MEDI-CAL PROGRAM

REPORT ON REVIEW OF THE MEDI-CAL PAYMENT PROCEDURES FOR AMBULANCE SERVICES

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INTRODUCTION

We have reviewed the Medi-Cal records at Blue Shield, the fiscal intermediary for both the state operated Medi-Cal program and the federal Medicare program, relating to 876 claims submitted to us by members of the Sacramento County Ambulance Association. These are copies of claims totalling $33,650 that had been previously submitted to Blue Shield for payment over a period of about four years that were still unpaid, in whole or in part, according to the association's representatives. Our review was made to determine the reasons that these claims had not been paid, to obtain payment where proper, and to make recommendations to improve the ambulance claim payment procedure where indicated.

We also reviewed the rules, regulations and procedures for processing ambulance claims for payment by the Medi-Cal program; interviewed the ambulance service vendors and personnel at Blue Shield and the Department of Health Care Services.

SUMMARY OF FINDINGS

Our research of Blue Shield records regarding the ambulance claims submitted to us revealed that:

1. Blue Shield had no record of having received 446 of the claims researched. Many of these claims did not "cross over" from the Medicare to the Medi-Cal system.

2. Proper Medi-Cal payments had been made on 216 of the claims researched.
   - 121 of these payments were made after our review began.
   - The elapsed time between the date service was rendered and the date of Medi-Cal payment for 74 of the paid claims was in excess of one year.

3. An apparent breakdown of the Blue Shield system resulted in 41 ambulance claims being erroneously rejected.

4. The principal causes of delay in payment of Medi-Cal ambulance claims by Blue Shield were:
   - Misinterpretation of Medi-Cal regulations and other errors by the claim examiners in the Blue Shield ambulance unit.
   - Blue Shield not taking corrective action within a reasonable time for claims pending in the system.

- Lack of diligence by the Department of Health Care Services in performing operations needed to facilitate ambulance claim payments.

5. The present procedure used by Blue Shield to process Medi-Cal only ambulance claims results in:

   - An excessive elapsed time between the receipt of claims by Blue Shield and the establishment of control over the claims.

   - An excessive turn-around time for ambulance claims returned to ambulance service vendors for additional information.

Our review of the rules, regulations and procedures pertaining to ambulance claims revealed three areas that create the most difficulty for ambulance service vendors. These are:

6. DHCS strict policy providing that unless the providers of service obtained a Proof of Eligibility (POE) sticky label or a copy from the beneficiary they will not get paid even if they provided the required service to an eligible beneficiary. This works an undue hardship on ambulance service providers and is considered the number one problem by them because in emergency situations they cannot refuse service and often are unable to obtain the label because of the condition of the patient.

7. The strict enforcement of the requirement that providers must submit claims to Blue Shield within two months after

the month the service was rendered in order to receive payment from Medi-Cal. This is in contrast to the minimum of 15 months allowed by Medicare. Ambulance service providers who have difficulty in obtaining Proof of Eligibility sticky labels must either submit incomplete claims within the two month period and subsequently rebill or not receive payment for their services.

8. DHCS procedures regarding treatment authorization requests which frequently result in nonpayment for ambulance services rendered to Medi-Cal recipients.

DISPOSITION OF THE 876 CLAIMS RESEARCHED AS OF SEPTEMBER 30, 1972

On September 12, 1972, a meeting was held in the office of Assemblyman Ray E. Johnson. The meeting was attended by Assemblyman Johnson and representatives from the Joint Legislative Audit Committee, the Department of Health Care Services, the Sacramento County Ambulance Association, and the Office of the Auditor General.

The representatives of the Sacramento County Ambulance Association expressed their displeasure with the current Medi-Cal rules, regulations, and procedures and presented 876 claims from nine association member ambulance service vendors. These 876 claims represented claims previously submitted to Blue Shield that were still outstanding, in whole or in part, according to the association representatives.

COMPOSITION OF THE 876 CLAIMS

The dates of service on the claims presented by the ambulance service vendors varied from a few months prior to September 1972, to as far back as 1968. Most of the claims had dates of service prior to October 1, 1971.

The total of the 876 claims is $33,649.54. However, this is not the amount the ambulance service vendors contend is due to them from the Medi-Cal program. Some of the claims are for persons with both Medicare and Medi-Cal coverage, in which case Medicare pays 80 percent of the claim, unless a $50.00 deductible has not been met.

For example, a Medicare/Medi-Cal claim for $40.00 would result in a Medicare payment of $32.00 and a Medi-Cal payment of $8.00 ($40.00 x 20%) if the Medicare $50.00 deductible had been met. If none of the $50.00 deductible had been met then Medi-Cal would pay the entire claim of $40.00.

Table 1 shows the composition of the 876 claims presented by the ambulance service vendors as to Medicare/Medi-Cal claims and Medi-Cal only claims.

Table 1

Summary of the Composition of the 876 Claims

Type of Claim	Number of Claims	Claim Amounts
Medicare/Medi-Cal	571	$20,585.72
Medi-Cal only	305	13,063.82
Total	876	$33,649.54

We are not authorized to examine Medicare records; therefore, we were not able to determine how much of the $20,585.72 shown above was actually paid by Medicare.

SEPTEMBER 20, 1972 MEETING AT CALIFORNIA BLUE SHIELD

On September 20, 1972, a meeting was held in the San Francisco office of the California Blue Shield to discuss our examination of their records. The meeting was attended by representatives of the Office of the Auditor General, Blue Shield, and the Department of Health Care Services.

During the meeting Blue Shield representatives explained the procedures by which ambulance claims are processed.

