# TEXAS
## Health and Human Services Commission

**Thomas M. Suehs, Executive Commissioner**

# Office of Inspector General

## Performance Audit Report
## Texas Medicaid & Healthcare Partnership
## Prior Authorization Follow-up

**August 1, 2012**

**Douglas C. Wilson, Inspector General**

OIG Report No. 11-70-05290801-MA-03

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TEXAS HEALTH AND HUMAN SERVICES COMMISSION

THOMAS M. SUEHS
EXECUTIVE COMMISSIONER

August 1, 2012

Donna Migoni, Managing Director
Texas Medicaid & Healthcare Partnership
12357-B Riata Trace Parkway
Austin, TX 78727

Dear Ms. Migoni:

The Texas Health and Human Services Commission (HHSC), Office of Inspector General (OIG), Audit Section has completed its audit of the Texas Medicaid & Healthcare Partnership (TMHP) Prior Authorization Follow-up. The audit objective was to determine whether corrective action had been taken regarding Finding 1 of the Prior Authorization (PA) Audit issued by OIG on August 12, 2008.

The detailed findings and recommendations with management responses and auditor follow-up comments are presented in the enclosed final report.

OIG would like to thank you for the courtesy extended to us by TMHP and staff during the audit. If you have any questions or concerns, please do not hesitate to contact Richard Hutchinson at richard.hutchinson@hhsc.state.tx.us or (512) 491-2884.

Sincerely,

Gwendolyn D. McDade, CPA
Deputy Inspector General of Compliance
Office of Inspector General

Enclosure

# EXECUTIVE SUMMARY

**Audit Results (*Statement of Findings*)**

This audit is a follow-up to Finding 1 of the Prior Authorization (PA) Audit issued by OIG on August 12, 2008. That finding addressed the issue that not all the documentation that supports a Dental/Orthodontic PA request was reviewed. This issue has not been addressed as of the date of this audit. In the audit, we noted:

1. The Texas Medicaid & Healthcare Partnership (TMHP) is not hiring medically knowledgeable personnel.
2. The Dental Director is not approving all orthodontic PA requests.
3. The Quality Assurance Review tool does not address medical necessity.
4. Orthodontic PAs were authorized while on the open case list.
5. There are control weaknesses in the PA request approval process.
6. Duplicate PA requests were found.
7. The Handicapping Labio-Lingual Deviation (HLD) Score Sheet used by TMHP requires updating.
8. Quality Services Group (QSG) awarded points for QA review without proper evidence.
9. QSG Scores do not report on a PA request level.
10. The sampling formula used by QSG does not follow sampling theory.

**Objective *(Subject)***

The Health and Human Services Commission (HHSC) - Office of the Inspector General (OIG), Audit Section has completed its audit of TMHP Prior Authorization Follow-up. The purpose of the audit was to review the use, administration, documentation of, and compliance with all applicable rules for the PA process used for Dental and Orthodontic services. The objectives of the audit were to:

a. Follow-up on items identified in the OIG Audit Report *Prior Authorization* dated August 12, 2008, and

b. Address other items coming to OIG's attention during the course of the follow-up.

**Summary of Scope and Methodology *(Summary of Activities Performed)***

The scope of the audit was from September 1, 2008 to May 28, 2011.

The methodology used was to review prior audit reports, search TMHP Internet site for references, interview key personnel, review policies and procedures, review reports submitted by TMHP, test processes for compliance, and review systems for control weaknesses.

This audit was conducted under the authority granted to OIG in the Texas Government Code Section 531.102(h)(4). This performance audit was conducted in accordance with Generally Accepted Government Auditing Standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

**Background**

As of January 1, 2004, TMHP assumed responsibility for select parts of the Texas Medicaid program under contract with the Texas Health and Human Services Commission (HHSC). Affiliated Computer Services (ACS) State Healthcare, LLC, is the legal company name, and ACS is wholly owned by Xerox Corporation. The Prior Authorization (PA) function is a part of the contract between ACS and HHSC.

National Heritage Insurance Corporation (NHIC) was responsible for reviewing PA requests prior to TMHP assuming the contract. NHIC had a process whereby an NHIC Dentist/Orthodontist reviewed all Dental/Orthodontist Prior Authorization requests submitted. When TMHP took over the contract, this process changed. Under TMHP's process, providers were required to submit Dental/Orthodontic PA requests in the same manner as the NHIC contract required; however, TMHP did not require the Dental Director to review all Dental/Orthodontic PA requests. Under the TMHP process, the Dental/Orthodontic PA specialists reviewed provider/client eligibility, the supporting documentation, and if the Handicapping Labio-Lingual Deviation (HLD) score sheet equaled 26 or above If these requirements were met, the claim was deemed medically necessary and approved. This contributed too millions being expended on Medicaid Orthodontics in 2010.

