

**INTERIM REPORT OF PRIMARY PROVIDER MANAGEMENT COMPANY, INC.
TO THE CALIFORNIA DEPARTMENT OF MANAGED HEALTH CARE
REGARDING CLAIMS DEPARTMENT PRACTICES**

May 17, 2018

I. Introduction

Primary Provider Management Company, Inc. (“PPMC” or the “Company”) provides management services, including claims adjudication and provider dispute resolution, to a network of California independent physician associations, including Vantage Medical Group, Inc. (“Vantage”), First Choice Medical Group (“FCMG”), Los Angeles Medical Center IPA (“LAMC”), and Cal Care IPA (collectively, “The IPAs”). PPMC submits this Interim Report on behalf of The IPAs regarding the disclosure letter sent to the California Department of Managed Health Care (“DMHC”) on February 15, 2018 and captioned “RBO No. 10488: Examination of Vantage Medical Group, Inc. Claims Settlement Practices and Provider Dispute Resolution Mechanism Claims” (the “Disclosure Letter”). The factual information contained in this Interim Report was developed with the assistance of outside legal counsel, Sheppard, Mullin, Richter & Hampton LLP, and Navigant Consulting, Inc. The facts relate to the historical practices of PPMC’s Claims Department that were the subject of the Disclosure Letter.

The facts in this Interim Report are based on PPMC’s internal investigation conducted to date. Related external audits and investigations conducted by DMHC and various health plans are ongoing and may cause PPMC to discover additional facts through the course of responding to various requests for information.¹ Accordingly, PPMC reserves the right to supplement this Interim Report with additional facts as they may become available in the course of responding to parallel external audits and investigations.²

II. Executive Summary

On February 15, 2018, PPMC, through its corporate parent, disclosed to DMHC certain improper practices it recently discovered within its Claims Department (the “Claims Department”).³ PPMC takes these matters seriously and has invested substantial resources to investigate the facts and circumstances related to the Claims Department’s historical practices. PPMC is committed to identifying and addressing these improper practices including implementation of corrective actions as appropriate. Consistent with that commitment, PPMC has cooperated, and will continue to cooperate, with audits and other requests made by DMHC and health plans contracted with The IPAs.

PPMC has confirmed the following historical practices occurred in the Claims Department:

¹ On April 5, 2018, PPMC received a courtesy copy of DMHC’s March 16, 2018 letter regarding “DMHC Enforcement Matter 18-349,” which directed various health plans to “undertake a focused investigation of PPMC” in response to the Disclosure Letter.

² PPMC recently learned from DMHC and health plans of an anonymous letter that contains allegations of improper conduct regarding PPMC’s UM and Claims Departments. Although PPMC has not yet received a copy of the anonymous letter, it has commenced a comprehensive investigation of its UM processes and practices, including employee interviews, process reviews, data and reporting assessments, and audit results, among other action items. In addition, the Company commissioned an external audit of its UM function in January 2018 and retained outside advisors to initiate a comprehensive redesign of its UM program shortly thereafter as part of a comprehensive program to upgrade the personnel, processes, and technology engaged in its MSO operations. PPMC will provide an update of its Claims and UM-related findings when its investigations are completed.

³ A copy of the disclosure letter is attached as **Exhibit A**.

1. For several years, a small group of Claims Department personnel altered documents within claims audit files before presenting them to auditors from DMHC and health plans as though they were true and correct copies of original documents.
2. During approximately the same period, a staff member in PPMC's Information Services Department (the "IS Department"), acting at the direction of the same small group of Claims Department personnel, altered data related to closed claims within the "Xpress" database (used by PPMC to house claims-related data). These alterations were unauthorized and incorporated into documents included within claims audit files.
3. During approximately the same period, Claims Department personnel and the above-referenced IS Department staff member, acting at the direction of Claims Department management, applied specific data codes within the Xpress database to certain claims and forward-dated (*i.e.*, made more recent) their respective "date received" data fields. As a result of this improper practice, certain claims were late-paid without interest and excluded from subsequently prepared monthly timeliness reports and audit Universes submitted to DMHC and health plans.

These improper practices were conceived and implemented several years before PPMC was acquired by its current corporate parent in approximately July 2016, and they were stopped by PPMC's current Director of Claims immediately following their discovery in late January 2018.⁴ PPMC has implemented or is in the process of implementing a comprehensive set of corrective actions to address these practices.

To date, no facts have been identified that suggest these improper practices were known or directed by senior leadership above the Senior Director of Claims. The Senior Director of Claims and Director of Claims responsible for these improper practices voluntarily left PPMC in July and November, 2017, respectively. Further, no facts have been identified that suggest these improper practices were known to anyone outside of the Claims Department, except for a single IS Department staff member. And importantly, no facts have been identified that suggest these improper practices resulted in substandard quality of care for health plan members.

III. Investigation Background

A. The Current Director of Claims Identified Questionable Claims Department Practices

Wendy Magnacca, PPMC's current Director of Claims, started working at PPMC on November 3, 2017. PPMC's former Director of Claims, Mary Maxon, was still working at PPMC at this time. However, Ms. Maxon resigned from PPMC shortly thereafter, effective November 24, 2017.

⁴ The current Director of Claims was hired by PPMC's current corporate parent as part of a program to centralize and standardize its MSO functions and integrate them within an enterprise level Compliance Department.

On January 26, 2018, two Claims Auditors in the Claims Department, Mariam Siddiq and Joanne Saycon, requested guidance from Ms. Magnacca regarding preparation for an upcoming health plan audit of the Claims Department.⁵ Specifically, Ms. Siddiq and Ms. Saycon wanted to know whether they should prepare for the audit following the same practices in place under Ms. Maxon and the former Senior Director of Claims, Roberto Aguinaldo. Ms. Siddiq and Ms. Saycon told Ms. Magnacca that, under the direction of Mr. Aguinaldo and Ms. Maxon, Claims Auditors prepared for claims audits by reviewing claims audit files and “fixing” any problems before presenting the files to outside auditors.

This was the first time that Ms. Magnacca heard that such a practice had been used in the Claims Department. Prior to this incident, Ms. Magnacca had not supervised Claims Department personnel with respect to claims audit preparation.⁶ She told Ms. Siddiq and Ms. Saycon that they were not permitted to fix or otherwise alter the contents of audit files, and that they must immediately discontinue that practice.

On January 29, 2018, two additional Claims Department staff members, Sisi King, a Claims Auditor, and Vicki Verkler, a Claims Analyst III, separately spoke with Ms. Magnacca and reported their concerns regarding potential improper applications of “special project” and “goodwill” code designations to claims. Improper uses of these code designations could cause certain claims to be excluded from monthly reports and audit Universes provided to DMHC and health plans.

On January 29, 2018, Ms. Magnacca promptly escalated these issues to her enterprise-level supervisor, Veeral Desai.

B. Investigation Tasks

On February 2, 2018, PPMC’s corporate parent formed an internal investigation team led by attorneys from Sheppard, Mullin, Richter & Hampton, LLP (“Sheppard Mullin”) to investigate the issues escalated by Ms. Magnacca. On February 6, 2018, Sheppard Mullin retained Navigant Consulting, Inc. (“Navigant”) to assist with the internal investigation. PPMC provided Sheppard Mullin and Navigant with full access to its records, data, and personnel, including current and former employees. PPMC and its corporate parent further supported the internal investigation by making available human resources as needed to perform tasks directed and supervised by Sheppard Mullin and Navigant.

1. Witnesses Interviewed

Sheppard Mullin interviewed the witnesses listed in Table 1 as part of the internal investigation:

⁵ Ms. Siddiq and Ms. Saycon were subsequently reassigned to different positions within PPMC.

⁶ IEHP conducted a claims audit in November 2017, after Ms. Magnacca joined PPMC. However, she did not supervise the Claims Department’s effort to prepare audit files for that audit. Ms. Maxon supervised that effort.

Table 1

Witness Name	Witness Job Title	Date(s) of Interview(s)
Joanne Saycon	Claims Auditor	2/2/2018, 2/8/2018
Mariam Siddiq	Claims Auditor	2/2/2018, 2/8/2018, 3/14/2018
Vicki Verkler	Claims Analyst III	2/2/2018
Sisi King	Claims Auditor	2/2/2018
Michael Thomas	Sen. Database Administrator	2/5/2018
Rebecca Johnson	(Former) Application Development Manager	2/7/2018, 3/7/2018
Jeremy Encarnacion Morrison	Claims Supervisor	2/8/2018, 3/7/2018
Pauline Lozano	Claims Auditor	3/7/2018
Marvelene Phrakonekham	Claims Supervisor	3/7/2018
Michelle Shaner	(Former) Claims Auditor, (Current) Provider Relations Coordinator	3/14/2018
Karen Hiteshi	(Former) Chief Operating Officer	3/19/2018
Ion Baroi	(Former) Senior Vice President	3/19/2018
Mary Maxon	(Former) Director of Claims, no longer employed by PPMC	4/10/2018
Roberto Aguinaldo	(Former) Senior Director of Claims, no longer employed by PPMC	4/30/2018

Sheppard Mullin attempted to interview Diane Eagle and Amanda Castro, who are both former Claims Auditors and are no longer employed by PPMC. Both declined to be interviewed.

