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**RESULTS OF ADHC INDUSTRY SURVEY ON
TREATMENT AUTHORIZATION REQUEST (TAR) CENTRALIZATION
AT LOS ANGELES FIELD OFFICE**

MAY 2010

In April 2010, CAADS conducted a survey of the ADHC industry to determine how the transfer of TAR adjudication to the Los Angeles Field Office was impacting providers. Questions regarding billing and satisfaction with the field office also were asked.

RESULTS

The survey was distributed to all ADHC providers in the state, and 106 ADHC providers responded to the survey, yielding a response rate of 34%. Of this group 36 ADHC sites (34%) are located in Los Angeles County and 66% are from the rest of the state. This is in contrast to the distribution of centers statewide, where 53.2% of providers are located in Los Angeles County.

Therefore, two-thirds of the respondents were unfamiliar with the Los Angeles Field Office (LAFO) adjudication standards, which the survey findings and interviews with providers indicate differ from other Field Office standards.

The LAFO standards for adjudication were not conveyed to the providers prior to the statewide consolidation of TAR adjudication to the LAFO. The providers had to learn by “trial and error” what the LAFO detailed expectations were for completing the Individual Plan of Care, submitted with the TAR. They are still learning because no training or written standards unique to LAFO have been made available to the provider community. This appears to have contributed considerably to the significant delays in adjudication as submitted TARs are deferred or modified, forcing the provider to re-submit and start the process over again. The result is a significant interruption in cash flow for providers, estimated to be \$7.8 million in delayed reimbursement. More than 44.8% of the providers are either dissatisfied or rarely satisfied with the responsiveness of the LAFO.

Turnaround Time

Reports from the field indicate that TAR adjudication turnaround time has increased in the time period leading up to and since the transfer of all ADHC TAR adjudication to the LAFO.

The survey revealed that almost two-thirds (63.8%) of all submitted TARS were reported to exceed the required maximum adjudication time of 30 days. 57% were up to one month late and 6.5% exceeded 60 days, but these numbers may be higher today because the survey was conducted in April, only two months post transfer to LAFO.

Turnaround Time for Adjudication	Count	Percent
less than 30 days	1172	36.15%
31-60 days	1858	57.31%
61-89 days	183	5.64%
more than 90 days	29	0.89%

Cash Flow

Eighty-one percent (81%) of providers reported significant cash flow problems that are impacting their operations because of the increased turnaround time for adjudication. Some centers are having difficulty meeting payroll as their reserves have been depleted over multiple years of cash flow interruptions caused by the State and Legislature.

- The median of all responses was 32% of a center's cash flow is being negatively affected by the state's unprecedented delays in adjudication.
- For an average size center this amounts to \$31,000 in delayed reimbursement for care already provided during the period of time that the TAR is at the Field Office being adjudicated.
- To illustrate, if the above average size center's cash flow impact is extrapolated to 81% of all centers, this equates to \$7.8 million in Medi-Cal reimbursements being delayed by the state due to the increased TAR adjudication time.

TAR Deferrals

The field office defers TARs when additional information is requested or there is incomplete information is submitted. TAR deferrals have increased significantly since September 2009. Reports from the field indicate that the LAFO has different unpublished standards for their expectation of how certain information in the Individual Plan of Care is displayed.

Provider Comments:

- "Frequency issues seem to be the major problem and anyone reading the paperwork could determine the frequency meanings. This is a significant issue that I'm hopeful will be resolved soon. These [LAFO] responses are totally opposite to our historic record with TAR/IPC, surveys etc."
- "There was a discrepancy [in frequency] because we have an IPC that included medical and Regional Center days. We must go back and redo the TAR separating the days out, essentially creating two IPCs for the same participant. This was never an issue in San Diego."
- "Other Field Offices accepted writing over the treatment and frequency column rather than having the intervention and frequency stay in their own columns."

Also, providers have had difficulty reaching the LAFO to clarify requirements once a TAR is deferred. One provider commented that it would have been more professional and efficient to have published the standards in advance or to call or send a note to the provider regarding the preferred format to avoid wasting time.

