

**EXHIBIT 6**  
*Part 3 of 3*



**Finding #9: Duplicate claims identification is largely dependent upon human intervention.** ProdAgio is supposed to have an authentication process that identifies duplicate claims. However, the findings from the latest April Management Alert report #2 issued by the Post Review Unit suggests that there may be some issues that prevent duplicate claims from being identified in ProdAgio. There does not appear to be a "Duplicate Claims Report" available based on a review of the CMD's "Validation and Clean Up Reports" listing. Table 14 lists the number of records by "No Pay Reason" documented in the FY 2006-2007 CMD database. Forty-one percent of the "No Pay" invoices (6,960 out of a total of 17,090 "No Pay" invoices) during the fiscal year 2006-2007 period were identified as duplicate claims, which resulted in a more than \$99 million in savings through the manual examination process. These duplicate claims represent approximately 3 percent of the total 241,731 invoices processed. It is worthwhile to consider implementing a process that is more effective to assist invoice processors in identifying potential duplicate claims in order to realize more savings for these unnecessary overpayments.

**Table 14  
Records by "No Pay Reason"**

NO PAY REASON	RECORDS	PERCENT	AMOUNT	PERCENT
	28	0%	\$ 262	0%
Anesthesia time was not provided	17	0%	\$ 14,298	0%
Cannot verify patient identity	274	2%	\$ 642,184	0%
Contrary to other authorization given	140	1%	\$ 378,859	0%
Dates of service missing	71	0%	\$ 775,158	0%
Diagnosis code/CPT code missing or inaccurate	167	1%	\$ 352,722	0%
Documentation not provided/available	237	1%	\$ 99,117,991	59%
Duplicate invoice	6,960	41%	\$ 40,842,134	24%
Inmate not at this Institution	6,245	37%	\$ 18,724,901	11%
Invoice does not include itemized detail	143	1%	\$ 1,504,355	1%
Invoice is illegible	36	0%	\$ 215,760	0%
No contract in place	150	1%	\$ 206,813	0%
No other payable issues on the invoice	887	5%	\$ 2,755,146	2%
Patient not CDC inmate	597	3%	\$ 1,276,952	1%
Physician should re-bill under hospital contract	263	2%	\$ 401,233	0%
Physician should re-bill under physician group contract	480	3%	\$ 278,500	0%
Professional charges included in hospital global rate	91	1%	\$ 141,242	0%
Services were not a necessity	30	0%	\$ 28,682	0%
Worker's Compensation Claim	274	2%	\$ 500,402	0%
<b>Total</b>	<b>17,090</b>	<b>100%</b>	<b>\$ 168,157,594</b>	<b>100%</b>



**Finding #10:** The adoption of the Medicare Fee Schedule (MFS) as the basis for physician payment is not totally understood by all staff levels within the invoice processing unit. Based on NCI's recommendation in our 2006 work, CDCR began negotiating contracts with select community providers based on the MFS. However, implementation of this recommendation did not take into consideration the lack of understanding among CDCR staff regarding the various Medicare Fee Schedules. For example, there are separate fee schedules for physician-administered drugs, durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), and laboratory. These fee schedules have not been made available to all invoice processors. Moreover, based on our interview with the CDCR Post Review Unit manager and the findings from her April Management Alert Report, there is a lack of understanding regarding the effective date for the CPT/HCPCS codes-driven fee schedule, which is January 1st of each year, and the fact that the codes are updated on a quarterly basis. Therefore, when an invoice is priced, invoice processors often apply outdated fee schedules, or cannot locate a code because they are not using the correct fee schedule. The lack of understanding regarding how a claim should be paid, and which fee schedule should be used are easily remedied by a formal claims processing system. However, because CDCR does not have a true medical claims processing system, the accuracy of these payments are largely dependent upon the skill level, knowledge and experience of invoice processing staff, and willingness of individual invoice processors to locate the correct fees and apply them.

**Finding #11:** The productivity of the invoice processors is relatively low when compared to industry standards. On average, in any given claims processing operation, a claims processor (1 FTE) should process 100 to 500 claims per day, depending upon the format of the claims received. During the fiscal year 2006-2007, there were a total of 241,731 invoices recorded in CMD. Using the minimum 100 claims per day per FTE and 218 working days as a base (365 days – 104 weekend days – 20 vacation days - 13 holidays – 10 sick days = 218 working days), it is estimated that PC&IB would need approximately 11 FTEs to process the 241,731 invoices for FY 2006-2007 ( $[241,731 \text{ invoices incurred during FY 2006-2007}] \div [100 \text{ claims} \times 218 \text{ days} \times 1 \text{ FTE}] = 11.1 \text{ FTEs}$ ). We were unable to calculate the actual claims processed per day per CDCR FTE due to the lack of FTE data from each institution. However, based on our interviews with staff, we found that there are 13 FTEs currently staffed at PC&IB who are processing invoices from six institutions. There were a total of 50,712 invoices incurred from these six institutions during FY 2006-2007 (see table below). Claims processed per FTE per day using 218 working days as a base, PC&IB invoice processing staff is processing about 18 claims per day per FTE ( $[50,712 \text{ invoices}] \div [13 \text{ FTEs} \times 218 \text{ days}] = 17.9 \text{ claims per day per FTE}$ ). It is clear that this number is much lower than the benchmark 100 claims processed per day per FTE. Many factors contribute to this low productivity:

- 1) *Lack of a standard claims processing system* – Invoice processing involves many fragmented steps because the current system does not automatically flag and alert the processors to



examine only the "exceptions." Rather, they must review every single invoice manually, for example, to ensure that it is not a duplicate.

- 2) *Manual entry* – The extensive manual processes involved in claims payment decrease the processing rate. Invoice processors rely on paper contracts, cheat sheets, "asking around," books and pricing tools to price each invoice individually. In addition, the invoice processors also have to enter data in both CMD and ProdAgio.
- 3) *Skill level* – The invoice processors may not have adequate training or knowledge to process the invoices and therefore, they may have to stop and ask for direction before they can proceed to the next steps.
- 4) *Low productivity and frustration* –Based on our review, we were unable to determine for certain if there are problems with absenteeism or other staff issues within the invoice processing unit. However, interviews with staff suggest that turnover rates are high as the unit struggles with hiring and retaining employees. The level of complexity of this job, coupled with the lack of proper tools to accomplish it may produce frustration and low morale among workers, resulting in absenteeism and high turnover rates.

**Finding #12:** On average, the invoice processing cycle from a provider's invoice date to the date the invoice is forwarded to an RAO for payment and GL processing is approximately 31 days and 15 days between the HCCUP Analyst receiving an invoice to forwarding the invoice to an RAO per a review of the 2006-2007 CMD. Due to the design of the CMD, these dates were manually entered by the HCCUP analysts or the PC&IB invoice processors. There is not enough data captured in CMD, e.g., check date, to allow for a complete AP Cycle analysis. Based on our RAO interviews, it usually takes an additional three to four days to complete a batch of invoices prior to sending the batch for RAO management approval. NCI was unable to determine how long it takes to obtain RAO management approval and for SCO check processing before the checks are mailed to providers. However, from the provider's perspective (starting with the provider's invoice date), approximately 19 percent of the invoices that have appropriate dates documented exceeded the 45-day AP cycle window that is typically considered within an acceptable range. The percentage will increase even more when the additional days required for RAO and SCO processes are taken into account. Table 15 outlines, the distribution of invoices by categories of day range. Approximately six percent of records have either blank dates or bad data, e.g., receipt date is greater than the RAO date, or invoice dates that are not valid.



**Table 15  
Invoice Distribution**

Invoice Age Group (CY:R.D.Y.C:R.O.Y) (C:MI):O:R:Y:O)	Invoice Count	% Invoices Count	Average Days per Invoice	Invoice Count	% Invoices Count	Average Days per Invoice
01-29	127,383	52.70%	17	194,864	80.60%	10
30-45	55,337	22.90%	36	24,204	10.00%	35
46-99	40,189	16.60%	60	7,760	3.20%	55
100-199	2,904	1.20%	125	466	0.20%	117
200-299	289	0.10%	238	21	0.00%	239
300-399	452	0.20%	343	34	0.00%	355
400-499	12	0.00%	415	-	-	-
<b>Good Data Subtotal</b>	<b>226,566</b>	<b>93.73%</b>	<b>31</b>	<b>227,349</b>	<b>94.05%</b>	<b>15</b>
Bad Data	159	0.10%		152	0.10%	
Blank Dates	15,006	6.20%		14,230	5.90%	
<b>Grand Total</b>	<b>241,731</b>	<b>100.00%</b>		<b>241,731</b>	<b>100.00%</b>	

8.3 *Recommendations Regarding Claims Processing and Data Capture*

**Immediate Action Steps:**

The immediate action steps described below are recommended under the following assumptions:

- Current systems and applications, such as CMD, IMSATS, ProdAgio will continue to be used.
  - BIS is to be implemented and will go live in October 2008.
  - The data center in Torrance, CA will be in place by the end of 2008.
1. Plan and conduct a "Claims Processing 101" training for both the institutional and PC&IB invoice processors on an on going basis. This training should be continued for both new hires and existing staff. The invoice processors should be trained to understand the differences between an invoice and a health care claim. They should also be trained to understand Medicare payment methodologies, particularly those under which new contracts have been negotiated by Chancellor Consulting Group. Without an in-depth understanding of the nuances of these methodologies, and the lack of a formal claims processing system, accurate and timely payment to providers under these methodologies will be difficult, if not impossible.



2. If CMD and ProdAgio will be used going forward, it is recommended that the adoption of ProdAgio and centralization of CMD be expedited across all institutions. However, in order for such an action to be effective, less cumbersome and less labor intensive, several recommended steps described in this section should also be considered. It is also recommended that CMD data should be consolidated and housed in a SQL server database to be accessed for all end-users so that all changes are up to date for all institutions, and reports can be run statewide rather than in a stand alone MS Access database as is currently done today. An important consideration is that the performance of the application (response time per click or per search) will largely depend upon how the database is set up and the connection between end-users and the server location. Many IT issues must be understood and addressed in order for the implementation of this recommendation to be successful. *NCI recommends that neither CMD nor ProdAgio be used for claims processing because neither was designed for claims processing purposes. It is therefore our recommendation that a formal claims processing system be purchased or the claims processing function and/or system to be contracted out to a third party which is described further under the "Long Term Action Steps" section.*
3. Instruct providers to submit invoices directly to institutions rather than to designated RAOs for non-ProdAgio institutions. As indicated in the previous finding section, there is a large quantity of inter-office mail transfers due to the "Inmate not at this Institution" reason (37 percent in 06-07 CMD). Moreover, as identified under Finding #12, there exists an average 16-day window for improvement between the provider invoice date and the HCCUP Analyst receipt date. If invoices are sent to the institutions first, the error volume should decline because many of the providers are local and familiar with the institutions they serve; therefore, fewer errors should occur. In addition, once the institutional HCCUP analysts receive the invoices, they can start the process immediately without waiting for the RAO's sorting and processing. He or she can forward misdirected invoices to RAOs or to the appropriate institution immediately upon the completion of the inmate validation process. As a result, the AP cycle should decrease for those providers who followed the rules and remain the same for those that did not follow the rules.
4. Due to the low success rate (40 percent) of OCR scanning, PC&IB should consider discontinuing the indexing and fixing of failed invoices but keep the scanned Adobe pdf invoices. Instead, data entered in CMD can be extracted and then imported into ProdAgio. Currently, invoice processors must enter data in ProdAgio and in CMD. Instead of doing both, a simple data extraction and import process can be developed between the two applications so that data only needs to be entered once. Since more data points are entered in CMD, it is recommended that CDCR select CMD data points



to be extracted for ProdAgio. This approach will reduce manual entry requirements of the PC&IB invoice processing staff and, at the same time, still utilize the workflow function of ProdAgio to move invoices through approval channels.

5. Design and create a batch process that will allow a regular extraction of electronic invoice data from CMD and/or ProdAgio to be uploaded onto BIS for AP processing. This should be planned ahead of time, anticipating the implementation of BIS. This implementation should eliminate the manual entry steps currently performed by RAO staff in addition to reducing errors caused by manual entries.
6. Perform a gap analysis between PC&IB and RAOs and reconcile key statistics such as Federal Tax ID format, Vendor Names, GL, small business discounts, etc. between CALSTARS (or BIS) and ProdAgio or CMD. In addition, small business discount information should be set up in CMD and/or ProdAgio to allow discounts to be applied prior to invoices being submitted to RAOs. Each RAO's function should be auditing the invoice amounts and GL rather than fixing data. This approach will eliminate several manual fixes RAO staff are currently doing and therefore, reduce the AP cycle. This gap analysis should be performed in coordination with the clean-up process that has been carried out by the BIS implementation team.
7. Eliminate manual entry points by utilizing a data extract function. For example, Daily Census Report statistics are currently being handwritten by OPHU nurses. The hard copy information is then forwarded and entered into three different databases (CMD, CADDIS and UMD) by three different staff members (HCCUP Analyst, HRT and UM RN). A simple electronic form can be designed and created using MS Access or Excel for the OPHU nurses to enter the essential statistics. This electronic data sheet can then be shared and imported to the three different MS Access database applications.
8. Eliminate the CMD cost estimate process that is being done currently by the institutional HCCUP analysts. Currently, in addition to the Daily Census Report, HCCUP analysts use a hard copy off-site medical appointment schedule report generated from IMSATS to enter data into CMD to perform estimations of the cost of services. We learned during our site visits that these estimates are not necessarily "real" numbers used for budgeting. Therefore, this step does not seem to serve any value-added function. Instead, we recommend that the off-site medical appointment schedules be extracted from IMSATS and then imported onto CMD without data entry or estimations performed. Alternatively, HCCUP analysts can wait until an invoice is submitted to perform the invoice processing function.