2. Documents Reviewed

Sheppard Mullin reviewed approximately 26,000 emails culled for relevance from over 2 million emails collected through the application of keyword and sender/recipient filters, date parameters, and other “smart” search techniques.

Navigant, at the direction of Sheppard Mullin, collected the computer hard drives used by the following current and former PPMC employees for evidence of potential document alteration:

- Robert Aguinaldo
- Ion Baroi
- Dianne Eagle
- Karen Hiteshi
- Rebecca Johnson
- Mary Maxon
- Jeremy Morrison
- Marvelene Phrakonekham
- Joanne Saycon
- Michelle Shaner

Navigant, at the direction of Sheppard Mullin, also forensically analyzed audit files prepared by the Claims Department in connection with the following audits for evidence of potential document alteration:

- 2014 Molina Healthcare audit of Vantage
- 2015 Inland Empire Health Plan (“IEHP”) audit of Vantage
- 2015 Blue Shield of California audit of Vantage
- 2016 Health Net audit of LAMC
- 2017 DMHC audit of Vantage

IV. Investigation Findings

A. Alterations of Claims Audit Files

1. General Overview of Claims Audit Process

DMHC and health plans that contract with The IPAs periodically audit PPMC's Claims Department. The audit process generally proceeds as follows:

First, the auditing entity (*i.e.*, DMHC or a health plan) requests from the subject IPA a set of data – commonly called a “Universe” – related to all claims that were closed within a specified time period (*e.g.*, January 1 through March 31 of a given year) and meet other specified criteria (*e.g.*, paid claims, contested claims, denied claims, Medicare claims, MediCAL claims, *etc.*). The auditing entity may specify the types of data to be provided for each claim in the Universe (*e.g.*, claim number, date of service, amount paid, *etc.*). PPMC provides Universes in response to these requests. Depending on the scope of the request, a Universe can include tens or hundreds of thousands of claims.

Second, the auditing entity selects from the Universe a subset of claims (generally numbering in the hundreds) to audit. The claims in this subset are commonly referred to as “audit selections.”

Third, PPMC prepares an audit file related to each audit selection that consists of copies of the claim form, the claim summary screen from the Xpress database, and other records related to PPMC's processing of the claim such as correspondence between PPMC and the claimant (*i.e.*, the provider), medical records related to the claimed service, explanation of payment (“EOP”), and bank-provided check registries showing the amounts and cashing dates of payment checks to providers. PPMC then provides the audit files to the auditing entity – in hard copy or in PDF format, depending on the preference of the auditing entity and the audit.

Finally, the auditing entity conducts its audit based primarily on the audit files.

2. Alteration of Documents Within Claims Audit Files

Beginning no later than September 2014, and potentially as early as sometime in 2013, and running through late-January 2018, a small group of Claims Department personnel (the “Audit Preparation Group”) reviewed and altered claims audit files to change content that would potentially result in a negative audit finding. The altered files would later be presented to DMHC or the health plans as though they were unaltered original files.

a. The Audit Preparation Group

The members of the Audit Preparation Group changed over time. The earliest members of the Group appear to have been Jeremy Encarnacion Morrison, Amanda Castro, and Dianne Eagle.⁷ Ms. Castro and Ms. Eagle resigned from PPMC some time ago.

⁷ Mr. Encarnacion Morrison claimed that he was initially instructed to alter claims audit files by Miriam Regalado, a Director of Claims whose tenure at PPMC preceded both Mr. Aguinaldo and Ms. Maxon's. No corroborating facts have been identified that support Mr. Encarnacion Morrison's claim.

Roberto Aguinaldo, the former Senior Director of Claims, became aware of the Audit Preparation Group's document alteration practice no later than early 2015. There are no facts to suggest that he affirmatively tried to stop the improper practice. Nor are there any facts suggesting that Mr. Aguinaldo affirmatively directed the Group's activities or altered audit files himself. Mr. Aguinaldo resigned from PPMC in late-July 2017. He stated that he was "drained out."

Former Director of Claims, Mary Maxon, also became aware of the Audit Preparation Group's document alteration practice no later than early 2015. She, like Mr. Aguinaldo, did not attempt to stop the improper practice. To the contrary, Ms. Maxon ultimately started directing the Audit Preparation Group's document alteration efforts, recommended specific alterations, and reviewed and approved alterations made by less experienced Group members. Ms. Maxon resigned from PPMC in late-November 2017. Her stated reason for resigning was "dissatisfaction with work."

Other Claims Department members of the Audit Preparation Group who altered audit files are (in approximate order of when they joined the Group): Michelle Shaner, Pauline Lozano, Marvelene Phrakonekham, Mariam Siddiq, and Joanne Saycon.

A Claims Analyst, Vicki Verkler, appears to have unwittingly facilitated the Audit Preparation Group's document alteration practice by helping them identify potential claim processing errors and advising on how to avoid them. Ms. Verkler stated that she believed her advice was prospective in nature, and did not realize that the Group was in fact using her advice to alter documents. Ms. Verkler stated that she ceased providing such assistance when she learned of the document alteration practice. No facts identified support that Ms. Verkler altered documents herself.

No facts have been identified that PPMC's senior management, Ion Baroi and Karen Hiteshi, who were with the Company from December 2012 until May 2018, were aware of the Audit Preparation Group's document alteration practice. All witnesses interviewed on this issue stated that they did not discuss the document alteration practice with PPMC's senior management, and that they did not believe that PPMC's senior management knew about the practice. To the contrary, members of the Audit Preparation Group stated that they attempted to conceal the practice from all non-Group members by, for example, making alterations outside of normal business hours. Mr. Baroi and Ms. Hiteshi denied any knowledge of the improper practice.⁸

b. Reasons for Document Alterations

All Audit Preparation Group members interviewed stated that they altered documents to avoid negative audit results. For example, if information appearing on the face of a document, such as a date, was (or was perceived to be) indicative that the claim was not timely dispositioned, such information would be removed from the document and/or replaced with innocuous information.

⁸ As further detailed in Section V (Corrective Action), Mr. Baroi and Ms. Hiteshi have been separated from PPMC, and controls to strengthen and require senior management's visibility into Claims Department practices are planned and in development.

It should be noted, however, that no evidence has been identified to suggest that PPMC’s senior management pressured or encouraged the Claims Department to improve its claims audit results through improper means.

c. Alteration Methodology

The Audit Preparation Group’s primary tool used to alter documents was Adobe software.⁹ PPMC, directly or through independent third party service providers, maintains a library of digital copies of original claims-related documents. Using Adobe software, Audit Preparation Group members created a digital copy of an original document; added, changed, or removed content from the copy; then printed the altered copy and inserted it into an audit file in place of the original.

No evidence has been identified suggesting that any original documents were altered or deleted using this method.

d. Types of Alterations

The following types of alterations to claims files have been identified:

(1) Dates and “Date Received” Information

Alterations to document dates and “date received” information have been identified.

- **Exhibit B** illustrates an alteration to the date of a document. The altered document was identified within the audit files prepared in connection with the 2017 DMHC audit of Vantage.
- **Exhibit C** illustrates an alteration to “date received” information. The altered document was identified within the audit files prepared in connection with the 2017 DMHC audit of Vantage.

(2) Secondary Payor Information

Alterations to information related to secondary payors have been identified.

- **Exhibit D** illustrates an alteration to information related to a secondary payor. The altered document was identified within the audit files prepared in connection with the 2015 Blue Shield of California audit of Vantage.

(3) Check Registries

Alterations to bank-generated check registries have been identified.

⁹ Mr. Encarnacion Morrison claimed to be aware of document alterations made using white-out. This claim has not been corroborated.

- **Exhibit E** illustrates an alteration to a bank-generated check registry where the date on which a check was cashed was changed. The altered document was identified within the audit files prepared in connection with the 2016 Health Net audit of LAMC.
- **Exhibit F** illustrates an alteration to a bank-generated check registry where a check was added. The altered document was identified within the audit files prepared in connection with the 2016 Health Net audit of LAMC.

(4) **Provider Dispute Resolution (“PDR”) Information**

Alterations to providers’ comments on PDRs have been identified.

