makers and review and revision of policies, procedures, tools, and reporting to ensure accurate decision-making. b. Refresher training on selecting, applying and documenting criteria; revisiting clinical decision-making hierarchy; appropriate referral to Medical Director for denials; a quarterly Inter-Rater Reliability (IRR) review for all clinical decision-making staff for at least one year; and quarterly reporting to the Medical Services Committee for identification of opportunities to improve. i. Physician and staff training regarding the proper documentation required for UM determinations, a UM workflow, all training materials, and sign-in sheets reflecting participation in such training.	

Corrective Action	Estimated Time to Complete
c. Designation of Dr. Khaliq Siddiq as the full-time Medical Director for UM in May 2018 with the following responsibilities: i. Documentation of clinical decision-making process ii. Development of UM program iii. Oversight and accountability for UM program iv. Referral reviews v. Development of language for Notice of Actions vi. Peer on peer communication vii. Review alternative medical source for medical criteria when evidence- based criteria is unavailable viii. Participate in oversight of clinical and non-clinical decision making of staff, including physicians ix. Review and analyze UM reports to identify opportunities for improvement and interventions x. Oversight of the Medical Services Committee and Quality Improvement activities In this role, Dr. Siddiq will ensure the appropriate staffing and resources available to perform all UM functions in accordance with contract and regulatory requirements and timelines. Under the direction of the UM Medical Director and with support from the UM Director and Senior Director and consultant support, PPMC will review and revising policies, procedures, tools, and reporting that will ensure accurate decision-making. This will include physician reviewing of UM cases for medical necessity and refresher training on selecting, applying and documenting criteria; revisiting clinical decision-making hierarchy; appropriate referral to Medical Director for reviews; a quarterly Inter-Rater Reliability (IRR) review for all clinical decision-making staff for at least one year; and quarterly reporting to the Medical Services Committee for identification of opportunities to improve.	

Corrective Action	Estimated Time to Complete
10. Provide documentary evidence that all dollar amount service thresholds have been eliminated and the dates on which they were eliminated.	
11. Documentation and implementation of a sustainable organizational structure for claims and compliance departments. a. Provide documentary evidence that Operational and Compliance functions within Primary Provider Management Company (PPMC) are independent from each other and are managed by two separate leaders, the President of Operations and Chief Compliance Officer, respectively. b. Separate roles and responsibilities so the Compliance area can oversee the implementation of the compliance program, including identifying and reducing risks of fraud through independent assessments and tracking of corrective action plans for remediation. c. Provide the Chief Compliance Officer with a direct reporting line to agilon Health's Board of Director's compliance committee.	
12. Development and Implementation of enhanced oversight of claims processing: a. Change in upper management, including a new Director of Claims i. Create an appropriate culture of compliance, by establishing appropriate tone from the senior management level b. Centralizing claims adjudication function i. Build a stronger and consistent regulatory oversight procedure of claims processing practices. c. Implementation of new operating system (CORE) to be implemented by end of Q3 2018 i. Enhanced system capabilities to track and process claims ii. Control over access to data fields iii. Improved reporting functionality	

Corrective Action	Estimated Time to Complete
d. Enhancement of 2018 Claims Internal Audit Function i. Development and implementation of a formal internal audit unit at PPMC to oversee claims compliance to ensure risk is mitigated and eliminate the probability of reoccurrence	
13. Develop the capability to generate weekly and daily reports to provide to contracted health plans that include open and pended claims and authorization reports, backlog reports with aging, along with a specific and measurable plan to reduce backlog in both claims and UM with an expected date of compliance by which claims and UM turnaround times and misdirected claim forward requirements will meet regulatory guidelines.	Q3 2018
14. Provide supporting documentation to demonstrate the implementation of an auto approval process, a complete list with diagnosis, provider specialty, place of service, type of service, and procedure codes. a. Develop approved policy and procedure that specifically allows a claim to pay or an authorization request to be approved without manual intervention by staff. b. Provide evidence of meetings and signed minutes indicating that a process was approved by the utilization management committee, as well as, evidence that staff has been trained on the new process. The auto approval process and list was updated to ensure systematic process without manual intervention. A written policy went to the UM Committee in May 2018 and was approved.	
15. Navigant Consulting will rerun contracted health plans' MTRs for the past 12 months. a. PPMC will provide examples of the open inventory and daily inventory summary reporting utilized by claims department and executive leadership	
16. Provide evidence of Fraud, Waste, and Abuse (FWA) training for all employees within 90 days of hire and annually thereafter. a. Training is to be electronically delivered through PPMC's administrative system, Workday. b. Provide the 2018 FWA training deck and attestation report.	