9. Create a "Potential Duplicate Claims Report" on CMD based on pre-set criteria before each batch of claims is processed. These reports can be completed easily by evaluating the newly entered invoices against those claims that were in CMD or ProdAgio already. The data points used to identify potential duplicate claims can be those with the same CDC Number, Provider ID, ICD-9 Diagnosis Code, ICD-9 Procedure Codes, Procedures (CPT/HCPCS), date of services, i.e., the same provider providing the same service to the same inmate on the same date. These claims should be examined further by the invoice processors to determine if they are indeed duplicate, and then noted as such in the system. Moreover, this report should be run and analyzed for every batch of claims processed, not just at the end of each month.
10. Create a process to combine all IMSATS data into one database to track on-site utilization monitoring as much as possible. This will allow sharing of data within the same institution at a minimum (consolidation on a statewide basis would be preferable).
11. Clean and update PHYSCAD so that it serves a useful purpose (*see previous recommendation in Network Management section*). The database should include all contracted healthcare providers, including registry providers. The database should be accessible at PC&IB and at each institution, and should be current and all-inclusive. Contract Analysts at each institution should be able to search this database to determine whether an existing contract is in place for any given service need. This effort would facilitate network management at the institutions and at the statewide level. The database should include a unique provider number for each contracted provider, and CDCR should consider including licensing information. A regular check against the California Medical Board (CMD) to validate the licensure status of the providers should be conducted at a minimum to ensure that providers with revoked, suspended or expired licenses are updated in a timely fashion. This function should not replace a formal credentialing process, but should be a complementary and coordinated effort with the provider credentialing unit.
12. Modify CMD and IMSATS to allow only code-driven entry on key data points, e.g., provider IDs should drive the provider name and demographic information, and end users should not be allowed to enter provider demographic information. In addition, modify the application to perform basic date validation process, e.g., date formats must be valid, dates should not be older than mm/dd/yyyy for each FY version of CMD, ToAcctDt should not be less than the InvDt, etc. Blank fields should not be allowed for critical date fields, such as Invoice Date, Invoice Receipt Date, etc.
13. Enter all claim line statistics (CPT/HCPCS codes, revenue codes, date of services, billed amounts, etc.) submitted on CMS 1500 and UB-04 forms. CMD currently has a Table



called tblProcedures which houses claim line statistics. But it does not appear that all statistics are entered for all institutions.

14. Start the planning and design of a data warehouse by utilizing the Data Center capabilities set up in Torrance, CA to house all utilization statistics that are currently captured in CMD and IMSATS, to allow for a basic central reporting function. The design should take into consideration future growth in addition to data available currently.
15. Create and enforce the regularly scheduled back up policies and procedures for all ProdAgio, IMSATS, CMD, CADDIS, UMD and other stand alone databases immediately if they are not already in place. In addition to nightly institution-specific back up, critical applications such as IMSATS, CMD, ProdAgio, etc. should also be backed up and archived in an off-site storage facility, especially in an earthquake-prone state such as California. IT staff should be consulted regarding the minimum Disaster Recovery criteria for these critical applications.
16. Start evaluating the long term action steps immediately to determine if any of the options described below would be viable within a relatively shorter period of time (as supposed to long term) while the above steps are being implemented to "smooth" the current processes using the existing system. This step is important because Chancellor Consulting Group continues to negotiate new contracts with new payment methodologies, which may be unfamiliar to the existing invoice processors. A more comprehensive claims processing system needs to be in place in order for the new contracts to be managed and paid correctly, effectively and timely.

**Long Term Action Steps:**

The long term action steps described below are recommended under the assumption that one or all of the current systems and applications, such as CMD, IMSATS, and ProdAgio can be *replaced*. However, these recommendations still assume that BIS will be implemented and go live in October 2008 and that the data center in Torrance, CA will be in place.



1. Claims processing system:

Objectives	Pros	Cons
<p>"Purchase Model" - Purchase a claims processing system with standard capabilities (described previously).</p>	<ul style="list-style-type: none"> <li>• Able to process all medical claims as described previously</li> <li>• All claims adjudication functions described previously are built in without additional human intervention</li> <li>• Utilizes industry standard coding which allows standard reporting and benchmarking</li> <li>• Reduces manual entry</li> <li>• Claims adjudicators can adjudicate claims rather than enter data</li> <li>• Reduces the AP cycle</li> <li>• Modern technology with web-based look and feel which allows end-users to be in various locations but follow the same business logic</li> <li>• Modern technology will enable the integration with BIS and/or data center technologies much easier</li> <li>• Will have more flexibility in making system modification via internal IT coordination if appropriate IT support is secured</li> </ul>	<ul style="list-style-type: none"> <li>• Requires an initial and annual cost including license, implementation, hardware and annual hardware/software maintenance costs</li> <li>• Implementation logistics could be complicated since the institutions are located across California</li> <li>• Technology capabilities may need to be upgraded within each institution</li> <li>• Need to hire additional IT staffs (database administrators, systems business analysts, help desk technicians, technical trainers, etc.) to maintain the existing software and hardware.</li> <li>• Disaster recovery plan on this critical system will need to be planned and implemented in house</li> <li>• Will be responsible for all supporting code updates and upload on a regular basis.</li> <li>• Requires retraining and on-going training of existing staffs</li> <li>• Required that qualified individuals be hired in order to realize the return on investments (ROI) quickly</li> <li>• People retention may be an issue once staffs are trained and experienced with the claims processing system as they will become more "marketable"</li> </ul>



Options	Pros	Cons
<p>“Host Model” - Contract with a Service Provider which owns the claims processing system to host the claims processing function. The “Host” provides all system software and hardware including the databases to house all claims data. CDCR staffs continue to be the end-users (business users) using the system.</p>	<ul style="list-style-type: none"> <li>• All benefits described above</li> <li>• No need to purchase the software and the hardware needed to house the software nor the annual maintenance and upgrade</li> <li>• Supporting codes updates and upload will be managed by the service provider</li> <li>• No need to hire additional IT staffs to maintain this claims processing system</li> <li>• Disaster recovery plan and implementation is the responsibility of the host</li> </ul>	<ul style="list-style-type: none"> <li>• Annual cost required – level of costs depends on how the contract is set up</li> <li>• The support staff and system response time from the Service Provider could become an issue if the service level agreement is not clear</li> <li>• CDCR must coordinate and receive a regular data extract for data warehousing purposes</li> <li>• CDCR would need to coordinate and provide UM, provider demographics, rate sheets, and inmate statistics updates to service provider on a regular basis</li> <li>• Implementation logistics could be complicated since the institutions are located across California.</li> <li>• Technology capabilities may need to be upgraded within each institution.</li> <li>• Requires retraining and on-going training of existing staffs</li> <li>• Required that qualified individuals be hired in order to realize the return on investments (ROI) quickly</li> <li>• People retention may be an issue once staffs are trained and experienced with the claims processing system as they will become more “marketable”</li> </ul>



Option	Pros	Cons
<p>"TPA Model" - Outsource the entire claims processing functions to a Third Party Administrator (TPA)</p>	<ul style="list-style-type: none"> <li>• All benefits described above.</li> <li>• CDCR can set up a maximum AP cycle requirement for the TPA who will be liable to these requirements.</li> <li>• Agreed on "dashboard" reporting requirements.</li> <li>• No need to purchase the software and the hardware needed to house the software nor the annual maintenance and upgrade</li> <li>• Supporting codes updates and upload will be managed by the TPA</li> <li>• No need to hire additional IT staffs to maintain this claims processing system</li> <li>• Train, re-train, and hire quality staffs will be the responsibilities of the TPA</li> <li>• Disaster recovery plan and implementation is the responsibility of the TPA</li> </ul>	<ul style="list-style-type: none"> <li>• Annual cost required – level of costs depends on how the contract is set up</li> <li>• The response time from the TPA could be tardy if the service level agreement is not clear.</li> <li>• CDCR must coordinate and receive a regular data extract for data warehousing purposes</li> <li>• CDCR would need to coordinate and provide UM, provider demographics, rate sheets, and inmate statistics updates to the TPA on a regular basis</li> <li>• Coordination between the TPA and RAO/SCO needs to be determined.</li> <li>• Need to negotiate and agreed on how an "Ad Hoc" reporting need can be met timely</li> <li>• Need to identify potential "out of scope" services and agreed on the method of payment if any were to occur</li> <li>• Existing CDCR invoice processing staff will need to be sourced to other responsibilities</li> </ul>

2. Because there are in-house medical services provided at institutions, we also recommend that a patient scheduling system be evaluated and implemented. The IMSATS application being utilized currently is an MS Access stand-alone desktop application as described previously. In order to understand the utilization level of all services performed, on-site service tracking is just as important as off-site service tracking. One way to ensure uniform registration and standardization of these services is to implement a patient scheduling system to be integrated with the claims processing system previously described. These options should be investigated in detail, and in relation to decisions regarding claims processing systems, prior to purchasing such a system.



## 9. Internal Audit

### 9.1 *Overview of Internal Auditing*

An activity as complex as the CDCR contracting unit needs an internal audit function to assure its effectiveness. It currently does not have such a function. Although management issues have been studied, it is important to distinguish internal auditing from these ongoing management reviews, the results of which have been disseminated as Management Alerts. Management Alerts have addressed important issues and should be continued in concert with internal auditing. The current reviews, however, do not meet internal auditing needs. Internal auditing is used to monitor operating results, verify financial records, evaluate internal controls, assist with efforts to improve efficiency and effectiveness, to detect fraud and to report on operations to senior managers. It is used to be certain that senior management has independent insights into operations.

An internal audit function needs to be independent of the unit that is audited to assure management that an objective examination of key issues is undertaken. The internal audit function should report to CDCR senior management rather than to the contracting unit manager. Internal auditors must perform both special studies and routine investigations and should be required to answer the following questions for senior management:

- Is each sub-unit and activity meeting its objectives?
- Is each sub-unit and activity operating efficiently?
- Are staff members responsible for each activity sufficiently trained to operate effectively?
- Are procedures being followed as intended?
- Are data available to monitor efficiency and effectiveness?
- Are claims being paid correctly?
- Are there sufficient controls in place to prevent losses and are those controls being used properly?
- Are risks identified and are risk management procedures in place?

Each of these questions must be answered periodically for each sub-unit/activity. The size of the internal audit staff will determine how frequently each question is addressed for each sub-unit/activity, but it is important for each activity to be reviewed at least once every three years. Internal audit leadership will prepare the audit program and the schedule for its completion.



## 9.2 Findings Regarding Internal Audit

**Finding #1:** The contracting unit does not have a formal Internal Audit function although several important ad hoc studies and reviews have been completed. The ongoing and substantial needs to improve the contracting unit's operations have led to the need to identify and complete studies. These studies, which have been extremely useful, are similar to management reviews that can be completed by internal auditors, but are typically undertaken by management after internal auditors have identified a problem. The team that has prepared Management Alerts will be aided by referrals of issues from internal auditing.

**Finding #2:** Lack of a formal program may limit the effectiveness of the studies and reviews that are completed. Internal auditors develop and implement a work program that identifies the efforts that they will undertake. Most work programs are prepared annually. The systematic design and management review of an internal audit work program assures managers that key issues will be addressed and that the internal audit team will not be sidetracked by "issues of the moment."

**Finding #3:** Studies and reviews to be undertaken are not selected systematically. There is no unit-wide internal audit program. As indicated previously, it is important to distinguish between the preparation of Management Alerts and internal auditing. Management Alerts are important since they address immediate issues and problems. Internal auditing will systematically address the operation of the contracting unit.

## 9.3 Recommendations Regarding Internal Audit

### Immediate Action Steps

1. Establish a formal Internal Audit function with the lead internal auditor reporting to a senior CPR/CDCR manager. The internal audit function should be independent of the contracting unit. It is important for the internal audit function to be established as soon as possible. If they are available, internal auditors will be able to evaluate how effectively needed changes that have been described in prior chapters have been implemented.
2. Develop an audit program that will be used to identify studies that need to be completed on a regular basis and which includes criteria for the selection of ad hoc studies. An audit program should be developed as soon after the function is established as possible. The program needs to address each of the contracting unit's activities. Efforts need to be made to match the schedule in the audit program with the schedule for the implementation of improvements in the contracting unit's activities. The first



two years of the internal audit effort is likely to be focused on reviewing the efficiency and effectiveness of the improvements that are made.



**10. Conclusion**

The structure, process and technology issues and other activities related to contracting and claims processing, such as provider payment methodologies, provider contracts and utilization management can be summarized in the SWOT (Strengths, Weaknesses, Opportunities and Threats) Analysis table below. Strengths and weaknesses are internal to CDCR (i.e. they can be directly influenced by CDCR’s action or inaction). Opportunities and threats are external to CDCR (i.e. circumstances which may or may not arise in the outside environment and over which CDCR has no control). Thus, the purpose of a SWOT is to actively promote the identified strengths, minimize weaknesses by planning them out of existence, exploit the opportunities before the window closes and have contingency plans in place to minimize threats before they materialize.