## DETAILED FINDINGS AND RECOMMENDATIONS

**Finding 1 – TMHP is not hiring medically knowledgeable personnel**

TMHP is not hiring medically knowledgeable personnel to process dental PA requests as required by the contract. OIG reviewed the application and work history of 17 full-time PA Specialists and found that only one had any medical/dental experience.

Prior Authorization Contractor (PAC) – 17 of the contract requires TMHP to provide sufficient and adequate professional medical staff for staffing and managing the PA function, including medically knowledgeable PA analysts for processing the requests and availability of licensed medical professionals to provide consultative services regarding all Medicaid and Children with Special Health Care Needs Services Program (CSHCN) covered service types.

As a result, more orthodontic PAs were approved, which has resulted in the State of Texas spending excessive dollars for orthodontic procedures.

**Recommendation:**

TMHP should ensure that sufficient qualified PA specialists or licensed dentists are hired and instructed to review orthodontic PA requests.

***Management Response:***

*The contract requirement as written specifies the provision of "knowledgeable staff" and "the availability of licensed professionals to provide consultative services". TMHP submits that the "knowledge" was imparted via the training that is provided to the staff on the orthodontia policy, operational policies and procedures, work instructions, and additional tools such as Phoenix and PA workflow.*

*In the 2008 OIG Performance Audit report specific to Prior Authorization it acknowledged that the PA dental team members did not have dental licensees, it further went on to indicate approximately 10% of the authorizations at that time were escalated for review by a licensed dentist. (see attachment pg. 3 and 4). TMHP did not receive any direction from HHSC as a result of the audit or the findings to change this process.*

*TMHP further acknowledges HHSC's request for a change in policies and procedures to have all orthodontic cases reviewed by a licensed dentist. TMHP has been able to accommodate this change effective as of October 1, 2011.*

**Auditor's Follow-up Comment:**

The dental PA specialists who were not sufficiently knowledgeable were approving approximately 90% of all dental PA requests without review by the Dental Director.

In our 2008 report, the OIG indicated in finding #1 that the PA dental team members do not review the additional documentation required per the Texas Medicaid Provider Procedures Manual (TMPPM) and do not have the dental licenses neeessary to determine if the additional documentation supports the HLD index score.

Further, OIG indicated that the PA dental team members could be approving a portion of orthodontic request that are not for the treatment of severe handicapping malocclusion and other special medically necessary circumstances.

OIG then recommended that TMHP sample the orthodontic PA requests and have the sample reviewed by a licensed dental professional to ensure that the orthodontic PA requests met the criteria for Texas Medicaid Program benefits.

There is no indication that this finding or recommendation was considered by TMHP during the audit period.

Further, OIG consulted with HHSC Medicaid Chip Division (MCD) and HHSC MCD's comments are as follows:

Further PAC-17 clearly states that the vendor must provide adequate professional medical staff for staffing and managing the PA function, including MEDICALLY knowledgeable PA analysts for processing the requests. OIG consulted with HHSC and HHSC believed that the PA analysts processing the requests had some form of dental experience (dental assistants or hygienists). HHSC was not aware that the PA analysts were unskilled staff who were simply sent to a short training course prior to processing the prior authorizations.

HHSC further disagrees with TMHP's statement that they did not receive any additional direction from HHSC as a result of the audit or the findings to change the prior authorization process.

Additionally, the Texas Dental Practices Act (Texas Occupations Code Chapter 251) requires that a dentist make determinations of medical necessity. Throughout the contract, HHSC requires that ACS comply with the law. See, i.e. PAC 1 and PAC 12.

The duty is on TMHP to comply with all laws and regulations. The law requires that a dentist make the determination of medical necessity. The prior claims administrator complied with the law and the prior claims administrator worked with TMHP for a transition period. HHSC indicates that it has repeatedly attempted to work with TMHP to ensure compliance with the contract requirements.

**Finding 2 – The Dental Director is not approving all orthodontic PAs**

The Dental Director is not approving all Orthodontic PA Requests. Auditors reviewed a sample of 97 orthodontic prior authorization requests and found the Dental Director reviewed 15 of the requests (16%).

PAC-06 of the contract requires TMHP to research, analyze, and evaluate all PA decisions and ensure all medical facts are considered and documented prior to determination. TMHP policy and procedures for PA state that the Dental Director will review all documentation associated with the prior authorization request and authorize the request if medically necessary.