- **Exhibit C** illustrates an alteration to a PDR where portions of the provider’s comments were removed.

e. **Results of Navigant’s Claims Audit Reviews**

Table 2 summarizes the results of Navigant’s review of historical claims audits.

Table 2

	2014 Molina Audit	2015 IEHP Audit	2015 Blue Shield of CA Audit	2016 Health Net Audit	2017 DMHC Audit
Date of Audit	9/17/2014	4/20/2015	7/17/2015	2/23/2016	8/7/2017
Claims in Audit	113	54	120	98	255 ¹⁰
Claims Altered	28	23	28	21	12
Total Alterations ¹¹	28	23	29	21	18
Document Alterations by Category					
Date/Date Received	-	-	-	2	7

¹⁰ The 2017 DMHC audit included claims processed by FCMG using its EZ CAP claims database system, which is separate from the Xpress database system used by PPMC. No alterations were identified with respect to claims processed by FCMG, and no facts identified suggest that FCMG was aware of or participated in any of the improper practices discussed in this Interim Report. FCMG joined PPMC’s network after PPMC was acquired by its current corporate parent.

¹¹ Some claims exhibited more than one alteration.

Claim Form/Secondary Payor Info	-	-	19	1	2
Check Registry	28	17	8	17	-
PDR	-	6	2	1	9

Based on witness interviews and Navigant’s historical claims audit sampling, there is a reasonable belief that the Audit Preparation Group altered audit files from the inception of the practice through January 2018, except for claims audits where PPMC was permitted to make its own audit selections. Witnesses from the Audit Preparation Group stated that they did not alter audit files when PPMC was allowed to make its own audit selections.

3. Alterations to Data Contained in the Xpress Database

Certain documents such as EOPs are printed from the Xpress database and added to audit files presented to DMHC and the health plans. The Audit Preparation Group, with the assistance of a member of the IS Department, Rebecca Johnson, altered certain original data in the Xpress database before printing related documents for use in the audit file. These alterations were not authorized by PPMC’s policies and procedures. Outside auditors receiving audit files that contained such documents would not know that the documents had been altered or were different from the original versions sent to providers.

This practice appears to have occurred over substantially the same period of time as the document alteration practice described in Section IV.A.2. It also appears that the Audit Preparation Group’s reason for making data alterations in Xpress was to avoid negative audit results.

a. Alteration Methodology

Claims Department personnel do not have rights to alter or change claim-related data in the Xpress database after the claim has been closed. Because outside auditing entities make audit selections from a Universe of closed claims, the Audit Preparation Group requested the assistance of Ms. Johnson, who had requisite database rights, to help them alter data related to closed claims. Specifically, members of the Audit Preparation Group sent emails to Ms. Johnson with requests to alter certain data and Ms. Johnson complied.

b. Types of Alterations

The following types of alterations to claims files have been identified:

(1) Claim Adjudication Codes

Alterations to claim adjudication codes have been identified.

- **Exhibit G** illustrates a request to change the denial codes related to a closed claim.

(2) **Notes and Remarks**

Alterations to notes, remarks, and other text incorporated into documents sent to providers have been identified.

- **Exhibit H** illustrates a request to add data in the remarks field of a closed claim.

c. **Alteration Scope**

Based on witness interviews and email review, there is a reasonable belief that the Audit Preparation Group altered Xpress data related to closed claims selected for audit from the inception of the practice through January 2018.

B. Manipulation of Reportable Claims Data

1. **Overview of “Goodwill” and “Special Projects”**

PPMC is required to process claims in compliance with applicable requirements, including rules governing timeliness. In the event that properly submitted claims are processed late, PPMC may be required to pay interest to the providers. Conversely, PPMC may deny claims that are not submitted in compliance with applicable requirements.

PPMC is permitted, but not required, to deny improperly submitted claims. It has the discretion to pay such claims as a gesture of “goodwill” (“Goodwill Claims”). Thus, where a provider’s claim is technically improper, but PPMC determines there is good cause to pay the claim anyway, it may do so. Because Goodwill Claims are paid at the discretion of PPMC, such payments generally do not include interest even if they are made outside of the timeframe applicable to properly submitted claims. PPMC identifies Goodwill Claims in the Xpress database by a specific user-applied code.

Similarly, providers are permitted to waive interest owed to them due to PPMC’s noncompliance with applicable processing timelines. For example, in instances where a provider has submitted a large number of claims and some of them were paid late by PPMC, the provider may agree to waive its claim to interest on the late-paid claims in exchange for early payment of its outstanding claims or payment of a lump sum to settle all claims submitted over a specified time period. PPMC personnel commonly refer to compromises or settlements with providers related to the payment of claims as “Special Projects.” In this Interim Report, claims paid pursuant to a Special Project agreement are called “Special Project Claims.” Like Goodwill Claims, PPMC identifies Special Project Claims in the Xpress database by a specific user-applied code.

PPMC’s Contracting Department negotiates the terms of Special Projects on behalf of PPMC. Formerly, Mr. Baroi was also involved in the process; he took the lead on negotiations where there was a significant amount of money at issue. The terms of Special Projects are documented in written agreements signed by PPMC and the settling provider.

2. Overview of Timeliness Reporting

PPMC, on behalf of The IPAs, is required to provide Monthly Timeliness Reports (“MTRs”), among other periodic reports, to DMHC and health plans. Generally, an MTR provides claims data related to PPMC’s compliance with applicable claims processing timelines. In addition, as discussed in Section IV.A.1, PPMC prepares claims data Universes in connection with audits conducted by DMHC and health plans. Universes, which provide selected data, but not the underlying documents, associated with closed claims, typically include data sufficient to show whether claims were timely processed.

Beginning in early 2014, if not earlier, PPMC excluded Goodwill and Special Project Claims from MTRs and Universes. Witnesses stated that because Goodwill Claims are claims that PPMC could have denied, they should not be considered when evaluating PPMC’s compliance with respect to processing properly submitted claims. They also explained that because providers agreed to compromise or settle their complaints regarding Special Project Claims in exchange for payment, there was no need to report Special Project Claims to DMHC or health plans. It has also been explained that Goodwill Claims were excluded from MTRs and Universes because DMHC and health plans did not expressly request that they to be included. For example, Mr. Aguinaldo stated that Ms. Maxon received permission from two health plans to exclude Goodwill and Special Project Claims from MTRs and Universes.

3. Misuse of Goodwill and Special Project Codes and Forward-Dating

No later than August 2014, and potentially earlier than that, Claims Department personnel had a practice of applying Goodwill and Special Project Claim codes to claims that did not qualify for either designation. Many personnel throughout the Claims Department (*i.e.*, beyond the members of the Audit Preparation Group) had been instructed to code claims that PPMC failed to pay within the applicable timeframe (also referred to as “out-of-compliance” or “OOC” claims) as *both* Goodwill and Special Project Claims in the Xpress database. In addition, Claims Department personnel knew how to, and did, forward-date the “received date” data field on OOC claims to make it appear that the applicable processing timeframe had not yet expired. This practice was corroborated by emails.

a. Effect of Code Misuse and Forward-Dating

It appears that by applying both Goodwill and Special Project Claim codes to OOC claims, Claims Department personnel were able to exclude such claims from MTRs and audit Universes. IS Department personnel, including Ms. Johnson and potentially others, modified queries used to gather MTR and audit Universe data from the Xpress database so that they excluded claims coded as Goodwill and Special Project.

b. Responsible Personnel

Emails suggest that multiple levels of Claims Department personnel, as well as Ms. Johnson from the IS Department, applied codes to, and forward-dated the received dates of, OOC claims as described above. According to emails, they received direction from Mr. Aguinaldo, Ms. Maxon, and Claims Department supervisors and auditors.

c. Unknown Scope

The scope and amount of the code misuse and received date changes described above are unknown. Two significant obstacles to determining the scope and amount of this improper practice are (1) the unreliability of received date data in the Xpress database (due to forward-dating), (2) de-centralization of records documenting legitimate Goodwill and Special Project Claims, such as Special Project agreements, which complicates differentiating between authorized and unauthorized Goodwill and Special Project Claims.

V. Corrective Action

PPMC appreciates the seriousness of the above-described improper practices and is committed to implementing corrective actions to prevent them from recurring. Substantial resources have been committed to effecting appropriate remediation. Some corrective actions were promptly implemented shortly after discovery of the improper practices. Other corrective actions are in the process of being implemented in parallel with the internal investigation and with the assistance of Navigant.

