2009

Medi-Cal Payment Error Study

State of California
Health and Human Services Agency
Department of Health Care Services

Fee-For-Service Program

DHCS
California Department of HealthCareServices

Table of Contents

I. Executive Summary **3**

II. Background **10**
1) Medi-Cal Overview 10
2) Medi-Cal Integrity 11
3) MPES Overview 11
4) Provider and Service Categories 11
5) Main Payment Error Types 12
6) MPES 2007 Findings 12

III. MPES Design and Methodology **13**
1) Process 13
2) Data Universe and Sample 14
3) Sample Stratification 15
4) Error Types 16
5) Estimation 17
6) Confidence Intervals and Formulas 19

IV. Findings **21**
1) Summary Statistics 21
2) Claims Processing Errors 23
3) Payment Errors 23
a) Payment Errors by Type 23
b) Payment Errors by Stratum (Provider Type) 25
c) Potential Fraud Errors 32
4) MPES Study Comparison of Significant Items (MPES 2005 – MPES 2009) 38

V. Significant Actions Taken After Previous MPES Studies **40**

VI. Other Error Studies **42**

VII. Conclusions and Recommendations **45**

Appendix 1 - Review Protocols **47**

Appendix 2 - MPES 2007 Summary Statistics **50**

Appendix 3 - Error Codes **59**

Appendix 4 - Description of all Claims in Error **65**

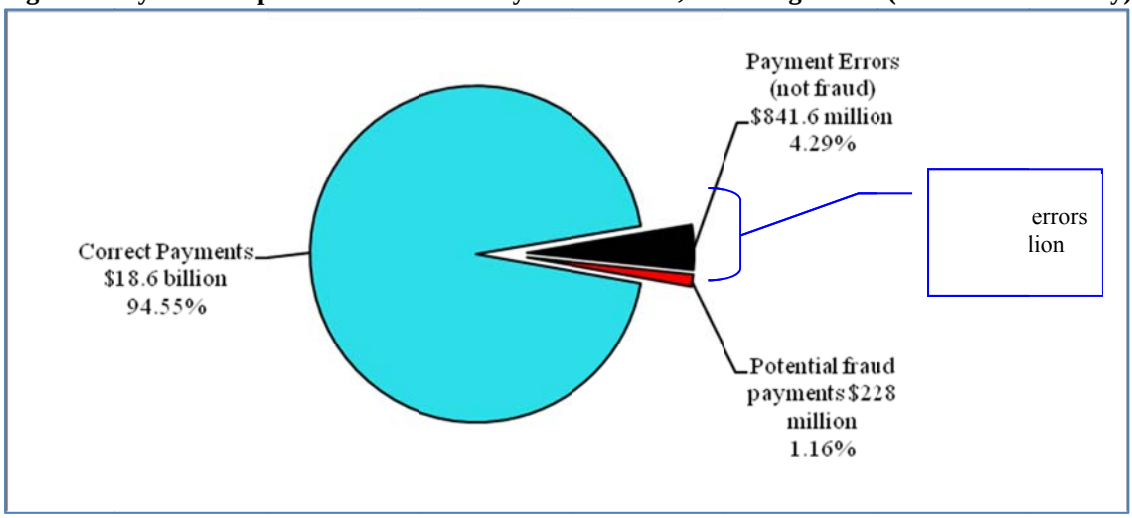
Appendix 5 - Glossary **114**

I. Executive Summary

The completion of the California Department of Health Care Services (DHCS) 2009 Medi-Cal Payment Error Study (MPES) documented 94% payment accuracy, thus continuing a trend in payment error reduction. The study continues to identify vulnerability in the Medi-Cal Fee-For-Service (FFS) program, which represents nearly half of the approximate $38 billion Medi-Cal program. DHCS analyzes the factors that influence the payment errors and determines what actions and strategies need to be taken to reduce the cost associated with those errors. This is the fourth study since 2005.

As with previous studies, MPES 2009 continues to show that the overwhelming majority of payments, 94.55 percent of total payments made in FFS medical programs, were billed and paid appropriately (Figure 1).

Figure 1-Payment Proportions Paid Correctly and in Error, Including Fraud (Estimated Annually)



A comparison of MPES 2009 with the three previous MPES studies (2005-2007) shows that the MPES overall payment error rate has continued to decline over time, from 8.40% in MPES 2005, to 5.45% in MPES 2009 (see Figure 2 below).

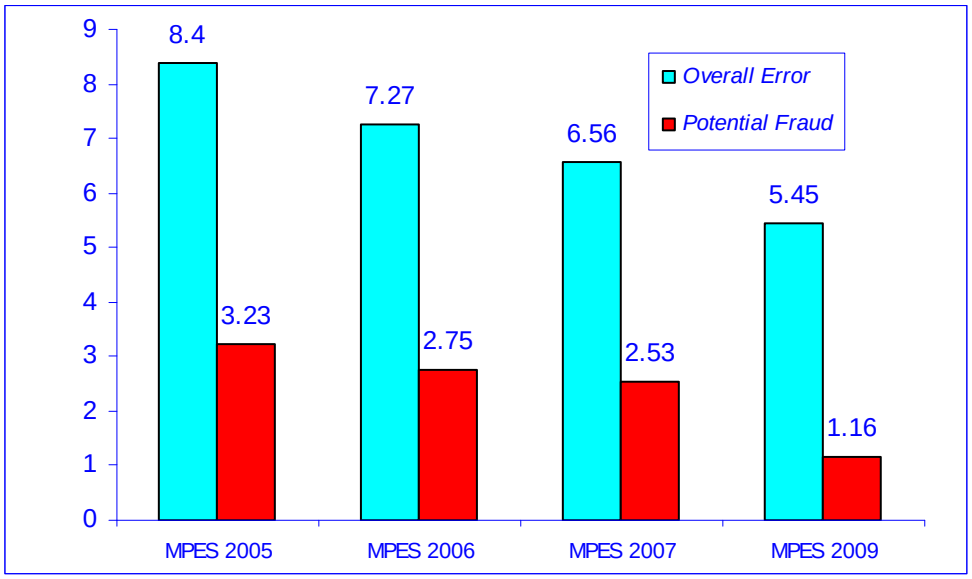
Extrapolating from the MPES 2009 sample to the program as a whole, the 5.45 percent error rate equates to a projected nearly $1.07 billion of the total payments made for non-dental FFS medical services in 2009. This extrapolated amount represents the percentage of payment error attributable to Medi-Cal program payments "at risk"[1] of being paid inappropriately, due to findings related to simple provider mistakes to more significant findings indicative of intentional fraud or abuse.

The 5.45 percent payment error shows an improvement over the 6.56 percentage rate of MPES 2007. Due to the growth of the Medi-Cal FFS program, the projected $1.07 billion payments in

[1]The term "at risk" is used because the $1.07 billion figure is derived by applying the 5.45 percnt rate to the program's annual expenditure level.The $1.07 billion cannot be considered as actual payments made in error unless all of the individual services that are questionable are identified through a complete medical review or audit of all services submitted for payment and found to be in error.

error in MPES 2009 is slightly higher than the nearly $1.05 billion payment errors found in MPES 2007 (see column 4 of Table 1).

Figure 2 - Error Rates, Including Potential Fraud Rates for MPES 2005-MPES 2009



MPES 2009 also reveals that 1.16 percent of the total payments in the FFS medical programs was for claims that disclosed characteristics of potential fraud. The 1.16 percent is equivalent to an annual amount of $228 million in potential fraud. The potential fraud rate has decreased from 3.23 percent in MPES 2005 to 1.16 percent in MPES 2009.

To determine accurately how much of the payment errors constitute actual fraud would require complete criminal investigations of the claims. This would be cost- and resource-prohibitive. For this reason, the MPES report refers to "potential" fraud rather than actual fraud.

The potential fraud error rate has much more significance to the Medi-Cal program than the overall MPES error rate, because it may reflect a provider's intent to defraud Medi-Cal, such as intentionally billing for an x-ray the beneficiary did not need or did not receive. This does not hold true for the overall MPES error rate since these errors may be due to provider billing mistakes, such as billing the wrong code, rather than a malicious intent to deceive or defraud.

Sampling

The MPES 2009 random sample includes 1,149 Medi-Cal claims paid during the fourth quarter of 2009 (October 1 through December 31) and is organized by provider type (or stratum): Adult Day Health Care (ADHC), Durable Medical Equipment (DME), Inpatient Services, Laboratory (referred to as lab), Other Practices and Clinics (referred to as physician services), Other Services and Supplies (referred to as other services), and Pharmacy. Because Medi-Cal stopped paying for most dental services as of July 1, 2009, dental claims are also excluded from MPES 2009.

Since MPES is designed to measure payment errors in the Medi-Cal program, the stratum that has the greatest impact on the error rate is the Inpatient Services which accounted for the highest

share, 50.2 percent of payments in the sample because they have the highest cost per claim ($2,677 on average) per provider stratum. Physician Services and Pharmacy were second and third, with 22.2 percent and 18.9 percent, respectively. The remaining four strata (ADHC, DME, Lab, and Others Services) each accounted for less than five percent of the MPES sample payments.

In contrast, an estimated 5.45 percent of the total payments had some indication that they contained a provider payment error (see Figure 1). Payment errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as billing for services not provided or services that were not medically necessary.

Table 1- Fewer Payments in Error – MPES 2005 Through MPES 2009

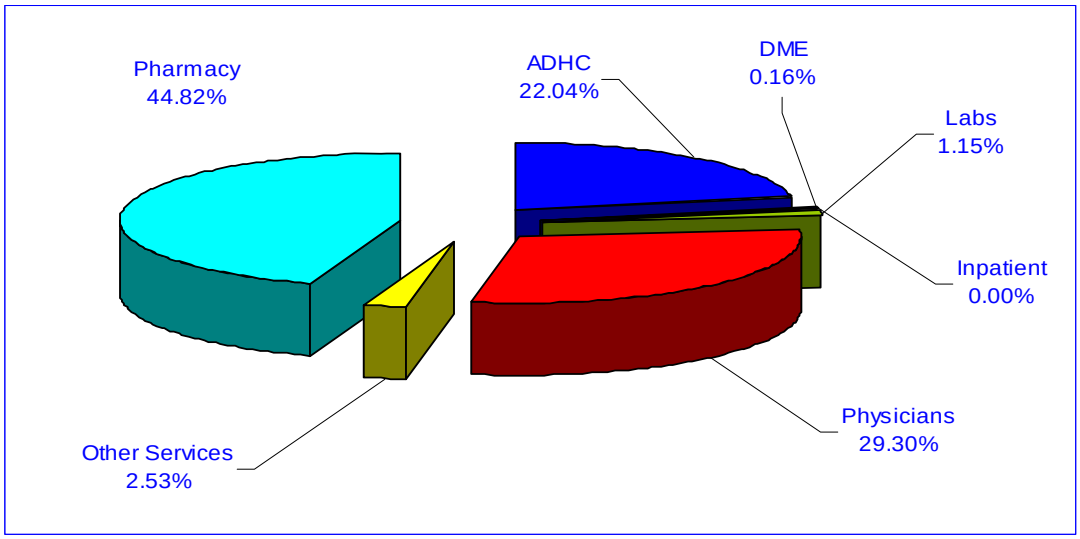
MPES	Error Rate	Payments In Universe (quarter data)	Projected Annual Payments in Error	Difference in Projected Payments Errors From Prior MPES Study
MPES 2005	8.4%	$4,193,397,689	$1,409,704,505	
MPES 2006	7.27%	$4,044,314,079	$1,176,521,646	-$233,182,859
MPES 2007	6.56%	$3,992,097,625	$1,047,708,877	-$128,812,769
MPES 2009	5.45%	$4,909,077,097	$1,070,041,382	$22,332,505
Projected Reduced Payments in Error Since MPES 2005				**-$339,663,123**

Overall projected payments in error totaled $1.07 billion in 2009, which is $339 million less than the total estimated payments in error in 2005. This substantial decline occurred despite a large increase in overall FFS payments over that period.

Types of Errors

Due to the dynamic nature of health care-related fraud schemes and provider behavior, the contribution of each provider type to the overall payment error rate is expected to change from year to year. Figure 3, below, shows the share by provider type of the overall 5.45 percent payment error rate.

Figure 3 - Stratum Contribution to the Overall Payment Error



Note**:** Inpatient services had no claims in error in the MPES 2009 sample

Pharmacy Errors

The Pharmacy stratum, which has, as expected, the largest number of sample claims (38 percent), contributed the most, nearly 45 percent, of the 5.45 overall payment error rate. Second and third in magnitude were Physician Services with 29 percent and ADHCs with 22 percent, respectively.

In terms of number of claim errors in the sample, Pharmacy ranked first with 87 errors out of 212 total errors (41 percent); physician services were second with 73 errors (34 percent) and ADHCs third with 31 errors (nearly 15 percent). However, physician errors were also implicated in 37 pharmacy errors, those committed by prescribers. These 37 prescriber errors in the pharmacy stratum were due to lack of medical necessity errors that involved non-needed prescriptions or referrals by physicians. Combining the 37 prescriber errors with the 73 physician errors in the sample gives us 110 total physician errors. That represents the majority (51 percent) of all the MPES 2009 sample errors and makes the physician services the stratum that poses the greatest threat to the Medi-Cal program, along with claims lacking medical necessity.

Errors related to drug diversion continue to be a problem in the Medi-Cal program. Five pharmacy claims (about six percent) in the MPES 2009 sample were for possible criminal acts involving a prescription drug (drug diversion). Drug diversion is generally associated with narcotic or other pain medication that is used for non-medical or recreational reasons. These products are also known to be acquired for street resale. In the five cases noted, two involved Codeine based products, two were for Vicodin and one for Methadone. In each of the claims there was a clear lack of documented medical need. This suggests that the products were prescribed based on the patients request and not a legitimate medical condition.

Other Claim Types

The 31 payment errors in the ADHC stratum represent a surprising big jump from the 17 errors found in MPES 2007. Out of those 31 errors, 77 percent were medical necessity errors and 23 percent were due to documentation errors. Without the inclusion of ADHC's, the overall error rate drops to 4.33% (which includes a 0.85% fraud indicator).

ADHCs' risk to Medi-Cal is probably the highest. While representing only about two percent of the payment volume in the universe, it has a share of nearly 22 percent in the overall 5.45 payment error in MPES 2009. This disproportional contribution continues to make ADHCs a high-risk provider type. ADHCs continue to enroll into their centers large numbers of beneficiaries that do not meet the five admission criteria. The following patient situation illustrates a case where ADHC services were not needed and yet a provider was able to enroll that participant:

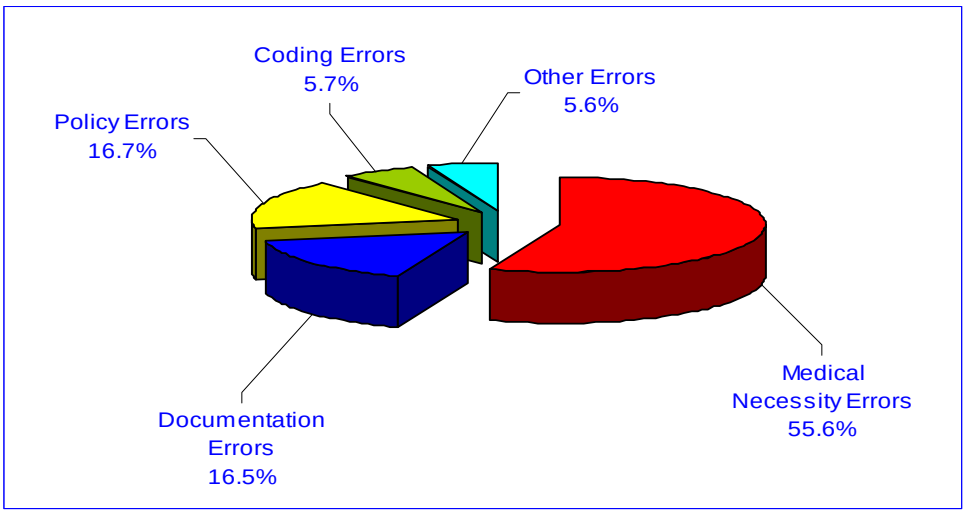
"This beneficiary had well controlled benign hypertension, esophageal reflux, heartburn, osteoarthritis and backache. The documentation provided by the center did not support that any of these conditions, individually or in combination, created a high potential for the deterioration of the beneficiary's conditions to levels that are likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services. The beneficiary was recently discharged from skilled physical therapy due to marked decrease in pain and practice of doing exercises at home. The beneficiary had no cognitive impairment or depression and recently obtained his driver's license."

A possible reason for the near doubling in ADHC errors in MPES 2009 may be a change in medical necessity criteria enacted in 2008. Implementation of Senate Bill 1755 in February 2008 made the five medical necessity criteria more stringent for beneficiaries to meet. ADHC providers may have not fully integrated the new criteria into their assessment of beneficiaries upon admission to their centers.

Inpatient claims had no errors in the MPES 2009 sample. All those claims were determined to be medically-necessary and contained sufficient documentation to support them. That is because institutional providers have strong internal controls and Medi-Cal's most rigorous prior authorizations processes are used to review the medical necessity for these services.
The Other Services stratum contributed a very small percentage, 2.5 percent, to the overall payment error. In particular, Local Education Agency (LEA) providers improved significantly over MPES 2007. They had seven claim errors in MPES 2009, compared to 16 in MPES 2007, a drop of 56 percent. During the time between the two studies, the Department conducted audits through its contract with the State Controller's Office and also implemented educational outreach to improve compliance in the documentation of services and the documenting medical necessity of services provided.

Figure 4 displays the breakdown of sample payment errors by error type. The majority of all payment errors in the sample were for claims that lacked medical necessity. There were 76 errors of this type, accounting for 55.6 percentof all the payments in error in the sample. This error category is the most significant because it means that the services should not have been provided, had no value, and were not simple mistakes for services that should not have been paid.

Figure 4 – Sample Payments Paid in Error by Error Type

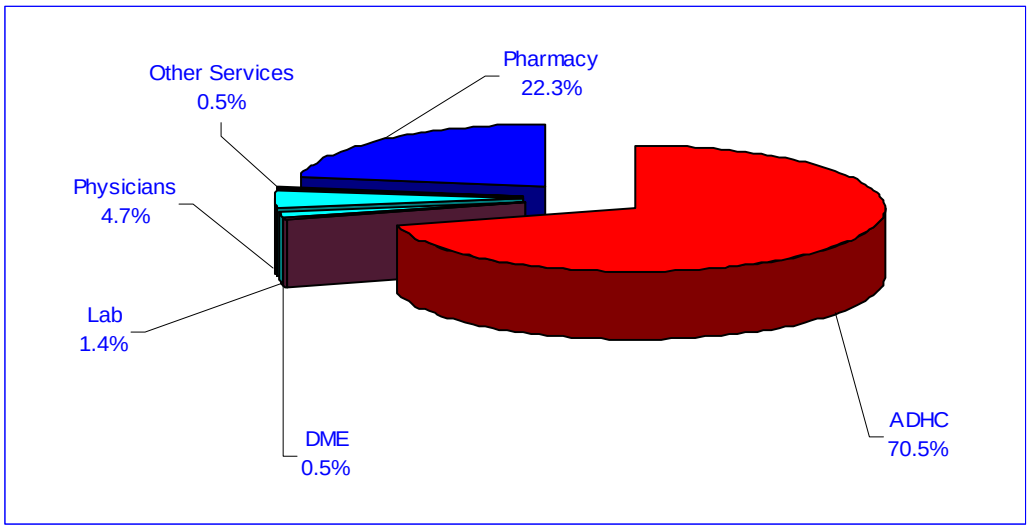


Medical necessity errors, then, constitute the greatest risk of fraud, waste, and abuse for DHCS. A rough estimate of the potential magnitude of the risk posed by the 55.6 percent of medical necessity errors can be illustrated by multiplying that percent by the estimated annual payments in error ($1.07 billion). This totals to approximately $594 million potential loss to the Medi-Cal program. In terms of expenditures, the reduction or elimination of medical necessity errors in DHCS's funded health care programs would lead to potentially significant savings during this era of scarce resources at the State level.

Looking closely to the 76 medical necessity payment errors by provider type in the sample, ADHCs were, by a large majority (70.5 percent), the biggest contributor (Figure 5).

The Pharmacy stratum, as expected, had the highest number of medical necessity claims in error, with 37 claims, compared to 24 ADHC medical necessity errors. However, those pharmacy errors are again generated by physicians prescribing unnecessary drugs. Therefore, ADHCs, by contributed three times more than the Pharmacy stratum to the overall medical necessity payment errors, represent a very high risk to the Medi-Cal program.

Figure 5 – Breakdown of Sample Medical Necessity Errors by Stratum



Conclusion

In conclusion, MPES assists the Department in maintaining program integrity by identifying trends which in turn refine target areas for reducing fraud, waste, and abuse in the Medi-Cal program. For instance, potential fraud has been reduced by more than half since MPES 2005. Still, additional efforts will focus on the provider types most at risk.

A robust anti-fraud strategy requires preventive actions as well as detection, utilization controls and enforcement. Preventive approaches include self-audit tools, outreach to provider groups and the most recent effort called the Individual Provider Claims Analysis Report (IP-CAR). The IP-CAR supplies providers with comparative billing information and trends within the provider's individual peer group. The project goals are to encourage providers to become more conscientious about their billing, persuade them to bill accurate diagnosis codes and educate physicians on how to conduct a self-audit

Future IP-CAR projects will focus on prescribing practices of physicians. These prescribing physicians generated the majority of medical necessity errors in the MPES 2009. In addition, as a follow-up to MPES 2009, all providers with errors identified in their claim, will be reviewed further, so that a determination of the magnitude of errors and possible actions can be made.

As the Department prepares for the implementation of the Affordable Care Act (ACA), there will be new opportunities for care as well as the responsibility to ensure compliance. There will be expanded coverage of individuals along with increased opportunity for preventive care and Health Homes. This will be coupled with increased communication between states and shared risk assessments between federal and state programs. Using the MPES model, the Department is preparing for the challenges and opportunities these changes will afford.

With the transition of the Medi-Cal Seniors and Persons with Disabilities (SPD) population into managed care, we are evolving into a different delivery system that will require us to identify

new program integrity opportunities and expectations within the managed care plans. To accomplish this change we will be working with our partners within the department and in consultation with our contracted Health Plans.