The PA specialists were instructed to forward only those PAs that had a score of less than 26 or had provider justification attached.

As a result, per the auditee, only 10% to 20% of the orthodontic PA requests were forwarded to Dental Director for review or approval.

**Recommendation:**

TMHP should ensure that all PA requests are forwarded to the Dental Director or other qualified individual for review prior to approval.

***Management Response:***

*The contract requirement as written specifies the provision of "knowledgeable staff" and "the availability of licensed professionals to provide consultative services". TMHP submits that the "knowledge" was imparted via the training that is provided to the staff on the orthodontia policy, operational policies and procedures, work instructions, and additional tools such as Phoenix and PA workflow.*

*In the 2008 OIG Performance Audit report specific to Prior Authorization it acknowledged that the PA dental team members did not have dental licenses; and it further outlined that approximately 10% of requests at the time were escalated to a Dentist for review.*

*TMHP did not receive any direction from HHSC as a result of the audit or the findings to change this process.*

*TMHP further acknowledges HHSC's request for a change in policies and procedure to have all orthodontic cases reviewed by a licensed dentist. TMHP has been able to accommodate this change effective as of October 1, 2011.*

**Auditor's Follow-up Comment:**

The dental PA specialists who were not sufficiently knowledgeable were approving approximately 90% of all dental PA requests without review by the Dental Director.

In our 2008 report, the OIG indicated in finding #1 that the PA dental team members do not review the additional documentation required per the Texas Medicaid Provider Procedures Manual (TMPPM) and do not have the dental licenses necessary to determine if the additional documentation supports the HLD index score.

Further, OIG indicated in the Prior Authorization Report dated August 29, 2008, that the PA dental team members could be approving a portion of orthodontic request that are not for the treatment of severe handicapping malocclusion and other special medically necessary circumstances.

OIG then recommended that TMHP sample the orthodontic PA requests and have the sample reviewed by a licensed dental professional to ensure that the orthodontic PA requests met the criteria for Texas Medicaid Program benefits.

There is no indication that this finding or recommendation was considered by TMHP during the audit period.

Further, OIG consulted with HHSC Medicaid Chip Division (MCD) and HHSC MCD's comments are as follows:

The Texas Statutes, Occupations Code, Title 3, Chapter 251 states that a person practices dentistry if the person represents to the public that the person is a dentist or dental surgeon or uses or permits to be used for the person or another person the title of "Doctor," "Dr.," "Doctor of Dental Surgery," "D.D.S.," "Doctor of Dental Medicine," "D.M.D.," or another description, including the use of the terms "denturist" or "denturism," that, directly or indirectly, represents that the person is able to **diagnose**, treat, or remove stains or concretions from human teeth; or provide surgical and adjunctive treatment for a disease, pain, injury, deficiency, deformity, or physical condition of the human teeth, oral cavity, alveolar process, gums, jaws, or directly related and adjacent masticatory structures. Chapter 256 requires a dentist to be licensed. The contract requires that TMHP comply with all laws and regulations, as indicated earlier in this document.

Further PAC-17 clearly states that the vendor must provide adequate professional medical staff for staffing and managing the PA function, including MEDICALLY knowledgeable PA analysts for processing the requests. HHSC believed that the PA analysts processing the requests had some form of dental experience (dental assistants or hygienists). HHSC was not aware that the PA analysts were unskilled staff who were simply sent to a short training course prior to processing the prior authorizations. PAC-17 also requires that the vendor must provide adequate professional medical staff for staffing and managing the PA function. PA analysts were not medically knowledgeable and were not able to diagnose conditions and make medical determinations based on medical records. A dentist would be the only professional able to make the final determinations.

HHSC staff indicated that they were unaware that the PA analysts were only reviewing the HLD scoring tool to make a determination of medical necessity.

Section 19.18.2 of the 2008 TMPPM requires the following for determination of the medical necessity via prior authorization:

> Requests for orthodontic services must be accompanied by all the following documentation: • An orthodontic treatment plan. The treatment plan must include all

procedures required to complete full treatment (such as, extractions, orthognathic surgery, upper and lower appliance, monthly adjustments, anticipated bracket replacements, appliance removal if indicated, special orthodontic appliances, etc.). The treatment plan should incorporate only the minimal number of appliances required to properly treat the case. Requests for multiple appliances to treat an individual arch are reviewed for duplication of purpose. • Cephalometric radiograph with tracing models • Completed and scored HLD sheet with diagnosis of Angle class (26 points required for approval of non-cleft palate cases). • Facial photographs. • Full series of radiographs or a panoramic radiograph; diagnostic-quality films are required (copies are accepted and radiographs will not be returned to the provider). • Any additional pertinent information as determined by the dentist or requested by TMHP's Dental Director Requests for crossbite therapy require properly trimmed models to be retained in the office and must demonstrate the following criteria: • Posterior teeth. Not end to end, but buccal cusp of upper teeth should be lingual to buccal cusp of lower teeth. • Anterior teeth. The incisal edge of upper should be lingual to the incisal of the opposing arch.