We stated the purpose of our review and that we intended to determine the disposition of the 876 claims presented by the ambulance service vendors, whether Medi-Cal had made proper payment on the 876 claims, and if not, why not.

RESULTS

Table 2 summarizes our determinations from Blue Shield's records regarding the 876 claims presented by the ambulance service vendors.

Table 2

Summary of Information Obtained from Blue Shield's Records Regarding the Disposition of the 876 Claims Researched As of September 30, 1972

Disposition	Medicare/Medi-Cal Claims		Medi-Cal Only Claims		Total	
	Number	Amount	Number	Amount	Number	Amount
No Record of Claim Available	317	$11,620.72	129	$ 5,148.70	446	$16,769.42
Paid According to Program Regulations	124	3,788.00	92	3,818.50	216	7,606.50
Underpayments	22	1,004.00	7	899.00	29	1,903.00
Overpayments	3	24.00	1	54.50	4	78.50
Payment Denied by Blue Shield	78	3,322.50	55	2,293.12	133	5,615.62
In Process (Pending)	27	826.50	21	850.00	48	1,676.50
Totals	571	$20,585.72	305	$13,063.82	876	$33,649.54

NO RECORD OF CLAIM AVAILABLE

There are several possible reasons why a claim would not be recorded in the Medi-Cal system:

1. The Claim Never "Crossed Over" from the Medicare System

Claims for beneficiaries covered by both Medicare and Medi-Cal are first processed through the Medicare system. The unpaid balance of the claim "crosses over" via computer tape to the Medi-Cal system for processing. According to Blue Shield personnel, a claim that "crosses over" from the Medicare system to the Medi-Cal system should be recorded in the Medi-Cal claim histories maintained by Blue Shield, even if the claim is rejected.

Of the 446 claims for which no records were available, 317 claims are for beneficiaries covered by both Medicare and Medi-Cal. The available documentation was not sufficient to allow us to ascertain if all of the 317 Medicare/Medi-Cal claims had been processed by Medicare. However, for some of the no record Medicare/Medi-Cal claims, we were able to determine that the claim had been processed through Medicare but did not "cross over" to the Medi-Cal system. For example:

- Eleven of the no record Medicare/Medi-Cal claims presented by the ambulance service vendors had a copy of the Medicare "EOMB" (Explanation of Medical Benefits) attached. A Medicare-system-generated

message at the bottom of these "EOMB's" stated "If also eligible for Medi-Cal payment the allowed balance will be paid to the provider on claim (Medi-Cal Number)". These claims should have "crossed over" to the Medi-Cal system and there should be records of these claims in the Medi-Cal system. We showed these claims to Blue Shield personnel who were at a loss to explain why no records were available in the Medi-Cal system for these claims.

- On 78 of the no record Medicare/Medi-Cal claims, the ambulance service vendors indicated that the claims had been paid in part by Medicare and that the balance was not paid by Medi-Cal. Theoretically, these claims should have "crossed over" to Medi-Cal for additional processing thus generating a record in the Medi-Cal system. Because no record is available in the Medi-Cal system for these claims, we can only conclude that these claims did not "cross over" from the Medicare system.

It appears that the failure of claims to "cross over" from the Medicare to the Medi-Cal system is responsible for many of the no record claims. The reasons why these claims did not "cross over" could be determined if access to Medicare records was available to us, which they are not.

2. Beneficiary Not Bought-In For Medicare Part B Benefits

There are no records available in the Medi-Cal system for claims being processed for the Medicare Part B Buy-In routine.

Nine of the no record Medicare/Medi-Cal claims were being "Bought-In" for Medicare Part B benefits. The Medicare Part B Buy-In routine can result in claim payments being delayed for months and is discussed in detail in a latter section of this report.

3. The Tri-County Prepaid Plan

Medi-Cal only claims for beneficiaries participating in the Tri-County Prepaid Plan would not have been processed by Blue Shield, thus no record would be generated in the Medi-Cal system. Thirty-five Medi-Cal only claims for which no record could be found are for beneficiaries participating in the Tri-County Prepaid Plan.

The claims were not paid by the Tri-County Prepaid Plan according to the ambulance service vendors. The Tri-County Prepaid Plan became defunct as of October 1, 1971, at which time Blue Shield assumed responsibility for all unpaid claims.

4. Medi-Cal Claims Returned to Provider Prior to System Upgrading

According to Blue Shield personnel, no record would be available in the Medi-Cal system for Medi-Cal only claims which were returned to ambulance service vendors for additional information prior to the implementation of the latest up-grading of the Medi-Cal system (December 1971). How many of the 129 no record Medi-Cal only claims fall into this category cannot be determined.

5. Other Possibilities

No record would be available in Blue Shield's records if a claim was lost somehow during processing or if the ambulance service vendor never submitted the claim in the first place. The available documentation is insufficient to determine if either of these possibilities actually occurred.

Blue Shield personnel informed us that unless the ambulance service vendors can prove they initially submitted the no record claims within two months after the month service was rendered they cannot pay the claims, even if payment is otherwise justified, without special dispensation from DHCS.

RECOMMENDATION

1. We recommend that the DHCS authorize Blue Shield to pay all no-record claims where the ambulance companies can furnish an affidavit or other evidence that the claims were originally submitted within the two month limitation period.

PAID ACCORDING TO PROGRAM REGULATIONS

There are several reasons why the ambulance service vendors would ask us to research claims that were properly paid by Medi-Cal as of September 30, 1972.

1. Medi-Cal Payment Made After Our Review Began

According to Blue Shield's records, proper Medi-Cal payments were made during the month of September 1972, on 121 of the 876 claims presented by the ambulance service vendors. Thus, the ambulance service vendors would not have known of payment at the time the claims were submitted for research.