<b>STRENGTHS</b>	<b>WEAKNESSES</b>
<ul style="list-style-type: none"> <li>• Clear strategic goals set by the receivership</li> <li>• Funding is independent from the State budget</li> <li>• Receivership is willing to try new approaches</li> <li>• New Facilities Capital Program</li> <li>• Adoption of new contracting methodologies</li> <li>• Telemedicine</li> <li>• Data Center in Torrance, CA for data warehousing and capture</li> <li>• Strategic vision for medical information management, including potential clinical data repository and “access to care” initiative</li> </ul>	<ul style="list-style-type: none"> <li>• Recruiting and retention of quality staff and management</li> <li>• Lack of an adequate claim processing, patient scheduling, provider network management and utilization management system</li> <li>• Limited institutional information technology to support efficient processes</li> <li>• Poorly integrated systems and applications</li> <li>• Lack of data capture protocols and standardization</li> <li>• Sustained new hires and existing staff training</li> <li>• Inconsistent business processes across institutions</li> <li>• Manually intensive processes including redundant steps performed by different entities</li> <li>• Lack of coordination to streamline business processes</li> <li>• Use of technology as a “Band Aid” solution to an isolated problem rather than using it to streamline processes</li> <li>• Lack of understanding of Medicare Fee Schedules and other payment methodologies at all levels</li> <li>• Outdated prison facilities and equipment</li> <li>• Critical application and system back up policies and procedures enforcement</li> </ul>



OPPORTUNITIES	THREATS
<ul style="list-style-type: none"> <li>• Institutions in a clustered geographic region can leverage contracts with providers in the region</li> <li>• Potential to leverage ProdAgio to capitalize on its strength as a document management system with proper integration with other systems</li> <li>• Several business models (“Purchase”, “Host” or “TPA” models) provided by healthcare IT vendors available for CDCR to consider.</li> <li>• Potential partnership possibilities between CDCR and Medi-Cal health plans (local initiatives public health plans) to leverage their claims processing, provider network and other functions.</li> </ul>	<ul style="list-style-type: none"> <li>• Lack of competitive edge to achieve better contract rates in remote geographic locations</li> <li>• Resistance to change by providers to accept new contracts and/or lower reimbursement rates</li> <li>• Providers’ potential discriminatory practices towards inmate population</li> <li>• Lack of competitive edge for recruiting quality health care people who are willing to work in a prison system</li> <li>• State bills, policies and procedures preventing contracts to be in place timely, e.g., bidding process</li> <li>• State budget crisis may impact funding sources depending upon the political environment</li> <li>• Lack of control over state or federal rules and regulations</li> </ul>



**Assessment of the California Department of Corrections  
and Rehabilitation's Healthcare Contracting Unit**

*Appendices*

April 21, 2008

Prepared by:

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CONSULTING

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Appendix A - Network Adequacy Results

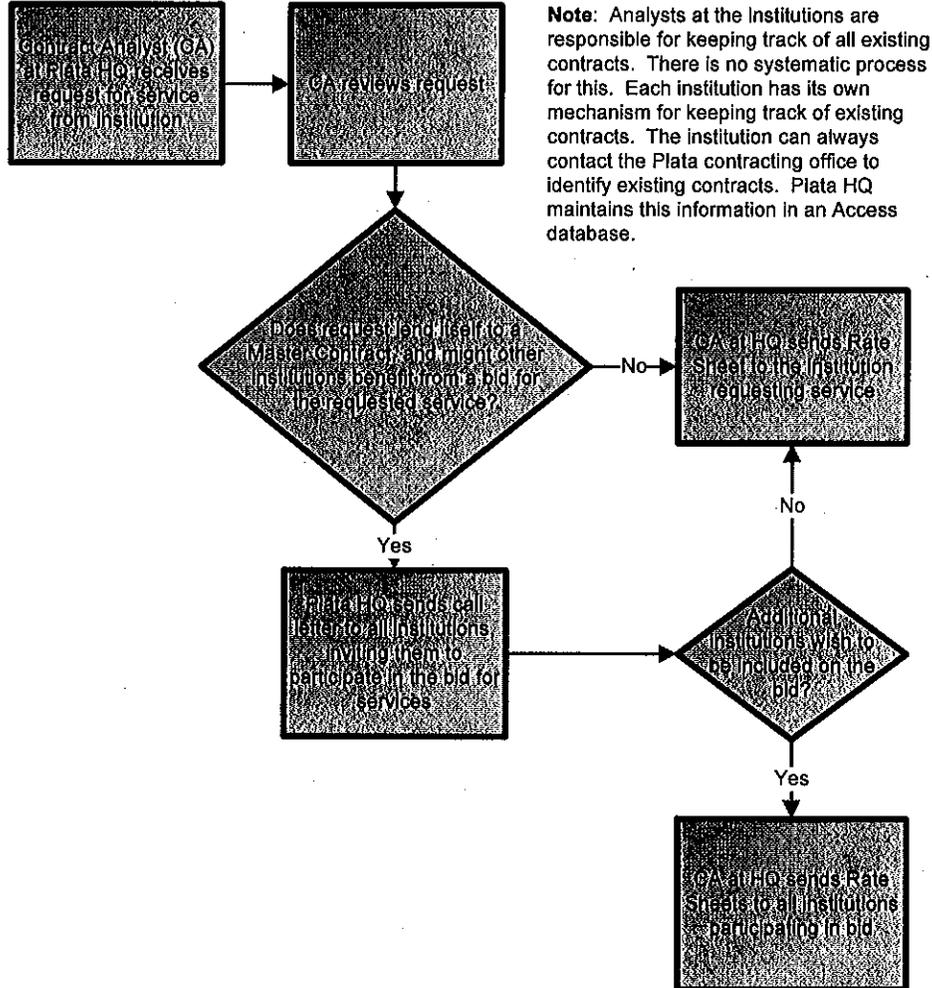
Institution	Air Amb	Ambulance	Allergy	Anes	Crit	CV Surg	Derm	Endocrine	ENT	Gen Surg	GI	Home	Hosp	III	Renal	Neuro	OH Cyn	Ortho	Optom	Oral Surg	Onc	Ortho	Pkstr	Plastic Surg	Podiatry	Prim	Rad Dx	Rad Tx	Urol	OT	PT	ST	AVG	
CCC California Correctional Ctr	2	2	1	2	2	2	1	1	1	1	1	1	1	1	1	2	NA	1	1	1	1	1	1	1	1	1	1	1	1	1	1	2.5		
CMF California Medical Fee	1	1	2	3	2	2	2	2	2	2	2	2	2	2	2	2	NA	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.0		
DVI Diesel Vocational Inst	2	2	3	4	3	3	3	3	3	3	3	3	3	3	3	3	NA	3	3	3	3	3	3	3	3	3	3	3	3	3	3.0			
ESP Folsom State Prison	NA	3	2	3	4	3	3	3	3	3	3	3	3	3	3	3	NA	3	2	2	2	2	2	2	2	2	2	2	2	2	2.8			
HOSP High Desert State Prison	2	2	1	2	2	2	1	1	1	1	1	1	1	1	1	2	NA	1	1	1	1	1	1	1	1	1	1	1	1	1	1.5			
MCSF Middle Creek State Prison	2	1	NA	NA	2	2	2	2	2	2	2	2	2	2	2	2	NA	2	3	3	1	2	1	NA	2	1	NA	1	NA	1	NA	1.7		
PPSP Pelican Bay State Prison	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	NA	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.1		
SAC CSP-Sacramento	NA	4	3	3	4	2	3	3	3	3	3	3	3	3	3	3	NA	2	4	4	3	1	2	NA	3	2	2	2	2	2	2	2.8		
SCC Sierra Conservation Ctr	3	2	1	1	2	1	1	1	1	1	1	1	1	1	1	2	NA	3	3	2	2	2	3	1	2	3	4	3	NA	2	1	2.3		
SOL CSP-Solano	3	2	1	1	2	1	1	1	1	1	1	1	1	1	1	2	NA	3	3	2	2	2	3	1	2	3	4	3	NA	2	1	2.3		
SQ San Quentin	3	3	NA	4	1	1	1	1	1	1	1	1	1	1	1	2	NA	2	3	3	1	2	3	4	1	3	1	1	3	1	3	1	2.1	
ASP Avenal State Prison	4	4	1	NA	4	3	3	3	3	3	3	3	3	3	3	3	NA	4	4	4	3	4	3	1	3	4	2	4	1	4	1	3.1		
CCWF Central California Women's Fac	4	4	1	2	1	1	1	1	1	1	1	1	1	1	1	2	NA	3	2	2	2	3	1	3	2	1	3	2	2	3	1	1	2.0	
CMC California Men's Colony	2	3	NA	4	4	4	2	1	1	1	1	1	1	1	1	4	NA	4	3	NA	2	4	1	3	2	3	3	3	1	3	1	1	2.7	
CDR CSP-Corcoran	1	1	2	2	1	1	1	1	1	1	1	1	1	1	1	1	NA	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1	1.2	
CTF Correctional Training Fac	4	4	2	NA	2	2	1	1	1	1	1	1	1	1	1	2	NA	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1.2	
KVSP Kern Valley State Prison	NA	NA	NA	NA	2	2	2	2	2	2	2	2	2	2	2	2	NA	2	2	1	1	1	1	1	1	1	1	1	1	1	1	1	1.4	
NSPP North Kern State Prison	NA	NA	NA	NA	2	2	2	2	2	2	2	2	2	2	2	2	NA	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.4	
PPSP Pleasant Valley State Prison	3	3	2	NA	3	2	3	3	3	3	3	3	3	3	3	3	NA	2	3	3	3	1	2	NA	3	2	3	2	2	2	2	2	2.5	
SATF Substance Abuse Treatment Fac	2	2	1	NA	1	1	1	1	1	1	1	1	1	1	1	1	NA	1	2	2	2	2	1	1	2	2	2	2	2	2	2	2	1	1.6
SVSP Salinas Valley State Prison	3	2	1	NA	2	2	1	2	2	2	2	2	2	2	2	2	NA	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2	2.0
VSPW Valley State Prison for Women	1	3	1	NA	3	1	1	1	1	1	1	1	1	1	1	3	NA	3	2	2	2	2	2	1	3	3	2	2	2	2	2	2	2	1.9
WSP Wasco State Prison	1	3	1	2	2	2	2	2	2	2	2	2	2	2	2	2	NA	2	3	3	2	2	2	2	2	2	2	2	2	2	2	2	2	2.4
CAL CSP-Calipatria	4	4	2	2	4	3	4	2	2	2	2	2	2	2	2	3	NA	3	4	3	4	4	4	3	4	2	3	3	3	3	3	3	3.1	
CCI California Correctional Inst	4	4	2	NA	4	4	2	2	2	2	2	2	2	2	2	2	NA	1	NA	4	4	4	4	4	4	2	3	3	3	3	3	3	3.1	
CEN Centinela State Prison	NA	2	1	2	4	2	3	3	3	3	3	3	3	3	3	3	NA	3	4	4	4	4	4	4	4	1	4	4	1	NA	2	NA	3.2	
CIM California Institution for Men	3	4	NA	3	2	3	3	2	2	2	2	2	2	2	2	2	NA	3	3	3	3	3	3	3	3	2	3	2	3	2	3	2	2.7	
CW California Institution for Women	NA	3	NA	4	2	3	1	2	2	1	1	1	1	1	1	3	NA	3	3	2	1	3	NA	3	3	2	1	3	1	NA	3	3	2.3	
CRC California Rehabilitation Ctr	3	3	2	3	1	1	2	2	2	2	2	2	2	2	2	2	NA	2	3	3	3	3	3	3	2	2	2	2	2	2	2	2	1.9	
CVSP Chukawalla Valley State Prison	3	3	1	3	2	3	1	3	2	4	1	2	2	2	2	3	NA	3	3	4	3	3	3	NA	3	3	4	3	3	NA	2	2	2.7	
ESP Inwood State Prison	2	2	2	NA	2	1	1	1	1	1	1	1	1	1	1	2	NA	1	4	3	4	1	2	1	3	4	2	3	1	3	NA	4	2.1	
LAC CSP-Lancaster	3	4	4	3	4	3	3	3	3	3	3	3	3	3	3	4	NA	4	3	4	4	4	2	2	NA	4	4	4	1	3	4	3	3.3	
RID R'Donovan Correctional Fac	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	3	NA	3	2	3	3	3	3	3	3	3	3	3	3	3	3	3	3.1	

Scale:  
 1=Inadequate supply/provider shortage | 2=Limited provider supply  
 3=Adequate provider supply | 4=Good provider supply  
 5=Too many providers/overcontracted | 6=Not needed/not applicable



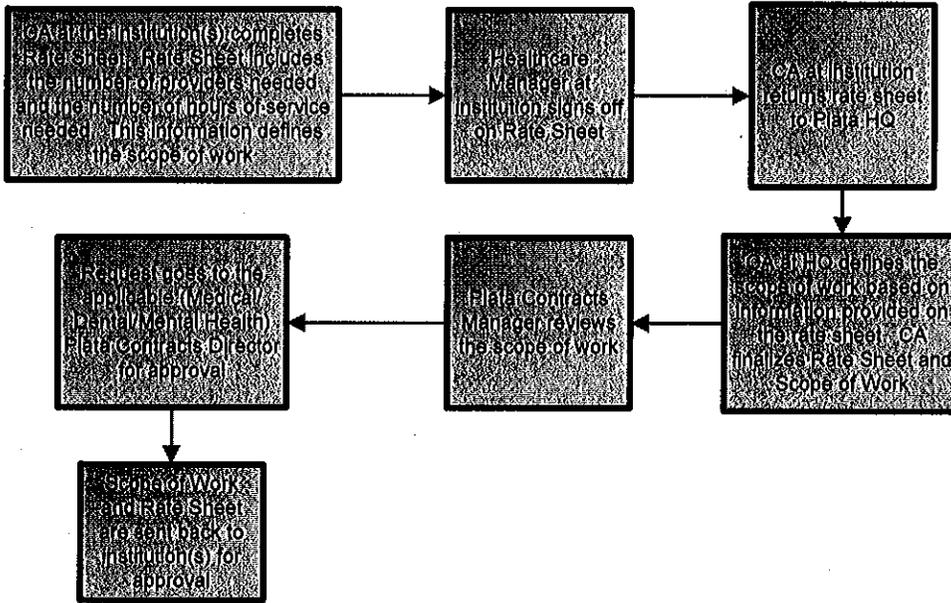
Appendix B – Contracting Process Flowcharts

California Department of Correction and Rehabilitation (CDCR)  
Manual Bid Process