Corrective Action	Estimated Time to Complete
17. Provide written documentation that a medical director is involved in UM operations. a. Redefine roles and responsibilities of clinical decision-makers and review and revise policies, procedures, tools, and reporting to ensure accurate decision-making. i. Provide refresher training on selecting, applying and documenting criteria; revisiting clinical decision-making hierarchy; appropriate referral to Medical Director for denials; a quarterly Inter-Rater Reliability (IRR) review for all clinical decision-making staff for at least one year; and quarterly reporting to the Medical Services Committee for identification of opportunities to improve. b. Provide physician and staff training on how to properly document UM determinations, a UM workflow, all training materials, and sign-in sheets reflecting participation in such training.	
18. Designation of Dr. Siddiq as the full-time Medical Director for UM with the following responsibilities: a. Documentation of clinical decision-making process b. Development of UM program c. Oversight and accountability for UM program d. Referral reviews e. Development of language for Notice of Actions f. Peer or peer communication g. Review alternative medical source for medical criteria when evidence- based criteria is unavailable h. Participate in oversight of clinical and non-clinical decision making of staff, including physicians i. Review and analyze UM reports to identify opportunities for improvement and interventions	

Corrective Action	Estimated Time to Complete
j. Oversight of the Medical Services Committee and Quality Improvement activities In this role, Dr. Siddiq will ensure the appropriate staffing and resources available to perform all UM functions in accordance with contract and regulatory requirements and timelines. Dr. Gaskins and Dr. Lee will continue to perform appropriate clinical review as needed. Dr. Siddiq will report up to the CMO-delegate, Dr. Manoj Mathew, National Medical Director.	
19. Discontinue use of "Supplemental Approval Protocol" (MX Punch)	Completed
20. Provide detail on the approach and workflow outline for the automated (OMS500, AIMS and DS200i) and non-automated jobs (DS200i only). All jobs that are automated with OMS500, AIMS and DS200i: a. Implementation of mailroom updates, controls and audits. i. Software has been purchased and configuration and implementation planning underway b. Utilize the Neopost system to monitor all jobs processed through OMS500 in a way that the OMS500 will output a print file (hard copy) to the printer as well as a "companion file" (electronic copy via AIMS) to the inserter. i. Once the print job is placed into the inserter it will recognize the applied serialized barcode from each sheet which will instruct the inserter as to which job it is processing, how many total pages are in the job and how many sheets per envelope. The inserter, along with AIMS, will monitor the job in its entirety to make sure that all pages were processed and placed into the appropriate envelope. This entire process is able to be audited right down to a control # (account#, customer#, etc...) within AIMS. c. Process all jobs manually by staff d. Utilize the DS200i to process and track the number of pieces ran for the day i. can be tallied by job # and/or employee that ran the machine. This amount is tracked by the amount of	

Corrective Action	Estimated Time to Complete
envelopes that receive the document, inserted into the envelope and exited the machine.	
21. Implementation of information technology system (CORE) prior to the end of calendar year 2018 for contracted medical groups. a. Provide documentation regarding implementation of new operating systems, CORE, that will provide: i. Enhanced system capabilities to track and process claims ii. Control over access to data fields iii. Improved reporting functionality b. CORE is scheduled for implementation by September 30th, 2018. c. CORE is an end-to-end operating system with functionality for eligibility, configuration, authorizations, population management, claims processing, customer service, and risk adjustment. The system has been fully operational in agilon's Hawaii market since September 2017; where it is processing all claim types (including inpatient, outpatient, and professional) with paid dollars greater than the California business that will transition to CORE. d. The California market is being implemented in three phases. The first phase has been live since January 2018. The second phase, the Fresno market, will go live by the end of July and the third phase, Southern California, is scheduled to go live by the last day of September.	
22. Development and/or implementation of the following enhancements to claims processing oversight: a. Change in upper management, including a new Director of Claims i. To create an appropriate culture of compliance, which begins with senior management setting the appropriate "tone at the top" message and leadership	

Corrective Action	Estimated Time to Complete
b. Centralizing claims adjudication function i. To help achieve building a stronger, consistent regulatory oversight procedure of claims processing practices. c. New operating system (CORE) i. Enhanced system capabilities to track and process claims ii. Control over access to data fields iii. Improved reporting functionality d. 2018 Claims Auditing Plan i. Develop and implement a formal audit plan to oversee claims compliance to ensure risk is mitigated and eliminate the probability of reoccurrence e. Auditing and Process Controls i. PPMC has implemented an SQL auditing tool that will show when users are changing data elements within the databases for claims and UM. This auditing tool creates an audit log for the fields identified within the claims and UM system that were changed or attempted to be changed inappropriately. f. Implementation of a set of controls and management oversight processes. i. If the SQL audit log has an entry for the key fields in the UM or Claims system, a copy of the audit log will forward to the following people: 1. Claims Director of Claims (Wendy Magnacca) President of MSO Operations (Joan Danieley) Manager of Claims (Sylvia Lerma) 2. UM Director of UM (Mary Peck)	