We noted that 74 of the claims paid during September 1972, had dates of service prior to October 1, 1971, of which 43 had dates of service prior to October 1, 1970.

2. Payment Differences

The ambulance service vendors may still show a balance due from Medi-Cal for claims paid in accordance with Medi-Cal regulations for the following reasons: 1) charge for services in excess of the Medi-Cal Schedule of Maximum Allowances, 2) 10 percent reduction in Medi-Cal payments during Medi-Cal Emergency Regulations (December 15, 1970 through June 30, 1971), 3) beneficiary Co-Pay ($1.00), and 4) service rendered not allowed under Medi-Cal regulations.

3. Medi-Cal Payments Recorded Incorrectly by Ambulance Service Vendors

Medi-Cal payments may have been recorded incorrectly by the ambulance service vendors. We noted thirty-one claims that were paid in full by Medi-Cal prior to July 1972, according to Blue Shield records. Table 3 summarizes these claims by the elapsed time between date of service per the ambulance service vendors and date of payment per Blue Shield's records.

Table 3

Summary of Medi-Cal Claims Paid In Full By Medi-Cal Prior to July 1972

Elapsed Time Between Date of Service and Date of Payment	Number of Claims	Amount
Less than Three Months	11	$610.00
Three to Six Months	3	196.00
Six Months to One Year	6	181.50
One Year to Two Years	7	254.50
Over Two Years	4	113.00
Total	31	$1,355.00

UNDERPAYMENTS

We reviewed the claims for which the ambulance service vendors appear to have been underpaid by Medi-Cal and determined that there are two primary causes for such underpayments.

1. Misinterpretation of Medi-Cal Regulations by Ambulance Unit Claims Examiners

   Ambulance claims are examined before processing in a special unit of Blue Shield. Claims examiners inspect every ambulance claim for completeness and program compliance. Some of the Medi-Cal underpayments resulted from misinterpretation of Medi-Cal regulations by ambulance claims examiners. For example, an ambulance service vendor billed $30.00 for transporting a patient from one medical facility to another via an ambulance. The examiner only allowed a $7.00 charge because the service was not rendered in an emergency situation. The examiner erred because any approved ambulance service should receive the $30.00 rate.

2. Claims Coded Incorrectly

   The ambulance unit claims examiners also code ambulance claims for processing. We noted several instances of Medi-Cal underpayments which resulted from the claims examiner incorrectly coding the ambulance claim for processing. Typical examples of coding errors were: 1) using the wrong procedure number for a service and 2) coding a claim to be paid for one unit of service when two or more units of that service were rendered.

OVERPAYMENTS

Medi-Cal overpayments were made by Blue Shield because of duplicate payments for the same claim and coding errors by the ambulance unit claim examiners. Currently the Blue Shield system has an edit routine to protect against duplicate payments; but some of the older claims which are resubmitted for payment require a manual record search.

The only significant overpayment of $47.00 resulted from two payments being made on the same claim. Both of the payments were made in 1970.

PAYMENT DENIED BY BLUE SHIELD

Table 4 summarizes the reasons Blue Shield denied payment on 133 of the 876 claims presented by the ambulance service vendors.

Table 4

Summary of Reasons Blue Shield Denied Payment
On Claims Presented by Ambulance Service Vendors

Reason Payment Denied	Number of Claims	Amount
Medi-Cal Identification Number Missing	37	$1,878.50
Other Information Missing	14	458.12
Duplicate Billing	44	1,911.00
Proof of Eligibility Missing	21	846.00
Treatment Authorization Needed	17	522.00
Totals	133	$5,615.62

We reviewed the ambulance claims rejected by Blue Shield and discovered that fifty-one of these ambulance claims should not have been rejected for the reason stated. For example:

1. System Breakdown

On June 28, 1972, the Blue Shield system rejected 41 of the 876 claims as being duplicates of claims not yet paid. Medi-Cal only ambulance claims are accumulated, controlled, and processed in batches of two hundred claims. Each claim is given an Internal Control Number (ICN) having 13 digits. The first four digits of the ICN indicate the geographic region of the claim and the year. The next three digits show the julian date on which the claim was controlled. The following three digits are the batch number of the claims and the last three digits indicate the sequential number of the claim within the batch. All of the 41 claims incorrectly rejected on June 28, 1972 were in the same batch. Blue Shield personnel have not been able to explain why or how these claims were rejected as being a duplicate of a claim not yet paid.

Upon further investigation, we discovered an additional 23 claims submitted to Blue Shield by members of the Sacramento County Ambulance Association that were in the same batch as the 41 claims discussed above and were similarly rejected as a duplicate of a claim not yet paid on June 28, 1972. These 23 claims were not included in the 876 claims presented by the ambulance service vendors. Thus, we noted a total of 64 ambulance claims (amounting to $2,840.50) that were submitted to Blue Shield by members

of the Sacramento County Ambulance Association that were erroneously rejected by Blue Shield as being duplicates of claims not yet paid. All of these claims were in the same batch and were rejected on June 28, 1972.

We have not determined if other providers not included in our review were affected by this apparent breakdown in the Blue Shield system.

2. Misinterpretation of Medi-Cal Regulation by Claim Examiners

Nine ambulance claims were returned to the ambulance service vendors because the ambulance unit claims examiners misinterpreted the medical regulations. The examiners indicated that the claims required approved treatment authorization requests because the service was rendered in a non-emergency situation. This interpretation is correct for services rendered after October 1, 1971; however, the dates of service for these nine claims were prior to October 1, 1971.