Through dialogue with TMHP staff and in reading the audit and SAR responses, HHSC staff believed TMHP was applying the approved medical policy requirements and criteria in making decision to approve or deny the orthodontic PAs. It now appears that TMHP staff never reviewed the diagnostic tools required to be submitted that were necessary to enable TMHP to make a determination of medical necessity. It also appears that the diagnostic tools were never imaged and that some were destroyed.

TMHP further states that they did not receive any additional direction from HHSC as a result of the audit or the findings to change the prior authorization process. HHSC disagrees with this statement. HHSC began meeting with TMHP in April 2009 to address the audit and issues related to non-compliance with the contract. TMHP has repeatedly misled HHSC as to what has been occurring.

**Finding 3 – The Quality Assurance Review tool does not address medical necessity**

The Quality Assessment Prior Authorization Tool is inadequate for meeting the intended purpose of satisfying the HHSC requirements of evaluating "medical necessity."

The tool contains various evaluation criteria including how long it took to process the PA, client eligibility, valid TPI/NPI, and if the Client Notification Letter was sent within one business day of the determination. The tool does not assess whether the medical necessity of the PA request was properly evaluated. A review of the QA Assessment Definitions document revealed that Medical Necessity is mentioned three times in the TMHP MAG-PA Non-phone document. The first and second mentions are examples of an incorrect reason for denying a PA request. The third mention is when there is a lack of response from the provider.

PAC-8 of the contract requires TMHP to conduct quality assurance reviews to ensure appropriateness of Medicaid and CSHCN PA analyst decisions.

The QA assessment tool does not provide a second level review of medical necessity unless the PA request is first forwarded to the Dental Director. The PA request is only forwarded to the Dental Director at the discretion of the reviewing PA specialist.

**Recommendation:**

TMHP should work with HHSC management to redesign the QA Prior Authorization Tool to clearly evaluate the determination of medical necessity.

***Management Response:***

*The QA tool does contain a criterion for assessing whether the medical necessity of the PA request was properly evaluated. Criterion # 4 on the non-phone QA tool (Version 4.0, 06/15/11) and criterion # 13 on the phone QA tool (Version 3.1, 05/01/10) each assess the medical necessity determination as to whether it was made according to Medical Policy and the Texas Medicaid Procedures Provider Manual (TMPPM). TMHP QA not only reviews Medicaid and CSHCN PA analyst decisions on a daily basis and reports biannually, per PAC-08 and PAC-48, but also performs reviews of Medical/Dental Director decisions per PAC-06.*

**Auditor's Follow-up Comment:**

QA tool (Version 4.0, 6/15/11) is outside the scope of the audit. A review of the tool provided does not address medical necessity. The closest criterion on the tool states "All medical facts are considered in PA determination...". Based on the evidence reviewed, neither the QA specialist performing the review, the PA specialist being reviewed, nor the Dental Director have been provided TMHP's definition of medical necessity.

Further, OIG consulted with HHSC Medicaid Chip Division (MCD) and HHSC MCD's comments are as follows:

In November of 2011 HHSC established a Quality Customer Service Workgroup comprised of State stakeholders to address their concerns about quality service issues with TMHP. The Workgroup members were already in the process of analyzing the effectiveness of TMHP's Quality Assurance Tools and began their analysis by Key Performance Requirements and Functional Activities under the contract as a first step to obtaining resolution to their issues.

Workgroup participants will continue to work with TMHP to ensure that each of the QA tools contain the appropriate assessment categories and proper weight assignments to assure that TMHP can effectively evaluate individual work performance in correlation with meeting expected outcomes, contract requirements and service level standards under the contract. The review of Prior Authorization QA tools will occur immediately as a high priority to ensure that the TMHP QA tools capture the appropriate categories, including those referenced in this report.

**Finding 4 – Orthodontic PAs were authorized while on the Open Case List**

The Medical Director is approving PA requests for providers which are on the OIG Open Case List. In a sample of 99 PA requests, auditors found four requests for providers that were on the Open Case List and approved by the Medical Director or Assistant Medical Director.

PA specialists are also currently approving PAs while Providers are on the Open Case List. In a sample of 99 there were 27 PAs identified as being paid while on the Open Case List.