A. Corrective Actions Implemented

1. New Leadership

Current ownership has affected wholesale and transformational changes throughout PPMC's leadership and organizational structure. Since the acquisition of PPMC in July 2016, the following senior leaders have joined the Company:

- Joan Danieley, Group President, MSO Operations
- Manoj Mathew, M.D., President, California Market
- John Wallace, Chief Operating Officer, California Market
- Sunmi Janicek, Chief Compliance Officer
- John Avila, Senior Director of Information Services
- Wendy Magnacca, Director of Claims

2. Enhanced Systems

A transition from PPMC's legacy Xpress database system to a new CORE technology platform with enhanced reporting, controls, functionality and performance, is already underway. CORE, which is already implemented in non-California markets, is part of current ownership's investment in enhancing, centralizing, and standardizing its MSO functions, vendors, and capabilities. The new platform is expected to ensure payment and processing accuracy. In addition, the new technology will enable end-to-end auditing at the process, team, and oversight levels to ensure accurate, timely, and compliant reporting.

3. Improper Practices Stopped

The improper practices discussed in this Interim Report have been discontinued.

- PPMC senior management (Mr. Baroi and Ms. Hiteshi) have exited the Company.
- Claims Department leadership that directed and condoned the improper practices detailed herein have exited the Company.
- All Claims and IS Department personnel known to have altered audit files have been terminated.
- The current Director of Claims, Ms. Magnacca, has not been implicated in any of the improper conduct. She recognized the potential impropriety of the Audit Preparation Group's historical practices when they were brought to her attention in late January 2018 and immediately escalated the information to appropriate supervisors.
- Since late January 2018, Ms. Magnacca and/or Ms. Janicek have supervised the Claims Department's audit preparation activities, ensuring that (1) Universes include all required data, including claims coded as Goodwill and Special Project, and (2) audit files are not altered in any way.
- Since November 2017, the queries used to gather MTR data from the Xpress have been corrected so they no longer exclude claims coded as Goodwill or Special Project. In April 2018, Navigant completed a project to standardize PPMC's methodologies for preparing MTRs and Universes to ensure compliance with applicable requirements.
- Ms. Magnacca has had in-person meetings with all current Claims Department personnel known to have altered audit files. She will conduct periodic refresher meetings with all Claims Department personnel to ensure ongoing compliance with the corrective actions.
- Ms. Magnacca has provided in-person coaching to Claims Department personnel regarding the proper use of Goodwill and Special Project Claim codes. The Company's policies and procedures related to Goodwill and Special Project Claims are currently under review. Database-level corrective action to ensure compliance with these policies and procedures is in development.

B. Corrective Actions Planned

Table 3 sets forth additional corrective actions that are planned and/or in-progress, along with their estimated time to completion.

Table 3

Corrective Action	Est. Time to Complete
Company-wide compliance training, including tailored programs for the Claims Department and PPMC’s senior management.	Completed
<p>Implementation of controls to regulate access to document editing software (e.g., Adobe):</p> <p>(a) Restrict Claims Department personnel access to document editing software.</p> <p>(b) Establish enhanced process for granting approval for access to document editing software.</p>	<p>(a) Completed</p> <p>(b) Q3 2018</p>
<p>Navigant will develop the MTR reporting criteria and code to be used for MTR and universe reporting going forward.</p> <p>Pending completion of this corrective action item, Navigant will assist PPMC to ensure audit universes are accurate, complete, and comply with federal and state requirements.</p>	Q2 2018
Navigant will develop and document practices and procedures related to claims data reporting, including reporting requirements and criteria, quality controls, and training.	Q3 2018
Increased focus on compliance monitoring as a performance measurement and indicator relative to PPMC’s mid-level and senior management.	Q3 2018
Review and enhancement of PPMC’s legacy Compliance policies and procedures.	Q3 2018
Review and enhancement of Claims Department policies and procedures to ensure compliance with applicable regulatory requirements and best practices.	Q3 2018
<p>Implementation of company-wide internal audit unit at PPMC for compliance with PPMC’s internal policies and procedures, PPMC’s code of conduct, and all applicable statutory, regulatory, and contractual rules and requirements. Three levels of audits are planned to be implemented:</p> <ul style="list-style-type: none"> • Corporate Internal Audit – including audits of internal control processes of claims processing and other key functions 	Q4 2018

Corrective Action	Est. Time to Complete
<ul style="list-style-type: none"> • Compliance Internal Audit – to test compliance with applicable contract and regulatory requirements • Claims Department Audit – with attention to departmental quality control 	
Document policies and procedures relative to the use of Goodwill and Special Project Claims, and develop monitoring process to for quality and compliance.	Q4 2018
Implementation of controls to validate the integrity of claims audit files (to be executed in collaboration with Compliance Department)	Q4 2018
Implementation of internal reporting and monitoring functions to ensure data integrity, identify vulnerabilities, and control database access	Q4 2018
Implementation of database-level controls to regulate and record data and database changes effected by IS Department personnel	Q4 2018

VI. Conclusion

PPMC is committed to completing a thorough investigation of these improper practices and implementing appropriate corrective action and remediation. It will continue to fully cooperate with DMHC and health plan audits and investigations, and do everything possible to earn their trust.

Exhibits

Exhibit A

[February 15, 2018 Letter to DMHC]



February 15, 2018

VIA ELECTRONIC MAIL ONLY

Derek Jang
Corporations Examiner
Department of Managed Health Care
980 9th Street, Suite 500
Sacramento, CA 95814
Email: derek.jang@dmhc.ca.gov

Re: RBO No. 10488
Examination of Vantage Medical Group, Inc. Claims Settlement Practices and Provider Dispute Resolution Mechanism

Dear Mr. Jang:

I am the Chief Compliance Officer for agilon health ("agilon"), whose subsidiary, Primary Provider Management Co., Inc. ("PPMC"), serves as the MSO for Vantage Medical Group, Inc. The purpose of this letter is to promptly notify you of recently-discovered events that may call into question the reliability of certain information provided to DMHC in connection with the above-referenced audit (the "Vantage Audit"). The following preliminary information is provided out of an abundance of caution and is based on an ongoing internal investigation that recently commenced and is subject to revision.

In mid-2017, agilon embarked on a program to centralize and standardize its MSO functions. As part of that process, agilon hired a new Director of Claims for PPMC in November 2017. In late January 2018, the new Director of Claims first received information that PPMC Claims Department personnel, acting on instructions given by the former Director of Claims (whose employment terminated in November 2017), reviewed and potentially altered some records compiled in connection with the Vantage Audit before providing those records to DMHC. The new Director of Claims immediately reported this information to her senior management and a task force, including outside legal counsel and consultants, was promptly created to investigate the situation.

The initial investigation included an immediate analysis of the records comprising the 255 audit files provided to DMHC in connection with the Vantage Audit. While that analysis is not yet complete, I can report the following preliminary findings:

- 2 audit files contain records signed by a provider that exhibit alteration to the signature date
- 1 audit file contains a FedEx receipt that exhibits alteration to the document date



- 9 audit files contain Provider Dispute Resolution forms that had provider comments removed from the “Description of Dispute” field

We also have commenced an analysis of the claims data – also referred to as the “claims universe” – submitted to DMHC in connection with the Vantage Audit. Our initial findings identified a variance of approximately 25% of claims that potentially should have been included in the claims universe, but were not. At this point, we do not have a complete understanding of the methodology used to prepare the claims universe sent to DMHC or whether the potentially omitted claims influenced the outcome of the Vantage Audit. However, our preliminary analysis suggests that inclusion of the potentially omitted claims would not materially affect the aggregate timeliness of the claims universe.

The above-described analyses of the 255 audit files and the claims universe related to the Vantage Audit are only two components of our overall investigation plan. Additional research and analyses that are planned or already underway include (1) evaluation of the methodology used to prepare the Vantage Audit claims universe and whether it contained all required information; (2) reviews of additional audit files and claims universes prepared in connection with audits predating the Vantage Audit of all medical groups within PPMC’s MSO network, including audits conducted by health plans; and (3) reviews of historical Monthly Timeliness Reports submitted to health plans on behalf of all medical groups within PPMC’s MSO network to ensure that they comply with applicable requirements.

In addition, PPMC has already taken the following steps to prevent recurrence of the alterations noted above:

- The practice of altering audit files prior to audit submission has been stopped.
- Pending the outcome of our investigation, which may require additional corrective and/or disciplinary action, personnel believed to have altered the audit files related to the Vantage Audit have been reassigned and effectively walled-off from work related to preparing for, assisting with, or responding to, third party audits.
- All Claims Department personnel will receive targeted retraining and education.
- We have brought new leadership into the PPMC Claims Department and enhanced the Compliance organization’s oversight of the claims audit function.