LAFO did not notify providers in advance that their standards differed from other field offices, so providers relied on their past experience in submitting TARs. When the submitted TARs did not meet the “unknown” LAFO standard, these TARs were deferred. This contributed to delays and additional workload burden on the LAFO and the providers. This burden could be avoided in the future by the Field Office publishing standards in advance of implementing idiosyncratic TAR requirements.

Several providers reported that the LAFO would not accept electronic signatures. ADHCs that rely on commercial software to create their IPCs and TARs upload the electronic signatures on the required documents, a practice that was accepted in other field offices. One provider had to obtain a letter from the software vendor stating that the software complied with all state mandates for electronic signatures, even though this software is used by a vast majority of the ADHCs in California.

For another example, one provider reported that the San Francisco Field Office explicitly asked providers never to print the start and end dates in the bottom right corner of the TARs, but the LA office sent 30+ TARs back and asked the provider to put the dates in these fields even though the information appears on the IPC.

- More than one-third (63.9%) of ADHCs have experienced a change in the frequency of TAR deferrals between September 2009 and April 2010.
- 65% stated an increase in the number of TAR deferrals

TAR Modification

TARs are modified when the adjudicator applies their own judgment about what is the minimum number of days medically necessary to achieve the Individual Plan of Care goals and treatments.

Nearly one-third (30%) of providers reported an increase in the number of TAR modifications compared to 12 months ago. The highest percentage of these modifications was a reduction in requested days from 3 days per week to 2 days per week (37.84%). The next highest was a reduction in requested days from 5 days per week to 4 days per week (23.2%). More than one-half of the modifications reported were a reduction from the 3 or 4 days requested to 2 days per week (54%) approved. These modifications in requested days translate to significant disruption to the care and attendance pattern for the participant because most ADHCs begin to provide service while waiting for the TAR to be approved. As centers are prohibited from providing free days of care for Medi-Cal beneficiaries, the center is at financial risk for the days that are not approved and the participant and family are adversely affected.

Modified TAR Summary	Count	Percent
Asked for 5 days, modified to 4	66	17.84%
Asked for 5 days, modified to 3	86	23.24%
Asked for 4 days, modified to 3	17	4.59%
Asked for 4 days, modified to 2	59	15.95%
Asked for 3 days, modified to 2	140	37.84%
Other	2	0.54%

Roughly one-fourth of these modifications were appealed at the LAFO level. This process is labor intensive for the State, participant, and provider and further delays final decisions on admission status of the participant.

- 26% of modifications have been appealed
- 82% requested a supervisory level appeal
- 6.3% of participants filed for a fair hearing request

TAR Denials

TARs may be denied when the LAFO determines that the beneficiary does not meet ADHC medical necessity criteria. Almost 1/5 of the ADHC survey respondents reported a change in the number of TAR denials compared to last year at this time. Of those 11.3% who filed for a fair hearing, it was reported that 33% were judged to be in the participant's favor.

- 11.6% reported a change in the number of TAR denials compared to last year
- 15.4% of those reported an increase in the number of denials
- 12.1% have appealed the denial
- 40% of those first level appeals have been successful
- 11.3% of beneficiaries have filed for a fair hearing
- 33% of those appeals have been successful

Private Pay Conversion to Medi-Cal

11.6% of providers reported TAR deferrals because of confusion over the correct initial assessment date when a participant converted from "private pay" status to Medi-Cal status. These providers reported that TARs were deferred when they submitted a TAR to LAFO for the first time within the middle of a TAR period because the participant converted from private pay to Medi-Cal. The LAFO appeared not to understand that a person could be part-way into their six-month period of ADHC service and then become eligible for Medi-Cal prior to the end of the period.

- 33% of providers resolved the issue satisfactorily
- 1.7% of these "conversion" TARS were denied

Medi-Cal Billing Questions

The survey included questions about problems providers were experiencing with the billing process. Out of the almost one-third of providers reporting billing issues, 21% of this group reported claims somehow had been “lost” in the system. This appears to be a new problem that we could not isolate to any particular pattern. In addition, providers reported that unusual Remittance Advice (RAD) codes appeared, they had to bill multiple times due to these unexpected errors, and entire batches of claims were deleted from the Medi-Cal claims computer system for no known reason.