Several of these claims had been submitted by the ambulance service vendors to Blue Shield three or more times only to be incorrectly returned by the examiners because treatment approval was missing.

Upon further investigation, we discovered that 55 additional claims with dates of service prior to October 1, 1971, had been incorrectly returned by the examiners because treatment

approval was missing. Many of these other 55 claims were eventually paid by Medi-Cal but only after the ambulance service vendors submitted the claims to Blue Shield two or more times.

Errors of this type by the examiners not only delay payment on claims but result in additional and unnecessary costs to both ambulance service vendors and the Medi-Cal program.

3. Medi-Cal Rejection Initiated by Medicare

One claim was rejected by the Medi-Cal system incorrectly as a duplicate of a previously paid claim because the claim was not coded properly by an ambulance unit claim examiner. The claim incorrectly rejected was a Medicare/Medi-Cal claim. The claim was processed through the Medicare system and because this was the first claim submitted for this particular beneficiary, the claim amount was applied against the Medicare $50.00 deductible and the claim "crossed over" to the Medi-Cal system. The claim was rejected in the Medi-Cal system because the Medi-Cal Proof of Eligibility (POE) label attached to the claim was for the wrong month. The ambulance service vendor subsequently attached the correct POE label to the claim and resubmitted the claim. The ambulance unit did not code the resubmitted claim to bypass the Medicare system so the claim was processed again through the Medicare system where

the claim was rejected as a duplicate of a previous claim processed (correctly). When the claim "crossed over" to the Medi-Cal system it was automatically rejected as a duplicate of a previous claim processed because of the Medicare rejection (incorrectly).

This claim will not be paid until the ambulance service vendor resubmits the claim and an examiner codes the resubmitted claim to bypass the Medicare system.

DENIED PAYMENT PROBLEM AREAS

Our review of ambulance claims rejected by Blue Shield revealed two problem areas.

1. DHCS Treatment Approval For Medicare/Medi-Cal Claims

DHCS treatment approval is not required for nonemergency ambulance service if the Medi-Cal beneficiary is also covered by Medicare and the service is allowable under Medicare regulations.

The Medi-Cal consultant offices will not issue a prior treatment authorization for Medicare/Medi-Cal ambulance claims. The ambulance service vendor submits the claim to Blue Shield without an approved treatment authorization. If the ambulance service is allowed under Medicare regulations then Medi-Cal will process the portion of the claim not paid by Medicare. If however, the service is not allowed

under Medicare regulations then Medi-Cal will not process the claim without an approved treatment authorization. (It should be noted that Medi-Cal will pay for several services not allowed by Medicare.) The ambulance service vendor must then obtain a retroactive treatment authorization from the Medi-Cal consultant for the ambulance service not allowed by Medicare and resubmit the claim to Blue Shield for Medi-Cal processing.

We noted several resubmitted Medicare/Medi-Cal claims containing retroactive treatment authorizations were reject coded because the ambulance service rendered "requires approved prior not retroactive authorization".

According to the ambulance service vendors this is a common occurrence and not restricted to the instances we observed.

2. Proof of Eligibility Sticky Labels

Ambulance service vendors are required to submit Medi-Cal proof of eligibility with ambulance claims for Medi-Cal recipients.

We noted several instances where claims submitted by the ambulance service vendors (copies of the original claims) had proof of Medi-Cal eligibility but the original claims were rejected by Blue Shield for not having Medi-Cal proof of eligibility.

There are three possible explanations as to why these original claims would be rejected by Blue Shield for not having Medi-Cal proof of eligibility when the claim copies did:

- The copies submitted by the ambulance service vendors are different than the original claim. There is the possibility that the claim copies we researched are different than the claims actually submitted. However, it seems likely that the corrected copies would have been resubmitted by the ambulance service vendors to Blue Shield for processing.

- The Proof of Eligibility (POE) sticky labels were torn off before the claims could be examined by the ambulance unit claim examiner. The ambulance service vendors stated that frequently claims are returned from Blue Shield because they are missing POE labels. These claims had the POE labels attached when originally submitted to Blue Shield but do not have POE labels attached when they are returned. The POE labels apparently are torn off the claims during processing. This can be a serious problem, particularly if the ambulance service vendor does not have available a copy of the POE label submitted with the original claim. Without a copy of the POE label the ambulance service vendor cannot receive Medi-Cal payment.

- Ambulance unit claim examiner coded the claim incorrectly. An ambulance claim coded incorrectly for POE by the ambulance unit claim examiner or keytaped incorrectly by the keytape operator would also be incorrectly rejected as not having proper Medi-Cal proof of eligibility.

IN PROCESS (PENDING)

Our review of the ambulance claims still in the Medi-Cal system but not being processed until the completion of a specific action (Pending Status) indicated that lengthy payment delays were the result of:

1. DHCS Lack of Diligence in Performing Operations Needed to Facilitate Ambulance Claim Payments

   We noted three types of ambulance claims that are not paid promptly because of DHCS lack of diligence. These claims are held-up by Blue Shield until DHCS takes specific action.

   The types of ambulance claims and the required DHCS responses for such claims are discussed in detail in a latter section of this report.

2. Ambulance Unit Claim Examiners' Errors

   One of the claims we researched was delayed in the Medi-Cal system simply because the ambulance unit claim examiners forwarded an incomplete claim for processing instead of either returning the claim to the ambulance service vendors for additional information

or entering the missing information on the claim. This particular claim was delayed 44 days (as of September 30, 1972) because the Medi-Cal case number was omitted from the front page of the claim. The case number was shown on other documentation submitted with the claim.