We value our health plan relationships and take seriously the responsibilities entrusted to us. Compliance with the law, including operating our business ethically and with integrity, is one of our guiding principles. We are committed to conducting a thorough investigation and updating DMHC and health plans as we learn more about the issues discussed herein, including whether they affect any audits beyond the Vantage Audit. In the meantime, please do not hesitate to contact me with any questions or concerns.

Sincerely,

A handwritten signature in black ink, appearing to read "Sunmi Janicek".

Sunmi Janicek, Chief Compliance Officer
agilon health
sunmi.janicek@agilonhealth.com
(714) 651-5661

cc: Sheri Lester, Blue Shield of California
sheri.lester@blueshieldca.com

Sarah Lorange, Anthem Blue Cross of California
medicarecompofficer@anthem.com

Connie Snyder, Brand New Day/Universal Care, Inc.
compliance@universalcare.com

Janet Eisenberg, Care1st Health Plan
jeisenberg@care1st.com

Annie Hsu Shieh, Central Health Care
compliance@centralhealth.com

John Tanner, Molina Healthcare of California
medicarecomplianceofficer@molinahealthcare.com

Christy Brosse, Health Net, Inc.
Christy.k.brosse@healthnet.com

Pamela Jackson, Inland Empire Health Plan
jackson-p@iehpa.org

Exhibit B: Original

Original



January 27, 2017

Dear Customer:

The following is the proof-of-delivery for tracking number **633837820538**.

Delivery Information:

Status:	Delivered	Delivered to:	Receptionist/Front Desk
Signed for by:	S.PARK	Delivery location:	VICTORVILLE, CA
Service type:	FedEx Priority Overnight	Delivery date:	Jan 27, 2017 09:14
Special Handling:	Deliver Weekday		

NO SIGNATURE REQUIRED

Proof-of-delivery details appear below; however, no signature is available for this FedEx Express shipment because a signature was not required.

Shipping Information:

Tracking number:	633837820538	Ship date:	Jan 26, 2017
		Weight:	3.0 lbs/1.4 kg

Recipient:
VICTORVILLE, CA US

Shipper:
palm desert, CA US

Thank you for choosing FedEx.

Exhibit B: Altered



March 10, 2017

Dear Customer:

The following is the proof-of-delivery for tracking number 633837820538.

Delivery Information:

Status:	Delivered	Delivered to:	Receptionist/Front Desk
Signed for by:	S.PARK	Delivery location:	VICTORVILLE, CA
Service type:	FedEx Priority Overnight	Delivery date:	Mar 10, 2017 09:14
Special Handling:	Deliver Weekday		

NO SIGNATURE REQUIRED
Proof-of-delivery details appear below; however, no signature is available for this FedEx Express shipment because a signature was not required.

Shipping Information:

Tracking number:	633837820538	Ship date:	Mar 9, 2017
		Weight:	3.0 lbs/1.4 kg

Recipient:
VICTORVILLE, CA US

Shipper:
palm desert, CA US

Thank you for choosing FedEx.

Exhibit C: Original

16258R00K2-M

PROVIDER DISPUTE RESOLUTION REQUEST

<p>INSTRUCTIONS</p> <ul style="list-style-type: none"> • Please complete the below form. Fields with an asterisk (*) are required. • Be specific when completing the DESCRIPTION OF DISPUTE and EXPECTED OUTCOME. • Provide additional information to support the description of the dispute. Do not include a copy of a claim that was previously processed. • For routine follow-up status, instead of the Provider Dispute Resolution Form, please utilize our online web portal, located at https://portal.ppmcinc.com/Login.aspx, or fax your status request to (951) 280-8206. • Mail or fax the completed form to: <p align="right">Vantage Medical Group 2115 Compton Avenue, Dept. 300 Corona, CA 92881 Fax: (951) 280-8206</p>

*PROVIDER NAME: Genetic Disease Screening Program	*PROVIDER TAX ID # / Medicare ID #: 943402381
PROVIDER ADDRESS: 850 Marina Bay Parkway, Richmond, CA 94804	

PROVIDER TYPE MD Mental Health Professional Mental Health Institutional Hospital ASC
 SNF DME Rehab Home Health Ambulance Other Laboratory
(please specify type of "other")

CLAIM INFORMATION Single Multiple "LIKE" Claims (complete attached spreadsheet) *Number of claims:* _____

* Patient Name: Please see attached		Date of Birth: Please see attached
* Health Plan ID Number: Please see attached	Patient Account Number: Please see attached	Original Claim ID Number: (if multiple claims, use attached spreadsheet) Please see attached
Service "From/To" Date: (* Required for Claim, Billing, and Reimbursement Of Overpayment Disputes) Please see attached	Original Claim Amount Billed: \$221.60	Original Claim Amount Paid: \$0.00
DISPUTE TYPE		
<input type="checkbox"/> Claim		<input checked="" type="checkbox"/> Seeking Resolution Of A Billing Determination
<input type="checkbox"/> Appeal of Medical Necessity / Utilization Management Decision		<input type="checkbox"/> Contract Dispute
<input type="checkbox"/> Disputing Request For Reimbursement Of Overpayment		<input type="checkbox"/> Other:

* DESCRIPTION OF DISPUTE:
 The attached claims are paid by Vantage medical group for \$204.93 after applying \$2.07 reduction (1% rate reduction based upon the AB97 Reduction policy. We would like to inform that, GDSP is excluded in the AB97 Policy). Attached supporting document, indicating GDSP is excluded from the AB97 policy.

EXPECTED OUTCOME:
 We require full reimbursement of the billed charges. Effective July 1st, 2016 GDSP has implemented a increase in fee rates from \$207.00 to \$221.60. At present, Medi-Cal managed care plans are still paying us at \$207 until the fee schedule is updated in the Medi-Cal website (see attached Operating Instruction Letter (OIL) regarding the request for updating the rate). Once updated, Medi-Cal managed care plans are required to reimburse GDSP for the remaining amount.

Jeffery Adams	Analyst – RCM	(585) 471- 7880
Contact Name (please print)	Title	Phone Number
Signature	Date	() PPMC Fax Number

CHECK HERE IF ADDITIONAL INFORMATION IS ATTACHED (Please do not staple)

For Health Plan/RBO Use Only

TRACKING NUMBER _____	PROV ID# _____
CONTRACTED _____	NON-CONTRACTED _____

MAR 28 2017
RECEIVED

Exhibit D: Original

001143211432300500831PPMC		Archive 6
 PRIMARY	VANTAGE MEDICAL GROUP COMMERC 2115 COMPTON AVE STE 300 CORONA, CA 92881-7277	
HEALTH INSURANCE CLAIM FORM		
APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12		(PPM01)
PICA VANTAGE MEDICAL GROUP COMMERC		PICA
1. MEDICARE <input type="checkbox"/> MEDICAID <input type="checkbox"/> TRICARE <input type="checkbox"/> CHAMPVA <input type="checkbox"/> GROUP HEALTH PLAN <input type="checkbox"/> FECA (LUNG) <input type="checkbox"/> OTHER <input checked="" type="checkbox"/> (Medicare#) (Medicaid#) (ID#/DoD#) (Member ID#) (ID#) (ID#) (ID#)	1a. INSURED'S I.D. NUMBER (For Program in Item 1)	
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)	3. PATIENT'S BIRTH DATE SEX	4. INSURED'S NAME (Last Name, First Name, Middle Initial)
5. PATIENT'S ADDRESS (No., Street)	6. PATIENT RELATIONSHIP TO INSURED	7. INSURED'S ADDRESS (No., Street)
CITY STATE	8. RESERVED FOR NUCC USE	CITY STATE
ZIP CODE TELEPHONE (Include Area Code)		ZIP CODE TELEPHONE (Include Area Code)
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)	10. IS PATIENT'S CONDITION RELATED TO:	11. INSURED'S POLICY GROUP OR FECA NUMBER
a. OTHER INSURED'S POLICY OR GROUP NUMBER	a. EMPLOYMENT? (Current or Previous)	a. INSURED'S DATE OF BIRTH SEX
b. RESERVED FOR NUCC USE	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	b. OTHER CLAIM ID (Designated by NUCC)
c. RESERVED FOR NUCC USE	b. AUTO ACCIDENT? PLACE (State)	c. INSURANCE PLAN NAME OR PROGRAM NAME
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	VANTAGE MEDICAL GROUP COM
	c. OTHER ACCIDENT?	d. IS THERE ANOTHER HEALTH BENEFIT PLAN?
	<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO # yes, complete items 9, 9a, and 9d.
10d. CLAIM CODES (Designated by NUCC)		13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.
12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.		SIGNATURE ON FILE SIGNED DATE
SIGNED DATE		SIGNATURE ON FILE SIGNED DATE
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) QUAL.	15. OTHER DATE QUAL.	16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION
MM DD YY	MM DD YY	FROM MM DD YY TO MM DD YY
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE	17a. NPI	18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES
DN ARIF, MUHAMMAD MD	1396728564	FROM MM DD YY TO MM DD YY
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)		20. OUTSIDE LAB? \$ CHARGES
		<input type="checkbox"/> YES <input checked="" type="checkbox"/> NO
21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E)	ICD Ind.	22. RESUBMISSION CODE ORIGINAL REF. NO.
A. 136.8 B. 995.91 C. 590.10 D. 789.07	9	
E. F. G. H. I. J. K. L.		23. PRIOR AUTHORIZATION NUMBER
24. A. DATE(S) OF SERVICE From To B. PLACE OF SERVICE C. EMG D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) E. DIAGNOSIS POINTER	F. CHARGES	G. DAYS OR UNITS H. EPSI/Par I. ID. QUAL J. RENDERING PROVIDER ID. #
MM DD YY MM DD YY		
1 09042014 09042014 21 99231 ABC 115 00 1 NPI 1558516963		
2 09052014 09052014 21 99239 ABCD 309 00 1 NPI 1558516963		
3		
4		
5		
6		
25. FEDERAL TAX I.D. NUMBER SSN EIN	26. PATIENT'S ACCOUNT NO.	27. ACCEPT ASSIGNMENT? (If print, circle, one only)
		<input checked="" type="checkbox"/> YES <input type="checkbox"/> NO
28. TOTAL CHARGE \$ 424 00	29. AMOUNT PAID \$	30. Rsvd for NUCC Use
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (If print, circle, one only)	32. SERVICE FACILITY LOCATION INFORMATION	33. BILLING PROVIDER INFO & PH # (855) 207 8344
PPMC NOV 17 2014 11 03 2014	TEMECULA VALLEY HOSPITAL 31700 TEMECULA PARKWAY TEMECULA CA 92592-5896	TEMECULA VLY HOSP MED GRP INC PO BOX 1430 ARCADIA CA 91077-1430
SIGNED DATE a. 1679816201 b.	a. 1265874135 b.	
NUCC Information is available at: www.nucc.org		PLEASE PRINT OR TYPE CLASS 112
RECEIVED		APPROVED OMB-0938-1197 FORM 1500 (02-12)