Another significant change will be the methodology of reimbursing Inpatient Care. The Department is moving away from its contacted per diem rates to a Diagnosis Related Group (DRG) based formula. This formula relies heavily on the selection of a DRG that most accurately reflects a patient's clinical condition. Future MPES studies will be able to measure how accurately Hospitals are making these selections.

II. Background

DHCS places significant priority on combating fraud, waste and abuse in California's largest publicly-funded health care program, Medi-Cal.

1) Medi-Cal Overview

Medi-Cal is California's version of the Federal Medicaid program. Operating in California since 1966, it is an entitlement program administered by the DHCS under the California Health and Human Services Agency. Medi-Cal reimburses medically-necessary health care services provided to specified, low-income, medically-needy California residents.[2] As such, it is California's largest publicly-funded health care program and California's largest health care purchaser. DHCS budgeted $38.5 billion in State (32%) and Federal (68%) funds for all of Medi-Cal 2009-10. DHCS estimates there were 7.3 million Medi-Cal beneficiaries per month in Fiscal Year (FY) 2009-10,[3] which made up approximately 19 percent of the 2010 total California resident population.[4]

Medi-Cal has two systems for paying for medical care: Fee-For-Service (FFS) and Medi-Cal Managed Care (MMC). FFS pays providers a fee for each service they render to Medi-Cal beneficiaries. MMC pays private health care plans a fixed monthly fee for each Medi-Cal beneficiary in their plan, regardless of the quantity or nature of the services the provider renders. There are approximately 3.4 million beneficiaries in each system, totaling approximately seven million beneficiaries.

The Medi-Cal budget for FY 2009-10 was $38.5 billion and is shown in Figure 7 below. MPES reviews only the FFS program providers, shown in red. The FFS budget totaled $20.5 billion.

---

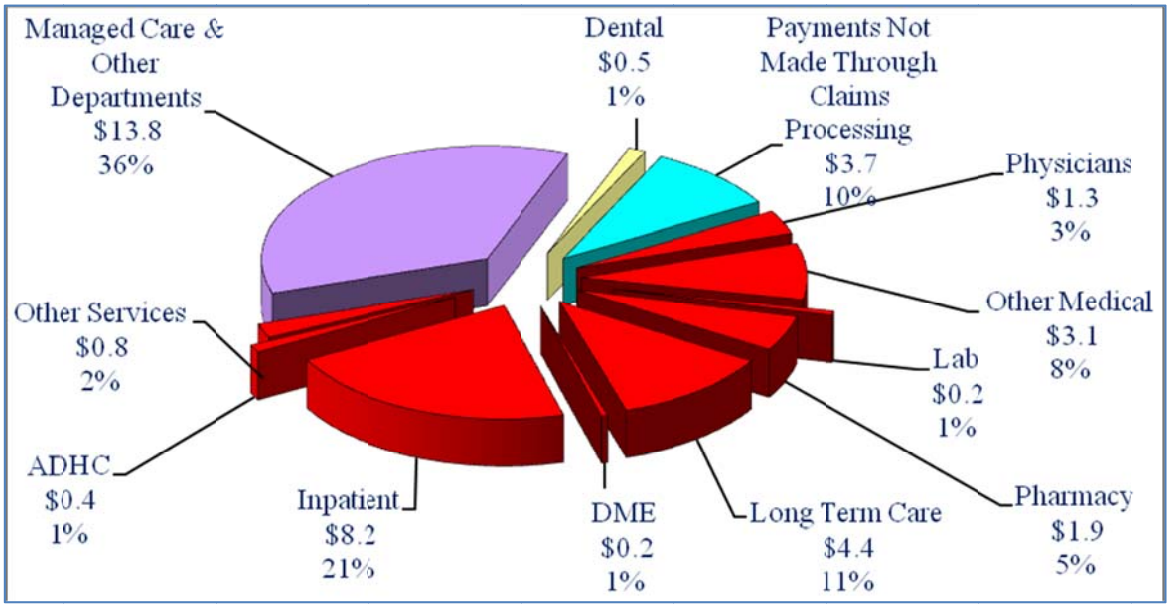
[2] Medi-Cal regulations are found under the California Code of Regulations, Title 22, and under the Welfare and Institutions Code of California Statutes.

[3] http://www.dhcs.ca.gov/dataandstats/reports/mcestimates/Documents/2010_May_Estimate/M10_CsLd_Doc_A.pdf.

[4] http://www.dof.ca.gov/html/fs_data/stat-abs/sec_B.htm.

The dollar amount and percent of the budget for pharmacy have declined from 2007, due to the new Medicare Part D program picking up our aged and disabled population. Physician services has also declined, due to a variety of factors, including DHCS efforts to counter fraud and payment errors and beneficiaries moving to MMC.

Figure 7: FY 2009-10 Medi-Cal Budget by Service Category, FFS in red(in billions)



2) Medi-Cal Integrity

DHCS places high priority on combating fraud, waste, and abuse of Medi-Cal. To that end, it continuously monitors and assesses emerging trends in Medi-Cal fraud, waste, and abuse to make informed decisions on the allocation of fraud control resources and to secure the program's integrity. In FY 2009-10, DHCS recovered approximately $102 million from Medi-Cal providers, due to fraud, waste and abuse.

3) MPES Overview

The California State Legislature mandates the Medi-Cal Payment Error Study (MPES) as part of DHCS' program integrity efforts. It takes about five years for studies of this type to be able to establish a trend. DHCS uses MPES to determine where the Medi-Cal program is at greatest risk for payment errors. On that basis, it then determines how to allocate and direct anti-fraud resources and activities. MPES is currently the only known study conducted by a state or federal entity that includes a potential fraud subset in its estimate of Medicaid payment errors.

4) Provider and Service Categories

MPES is based upon claims paid to the following list of Medi-Cal providers:

- Adult Day Healthcare Centers (ADHC)

- Durable Medical Equipment (DME)
- Pharmacy
- Inpatient
- Labs
- Other Practices & Clinics
- Other Services & Supplies

5) Main Payment Error Types

MPES measures what is called "payment error." Payment error occurs when DHCS reimburses a provider for a Medi-Cal claim for which, unknown to DHCS, that provider either billed Medi-Cal incorrectly or by which the provider intended to commit fraud, waste, or abuse. It is important to understand that most payment errors are not attempts to defraud, waste, or abuse Medi-Cal.

The four significant types of payment errors among the many types studied and reported by MPES are described below:

- *Medical Necessity:* This occurs when a Medi-Cal beneficiary does receive a product or service, but the beneficiary does not have a medical need for it. Medi-Cal will only reimburse providers for products or services for which a beneficiary has a medical need.
- *Documentation:* This occurs when the presence or absence of documentation in the provider's records fails to adequately substantiate whether the service or product was medically-necessary or whether it was received by a Medi-Cal beneficiary.
- *Coding:* This occurs when a provider bills Medi-Cal using the wrong code for the diagnosis or the product or service that the beneficiary received. "Up-coding" refers to billing using a code for which the provider will receive a higher level of reimbursement amount than what is justified by the product or service the beneficiary actually received.
- *Policy Violation:* Violation of Medi-Cal policy.
- *Other:* Payment errors that do not fall into the categories above, such as the recipient's signature missing or the provider or recipient ineligibility.

6) MPES 2007 Findings

The previous MPES (2007) reported that 93.44 percent of all Medi-Cal FFS payments were correct, with a payment error rate of 6.56 percent. It stated that the 6.56 percent rate represented a steady decline in payment errors since MPES 2005. It further stated that DHCS was mostly concerned about payment errors for medically-unnecessary services and potentially fraudulent payment errors.[5]

[5] MPES 2007, pp 1, 2, 9.

III. MPES Design and Methodology

The MPES 2009 reviews only Fee-For-Service (FFS) claims. MMC plans and programs are excluded from the MPES studies. Furthermore, because Medi-Cal stopped paying for most dental services as of July 1, 2009, dental claims are now also excluded from MPES 2009.

Previously, MPES was conducted annually, but DHCS now conducts the MPES every odd year (2009, 2011, etc.). The methodology continues to be refined and improved to enhance the effectiveness of both the study and DHCS' monitoring of waste, abuse, and fraud.

1) Process

MPES follows a multiple-stage process:

a) *Draw a Sample of Claims: Using the same statistical sampling design as in previous MPES studies,*[6] *DHCS began by sampling 1,149 FFS claims paid in the fourth quarter of 2009. DHCS further refined the review processes this year to minimize the non-sampling errors and improve the reliability of the review process between the medical reviewers and the auditors*.

b) *Peer Review of Medical Records to Validate the Sampled Claims*: *To ensure the integrity of the study, DHCS auditors and medical staff visited the providers at their locations, collected, and reviewed the medical records related to the sampled claims. These first-level reviews confirmed the presence of the following six components of a claim:*
- *the beneficiary received the service,*
- *the provider was eligible to render the service*
- *the documentation was complete and included in the medical files, as required by statute or regulation,*
- *the services were billed in accordance with applicable Medi-Cal regulations and policies,*
- *the claim was paid accurately, and*
- *the documentation supported the medical necessity of the service provided.*

c) *Medical Staff Perform a Second Review to Confirm the First Review Findings: After the first-level reviews, DHCS medical staff performs a second-level review to validate the first review findings and identify claims that show characteristics of fraud, waste, or abuse.*[7] *Their findings are compiled into a database for analysis.*

d) *Department of Justice Review of Fraudulent Claims: DHCS sends each claim that it determines is in error to the California Department of Justice (DOJ) Medicaid Fraud*

---

[6] The MPES 2009 sampling strategy uses a widely accepted proportional stratified random sampling to generate estimates of payment and fraud error then uses a ratio estimator to determine the potential dollar loss to the program due to provider claiming errors.

[7] Common indicators of fraud are provided in Section VI.

Control Unit for validation according to their fraud protocols. DHCS then reevaluates its findings based upon DOJ's review.

e) *Review of physician and ADHC claims by DHCS Medical Policy Review Branch, Pharmacy claims by DHCS Pharmacy Policy Branch and LEA claims by State Controller office (SCO).*

f) *Analyze Data and Issue Report: Researchers then analyze the data produced by the reviews, summarize those data, and write the MPES report.*

g) *Executive review: Executive staff reviews the final draft before publication.*

For more details about the claims review process, please see Appendix 1, Review Protocols.

2) Data Universe and Sample

The sampling universe consists of Medi-Cal fee-for-service claims paid through the Fiscal Intermediary (FY), Hewlett Packard (formerly Electronic Data Systems),during the period of October 1, 2009 through December 31, 2009 (Table III.1).

Table III.1 – Medi-Cal Paid Claims in the Universe

Stratum	Number of Claims in Universe	Medi-Cal Payments in Universe	Percent of Claims Volume	Percent of Payments Volume
ADHC	391,152	$92,904,408	1.55%	1.89%
Durable Medical Equipment	337,090	$37,852,609	1.34%	0.77%
Inpatient	919,926	$2,462,881,891	3.65%	50.17%
Labs	1,627,501	$67,402,480	6.45%	1.37%
Other Practices and Clinics	10,151,880	$1,087,412,034	40.23%	22.15%
Other Services and Supplies	1,419,894	$232,287,423	5.63%	4.73%
Pharmacy	10,389,459	$928,336,254	41.17%	18.91%
Total	**25,236,902**	**$4,909,077,097**	**100.00%**	**100.00%**

The 1,149 claims sampled for MPES 2009 represent the seven major provider types and distributed as follows:

- 440 Pharmacy claims; 430 Other Practices and Clinics claims (referred to as physician services);
- 69 Laboratory (referred to as lab) claims;
- 60 Other Services and Supplies (referred to as other services) claims;
- 50 Adult Day Health Care (ADHC) claims;
- 50 Durable Medical Equipment (DME) claims; and
- 50 Inpatient Services claims.

Each claim includes all detail lines (claim lines). Claims with zero payment amounts and adjustments were excluded from the universe; however, all adjustments to a sampled claim that occurred within 60 calendar days of the original adjudication date were included. Dental claims are not included in the sampling universe because Medi-Cal no longer

provides dental benefits to adult Medi-Cal beneficiaries. Therefore, this provider type is no longer one of the strata used in the MPES sampling

The MPES 2009 sample size was extracted from a universe of 25,236,902 Medi-Cal paid claims. It was used to ensure a 95% confidence level with a ± 3% precision relative to the overall payment error rate. Proportional allocation of the sample size was used to determine the sample size from each stratum ensuring a minimum sample size of 50 claims for each stratum. Simple random sampling without replacement was used in each stratum for overall the sample selection[8].

3) Sample Stratification

The proportional stratified random sample is divided into seven strata. Each stratum is listed below. The list includes all vendor codes associated with each stratum (or provider type). These codes are used in queries to determine the appropriate claim categories for each of the strata used in the sample.

- Stratum 1: Adult Day Health Care (ADHC), vendor code = 01

- Stratum 2: Durable Medical Equipment (DME), [provider type equal to 002 and category of service not equal to 017 or 039] or [category of service equal to 059]

- Stratum 3: Inpatient, claim type = 2 (Inpatient), and vendor code list:

Vendor Code Description

47	Intermediate Care Facility
50	County Hospital – Acute Inpatient
51	County Hospital – Extended Care
60	Community Hospital – Acute Inpatient
61	Community Hospital – Extended Care
63	Mental Health Inpatient
80	Nursing Facility (SNF)
83	Pediatric Sub acute Rehab/Weaning

- Stratum 4: Lab, vendor code list:

11	Fabricating Optical Labs
19	Portable X-ray Laboratory
23	Lay-owned Laboratory Service
24	Physician Participated Lab Service

- Stratum 5: Other Practices and Clinics, vendor code list:

05	Certified Nurse Midwife
7	Certified Pediatric Nurse Practitioner
8	Certified Family Nurse Practitioner

[8] This sampling methodology, also used for MPES 2006 and MPES 2007, was reviewed and approved by Dr. Geetha Ramachandran, Professor of Statistics at California State University, Sacramento.

9	Respiratory Care Practitioner
10	Licensed Midwife
12	Optometric Group Practice
13	Nurse Anesthetists
20	Physicians Group
21	Ophthalmologist
22	Physicians Group
26	Physicians
28	Optometrists
30	Chiropractors
31	Psychologists
32	Podiatrists
33	Certified Acupuncturists
34	Physical Therapists
35	Occupational Therapists
36	Speech Therapists
37	Audiologists
38	Prosthetists
39	Orthotists
49	Birthing Center
52	County Hospital – Outpatient
58	County Hospital - Hemodialysis
62	Community Hospital – Outpatient
68	Community Hospital – Renal Dialysis
72	Surgicenter
75	Organized Outpatient Clinics
77	Rural Health Clinics / FQHCs
78	Comm Hemodialysis Center
91	Outpatient Heroin Detox

- Stratum 6: Other Services and Supplies, all other claims that do not meet the criteria for the other strata.

- Stratum 7: Pharmacy, vendor code = 26

Each stratum size was determined using the proportion of the total number of claims represented by each stratum for claims paid for dates of October 1, 2009 through December 31, 2009. The sampling strata and their respective claim sizes and paid amounts are shown below (Table III.2).

4) Error Types

Each claim in error was given an error code. Appendix 3 lists all possible error codes (38 of them) and their respective error descriptions. MRB grouped these 38 error codes into five categories (or types) as follows:

Error Category	Error Type	Error Type Description
Medical Necessity	MR5	Medically unnecessary service
Documentation	MR1	No documents submitted
	MR2A	Poor/insufficient documentation
	MR2B	No documentation
Policy	MR7	Policy violation
	MR8	Other medical error
	PH10	Other pharmacy policy error
Coding	MR3	Coding error
	MR4	Unbundling error
Other	MR9	Recipient signature missing (DME/Lab) (Non-dollar Error)
	P9A	Billing provider ineligible to bill for claimed services/supplies
	P1	Duplicate item (claim)
	P9	Ineligible provider
	P7	Ineligible recipient
	P2	Non-covered service
	P10	Other
	O	Other error found
	PH7B	Prescription Splitting
	P9B	Rendering provider not eligible to bill for services/supplies
	MR4	Unbundling error
	WCI	Wrong client identified

5) Estimation

DHCS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits[9]. To calculate the payment error rate, the following steps were utilized:

- First, payments for services included in the sample that were paid correctly were totaled by stratum and divided by the total payments for all services in the sample. This resulted in payment accuracy rates for each of the seven strata.

- Second, each of the accuracy rates for the seven strata was weighted by multiplying the payments made for services in the corresponding universe stratum and summed to arrive at an overall estimate of payments that were made correctly.

- Third, this estimate of the correct payments was divided by the total payments made for all services in the universe to arrive at the overall payment accuracy rate (Table III.2).

[9] William G. Cochran, Sampling Techniques (John Wiley & Sons, 1977), 164.

Table III.2 - Calculation of Payment Accuracy Rate by Stratum

Stratum	Sample Size	Amounts Paid in Sample	Amounts Paid Correctly After Review	Payment Accuracy Rate	Payment Error Rate
ADHC	50	$11,299	$4,130	36.55%	63.45%
Durable Medical Equipment	50	$4,292	$4,244	98.89%	1.11%
Inpatient	50	$106,436	$106,436	100.00%	0.00%
Labs	69	$2,931	$2,797	95.42%	4.58%
Other Practices and Clinics	430	$40,015	$37,131	92.79%	7.21%
Other Services and Supplies	60	$9,473	$9,197	97.09%	2.91%
Pharmacy	440	$39,176	$34,116	87.08%	12.92%
Total	**1,149**	**$213,622**	**$198,050**	**94.55%**	**5.45%**

The projected annual payments made correctly were calculated by multiplying three quantities: 1) the payment accuracy rate, 2) the 4th quarter 2009 Medi-Cal FFS payments universe subject to sampling, and 3) the number 4 (for the 4 quarters of the year).Finally, the error rate and projected annual dollars paid in error were computed as follows:

Payment error rate = 100 percent minus the overall payment accuracy rate (Table III.3)

Projected annual payments made in error = payment error rate X (times) 4th quarter 2009 Medi-Cal FFS payments universe subject to sampling X (times) 4 quarters (Table III.3).

Table III.3 - Overall Estimate of Payments Made Correctly and Incorrectly

Stratum	Payment Accuracy Rate	Total Payments in Universe	Overall Estimated Payments Made Correctly	Overall Estimated Payments Made Incorrectly	Projected Annual Payments in Error
ADHC	36.55%	$92,904,408	$33,957,243	$58,947,165	$235,788,658
Durable Medical Equipment	98.89%	$37,852,609	$37,433,205	$419,404	$1,677,614
Inpatient	100.00%	$2,462,881,891	$2,462,881,891	$0	$0
Labs	95.42%	$67,402,480	$64,313,769	$3,088,711	$12,354,845
Other Practices and Clinics	92.79%	$1,087,412,034	$1,009,033,840	$78,378,193	$313,512,773
Other Services and Supplies	97.09%	$232,287,423	$225,517,430	$6,769,993	$27,079,973
Pharmacy	87.08%	$928,336,254	$808,429,374	$119,906,880	$479,627,519
Total	**94.55%**	**$4,909,077,097**	**$4,641,566,752**	**$267,510,345**	**$1,070,041,382**

6. Confidence Intervals and Formulas

Confidence limits were calculated for the payment accuracy rate at the 95 percent confidence level. The standard deviation of the estimated payments was multiplied by 1.96 and subtracted (added) from the point estimate for correct payments to arrive at the lower-bound (upper-bound) estimate. These lower- and upper-bound estimates were divided by the total payments made for all services included in the universe to determine the upper- and lower-bound payment accuracy rates.

The formulas used to perform the above-described operations, along with terms defined for quantities specifically calculated in this study, are presented below.

Let

$\hat{H}$ = estimated payment accuracy rate

$\hat{Y}$ = estimated value of accurate payments
X = known value of total payments in the universe
Xh = known value of total payments in the universe for stratum h
yh = sample estimate of the value of accurate payments for stratum h

$x\,h$ = sample estimate of the value of the total payments for stratum h
The formula for the payment accuracy rate estimate is as follows:

$$\hat{H} = \hat{Y} / X$$

where

$$\hat{Y} \sum_{h=1}^{8} (yh / xh) Xh$$

(The formula above is equation 6.44 from Cochran, found on page 164.)

The upper- and lower-limits are calculated using the 95 percent confidence interval and the following formulas:

$\hat{H}$ lower limit = $\hat{Y}$ lower limit / X

$\hat{H}$ upper limit = $\hat{Y}$ upper limit / X, *where*

$$\hat{Y} \text{ lower limit} = \sum_{h=1}^{8} (yh / xh)\, Xh \;\; - 1.96S$$

$$\hat{Y} \text{ upper limit} = \sum_{h=1}^{8} (yh / xh)\, Xh + 1.96S, \textit{ and}$$

$$S = \sqrt{S^2} = \sqrt{\sum_{h=1}^{8} S_h{}^2}$$

$$S_h^2 = A_h B_h, \textit{where}$$

$$A_h = \left[N_h^2 (1 - f_h) / (n_h (n_h - 1))\right] \text{ and } B_h = \left[\sum y_{hi}^2 + R_h^2 \sum x_{hi}^2 - 2R_h \sum y_{hi} x_{hi}\right]$$

where $f_h = n_h / N_h$ and $R_h = y_h / x_h$

(The formula for S_h^2 used above is equation 6.10 on page 155 of Cochran.)

IV. Findings

Overall, MPES 2009 results estimate that, of the $19.6 billion in all Medi-Cal FFS payments made in 2009, a very large majority, $18.6 billion (or 94.55 percent), were appropriately and correctly billed and paid. In contrast, about $1.07 billion (5.45 percent) were erroneous payments to Medi-Cal providers.

1) Summary Statistics

The following three tables summarize the main MPES 2009 findings, including the overall payment error rate, the potential fraud rate, the error rates for each stratum (provider type), the payments amounts in error, projected annual payments in error, and calendar year 2009 total Medi-Cal payments. In addition, the first two tables show the computed margins of errors and confidence intervals per stratum for MPES 2009.A detailed explanation on how these amounts were computed and the statistical methodology used in MPES is described in Section III of this report.