We also noted several ambulance claim processing delays resulting from other examiners' errors. For example:

- Invalid procedure numbers. Two claims were delayed 121 and 40 days respectively (as of September 30, 1972) because the examiner used an invalid procedure number when coding the claims for processing.

- Invalid Explanation of Benefits (EOB) code. Two claims were delayed 82 days each (as of September 30, 1972) because the examiner used an invalid EOB code number when coding the claims for processing.

3. Blue Shield Not Taking Corrective Action Within a Reasonable Time

Blue Shield has formal procedures for correcting the type of examiner errors noted above. Thus, while these delays are initially the result of claim examiner coding errors, excessive delays could be avoided if corrective action were taken by Blue Shield within a reasonable time.

The procedures for correcting claims with case numbers missing or with invalid EOB or procedure numbers are relatively uncomplicated. We believe that the observed delays in correcting these errors are excessive.

BLUE SHIELD PROCEDURES FOR PROCESSING AMBULANCE CLAIMS

Blue Shield has a special unit for ambulance claims which is located at 475 Sansome Street, San Francisco. The claims examiners for ambulance claims are in the ambulance unit which handles both Medicare/Medi-Cal claims and Medi-Cal only claims. We noted that Medicare/Medi-Cal claims are processed differently in the ambulance unit than are Medi-Cal only claims. The most significant difference being that system control is established for Medicare/Medi-Cal claims before the claims are inspected by the ambulance unit claim examiners, whereas, system control is not established for Medi-Cal only claims until after the claims have been inspected by the claim examiners and transported to Blue Shield's Medi-Cal unit at 1520 Stockton Street.

DELAY BETWEEN RECEIPT OF AND CONTROL OF CLAIMS

One of the members of the Sacramento County Ambulance Association sends its Medi-Cal only claims to Blue Shield by certified mail. We selected several claims submitted to Blue Shield during recent months and noted the date Blue Shield received the claims as indicated on the signed receipt. We compared the receipt dates to the dates system control was established for these claims (per the Internal Control Numbers) and found the elapsed times to be from seven to 14 days with most of the claims in the 14-day bracket. We believe that the elapsed time between receipt by Blue Shield of Medi-Cal only claims and system control for these claims is excessive.

RECOMMENDATION

2. We recommend that Blue Shield establish system control over the Medi-Cal only ambulance claims prior to claims examination.

EXCESSIVE TURN-AROUND TIME FOR CLAIMS RETURNED TO AMBULANCE SERVICE VENDORS

If, in the opinion of an ambulance unit claim examiner, a Medi-Cal only claim does not contain sufficient information then the claim is returned to the ambulance service vendor with an explanation of why the claim could not be processed.

Blue Shield's current procedure for returning incomplete claims to ambulance service vendors is to code the claims "Return to Provider" and then to forward the claims, along with completed claims, for processing. The claims to be returned go through the same processing as the completed claims with the exception of the various computer edit routines. The computer generates a "green sheet" for ambulance claims to be returned to ambulance service vendors for additional information. The "green sheet" informs Blue Shield personnel at 1520 Stockton Street to locate the claim in storage, remove the claim from its batch box, and mail it back to the provider. According to Blue Shield personnel, approximately 15 percent of the ambulance claims received at the ambulance unit are returned to the ambulance service vendors for additional information.

We selected several claims returned to one of the members of the Sacramento County Ambulance Association for additional information during August and September 1972, in order to ascertain the time it takes to return an ambulance claim. The ambulance service vendor selected maintains a log which indicates the date returned claims are received from Blue Shield.

The results of our test are summarized below:

- Elapsed time between claim receipt by Blue Shield (per signed mail receipts) and claim return (per Blue Shield records) varied from a low of 13 days to a high of 28 days. Average elapsed time was 22 days.

- The ambulance service vendor received the returned claims from six to 19 days after Blue Shield records indicate the claims were returned.

- The ambulance service vendor has no record of having received 12 of the claims Blue Shield's records indicate were returned for additional information. This means that either the ambulance service vendor did not log the returned claims correctly or that not all claims are returned to ambulance service vendors that Blue Shield's records indicate are returned. We discussed the second possibility with Blue Shield and were informed that some claims are not returned to the ambulance service vendor even though Blue Shield's records indicate they were. According to Blue Shield, when claims to be returned are removed from batch boxes they are checked to see if an ambulance unit head has approved the "Return to Provider" designation assigned by the claim examiner. If the unit head approval is missing, the claim is sent back to the ambulance unit for such approval. We noted that some of the claims supposedly returned for additional information, that were never received by the ambulance service vendor, were subsequently reentered into the Blue Shield system. The elapsed time to reenter these claims into the Blue Shield system was about 30 days.

It is obvious that the procedures for getting incomplete claims returned to ambulance service vendors require excessive time. We believe that incomplete claims should be returned directly from the ambulance unit because at that point the decision has been made that additional information is required and that the claim cannot be processed. The processing time could be reduced about two weeks if this were done.

RECOMMENDATION

3. We recommend that Blue Shield return unsatisfactory ambulance claims directly to the provider from the Ambulance Claims Unit.

DEPARTMENT OF HEALTH CARE SERVICES OPERATIONS NEEDED TO FACILITATE AMBULANCE CLAIM PAYMENTS

During our review of the processing of ambulance claims, we noted that some rather significant payment delays were the result of lack of diligence on the part of DHCS. While we were only concerned with ambulance claims, our findings would also apply to other types of claims.