Corrective Action	Estimated Time to Complete
Medical Director of UM (Dr. Khaliq Siddiq) Manager of UM (Sophia Mani) Director of UM Process Improvement (Randie Myers) PPMC has developed an SQL auditing tool, described above, and corresponding reports that will identify any inappropriate activity in the live data. As mentioned earlier, these reports will be escalated to the CSIO and department management for appropriate action.	
23. Evaluation and analysis of data contained in SNARE or other log vaulting system to determine if modifications or deletions have occurred -requires purchasing, staffing, and completion within four (4) weeks. a. Continue to evaluate other solutions but solutions system changes, audit trails, monitoring reports, and control processes/oversight described above remediate this area.	

Appendix A

Denial reasons comprising the Other denial category presented in Table 1.

	2014	2015	2016	2017	2018
Total Denials	**7,650**	**10,772**	**7,236**	**5,059**	**3,266**
Percent of All Authorizations	2.35%	2.85%	1.74%	1.02%	1.13%
Reason Blank	**79**	**20**	**26**	**7**	**5**
Percent of all Denials	1.03%	0.19%	0.36%	0.14%	0.15%
CCS Fresno	-	-	-	**99**	**58**
	0.00%	0.00%	0.00%	1.96%	0.00%
CCS Los Angeles	**19**	**21**	**38**	**46**	**13**
	0.25%	0.19%	0.53%	0.91%	0.40%
CCS Madera	-	-	-	**3**	**1**
	0.00%	0.00%	0.00%	0.06%	0.03%
CCS Riverside	**262**	**620**	**827**	**712**	**304**
	3.42%	5.76%	11.43%	14.07%	0.00%
CCS San Bernardino	**137**	**360**	**626**	**364**	**162**
	1.79%	3.34%	8.65%	7.20%	4.96%
CCS San Diego	**21**	**24**	**14**	**23**	**20**
	0.27%	0.22%	0.19%	0.45%	0.61%
Commercial Primary	**58**	**52**	**6**	**1**	-
	0.76%	0.48%	0.08%	0.02%	0.00%
Deny by Health Plan	**7**	**442**	**542**	**48**	**6**
	0.09%	4.10%	7.49%	0.95%	0.18%
Deny lack of HP notification form	**1**	**128**	**190**	**92**	**3**
	0.01%	1.19%	2.63%	1.82%	0.09%
Documentation of non	-	**1**	-	-	-
	0.00%	0.01%	0.00%	0.00%	0.00%
Global OB not per visit	-	-	**1**	-	-
	0.00%	0.00%	0.01%	0.00%	0.00%
Inpatient Peds Denial	**2**	-	**5**	-	-
	0.03%	0.00%	0.07%	0.00%	0.00%
Invalid Member	**8**	**5**	**1**	**1**	-
	0.10%	0.05%	0.01%	0.02%	0.00%
Medicare Primary	**326**	**159**	**30**	**3**	**1**
	4.26%	1.48%	0.41%	0.06%	0.03%
Not qualifying retro	**13**	**23**	**19**	**9**	**8**
	0.17%	0.21%	0.26%	0.18%	0.24%
Out of Area	**1**	**15**	**5**	**1**	-
	0.01%	0.14%	0.07%	0.02%	0.00%
Out of Network	**32**	**2**	-	-	-
	0.42%	0.02%	0.00%	0.00%	0.00%
Terminated member	**3**	**2**	-	-	-
	0.04%	0.02%	0.00%	0.00%	0.00%

Cancellation reasons comprising the Other cancellation category presented in Table 1.