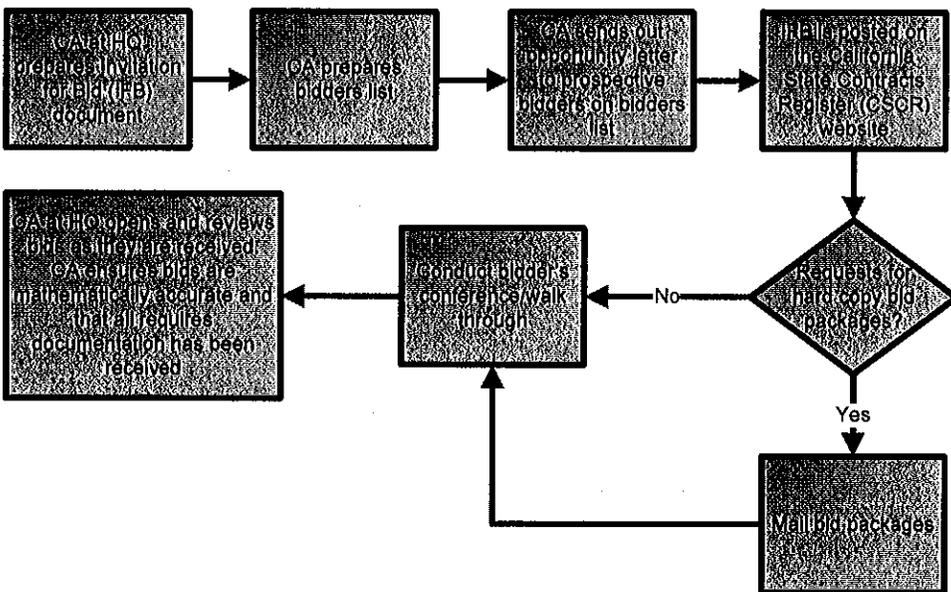




**California Department of Correction and Rehabilitation (CDCR)  
Manual Bid Process, continued**

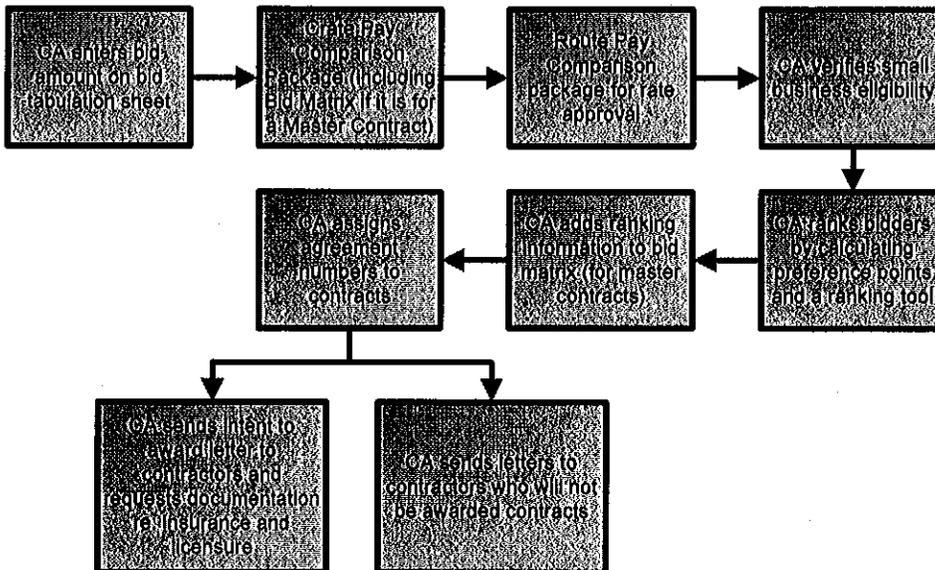


**California Department of Correction and Rehabilitation (CDCR)  
Manual Bid Process, continued**

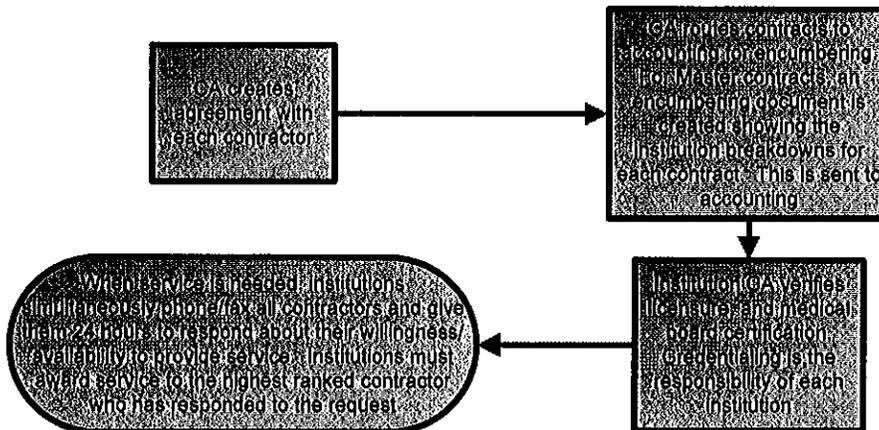




**California Department of Correction and Rehabilitation (CDCR)  
Manual Bid Process, continued**



**California Department of Correction and Rehabilitation (CDCR)  
Manual Bid Process, continued**



Note: Contracts can be processed and fully executed by Plata HQ; however, unless credentialing has been completed by the institution, the contract cannot be implemented (the institution will not be able to acquire gate access for the provider, and no services can be provided)

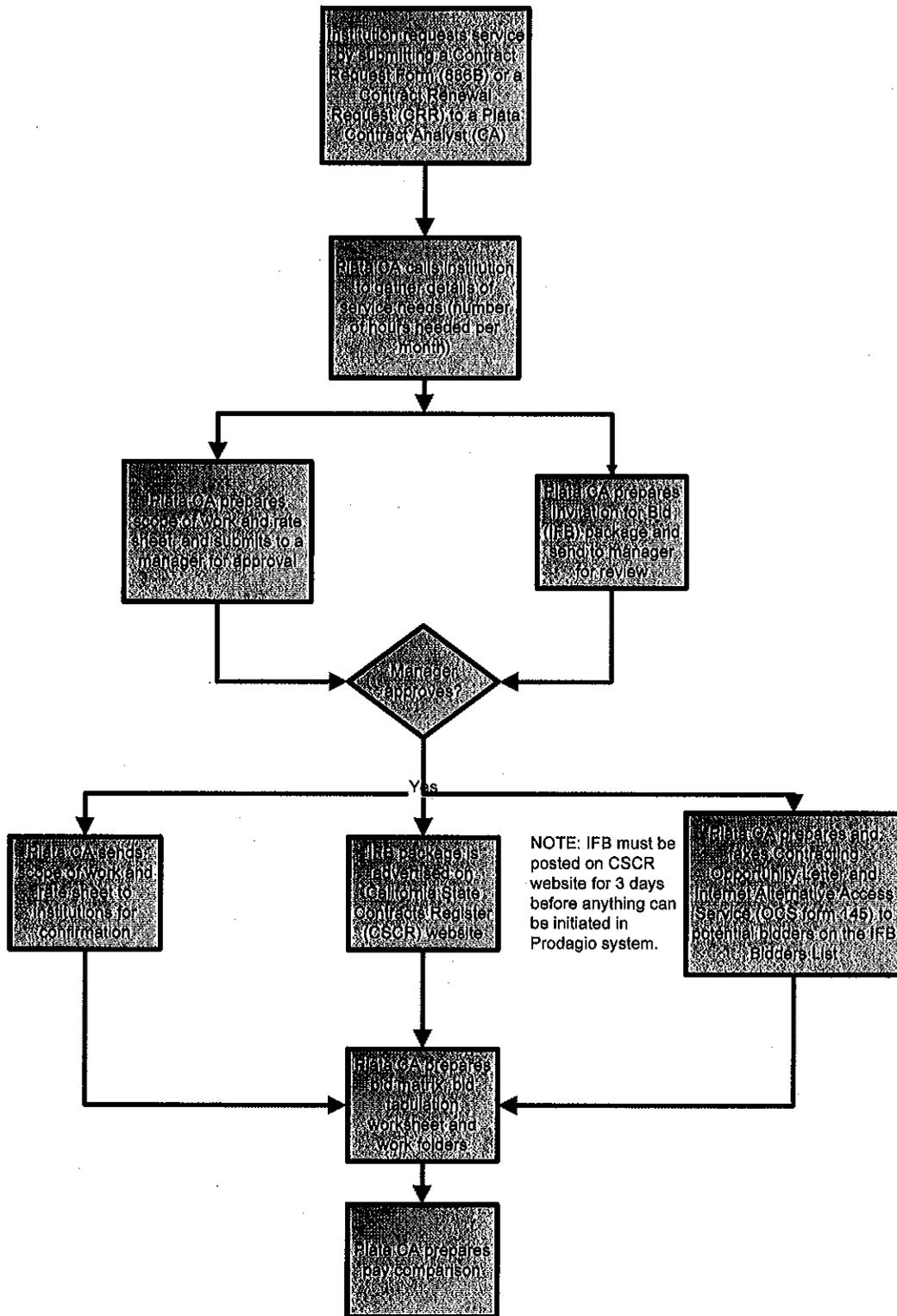


### Manual Bid Process Summary

<b>Steps</b>	<b>Process Description</b>
1)	Institutions contact the Plata Contract and Invoice Branch when they identify a need for a contracted service
2)	A Plata Contract Analyst (CA) reviews the details of the request
3)	Plata CA evaluates whether the request lends itself to a Master Contract, and whether other institutions might benefit from a bid for the requested service <ol style="list-style-type: none"> <li>a) If so, call letters are sent to all institutions inviting them to participate in the bid</li> <li>b) If not, the contracting process proceeds with the institution requesting service</li> </ol>
4)	Plata CA sends Rate Sheet to institution(s) participating in the bid
5)	The CA at the institution(s) completes the Rate Sheet
6)	Healthcare Manager at the institution approves Rate Sheet
7)	Rate Sheet is sent to Plata
8)	Plata CA develops Scope of Work using information from the Rate Sheet
9)	Plata Contracts Manager reviews Scope of Work
10)	Request for service goes to Plata Contracts Director for approval
11)	Scope of Work and Rate Sheet are sent back to institution(s) for approval
12)	Plata CA prepares Invitation for Bid (IFB) document
13)	Plata CA prepares bidders list
14)	Plata CA sends opportunity letter to prospective bidders on bidders list
15)	Plata CA posts IFB on the California State Contracts Register (CSCR) website
16)	Plata CA sends hard copies of the IFB upon request
17)	Plata CA conducts bidder's conference/walk through
18)	Plata CA reviews bids as they are received - bids are reviewed for completeness and mathematical accuracy
19)	Plata CA enters bid amounts on Bid Tabulation Sheet
20)	Plata CA creates Pay Comparison Package and a Bid Matrix
21)	Pay Comparison Package is sent for approval
22)	Plata CA verifies bidders' small business eligibility
23)	Plata CA ranks bidders according to rates and small business status
24)	Plata CA adds ranking information to Bid Matrix
25)	Decisions on bid awards are made
26)	Plata CA notifies bidders about award decisions <ol style="list-style-type: none"> <li>a) CA sends Intent to Award letters to contractors, and requests insurance and licensure documents</li> <li>b) CA sends rejection letters to bidders who will not be awarded contracts</li> </ol>
27)	Plata CA creates agreement with each contractor
28)	Plata CA routes contracts to Accounting for encumbering <ol style="list-style-type: none"> <li>a) For Master Contracts, an encumbering document is included showing the institution breakdowns for each contract</li> </ol>
29)	Institution CA verifies each provider's credentials, licensure and board certification
30)	When service is needed, institutions simultaneously phone/fax all contractors and give them 24 hours to respond about their willingness/availability to provide the service. Institutions must award service to the highest ranked contractor who has responded
31)	END.

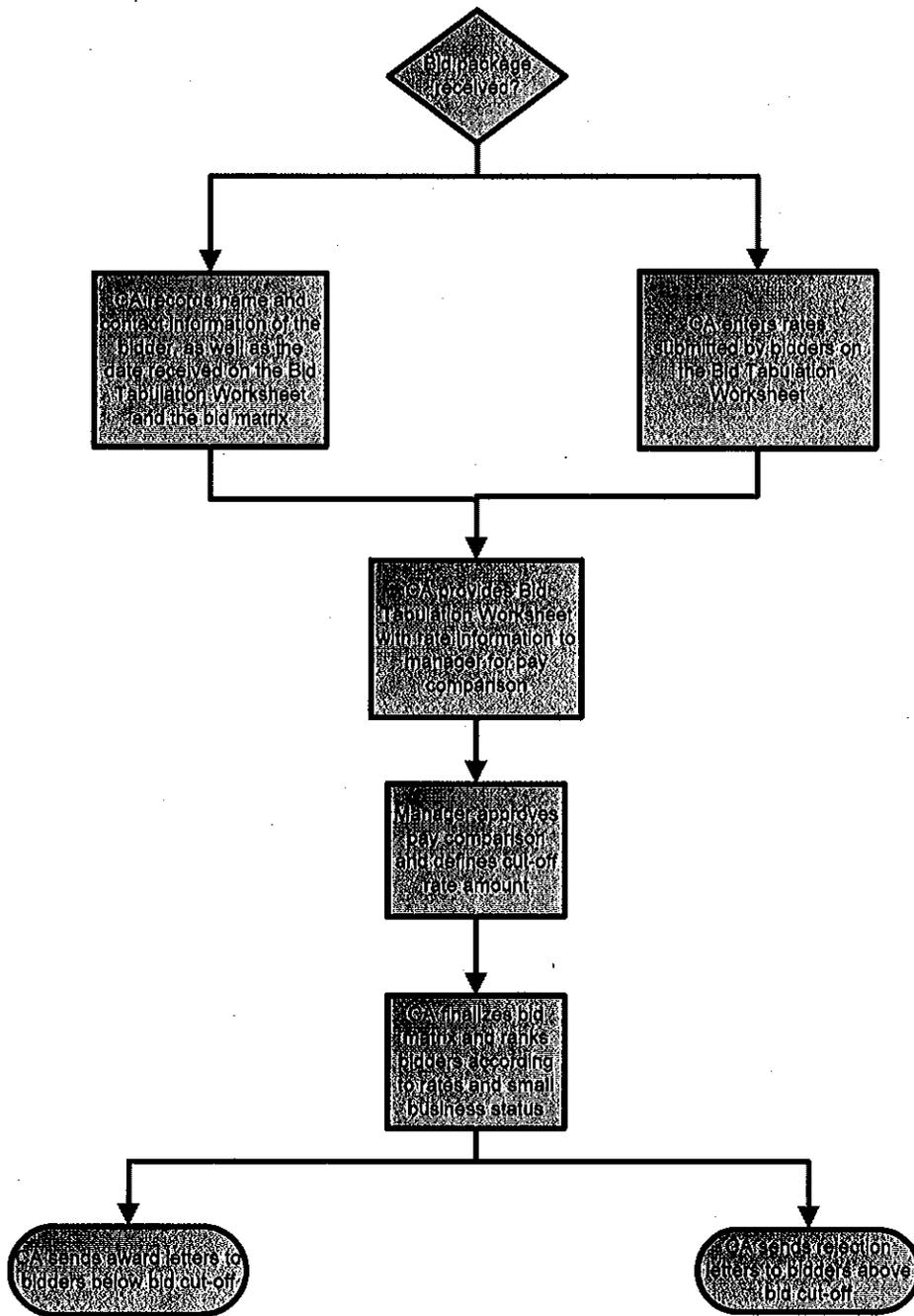


California Department of Correction and Rehabilitation (CDCR)  
Prodagio Bid Process