MEDI-CAL ELIGIBILITY FOR DATES OF SERVICE PRIOR TO OCTOBER 1, 1971

Claims for services to Medi-Cal recipients rendered prior to October 1, 1971, were sent by Blue Shield via computer tape to DHCS, who checked the beneficiary on the tape against the "Master Persons File" to determine if the beneficiary was eligible for Medi-Cal benefits. The "Master Persons File" is a compilation of information regarding Medi-Cal recipients generated by county welfare departments.

Blue Shield could not process claims any further until DHCS responded as to Medi-Cal eligibility for the beneficiaries on the computer tape.

We discovered that Blue Shield had not received a response from DHCS on over 48,000 claims with dates of service prior to October 1, 1971, as of September 1972. Several of the ambulance claims we researched were included in those claims awaiting DHCS action.

We questioned DHCS (Fiscal Intermediary Bureau) about the "Master Eligibility File" in an effort to determine the cause of the excessive delays in responding to Blue Shield. We were told that there were over 93,000 claims statewide with dates of service prior to October 1, 1971, awaiting DHCS responses as

to Medi-Cal eligibility. We were also told that the problem had been identified (an error in the program) and that responses regarding Medi-Cal eligibility would be forthcoming.

On or about October 1, 1972, Blue Shield started receiving the long awaited eligibility responses from the DHCS. Apparently, DHCS remedied the "Master Eligibility File" problem; however, we feel that the time required to solve the problem was excessive.

MEDICARE PART B "BUY IN"

Medicare has two types of coverage: Part A and Part B. Part A coverage is for hospital insurance and is financed by contributions from employees and self-employed persons under the federal Social Security program.

Part B coverage is for medical insurance (doctor bills and other medical services) and is financed by monthly premiums paid by the insured ($5.80 per month starting July 1972) which is matched by the federal government.

In general, Part A benefits are available to all persons 65 years or older enrolled in Medicare, but Part B benefits are available only to persons 65 years or older who elect to pay the monthly medical insurance premiums. It is the policy of the Department of Health Care Services to pay the monthly medical insurance premium for Medi-Cal beneficiaries 65 years or older, thus qualifying the Medi-Cal recipient for Part B Medicare benefits. The Medicare program pays 80 percent of a Part B service (after a $50.00 deductible has been met) thus, theoretically, the rather moderate monthly premiums paid by Medi-Cal generate a net cost savings to the Medi-Cal program. It is also the policy of the Department of Health Care Services to pay the Part B medical insurance premiums retroactively to the time a Medi-Cal recipient first became eligible for Part B coverage.

The above procedure of adding Medi-Cal recipients 65 years or older to the Medicare Part B program is known as "Buy-In". Unfortunately, not all Medi-Cal recipients 65 years or older have been "Bought-In" by the state, contrary to DHCS policy. The scope of our review did not allow us to determine why omissions occur. We were informed that some failures to "Buy-In" are attributable to the Social Security Administration's mishandling of the "Buy-In" transactions. The failure to "Buy-In" results in claim payments being delayed a year or more in some cases.

A "Buy-In" situation occurs when an ambulance claim (a Part B Medicare service) is sent to Medicare for processing but the beneficiary is not eligible for Part B Medicare coverage according to Medicare. The claim is sent to Blue Shield (Medi-Cal) for "Buy-In". Blue Shield forwards pertinent information regarding the beneficiary to the DHCS who checks to see if the beneficiary was in fact bought-in for Medicare Part B coverage. If the beneficiary was bought-in for Medicare Part B coverage, Blue Shield is notified and the claim is resubmitted to Medicare. If the beneficiary was not bought-in for Medicare Part B coverage, the DHCS initiates a "Buy-In" for that Medi-Cal recipient. When the DHCS receives notification from the Social Security Administration that a "Buy-In" has been effectuated, the department notifies Blue Shield, who resubmits the claim to Medicare. We noted that Blue Shield has no system control over claims going through the above routine and, therefore, no record is available in the Medi-Cal system for the claims in the "Buy-In" routine.

Our review of the Medicare Part B "Buy-In" routine revealed that control is poor over the claims in the "Buy-In" routine and that lengthy payment delays can result while DHCS and the Social Security Administration attempt to get their records to agree. The end result is that the service vendor does not receive payment within a reasonable time through no fault of his own.

RECOMMENDATION

4. We recommend that the DHCS arrange to have Medi-Cal pay for services rendered to non-enrolled Medicare eligibles and credit the subsequent Medicare reimbursement to Medi-Cal upon enrollment.

MEDICALLY NEEDY ONLY INQUIRY (MNO)

A Medically Needy Only inquiry occurs when the date of service on a claim is on or before the certification date on the Medi-Cal Proof of Eligibility (POE) sticky label which is attached to claims. The county welfare departments notify DHCS when a patient is eligible to receive Medi-Cal benefits (certification date). Certain patients become eligible for Medi-Cal benefits by paying for a specified amount of medical expenses with their own funds. The amounts these patients must pay are established by county welfare departments.

If a claim has a date of service on or prior to the certification date on the POE attached to the claim, then Blue Shield forwards the claim to DHCS (Benefits Review Unit) who check the records to determine if the service on the claim was not also paid by the patient in satisfying his program requirement.

We reviewed the MNO inquiry routine and found that DHCS is slow to respond to claims received from Blue Shield. Control over MNO inquiry claims and communication between Blue Shield and DHCS are both inadequate.

The current MNO inquiry routine results in unreasonable and unnecessary delays in claim payments.

DEPARTMENT OF HEALTH CARE SERVICES
RULES AND REGULATIONS
REGARDING AMBULANCE CLAIMS

Our review of DHCS rules and regulations regarding ambulance claims and discussions with ambulance service vendors revealed three areas that create the most difficulty for ambulance service vendors.