Table IV.1 - Payment Error Rates in the Sample and Projected Annual Payments made in Error by Stratum (Using Claims Paid in Fourth Quarter of 2009)

Stratum	Payment Error and Confidence Intervals	Payments in Universe	Payments in Error	Projected Annual Payments In Error
ADHC	63.45% ± 15.24%	$92,904,408	$58,947,165	$235,788,658
Durable Medical Equipment	1.11% ± 1.88%	$37,852,609	$419,404	$1,677,614
Inpatient	0.00% ± 0.00%	$2,462,881,891	$0	$0
Labs	4.58% ± 5.55%	$67,402,480	$3,088,711	$12,354,845
Other Practices and Clinics	7.21% ± 2.08%	$1,087,412,034	$78,378,193	$313,512,773
Other Services and Supplies	2.91% ± 2.91%	$232,287,423	$6,769,993	$27,079,973
Pharmacy	12.92% ± 7.37%	$928,336,254	$119,906,880	$479,627,519
Overall Payment Error Rate	**5.45% ± 1.50%**			
Totals		**$4,909,077,097**	**$267,510,345**	**$1,070,041,382**

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual error rate for the population of claims is 5.45%, plus or minus 1.5%, or that the true error rate lies within the range of 3.95% and 6.95%.

The projected annual payments in error are computed by multiplying the following quantities: the payment error rate, the 4th quarter 2009 Medi-Cal FFS payments universe included in the sampling, and the number 4 (four quarters in a year).

An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighted by total payments within each stratum. The error rate and payment error projections for each stratum are independent from one another.

Therefore, the sum of the seven individual strata payment errors is not equal to the overall payment error.

Table IV.2 - Potential Fraud Rates in the Sample and Projected Annual Fraudulent Payments by Stratum(Using Claims Paid in Fourth Quarter of 2009)

Stratum	Potential Fraud Rate and Confidence Intervals	Payments in Universe	Fraudulent Payments	Projected Annual Fraudulent Payments
ADHC	17.55% ± 11.40%	$92,904,408	$16,304,535	$65,218,139
Durable Medical Equipment	0.00% ± N/A	$37,852,609	$0	$0
Inpatient	0.00% ± N/A	$2,462,881,891	$0	$0
Labs	1.21% ± 1.55%	$67,402,480	$813,860	$3,255,439
Other Practices and Clinics	2.40% ± 1.35%	$1,087,412,034	$26,066,914	$104,267,655
Other Services and Supplies	0.00% ± N/A	$232,287,423	$0	$0
Pharmacy	1.50% ± 1.50%	$928,336,254	$13,930,360	$55,721,441
Overall Potential Fraud Rate	**1.16% ± 0.47%**			
Totals		**$4,909,077,097**	**$57,115,669**	**$228,462,674**

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual potential fraud rate for the population of claims is 1.16 %, plus or minus 0.47%, or that the true error rate lies within the range of 0.7 and 1.63%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the 4th quarter 2009 Medi-Cal FFS payments universe included in the sampling, and the number 4 (four quarters in a year).

Table IV.3 – Calendar Year 2009 Medi-Cal FFS Payments by Quarter

Stratum	CY 2009 Fee-for-Service (FFS) Payments by Quarter				
	First	Second	Third	Fourth	Total
ADHC	$98,532,582	$108,314,637	$107,917,758	$92,850,142	**$407,615,119**
Durable Medical Equipment	$29,621,538	$33,119,640	$40,353,180	$37,134,709	**$140,229,067**
Inpatient	$2,074,838,521	$2,355,368,136	$2,463,131,053	$2,452,327,248	**$9,345,664,958**
Labs	$58,244,366	$67,349,739	$68,800,945	$64,382,897	**$258,777,948**
Other Practices & Clinics	$919,744,411	$947,714,714	$1,124,419,639	$1,054,183,374	**$4,046,062,137**
Other Services & Supplies	$195,467,702	$215,326,201	$274,032,733	$240,368,486	**$925,195,122**
Pharmacy	$805,310,646	$764,593,148	$839,014,551	$807,226,346	**$3,216,144,691**
Totals	**$4,181,759,766**	**$4,491,786,214**	**$4,917,669,860**	**$4,748,473,201**	**$18,339,689,041**

2) Claims Processing Errors

This is the fifth consecutive MPES in which no claims processing errors were made by the fiscal intermediaries, HP (formerly EDS). This indicates that the prepayment edits, audit methods and pricing tables prescribed by DHCS continue to be accurately applied.

3) Payment Errors

The MPES 2009 sample findings identified nearly $268 million erroneous payments, or 5.45 percent of Medi-Cal FFS payments made during the 4th quarter of 2009. This amount extrapolates to $1.07 billion annually in payment errors. Of the $1.07billionannualized payments in error, $228.5 million (or 1.16 percent) were for potentially fraudulent claims.

The projected $1.07 billion in MPES 2009 erroneous payments are slightly higher than the $1.05 billion payments in error found in MPES 2007. Cumulatively, there were $340 million fewer projected payment errors from MPES 2005 to MPES 2009 (Table IV.4 below). Both the overall payment error rate and the potential fraud rate continue to decline, when compared to MPES 2005, demonstrating the success of DHCS efforts to reduce and minimize payment errors, fraud, waste, and abuse in Medi-Cal.

Table IV.4- Fewer Payments in Error – MPES 2005 Through MPES 2009

MPES Study	Error Rate	Payments In Universe	Projected Annual Payments in Error	Difference in Payment Errors From Prior MPES
MPES 2005	8.4%	$4,193,397,689	$1,409,704,505	
MPES 2006	7.27%	$4,044,314,079	$1,176,521,646	-$233,182,859
MPES 2007	6.56%	$3,992,097,625	$1,047,708,877	-$128,812,769
MPES 2009	5.45%	$4,909,077,097	$1,070,041,382	$22,332,505
Total Projected Reduction in Payments in Error Since MPES 2005				**-$339,663,123**

a) Payment Errors by Type[10]

The 76medical necessity payment errors accounted for the majority (55.6 percent) of all the payment errors found in the MPES 2009 sample (Table IV.5), making this the most common payment error type in the sample. This means that more than half of all the payment errors in the sample submitted by Medi-Cal providers were claims for services that were not medically necessary.

[10] See Section II for a definition of "payment error" and a description of the various error types.

Table IV.5 – Sample Payments Made in Error by Error Type

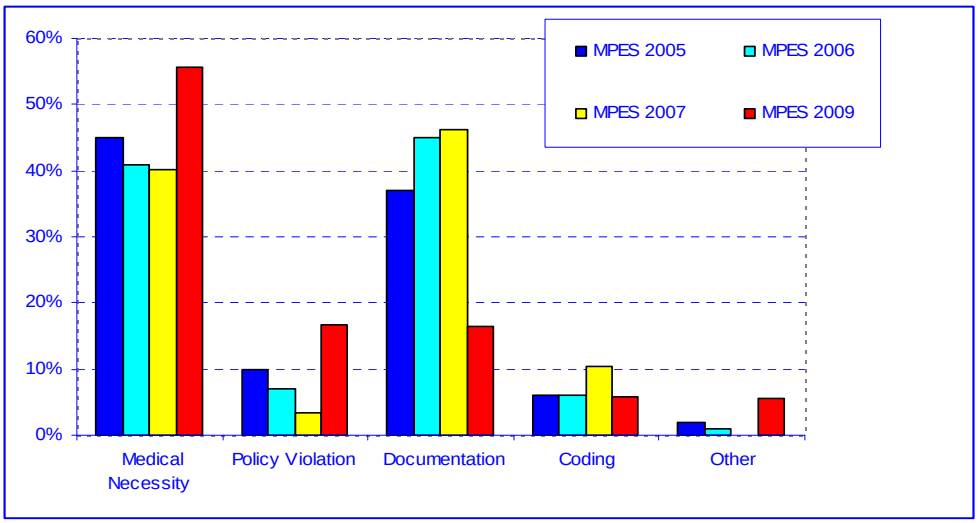
Payment Error Type	Amount	Percent
Medical Necessity	$8,650	55.6%
Policy	$2,594	16.7%
Documentation	$2,566	16.5%
Coding	$881	5.7%
Other Errors	$880	5.6%
Total Sample Payments in Error	**$15,572**	**100.0%**

In looking at the breakdown of medical necessity errors by provider type in the sample, we note that nearly 71 percent of all payments in error due to medical necessity errors were attributed to ADHC providers. Medical necessity error payments pertaining to pharmacy providers came in second, with 21 percent. Physician services ranked third with about a six percent contribution to all medical necessity errors in the MPES 2009 sample.

Because medically unnecessary claims are the most frequently occurring error type and because the full dollar amount paid for them is in error, this payment error type is Medi-Cal's greatest fraud, waste, and abuse vulnerability. Therefore, DHCS anti-fraud efforts will continue to emphasize medically-unnecessary billing, particularly among ADHC and pharmacy providers.

Figure 8 shows the trend of payment error by type, from MPES 2005 through MPES 2009. The chart shows that from 2005 through 2007, when medical necessity and policy violation errors declined, documentation and coding errors increased. From 2007 to 2009, however, both trends reversed, with medical necessity retaking the lead.

Figure 8 – Payment Errors by Type Across MPES Studies



To ensure the sample included claims from all types of providers, DHCS first organized the universe of claims by provider type and *then* randomly sampled claims in proportion to the number of providers existing in each provider type category with no fewer than 50 claims drawn from each category. This is called "stratifying the sample" and ensures that the sample represents all provider types.[11]

b) Payment Errors by Stratum (Provider Type)

Payment errors, as defined in Section II, are identified as potential dollar value loss due to payment or billing errors, including potential loss due to fraud, waste and/or abuse. Claim errors in MPES 2009 study ranged from simple mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided.

The following table shows the breakdown of the 212 errors by stratum and by error type. Note that inpatient claims did not have any payment error in MPES 2009.

Table IV.6 - Payment Errors by Stratum and Error Type

Error Type	Code	ADHC	DME	Labs	Pharmacy	Physicians	Other	Total
Insufficient Documentation	MR2	7		2	20	18	8	**55**
Medically Unnecessary	MR5	24	1	5	37	8	1	**76**
Coding Error	MR3					36	3	**39**
No Documents Submitted	MR1				1			**1**
Policy Violation	MR7					3	1	**4**
Other Medical Error	MR8				1	4		**5**
Other Pharmacy Policy Error	PH10				21			**21**
Non-Covered Service	P2					2		**2**
Ineligible Recipient	P7					1		**1**
Provider Ineligible to Bill	P9					1		**1**
No Legal Prescription	PH2				3			**3**
Prescription Split	PH7				1			**1**
No Signature of Receipt	PH1				1			**1**
Prescription Missing Essential Information	PH3				1			**1**
Wrong Client Identified	WCI				1			**1**
Total Errors		**31**	**1**	**7**	**87**	**73**	**13**	**212**

There were 206 unique providers represented in the 212 claims in error in the MPES 2009 sample. Of those 206 unique providers, 103 had more than one error and one had

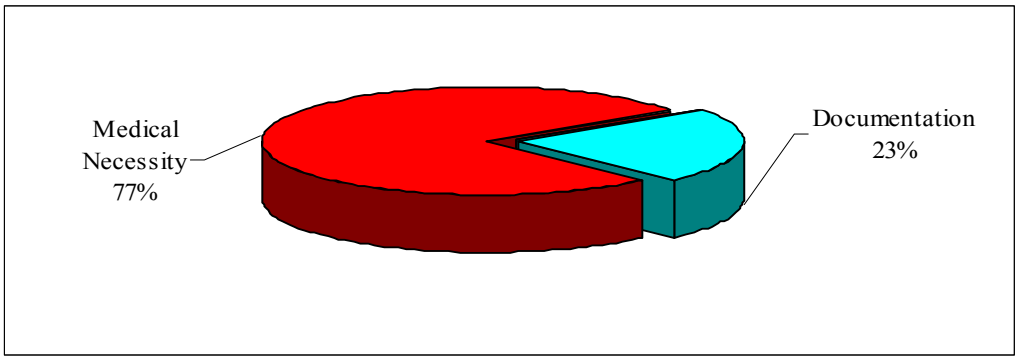
[11] Because the claim universe is first stratified by provider type prior to random sampling, to sub-stratify the sample again by error type would produce unreliable results and inferences. For this reason this report does not attempt to project or infer anything about the Medi-Cal universe from the individual error types. To be able to infer from the error types to the claim universe, DHCS would have to first draw a random sample of 1149 claims and then stratify that random sample by error type. This, however, would likely mean that some provider types would not be represented in the sample, given that some provider types are small in number relative to other provider types. Since the priority in MPES is to represent provider types rather than error types, the claim universe was sampled as described above and the report does not project by error type to the claim universe.

eight errors. See Appendix 3 for a complete description of the error codes and Appendix 4 for a detailed explanation of each error.

Payment errors include those claims with insufficient or no documentation, claims with coding errors (e.g., up-coding), claims where the documentation did not support medical necessity of the service, missing signature of the recipient, and claims paid which were in conflict with Medi-Cal rules and regulations. Error types are assigned depending upon the error and the most potentially costly errors. The most serious errors are: a lack of medical necessity, a legal requirement not met by the provider; insufficient or no documentation; coding errors; ineligible providers and policy violation errors. Examples of the types of error within each stratum follow.

Adult Day Health Care

Thirty-one ADHC claims were found to have payment errors, 24 of which (77 percent) were medical necessity errors and seven (23 percent) documentation errors (see chart below).



Examples of ADHC Errors:

Insufficient Documentation - This claim is for four days of Adult Day Health Care (ADHC) services. The provider was unable to provide a current Individual Plan of Care (IPC), history and physical with request for services from primary care provider and flow sheets[12] *or other documentation describing the delivery of the services the ADHC was authorized to provide. Therefore, the center was unable to support whether the services were requested, needed or provided. This error is calculated as the total amount paid for this claim.*

Medically Unnecessary – This claim is for three days of ADHC services. The beneficiary has several common medical conditions, such as low back pain, osteoarthritis, and an enlarged prostate gland. None of these conditions are unstable or require care beyond that which can be accomplished with routine monitoring with the primary care provider. The criteria for ADHC services include the requirement for

[12] A medical flow sheet is a graphic summary of changing factors in the patient's condition, including vital signs, weight, and the treatments and medications given to the patient.

a high potential for deterioration of the beneficiary's condition or conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services and without specific ADHC services on each day of attendance. The documentation does not demonstrate the beneficiary meets either of these requirements. This error is calculated as the total amount paid for this claim.

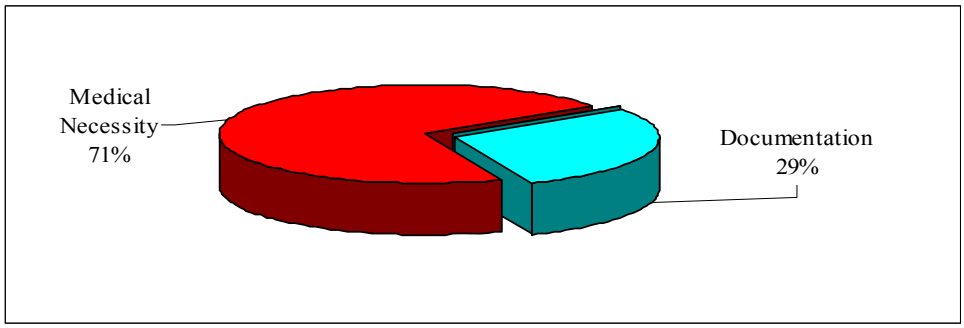
Durable Medical Equipment

One DME claim was noted as having an error in the MPES 2009 sample. It was due to lack of medical necessity.

Example of DME Medical Necessity Error - This claim is for a bath tub wall rail. The DHCS did not identify errors in the documentation the DME provider submitted. There is no documentation in the referring provider's records to indicate a need for a grab bar for the bath tub or that he intended for the patient to have such an assistive device. The error is calculated as the total amount paid for this claim.

Laboratory

Claims from seven laboratories were noted as having payment errors. Two of them (29 percent) were for insufficient documentation. The other five errors were attributed to lack of medical necessity (see below).



Examples of Laboratory Errors:

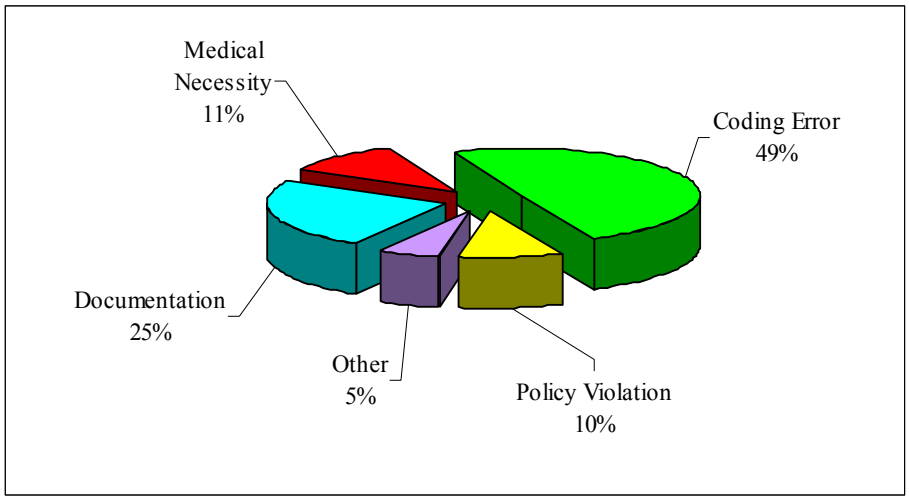
Insufficient Documentation - This claim is for three different laboratory tests, including a blood serology, which is a test used to detect syphilis, which would be indicated if a person had symptoms of the disease, characteristics of high risk, exposure to someone with high risk or known disease, or were pregnant. The ordering provider's record indicated the beneficiary had received a blood serology test 4 months previously with a normal result. No reason for repeating the test was documented. This error is calculated as the difference between the total amount for the claim and the amount that was paid for the serology test.

Medically Unnecessary - This claim is for two laboratory tests for Chlamydia and Gonorrhea. According to the referring provider medical record, the patient requested the tests although there is no medical/social history to indicate a need for the tests. The tests were not ordered by a physician or other non-physician medical practitioner authorized to order laboratory tests. The clinic registered nurse ordered the tests, which is outside her scope of practice. There is no indication the patient signed verifying the source of the specimen as required by Welfare and Institutions Code Section 14043.341. This error is calculated as the total amount paid for this claim.

Physician Services

The physician services had 73 payment errors in the MPES 2009 sample. This provider type includes physicians, clinics, emergency room visits and other licensed providers.

Nearly half of all physician errors were coding errors, 25 percent were documentation errors, and 11percent were for medical necessity. Policy violation errors accounted for 10 percent. The remaining five percent were for other miscellaneous error types.



Examples of Physician Services Errors:

Insufficient Documentation - This claim is for one managed care differential rate for a Rural Health Clinic/Federally Qualified Health Center. The only documentation provided is for an office visit with no date of service. There is no indication it is for the date of service on the claim. There is no way to determine when this documentation was written and for which of several claimed days it is for. Therefore, this error is calculated as the total amount paid for this claim.

Medically Unnecessary- This claim is for the professional and technical components for an x-ray of the lower spine and an x-ray of the right ankle. There were no errors identified in the documentation provided by the radiology provider. There was no indication in the referring provider records why either x-ray was ordered. The exam was one check mark on "General" with no documentation any systems were assessed.

There was a note that the patient was a heavy smoker and had degenerative joint disease on lumbar spine. There was no examination of the back or ankle documented. Medical necessity for these two x-rays could not be determined. This error is calculated as the total amount paid for this claim.

Coding Error - This claim is for a level five consultation. A level five consultation requires all of the following three key components: a comprehensive history, comprehensive examination and medical decision making of high complexity. The documentation provided a history that said "unremarkable" so it could not be evaluated other than the problem focused information that was included. The examination was problem-focused examination of the abdomen only with a review of an abdominal ultrasound showing gall stones. The medical decision making documented was of low complexity as a plan for gall bladder surgery. The documentation provided supports a level one consultation. The error is calculated as the difference between what was paid for this claim and what would have been paid for a level one visit CPT Code 99241.

Policy Violation - This claim is for psychological services through a rural health clinic. A rural health clinic/federally qualified health center must follow all Medi-Cal policies as they relate to services provided at the clinic. Psychological services are limited to a maximum of two visits per month per Medi-Cal policy. This claim is for a third psychological visit according to the medical record documentation. Therefore, this error is calculated as the total amount paid for this claim.

Other Medical Error - This claim is for a medical visit to a rural health clinic. The actual visit was to a newborn infant in an acute care hospital. This is not a service covered by rural health clinics. The service should have been claimed using the provider's individual provider number not as a clinic service. Since this is a service not covered by rural health clinics, this error is calculated as the total amount paid for this claim.

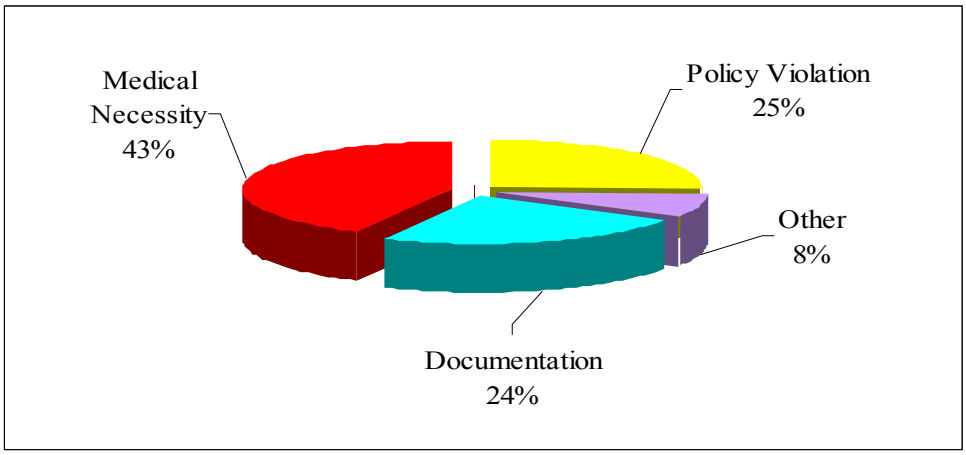
Non-Covered Service - This claim is for chiropractic manipulation of the spine. The service was provided in September 2009. Chiropractic services were discontinued as a Medi-Cal benefit effective July 1, 2009. This patient did not meet any of the exceptions to coverage discontinuation rule. There was no documentation of any manipulation for the date of service. This error is calculated as the total amount paid for this claim.