California Department of Correction and Rehabilitation (CDCR)  
Prodagio Bid Process, continued



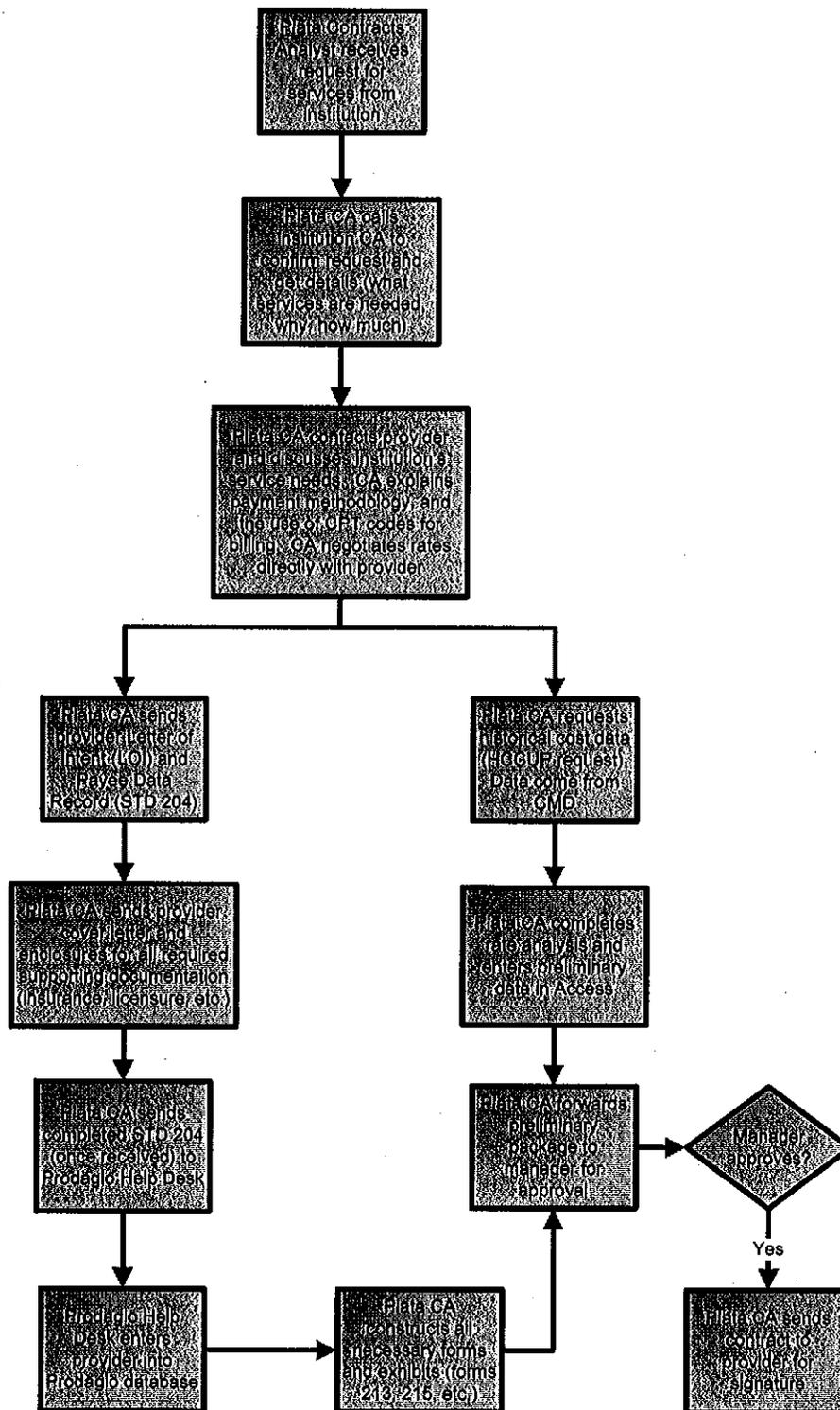


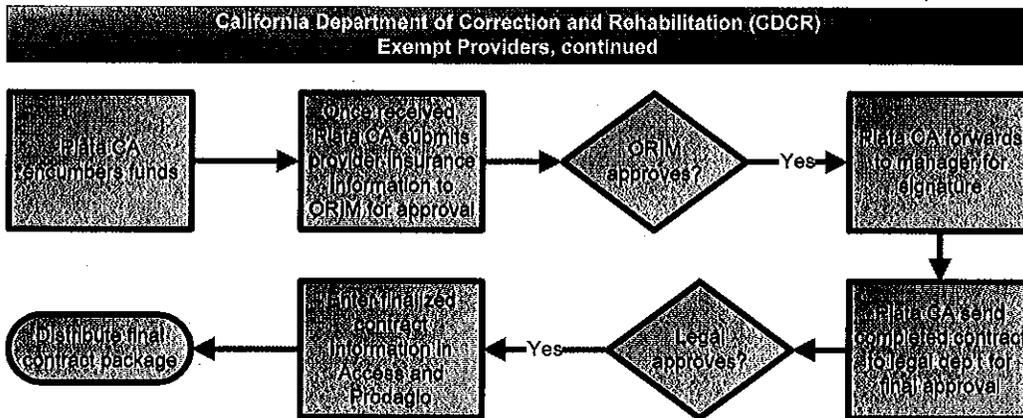
### Prodagio Bid Process Summary

<b>Steps</b>	<b>Process Description</b>
1)	Institution submits a Contract Request Form (886B) or a Contract Renewal Request (CRR) to the Plata Contract and Invoice Branch when they identify a need for a contracted service
2)	A Plata Contract Analyst (CA) confirms the request with the institution-based Contract Analyst and gathers the details of the request (what services are needed, how much)
3)	Plata CA prepares Scope of Work, Rate Sheet, and Invitation for Bid (IFB) package
4)	Plata CA submits Scope of Work, Rate Sheet, and IFB to a manager for review
5)	Once approved the Plata CA conducts the following tasks: <ol style="list-style-type: none"> <li>a) Sends the Scope of Work and Rate Sheet to the institution for confirmation</li> <li>b) Advertises the IFB package on the California State Contracts Register (CSCR) website (must be posted on website for three days before anything can be initiated in the Prodagio system)</li> <li>c) Prepares and faxes Contracting Opportunity Letter and Internet Alternative Access Service (OCS-Form 145) to potential bidders on the IFB bidders list</li> </ol>
6)	Plata CA prepares Bid Matrix, Bid Tabulation Worksheet, and Work Folders
7)	Plata CA prepares Pay Comparison package
8)	As bid packages are received, the Plata CA conducts the following tasks: <ol style="list-style-type: none"> <li>a) Records the name and contact information of the bidder, as well as the date received on the Bid Tabulation Worksheet and the Bid Matrix</li> <li>b) Enters the rates submitted by bidders on the Bid Tabulation Worksheet</li> </ol>
9)	Plata CA send Bid Tabulation Worksheet to a manager for pay comparison
10)	Manager reviews pay comparison and defines the cut-off rate amount
11)	Plata CA finalized Bid Matrix and ranks bidders according to rates and small business status
12)	Plata CA notifies bidders about award decisions: <ol style="list-style-type: none"> <li>a) CA sends Intent to Award letters to bidders below bid cut-off, and requests insurance and licensure documents</li> <li>b) CA sends rejection letters to bidders above the bid cut-off</li> </ol>
13)	END.



California Department of Correction and Rehabilitation (CDCR)  
Exempt Providers





**Exempt Provider Contracting Process Summary**

Steps	Process Description
1)	Institutions contact the Plata Contract and Invoice Branch when they identify a need for a contracted service
2)	A Plata Contract Analyst (CA) confirms the request with the institution-based Contract Analyst and gathers the details of the request (what services are needed, why, how much)
3)	Plata CA recruits potential contractor(s) and negotiate rates
4)	Plata CA sends provider a package of materials including a letter of intent, a payee data record, and a request for supporting documentation (insurance, licensure)
5)	Plata CA conducts rate analysis
6)	Provider returns the data record (STD 204) to Plata
7)	Plata CA forwards STD 204 to Prodagio help desk
8)	Prodagio help desk enters data from STD 204 into Prodagio
9)	Provider information (including rates) are reviewed by a Plata Contract Manager for approval
10)	Once approved, the Plata CA sends a contract to the provider to be signed
11)	Plata CA encumbers funds
12)	Once received, Plata CA submits provider's insurance information to ORIM for approval
13)	Once approved, contract is submitted to Plata Contract Manager for approval
14)	Once approved by manager, contract is submitted to legal department for final approval
15)	Once approved, final contract information is entered in Prodagio and the contracts Access database
16)	END.



**Appendix C - State Contracting Manual Chapter 5, Section 5.80**

*The following are excerpts from the State Contracting Manual (Rev. 10/2005), Chapter 5.80:*

The specific types of contracts listed below...are not required to be competitively bid.

- 1) Emergency contracts which are necessary for the immediate preservation of life or state property.
- 2) Contracts for the work of services of a state, local or federal agency, the University of California, the California State University, a California community college, a foundation or auxiliary organization incorporated to support the universities and colleges, or a Joint Powers Agency.
- 3) Services for which the state has entered into a master service agreement.
- 4) Subvention and local assistance contracts.
- 5) Maintenance agreements for equipment that is under documented warranty, or where there is only one authorized or qualified representative, or where there is only one distributor in the area for parts and services, under \$250,000.00 per year.
- 6) Contracts for designated contractors that have been selected by a federal, state, city, county, or other regulatory entity, usually through a competitive process to perform a service in a specific geographical area (e.g., garbage, refuse, etc.).
- 7) Public entertainment contracts for state-sponsored fairs and expositions.
- 8) Contracts for which only per diem and travel expenses are paid not to exceed \$5,000 and there is no payment for services rendered.
- 9) Contracts solely for the purpose of obtaining expert witnesses for litigation.
- 10) Contracts for legal defense, legal advice, or legal services by an attorney or the attorney's staff.
- 11) Contracts with business entities operating Community-based Rehabilitation Program (CRP), that are justified under one of the exceptions in Government Code (GC) § 19130(b), and that meet the criteria established by Welfare and Institutions Code Section 19404. Note: Contracts with CRPs that are justified under GC § 19130(A), are required to be competitively bid.
- 12) Contracts that can only be performed by a public entity as defined in Unemployment Insurance Code Section 605(b);
- 13) Contracts for conference or meeting facilities, including room accommodations for conference attendees, not to exceed \$250,000.00.



- 14) Contracts for ambulance services (including but no limited to 9-1-1) when there is no competition because the contractor is designated by a local jurisdiction for the specific geographic region. (Management Memo 05-04.)
- 15) Contracts for emergency room hospitals, and medical groups, physicians, and ancillary staff providing services at emergency room hospitals, when a patient is transported to a designated emergency room hospital for the immediate preservation of life and limb and there is no competition because the emergency room hospital is designated by a local emergency medical services agency and medical staffing is designated by the hospital. This exemption covers only those services provided in response to the emergency room transport. (Management Memo 05-04.)
- 16) Contracts with health maintenance organizations (HMOs) through a cooperative agreement with the Centers for Medicare and Medicaid Services (CMS) to pay monthly premium payments for medical/Medicare eligible members, where services are essential or necessary for health and safety.
- 17) Proprietary subscriptions, proprietary publications and/or technical manuals regardless of media format, up to \$250,000. This includes access to pre-existing proprietary research data through a non-IT services contract.
- 18) Rental of proprietary postage meters if they are interfaced and intermembered with existing mailing equipment and there is only one authorized manufacturer's branch or qualified dealer representative providing services for a manufacturer in a specified geographical area. This exemption applies only in circumstances where annual postage meter rental services are less than \$100,000.
- 19) Departmental memberships in professional organizations. Note: Memberships for represented employees are governed by applicable collective bargaining agreements and memberships for non-represented employees are governed by Department of Personnel Administration rules.