Exhibit D: Altered

001143211432300500831PPMC



VANTAGE MEDICAL GROUP COMMERC
2115 COMPTON AVE STE 300
CORONA, CA 92881-7277

CARRIER

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 6212

(PPM01)

PICA VANTAGE MEDICAL GROUP COMMERC										PICA																																																													
1. MEDICARE <input type="checkbox"/> (Federal) MEDICAID <input type="checkbox"/> (Federal/State) TRICARE <input type="checkbox"/> (DoD) CHAMPVA <input type="checkbox"/> (Member ID#) GROUP HEALTH PLAN <input type="checkbox"/> (ID#) FECA <input type="checkbox"/> (LUNO) (ID#) OTHER <input type="checkbox"/> (ID#)										1a. INSURED'S ID. NUMBER (For Program or Item)																																																													
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)				3. PATIENT'S BIRTH DATE			SEX		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																																																														
5. PATIENT'S ADDRESS (No., Street)				6. PATIENT RELATIONSHIP TO INSURED			7. INSURED'S ADDRESS (No., Street)																																																																
CITY				STATE			8. RESERVED FOR NUCC USE		CITY																																																														
ZIP CODE				TELEPHONE (Include Area Code)			9. RESERVED FOR NUCC USE		ZIP CODE																																																														
8. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)				10. IS PATIENT'S CONDITION RELATED TO:			11. INSURED'S POLICY GROUP OR FECA NUMBER																																																																
a. OTHER INSURED'S POLICY OR GROUP NUMBER				a. EMPLOYMENT? (Current or Previous)			a. INSURED'S DATE OF BIRTH																																																																
b. RESERVED FOR NUCC USE				b. AUTO ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			b. OTHER CLAIM ID (Designated by NUCC)		b. INSURED'S DATE OF BIRTH																																																														
c. RESERVED FOR NUCC USE				c. OTHER ACCIDENT? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO			c. INSURANCE PLAN NAME OR PROGRAM NAME																																																																
d. INSURANCE PLAN NAME OR PROGRAM NAME				10a. CLAIM CODES (Designated by NUCC)			d. IS THERE ANOTHER HEALTH BENEFIT PLAN?																																																																
READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM. 12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE. I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.																																																																							
SIGNATURE ON FILE						SIGNATURE ON FILE																																																																	
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY 15. OTHER DATE MM DD YY 17. NAME OF REFERRING PROVIDER OR OTHER SOURCE DN ARIF, MUHAMMAD MD 17a. NPI 1396728564 18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY FROM 09 01 2014 TO 19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC) 21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY (Relate A-L to service line below (24E)) A. 136.8 B. 995.91 C. 590.10 D. 789.07 E. F. G. H. I. J. K. L. 22. RESUBMISSION CODE ORIGINAL REF. NO. 23. PRIOR AUTHORIZATION NUMBER																																																																							
24. A. DATE(S) OF SERVICE FROM MM DD YY TO MM DD YY B. PLACE OF SERVICE EMO C. D. PROCEDURES, SERVICES, OR SUPPLIES (Specify unusual circumstances) EMOPTHCPCS MODIFIER E. DIAGNOSIS POINTER F. CHARGES G. DAYS ON LATE H. SPRT (Percy Inv) I. ID. QUAL J. RENDERING PROVIDER ID.#																																																																							
<table border="1"> <tr> <td>1</td> <td>09042014</td> <td>09042014</td> <td>21</td> <td>99231</td> <td>ABC</td> <td>115 00</td> <td>1</td> <td>NPI</td> <td>1558516963</td> </tr> <tr> <td>2</td> <td>09052014</td> <td>09052014</td> <td>21</td> <td>99239</td> <td>ABCD</td> <td>309 00</td> <td>1</td> <td>NPI</td> <td>1558516963</td> </tr> <tr> <td>3</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>4</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>5</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> <tr> <td>6</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>NPI</td> <td></td> </tr> </table>												1	09042014	09042014	21	99231	ABC	115 00	1	NPI	1558516963	2	09052014	09052014	21	99239	ABCD	309 00	1	NPI	1558516963	3								NPI		4								NPI		5								NPI		6								NPI	
1	09042014	09042014	21	99231	ABC	115 00	1	NPI	1558516963																																																														
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30. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREE(S) OR CREDENTIALS (If none, print "N/A" on the reverse)				32. SERVICE FACILITY LOCATION INFORMATION				33. BILLING PROVIDER INFO 4 PH#																																																															
PPMC 11 03 2014				TEMECULA VALLEY HOSPITAL 31700 TEMECULA PARKWAY TEMECULA CA 92592-5896				TEMECULA VLY HOSP MED GRP INC PO BOX 1430 ARCADIA CA 91077-1430																																																															
SIGNED DATE				a. 1679816201 b.				a. 424 00 b.																																																															