Ineligible Recipient - this claim is for physician services for a patient while a patient in an acute care hospital. An approved Treatment Authorization Request (TAR) must be obtained for inpatient services to be billable. The TAR request for this patient was denied since the patient is eligible for emergency and obstetrical services only and this was deemed to not be an emergency admission. Without an approved TAR none of the services rendered to the patient in the hospital for these dates of service are reimbursable. This includes physician services. Therefore, this error is calculated as the total amount paid for this claim.

Provider Ineligible to Bill - This claim is for a level three office visit for an established patient. The incorrect rendering provider was listed on the claim. The actual rendering provider had been suspended from the Medi-Cal program five months before this date of service and is listed as such on the public suspended an ineligible list. Therefore, this information is readily available to the billing providers. This error is calculated as the total amount paid for this claim.

Pharmacy

Errors in pharmacy claims were due to both the pharmacies making errors and errors found in the prescriber's documentation. Medical necessity payment errors are the fault of the prescribing provider, not of the pharmacy. Forty-three percent of the 87 pharmacy errors were attributed to medical necessity (again these are committed by prescribing physicians) and 25 percent to policy violations. About 24 percent of the errors were due to documentation errors. The remaining seven percent of pharmacy errors were due to other errors (including the absence of a legal prescription for the date of service, or a prescription that is missing essential information). A breakdown of pharmacy errors in the MPES 2009 sample is shown below.



Examples of Pharmacy Errors:

Medical Necessity - This claim is for Nexium, a medication used to treat gastro-esophageal reflux disease. There were no errors identified in the documentation provided by the pharmacy. The referring provider's documentation does not include any medical need for this medication. This error is calculated as the total amount paid for this claim.

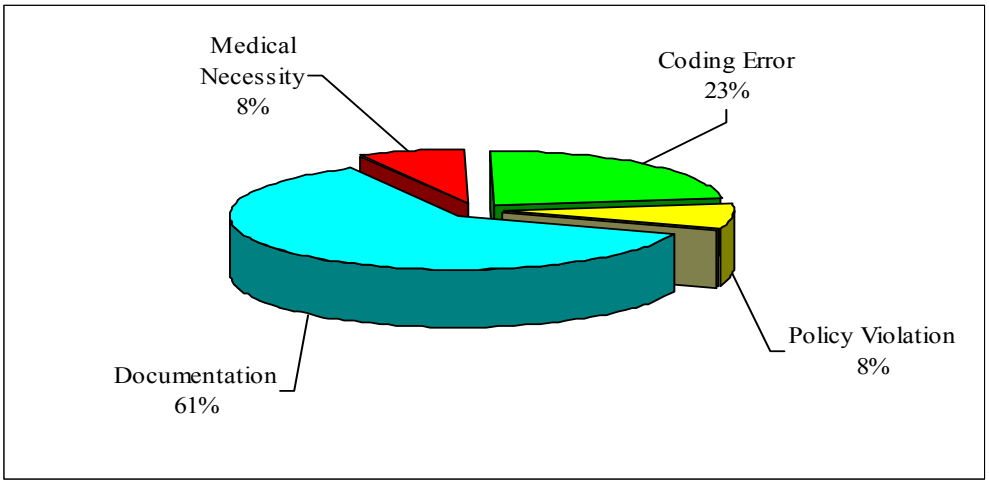
Documentation -This claim is for Prozac, a medication used to treat depression, for a patient in a skilled nursing facility. The prescribing provider documentation lacks detailed information about the patient's symptoms, the effectiveness of the medication, or any need for dose adjustments. This error is calculated as the total amount paid for this claim.

Policy violation - This claim is Coreg, a medication with a Medi-Cal Code one restriction for use in the treatment of heart failure only. There is no documentation in the pharmacy or prescribing provider records that the patient has heart failure. The medication seems to be being used to treat high blood pressure. This error is calculated as the total amount paid for this claim.

Other error - This claim is for Actonel, a medication used to treat osteoporosis. The prescription was written for three tablets, one tablet taken monthly for three months. The pharmacist dispensed one tablet each month. This allows the pharmacy to collect additional dispensing fees for the two additional fills for the prescription. According to the pharmacist and prescribing provider, no authorization to alter the prescription was obtained as required. The pharmacist told the auditor she split the prescription to make money. This error is calculated as the total amount paid for this claim.

Other Services and Supplies

Included in this category were transportation, medical supplies, and Local Education Assistance (LEA) programs, among others. The major error type in this stratum was inadequate documentation, accounting for 61 percent of 13 total errors in this category. Coding errors, with 3 errors (23 percent), was the second largest category. One policy violation error and one medical necessity (each about eight percent) also were detected in this stratum. A detailed breakdown of errors is shown on the chart below.



Examples of Errors for Other Services and Supplies:

Documentation - This claim is for a nursing assessment of a child through the Local Education Agency. The record of the assessment had not been signed. Therefore it is not possible to determine if the nursing assessment had been performed by a qualified nurse as required. The assessment states the child is overweight. However, there is no documentation of height or actual weight or Body Mass Index to objectively determine the significance or accuracy of this comment. This error is calculated as the total amount paid for this claim.

Medical Necessity - This claim is for incontinence supplies. There were no errors identified in the documentation provided by the Durable Medical Equipment (DME) provider. There was no documentation in the referring provider's records to indicate the patient had incontinence and was in need of incontinence supplies. The error was calculated as the total amount paid for this claim.

Coding Error - This claim is for ambulance service, basic life support with mileage, oxygen and an electrocardiogram. The patient's vital signs and general medical condition were stable when the ambulance arrived so the emergent situation had passed. The mileage, oxygen and electrocardiogram were appropriate. The ambulance service should have been claimed as non-emergency ambulance service. This error is calculated as the difference between the amount paid for ambulance service, basic life support and the amount that would have been paid for non-emergency ambulance service

Policy Violation - This claim is for ambulance service, an electrocardiogram and mileage to transport a patient. The ambulance service was medically appropriate as was the electrocardiogram. There were no odometer readings documented to verify the miles traveled during the transport. This error is calculated as the difference between the amount that was paid for this claim less the amount paid for the mileage.

c) Potential Fraud Errors

One of the most significant MPES goals is to identify potentially fraudulent claims. Nineteen percent (40 of 212) of the claims in error were identified as having characteristics of potential fraud or abuse, such as claiming for services that were not medically necessary. While this finding appears significant, it needs to be interpreted with caution as a single claim does not prove fraud. Without a full criminal investigation of the actual practice of the provider, there is no certainty that actual fraud has occurred.

The number of claims identified as having characteristics for potential fraud occurred in pharmacy, ADHC, and labs. Medically unnecessary potentially fraudulent errors were dominant among potentially fraudulent claims in the both the 2007 and 2009 MPES. The table below displays the breakdown of potential fraud errors.

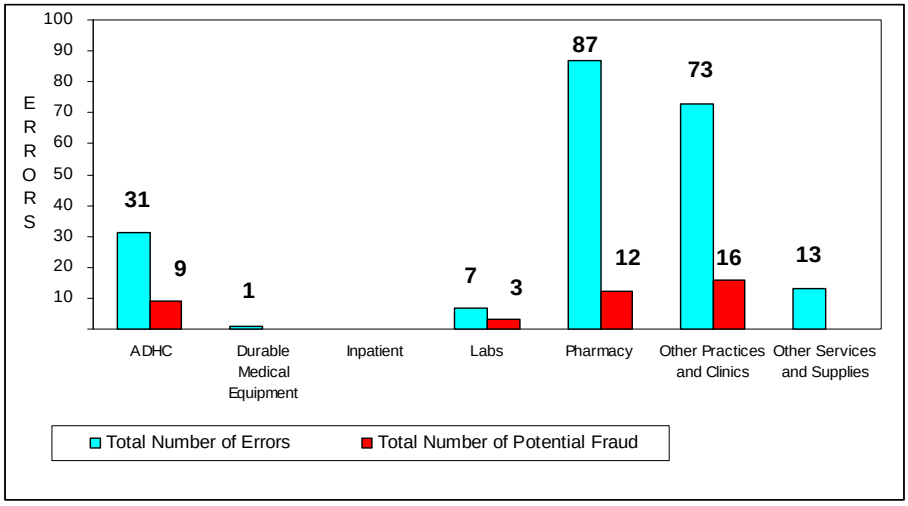
Table IV.7 Potential Fraudulent Errors by Stratum and Error Type

Error Type	ADHC	DME	Lab	Physicians	Other Services	Pharmacy	Total
Insufficient Documentation	2		1	3		3	**9**
Medically Unnecessary	7		2	4		5	**18**
Coding Error				5			**5**
No Documents Submitted						1	**1**
Policy Violation				1			**1**
Other Medical Error				2			**2**
Other Pharmacy Policy Error						1	**1**
Non-Covered Service							**0**
Ineligible Recipient							**0**
Provider Ineligible to Bill				1			**1**
No Legal Prescription							**0**
Prescription Split						1	**1**
No Signature of Receipt						1	**1**
Prescription Missing Essential Information							**0**
Wrong Client Identified							**0**
Total Errors	**9**	**0**	**3**	**16**	**0**	**12**	**40**

MPES review protocols call for the medical review team to examine each claim for potential fraud, waste, and/or abuse. See Appendix 1 regarding the steps utilized during each level of the review process in regard to potential fraud**.**

MPES 2009 consisted of 1,007 unique providers represented in the sample of 1,149 claims. A total of 40 claims, submitted by 39 unique providers, were found to be potentially fraudulent. All of these claims were forwarded to the DOJ. DOJ reviewed all claims so designated and concurred with DHCS' assessment of potentially fraudulent activity**.** All 39 providers of these claims are undergoing further review by field audit staff to determine the appropriate actions needed. Sixteen of the providers identified as submitting potentially fraudulent claims had been independently identified by DHCS prior to the MPES 2009 and were already undergoing case development and/or placed on administrative sanction when the study was conducted. The following chart compares total claims in error in the MPES 2009 sample to the potentially fraudulent claims in error.

Figure9 – Sample Errors and Fraud Errors by Stratum



The following table describes, for each error type, examples of claims in error juxtaposed to claims that have been determined to show characteristics of potential fraud.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
No Documents Submitted (MR1)	**Pharmacy Claim** This claim is for Flurazepam, a medication used to treat insomnia. There were no errors identified in the documentation provided by the pharmacy. The prescriber, a physician assistant, refused to provide any medical records to support the medical need for this medication. After several visits to the clinic and several phone calls, DHCS served a subpoena to the provider, who still refused to provide any records. This physician assistant and her supervising physician have been referred to the appropriate agencies for actions as indicated. Since no records could be obtained for review this error is calculated as the total amount paid for this claim.	There is no example of this type of error as it always considered a potential for fraud.
Medically Unnecessary (MR5)	**Pharmacy Claim** This claim is for 200 blood sugar test strips for diabetic patients. The test strips are delivered to the ADHC where the beneficiary goes twice a week. According to the beneficiary and verified by the ADHC, she does not take the strips home, and her blood sugar is tested only at the ADHC twice a week. Therefore she only needs 8 strips per month or 16 for two months. Her primary care provider has not ordered these strips for her for three years. They are being ordered by the ADHC staff physician. The prescription was for 100 test strips and the pharmacy dispensed 200 test strips as a two month order. At the rate this beneficiary's blood sugar is being tested, these 200 test strips would	**Pharmacy Claim** This claim is for Cipro, a medication used to treat bacterial infections. It is restricted for use in lower respiratory infections for persons 50 or older, osteomyelitis or pulmonary exacerbation of cystic fibrosis. This patient was 46 years old at the time she was seen. The patient complained of symptoms of a viral upper respiratory infection and perhaps a urinary tract infection. There is no indication any further evaluation was performed to determine the cause of the symptoms The patient is enrolled in Family PACT services only. None of the symptoms this medication was prescribed for are associated with family

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	last more than a year. The same number, however, was dispensed less than four months before this date of service and again six weeks after this date of service. Since 200 test strips were dispensed to the patient less than four months before this date of service, there is no need for two hundred more test strips on this date of service. There is no indication the pharmacy had authorization from the prescribing provider to change the quantity on the prescription. The date of service and the prescription date are two days after the test strips were delivered to the ADHC. Therefore, there was no legal prescription at the time of dispensing. This error is calculated as the total amount paid for this claim.	planning issues, therefore this beneficiary is not eligible for these services. This error is calculated as the total amount paid for this claim.
Poor/insufficient documentation (MR2-A)	**Pharmacy Claim** This claim is for birth control pills. The pharmacy was unable to provide proof of receipt by the patient. The prescribing provider did a pregnancy test prior to prescribing this new medication, but the results are not indicated in the record. The clinic licensed vocational nurse (LVN) performed the counseling, patient assessment, education, and the actual prescribing of the medication. This is outside the scope of LVN practice. There is no indication there was any evaluation of the appropriateness of this medication by any medical practitioner. This error is calculated as the total amount paid for this claim.	**Physician/Clinic Claim** This claim is for health/nutrition assessment one increment through a Local Education Agency (LEA). One increment is for fifteen minutes. Any service time that is at least seven minutes can be counted as an increment. The documentation provided includes a blood pressure, height, weight and Body Mass Index (BMI). This limited documentation does not support a minimum of seven minutes, as required. This error is calculated as the total amount paid for this claim.
No Documentation (MR2-B)	**Pharmacy Claim** This claim is for Flurazepam, a medication used to treat insomnia. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider, a physician assistant, refused to provide any medical records to support the medical need for this medication. After several visits to the clinic and several phone calls, the provider was served a subpoena and still refused to provide any records. This physician assistant and her supervising physician have been referred to the appropriate agencies for actions as indicated. A procedure code limitation was placed on both the physician assistant and the supervising physician. Since no records could be obtained to be reviewed, this error is calculated as the total amount paid for this claim.	**Pharmacy Claim** This claim is for Nora-Be tablets, an oral contraceptive pill (OCP). The prescription was written for three cycles. The pharmacy dispensed one cycle each month for three months, allowing the pharmacy to collect two additional dispensing fees. The pharmacy had no documentation to support the prescribing provider authorized the change in this prescription. The prescriber was unable to find any medical records for this patient. Therefore, the medical appropriateness and intent for the prescription could not be verified. This error is calculated as the total amount paid for this claim.
Coding Error (MR3)	**Physician/Clinic Claim** This claim is for a level four office visit for an established patient with the modifier for separately identifiable evaluation and management service by the same physician on the same day of a procedure and the injection	**Physician/Clinic Claim** This claim is for a comprehensive eye examination for a new patient. This examination includes a complete visual system examination, review of patient's medical history, general medical observation

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	and drainage of a joint. Use of the modifier to support an office visit is appropriate. However, the documentation provided does not support the needed components for a level four visit which are a detailed history, detailed examination and medical decision making of moderate complexity. The history and examination were problem focused and the medical decision making was of low to moderate complexity. This documentation supports a level two office visit. The documentation for the injection and drainage of the knees met the standard for the service as billed. There is some concern when reviewing the claiming pattern for this patient, that this injection/drainage procedure is being done on a monthly basis which is more frequent that the generally established standard.	and an external and ophthalmoscopic examination. The documentation supplied does not include a complete ophthalmoscopic examination. There was no examination of the posterior portion of the retina. This examination constitutes an intermediate eye examination. This patient is an established patient with this provider. This error is calculated as the difference between what was paid for the comprehensive examination for a new patient and what would have been paid for an intermediate examination for an established patient. (CPT 92012)
Policy Violation (MR 7)	**Rural Health** This claim is for psychological services through a rural health clinic. A rural health clinic/federally qualified health center must follow all Medi-Cal policies as they relate to services provided at the clinic. Psychology services are limited to a maximum of two visits per month per Medi-Cal policy. The medical records show this claim is for a third visit.	**Other Services & Supplies** This claim is for ambulance service, an electrocardiogram and mileage to transport a patient. The ambulance service was medically appropriate as was the electrocardiogram. There were no odometer readings documented to verify the miles traveled during the transport. The provider moved their place of business several years ago but Medi-Cal had no record of the change of business site. This error is calculated as the difference between the amount paid for this claim and the amount that would have been paid for the mileage.
Ineligible recipient (P7)	There is no example of this type of error as there was only one ineligible recipient identified and there were no indications of fraud.	**Physician/Clinic Claim** This claim is for physician services for a patient in an acute care hospital. DHCS denied the Treatment Authorization Request (TAR) request since the patient is eligible for emergency and obstetrical services only, and this was not an emergency admission. Without an approved TAR none of the services rendered to the patient in the hospital for these dates of service are reimbursable, including physician services. Therefore, this error is calculated as the total amount paid for this claim.
Rendering provider not eligible to bill for services/ supplies (P9-B)	**Physician/Clinic Claim** This claim is for a level three office visit for an established patient. The claim listed an incorrect rendering provider. The actual rendering provider had been suspended from the Medi-Cal program five months before this date of service and is listed as such on the public Suspended And Ineligible List. Therefore, this information	There is no example of this type of error because prescription splitting to increase reimbursement is always considered potential fraud.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	is readily available to the billing providers. This error is calculated as the total amount paid for this claim.	
Policy Violation Pharmacy (PH10)	**Pharmacy Claim** This claim is for 35 tablets of the pain medication Hydrocodone. The pharmacy claimed for 30 tablets to avoid the code one restriction of only 30 tablets per dispensing. The dispensing label stated 35 tablets and the claim was for only 30 tablets. The pharmacist states the five additional tablets were purchased separately for cash since Medi-Cal only authorized 30 tablets without prior authorization. The pharmacy had no documentation to support this cash purchase. Providers are not allowed to charge Medi-Cal patients for services covered by Medi-Cal. The pharmacy only needed authorization to claim for the additional medication.	**Pharmacy Claim** This claim is for Rifampin, a medication used to treat tuberculosis. The prescription was written for two 300mg capsules twice a week with a quantity of one month's supply. That would be 16 capsules. The pharmacy dispensed 30 capsules. The label for the medication had different directions than were on the prescription. The directions on the label were two capsules twice daily per week. This could cause the patient to take the medication incorrectly. This error is calculated as the difference between the amount that was paid for 30 capsules and the amount that should have been paid for 16 capsules.
Prescription Splitting (PH7B)	**Pharmacy Claim** This claim is for Actonel, a medication used to treat osteoporosis. The prescription was written for three tablets, one tablet taken monthly for three months. The pharmacist dispensed one tablet each month. This allows the pharmacy to collect additional dispensing fees for the two additional fills for the prescription. According to the pharmacist and prescribing provider, no authorization to alter the prescription was obtained as required. The pharmacist told the auditor she split the prescription to make money.	There is no example of this type of error because prescription splitting to increase reimbursement is always considered a potential for fraud.
Other Medical Error (MR8)	**Rural Health Clinic** This claim is for a medical visit to a rural health clinic. The actual visit was to a newborn infant in an acute care hospital. This is not a service covered by rural health clinics. The service should have been claimed using the provider's individual provider number not as a clinic service.	**Laboratory Claim** This claim is for a lab test urinalysis. This test was ordered by the Comprehensive Perinatal Health Worker (CPHW). It is outside the scope of The CPHW to order laboratory tests. There was no counter signature or separate order by a health care provider that is qualified to order laboratory tests. There was no signature from the beneficiary verifying source of the specimen, which is required. This error is calculated as the total amount paid for this claim.
Rendering provider not eligible to bill for services/ supplies (P9-B)	**Community Clinic** This claim is for a level three office visit for an established patient. The claim listed an incorrect rendering provider. The actual rendering provider had been suspended from the Medi-Cal program five months before this date of service and is listed as such on the public suspended and ineligible list. Therefore, this information is readily available to the billing providers.	There is no example of this type of error because claiming for services by a provider who has been suspended from the Medi-Cal program is always considered a potential for fraud

Error Type	Potential Fraud Identified	No Potential Fraud Identified
Wrong client identified (WCI)	There is no example of this type of error as there was only one ineligible recipient identified and it had no fraud indicators.	**Pharmacy Claim** This claim was for intravenous tubing .The claim was billed to the wrong patient and should not have been submitted. This error is calculated as the total amount paid for this claim.

4) MPES Study Comparison of Significant Items (MPES 2005 – MPES 2009)

The following lists the main findings of each MPES study, since 2005, and makes comparisons of most significant items in each study.

Study Objective	The study objectives remained the same for 2005-2009 1. Measure the payment amount of errors in Medi-Cal FFS system; 2. Identify the amount of potential fraud or abuse in Medi-Cal; 3. Identify the vulnerabilities of the Medi-Cal program.
Study Universe	The universe has changed from the second quarter in MPES 2005-2007 to the last quarter of MPES 2009.
Sampling Design	Methodology is unchanged: proportioned stratified random sampling which is dollar-weighed. This means a hospital claim in error has more of an impact than a DME claim because of the dollars associated with the stratum. All other design items, i.e.; sample size, units, confidence level, precision level, and stratum composition had no significant changes.
Error Rate & Fraud Error	The payment error rate and its subset, fraud rate, are decreasing: Error Rate — Fraud Error Rate 2005 – 8.40% — 2005 – 3.23% 2006 – 7.27% — 2006 – 2.75% 2007 – 6.56% — 2007 – 2.53% 2009 – 5.45% — 2009 – 1.16%
Trends	The MPES studies have been successful in identifying vulnerabilities in the Medi-Cal program and in redeploying resources to decrease their impact. **MPES 2005** identified ADHC providers as being a significant risk to the program with the highest percentage of claims in error and the greatest number of medical necessity errors, 31 and 28, respectively).DHCS initiated large exercises involving ADHC field reviews resulting in numerous sanctions and utilization controls being placed on providers. MPES 2006 and 2007 demonstrated a decrease in the number of errors in ADHC. **MPES 2006** showed dental claims with the highest percentage of errors – 57 percent or 29/51 claims. The increased focuses were directed to the area of dental provider education and increased dental provider reviews, as well as in a "top to bottom" review of anti-fraud activities to assess the appropriateness of anti-fraud errors. MPES 2007 showed a decline in the number of dental errors (29 vs. 14 or a reduction of 15). **MPES 2007** identified the following areas of risk: • This is the first study to find inpatient errors (two in Long Term Care

	facilities). • Physician Services, which contributed the most errors (71), have an even higher rate when those errors are combined with those in other strata caused by physicians (primarily due to lack of medical necessity and non-needed prescriptions or referrals by physicians – an additional 43 errors). When combining Physician Services errors with other strata errors caused by prescribing providers, they account for 55 percent of all errors. • Fifty percent of all Local Education Agencies claims had errors. • Half of Ground Medical Transportation Claims Other Services) had errors. • One hundred percent Incontinence Supplies errors also were associated with fraud characteristics. **MPES 2009** identified the following areas of risk • MPES 2009 identified claims lacking medical necessity as the payment error type with greatest vulnerability. This occurs with greatest frequency among ADHC providers. • Physician Services that include prescribing errors identified in pharmacy claims are the provider type posing the greatest payment error vulnerability. • Pharmacies pose the second-greatest threat with 45 percent of the sample payment errors. • ADHCs pose the third highest threat. Though they represent only about 2 percent of the payment volume in the universe, they share 22 percent of the overall 5.45 payment error in MPES 2009. • Potential fraud has decreased 64 percent since MPES 2005.
Trend in Payment Errors	Prevalent error types have changed from less-serious documentation errors to more costly and serious errors of medical necessity.
Fraud Trends	• ADHC stratum had more characteristics of fraud in MPES 2005 and 2009 than in MPES 2007. • In MPES 2007 physician services, including prescribing physicians, replaced ADHCs as the greatest risk for fraud. • MPES 2007 also identified a possible new area with characteristics of fraud – Incontinence Supplies. • MPES 2009 showed that ADHCs billing for medically-unnecessary services were the providers showing the greatest vulnerability.
Conclusion	MPES studies have successfully measured the impact of payment errors to the Medi-Cal program, identified vulnerabilities, and evaluated the effectiveness of the DHCS actions to mitigate these vulnerabilities.