**Appendix D – List of Requested Documents from Credentialing & Privileging Unit**

Requested Documents

- |   |                          |
|---|--------------------------|
| 1. Credentialing policies and procedures, including:          | (not available)          |
| a. minimum standards for approval                             |                          |
| b. draft standards for credentialing denials                  |                          |
| c. manual describing functions done at institutions           |                          |
| 2. Recredentialing policies and procedures                    | (not available)          |
| 3. Peer Review as related to the credentialing process        | (not available)          |
| 4. Complaints and Grievances related to credentialing process | (not available)          |
| 5. Practitioner appeal rights for credentialing               |                          |
| 6. 805 and NPDB reporting procedures                          | (not available)          |
| 7. Delegation oversight of credentialing if delegated         | (not available)          |
| 8. Table of Organization                                      | Received                 |
| 9. Credentialing department staffing plan                     | Received duty statements |
| a. including job descriptions                                 |                          |
| 10. Committee Structure                                       | (not available)          |
| 11. Credentials Committee charter                             | (not available)          |
| 12. Any survey or audit result from the past 24 months        | (not available)          |
| 13. A sampling of credentialing QI trending reports           | (not available)          |
| 14. Any credentialing QI related reports Governing Board      | (not available)          |
| 15. Description of resources (IT, software, etc.)             | (not available)          |



## Appendix E – List of Requested & Reviewed Documents Relating to Utilization Management and Quality Improvement

### Requested Documents

- |   |   |
|---|---|
| 1. QI Program 2008  | (not available)                         |
| 2. QI Program 2007  | (not available)                         |
| 3. Annual Evaluation of the 2007 QI Program   | (not available)                         |
| 4. Annual Evaluation of the 2006 QI Program   | (not available)                         |
| 5. UM Program 2008  | (not available)                         |
| 6. UM Program 2007  | (not available)                         |
| 7. Annual Evaluation of the 2007 UM Program   | (not available)                         |
| 8. Disease Management Program 2008  | (not available)                         |
| 9. Disease Management Program 200   | (not available)                         |
| 10. Case Management   | (not available)                         |
| 11. Peer Review policy and procedure  | (referred to physician due process P&P) |
| 12. Complaints and Grievances   | (referred to UM Guidelines)             |
| 13. Appeals   | (referred to Inmate Medical Appeals)    |
| 14. Utilization Management to include prospective, concurrent, and retrospective review, preauthorization process | (referred to UM Guidelines)             |
| 15. Medical necessity criteria  | (referred to UM Guidelines)             |
| 16. Table of Organization   | (not available)                         |
| 17. Committee Structure   | (referred to UM Guidelines)             |
| 18. Job descriptions  | (referred to UM Guidelines)             |
| 19. Survey or audit results for past 24 months  | (not available)                         |
| 20. Trending reports for QI program   | (not available)                         |
| 21. QI reports submitted to Governing Board   | (not available)                         |

### Reviewed Documents

1. Utilization Management Guidelines, 2005
2. Inmate Medical Appeals Tracking Program
3. Medical Authorization Review Subcommittee Time and Unscheduled Transfer Evaluation Log Template
4. Unscheduled Review Outcomes for January 2006
5. Unscheduled Inpatient Admit Review for May 2006
6. Health Care Review Subcommittee Minutes Feb. 13, 2008
7. Daily Census, Un-discharged Inpatients, sample
8. UM Level of Care Assessment Tool
9. Monthly Inpatient Service Log for May and September 2006
10. Monthly Outpatient Service Log for May 2006
11. Cost Savings and Avoidance Report FY 03/04



## **Appendix F –Business process flow diagrams from inmates requesting medical attention to provider receiving payments**

As a result of the review of the current business processes, policies/procedures, and end-user manuals, and interviews of key staff regarding invoice/data processing and retention processes and information systems and applications, we developed workflow diagrams of operations related to the receipt, processing and payment of claims and the related activities such as provider contracting, medical visit scheduling, etc. The diagrams detailed the business processes from an inmate requesting for medical attentions to providers receiving a payments for services provided. The diagrams are separated into the following sections:

### *1) Medical Visit and Invoice Processing Flow – Overall*

This diagram describes the high level business process flow from patient requesting medical attentions to providers receiving payments for services provided. The more detailed step-by-step process flow are segregated and described in more detail under the following four major processes.

### *2) Medical Scheduling and Visit Flow – Institutional Level*

Before an invoice is submitted by a provider, a service must be rendered. This diagram describes both the on site and off site medical appointment scheduling processes. Specifically, the processes contain major activities performed by the triage nurses, clinicians, unit schedulers, UM and providers.

### *3) Health Care Invoice Processing Flow – Institutional Contracting*

The trigger for activating an institutional contracting process is when there is a lack of or no coverage in place for a particular medical service needs are identified within each institution. This diagram describes the business processes carried out by the Institutional Contract Analyst to secure a contract for providing needed medical services.

### *4) ProdAgio Medical Invoice Processing – Plata Contract & Invoice Branch Level*

Due to the adoption of ProdAgio, the invoice processing functions have been centralized for six institutions. The business processes for these institutions are somewhat varied from those institutions that are still using CMD as the primary invoice tracking application. This diagram describes the business processes and activities performed, primarily, by PC&IB and RAO staff.

### *5) Non-ProdAgio Medical Invoice Processing – Institutional Level*

The institutions using CMD as the primary application for invoice processing and tracking follow separate business processes which are different from the ProdAgio institutions. This diagram describes the business processes and activities performed, primarily, by institutional HCCUP analysts and RAO staff.





### Medical Visit and Invoice Processing Flow – Overall

<u>Steps</u>	<u>Process Description</u>
1)	A request for medical service from an inmate triggers the medical appointment scheduling and office visit process. <ol style="list-style-type: none"> <li>a) IMSATS, UMD, DDPS and Form 7252 database applications are used to track the movement of an appointment.</li> <li>b) The institutional contracting process will also take place if securing additional provider is needed.</li> </ol>
2)	Scheduled services are provided to inmates on site or off site.
3)	Once a service provided by an off site provider, an invoice is prepared and submitted to CDCR for payment. <ol style="list-style-type: none"> <li>a) ProdAgio institution invoices are submitted to PC&amp;IB for processing. Go to Step 4).</li> <li>b) Non-ProdAgio institution invoices are submitted to designated RAOs for processing. Go to Step 10).</li> </ol>
4)	PC&IB receives invoices and time stamp and sort invoices <ol style="list-style-type: none"> <li>a) Determine if the invoices are for ProdAgio institution inmates?</li> <li>b) If yes, go to Step 5).</li> <li>c) If no, scan invoices in pdf format then forward to the corresponding institution. Go to Step 12).</li> </ol>
5)	Scan and index invoices onto ProdAgio using Captiva
6)	Fix data errors due to incomplete scanning and enter additional data points in ProdAgio. Go to Step 8).
7)	Enter invoice data and price each invoice in CMD. Go to Step 8). <ol style="list-style-type: none"> <li>a) Price and adjust each invoice using various pricing reference materials and tools, e.g., contracts and pricer applications.</li> <li>b) Perform invoice authentication for identifying duplicate claims</li> <li>c) Obtain admission number from CADDIS for tracking.</li> </ol>
8)	Forward invoices to institutional reviewer/approver for final payment.
9)	Forward invoices to RAO for GL process via ProdAgio workflow function.
10)	RAO assigns Claim Schedule number and performs additional adjustments, match GL accounts, and finalize payment for check processing in ProdAgio. Go to Step 19).
11)	Designated RAO receives Non-ProdAgio institution invoices. Time stamp, sort and forward to the corresponding institution for processing.
12)	Receive invoices from RAOs and PC&IB.
13)	Time Stamp and sort invoices by invoice type.
14)	Price and adjust each paper invoice using various pricing reference materials and tools, e.g., contracts and pricer applications.
15)	Enter invoice data and price each invoice in CMD. <ol style="list-style-type: none"> <li>a) Validate inmate via OBIS.</li> <li>b) Perform invoice authentication for identifying duplicate claims.</li> <li>c) Obtain admission number from CADDIS for tracking.</li> </ol>
16)	Forward a paper batch of invoices to institutional reviewer/approver for final payment.
17)	Forward invoices to RAO for GL process via inter-office mail system.
18)	RAO assigns Claim Schedule number and performs additional adjustments, match GL accounts, and finalize payment for check processing on each hard copy invoice.



**Medical Visit and Invoice Processing Flow – Overall**

<b>Steps</b>	<b>Process Description</b>
19)	RAO enter select data points in CALSTARS for check processing. a) RAO cut checks for those involved in the use of the Revolving Account.
20)	SCO cut checks for those invoices that non-Revolving Account invoices. a) SCO produces H09 Report for monthly reconciliation.
21)	Perform monthly processes, e.g., consolidate statewide CMD, reconciliation, clean up data, etc. a) Review CMD operation and clean reports to carry out monthly processes. b) Similar processes are also conducted at year end.
22)	SCO or RAO sends checks to providers.
23)	END.





### Medical Scheduling and Visit Flow – Institutional Level

Steps	Process Description
-------	---------------------

- |    |   |
|----|---|
| 1) | <p>An inmate can be entering into the medical appointment scheduling systems via the following sources:</p> <ul style="list-style-type: none"> <li>a) An inmate completes a self-request for medical care (Form 7362). Go to Step 3).</li> <li>b) New inmates, go to Step 2).</li> <li>c) Chronic Care Program.</li> <li>d) Release from community hospital via OPHU nurse station processing.</li> <li>e) External OP follow up care.</li> <li>f) External x-ray and lab.</li> <li>g) Emergency.</li> </ul>  |
| 2) | <p>A new inmate enters the facility and is processed at which point a medical provider determines the need for medical services, thereby completing a Request for Service (Form 7243).</p> <ul style="list-style-type: none"> <li>a) Urgent Care, go to Step 4).</li> <li>b) Primary Care, go to Step 5).</li> <li>c) Specialty Care, go to Step 6).</li> </ul>   |
| 3) | <p>Triage nurse receives the inmate's Form 7362 within 24 hours of completion. He/She assesses the medical need for services. If the triage nurse can appropriately deliver treatment without physical examination of the inmate's condition, then he/she will do so. If the triage nurse determines that medical services must be rendered in person, jump to one of the following steps based on the services needed:</p> <ul style="list-style-type: none"> <li>a) Urgent Care, go to Step 5).</li> <li>b) Primary Care, go to Step 6).</li> <li>c) Specialty Care, go to Step 7).</li> </ul>  |
| 4) | <p>OPHU nurse generates Daily Census &amp; Discharge report before mid-night of each day. This report, as part of the Medical AM Report, is routed to several units for further processing:</p> <ul style="list-style-type: none"> <li>a) HRT enters the Inpatient data in CADDIS to track inpatient utilization statistics.</li> <li>b) UM enters both IP and OP requests in UMD, go to Step 8).</li> <li>c) Specialty Clinic enters specialty clinic statistics in IMSATS and 7252 database, go to Step 7).</li> <li>d) HCCUP Analyst enters off site service request data in CMD to perform cost of service estimates.</li> <li>e) Clinic physicians and nurses track and document follow up care needs for scheduled visits of the day. Go to Steps 5), 6) and 7).</li> <li>f) Management tracks daily medical care activities within the institution.</li> </ul> |
| 5) | <p>For Urgent Care, where inmates are treated for emergent or urgent healthcare needs:</p> <ul style="list-style-type: none"> <li>a) Personnel transfer the prisoner to the on-site urgent care unit for delivery of services.</li> <li>b) Information is entered into the Urgent Care IMSATS.</li> <li>c) If no follow-up care is required, then medical personnel treat and discharge the patient. If follow up care is required, jump to following steps based on the services needed:               <ul style="list-style-type: none"> <li>i) Primary Care, go to Step 5).</li> <li>ii) Specialty Care, go to Step 7).</li> </ul> </li> </ul>   |



**Medical Scheduling and Visit Flow – Institutional Level**

<b>Steps</b>	<b>Process Description</b>
6)	<p>For Primary Care:</p> <ul style="list-style-type: none"> <li>a) Information is received by Health Record Technician indicating care needed and timeframe for delivering that care.</li> <li>b) Information entered into Primary Care IMSATS for scheduling of appointment.</li> <li>c) Care is delivered on date of service. If follow up care is required, jump to one of the following steps based on the services needed:               <ul style="list-style-type: none"> <li>i) Primary Care, repeat Step 6).</li> <li>ii) Specialty Care, go to Step 7).</li> </ul> </li> </ul>
7)	<p>For Specialty Care:</p> <ul style="list-style-type: none"> <li>a) The unit OT inputs the RFS (CDC 7243) in IMSATS at the time its request by unit MD pending authorization by UM, then submits it to the specialty clinic.               <ul style="list-style-type: none"> <li>i) Specialty Clinic enters RFS onto IMSATS</li> <li>ii) Verify inmates via DDPS</li> </ul> </li> <li>b) The Specialty Clinic RN receives the RFS from the Unit OT/OPHU then submits them to the UM for approval. Go to Step 8).</li> <li>c) The designated LVN in the specialty clinic schedules all approved RFS's for the on site clinics in the Specialty Clinic IMSATS.</li> <li>d) On site?               <ul style="list-style-type: none"> <li>i) If yes, generate on site appointment schedule report. Specialty clinic and Infirmary/Outpatient Housing Unit (OPHU), where inmates are housed for psych/medical needs, provide non primary specialty services on site.</li> </ul> </li> <li>e) If no, go to Step 9).</li> </ul>
8)	<p>UM receives RFS and other appoint request reports and forms.</p> <ul style="list-style-type: none"> <li>a) Enter IP and OP data in UMD.</li> <li>b) If IP, CPS or POC determines IP needs and approve or disapprove service requests.               <ul style="list-style-type: none"> <li>i) If no, CPS or POC communicate with the medical provider who requested the services of the denial. The medical provider informs the inmate.</li> <li>ii) If yes, UM forward approved request to Specialty Clinic. Go to Step 9).</li> <li>iii) Once an inmate is admitted as an inpatient, UM performs the following:                   <ul style="list-style-type: none"> <li>(1) Performs concurrent review via phone or on site visit during the entire IP stay.</li> <li>(2) Generate daily report and document progress note for each IP case.</li> <li>(3) Use Interqual criteria to determine if additional IP stay is needed.                       <ul style="list-style-type: none"> <li>(a) If yes, patient stays in the hospital</li> <li>(b) If no, perform discharge planning. Patient discharge from hospital and return to OPHU for processing. Go to Step 1d).</li> </ul> </li> </ul> </li> </ul> </li> <li>c) If OP,               <ul style="list-style-type: none"> <li>i) Determine if the service meets the service guideline.                   <ul style="list-style-type: none"> <li>(1) If no, MARC approved?                       <ul style="list-style-type: none"> <li>(a) If no, UM informs the medical provider who requested the services of the denial. The medical provider informs the inmate.</li> <li>(b) If yes, go to Step 9).</li> </ul> </li> <li>(2) If yes, go to Step 9).</li> </ul> </li> </ul> </li> </ul>