PATIENT AND INSURED INFORMATION
PHYSICIAN OR SUPPLIER INFORMATION

RECEIVED

Exhibit E: Original



010 00026 01 PAGE: 5
 ACCOUNT: XXXXXXXXXXXX1895 11/30/2015

Bank

LOS ANGELES MEDICAL CENTER IPA

BUSINESS CKG-REG ACCOUNT XXXXXXXXXXXX1895

CHECKS											
CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT
3557722	11/05	61.54	3557767	11/09	65.02	3557812	11/10	48.84			
3557723	11/03	459.35	3557768	11/04	1,447.01	3557813	11/17	231.84			
3557724	11/03	56.63	3557769	11/04	111.82	3557814	11/12	23.76			
3557725	11/05	155.97	3557770	11/03	498.88	3557815	11/16	7.16			
3557726	11/02	392.40	3557771	11/06	238.30	3557816	11/17	36.78			
3557727	11/10	62.13	3557772	11/09	19.07	3557817	11/09	283.80			
3557728	11/03	1,599.63	3557773	11/09	4.19	3557818	11/16	191.97			
3557729	11/06	23.76	3557774	11/03	39.86	3557819	11/13	95.04			
3557730	11/05	50.55	3557775	11/05	58.61	3557820	11/17	16.12			
3557731	11/05	40.63	3557776	11/03	760.61	3557821	11/10	663.18			
3557732	11/04	831.78	3557777	11/03	1,066.33	3557822*	11/06	49.28			
3557733	11/12	56.63	3557778	11/05	6.23	3557824*	11/23	113.26			
3557734	11/04	22.04	3557779	11/09	219.85	3557826	11/06	78.38			
3557735	11/02	58.90	3557780	11/03	6.23	3557827	11/06	44.15			
3557736	11/02	67.67	3557781	11/02	120.38	3557828	11/06	37.42			
3557737	11/03	231.84	3557782	11/03	538.84	3557829	11/17	235.59			
3557738	11/04	135.34	3557783	11/09	36.78	3557830	11/12	23.76			
3557739*	11/02	39.97	3557784*	11/06	113.47	3557831	11/12	539.27			
3557741	11/13	225.37	3557786	11/03	88.30	3557832	11/16	127.99			
3557742	11/24	202.64	3557787	11/04	52.87	3557833	11/13	44.15			
3557743	11/12	56.63	3557788	11/05	1,159.99	3557834	11/12	2.30			
3557744*	11/03	602.99	3557789	11/03	30.06	3557835	11/06	87.61			
3557746	11/04	1,499.98	3557790	11/03	346.09	3557836	11/06	7.16			
3557747	11/27	264.52	3557791	11/06	44.15	3557837	11/13	739.16			
3557748	11/10	554.28	3557792	11/06	46.15	3557838	11/06	6.23			
3557749	11/06	15.18	3557793	11/18	56.63	3557839	11/09	255.56			
3557750	11/06	80.39	3557794	11/05	1,208.58	3557840	11/09	7.71			
3557751	11/10	60.63	3557795	11/24	20.09	3557841	11/09	143.12			
3557752	11/10	5,746.36	3557796	11/16	56.35	3557842	11/09	298.85			
3557753	11/04	38.05	3557797	11/06	37.58	3557843	11/12	1,282.56			
3557754	11/04	2,301.46	3557798	11/04	84.78	3557844	11/12	74.83			
3557755	11/09	104.31	3557799	11/03	514.24	3557845	11/10	67.67			
3557756	11/09	295.50	3557800	11/12	55.42	3557846	11/10	254.32			
3557757*	11/06	500.90	3557801	11/24	357.43	3557847	11/10	67.67			
3557759	11/09	90.44	3557802	11/05	369.69	3557848	11/13	9.03			
3557760	11/03	134.62	3557803	11/09	396.22	3557849	11/10	40.06			
3557761	11/03	141.47	3557804	11/12	63.86	3557850	11/10	120.50			
3557762	11/04	531.12	3557805	11/04	51.63	3557851	11/06	74.64			
3557763	11/16	64.11	3557806	11/10	580.82	3557852	11/13	119.76			
3557764	11/04	380.32	3557807	11/04	308.50	3557853	11/06	67.67			
3557765	11/04	734.45	3557808*	11/05	2,007.85	3557854	11/13	64.22			
3557766	11/03	67.67	3557810*	11/06	65.39	3557855	11/10	1,133.12			

* * * C O N T I N U E D * * *

Exhibit E: Altered



010 00026 01 PAGE: 5
 ACCOUNT: XXXXXXXXXXXX1895 11/30/2015

Audit

LOS ANGELES MEDICAL CENTER IPA

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BUSINESS CRG-REG ACCOUNT XXXXXXXXXXXX1895

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----- CHECKS -----								
CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT
3557722	11/05	61.54	3557767	11/09	65.02	3557812	11/10	48.84
3557723	11/03	459.35	3557768	11/04	1,447.01	3557813	11/17	231.84
3557724	11/03	56.63	3557769	11/04	111.82	3557814	11/12	23.76
3557725	11/05	155.97	3557770	11/03	498.88	3557815	11/16	7.16
3557726	11/02	392.40	3557771	11/06	238.30	3557816	11/17	36.78
3557727	11/10	62.13	3557772	11/09	19.07	3557817	11/09	283.80
3557728	11/03	1,599.63	3557773	11/09	4.19	3557818	11/16	191.97
3557729	11/06	23.76	3557774	11/03	39.86	3557819	11/13	95.04
3557730	11/05	50.55	3557775	11/05	58.61	3557820	11/17	16.12
3557731	11/05	40.63	3557776	11/03	760.61	3557821	11/10	663.18
3557732	11/04	831.78	3557777	11/03	1,066.33	3557822*	11/06	49.28
3557733	11/12	56.63	3557778	11/05	6.23	3557824*	11/23	113.26
3557734	11/04	22.04	3557779	11/09	219.85	3557826	11/06	78.38
3557735	11/02	58.90	3557780	11/03	6.23	3557827	11/06	44.15
3557736	11/02	67.67	3557781	11/02	120.38	3557828	11/06	37.42
3557737	11/03	231.84	3557782	11/03	538.84	3557829	11/17	235.59
3557738	11/04	135.34	3557783	11/09	36.78	3557830	11/12	23.76
3557739*	11/02	39.97	3557784*	11/06	113.47	3557831	11/12	539.27
3557741	11/13	225.37	3557786	11/03	88.30	3557832	11/16	127.99
3557742	11/24	202.64	3557787	11/04	52.87	3557833	11/13	44.15
3557743	11/12	56.63	3557788	11/05	1,159.99	3557834	11/12	2.30
3557744*	11/03	602.99	3557789	11/03	30.06	3557835	11/06	87.61
3557746	11/04	1,499.98	3557790	11/03	346.09	3557836	11/06	7.16
3557747	11/09	264.52	3557791	11/06	44.15	3557837	11/13	739.16
3557748	11/10	554.28	3557792	11/06	46.15	3557838	11/06	6.23
3557749	11/06	15.18	3557793	11/18	56.63	3557839	11/09	255.56
3557750	11/06	80.39	3557794	11/05	1,208.58	3557840	11/09	7.71
3557751	11/10	60.63	3557795	11/24	20.09	3557841	11/09	143.12
3557752	11/10	5,746.36	3557796	11/16	56.35	3557842	11/09	298.85
3557753	11/04	38.05	3557797	11/06	37.58	3557843	11/12	1,282.56
3557754	11/04	2,301.46	3557798	11/04	84.78	3557844	11/12	74.83
3557755	11/09	104.31	3557799	11/03	514.24	3557845	11/10	67.67
3557756	11/09	295.50	3557800	11/12	55.42	3557846	11/10	254.32
3557757*	11/06	500.90	3557801	11/24	357.43	3557847	11/10	67.67
3557759	11/09	90.44	3557802	11/05	369.69	3557848	11/13	9.03
3557760	11/03	134.62	3557803	11/09	396.22	3557849	11/10	40.06
3557761	11/03	141.47	3557804	11/12	63.86	3557850	11/10	120.50
3557762	11/04	531.12	3557805	11/04	51.63	3557851	11/06	74.64
3557763	11/16	64.11	3557806	11/10	580.82	3557852	11/13	119.76
3557764	11/04	380.32	3557807	11/04	308.50	3557853	11/06	67.67
3557765	11/04	734.45	3557808*	11/05	2,007.85	3557854	11/13	64.22
3557766	11/03	67.67	3557810*	11/06	65.39	3557855	11/10	1,133.12