In addition, there were also previous findings noted on a State Action Request of at least four requests where the PA Specialists approved PAs after the Dental Director review while the Provider was on Open Case List, Vendor Hold, when it was a duplicate, or when there was insufficient documentation.

Provider Recruitment Contractor (PRC) – 36 of the contract requires TMHP, prior to initial enrollment of a new provider in the Medicaid and CSHCN program, to verify electronically that the provider and the provider's business owner are not listed on the Medicaid and CSHCN and Medicare Exclusion listings nor are they listed on the HHSC Medicaid Program Integrity (MPI) list of providers under investigation. In addition, TMHP must verify electronically that a potential provider's physical or billing address, SSN, and tax ID are not associated with any of the providers on any of the above-mentioned lists. If TMHP determines that the potential provider is on these lists or has any of the associations listed above, TMHP is not to approve the application request and should refer the application to the HHSC OIG MPI. While the contract does not require TMHP to check the status of an existing provider before authorizing requests, OIG has communicated in previous audits and still believes that it is a good business practice to maintain the integrity of the Medicaid system.

The contract, as written between HHSC and TMHP, allowed providers which were under investigation to submit claims to TMHP.

The inherent risk associated with the current practice is that Medicaid funds could be expended for services by a provider who is currently under investigation or undergoing sanctions by OIG.

**Recommendation:**

TMHP should work with HHSC to incorporate into the contract the requirement to check the MPI open case list on an ongoing basis, in particular, prior to authorizing a PA.

***Management Response:***

*TMHP acknowledges the statement that the contract as written allows providers which are or were under investigation to submit claims to TMHP and further clarifies it also allows for prior authorization requests to be considered as it is written as well. Providers may remain under investigation without being debarred or excluded from the health care programs as determined by HHSC. TMHP is unsure why this item is included as a finding in this audit as there is no current contract requirement to perform this function prior to issuing the PA.*

**Auditor's Follow-up Comment:**

Auditors acknowledge that the contract does not require subsequent review of the Open Case List prior to approving a provider request. However, TAC Title 1, Section 371.1677 requires the provider to certify that all employees and contractors have been screened upon application and that none are excluded from participation in federally funded health care programs. It also requires that this screening be performed on an ongoing basis. As stated above, OIG believes it would be a good business practice to ensure all providers requesting prior authorization of a service are checked against the Open Case List, the Medicaid and CSHCN, and Medicare Exclusion listings.

**Finding 5 – There are control weaknesses in the PA request approval process**

Data integrity is impaired by having approved PA requests entered into the system:

- with dollars paid that show a deny reason code, and
- with an incorrect authorization area code.

The database contains PA requests that were initially denied, but later approved. These requests show dollars paid while still showing a deny reason code. Auditors sampled 95 of 3,796 PA's with a deny reason code and dollars paid. Further discussion with PA management confirmed that the PA requests were subsequently approved and paid and the deny code was not removed.

To further illustrate the weak control environment, Auditors tested and confirmed 518 PAs out of 339,917 that were incorrectly coded, with an inappropriate authorization area code. The Auth_Area_Cd (field name) did not agree with the type of PA Auth_Type_Cd requested. Auditors selected a judgmental sample of 30 PA forms to review the services actually requested by the providers. Auditors found that services were appropriate to the type of PA being approved but were entered into the system incorrectly.

Recipient Eligibility Contractor (REC) – 17 of the contract requires TMHP to maintain appropriate controls and audit trails to ensure that the most current recipient data is used during each claims processing cycle.

An absence of edit checks and a weakness in the business process could permit previously denied PA requests to be approved in the Phoenix and PA Workflow systems without removing the deny reason code.

Data integrity is compromised, and therefore subsequent decision making could be impaired.

**Recommendation:**

TMHP should implement system edit checks that prevent a PA request from being approved when a denial code is present and modify work instructions to direct PA specialists to remove the

deny reason code when a previously denied request is later approved. TMHP should also add a field or other indicator that would track approval/denial history.

***Management Response:***

*Prior authorizations initially denied and subsequently approved on appeal retain the original denial reason code. The denial reason code is left in place for audit and reporting purposes. For example, the prior authorization quarterly reports require that we determine volume of denied prior authorizations. A prior authorization can be denied in one month and approved a subsequent month. Currently the denial reason code is the only way to identify authorizations that were previously denied. This is functioning as the system was designed and to accommodate reporting requirements. Due to the compressed timeframe required on the audit response, TMHP, is unable to research the scope and further analyze the impact of other potential options/solutions. However, if HHSC would like to pursue a system modification on this specific recommendation we could do so following the existing SAR-SRI project process.*

**Auditor's Follow-up Comment:**

Auditors believe that a system modification to meet reporting requirements that would not require deny reason codes to remain on subsequently approved PA requests would be more consistent with best practices in ensuring data integrity. Additionally, TMHP acknowledged during field work that some of the PA requests did in fact have deny reason codes improperly associated with them. The Prior Authorization Dental Supervisor corrected several PA requests where the TMHP acknowledged the deny reason code was in error.