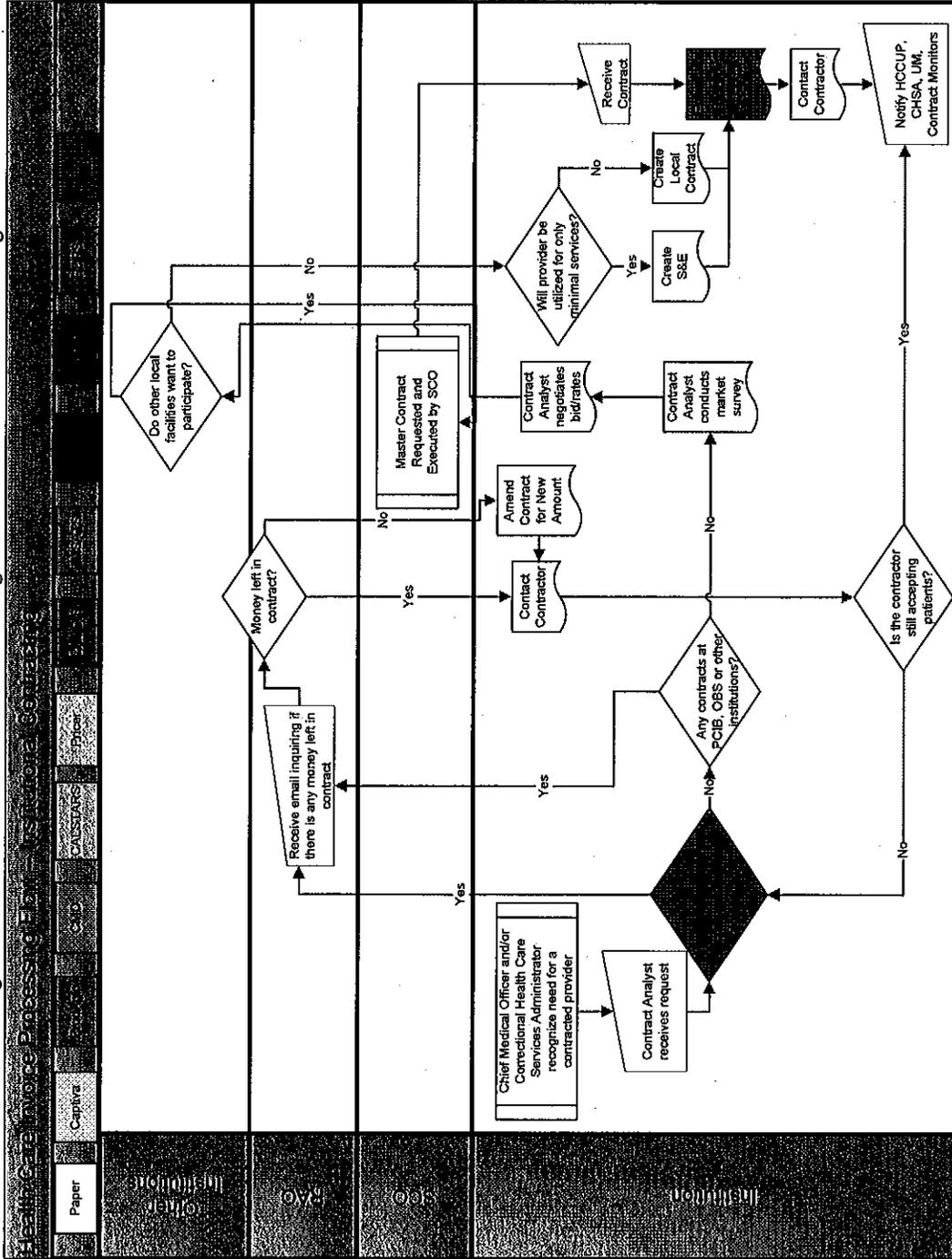
**Medical Scheduling and Visit Flow – Institutional Level**

**Steps Process Description**

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- 9) For external services provided by off site providers:
  - a) Receive UM authorization notice.
  - b) Specialty clinic designated RN coordinates/schedules requested healthcare services with outside healthcare providers via fax.
    - i) Schedule external appointment via IMSATS
    - ii) Generate CDC 7252 to be routed for appropriate signature in preparation for transporting inmates to external providers.
    - iii) Forward CDC 7252 to Felon Records or N-Record for documentation.
  - c) Receive confirmation from external providers.
  - d) Generate outside facility medical appointment schedule and distribute to:
    - i) OPHU
    - ii) HRT
    - iii) HCCUP
    - iv) AWHCS, Medical Transport Unit/Lieutenant, and Watch Office
  - e) Inmate agrees to receive service?
    - i) If yes,
      - (1) Document on Schedule and Transportation logs and update Daily Movement Sheet.
      - (2) Transport inmates to external provider as scheduled.
      - (3) Services provided to inmates by the off site providers
      - (4) Inmates return to OPHU for return processing. Go to Step 1d).
    - ii) If no, go to Step 10).
- 10) When an inmate refuse to attend to a scheduled appointment,
  - a) Inmate fills out CDC 7225
  - b) CDC 7225 forwarded to Unit OT, Specialty Clinic to update IMSATS accordingly.
  - c) Forward CDC 7225 to Felon Records or N-Record for documentation.
  - d) END.

Diagram 3 - Health Care Invoice Processing Flow – Institutional Contracting

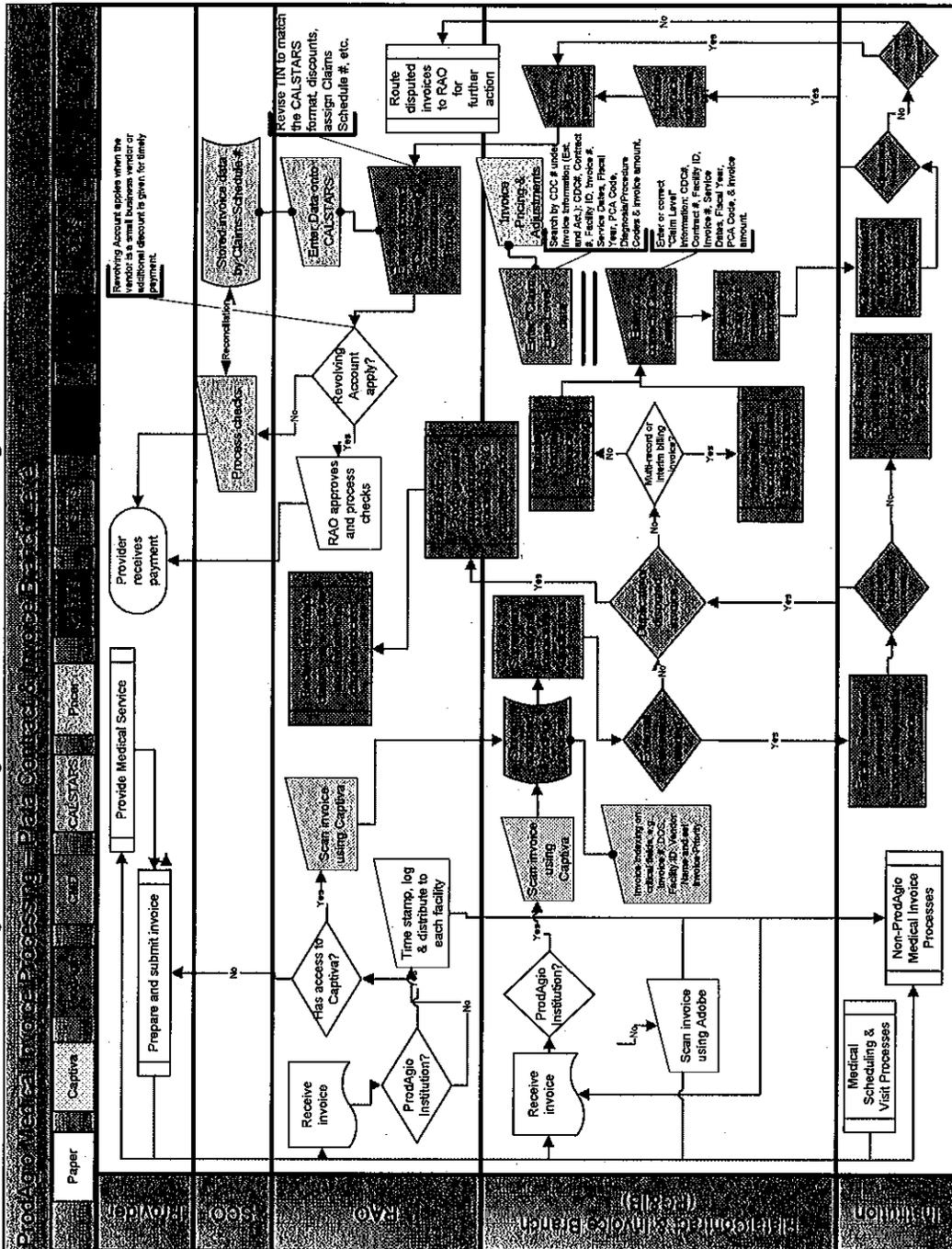




### Health Care Invoice Processing Flow – Institutional Contracting

<b>Steps</b>	<b>Process Description</b>
1)	The Chief Medical Officer and/or Correctional Health Care Services Administrator recognize the need for a contracted provider. An inmate completes a self-request for medical care (Form 7362). Go to Step 3).
2)	A request is sent to the Contract Analyst to find providers of the type identified.
3)	A request is sent to the Contract Analyst to find providers of the type identified.
4)	The Contract Analyst determines if there are any existing providers of that type. <ol style="list-style-type: none"> <li>If there are existing providers, go to Step 4).</li> <li>If there are no providers, go to Step 6).</li> </ol>
5)	The Contract Analyst now has an existing contract with funds left to be spent. In this case, the provider is contacted to determine if they are still accepting patients. <ol style="list-style-type: none"> <li>If they are no longer accepting patients, go to Step 3).</li> <li>If they are still accepting patients, then the Contract Analyst will contact the HCCUP analyst, the Correctional Healthcare Services Administrator, the Utilization Manager, and the Contract Monitors.</li> <li><b>END.</b></li> </ol>
6)	In the case that no contract exists, the Contract Analyst will determine if any contracts exist at PCIB, OBS or other institutions. <ol style="list-style-type: none"> <li>If a contract does exist, go to Step 4).</li> <li>If no contract exists, go to Step 7).</li> </ol>
7)	The Contract Analyst conducts a market survey and compiles necessary data.
8)	The Contract Analyst negotiates rates with the provider.
9)	The Contract Analyst contacts local facilities to determine if they would like to participate in the contract as well. <ol style="list-style-type: none"> <li>If they do wish to participate, go to Step 10).</li> <li>If no other facility wishes to participate, go to Step 12).</li> </ol>
10)	The Contract Analyst should request a Master Contract from SCO, which also executes this contract. After execution of the contract, SCO forwards it back to the Contract Analyst at the facility.
11)	The Contract Analyst receives the Master Contract from SCO. They enter the information into their list of eligible providers and contact the contractor. In addition the Contract Analyst will contact the HCCUP analyst, the Correctional Healthcare Services Administrator, the Utilization Manager, and the Contract Monitors. <b>END.</b>
12)	If no other facilities wish to participate in the contract, then the Contract Analyst can execute a local payment mechanism. If the Contract Analyst does not expect many services to be provided by the provider, they will execute a Services & Expense Contract. If the Contract Analyst expects many services to be provided, then they will execute a typical contract.
13)	After execution of the contract, the Contract Analyst enters the information into their list of available providers.
14)	The Contract Analyst then contacts the provider.
15)	The Contract Analyst will contact the HCCUP analyst, the Correctional Healthcare Services Administrator, the Utilization Manager, and the Contract Monitors.
16)	<b>END.</b>

Diagram 4 - ProdAgio Medical Invoice Processing - PC&IB Level





**ProdAgio Medical Invoice Processing – Plata Contract & Invoice Branch Level**

**Steps Process Description**

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- 1) A provider delivers medical services then prepares and submits the invoice.
- 2) The RAO or Plata Contract & Invoice Branch (PCIB) receives the invoice at which time they determine if the invoice is for a ProdAgio institution.
  - a) If it is a ProdAgio institution invoice, go to Step 4).
  - b) If not, go to Step 3).
- 3) If the institution is not on ProdAgio, then the RAO will time stamp, log and distribute the invoice, which will follow the flow described in the Non-ProdAgio Medical Invoice Flowchart. If the PC&IB received the invoice, they scan using Adobe before it enters the Non-ProdAgio Medical Invoice Flowchart.
- 4) RAO or PC&IB receives the ProdAgio invoices?
  - a) If the RAO receives a ProdAgio Invoice by mistake and if it does not have access to Captiva, then the invoice is returned to the provider to be re-submitted to PC&IB. If the RAO has access to Captiva, then the invoice is scanned into the Captiva system directly by the RAO.
  - b) If PC&IB receives the ProdAgio invoices, scan invoices using Captiva.
- 5) The invoice processing unit supervisor at the PC&IB assigns invoices to invoice processors based on institutions.
  - a) Invoice processor determines if external review is needed.
    - i) If external receive is needed, go to Step 6).
    - ii) If no external review is needed, go to Step 8).
- 6) The Facility Reviewer reviews the validity of the invoice.
  - a) If the invoice is approved go to Step 8).
  - b) If the invoice is not approved, go to Step 7).
- 7) The Facility Reviewer should mark the invoice as "disputed" and route it to the RAO for further action. Go to Step 10).
- 8) The PC&IB invoice processor reviews the invoice to ensure that it is neither disputed nor a duplicate.
  - a) If it is, go to Step 9).
  - b) If the invoice is not disputed or a duplicate, go to Step 11).
- 9) Determine if it is disputed or a duplicate,
  - a) If disputed, mark it as such in ProdAgio system and route it to the RAO for further action.
  - b) If duplicate, mark it as such in ProdAgio. END.
- 10) The RAO receives disputed invoices via ProdAgio from PC&IB and initiates the dispute process. END.
- 11) The invoice processor determines if the invoice is a multi-record or interim billing invoice for processing purposes.
  - a) If multi-record or interim bills, follow the multi-record or interim bills processes documented in the end-user manual.
  - b) If not, initiate normal invoice processing.
- 12) Invoice processors enter invoice data in both ProdAgio and CMD following different methods based on the invoice type described in Step 11).
  - a) Enter or adjust the "claim level" data, such as the CDC #, Contract #, Facility ID, invoice #, Service Dates, Fiscal Year, PCA Code and invoice amount.