* * * C O N T I N U E D * * *

Exhibit F: Original

Hanmi Bank™		010 00026 01	PAGE: 3		
		ACCOUNT: XXXXXXXXXXXX1895	11/30/2015		
Bank					
LOS ANGELES MEDICAL CENTER IPA					
=====					
BUSINESS CRG-REG ACCOUNT XXXXXXXXXXXX1895					
=====					
CHECKS					
CHECK #..DATE.....	AMOUNT	CHECK #..DATE.....	AMOUNT	CHECK #..DATE.....	AMOUNT
3557300*11/05	263.53	3557445*11/06	61.72	3557552 11/04	146.14
3557303*11/02	23.76	3557447 11/02	105.42	3557553 11/27	113.26
3557305 11/02	16.12	3557448 11/02	58.90	3557554 11/13	282.14
3557306*11/12	314.01	3557449*11/04	107.00	3557555 11/05	1,294.48
3557308*11/02	226.34	3557452*11/09	63.18	3557556 11/16	102.91
3557310*11/03	207.20	3557454 11/23	64.26	3557557 11/16	15.44
3557316*11/02	1.63	3557455 11/16	56.63	3557558 11/04	74.39
3557322*11/03	23.63	3557456 11/02	71.28	3557559 11/13	12.60
3557327 11/18	686.29	3557457*11/03	37.42	3557560 11/23	107.46
3557328*11/16	7.71	3557460*11/19	73.90	3557561 11/13	23.76
3557330*11/06	30.22	3557462*11/18	50.40	3557562 11/10	250.35
3557333*11/03	85.92	3557464*11/02	153.94	3557563 11/09	79.30
3557338 11/02	53.58	3557466*11/02	23.76	3557564 11/04	4.91
3557339*11/03	122.98	3557469 11/05	68.21	3557565 11/06	550.86
3557342*11/02	172.88	3557470 11/02	49.68	3557566 11/03	6.30
3557344 11/06	498.48	3557471*11/05	112.41	3557567 11/04	6.48
3557345*11/19	56.63	3557474*11/16	68.79	3557568 11/02	276.57
3557349*11/13	154.14	3557479*11/02	6.72	3557569 11/10	37.41
3557355*11/02	531.12	3557483*11/02	513.89	3557570 11/09	130.65
3557362*11/02	23.76	3557493*11/04	67.67	3557571 11/10	34.84
3557364*11/10	120.92	3557497 11/02	76.37	3557572 11/02	149.52
3557367*11/02	4.67	3557498 11/02	23.76	3557573 11/02	67.67
3557370*11/12	292.26	3557499*11/03	67.67	3557574 11/02	56.63
3557372*11/05	294.29	3557501 11/02	140.71	3557575 11/13	71.38
3557377*11/05	6.23	3557502*11/02	251.44	3557576 11/02	257.27
3557389*11/02	6.12	3557509*11/03	1,143.91	3557577 11/04	124.64
3557396 11/12	149.48	3557515 11/02	54.93	3557578 11/09	278.52
3557397 11/02	170.27	3557516*11/18	70.78	3557579 11/02	49.68
3557398 11/02	1.39	3557521 11/13	156.20	3557580 11/09	65.45
3557399*11/02	206.77	3557522 11/03	19.01	3557581 11/05	90.83
3557408 11/02	327.38	3557523 11/02	79.30	3557582 11/02	423.34
3557409*11/02	42.40	3557524*11/02	79.30	3557583 11/04	182.92
3557411*11/16	48.70	3557526*11/02	154.14	3557584 11/16	73.98
3557420*11/02	213.59	3557528 11/04	66.80	3557585 11/06	3.97
3557425*11/02	296.10	3557529*11/02	191.25	3557586 11/03	1,432.39
3557427 11/06	237.36	3557534*11/03	1,554.67	3557587 11/02	79.30
3557428 11/19	108.00	3557544 11/09	59.88	3557588 11/04	631.74
3557429*11/06	23.76	3557545 11/16	200.00	3557589 11/02	481.52
3557431*11/02	157.88	3557546*11/03	879.50	3557590 11/03	139.71
3557437 11/12	23.76	3557548*11/03	85.28	3557591 11/05	71.90
3557438*11/16	184.64	3557550 11/04	186.50	3557592 11/02	6.23
3557440*11/12	6.23	3557551 11/16	74.53	3557593 11/05	67.67
*** CONTINUED ***					

Exhibit F: Altered



010 00026 01 PAGE: 3
 ACCOUNT: XXXXXXXXXXXX1895 11/30/2015

LOS ANGELES MEDICAL CENTER IPA

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BUSINESS CRG-REG ACCOUNT XXXXXXXXXXXX1895

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----- CHECKS -----					
CHECK #	DATE	AMOUNT	CHECK #	DATE	AMOUNT
3557300*	11/05	263.53	3557445*	11/06	61.72
3557303*	11/02	23.76	3557447	11/02	105.42
3557305	11/02	16.12	3557448	11/02	58.90
3557306*	11/12	314.01	3557449*	11/04	107.00
3557308*	11/02	226.34	3557452*	11/09	63.18
3557310*	11/03	207.20	3557454	11/23	64.26
3557316*	11/02	1.63	3557455	11/16	56.63
3557322*	11/03	23.63	3557456	11/02	71.28
3557327	11/18	686.29	3557457*	11/03	37.42
3557328*	11/16	7.71	3557460*	11/19	73.90
3557330*	11/06	30.22	3557462*	11/18	50.40
3557333*	11/03	85.92	3557464*	11/02	153.94
3557338	11/02	53.58	3557466*	11/02	23.76
3557339*	11/03	122.98	3557469	11/05	68.21
3557342*	11/02	172.88	3557470	11/02	49.68
3557344	11/06	498.48	3557471*	11/05	112.41
3557345*	11/19	56.63	3557474*	11/16	68.79
3557349*	11/13	154.14	3557479*	11/02	6.72
3557355*	11/02	531.12	3557483*	11/02	513.89
3557362*	11/02	23.76	3557493*	11/04	67.67
3557364*	11/10	120.92	3557497	11/02	76.37
3557367*	11/02	4.67	3557498	11/02	23.76
3557370*	11/12	292.26	3557499*	11/03	67.67
3557372*	11/05	294.29	3557501	11/02	140.71
3557377*	11/05	6.23	3557502*	11/02	251.44
3557389*	11/02	6.12	3557509*	11/03	1,143.91
3557396	11/12	149.48	3557515	11/02	54.93
3557397	11/02	170.27	3557516*	11/18	70.78
3557398	11/02	1.39	3557521	11/13	156.20
3557399*	11/02	206.77	3557522	11/03	19.01
3557408	11/02	327.38	3557523	11/02	79.30
3557409*	11/02	42.40	3557524*	11/02	79.30
3557411*	11/16	48.70	3557526*	11/02	154.14
3557420*	11/02	213.59	3557528	11/04	66.80
3557425*	11/02	296.10	3557529*	11/02	191.25
3557427	11/06	237.36	3557534*	11/03	1,554.67
3557428	11/19	108.00	3557544	11/09	59.88
3557429*	11/06	23.76	3557545	11/16	200.00
3557431*	11/02	157.88	3557546*	11/03	879.50
3557437	11/12	23.76	3557548	11/03	85.28
3557438*	11/16	184.64	3557549*	11/04	207.39
3557440*	11/12	6.23	3557551	11/02	74.53
					3557593 11/05 67.67

* * * C O N T I N U E D * * *

Exhibit G

Message

Sent: 11/15/2017 3:46:42 PM
To: Joanne Saycon [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=84378196e6ec44f2a4ecaf164060d906-Joanne Sayc]
CC: Marvelene Phrakonekham [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=057772ad02424818954c207ec2d51299-Marvelene P]; Jeremy Encarnacion-Morrison [/o=ExchangeLabs/ou=Exchange Administrative Group (FYDIBOHF23SPDLT)/cn=Recipients/cn=7207ee04da4a4e1d928e1c2a44019aa5-Jeremy Enca]
Subject: RE: 17038R06X9 - Medical Claim

doen

Thank you,

*Rebecca Johnson
Manager Application Development*

Direct (951) 280-7880
Main (951) 280-7700
Email rjohnson@ppmcinc.com

From: Joanne Saycon
Sent: Monday, November 13, 2017 1:02 PM
To: Rebecca Johnson <rjohnson@ppmcinc.com>
Cc: Marvelene Phrakonekham <marvelenep@ppmcinc.com>; Jeremy Encarnacion-Morrison <jmorrison@ppmcinc.com>
Subject: 17038R06X9 - Medical Claim

Hi Rebecca,

For the claim referenced above, can you please add Z11 in the adjustment field so an Overturn Letter can be generated? This is for the health plan audit due today.

- 1 Procedure

From Date	To Date	Loc	CPT	Mod	DX	Deny	CPT Description	Units	Billed	Allowed	CDB	Balance	Captured	Withhold	Copay	Paid	Benefit
01/17/2017	01/17/2017	11	73562	LT	1,2,3		RADEX KNE 3'VIEWS	1	96.00	38.43	0.00	38.43	0.00	0.77	0.00	37.66	RADIOLOGY

Thank you,



Joanne Saycon
Claims Auditor
Ext 7839

Exhibit H

Message

From: Rebecca Johnson [/O=BENEFIT MANAGEMENT SYSTEMS/OU=EXCHANGE ADMINISTRATIVE GROUP (FYDIBOHF23SPDLT)/CN=RECIPIENTS/CN=REBECCA JOHNSONDFE]
Sent: 6/5/2017 5:43:11 PM
To: Pauline Lozano [/O=BENEFIT MANAGEMENT SYSTEMS/OU=BMS_SD/cn=Recipients/cn=paulinel]
Subject: RE: #15007R23FL-M BLUE SHIELD COMMERCIAL PDR'S AUDIT

done

Thank you,

Rebecca Johnson
Manager Application Development

Phone (951) 280-7880
Email rjohnson@ppmcinc.com

From: Pauline Lozano
Sent: Monday, June 05, 2017 9:25 AM
To: Rebecca Johnson <rjohnson@ppmcinc.com>
Subject: #15007R23FL-M BLUE SHIELD COMMERCIAL PDR'S AUDIT

Hi Rebecca,

Please remove denial codes D7 and D9 and replace with D175

Please remove ADJ code X59 and replace with X6

Please add comment printed on Voucher: Initial appeal not filed within 365 day filing limit. No further reviews.