	2014	2015	2016	2017	2018
Total Cancellations	**20,890**	**26,876**	**27,174**	**29,415**	**15,034**
Percent of All Authorizations	6.43%	7.11%	6.53%	5.94%	5.21%
Reason Blank	**1**	**14**	**14**	**-**	**1**
Percent of all Cancellations	0.00%	0.05%	0.05%	0.00%	0.01%
Against Medical Advice	**-**	**3**	**2**	**2**	**2**
	0.00%	0.01%	0.01%	0.01%	0.01%
Cancelled by the Health Plan	**-**	**12**	**499**	**68**	**98**
	0.00%	0.04%	1.84%	0.23%	0.65%
Cancelled Expired	**46**	**10**	**15**	**34**	**6**
	0.22%	0.04%	0.06%	0.12%	0.04%
Carve Out	**-**	**6**	**99**	**35**	**8**
	0.00%	0.02%	0.36%	0.12%	0.05%
Incomplete Hospital Authorization	**11**	**8**	**8**	**9**	**1**
	0.05%	0.03%	0.03%	0.03%	0.01%
Medicare Primary	**7**	**43**	**191**	**948**	**671**
	0.03%	0.16%	0.70%	3.22%	4.46%
Other Health Plan	**-**	**16**	**56**	**1,320**	**1,015**
	0.00%	0.06%	0.21%	4.49%	6.75%
Out of Area	**-**	**103**	**70**	**94**	**69**
	0.00%	0.38%	0.26%	0.32%	0.46%
Out of Network	**283**	**12**	**3**	**3**	**1**
	1.35%	0.04%	0.01%	0.01%	0.01%
Redirected	**-**	**4**	**8**	**10**	**17**
	0.00%	0.01%	0.03%	0.03%	0.11%
SAR Approved by CCS	**-**	**-**	**14**	**211**	**121**
	0.00%	0.00%	0.05%	0.72%	0.80%
Submitted for Reconsideration	**54**	**20**	**1**	**-**	**6**
	0.26%	0.07%	0.00%	0.00%	0.04%

Appendix B

CPT Codes Suitable for Approval by Auto-Approval Script

Specialty	CPT Code	CPT Description
Allergy, Pain Management, Audiology, Cardiology, Dermatology, Endocrinology, Hematology/Oncology, Gastroenterology, Infectious Disease, Nephrology, Pulmonology, Rheumatology, OB/Gyn, ENT, Orthopedics, Urology	99243	Consult
	99203	Consult
	99213	Follow up
Allergy	95004	Scratch Test
	95024	Intradermal Test
Cardiology	93303	Transthoracic Echo Complete
	93304	Transthoracic Echo Limited
	93306	Transthoracic Echo with Doppler and Color Flow
	93307	Transthoracic Echo without Doppler and Color Flow
	93308	Follow up or limited Transthoracic Echo Only
	93320	Doppler Echocardiography, Pulse Wave
	93325	Doppler Echocardiography Color Flow Velocity Mapping
	93015	Cardiovascular Stress Test
Dermatology	11301	Shave or Biospy of Lesion
	11306	Removal of Benign Lesions other than Skin Tags (up to 14 lesion)
	11310	Under Shaving of Epidermal Lesions
	17000	Destruction Procedure on Benign or Premalignant Lesion (first)
	17003	Destruction Procedure on Benign or Premalignant Lesion (additional)
	17110	Removal of Benign Lesions other than Skin Tags (up to 14 lesion)
	17111	Removal of Benign Lesions other than Skin Tags (additional)
Endocrinology	81003	Urinalysis
	82947	Glucose test
ENT	92557	Comprehensive audiometry threshold evaluation and speech recognition
	92582	Under Audiologic Function Tests

Specialty	CPT Code	CPT Description
	69200	Under Removal Procedures on the External Ear
	30300	Under Removal of Foreign Body Procedures on the Nose
OB/Gyn	88164	Pap Smear Cytopathology
	57454	Colposcopy of Cervix
Pulmonology	94060	Nebulizer Treatment
	94010	Spirometry
Podiatry	11730	Under Surgical Procedures on the Nails
	11732	Under Surgical Procedures on the Nails
	11765	Under Surgical Procedures on the Nails
Radiology 2V and 6V	73000	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Upper Extremities
	73140	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Upper Extremities
	73501	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Lower Extremities
	73660	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Lower Extremities
	72020	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis
	72120	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis
	73140	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Upper Extremities
	73660	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Lower Extremities
	72120	Under Diagnostic Radiology (Diagnostic Imaging) Procedures of the Spine and Pelvis
Urology	51798	Under Urodynamic Procedures on the Bladder
	51741	Under Urodynamic Procedures on the Bladder

Specialty	CPT Code	CPT Description
	52000	Under Endoscopy-Cystoscopy, Urethroscopy, Cystourethroscopy Procedures on the Bladder
	81003	Urinalysis

Appendix C

Top 10 CPT Codes Approved by Supplemental Approval Protocol (2016-2018)

CPT Code	Description	Total Count
99213	Follow up	126,355
99203	Consult	89,551
99243	Consult	37,820
99214	OFFICE OUTPT EST 25 MIN	33,967
99204	OFFICE OUTPT NEW 45 MIN	20,001
93000	ECG ROUTINE ECG W/LEAST 12 LDS W/I&R	17,504
99215	OFFICE OUTPT EST 40 MIN	13,875
92014	OPH MEDICAL XM&EVAL COMPRE EST PT 1+ VST	11,709
99244	OFFICE CONSULT 60 MIN	8,665
93306	Transthoracic Echo with Doppler and Color Flow	7,415