**ProdAgio Medical Invoice Processing – Plata Contract & Invoice Branch Level**

**Steps Process Description**

- | Steps | Process Description   |
|-------|---|
|       | <ul style="list-style-type: none"> <li>b) Enter or adjust both "claim" and "claim line" data, e.g., CDC#, Contract #, Facility ID, Invoice #, Service Dates, Fiscal Year, PCA Code, Diagnosis/Procedure Codes and invoice amount, in CMD.</li> <li>c) Price each invoice payment amount using contracts, cheat sheets, pricer tools, or reference books, etc.</li> <li>d) Enter or adjust payment amount in both CMD and ProdAgio.</li> </ul>   |
| 13)   | The adjudicated invoice is routed to the appropriate facility for review and approval via ProdAgio workflow function.   |
| 14)   | <p>Once received at the facility, the Contract Manager reviews the invoice for payment.</p> <ul style="list-style-type: none"> <li>a) If an adjustment is necessary, the Contract Manager will forward updated information back to PC&amp;IB invoice processor.</li> <li>b) If no adjustment is necessary and the invoice is approved for payment via a marking of approval in ProdAgio.</li> <li>c) If the invoice is not approved for payment, then the invoice will be marked as "disputed" and routed to the RAO for further action. Go to step 10).</li> </ul>   |
| 15)   | Once an invoice is marked "approved" in ProdAgio, it is routed to RAO for payment via the ProdAgio workflow function.   |
| 16)   | <p>The RAO enters or correct "claim level" information on ProdAgio and process checks for Revolving Account invoices.</p> <ul style="list-style-type: none"> <li>a) ProdAgio data processing performed by RAO included but not limited to the following:               <ul style="list-style-type: none"> <li>i) Assign a Claim Schedule Number to each batch of invoices.</li> <li>ii) Correct "claim level" data and revise format inconsistencies found between ProdAgio and GL account, e.g., modify the TIN to match the CALSTARS format.</li> <li>iii) Adjust the invoice for discounts, e.g., small business discount or prompt pay invoices.</li> <li>iv) Fix other errors found.</li> </ul> </li> <li>b) Enter the invoice information into the CALSTARS system for check processing.</li> <li>c) Perform batch reconciliation and forward for RAO supervisor approval.</li> <li>d) If Revolving Account invoices, perform check processing in RAO. Go to Step 18).</li> <li>e) All else, go to Step 17).</li> </ul> |
| 17)   | SCO processes the checks and send to providers. A monthly reconciliation report is generated from the CALSTARS system and distributed to RAO's, PC&IB, and each institution for monthly reconciliation purposes.  |
| 18)   | The provider receives payment for services rendered.  |
| 19)   | END.  |





**Non-ProdAgio Medical Invoice Processing – Institutional Level**

<b>Steps</b>	<b>Process Description</b>
1)	When an inmate is scheduled for a medical appointment, the institutional HCCUP analyst is informed via various reports and forms distributed within each institution.
2)	The HCCUP Analyst receives notification of an inmate's expected utilization of services. The HCCUP Analyst then enters an estimated cost of the services in CMD.
3)	A provider delivers medical services then prepares and submits the invoice to the designated RAO.
4)	The designated RAO receives invoices, <ol style="list-style-type: none"> <li>a) Determine if it is a ProdAgio invoice. If yes, see ProdAgio Medical Invoice Process Flow.</li> <li>b) If no,               <ol style="list-style-type: none"> <li>i) Time stamp and sort invoice per each institution.</li> <li>ii) Forward invoices to the corresponding institutional HCCUP analyst.</li> <li>iii) Go to Step 7).</li> </ol> </li> </ol>
5)	Depending upon from which source the HCCUP Analyst receives the invoice, <ol style="list-style-type: none"> <li>a) If received from the designated RAO               <ol style="list-style-type: none"> <li>i) Time stamp and verify with RAO log sheet for each batch received.</li> <li>ii) Sort hard copy invoices by type, e.g., per diem, registry, RVP, Medicare Fee Schedule, etc.</li> <li>iii) Determine if the batch contains non-medical invoices, he or she will return the invoices to RAO for non-medical invoice processing. If the invoices belong to another institution, he or she can choose to return the invoices back to the RAO or forward directly to the appropriate institution.</li> <li>iv) The following steps are then performed for each invoice on paper:                   <ol style="list-style-type: none"> <li>(1) Registry invoices (hourly invoices) are forwarded and verified by Contract Monitors who are usually the supervisor or lead of each service area, e.g., Lead Lab Tech or Pharmacist II, etc. who signs the time card for the hourly registry staff.</li> <li>(2) All other invoices (RVP, Medicare Fee Schedule, Per Diem, etc.) are priced based on a review of the hard copy contract for the invoiced vendor or based on the HCCUP Analyst's personal and historical knowledge of the invoiced vendor or a simple "cheat sheet" taped on the cubicle wall. The priced amount is then handwritten on each invoice.</li> <li>(3) HCCUP Analyst also verifies inmates using OBIS. If an inmate belongs to another institution according to OBIS, the invoice will be returned to the RAO for further action.</li> <li>(4) If contractual disputes or issues are observed, the HCCUP Analyst will work with the Institutional Contract Analyst to resolve these issues or disputes. The Institutional Contract Analyst may contact the provider if there is a need to do so at this time.</li> <li>(5) The HCCUP Analyst also verifies with UM nurse regarding medical necessity of services performed and admit and discharge dates for each inpatient invoices.</li> </ol> </li> </ol> </li> <li>b) If received from provider directly, go to 7aiii).</li> </ol>



**Non-ProdAgio Medical Invoice Processing – Institutional Level**

<b>Steps</b>	<b>Process Description</b>
6)	Price each invoice via referencing to the findings from the above steps, contracts, pricer tools, cheat sheets, books, etc. and then write the payment amount on each invoice.
7)	Identify if the invoice is a duplicate. If yes, duplicate invoices should be shredded. END.
8)	The HCCUP Analyst verifies the inmate is a resident of the institution using DDPS and OBIS. <ul style="list-style-type: none"> <li>a) If they cannot verify this, then the invoice is sent back to the RAO or to the known institution per the discretion of the HCCUP analyst.</li> <li>b) If this information is verified, go to Step 9).</li> </ul>
9)	Enter the invoice data including the payment amount priced into CMD, then review and process the invoices. <ul style="list-style-type: none"> <li>a) The payment amount should correspond with the estimates entered in Step 2).</li> <li>b) Assign a batch number to all invoices contained in a batch.</li> <li>c) Print pay stickers for each invoice and affixed to each paper copy invoice.</li> </ul>
10)	Multiple invoices are grouped by their batch numbers and forwarded to the Contract Manager for review and approval.
11)	An invoice batch along with a "calculator print out" of invoice balance for the batch is then sent to the Contract Manager for approval. The Contract Manager determines if any adjustments are necessary. <ul style="list-style-type: none"> <li>a) If yes, go to Step 12).</li> <li>b) If not, go to Step 13).</li> </ul>
12)	The HCCUP Analyst receives adjustment instruction from Contract Manager and makes adjustment in CMD accordingly. Go to Step 14).
13)	The Contract Manager determines if the invoice should be approved for payment. <ul style="list-style-type: none"> <li>a) If it is approved, go to Step 14).</li> <li>b) If not, then the invoice should be marked "disputed" and routed to the RAO for further action.</li> </ul>
14)	The HCCUP Analyst batches approved invoices including basic accounting of each batch along with a face sheet.
15)	The HCCUP Analyst forwards to each invoice batch to the RAO for GL and check processing via the inter-office mail delivery system.
16)	When the RAO staff receives the batch from the HCCUP Analyst, he or she assigns the Claim Schedule number to each batch. The RAO staff enters basic invoice data (Tax ID, Invoice amount, etc.) along with the Claim Schedule number in CALSTARS.
17)	The RAO staff member also updates the MS Excel spreadsheet, which was originally used to create the face sheet when the invoices were forwarded to each institution for invoice processing, and perform basic reconciliation. A hard copy is then printed to be attached to each Claim Schedule folder then routed for approval by the RAO Management for check processing.
18)	SCO processes the checks and send to providers. A monthly reconciliation report is generated from the CALSTARS system and distributed to RAO's, PC&IB, and each institution for monthly reconciliation purposes.
19)	The provider receives payment for services rendered.
20)	END.



**Medical Scheduling/Visit and Invoice Processing - List of Acronyms**

<b>Acronym</b>	<b>Definition</b>
7252	Specialty Clinic Outpatient Database is an MS Access database that generates CDC 7252 (Request for temporary Release Removal for Treatment)
AWHCS	Associate Warden for Healthcare Services
CADDIS	Census and Discharge Data Information System tracks all internal and external IP admission and discharge data.
CALSTARS	It is the State of California's General Accounting and Ledger system which processes checks.
Captiva	A canning software application packaged with ProdAgio Contract Management system
CCG	Chancellor's Consulting Group is an external consulting firm retained by PC&IB to perform provider contract negotiation.
CCP	Chronic Care Program plans and deploys chronic disease care processes as well as tracking inmates with chronic diseases within each institution.
CDC #	California Department of Correction Number is assigned to each inmate when he or she is incarcerated and is unique to each inmate although repeat offenders will have new CDC # assigned for each incarceration until three-strike law applies.
CDC 7225	A form for inmates to fill out and signed when an inmate refused for a scheduled medical care.
CDC 7243	Request for Service (RFS) form used by clinicians and triage nurses to request for additional medical services for inmates both externally and internally.
CDC 7362	A form for inmates to fill out to request for medical care.
CDC 7552	Request for temporary Release Removal for Treatment form to filled and signed off by various management team prior to inmates are sent for external medical visits.
CDCR	California Department of Corrections and Rehabilitation
CHSA	Correctional Healthcare Service Administrator assumes the management of all medical care needs for an institution including the review and approval of final invoice payment.
CM	Contract Monitor tracks various hourly or registry staff and signs off on their time card.
CMA	Contract Manager reviews and approves invoices for final payment.
CMD	Contract Management Database is an MS Access database model which tracks vendor/provider contract data and is also used to process claims payment.
CMO	Chief Medical Officer
CPR	California Prison Health Care Receivership Corporation
CPS	Chief Physician & Surgeon
DDPS	Distributed Data Processing System tracks institutional inmate movement and demographic information.
DON	Director of Nursing
HCCUP Analyst	Health Care Cost and Utilization Program Analyst process CMS 1500, UB-04 and Registry invoices using CMD.
HCM	Healthcare Manager
HPS	Healthcare Program Specialist



**Medical Scheduling/Visit and Invoice Processing - List of Acronyms**

<b>Acronym</b>	<b>Definition</b>
HRT	Health Record Technician codes and enters data in CADDIS.
ICA	Institution Contract Analyst manages the contracting processes, negotiates and tracks contract terms and rates, initiates a new contract, resolve contract disputes with providers, etc.
IMSATS	Inmate Medical Scheduling and Tracking System tracks both internal and external scheduled medical appointments.
NCI	Navigant Consulting, Inc.
OBIS	Offender Based Information System tracks statewide movement of inmates including paroles, transfers, demographics, and other history.
OL	Operations Lieutenant updates and maintains daily movement sheet, schedule log and transportation log prior to inmates being transported to external providers.
OPHU	Outpatient Housing Unit is the on-site inpatient unit which admits inmates who require overnight observation but not external hospital admission.
PC&IB	Plata Contract & Invoice Brach is responsible for medical provider contracting and invoice processing activities for all CDCR institutions and is located on J St. in Sacramento.
PHS	Public Health System plans and deploys immunization and vaccination (TB or flu shots) or screening programs (TB screening) within each institution.
POC	Physician on Call
Pricer	RVP Pricer (MS Access) and other CMS pricer applications (MS Access & Web) are used to price invoices based on RVUs or DRGs depending upon the type of invoices.
ProdAgio	ProdAgio Contract Management is used as a contract document management and work flow application.
S&E	Service & Expense is a fixed and not to exceed annual amount set for a provider who provided services to CDCR inmates without an existing contract in place.
UM SRN	Utilization Management Supervising Registered Nurse oversees regional UM function.
UMD	Utilization Management Database is used by UM nurse to track all authorization, MARC minutes and results.