PROOF OF MEDI-CAL ELIGIBILITY

The providers involved in our review have made it clear that obtaining Proof of Eligibility (POE) sticky labels or copies of Medi-Cal cards, either of which must be submitted along with claims for service rendered to Medi-Cal recipients, is their number one problem. Under current procedures, DHCS sends POE's to eligible Medi-Cal recipients who give the POE's to medical service vendors when they receive a medical service. Most medical service vendors can refuse to render service to a Medi-Cal recipient unless the required POE is produced before the service is rendered. This is often not the case with ambulance service vendors, especially in an emergency situation.

In an emergency situation, an ambulance service vendor must provide service regardless of whether or not the beneficiary has his POE readily available. The emergency situation POE problem is compounded if the beneficiary is unconscious and/or dies on the way to the hospital.

The severity of the POE problem for ambulance service vendors is pointed out in the following excerpt of a letter from an ambulance service vendor to one of the ambulance associations (this letter was subsequently forwarded to the Director of the Department of Health Care Services, Dr. Earl Brian).

> "...Just today our billing office turned over 17 claims (representing $716.75 in services already rendered and in some cases already authorized) which could not be submitted to the intermediary for payment because they could not obtain the necessary eligibility verification although the people are on Medi-Cal. We have tried calling, writing for, and visiting the private homes of recipients or their family members, and even contacting the various medical facilities which may have a copy of the necessary car(d) or sticker.
>
> "The current system of forcing the sole responsibility of eligibility verification upon the recipient or his family members is not, will not nor cannot work! Many recipients or their family members are not responsible enough to see that the providers of service receive the sticker no matter how nicely the provider pleads, humbly begs, or aggres(s)ively threatens. Many recipients are just plain confused about the sticker system especially some who are also covered with Medicare benefits. In some cases the recipient may expire shortly after the service is rendered and the location of the sticker expires with the patient..."

DHCS will not assist any ambulance service vendor in obtaining POE's nor will county or state welfare agencies. DHCS personnel feel that it is a service vendor's responsibility to get the POE's and that service vendors would abuse DHCS assistance if it were available.

We feel that the department's policy to refuse all requests for assistance in obtaining Medi-Cal POE's is unreasonable and works an unjustifiable hardship on service vendors, particularly ambulance service vendors.

RECOMMENDATION

5. We recommend that the DHCS assist providers in getting eligibility labels after reasonable effort by the provider has failed.

TWO MONTH BILLING LIMITATION

Current Medi-Cal regulations require service vendors to submit claims to Blue Shield within two months after the month service was rendered in order to receive payment from Medi-Cal. There are four conditions under which the two month allowable billing period can be extended (up to one year): 1) other coverage, 2) Medi-Cal coverage not known, 3) retroactive Medi-Cal eligibility, and 4) completion of a treatment plan.

The refusal of the beneficiary to provide a service vendor with a POE or the inability of the service vendor to otherwise obtain a POE is not a condition warranting extention of the two month billing period under current DHCS policy. The only alternative available to a service vendor faced with the prospect of exceeding the two month billing limitation because of the inability to obtain a POE is to submit the claim to Blue Shield without the POE. The claim will be rejected by Blue Shield and returned to the service vendor for the POE. If the service vendor can subsequently obtain the POE, then the claim can be resubmitted to Blue Shield as the first submission date is the controlling date as far as compliance with the two month limitation is concerned. This procedure has two drawbacks: 1) the service vendor must submit two billings for the same service, and 2) there is no guarantee the service vendor will be able to subsequently obtain the required POE.

One of the ambulance service vendors in our review showed us a claim which illustrates the inequity of the two month billing limitation. This particular vendor made 19 round trips from an institution to a radiation therapy center for a patient with brain cancer. The trips were made from August 5, 1971, to August 31, 1971, and the total of the claim was $1,216.00. Blue Shield date

stamped the claim at the ambulance unit on November 18, 1971, which exceeds the two month billing limitation by 18 days. Actually, this claim missed complying with the two month limitation by one day because if the last ambulance trip had been made on September 1, 1971, instead of August 31, 1971, then the November 18, 1971, submission date would have qualified the entire claim. In any event, Blue Shield rejected the claim because of the two month billing limitation.

Under current law and regulation, the director of DHCS may extend the two month billing limitation up to one year if the delay in claim submission was caused by circumstances beyond the control of the service vendor. We believe that the limited circumstances under which DHCS will extend the two month limitation are too restrictive, particularly regarding Medi-Cal proof of eligibility.

RECOMMENDATION

6. We recommend that the DHCS relax its two month billing limitation criteria.

TREATMENT AUTHORIZATION REQUESTS (TAR's)

Treatment Authorization Requests control the program utilization for nonemergency ambulance service. TAR's for nonemergency ambulance service are of two basic types called prior authorizations and retroactive authorizations, both of which must be approved by DHCS via district Medi-Cal consultant offices before Medi-Cal will pay for any nonemergency ambulance service rendered to Medi-Cal recipients. The TAR requirements do not apply for Medicare/Medi-Cal claims if the service is allowable under Medicare regulations.

Prior Treatment Authorizations

For nonemergency ambulance service rendered when the district Medi-Cal consultant's office is open (8:00 AM to 5:00 PM Monday through Friday, except on regular state holidays) a prior authorization is required.

Nonemergency ambulance service is initially requested by a doctor, hospital, or nursing home. If the request is made when the district Medi-Cal consultant's office is open, then the ambulance service vendor must call the consultant's office and explain the reasons why the ambulance service was requested.