V. Significant Actions Taken After Previous MPES Studies

One of the most important goals of MPES is to identify potentially fraudulent claims. While this finding is significant, it needs to be interpreted with caution since a single claim in error does not necessarily prove fraud. Without a full investigation of the actual practice of the provider, there is no certainty that fraud has occurred. The term "potential fraud" is used becausein order to determine exactly how much of the payment error is attributable to fraud requires an in-depth investigation of the provider's practice, which is beyond the scope of MPES.

All cases identified as potentially fraudulent in MPES studies are forwarded to the Department of Justice (DOJ) for a preliminary review. All cases DOJ determines as potentially fraudulent are reviewed one more time by MRB to determine if a field audit is warranted. An audit of the provider's entire practice begins with an onsite and in-depth review of all aspects of the practice. These audits are specific to each provider type. Sanctions and/or utilization controls based on Medi-Cal regulations are placed on providers depending on the audit findings. Referrals to other state agencies and/or licensing boards are based on the findings of the in-depth audits. Multiple actions may be taken on a single provider. Various agencies and licensing boards may work together for a complete and thorough investigation.

The following lists actions taken by MRB as a result of the previous MPES studies:

- MPES 2005 identified 124 claims potentially fraudulent claims out of the 1,123 sampled claims. Out of those resulted 122 actions and 30 referrals. Provider training was given to ADHCs providers because MRB audits identified issues common to several of these ADHC providers.

- Eighty of the 1,147 claims in the MPES 2006 sample were identified as potentially fraudulent, resulting in 81 actions and 37 referrals to date.

- Eighty of the 1,148 claims in the MPES 2007 sample were identified as potentially fraudulent. DOJ reviewed these and agreed that they possessed indicators of potential fraud. Although the field audits of these 80 providers are not all completed, 106 actions have already been taken and 20 referrals to other agencies and/or licensing boards have been made. Cases referred to various licensing boards or other agencies take time to complete, as each agency has its own internal protocol to follow up on investigations. Every case referred from MPES 2007 thus far is still pending.

Table V.1 below shows the number and type of all actions taken as a result of MPES 2005 through 2007 findings.

Table V.1–MPES 2005 through 2007 Sanctions and Referrals

Type of Sanction/Referral	Number of Sanctions/Referrals		
	2005	2006	2007
Sanctions			
Withholds	12	4	3
Temporary Suspensions	6	7	7
Civil Money Penalty Warning Letters	63	60	74
Prepayment Post Service Reviews		11	3
Audits for Recovery			10
Special Claims Review	37		
Procedure Code Limitations	11	1	2
Minor Problem Letters	4	6	7
Permissive Suspension	1	1	
Prior Authorization		1	
Total	**134**	**91**	**106**
Referrals			
Investigations Branch	17	8	10
Department of Justice	11	8	9
Board of Pharmacy		3	1
Denti-Cal (Delta Dental)	4	12	
Department of Aging	9	4	
Licensing & Certification	9	2	
Board of Registered Nursing	2	1	
California Medical Board		2	
Comprehensive Perinatal Services Program			
Center for Medicare & Medicaid	2		
Occupational Therapy Board	1		
Physical Therapy Board	1		
Vaccines for Children	1		
Total	**57**	**40**	**20**

VI. Other Error Studies

This Section contains reports of PERM and California's Health and Human Services' (CHHS) annual Agency Financial Report.

CHHS Improper Medicare Fee-For-Service Payments – November 2009

The CHHS annual Agency Financial Report provides a fiscal and a high-level performance overview of CHHS programs and accomplishments.[13] Section III of that document includes the detailed *Improper Payments Information Act of 2002 Report*, which indicates that the CMS had established two programs to monitor the accuracy of payments made in the Medicare Fee-for-Service (FFS) program: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). This national paid claims error rate is a combination of error rates calculated by the CERT program and HPMP. The CERT program represents approximately 60% of the payments from which the error rate is calculated and the HPMP the remaining 40%. HPMP calculates the error rate for the Quality Improvement Organizations (QIOs).[14] The CERT program calculates the error rates for all Medicare Administrative Contractors (MACs), which are the new claims processing entities created under the Medicare Prescription Drug Improvement and Modernization Act of 2003. Until the transition to MACs is completed, the CERT program will also report on Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs).[15]

Both programs mentioned above are designed to be a measurement of improper payments, which are any claims that are paid, but that should not have been paid. This includes fraudulent claims.

Neither program can measure fraud specifically, because, though both programs sample providers randomly for improper payments, they do not filter fraudulent payments from other improper payments. The CERT program, however, can identify potential fraud when the provider or supplier who submitted the bill is not located at his/her registered address.

The national Medicare FFS payment error rate calculated for the November 2009 report shows that, nationally, 7.8 percent of the payments made did not comply with one or more Medicare coverage coding, billing, and payment rules. This is 210 percent higher than the 2008 rate of 3.7 percent. HHS projected the total of all improper payments at $24.1 billion, up from $10.2 billion in 2008.[16]CHHS attributes the majority of the error rate increase to changes in the payment review methodology that made it more aggressive in detecting improper payments. The report also claims that its aggressive approach is ensuring only legitimate providers and suppliers

---

[13] http://www.hhs.gov/afr/.

[14] FY 2009 HHS Agency Financial Report, Section III Other Accompanying Information, page 52, http://www.hhs.gov/afr/2009sectiii-oai.pdf. The report states that its QIO program is its "primary program for addressing substandard care [and] includes … medical review of beneficiary complaints and quality improvement activities."

[15] https://www.cms.gov/cert/

[16] Ibid., 13. The 2009 report did not give figures for the total of all underpayments as it did the previous year.

receive Medicare payments and has nearly eliminated the no-documentation payment errors caused by potentially fraudulent providers and suppliers.[17]

"Medically Unnecessary Services" are services that were rendered to a beneficiary, but that CERT or HPMP later determined, based upon sufficient documentation, were medically unnecessary and were, therefore, paid improperly. In addition to the type of care rendered, determinations are also made in the case of inpatient claims with regard to the level of care. For example, if a Quality Improvement Organization determines that a hospital admission was medically unnecessary because it did not meet the requirements of an acute level of care, the entire payment for the admission is denied.

CMS Federal Payment Error Rate Measurement - Federal Fiscal Year 2009

Medicaid is identified as a Federal program at risk for significant erroneous payments. PERM is required by CMS pursuant to the Improper Payments Information Act of 2002.[18] The IPIA was augmented by the July 22, 2010. Improper Payments Elimination and Recovery Act (IPER).[19] Federal agencies are directed to annually review their programs and report the improper payment to Congress. CMS must use PERM to provide estimates of the accuracy of medical payments made by Medicaid as part of its annual budget request. The statutory provisions of the Social Security Act (the "Act") require states to participate. States must submit all necessary information for purposes of identifying improper payments and reducing payment error rates. The Act also requires providers to submit all necessary information regarding services provided to Medicaid beneficiaries and any payments claimed for such services.[20]

For the purposes of this study, the Centers for Medicare and Medicaid (CMS) divided all 50 states into three groups, or "cycles," of 17 states each. The states assigned to each cycle perform the PERM once every three years. California is among the "Cycle 2" states and, therefore, performed its first PERM in Federal Fiscal Year 2007[21] and is doing so again in 2010. For FY 2007, CMS measured for accuracy Medicaid FFS, Managed Care, the State Children Health Insurance Program (SCHIP), Medicaid and SCHIP beneficiary eligibility, claim payments, and premium payments made on behalf of beneficiaries.

For FFS, the PERM review is a two-part process:

Part one is the Medical Review, which began in April 2008. It compared claims to the original medical records to validate that they are accurate and processed correctly, and to verify that the services were medically necessary, coded correctly, and properly paid or denied. This process, however, excludes the review of medical records to validate the medical necessity of prescriptions.

---

[17] Ibid., 15.
[18] IPIA; Public Law 107-300.
[19] Based on Executive Order 13520.
[20] Sections 1902(a)(6), 2107(b)(1), and 1902(a)(27)
[21] October 1, 2006 - September 30, 2007.

Part two of the PERM review is the Data Processing Review. It began in May 2008 and examined the accuracy of the claims processing system.

On November 16, 2007, the CMS Office of Public Affairs announced that the Fiscal Year 2006 Medicaid FFS preliminary component error rate was 18.5 percent. In contrast, the FY 2008 Agency Financial Report (AFR) published by the U. S. Department of Health and Human Services on November 16, 2009, reported that the FY 2006 Medicaid FFS error rate was 4.7 percent. The FY 2008 AFR also reported that the FY 2007 error rate was 8.9 percent.

The PERM error rate is inaccurate because it is both overstated and understated. It is overstated because the guidance given to providers about the PERM process is unclear, and the contractors lack knowledge regarding each state's policies and regulations, resulting in the contractors misidentifying errors. The PERM error rate is understated also because physician prescription records are not reviewed for medical necessity.

For FY 2007, a total of 199 combination medical and data processing review errors were found. A majority of these errors were modified or reversed through the Difference Resolution Process, resulting in a lower error rate. In March 2008, California revised its FY 2007 FFS error rate to 4.47 percent for Medicaid and 7.80 percent for SCHIP.

Due to the differences in approach and methodology between the PERM and MPES, their results do not correlate. Medical necessity is a component of MPES but not of PERM. In addition, the MPES sample is derived from only the FFS claims adjudicated through the State's Fiscal Intermediary[22] during a 3 month time period. On the other hand, the PERM sample is derived from all Medi-Cal claims paid in a Federal Fiscal Year, including Medi-Cal Managed Care and claims paid by other state departments that administer Medi-Cal programs, such as the Department of Mental Health. Additionally, unlike PERM, MPES includes multiple levels of review for validity and medical necessity and performs a potential fraud estimate. Finally, PERM conducts an eligibility review to identify ineligible beneficiaries, whereas the MPES does not. California's revised FY 2007 eligibility error rate, published in the March 2008 PERM, was 1.17 percent for Medicaid and 0.10 percent for SCHIP.

[22] HP Enterprise Services

VII. Conclusions and Recommendations

MPES is reaching its goal of identifying and reducing fraud, waste, and abuse in Medi-Cal. For instance the overall MPES 2009 rate of 5.45 percent has been lowered from the MPES 2005 rate of 8.40 percent. That represents a decline of more than 54 percent. Similarly, fraud claims in the sample were reduced 50 percent from MPES 2009 (80 potentially fraudulent claims in MPES 2007 vs. 40 in MPES 2009. The potential fraud rate declined 63 percent from MPES 2005.

In terms of payments made in error, of the $20.5 billion dollars budgeted for Medi-Cal FFS payments, an estimated $1.07 billion dollars were paid in error. This is slightly more than the nearly $1.05 billion payment error for 2007; however, cumulatively, there are nearly $340 million fewer projected payments in error between MPES 2005 and MPES 2009.

In terms of potentially fraudulent payments, 1.16 percent of the $1.07 billion in erroneous payments showed some characteristic of potential fraud. That is equivalent to $228 million, annually, in potential fraud. DHCS uses the term "potential" fraud because to confirm the actual presence of fraud requires a more detailed criminal investigation.

The Other Services stratum contributed a very small percentage, 2.5 percent, to the overall payment error. In particular, Local Education Agency (LEA) providers improved significantly over MPES 2007. They had seven claim errors in MPES 2009, compared to 16 in MPES 2007, a reduction of 56 percent.

The DME provider type showed less than 0.2 percent share of MPES 2009 overall payment error rate, while labs, too, had a small contribution (1.2 percent).

There were no payment errors for claims for inpatient services in the MPES 2009 sample. This is due to institutional providers performing strong internal controls and Medi-Cal's rigorous use of prior authorization requirements for these services.

The lack of medical necessity for claims continues to be the most serious payment error type uncovered by MPES 2009 and constitutes the greatest vulnerability among error types. In MPES 2009, 55.6 percent of all sample errors were medical necessity errors. This totals to approximately $594 million in potential loss (or waste) to the Medi-Cal program. Medical necessity errors have represented a major threat to the Medi-Cal program in all MPES studies.

Physician services, which contributed about 29 percent of the overall payment error, is the provider type that poses the greatest threat to the Medi-Cal program. That is because physician services comprise 51 percent of all the sample errors when combined with the medical necessity errors found in the pharmacy stratum that were due to prescriber error.

Pharmacy claims accounted 45 percent of the sample errors and ADHCs 22 percent.

Although errors associated with ADHC claims represented 22 percent of the overall MPES payment error rate, this optional benefit was eliminated by the legislature and Governor beginning with the 2011-2012 Fiscal Year.

DHCS will target its efforts on the provider type determined to be most at risk, physician services. For instance, DHCS has started implementing the Individual Provider Claims Analysis Report (IP-CAR) whose purpose is to develop a more collaborative partnership among the physician community. In addition to supplying providers with billing information they compare to peers, the IP-CAR project goals are to encourage providers to become more conscientious about their billing, persuade them to bill accurate diagnosis codes and educate physicians on how to conduct a self-audit. Future IP-CAR projects will focus on prescribing practices of physicians. These prescribing physicians generated the majority of medical necessity errors in MPES 2009.

With the transition of the Medi-Cal SPD population into managed care, we are evolving into a different delivery system that will require us to identify new program integrity opportunities and expectations within the managed care plans. To accomplish this change we will be working with our partners within the department and in consultation with our contracted Health Plans.

Another significant change will be the methodology of reimbursing Inpatient Care. The Department is moving away from its contacted per diem rates to a Diagnosis Related Group (DRG) based formula. This formula relies heavily on the selection of a DRG that most accurately reflects a patient's clinical condition. Future MPES studies will be able to measure how accurately Hospitals are making these selections.

Statistically valid and reliable MPES results are contingent upon the proper evaluation of claim payments by well-qualified and comprehensively-trained medical reviewers. This review protocol is intended as a description of and reference for a consistent and understandable review process used by all reviewers to ensure inter-rater reliability.

A. Claims Processing Review Protocol

The validation of claims processing focuses on the correctness of claim data submitted to the fiscal intermediaries (Hewlett Packard) for the Department of Health Care Services (DHCS), including accurate claim adjudication resulting in payment. The claims are reviewed by comparing the providers' billing information and medical records to the adjudicated claims. Prescribed audits and edits within the HP adjudication processes are reviewed in conjunction with medical review of the sample claims. In addition, DHCS conducts pricing errors analysis to determine whether EDS made errors in payments.

a) Medical Review Protocol

Documentation Retrieval for Claim Substantiation

To ensure the integrity of documentation, the multidisciplinary staff will attend comprehensive standardized training sessions on the data collection and evaluation process. The team will then collects documentation supporting the ordered services from prescribing or referring providers in person, with follow-up requests by telephone or fax. In some cases, more than one request may be necessary to obtain the documents needed to complete the claim review. These efforts occur at multiple levels in the medical review process.

b) Multiple Review Processes

First Level Review

- Initial review of claims assigned to each Audit & Investigation (A&I) Field Office (FO) is conducted by the respective FO staff, using standardized audit program guidelines specific to each provider type. The reviewer personally collects data, conducts the initial review, and completes the data entry form.
- Medical consultants perform a secondary level review of the findings.
- Supervisors conduct a final review.
- Each claim is reviewed for the following six components:
    1. Episode of treatment is accurately documented;
    2. Provider is eligible to render the service;
    3. Documentation is complete;
    4. Claim is billed in accordance with laws and regulations;
    5. Payment of the claim is accurate;
    6. Documentation supports medical necessity.

Failure to comply with any one of the six components may constitute an error. A claim in error is any claim submitted and/or paid in error because the provider did not comply with a statute, regulation or instruction in the Medi-Cal manual, or the provider failed to document that services were medically necessary.

Second Level Review to Ensure Inter-rater Reliability

To determine the reliability of the first level review process and ensure consistency and accuracy of the findings, all cases with claims found in error plus a random sample of 10 percent of the non-error claims will be intermingled and reviewed by three different teams (each comprising three physicians) of medical consultants.

This will be a blind[23], but sequential review achieving three purposes: (a) that the dollar error identified truly reflects dollars *at risk* of being paid inappropriately, and (b) that the interviewer bias (the reviewer) has been minimized, and (c) the estimate of overall payment error is a true reflection of the universe being studied.

Specifically, multiple level reviews are conducted as follows:

- Errors deemed in the medically unnecessary category are first independently reviewed by *at least three* different medical consultants. If all three independent reviewers reach the same conclusion, the error status of the claim is held;
- If there is a difference of opinion among the independent reviewers, all initial reviewers discuss the claim and reach a consensus or majority vote decision is held. All physicians may be gathered in one room to complete this work; however, optometry and dental claims will require specialty reviews.
- The same process is repeated by clinical staff to review all claims identified as having errors not related to medical necessity. For MPES 2009, all MDs will participate in the second level medical review.

At all stages of the medical review, an electronic audit trail of each and every claim reviewed will be retained. With respect to each claim's error status at each stage in the review, the audit trail will specify decisions made, justification for that decision, who made the decision, and when. For the purpose of ensuring objectivity and consistency of the review processes, the audit trail will be available for subsequent analysis and evaluation of the review process. The audit trail will enhance inter-rater reliability and minimize non-sampling errors in the review process. This information will be made part of the MPES 2009 database.

Third Level Medical Review

Policy specialists will conduct a third level review to ensure that errors identified thus far are not actually allowable by some provision of Medi-Cal policy. All claims identified as potentially fraudulent are reviewed by the Department of Justice and confirmed as fraudulent.

---

[23] The reviewers will not be told which ones have errors and which ones do not. They will be told that "there are errors" to determine if inter-rater reliability is an issue,

B. Review Protocol for Potentially Fraudulent Claims

a) Level I Review: *Presence or absence of medical documentation by FOs*

b) Level II Review: *Was the service medically necessary?*

c) Level III Review: *Contextual analysis of all aspects of the claim and evaluation for characteristics associated with fraud. Often suspicious cases would have more than one characteristic of fraud. Some of the characteristics for potential fraud include:*

- Medical records are submitted, but documentation of the billed service does not exist and is out of context with the medical record.
- Context of claim and course of events laid out in the medical record does not make medical sense.
- No record that the beneficiary ever received the service.
- No record to confirm the beneficiary was present on the day the service was billed.
- Direct denial that the service was ever ordered by the listed referring provider.
- Level of service billed is markedly outside the level documented.
- Policy violations that were illegal or outside accepted standards of ethical practice or contractual agreements.
- Multiple types of errors on one claim.
- Billing for a more expensive service than what is documented as rendered.
- No actual place of business at the provider site listed.

d) Level IV Review

Review of provider billing patterns and presence of stereotyped errors or other suspicious activity not necessarily apparent on the claim under review.

e) Level V Review

DOJ staff review reports of all errors determined to have characteristics of potential for fraud by DHCS' A&I staff. After review, the assigned DOJ attorney discusses all findings with A&I staff before a final determination is made. Findings with which the senior attorney disagrees or has concerns are discussed with A&I staff. Before the final determination of "potential fraud" is assigned to the claim, a consensus is reached as to whether the claim is simply an error or indeed reaches the level of "potential fraud."

C. Beneficiary Eligibility Selected Sample Methodology for Fee-For-Service

In addition to the overall assessment of payment error, the MPES 2009 also includes reviews of both the FFS and Medi-Cal Managed Care programs to determine whether beneficiaries were eligible for Medi-Cal at the time services were rendered. This review process is conducted by the Program Review Section of DHCS' Medi-Cal Eligibility Branch.

Appendix 2 - MPES 2007 Summary Statistics

MPES 2007 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2007)

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	Payments in Error	Projected Annual Payments in Error
Stratum 1 - ADHC	42.54% ± 18.42%	$87,735,925.20	$37,320,505.50	$149,282,021.98
Stratum 2 - Dental	14.27% ± 14.05%	$148,182,559.00	$21,147,962.48	$84,591,849.92
Stratum 3 - DME	16.22% ± 16.28%	$30,040,760.34	$4,872,193.01	$19,488,772.06
Stratum 4 - Inpatient	1.56% ± 1.96%	$1,976,905,935.00	$30,901,758.33	$123,607,033.31
Stratum 5 - Labs	10.84% ± 9.41%	$48,077,765.07	$5,211,684.30	$20,846,737.21
Stratum 6 - Other practices and clinics	9.72% ± 6.24%	$798,043,724.00	$77,545,902.53	$310,183,610.13
Stratum 7 - Other services	7.88% ± 12.48%	$173,554,947.00	$13,680,364.68	$54,721,458.70
Stratum 8 - Pharmacy	9.77% ± 5.77%	$729,556,010.00	$71,246,848.31	$284,987,393.23
Overall Payment Error Rate	**6.56% ± 2.25%**			
Totals*		**$3,992,097,625.61**	**$261,927,219.14**	**$1,047,708,876.54**

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual error rate for the population of claims is 6.56% plus or minus 2.25%, or that the true error rate lies within the range of 4.31% and 8.81%.

The projected annual payments in error are computed by multiplying the following quantities: the payment error rate, the second quarter of 2007 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighed by total payments within each stratum. The error rate and payment error projections for each stratum are independent from each other. Therefore, adding the eight strata payment errors does not total to the overall payment error.