**Finding 6 – Duplicate PAs**

PA Specialists were approving duplicate PAs. OIG obtained a listing of 428 orthodontic PAs with an anesthesia code from TMHP. While the original intent of reviewing these PAs was not to identify duplicate payments, Auditors identified three of the 428 PAs reviewed with anesthesia codes that had duplicate payments on the same PA.

PAC-20 requires that TMHP receive, correctly disposition (i.e., approve, deny, modify, or determine incomplete), and enter into the PA system, prior authorization requests for all services, except for non-emergency ambulance requests, within three (3) business days of receipt. Any exception to this requirement will be determined by the State including but not limited to exceptions related to Alberto N. litigation.

A lack of due diligence on the part of PA specialists resulted in inappropriately approving PA requests.

As a result, additional funds could have been expended for duplicate payments.

**Recommendation:**

TMHP should ensure the PA specialists check all PA requests received against any prior PA requests to ensure there are no duplicates approved.

***Management Response:***

*TMHP has reviewed the examples provided in relation to this finding, and provides the following clarification. The prior authorization process is to establish medical necessity for the service in accordance with the medical/dental policies and procedures. A prior authorization is not a guarantee of payment. During claims processing, the presence of an authorization (if required for the service) is validated; however, that does not take the place of the edits and audits in the system that are established to help ensure that duplicate consideration for services does not occur. On the examples provided the authorizations reflect multiple details for a couple reasons; 1.) It is a generic code that can be used for multiple services (not necessarily duplicate services; but it is the same code with a different meaning). 2.) The national code actually maps to multiple local codes in our system; and 3.) The service is authorized for two different provider types (as in the case of the anesthesia examples) where both the facility and a provider submit an authorization. This practice occurs because the facility at the time the service is scheduled does not know who will actually render the service but wants to ensure all procedures are covered. When the provider who actually renders the service is identified, they submit the authorization for themselves. TMHP did not find any duplicate payments associated with the multiple details on the authorization examples in this finding.*

**Auditor's Follow-up Comment:**

Auditors acknowledge that there are edit checks and audits later in the system. TMHP is approving multiple PAs for the same client and the same service which increases the risk of multiple payments for the same service.

**Finding 7 – Handicapping Labio-Lingual Deviation (HLD) Score sheet Used by TMHP Requires Updating**

The HLD Score Sheet used by TMHP to evaluate medical necessity of dental prior authorizations requires improvement. The Score Sheet does not clearly express the crossbite exception that allows a score of less than 26 to be approved when a crossbite is indicated. TMHP management stated during an interview that "Cross bites can have a score of '0.' If it's a cross bite diagnosis, the score of 26 does not have to be met."

Texas Medicaid Provider Manual, Section 5.3.26 states "The case must be considered dysfunctional and have a minimum of 26 points on the HLD index to qualify for any orthodontic care **other than crossbite correction.**"

A poorly designed HLD score sheet has caused some PA requests to be denied and resubmitted by Providers.

Unnecessary and inappropriate prior authorization rejections can overburden Providers who have to resubmit prior authorization requests. The poorly designed score sheet could also cause litigation to be filed as in the case of California, *Brown v. Kizer*.

**Recommendation:**

TMHP should work with HHSC management to re-design the HLD score sheet to clearly indicate those cases that are exempt from the minimum score of 26.

***Management Response:***

*The HLD score sheet is a national score sheet that went into effect in 2001 (prior to this contract). TMHP does not believe that it was created by the HHSC or the prior claims administrator incumbent. If HHSC agrees with this recommendation then TMHP could work jointly with the HHSC to improve/clarify the tool through the existing Benefits Management Workgroup.*

**Auditor's Follow-up Comment:**

TMHP has acknowledged they would be willing to improve the HLD score sheet if HHSC initiates a State Action Request. However, each day the HLD score sheet is not revised, the client is potentially denied services they are entitled to receive.

Further, OIG consulted with HHSC Medicaid Chip Division (MCD) and HHSC MCD's comments are as follows:

HHSC stated their staff has already begun work on redesigning the authorization request form as well as revamping the current dental and orthodontic medical policies. The review is in the final stages and is expected to be completed in the Summer of 2012.