- 31% of providers reported an unusual number of billing problems
- 21% of this group reported claims being "lost" in the system, forcing most to re-bill
- 20% reported receiving unusual RAD codes that were not consistent with the claim history or documentation:

0006	The date(s) of service reported on the claim is not within the TAR authorized period.
0031	The provider was not eligible for the services billed on the date of service.
0079	Service billed exceeds remaining occurrence approved on the TAR.
0243	The TAR control number submitted on the claim is not found on the TAR master file.
0314	Recipient is not eligible for the month of service billed.
0389	Documentation does not establish the medical necessity for procedure/appliance billed.
0433	Payment was reduced because of patient liability (Share of Cost).
0475	Claims submitted during the seventh through ninth month after the month of service without a valid billing limit exception are reduced to 75 percent of the allowed amount.
0476	Claims submitted during the 10th through 12th month after the month of service without a valid billing limit exception are reduced to 50 percent of the allowed amount.

“Carry-Over” Days

Responses to the question on carry-over days revealed that only 17.4% of providers attempt to bill for carry-over days. This is permitted when a participant misses a day of attendance near the end of the month and cannot make up the day within the same month. The provider can submit additional paperwork to the field office to seek approval for the carry-over day or days but the process is simply too complex and time-consuming to make it worthwhile for most centers. Others believed that the carry-over days were no longer allowed.

Field Office Questions

Survey questions about the field office personnel were included because of the change for many providers in dealing with a new field office. A number of respondents commented that it is difficult to reach a person by telephone at the LAFO to discuss questions or problems. Nearly forty-four percent (43.8%) were not satisfied with LAFO responsiveness. We did not analyze whether this percent disproportionately included those providers who are new to the LAFO.

On a more positive note, once a LAFO staff member is reached, nearly one-half of the survey respondents felt they were treated courteously, obtained the help they were seeking, and were satisfied with the responsiveness they sought.

Satisfaction with the responsiveness of the LAFO:

Responsiveness of LAFO	Percent
Very satisfied	6.8%
Satisfied	49.3%
Rarely satisfied	23.3%
Not satisfied	20.5%

Field Office Staff Ratings:

Helpful	Percent
Always helpful	19.1%
Frequently helpful	30.9%
Sometimes helpful	33.8%
Occasionally helpful	11.8%
Never helpful	4.4%

Courteous	Percent
Always courteous	35.8%
Frequently courteous	32.8%
Sometimes courteous	13.4%
Occasionally courteous	11.9%
Never courteous	6.0%

Knowledgeable	Percent
Always knowledgeable	18.5%
Frequently knowledgeable	24.6%
Sometimes knowledgeable	38.5%
Occasionally knowledgeable	16.9%
Never knowledgeable	1.5%

Responsive	Percent
Always responsive	20.9%
Frequently responsive	29.9%
Sometimes responsive	25.4%
Occasionally responsive	22.4%
Never responsive	1.5%

Patient	Percent
Always patient	16.4%
Frequently patient	38.8%
Sometimes patient	23.9%
Occasionally patient	14.9%
Never patient	6.0%

Reasonable	Percent
Always reasonable	18.8%
Frequently reasonable	28.1%
Sometimes reasonable	28.1%
Occasionally reasonable	21.9%
Never reasonable	3.1%

Responsiveness to ADHC inquiries	Percent
Always responsive to ADHC inquiries	25.0%
Frequently responsive to ADHC inquiries	26.3%
Sometimes responsive to ADHC inquiries	26.3%
Occasionally responsive to ADHC inquiries	18.49%
Never responsive to ADHC inquiries	3.9%

Problem resolution	Percent
Often problem resolution	30.7%
Sometimes problem resolution	39.3%
Rarely problem resolution	20.0%

Knowledge of ADHC medical necessity criteria	Percent
Highly knowledgeable	17.1%
Moderately knowledgeable	39.3%
Barely knowledgeable	18.6%

Consistency between adjudicators	Percent
Consistent	20.3%
Somewhat consistent	53.6%
Rarely consistent	17.4%
Inconsistent	8.7%