Ambulance service vendors telephone for prior authorizations because the service must be rendered immediately. For example, a hospital calls an ambulance service and wants a patient moved to a nursing home that afternoon. Most other types of service vendors can anticipate providing services which require DHCS approval far enough in advance to have an approved TAR in their possession before service is rendered to a Medi-Cal recipient. Ambulance service vendors are particularly vulnerable to nonpayment for service rendered because of current DHCS policy regarding TAR's just as they were to the policy regarding POE's.

The consultant's office gives the ambulance service vendor an authorization number over the telephone. The ambulance service vendor proceeds to transport the Medi-Cal patient as requested.

The ambulance service vendor prepares a "Treatment Authorization Request" which lists pertinent information regarding the service rendered including the authorization number which was given over the telephone by the consultant's

office. The "Treatment Authorization Request" must be received by the district Medi-Cal consultant's office within ten calendar days after the ambulance service was rendered.

The Medi-Cal consultant reviews the TAR submitted by the ambulance service vendor and either approves or disapproves the service listed on the TAR and returns it to the ambulance service vendor.

If the Medi-Cal consultant does not approve the TAR, the ambulance service vendor is precluded from receiving payment from Medi-Cal for the service rendered. The authorization number given over the telephone by the consultant's office does not guarantee subsequent TAR approval by the Medi-Cal consultant.

Retroactive Treatment Authorizations

A retroactive authorization is required for nonemergency ambulance service rendered when the district Medi-Cal consultant's office is closed.

The procedure is the same for submitting retroactive TAR's as for prior TAR's except that the ambulance service vendor does not have an authorization number to show on the retroactive TAR. Prior to November 1, 1972, retroactive TAR's had to be received by the district Medi-Cal consultant's office within five calendar days after the ambulance service was rendered. Effective November 1, 1972, the submission requirements are the same for both prior and retroactive TAR's; i.e., ten calendar days.

Retroactive TAR's will not be approved for ambulance service rendered when the Medi-Cal consultant's office was open but the ambulance service vendor did not call the consultant's office to get an authorization number prior to rendering service.

Medi-Cal Consultant Offices

There are 11 district Medi-Cal consultant offices outside of Los Angeles County in California. Each district office serves several counties. For example, service vendors located in Alpine, Colusa, El Dorado, Nevada, Placer, Sacramento, Sierra, Sutter, Yolo, and Yuba Counties must send their TAR's to the Sacramento District Medi-Cal consultant office located at 1507 21st Street, Sacramento, California. The service vendors in these counties must also telephone the Sacramento District office to obtain prior authorizations which means that the service vendors located outside of Sacramento incur additional costs because their calls are long distance.

When Medi-Cal consultants review TAR's for ambulance service, the criteria applicable is the medical necessity of transporting the patient by ambulance and the necessity of the trip itself. All nonemergency ambulance service is initially prescribed by the patient's attending physician; thus, the medical necessity of the mode of transportation requested is already attested to by the person in the best position to make such a determination.

Section 51323, Title 22 of the California Administrative Code regarding medical transportation states:

> "51323. Medical Transportation Services. (a) Ambulance and other medical transportation services are covered when the beneficiary's medical and physical condition is such that transport by ordinary means of public or private conveyance is medically contraindicated, and transportation is required for the purpose of obtaining needed medical care."

The function of the Medi-Cal consultant with regard to nonemergency ambulance service is program utilization control. However, DHCS policy regarding the types of nonemergency ambulance service the consultant's will approve is

vague and subject to different interpretation by different Medi-Cal consultants. As a result, the ambulance service vendors are not sure what types of nonemergency ambulance service will be approved once submitted to the consultant's office.

Regulation Changes Effective November 1, 1972

Section 51003, Title 22 of the California Administrative Code was amended effective November 1, 1972. Under this amended section, service vendors now have ten calendar days within which to submit retroactive TAR's to the Medi-Cal consultant's office for approval instead of five calendar days as required before November 1972.

In addition, service vendors can now receive retroactive authorization in cases where the patient did not identify himself as a Medi-Cal beneficiary until after the ten day TAR submission requirement had elapsed. Such retroactive authorization is available up to one year after the month in which service was rendered. Prior to November 1, 1972, retroactive authorization would not be granted in cases of patient concealment of Medi-Cal status.

New TAR Procedure - Sacramento
District Medi-Cal Consultant's Office

Beginning November 1, 1972, the Sacramento District Medi-Cal consultant's office initiated a new program aimed at correcting some of the prior telephone TAR's problems.

Basically, the new program does three things as far as prior telephone TAR's are concerned: 1) it eliminates the provider's need to prepare a TAR form and mail it to the consultant's office, 2) it eliminates the ten day TAR submission

requirement and, most important, 3) it eliminates the conditional approval situation. In other words, the service vendor will be guaranteed subsequent TAR approval before service is rendered.

The Sacramento District office is currently the only office using the new TAR program. The providers in our review that use the Sacramento District office report that they are very pleased with the new program and the way it is working.

After reviewing the current TAR regulations as they relate to ambulance service, we have concluded that: 1) DHCS policy of not granting retroactive TAR's for service rendered when the Medi-Cal consultant's office was open is unreasonable, 2) DHCS policy regarding the types of nonemergency service the department will approve should be stated, and 3) the current prior TAR procedure being used by the Sacramento District Medi-Cal consultant's office appears to be a workable solution to many of the TAR problems.

RECOMMENDATION

7. We recommend that the DHCS adopt the new TAR procedures used by the Sacramento District Medi-Cal consultant's office on a statewide basis.

William H. Merrifield
Auditor General

December 21, 1972

SUMMARY OF RECOMMENDATIONS

The recommendations contained in this report are listed below in the order in which they have appeared:

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