**Finding 8 – Quality Services Group (QSG) awarded points for QA review without proper evidence**

The PA process requires TMHP to provide a notification letter to the provider/client upon the approval or denial of a PA request. The QSG picks a sample of PAs to review for quality purposes. QSG has developed a tool with 21 criteria to evaluate the correctness of the approval/denial of a PA request. Using this tool, the QA Specialist can award up to 9 points to criterion #21, "Provider and Client Notification letters sent within one business day of the determination." When the QA Specialists could not see the notification letter on the TMHP portal, they would give the PA request 9 points and indicate a "technical issue." Auditors found four of 10 QA evaluations selected for review had this "technical issue."

The technical issue was actually a timing issue regarding the availability of letter on the portal for the QA specialist to review. From the time the letter is issued, it takes approximately

24 hours for the letter to be visible on the portal. If the QA specialist picks a PA to review the day after the PA specialist completes it, the letter will not be visible on the portal to the QA specialist.

According to a follow-up meeting with TMHP management, they have other means to verify the letter was sent to the client/provider. TMHP management provided a copy of a RightFax log that shows the items faxed along with the date, phone number, etc. However, Auditors were not told of this until the end of the audit, therefore the log was not tested.

PAC-8 of the contract requires TMHP to conduct quality assurance reviews to ensure appropriateness of Medicaid and CSHCN PA analyst decisions.

**Recommendation:**

TMHP management should ensure that QA specialists are instructed to award points only with proper evidence.

***Management Response:***

*During the audit period, QSG deducted points for the "Provider and Client Notification letters sent within one business day of the determination" criterion if, upon the initial review, the letter is not attached to the portal. However, PA could dispute this initial finding, saying that the letter was generated and sent, but that a known technical issue during that time (delay of letters posting to the portal) caused the letter to not be posted by the time of QA review. If disputed, QSG could use the RightFax log mentioned above to verify that a letter was indeed generated and sent; it just had not attacked to the portal by the time QSG did their review. If QSG could prove that the letter was generated and sent, the points were returned on the review with the explanation. The technical issue was resolved in 2011.*

**Auditor's Follow-up Comment:**

During an interview the Prior Authorization Director stated this was a known technical issue and points were not deducted. This could have affected the overall performance reports submitted to HHSC during this period causing an inflated score.

**Finding 9 – QSG Scores do not report on PA request level**

The QSG provides input to the monthly Operational Quality Assessment Report on the accuracy of the PA requests processed. These numbers represent the average accuracy score of all PA attributes tested rather than the accuracy of each PA request tested. Each review on the Monthly Operational Quality Assessment Report has an associated quality target. The target (in most cases) has been established internally by TMHP and agreed to by HHSC. The report calls for a 98% accuracy rate or above for PA  CSHCN and PA – Ambulance, Comprehensive Care Inpatient Psychiatric (CCIP), Comprehensive Care program (CCP), Dental, Home Health (HH),

and Special Medical Prior Authorization (SMPA). The contract does not define 'accuracy' and how the measurements should be calculated.

The QSG assessment tool in effect for May 2011 had 21 questions, or attributes, used to score the accuracy of PA requests processed. If, for example, a PA Specialist enters the information for a prior authorization but does not check for a duplicate prior authorization, the accuracy score for that transaction would be 97% (3 points out of a possible 100 points per the QSG's PA assessment tool). If the same PA Specialist makes the same mistake on 5 out of 20 PAs processed for the month, the score would be averaged at 99.25% (5 PAs at 97% plus 15 PAs at 100% divided by 20 PAs). If instead, each PA is rated as a pass/fail, the accuracy rate would be 75% (5 PAs failed and 15 passed).

General Operating Contractor (GOC)-65 and GOC-72 requires TMHP to "Prepare and submit to the State a monthly Operational Quality Assessment Report by program, with content, and in a media and format approved by the State." PRC-23 requires TMHP to maintain a 98% accuracy rate for processing provider applications and entering provider information into the system.

As a result of the unclear wording of the contract, TMHP was allowed to interpret the manner in which to report the processing of provider prior authorization requests.

At the end of fieldwork, TMHP explained that the reason for this scoring method is because they use the QSG scores for two purposes. They use the scores not only to report accuracy to HHSC, but also to assess the performance of the individual PA specialists. If they are too stringent, they run the risk of being over burdensome in how the PA specialists are rated (i.e., the number of points deducted for a minor technical deficiency that does not impact accuracy of the PA approval). At the same time, they must report scores that are meaningful for HHSC's purposes.

Reporting of results regarding PA accuracy can easily be misinterpreted. Consequently, these reports might not be a useful tool for decisions and actions taken as a result of such data.