MPES 2006 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2006)

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	Payments in Error	Projected Annual Payments in Error
Stratum 1 - ADHC	33.51% ± 18.56%	$85,818,259	$28,758,246	$115,032,985
Stratum 2 - Dental	47.62% ± 20.86%	$143,949,022	$68,552,841	$274,211,366
Stratum 3 - DME	2.16% ± 1.95%	$31,704,970	$683,564	$2,734,257
Stratum 4 - Inpatient	0.00% ± 0.00%	$2,163,550,993	$0	$0
Stratum 5 - Labs	9.01% ± 10.00%	$45,950,912	$4,138,875	$16,555,501
Stratum 6 - Other practices & clinics	5.58% ± 2.35%	$752,146,794	$42,000,996	$168,003,985
Stratum 7 - Other services	17.03% ± 8.35%	$142,293,501	$24,239,410	$96,957,641
Stratum 8 - Pharmacy	18.52% ± 7.41%	$678,899,628	$125,756,478	$503,025,913
Overall Payment Error Rate	**7.27% ± 1.60%**			
Totals		***$4,044,314,079**	***$294,130,412**	***$1,176,521,646**

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual error rate for the population of claims is 7.27% plus or minus 1.60%, or that the true error rate lies within the range of 5.67% and 8.87%.

The projected annual payments in error are computed by multiplying the following quantities: the payment error rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighed by total payments within each stratum. The error rate and payment error projections for each stratum are independent from one another. Therefore, adding the eight strata payment errors does not total to the overall payment error.

MPES 2005 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 2004)

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	Payments in Error	Projected Annual Payments in Error
Stratum 1 - ADHC	62.23% ± 13.06%	$87,655,628	$54,548,097	$218,192,389
Stratum 2 - Dental	19.95% ± 16.72%	$154,041,783	$30,731,336	$122,925,343
Stratum 3 - DME	7.51% ± 11.85%	$29,558,596	$2,219,851	$8,879,402
Stratum 4 - Inpatient	0.00% ± N/A	$1,656,440,246	N/A	N/A
Stratum 5 - Labs	13.80% ± 6.71%	$46,185,003	$6,373,530	$25,494,122
Stratum 6 - Other practices and clinics	9.65% ± 5.22%	$744,417,656	$71,836,304	$287,345,215
Stratum 7 - Other services	10.13% ± 3.16%	$166,695,184	$16,886,222	$67,544,889
Stratum 8 - Pharmacy	12.98% ± 4.64%	$1,308,403,593	$169,830,786	$679,323,145
Overall Payment Error Rate	**8.40% ± 1.85%**			
Totals		***$4,193,397,689**	**$352,426,126**	**$1,409,704,505**

The confidence interval for the payment error rate is calculated at 95% confidence. There is a 95% probability that the actual rate for the population is 8.40% ± 1.85%, or that the true error rate lies within the range 6.55% and 10.25%.

The projected annual payments in error are computed by multiplying the following quantities: the payment error rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn in each stratum. A separate ratio estimate of the total of each stratum was calculated and weighted by total payments within each stratum. The error rate and payment error projections for each stratum are independent from one another. Therefore, the summations of the eight strata payment errors do not total the overall payment error.

MPES 2007 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2007)

Stratum	Potential Fraud Rate and Confidence Interval	Payments in Universe	Payments in Error	Projected Annual Payments in Error
Stratum 1 - ADHC	17.16% ± 10.27%	$87,735,925	$15,059,151	$60,236,605
Stratum 2 - Dental	0.00% N/A	$148,182,559	$0	$0
Stratum 3 - DME	0.46% ± 0.48%	$30,040,760	$139,413	$557,651
Stratum 4 - Inpatient	0.00% N/A	$1,976,905,935	$0	$0
Stratum 5 - Labs	0.94% ± 1.52%	$48,077,765	$450,153	$1,800,614
Stratum 6 - Other practices and clinics	5.22% ± 5.38%	$798,043,724	$41,650,008	$166,600,031
Stratum 7 - Other services	2.97% ± 5.23%	$173,554,947	$5,150,873	$20,603,493
Stratum 8 - Pharmacy	5.33% ± 4.73%	$729,556,010	$38,868,495	$155,473,981
Overall Payment Error Rate	**2.538% ± 1.46%**			
Totals*		**$3,992,097,626**	**$101,318,094**	**$405,272,376**

The confidence interval for the potential fraud rate is calculated at 95%. There is a 95% probability that the actual potential Fraud rate for the population of claims is 2.54% plus or minus 1.46%, or that the true fraud rate lies within the range of 1.08% and 4.00%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighed by total payments within each stratum. The potential fraud rate and fraudulent payment projections for each stratum are independent from one another. Therefore, adding the eight strata fraud errors does not total to the overall potential fraud error.

MPES 2006 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2006)

Stratum	Fraud Rate and Confidence Interval	Payments in Universe	Potential Fraud	Projected Annual Fraud Payments
Stratum 1 - ADHC	19.68% ± 15.72%	$85,818,259	$16,889,764	$67,559,055
Stratum 2 - Dental	29.12% ± 23.39%	$143,949,022	$41,915,724	$167,662,897
Stratum 3 - DME	0.78% ± 1.06%	$31,704,970	$246,669	$986,675
Stratum 4 - Inpatient	0.00% ± 0.00%	$2,163,550,993	$0	$0
Stratum 5 - Labs	4.01% ± 5.28%	$45,950,912	$1,840,540	$7,362,160
Stratum 6 - Other practices & clinics	3.61% ± 1.89%	$752,146,794	$27,131,101	$108,524,404
Stratum 7 - Other services	4.20% ± 2.71%	$142,293,501	$5,972,832	$23,891,327
Stratum 8 - Pharmacy	2.55% ± 1.90%	$678,899,628	$17,279,662	$69,118,648
Overall Payment Error Rate	**2.75% ± 1.02%**			
Totals*		**$4,044,314,079**	***$111,276,292**	***$445,105,166**

The confidence interval for the potential fraud rate is calculated at 95%. There is a 95% probability that the actual potential fraud rate for the population of claims is 2.75% plus or minus 1.02%, or that the true fraud rate lies within the range of 1.73% and 3.77%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighed by total payments within each stratum. The potential fraud rate and fraudulent payment projections for each stratum are independent from one another. Therefore, adding the eight strata fraud errors does not total to the overall potential fraud error.

MPES 2005 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 2004)

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	Payments in Error	Projected Annual Payments in Error
Stratum 1 - ADHC	58.04% ± 13.41%	$87,655,628	$50,875,326	$203,501,306
Stratum 2 - Dental	6.50% ± 6.46%	$154,041,783	$10,012,716	$40,050,864
Stratum 3 - DME	5.22% ± 9.11%	$29,558,596	$1,542,959	$6,171,835
Stratum 4 - Inpatient	0.00% ± N/A	$1,656,440,246	$0	$0
Stratum 5 - Labs	10.28% ± 5.16%	$46,185,003	$4,747,818	$18,991,273
Stratum 6 - Other practices and clinics	7.88% ± 4.65%	$744,417,656	$58,660,111	$234,640,445
Stratum 7 - Other services	9.73% ± 3.12%	$166,695,184	$16,219,441	$64,877,766
Stratum 8 - Pharmacy	5.31% ± 3.28%	$1,308,403,593	$69,476,231	$277,904,923
Overall Payment Error Rate	**5.04%±1.37%**			
Totals*		**$4,193,397,689**	**$211,534,602**	**$846,138,412**

The confidence interval for the potential fraud rate is calculated at 95% confidence. There is a 95% probability that the actual fraud rate for the population is 5.04% ± 1.37%, or that the true fraud rate lies within the range 3.67% and 6.41%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).

*An independent simple random sample was drawn in each stratum. A separate ratio estimate of each stratum was calculated and weighted by total payments within each stratum. The potential fraud rate and fraudulent payment projections for each stratum are independent from one another. Therefore, the summations of the eight strata fraud rates do not total the overall potential fraud rate.

Calendar Year 2007 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	CY 2006 Fee-for-Service and Dental Payments by Quarter				Total
	First	Second	Third	Fourth	
Dental	$145,452,656.21	$153,629,906.84	$154,662,453.09	$152,388,630.29	$ 606,133,646
ADHC	$108,131,879.76	$ 87,712,953.68	$104,482,682.16	$107,034,032.39	$407,361,548
Durable Medical Equipment	$33,398,483.47	$25,457,659.18	$34,241,033.17	$32,761,891.37	$125,859,067
Inpatient	$2,054,635,806.20	$1,963,153,453.30	$2,169,976,368.60	$2,162,549,291.30	$8,350,314,919
Labs	$50,758,808.47	$48,044,832.44	$57,311,520.15	$ 55,649,622.52	$211,764,784
Other Practices & Clinics	$ 883,459,577.04	$798,233,864.43	$911,732,194.61	$894,170,227.59	$3,487,595,864
Other Services & Supplies	$182,215,056.92	$173,040,911.97	$200,885,993.87	$195,361,246.27	$751,503,209
Pharmacy	$697,381,996.43	$ 649,651,080.27	$764,498,078.25	$738,314,781.21	$2,849,845,936
FFS Subtotal	**$4,009,981,608**	**$3,745,294,755**	**$4,243,127,871**	**$4,185,841,093**	**$16,184,245,327**
Total Dental & FFS	**$4,155,434,265**	**$3,898,924,662**	**$4,397,790,324**	**$4,338,229,723**	**$16,790,378,973**

Calendar Year 2006 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	CY 2006 Fee-for-Service and Dental Payments by Quarter				Total
	First	Second	Third	Fourth	
Dental	$145,452,656	$153,629,907	$154,662,453	$152,388,630	$606,133,646
ADHC	$104,211,340	$85,803,586	$97,900,452	$94,001,060	$381,916,438
Durable Medical Equipment	$28,141,104	$26,968,565	$29,656,147	$29,308,103	$114,073,920
Inpatient	$1,853,000,303	$1,998,572,102	$2,089,924,309	$1,903,410,322	$7,844,907,035
Labs	$50,438,577	$46,754,614	$56,207,717	$50,871,708	$204,272,616
Other Practices & Clinics	$771,196,694	$792,102,836	$887,287,370	$852,313,145	$3,302,900,045
Other Services & Supplies	$181,712,566	$178,462,115	$201,558,467	$184,288,689	$746,021,837
Pharmacy	$857,027,295	$616,770,479	$701,631,689	$672,394,319	$2,847,823,782
FFS Subtotal	**$3,845,727,879**	**$3,745,434,297**	**$4,064,166,152**	**$3,786,587,345**	**$15,441,915,674**
Total Dental & FFS	**$3,991,180,536**	**$3,899,064,204**	**$4,218,828,605**	**$3,938,975,975**	**$16,048,049,320**

Calendar Year 2005 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	CY 2006 Fee-for-Service and Dental Payments by Quarter				Total
	First	Second	Third	Fourth	
Dental	$143,822,337	$159,571,995	$153,301,248	$148,804,324	$605,499,904
ADHC	$83,353,271	$93,143,673	$102,707,342	$95,227,597	$374,431,883
Durable Medical Equipment	$27,384,599	$31,632,590	$33,265,845	$28,671,897	$120,954,930
Inpatient	$1,511,613,400	$1,710,600,634	$1,815,489,961	$1,881,662,618	$6,919,366,612
Labs	$43,624,490	$53,305,564	$54,870,472	$52,662,561	$204,463,086
Other Practices & Clinics	$687,497,066	$809,282,635	$833,059,577	$743,278,861	$3,073,118,139
Other Services & Supplies	$155,431,736	$185,317,786	$193,830,666	$173,600,428	$708,180,617
Pharmacy	$1,187,428,813	$1,336,486,673	$1,425,372,612	$1,434,810,950	$5,384,099,046
FFS Subtotal	**$3,696,333,374**	**$4,219,769,553**	**$4,458,596,476**	**$4,409,914,910**	**$16,784,614,313**
Total Dental & FFS	**$3,840,155,711**	**$4,379,341,548**	**$4,611,897,724**	**$4,558,719,234**	**$17,390,114,217**

Appendix 3 - Error Codes

A. Administrative Error Codes

NE - No Error

WPI - Wrong Provider Identified on the Claim

WPI-A - Wrong Rendering Provider Identified on the Claim

If the actual rendering provider is a Medi-Cal provider, has a license in good standing, and has a notice from DHCS' Provider Enrollment Division (PED) documenting that his/her application for this location has been received, OR there is a written locum tenens agreement, this is considered a compliance error.

Note: If the provider does not have a license in good standing, or is otherwise ineligible to bill Medi-Cal (i.e. is a Medi-Cal provider who has not submitted an application for this location and does not have a written locum tenens agreement, OR is NOT a Medi-Cal provider), see error code **P9 - Ineligible Provider.**

WPI-B - Wrong Referring Provider

Example: A pharmacy uses an incorrect or fictitious number in the Referring Provider field on the claim. If there is a legal prescription from a licensed provider eligible to prescribe for Medi-Cal beneficiaries, and the correct prescriber is identified on the label, this is designated a compliance error.

WPI-C - Non-physician Medical Provider Not Identified

A provider submits a claim for a service, which was actually rendered by a non-physician medical provider (NMP), but fails to use the NMP modifier, and does not document the name of the NMP on the claim or if the provider has not submitted an application to PEB for the NMP. However, if the NMP has a license in good standing, and the services are medically appropriate, this is a compliance error.

WCI - Wrong Client Identified

O - Other (List or Describe)

B. Processing Validation Error Codes

P1 - Duplicate Item (claim)

An exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.

P2 - Non-Covered Service

Policies indicate that the service is not payable by Medi-Cal.

P3 - MCO Covered Service

MCO should have covered the service and it was inappropriate to bill Medi-Cal.

P4 - Third Party Liability

Inappropriately billed to Medi-Cal; should have been billed to other health coverage.

P5 - Pricing Error

Payment for the service does not correspond with the pricing schedule, contract, and reimbursable amount.

P6 - Logical Edit

A system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid.

P7 - Ineligible Recipient (not eligible for Medi-Cal)

The recipient was not eligible for the services or supplies and the provider should have been able to make this determination.

Example: Beneficiary's eligibility is limited and is not eligible for the service billed such as eligible for emergency and obstetrical services only but received other services unrelated to authorized services.

P9 - Ineligible Provider

This code includes the following situations:

P9-A - The billing provider was not eligible to bill for the services or supplies, or has already been paid for the service by another provider.

Example 1: A provider failed to report an action by the Medical Board against his/her license.

Example 2: A provider was not appropriately licensed, certified, or trained to render the procedure billed.

Example 3: A Durable Medical Equipment (DME) provider changed ownership without notifying PED.

P9-B - The rendering provider was not eligible to bill for the services or supplies.

Example 1: The rendering provider is not a Medi-Cal provider and has not submitted an application to PED.

Example 2: The rendering provider is not licensed, or is suspended from Medi-Cal.

Example 3: The rendering provider is a NMP who is not licensed, not appropriately trained to provide the service, or who is not appropriately supervised.
Example 4: The referring/prescribing provider was suspended from Medi-Cal, is not licensed, or is otherwise ineligible to prescribe the service.

P9-C - The billing or rendering provider is a Medi-Cal provider, but not at this location.

When the error is due to a change of location, or new provider, PEB is contacted to see if there had been a delay in entering an approved change.

P10 – Other

If this category is selected, a written explanation is provided

C. Medical Review Error Codes

MR1 – No Documents Submitted

The provider did not respond to the request for documentation. The claim is unsupported due to lack of cooperation from the provider. The referring provider did not respond to the request for documentation. The claim is unsupported due to lack of cooperation from the referring provider.

MR2 – Documentation Problem Error

MR2-A - Poor Documentation

Documentation was submitted as requested, and there is some evidence that the service may have been rendered to the patient on the date of the claim. However, the documentation failed to document the nature and extent of the service provided, or failed to document all of the required components of a service or procedure as specified in the CPT or Medi-Cal Provider Manuals.

Example 1: A sign-in sheet is provided to document that a patient received a health education class. However, there was no documentation of the time, duration of the class, or contents of the class.

Example 2: An ophthalmology examination fails to include examination of the retina.

MR2 –B - No Documentation

The provider cooperated with the request for documents, but could not document that the service or procedure was performed on the date of service claimed.

MR3 – Coding Error

The procedure was performed and sufficiently documented, but billed using an incorrect procedure code. This error includes up-coding for office visits.

MR4 – Unbundling Error

The billing provider claimed separate components of a procedure code when only one procedure code is appropriate.

MR5 – Medically Unnecessary Service

Medical review indicates that the service was medically unnecessary based upon the documentation of the patient's condition in the medical record. Or in the case of Pharmacy, Labs, DME, etc., the information in the referring provider's record did not document medical necessity.

MR6 – No Record of Product Acquisition

The DME was unable to provide an invoice or other proof of purchase of the dispensed DME product

MR7 – Policy Violation

A policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with documented policy.

Example: An obstetrician bills for a routine pregnancy ultrasound, which is not covered by Medi-Cal. However, he/she uses a diagnosis of "threatened abortion" in order for the claim to be paid.

MR8 – Other Medical Error

If this category is selected, a written explanation is provided.

Example 1: The rendering provider was not clearly identified in the medical record.

Example 2: The rendering provider did not sign the medical record

MR9 – Recipient Signature Missing

A statute is in place requiring that the beneficiary, or their representative, sign for receipt of the service. If no signature was obtained, it is considered a compliance error

unless the beneficiary denies the service occurred. This code is used for DME and Laboratory signatures.

D. Pharmacy Error Codes

In MPES 2009 pharmacy claims were reviewed and assigned errors using the Medical Review Error Codes. To better reflect the errors found in pharmacy claims, the following codes were developed for subsequent Medi-Cal payment error studies.

PH1 - No Signature Log

Statute is in place requiring a beneficiary or their representative sign for the receipt of medication or other item.

PH2 - No Legal Rx for Date of Service

This code was used when no legal prescription (e.g., expired Rx, no Rx) could be found in the pharmacist's file.

PH3 - Rx Missing Essential Information

The prescription lacked information required for a legal prescription, such as the patient's full name, the quantity to be dispensed, or instructions for use.

PH5 - Wrong Information on Label

This code was used when the label did not match the prescription. For example, the physician's name on the prescription label did not match the prescription.

PH7 - Refills Too Frequent

PH7-A – Refilled earlier than 75 percent of product/drug should have been used.

PH7-B – Prescription split into several smaller prescriptions increasing dispensing fee.

PH10 - Other Pharmacy Policy Violation

Example 1: A pharmacist circumvents the policy that a 20-mg dosage of a medicine requires a TAR, by giving two 10-mg dosages/tablets instead.

Example 2: A pharmacist changes a prescription without documenting the prescribing physician's authorization to do so.

E. Compliance Error Codes

CE1 – Medi-Cal policy or rule not followed but service medically appropriate and a benefit to the Medi-Cal program.

These claims are usually assigned other error codes and then determined to be compliance errors.

Example 1- PH1 – No signature of receipt if medically appropriate considered a compliance error unless the beneficiary denies receipt of the pharmaceutical or product.

Example 2 – P9-C -Provider not enrolled at address – if otherwise eligible to provide services and services are medically appropriate, considered a compliance error.

Example 3 - WPI A, B, of C. If medically appropriate service, considered compliance error.

If the primary error is an error with a dollar impact then compliance error is not assigned
Example PH-1 – The beneficiary denies ever receiving or taking the medication – This would be a dollar error because the medication may not have been dispensed. This would not be a compliance error.

F. Indication of Fraud or Abuse

DHCS sent claims that indicated fraud to the California Department of Justice (DOJ) Medicaid Fraud Control Unit for validation according to DOJ fraud protocols. DHCS then reevaluated its own findings based upon DOJ's review.