This is a repeat finding from the prior OIG audit report, "TMHP Quality Services Group".

**Recommendation:**

TMHP should develop procedures to ensure that the points on the QSG PA assessment tool are weighted and scored independently for the two purposes for which they are intended. For example, TMHP could report the number of PAs that are actually in error for HHSC purposes, as opposed to how they were processed. For purpose of rating performance, TMHP could use the number of PAs processed with a meaningful score to enhance skill building.

***Management Response:***

*TMHP's procedures for sampling, scoring and reporting are contained in our Policies and Procedures which have been reviewed by HHSC. TMHP created the scoring methodology used to ensure an accurate representation of the error rate when considering all aspects of the prior authorization. Items are weighted to show significance in those items considered "most*

*important", as TMHP believes that assigning the same value to each criterion skews this significance. Some errors are considered to be clerical in nature and do not affect the overall outcome of the authorization, the client's ability to receive treatment or the provider's ability to file a claim for the services authorized. Those errors that are in conflict with a contract requirement or that may negatively impact the client or provider are given a higher point value than an error that is considered to be clerical in nature.*

**Auditor's Follow-up Comment:**

This process was implemented after the audit period and therefore not audited. Auditors understand this new process may better represent the scoring currently being reported but we cannot address that at this time because it has not been audited.

**Finding 10 – The sampling formula used by QSG does not follow sampling theory**

Auditors reviewed the process used to calculate the sample size to determine the accuracy rate of PA requests processed by the PA Specialists. The formula used to calculate the sample size for reporting accuracy of orthodontic PAs is based on a mixture of variable and attribute sampling theory. However, the quality control function is based on the sampling and testing of attributes. The current formula uses the average of all scores of PA transactions processed, rather than the number of transactions that passed the 98% target, as the basis for its historical error rate. Also, the formula does not take into account the number of attributes tested (attributes as measured on the PA Assessment tool).

PAC-40 requires TMHP to implement a quality assurance process and establish procedures to periodically sample and review PA requests to determine if PA policy and procedures are being followed. PAC-47 requires TMHP to report all quality assurance reviews conducted using nationally recognized standards to the State within timeframes, with content and in a media and format approved by the State.

The manner in which the formula is used does not clearly distinguish between qualitative and quantitative aspects. Determining whether or not a given variable is qualitative (attribute) or quantitative (variable) is necessary to ensure valid results. Attribute sampling generally produces percentages which, though somewhat counterintuitive, are not numbers in the same way that variables are numbers. Use of variable sampling results in a smaller sample size may not be statistically valid.

Misspecification of variable type may produce statistically invalid results, thus invalidating data reported to HHSC. The quality assurance plan may not meet the requirements established by the State.

In a follow-up meeting at the end of fieldwork with TMHP, management stated they had changed their sampling methodology to attribute sampling which had increased their sample size; however, they were still having problems reporting the results to HHSC. OIG Audit has not audited the new procedures.

This is a repeat finding from the prior OIG audit report, "TMHP Quality Services Group".

**Recommendation:**

We recommend TMHP QSG ensure consistency in the use of the formula for calculating sample size, the methodology used in testing the samples selected, and the method used in reporting the results of its monitoring efforts. Because the quality control function involves the sampling and testing of attributes, the attribute testing formula should be used. However, if variable formulas are to continue to be used, then TMHP should adjust the formula mathematically to achieve appropriate results. The sampling plan should be revised to use attribute sampling and TMHP should work with the State to define the 98% accuracy rate that will meet State requirements.

***Management Response:***
*QSG is using an attribute sampling formula in all areas as of 4/2/2012. This sampling methodology was implemented in the reporting process for March 2012 data.*

# APPENDIXES

# APPENDIX A

## OBJECTIVE, SCOPE, AND METHODOLOGY

**Objective:** The objectives of the audit were to determine:

a. follow-up on items identified in the OIG Audit Report *Prior Authorization* dated August 12, 2008, and

b. address other items coming to OIG's attention during the course of this audit.

**Scope:** The scope of the audit was from September 1, 2008 to May 28, 2011.

**Methodology:** The methodology used was to review prior audit reports, search TMHP Internet site for references, interview key personnel, review policies and procedures including WIKI instructions, review TMHP internal reports, test processes for compliance, and review systems for control weaknesses.

**Criteria Used:** Contract between TMHP and HHSC signed February 2, 2003, and June 30, 2010, the Change Control Process (State Authorization Request), and State Statutes, Occupations Code, Title 3, Chapter 251 and Chapter 256.

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# APPENDIX B

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