Appendix 4–Description of All Claims in Error

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0001	ADHC	MR2B	No documentation	This claim is for three days of Adult Day Health Care (ADHC) services. No documentation could be obtained to review for this claim. The ADHC is no longer open and forwarding telephone numbers are disconnected. The owner of the building stated the building had been sold. A provider is responsible for the secure maintenance of medical records for seven years after the date of service. Closing the business does not negate this requirement. The provider could not be found to obtain these records. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0006	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria according to Welfare and Institutions Code 14526.1(d). The documentation provided by the ADHC demonstrates the patient's medical condition consisting of hypertension, Type II diabetes; mild dementia and mild pain are stable. There is no indication in the documentation provided by the ADHC the beneficiary has a high potential for deterioration of her conditions to the levels that would result in emergency department visits, hospitalization, or other institutionalization if the ADHC services were not provided. The beneficiary does not meet medical necessity criteria for ADHC services. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0008	ADHC	MR5	Medically unnecessary service	This claim is for 14 days of ADHC services. A beneficiary must meet all five medical necessity criteria to be eligible for ADHC services. This beneficiary has stable medical conditions that are not impacted by ADHC services. These conditions are not at a level where without them there is a high potential for deterioration to the level likely to result in emergency department visits, hospitalization or other institutionalization if ADHC services were not provided. The beneficiary's dementia is mild and the documentation does not support a need for nursing supervision to allow the beneficiary to remain in the community and avoid emergency department visits, hospitalization or other institutionalization which is required to meet criterion five. This error is calculated as the total amount paid for this claim.	$1,067.78	$0.00	$1,067.78

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0010	ADHC	MR5	Medically unnecessary service	This claim is for one day of ADHC services. The beneficiary must meet all five medical necessity criteria to qualify for ADHC services. According to the documentation provided by the ADHC, this beneficiary's medical conditions, Type II Diabetes, hypertension, arthritis in the knees, peptic ulcer disease and depression are managed with medication which the beneficiary takes independently and are well controlled. The patient's depression is mild enough to not need medication. The documentation supports these conditions are stable and do not indicate a potential for deterioration to the levels needing emergency department service, hospitalization or other institutionalization if ADHC services were not provided. There was some inconsistencies in the documentation provided, as well. The Individualized Plan of Care (IPC) stated beneficiary needed assistance with ambulation. However, the physical therapist and professional nurse both described the beneficiary as ambulating independently. The IPC also stated the beneficiary had depression. There was no nursing or social worker documentation of services related to depression. This error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0011	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for six days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. The documentation provided by the ADHC describes conditions such as hypertension, hypothyroidism, Benign Prostatic Hyperplasia (BPH), peripheral vascular disease and mild shortness of breath, all of which are stable and can be well managed by the primary care provider (PCP) through periodic office visits. There is no indication in the documentation this beneficiary is likely to deteriorate to the levels needing emergency department visits, hospitalization or other institutionalization without ADHC services. The IPC states the beneficiary has depression. There is no mention of this by the PCP and the beneficiary is not on any medication for depression. There are no individual services provided by the ADHC for this depression. This error is calculated as the total amount paid for this claim.	$457.62	$0.00	$457.62

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0017	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria according to Welfare and Institutions Code 14526.1(d). According to the documentation provided by the ADHC, this beneficiary's medical conditions, high blood pressure, dizziness, arthritis, insomnia appear to be stable. These conditions seem well controlled with medication as prescribed by the beneficiary's primary care provider. The beneficiary takes her own medications. There is no indication in the documentation provided by the ADHC the beneficiary has a high potential for deterioration of her conditions to the levels that would result in emergency department visits, hospitalization, or other institutionalization if ADHC services were not provided. The beneficiary does not meet medical necessity criteria for ADHC services. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0018	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria as defined in Welfare and Institutions Code section 14526.1 to qualify for ADHC services. According to the documentation provided by the ADHC, this beneficiary's medical conditions are stable and well managed as an outpatient by the beneficiary's primary care provider. There is no indication a high potential exists for the deterioration of the beneficiary's conditions to levels likely to result in emergency department visits, hospitalization or other institutionalization without ADHC services. This error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0019	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. The beneficiary must meet all five medical necessity criteria to qualify for ADHC Services. The documentation from the ADHC does not demonstrate the beneficiary meets all five criteria. His conditions are essentially stable. For the two months before these dates of service, the beneficiary was absent from the ADHC for personal reasons. There is no indication there was any decline in his conditions as a result of this absence. There is no indication this beneficiary is a high risk for deterioration to the levels that emergency department visits, hospitalizations or other institutionalization is likely to result without ADHC services. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0021	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary lives in a board and care facility that meets all her Activities of Daily Living (ADLs) and Instrumental Activities of Daily Living (IADLs). To meet criterion two, the beneficiary must have limitations in the performance of two or more of these activities and need supervision or assistance with these activities. This supervision or assistance must be in addition to any other support the beneficiary is receiving in their place of residence. According to the documentation provided by the ADHC, this beneficiary's conditions appear stable and she does not demonstrate a high potential for deterioration in these conditions that would likely result in emergency department visits, hospitalization or other institutionalization if ADHC services were not provided. The beneficiary does not meet all criterion for ADHC services. This error is calculated as the total amount of this claim.	$152.54	$0.00	$152.54
0022	ADHC	MR2B	No documentation	This claim is for three days of ADHC services. The provider is no longer in business and no contact information was provided. Since records were not available for review a determination that the services were medically necessary and appropriately provided could not be made. Therefore, this error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0023	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. The documentation provided by the ADHC describes a beneficiary whose conditions such as dementia, Type II diabetes, osteoarthritis and osteoporosis are well managed with medication and are not at a point where there is a high potential for deterioration of these conditions in a manner likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services. Medication management is accomplished by the caregiver. The beneficiary lives with his wife. This beneficiary does not meet criterion for ADHC services. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0024	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria as described in Welfare and Institutions Code, Section 14526.1 to be qualified for ADHC services. The documentation provided by the ADHC shows the patient has hypertension and Type II diabetes both of which are within acceptable ranges. The documentation does not describe any conditions that would indicate the beneficiary has a high probability of deteriorating to the level requiring emergency department visits, hospitalization or other institutionalization if ADHC services were not available. The beneficiary does not meet all the criterion for ADHC services. There is no documentation for one of the required core services, therapeutic activities as described on the IPC, was provided on each day of attendance as required to meet criterion number five. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0026	ADHC	MR2A (Potential for fraud or abuse noted)	Poor/insufficient documentation	This claim is for one day of ADHC services. Medical necessity criteria number five requires that all core services be required and provided on each day of attendance. The core services which need to be required and provided on each day of attendance are not planned for on the IPC. The center is required to provide personal care services or social services on each day of attendance. There are no personal care services needed at all. The social services will at best provide services twice a week and the beneficiary is scheduled to attend 3 times a week. Therefore, this core service requirement of either personal care or social service on each day of attendance is not being met. There were no social services provided on the date of service for this claim. Since not all of the required core services were provided on this day of service, this error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0027	ADHC	MR2B (Potential for fraud or abuse noted)	No documentation	This claim is for four days of ADHC services. The provider was unable to provide a current IPC, history and physical with request for services from primary care provider and many of the needed flow sheets. According to the program director many records were taken by employees that had been fired. There was no indication an new history and physical or IPC had been accomplished by the center. Therefore, center was unable to support the services were, requested, needed or provided. This error is calculated as the total amount paid for this claim.	$305.08	$0.00	$305.08

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0028	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary lives in a Community Care Licensed Facility where all his ADL/IADL needs are met. Therefore, he does not met criterion two. There is no indication a high potential exists that this beneficiary's conditions are likely deteriorate to the levels where emergency department visits, hospitalization, or other institutionalization will occur to ADHC services were not provided. Therefore, the beneficiary does not meet all criterion for ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0029	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary lives in a Community Care Licensed Facility where all his ADL/IADL needs are met. Therefore, he does not meet criterion two. There is no indication a high potential exists that this beneficiary's conditions are likely to deteriorate to the levels where emergency department visits, hospitalization, or other institutionalization will occur to ADHC services were not provided. His conditions are at a level where they can be managed effectively through outpatient care. Therefore, the beneficiary does not meet all criterion for ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0030	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary has well controlled benign hypertension, esophageal reflux, heartburn, osteoarthritis and backache. The documentation provided by the ADHC does not support that any of these conditions individually or in combination creates a high potential for the deterioration of the beneficiary's conditions to levels that are likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services. The beneficiary was recently discharged from skilled physical therapy due to marked decrease in pain and practice of doing exercises at home. The beneficiary has no cognitive impairment or depression and recently obtained his driver's license. This beneficiary does not meet criterion number four. This error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0031	ADHC	MR2A	Poor/insufficient documentation	This claim is for one day of ADHC services. There is some conflicting information related to the beneficiary's level of functioning in the documentation provided by the ADHC. The beneficiary has cognitive and memory problems. However, these problems and any substantive services are not well documented. Her medical conditions are within acceptable range and could easily be managed by her primary care provider. The beneficiary states she is more independent in ADLs/IADLs than the center documentation supports. However, she has some memory problems so the accuracy cannot be verified. She also has in home support services so many of her ADL/IADL needs are met outside the center. This is not addressed by the ADHC. The error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0032	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary has some cognitive difficulties and limitations in her ADLs/IADLs. However, she has 125 hours of In Home Support Services (IHSS) which should be sufficient hours to meet her specific needs. She also lives with her son who is able to provide additional services if needed. Her son also administers her medications without problems so there is no need for further intervention related to medications from the ADHC. Her other conditions are all maintained within acceptable parameters by services outside the ADHC. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0034	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. According to the documentation provided by the ADHC, this beneficiary's conditions are well within acceptable parameters. His hypertension, knee pain, COPD, angina, coronary artery disease are controlled with medication and documented as such in the center's nursing notes. The center's documentation shows these conditions to be well managed by the participant’s primary care provider. The patient exercises at home according to center documentation. There is no indication this beneficiary needs services at the ADHC for these conditions to remain within acceptable parameters. There is no high potential of deterioration in the beneficiary's conditions to the level likely to result in emergency department visits, hospitalizations or other institutionalization without ADHC services. This beneficiary does not meet all criterion for ADHC services. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0035	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary lives in a board and care facility so his ADLs and IADLs are provided outside the ADHC. This beneficiary does not meet criterion number two. The documentation provided by the ADHC shows a beneficiary without mental conditions and his medical conditions have been within acceptable parameters for at least six months prior to this claim. The only actual problem the center is addressing is the patient's pain level. Yet, the center has documented the patient has had no pain for several months. There is no intervention being provided by the center that is maintaining this patient without pain. There is no indication this beneficiary has a high potential for deterioration of his conditions to levels likely to result in emergency department visits, hospitalization, or other institutionalization if ADHC services were not provided. This beneficiary does not meet criterion for ADHC services. This error is calculated at the total amount paid for this claim.	$152.54	$0.00	$152.54
0036	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria according to Welfare and Institutions Code 14526.1(d) to receive ADHC services. According to the documentation provided by the ADHC, this beneficiary's medical conditions, hypertension and pain are well controlled. The center is not providing any services to keep these conditions within acceptable parameters. The center is only documenting that they are within acceptable parameters. There is some confusion in the documentation. On the IPC the center has documented the patient lives alone. According to the social work assessment she lives with spouse, daughter and son-in-law. Her ADLs and IADL needs can easily be met by herself, her family and her IHSS care giver. Since the ADLs and IADLs are met outside the center. There is no indication in the documentation provided by the ADHC the beneficiary has a high potential for deterioration of her conditions to the levels that would result in emergency department visits, hospitalization, or other institutionalization if ADHC services were not provided. The beneficiary does not meet all medical necessity criteria for ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0038	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary has significant mental health problems and is receiving intensive services for these problems two to three times a week at a health organization outside the ADHC. There is no indication in the documentation provided by the ADHC this beneficiary is receiving any nursing service for these mental health conditions. He has no assessment by the ADHC's psychological consultant and the documentation by the social work staff at the ADHC is minimal and it is difficult to determine what, if any, services are provided. There is no indication this beneficiary's condition will deteriorate to the level needing emergency room visits, hospitalization or other institutionalization without ADHC services. The beneficiary does not meet all medical necessity criterion for ADHC services. The documentation for nursing services and social services is minimal and it can't be determined what if any services were provided. This error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0041	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for one day of ADHC services. To receive ADHC services a beneficiary must meet all five medical necessity criteria. According to the ADHC documentation, this beneficiary's medical conditions were stable and the ADHC documentation did not demonstrate a potential for deterioration to the levels needing emergency department visits, hospitalization, or other institutionalization if ADHC services were not provided. According to W&I Code 14528.1(a), the personal health care provider, as defined in Section 14552.3, shall have and retain responsibility for the participant's medical care. Section 14528.1(b), The initial assessment for ADHC services may be performed by the center's staff physician if the participant does not have a personal health care provider. The center's physician did this participant's initial assessment; however, the participant did have a personal health care provider. The PCP denied ever signing any authorization for his patient to attend ADHC. This participant attends the center two days a week. The Social work IPC states the participant will receive care coordinator two times a week. There was no documentation this service was provided. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0043	ADHC	MR2B	No documentation	This claim is for one day of ADHC services. The provider has closed the business and no records could be obtained for review. The provider is responsible for secure maintenance of records for seven years are date of service. This requirement is not negated when the business closes. The leasing agent for the building stated the ADHC had closed and left no forwarding contact information. This error is calculated as	$76.27	$0.00	$76.27

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				the total amount paid for this claim.			
0044	ADHC	MR2B	No documentation	This claim is for one day of ADHC services. The provider has closed the business and no records could be obtained for review. The provider is responsible for secure maintenance of records for seven years are date of service. This requirement is not negated when the business closes. The leasing agent for the building stated the ADHC had closed and left no forwarding contact information. This error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0046	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for two days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. This beneficiary's medical conditions, hypertension, angina, osteoarthritis, Type II Diabetes, and chronic obstructive pulmonary disease, are being maintained within acceptable levels where routine outpatient monitoring is an acceptable level of service. This beneficiary does not demonstrate a high potential for deterioration of his conditions to a level that would be likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services. The IPC used to obtain authorization to bill Medi-Cal for these services was signed by the physician contracted with the center. This physician is suspended from the Medi-Cal program. Therefore, the ADHC is in violation of Welfare and Institutions Code section 14043.61. This code explains a suspended provider may not directly or indirectly submit claims or receive reimbursement from the Medi-Cal program. Since a physician's signature is required to obtain authorization to submit claims and the resulting payments are used to reimburse this physician, this ADHC is in violation of this code. Suspended and Ineligible providers are listed at the Medi-Cal website which is available to the public. This error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0047	ADHC	MR5	Medically unnecessary service	This claim is for eight days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. According to the documentation provided by the ADHC, this beneficiary has several conditions, all of which are at a level where regular outpatient monitoring by her primary care provider would be appropriate. She lives alone and gets regular assistance with her IADLs as needed through regular visits by her daughter. This support is sufficient to maintain her in the community. She also does not meet medical necessity criterion since her conditions, such as osteoporosis and dizziness, do not demonstrate a high potential for deterioration to the levels where emergency department visits, hospitalizations, or other institutionalization are likely to occur without ADHC services. This error is calculated as the total amount paid for this claim.	$610.16	$0.00	$610.16
0048	ADHC	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for three days of ADHC services. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. The beneficiary has several medical conditions, such as low back pain, osteoarthritis, and BPH, none of which appear to be in need of care at the frequency provided by the ADHC. According to the ADHC documentation this beneficiary's health conditions are at a level where routine monitoring by the beneficiary's primary care provider is an acceptable level of care. The beneficiary does not meet criterion number four since the conditions he has do not demonstrate a high potential for deterioration to levels likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services. The beneficiary also does not meet criterion five. He conditions are stable and need only occasional evaluation and intervention which can be accommodated with routine visits to his primary care provider. His conditions do not require the services specified in W&I Code Section 4550.0 on each day of attendance to remain in the community and avoid emergency department visits, hospitalization or other institutionalization. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0049	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. The documentation provided by the center demonstrated the beneficiary's conditions, such as type II diabetes, hypertension and osteoarthritis were at a level where routine monitoring by their PCP was sufficient. The patient checked her own blood sugar levels so the ADHC was not needed for this. Her blood pressure was elevated on occasion at the center with only minimal intervention. Which was rest and rechecks of the blood pressure was implemented and effective. Both are actions the beneficiary can do independently. There is no indication in the documentation the beneficiary's conditions are such that there is a high risk of deterioration to the levels where it is likely the beneficiary will require emergency department visits, hospitalization. Or other institutionalization without ADHC services. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0050	ADHC	MR5	Medically unnecessary service	This claim is for three days of ADHC services. To be qualified to receive ADHC services, a beneficiary must meet all five medical necessity criteria. The documentation provided by the ADHC demonstrates the beneficiary’s conditions were stable. Therefore, the beneficiary does not meet criterion four which states the beneficiary must have a condition or conditions that would likely deteriorate to the level that results in emergency department visits, hospitalization, or other institutionalization without services from the ADHC. This error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0095	DME	MR5	Medically unnecessary service	This claim is for a bath tub wall rail. There were no errors identified in the documentation provided by the Durable Medical Equipment (DME) provider. The prescribing provider's records were mostly illegible. There is no documentation in the referring provider's records to indicate a need for a grab bar for the bath-tub or that he intended for the patient to have such an assistive device. The error is calculated as the total amount paid for this claim.	$47.55	$0.00	$47.55
0154	Labs	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for multiple laboratory tests through the Family PACT program. Their justification for all tests when billing with diagnosis code S101 was not documented, except the lipid profile. There is no indication in the referring provider's record the beneficiary had an elevated screening cholesterol or significant risk factors for cardiovascular disease which is required by the Family PACT program. The beneficiary did not sign verifying the source of her specimens. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the lipid profile CPT Code 80061.	$79.35	$65.47	$13.88

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0158	Labs	MR5	Medically unnecessary service	This claim is for a hemogram laboratory test. There were no errors identified with the documentation provided by the laboratory. The documentation provided by the referring provider was mostly illegible. There was no indication discernable in the referring provider records for the test. The error is calculated as the total amount paid for the claim.	$8.50	$0.00	$8.50
0162	Labs	MR2A	Poor/insufficient documentation	This claim is for three different laboratory tests. There were no errors identified in the laboratory documentation. According to the referring provider's records, the patient had one of the three tests done four months before and the results were normal. There is no documentation to suggest there was a need for a repeat test. This error is calculated as the difference between the total amount for the claim and the amount that was paid for the serology test.	$18.02	$13.51	$4.51
0163	Labs	MR2B (Potential for fraud or abuse noted)	No documentation	This claim is for a urine pregnancy test. The provider had no records to support services were provided on the claimed date of service. The provider stated the patient was scheduled for an appointment that date but did not keep the appointment and that the test should not have been billed. This error is calculated as the total amount paid for this claim.	$4.30	$0.00	$4.30
0177	Labs	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for two laboratory tests for syphilis and HIV. There was no documentation in the referring provider's record justifying the need for the tests. There was no beneficiary signature verifying the source of the specimens collected. This error is calculated as the total amount paid for this claim.	$17.21	$0.00	$17.21
0187	Labs	MR5	Medically unnecessary service	This claim is for two laboratory tests for Chlamydia and Gonorrhea. According to the referring provider medical record, the tests were requested by the patient although there is no medical/social history to indicate a need for the tests. The tests were not ordered by a physician or other non-physician medical practitioner authorized to order laboratory tests. The tests were ordered by the clinic registered nurse which is outside her scope of practice. There is no indication the patient signed verifying the source of the specimen as required by Welfare and Institutions Code Section 14043.341. This error is calculated as the total amount paid for this claim.	$77.60	$0.00	$77.60
0209	Labs	MR5	Medically unnecessary service	This claim is for four laboratory tests related to gastro intestinal problems. Medical necessity for three of the four tests is well documented and there is no error with the laboratory documentation. There is no medical necessity documented for the fourth test. There is no indication the test was ordered and there are no results for the test. This error is calculated as the difference between the amount that was paid for the entire claim and the amount that was paid for the Cryptosporidium test.	$18.48	$10.17	$8.31

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0220	Other Practices & Clinics	MR3	Coding error	This claim is for a comprehensive eye examination for a new patient. This examination includes a complete visual system examination, review of patient's medical history, general medical observation and an external and ophthalmoscopic examination. The documentation supplied does not include a complete ophthalmoscopic examination. There was no examination of the posterior portion of the retina. This examination constitutes an intermediate eye examination. This patient is an established patient with this provider. This error is calculated as the difference between what was paid for the comprehensive examination for a new patient and what would have been paid for an intermediate examination for an established patient. (CPT 92012)	$46.98	$30.29	$16.69
0227	Other Practices & Clinics	MR3	Coding error	This claims is for a level five consultation. A level five consultation requires all of the following three key components: a comprehensive history, comprehensive examination and medical decision making of high complexity. The documentation provided a history that said "unremarkable" so it could not be evaluated other than the problem focused information that was included. The examination was a problem focused examination of the abdomen only with a review of an abdominal ultrasound showing gall stones. The medical decision making documented was of low complexity as a plan for gall bladder surgery. The documentation provided supports a level one consultation. The error is calculated as the difference between what was paid for this claim and what would have been paid for a level one visit CPT Code 99241.	$101.08	$30.29	$70.79
0231	Other Practices & Clinics	MR3	Coding error	This claim is for a level four emergency department visit. A level four emergency department visit must have the following three components: a detailed history, a detailed examination and medical decision making of moderate complexity. The documentation supported a detailed history and examination. The medical decision making was of low complexity for flu symptoms. This is consistent with a level three emergency department visit. The error is calculated as the difference between the amount that was paid for the level four emergency department visit and the amount that would have been paid for a level three emergency department visit CPT Code 99283.	$67.67	$44.15	$23.52
0232	Other Practices & Clinics	MR8 (Potential for fraud or abuse noted)	Other medical error	This claim is for the managed care differential payment to a rural health clinic. The documentation for the visit is not signed by any provider. The clinic staff could not identify who provided the service. Since there is no identification of the person providing the service, it is not possible to determine if they are appropriately qualified to do so. This error is calculated as the total amount paid for this claim.	$107.67	$0.00	$107.67

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0233	Other Practices & Clinics	MR5	Medically unnecessary service	This claim is for one day of ADHC services through a Rural Health Clinic. A beneficiary must meet all five medical necessity criteria to qualify for ADHC services. According to the documents provided by the ADHC, this beneficiary has several chronic health conditions such as cerebral palsy, herniated disc, osteoarthritis and neurotic pain, all of which are at a level where routine out patient management by her primary care provider would be sufficient to maintain these conditions. Documentation does not support a high potential for deterioration of the conditions to a level likely to result in emergency department visits, hospitalization, or other institutionalization without ADHC services exists. Furthermore, this beneficiary's conditions are at a level where they do not require daily nursing services to maintain her ability to remain in the community and avoid emergency department visits, hospitalization, and other institutionalization. What nursing services she does receive such as monitoring pain levels, do not impact the condition or influence her ability to remain in the community. Therefore, she does not meet all medical criterion for ADHC services. This error is calculated as the total amount paid for this claim.	$171.88	$0.00	$171.88
0234	Other Practices & Clinics	MR2B (Potential for fraud or abuse noted)	No documentation	This claim is for one managed care differential rate for a Rural Health Clinic/Federally Qualified Health Center. The only documentation provided is for an office visit with no date of service. There is no indication it is for the date of service on the claim. There is no way to determine when this documentation was written and for which of several claimed days it is for. Therefore, this error is calculated as the total amount paid for this claim.	$111.48	$0.00	$111.48
0245	Other Practices & Clinics	MR2B	No documentation	This claim is for six physician services for an acute care hospital inpatient. CPT Code 90935 is used for dialysis with a single physician evaluation. There is no documentation provided to support this code. The remaining five services are for hospital care level one and level two. The documentation is mostly illegible but all services appear to be appropriately billed except for the services on November 24, 2009. This services was billed as a level two hospital care visit. The documentation supports only a level one hospital care visit. The error is calculated as the difference between the total amount of the claim and the amount paid for CPT Code 90935. Also the difference between the amount billed for one level two hospital care visit CPT Code 99232 and the amount that would have been paid for a level one hospital care visit CPT Code 99231.	$212.53	$146.52	$66.01
0247	Other Practices & Clinics	MR2B	No documentation	This claim is for a lung function test and immunotherapy injection. There is no error in the documentation for the immunotherapy. There is no documentation to support the lung function test as claimed was provided. The only test documented was a peak flow test which is a	$20.32	$8.02	$12.30

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
		(Potential for fraud or abuse noted)		non-skilled procedure which is not part of the procedure code claimed. Therefore, the lung function test as claimed is not payable. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the lung function test. (CPT Code 94200)			
0248	Other Practices & Clinics	MR2B	No documentation	This claim is for an office visit to a Rural Health Clinic. Several attempts to contact this provider were unsuccessful. The phone numbers obtained were no longer in service. Another local medical clinic verified with the auditor that this clinic was closed. Since no records could be obtained to verify medical necessity, this error is calculated as the total amount paid for this claim.	$73.71	$0.00	$73.71
0254	Other Practices & Clinics	MR2A	Poor/insufficient documentation	This claim is for the technical and professional components for two non-stress tests for a woman with a high risk pregnancy. The documentation for the test of the second date of service is complete. The documentation provided for the first date of service consisted of only the technical component of the test. There was no professional component of the test provided. This date of service should have been claimed as the technical component only. This error is calculated as the difference between the total amount paid for this claim and the amount that would have been paid for the professional component of the first test. CPT Code 59025	$45.14	$36.11	$9.03
0255	Other Practices & Clinics	MR2B (Potential for fraud or abuse noted)	No documentation	This claim is for an antepartum follow-up office visit. There is no documentation this antepartum visit ever occurred. The only documentation available was an ultrasound done the date of service on the claim by the ultrasound technician. The office manager stated the provider is in this office on Tuesdays only. This date of service was a Monday. This error is calculated as the total amount paid for this claim.	$59.88	$0.00	$59.88
0260	Other Practices & Clinics	MR2B	No documentation	This claim is for a simple telex isodose plan for a patient before beginning radiation therapy. There was no documentation provided that this plan was accomplished. The error is calculated as the total amount paid for this claim.	$24.11	$0.00	$24.11
0262	Other Practices & Clinics	MR3	Coding error	This claim is for a level five emergency department visit. To be a level five visit the three components must be present: a comprehensive history, comprehensive examination and medical decision making of high complexity. The documentation provided contained a comprehensive history and examination and medical decision making of moderate complexity for nausea, vomiting, syncope in a pregnant woman. This documentation is consistent with a level four visit. This error is calculated as the difference between the amount paid for the level five emergency department visit and the amount that would have been paid for CPT Code 99284.	$107.00	$67.67	$39.33

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0263	Other Practices & Clinics	MR3	Coding error	This claim is for a level three emergency department visit. To be a level three visit the following three components must be present: an expanded focused history expanded focused examination and decision making of moderate complexity. The documentation provided contains expanded focused history and examination and decision making of low complexity for viral syndrome with no medical intervention which supports a level two visit. This error is calculated as the difference between the amount that was paid for the level three emergency department visit and the amount that would have been paid for a level two visit, CPT Code 99282	$44.15	$24.14	$20.01
0269	Other Practices & Clinics	MR3 (Potential for fraud or abuse noted)	Coding error	This claim is for a level three office visit for an established patient. A level three office visit requires two of the following three components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. There was no history and no examination in the record. Therefore, the documentation for this claim supports a level one office visit. This error is calculated as the difference between what was paid for CPT Code 99213 and what would have been paid for CPT Code 99211.	$45.82	$34.55	$11.27
0278	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit two of the three following components must be present: An expanded problem focused history, an expanded problem focused examination and medical decision making of low complexity. The documentation provided contains a problem focused history which is only the patient's complaint and examination which includes the head, eyes, ear, nose and throat examination and straight forward medical decision making only documented as “benign” which supports a level two office visit. This error is calculated as the difference between the amount that was paid for the level three office visit and the amount that should have been paid for a level two office visit, CPT Code 99212.	$25.92	$19.55	$6.37
0279	Other Practices & Clinics	P2	Non-covered service	This claim is for three acupuncture services. One of the three services was provided after July 1, 2009, when acupuncture was removed as a covered benefit. There was no documentation to support this service met any of the exemption criteria for continued service. The Medi-Cal fiscal intermediary verified this claim was paid in error. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the one service after July 1, 2009. (CPT Code 97814)	$28.65	$17.19	$11.46
0280	Other Practices & Clinics	MR2B	No documentation	This claim is for two laboratory tests for a patient in the emergency department. There is no order for the Thromboplastin time, Partial (PTT) test. The other test was ordered and accomplished without error. This error is calculated as the difference between the total amount paid	$3.48	$2.16	$1.32

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				for this claim and the amount that was paid for the PTT. CPT Code 85730			
0290	Other Practices & Clinics	MR3	Coding error	This claim is for a level three emergency department visit. To be a level three emergency department visit all three of the following components must be present: an expanded problem focused history; an expanded problem focused examination, medical decision making of moderate complexity. The documentation provided had an expanded focused history and examination with medical decision making of low complexity which is consistent with a level two emergency department visit. This error is calculated as the difference between the amount that was paid for the level three emergency department visit and the amount that would have been paid for a level two emergency department visit, CPT Code 99282.	$44.15	$24.38	$19.77
0291	Other Practices & Clinics	MR2A	Poor/insufficient documentation	This claim is for an initial antepartum office visit. This patient transferred to this provider to continue her obstetrical care. The initial examination was not complete. The documentation for this new antepartum visit was incomplete. There is no indication any pelvic examination was accomplished nor was there any indication in the documentation why it was not done. The records form the referring provider also did not include a pelvic evaluation. This level of documentation is more consistent with a follow-up visit than a new visit. This error is calculated as the difference between the amount that was paid for this new patient visit and the amount that would have been paid for a follow-up visit. HCPCS code Z1034.	$125.05	$59.88	$65.17
0313	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient and the use of an examination room. The claim for the use of the examination room is without error. To be a level three office visit for an established patient the documentation must include two of the following three components: an expanded problem focuses history; an expanded problem focused examination; and medical decision making of low complexity. The documentation for this office visit had a problem focused history and examination and medical decision making of low complexity for review of normal lab results and follow-up in 6 months. The service was provided by a non-physician medical practitioner. The modifier for the nurse practitioner was not used on the claim. This error is calculated as the difference between the amount paid for CPT Code 99213 and what would have been paid for CPT Code 99212.	$58.66	$49.56	$9.10
0322	Other Practices & Clinics	MR5	Medically unnecessary service	This claim is for the professional and technical components for an x-ray of the lower spine and an x-ray of the right ankle. There were no errors identified in the documentation provided by the radiology provider. There was no indication in the referring provider records	$54.88	$0.00	$54.88

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				why either x-ray was ordered. The exam was one check mark on "General" with no documentation any systems were assessed. There was a note that the patient was a heavy smoker and had degenerative joint disease on lumbar spine. There was no examination of the back or ankle documented. Medical necessity for these two x-rays could not be determined. This error is calculated as the total amount paid for this claim.			
0341	Other Practices & Clinics	MR7 (Potential for fraud or abuse noted)	Policy violation	This claim is for psychological services through a rural health clinic. A rural health clinic/federally qualified health center must follow all Medi-Cal policies as they relate to services provided at the clinic. Psychological services are limited to a maximum of two visits per month per Medi-Cal policy. This claim is for a third routine psychological visit according to the medical record documentation. Therefore, this error is calculated as the total amount paid for this claim.	$189.58	$0.00	$189.58
0344	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit two of the three following components must be present: A detailed history; a detailed examination and medical decision making of moderate complexity. The documentation provided by the provider had a detailed history; No examination at all and medical decision making of low complexity to continue present plan. The documentation supports a level three office visit for an established patient. This error is calculated as the difference between the amount paid for the level four office visit and the amount that would have been paid for a level three office visit, CPT Code 99213.	$85.00	$54.45	$30.55
0346	Other Practices & Clinics	MR3	Coding error	This claim is for a level two office visit for an established patient. To be a level two office visit, two of the three following components must be present: A problem focused history, a problem focused examination and straightforward medical decision making. According to the provider's documentation the patient came to the provider for a birth control injection. There was no history, no physical and no medical decision making documented. The documentation supports a level one office visit only. The wrong modifier was used on the claim. The modifier for nurse practitioner was used but the service was provided by a physician assistant so the physician assistant modifier should have been used. This error is calculated as the difference between the amount that was paid for the level two office visit and the amount that would have been paid for a level one office visit, CPT Code 99211.	$34.55	$22.90	$11.65
0349	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit, two of the following three components must be present: A detailed history, a detailed examination and medical decision making of moderate complexity. The documentation provided	$37.12	$17.92	$19.20

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
		(Potential for fraud or abuse noted)		by the provider has a problem focused history and examination with medical decision making of low complexity. The mostly illegible documentation shows prescription refills only. This supports a level two office visit for an established patient. This error is calculated as the difference between the amount paid for the level four office visit and the amount that would have been paid for a level two office visit, CPT Code 99212.			
0350	Other Practices & Clinics	MR8	Other medical error	This claim is for a lab test urinalysis. This test was ordered by the Comprehensive Perinatal Health Worker (CPHW). It is outside the scope of The CPHW to order laboratory tests. There was no counter signature or separate order by a health care provider that is qualified to order laboratory tests. There was no signature from the beneficiary verifying source of the specimen which is required. This error is calculated as the total amount paid for this claim.	$4.43	$0.00	$4.43
0355	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit two of the three following components must be present: a detailed history; a detailed examination; medical decision making of moderate complexity. The documentation provided by the provider contains an expanded problem focused history and examination and medical decision making of low complexity, instructions of illness, meds and to return if symptoms persist, which supports a level three office visit for an established patient. This error is calculated as the difference between the amount that was paid for a level four office visit and the amount that would have been paid for a level three office visit, CPT Code 99213.	$37.12	$23.76	$13.36
0363	Other Practices & Clinics	MR2B	No documentation	This claim is for the managed care differential paid for a visit to a Rural Health Care clinic by a patient enrolled in managed care. The clinic was unable to find any documentation to support a visit occurred on the date of service claimed. The claims for dates near this date of service all have documentation the service occurred so this was not an error in dates. Since there is no documentation to support this claim, this error is calculated as the total amount paid for this claim.	$78.09	$0.00	$78.09
0367	Other Practices & Clinics	MR3	Coding error	This claim is for a level two office visit for an established patient. To be a level two office visit two of the three following components must be present: a problem focused history; a problem focused examination and straightforward medical lesion making. The patient came to the provider for a flu shot only. There was no history, no examination and no medical decision making. This documentation supports a level one office visit. This error is calculated as the difference between the amount that was paid for the level two office visit and the amount that would have been paid for a level one office visit, CPT Code 99211.	$19.55	$12.96	$6.59

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0370	Other Practices & Clinics	MR3	Coding error	This claim was for a level three office visit for a new patient, Family PACT education and contraceptive supplies. The documentation for the education and supplies was without error. To be a level three office visit for a new patient all of the following three components are required: a detailed history; a detailed examination, and medical decision making of low complexity. The documentation provided contained an expanded problem focused history and examination and medical decision making of low complexity which supports a level two visit for a new patient. This error is calculated as the difference between the amount paid for the level three office visit for a new patient and the amount that would have been paid for a level two office visit for a new patient, CPT Code 99202.	$136.90	$93.19	$43.71
0374	Other Practices & Clinics	MR3 (Potential for fraud or abuse noted)	Coding error	This claim is for a level three emergency department visit and miscellaneous drugs and medical supplies claimed by the hospital. Emergency department physician evaluation and management services are not billable by the hospital. These codes are billed by the physician actually providing the service which this physician did. There were no errors identified with the miscellaneous drugs and medical supplies claim. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the level three emergency department visit, CPT Code 99283.	$81.18	$17.39	$63.79
0378	Other Practices & Clinics	MR3	Coding error	This claim is for an antibiotic injection and use of an emergency room. The emergency room use code is billable only when the service is an emergency. This patient was seen in the emergency department but did not have an emergent medical condition. Therefore, use of a hospital examination room should have been billed. The patient received 250 milligrams of Rocephin intramuscularly. The claim was for 1 Gram of Rocephin. That is 750 milligrams more than was administered. This error is for the difference between the amount paid for use of the emergency room, Z7502, and the amount that would have been paid for use of an examination room , Z7500 and the difference between the amount that was paid for 1Gram of Rocephin and the amount that would have been paid for 250 milligrams of Rocephin.	$100.17	$39.96	$60.21
0385	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. Much of the documentation provided is not legible. To be a level four office visit two of the three following components must be present: an expanded problem focused history; a detailed examination; and medical decision making of moderate complexity. The documentation provided contained a problem focused history; problem focused examination and straightforward decision making. This supports a level two office visit. This error is calculated as the difference between the amount paid for a level four office visit and the amount that would	$32.40	$15.64	$16.76

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				have been paid for a level two office visit, CPT Code 99212.			
0389	Other Practices & Clinics	MR3	Coding error	This claim is for a level two emergency department visit. To be a level two emergency department visit the following three components must be present: An expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided contains a problem focused history, problem focused examination and medical decision making of low complexity . The patient was in the emergency department for a wound check and was discharged to continue antibiotics and return for wound check. The documentation is consistent with a level one emergency department visit. This error is calculated as the difference between the amount paid for a level two emergency department visit and the amount that would have been for a level one emergency department visit, CPT Code 99281.	$24.14	$15.03	$9.11
0390	Other Practices & Clinics	MR3	Coding error	This claim is for a level five emergency department visit. To be a level five emergency department visit all three of the following components must be present: a comprehensive history; a comprehensive examination and medical decision making of high complexity. The documentation submitted contains an expanded problem focused history, comprehensive examination and medical decision making of moderate complexity for fever and diarrhea in a child supports a level three emergency department visit. This error is calculated as the difference between the amount paid for the level five emergency department visit and the amount that would have been paid for a level three emergency department visit, CPT Code 99283.	$107.00	$44.15	$62.85
0393	Other Practices & Clinics	MR3 (Potential for fraud or abuse noted)	Coding error	This claim is for a level four office visit for an established patient. To be a level four visit two of the following three components must be present: a detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation provided contains a problem focused history; detailed examination and straightforward decision making to continue medications and have laboratory tests, EKG and chest X-ray. This documentation supports a level two office visit for an established patient. These services were provided by a physician assistant. The modifier for physician assistant was not included on the claim. This error is calculated as the difference between the amount paid for a level four office visit and what would have been paid for a level two office visit, CPT Code 99212.	$28.08	$17.92	$10.16
0401	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. A level four office visit requires at least two of the following three components: a detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation to support this claim has an expanded problem focused history, detailed	$40.71	$27.35	$13.36

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				examination and medical decision making of low complexity for medications to treat symptoms and routine laboratory tests which supports a level three office visit. The error is calculated as the difference between the amount that was paid for CPT Code 99214 and the amount that would have been paid for CPT Code 99213.			
0408	Other Practices & Clinics	MR3 (Potential for fraud or abuse noted)	Coding error	This claim is for a level four office visit for an established patient with the modifier for separately identifiable evaluation and management service by the same physician on the same day of a procedure and the injection and drainage of a joint. Use of the modifier to support an office visit is appropriate. However, the documentation provided does not support the needed components for a level four visit which are a detailed history, detailed examination and medical decision making of moderate complexity. The history and examination were problem focused and the medical decision making was of low to moderate complexity which included the plan for re-injection and continues on current medications. The documentation supports a level two office visit. The documentation for the injection and drainage of the knees met the standard for the service as billed. There is some concern when reviewing the claiming pattern for this patient that this injection/drainage procedure is being done on a monthly basis which is more frequent than the generally established standard. This error is calculated as the difference between the amount paid for the level four visit and the amount that would have been paid for a level two office visit, CPT Code 99212.	$82.45	$63.25	$19.20
0412	Other Practices & Clinics	MR2B	No documentation	This claim is for a level two office visit. The provider is no longer at the service address on the claim. The forwarding phone numbers were disconnected. There was no listing found on information (411). The closed address had a sign with a new address. This new address is also vacant with no forwarding address or phone number. According to other tenants, the doctor moved without notice to patients or building management. Since no records could be found to review, this error is calculated as the total amount paid for this claim.	$34.55	$0.00	$34.55
0421	Other Practices & Clinics	MR2B	No documentation	This claim is for five services related to a case conference for a child through the California Children's Services. All services were documented as required except the claim for the physician services for the case conference. There is no documentation to support the physician participated in or contributed to the conference as required for reimbursement. The case coordinator and pediatric nurse practitioner were the only listed participants in the conference. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the physician services. (Z4306)	$231.00	$176.89	$54.11

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0433	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit two of the following three components must be present: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided contains no history of present illness so is not problem focused. There is a detailed examination which is not necessary for a patient who is being seen for follow-up of a problem that is being treated and is improving. A problem focused examination would be appropriate. The decision making which was to continue current medication is straightforward. This documentation would support a level two office visit. This error is calculated as the difference between the amount that was paid for a level three office visit and the amount that would have been paid for a level two office visit, CPT Code 99212.	$25.92	$19.55	$6.37
0448	Other Practices & Clinics	MR3	Coding error	This claim is for a level three emergency department visit. To be a level three emergency department visit the following three components must be present: an expanded problem focused history; an expanded problem focused examination; and medical decision making of moderate complexity. The documentation provided contained an expanded focused history and examination and straightforward medical decision making for this follow-up visit with instructions to see primary provider and Tylenol for pain or fever. This supports a level one emergency department visit. This error is calculated as the difference between the amount that was paid for the level three emergency department visit and the amount that would have been paid for a level one emergency department visit, CPT Code 99281.	$44.15	$15.03	$29.12
0453	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit, two of the following three components must be present: a detailed history; a detailed examination and medical decision making of moderate complexity. The documentation provided contained a problem focused history, no physical examination and medical decision making for an over the counter medication for a minor problem, one blood test and verifying surgery was scheduled. This is of low complexity which would make this a level two office visit. This error is calculated as the difference between the amount paid for the level four office visit and the amount that would have been paid for a level two office visit.	$24.00	$18.10	$5.90
0456	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office consultation. To be a level three office consultation the following three components must be present: a detailed history; a detailed examination and medical decision making of low complexity. The documentation from the consulting provider contained a problem focused history and examination and medical	$64.26	$50.99	$13.27

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				decision making of low complexity with review of ultrasound and decision for surgery. This level of documentation is consistent with a level two office consultation. This error is calculated as the difference between the amount paid for the level three office consultation and the amount that would have been paid for a level two office consultation.			
0460	Other Practices & Clinics	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for a level three office visit. The patient visited the provider to obtain a letter to excuse her from court ordered community service. Writing letters for this or any other reason is not a covered service. No evaluation or management of a health condition or complaint was accomplished during this visit. This error is calculated as the total amount paid for this claim.	$23.76	$0.00	$23.76
0462	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. For a level three office visit two of the following three components are requires: An expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. The documentation for this service has a problem focused history and physical examination; and straight forward decision making. This supports a level two office visit. This error is calculated as the difference between the amount paid for CPT Code 99213 and the amount that would have been paid for CPT Code 99212.	$56.72	$42.78	$13.94
0467	Other Practices & Clinics	MR2A	Poor/insufficient documentation	This claim is for three procedures and Family PACT family planning counseling during one office visit. The three procedures are documented appropriately. There is no documentation the Family PACT family planning counseling was provided. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the Family PACT family planning counseling.	$173.35	$154.28	$19.07
0476	Other Practices & Clinics	MR3	Coding error	This claim is for a level two office visit. According to the documentation and report by the medical assistant, the physician did not actually see the patient. He just renewed a prescription for the patient. Since no visit actually took place this error is calculated as the total amount paid for this claim.	$17.92	$0.00	$17.92
0477	Other Practices & Clinics	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for a urine pregnancy test. According to a signed statement by the patient there is no need for her to have a pregnancy test. The only documentation in the record for this date of service is documentation of the administration of Gardasil, a vaccine for HPV to help prevent cervical cancer. There is no documentation a urine pregnancy test was done. This error is calculated as the total amount paid for this claim.	$4.34	$0.00	$4.34
0478	Other Practices & Clinics	MR8 (Potential	Other medical error	This claim is for a medical visit to a rural health clinic. The actual visit was to a newborn infant in an acute care hospital. This is not a service covered by rural health clinics. The service should have been claimed	$134.96	$0.00	$134.96

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
		for fraud or abuse noted)		using the provider's individual provider number not as a clinic service. Since this is a service not covered by rural health clinics, this error is calculated as the total amount paid for this claim.			
0495	Other Practices & Clinics	MR8	Other medical error	This claim is for optometry services for a patient in a skilled nursing facility. There are no errors in the documentation of the service provided. The provider billed for the same service twice on the same day identifying the service as from different provider types. One claim was billed as physician services and one claim was billed as optometry services. One of the two claims were billed in error. This error is calculated as the total amount paid for this claim.	$8.01	$0.00	$8.01
0499	Other Practices & Clinics	MR7	Policy violation	This claim is for 16 services/procedures related to an emergency department visit. All services/procedures were correct except the Chronic Gonadotropin (HCG) test, CPT Code 84702. The Medi-Cal manual states this test is billable only with certain diagnosis codes. The diagnosis codes used on this claim are not included in the allowable codes. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the HCG test.	$332.47	$316.32	$16.15
0506	Other Practices & Clinics	MR2B	No documentation	This claim is for a level one office visit for an established patient for a urine pregnancy test and dispensing other contraceptive supplies. The documentation provided supports the office visit and the pregnancy test. There is no documentation the contraceptive supplies were provided to the patient. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the contraceptive supplies. (HCPCS X1500)	$40.10	$32.71	$7.39
0508	Other Practices & Clinics	MR5	Medically unnecessary service	This claim is for a level four office visit for an established patient for a urine pregnancy test and specimen handling. There is no documentation to support the need for the pregnancy test. Specimen handling CPT Code 99000 is billable only when handling blood specimens that are sent to an unaffiliated laboratory. Only urine was collected for this test and the test was run in the provider's office. This error is calculated as the difference between the amount that was paid for the claim and the amount paid for the pregnancy test and specimen handling. CPT Code 81025 and CPT Code 99000.	$96.60	$88.63	$7.97
0509	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for a new patient and Family-PACT education and counseling for 15 minutes. Although the time for the education and counseling was not documented as required, the topics covered are reasonably sufficient to meet the time requirement for one unit. To be a level three office visit for a new patient the following three components are required: a detailed history, a detailed examination and medical decision making of low complexity. The history and examination are problem focused and the medical decision	$361.44	$304.59	$56.85

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				making is of low complexity. This error is calculated as the difference between the amount paid for CPT Code 99203 and the amount that would be paid for CPT Code 99202.			
0510	Other Practices & Clinics	MR3	Coding error	This claim is for a level four office visit for an existing patient and a urine pregnancy test. To be a level four office visit two of the three following components must be met: a detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation provided contained an expanded problem, focused history, and examination with medical decision making of low complexity which is consistent with a level three office visit for an established patient. The modifier for non-physician medical practitioner was not used. The beneficiary's signature verifying source of the laboratory specimen was not obtained. The name of the clinic was listed as the rendering provider rather than the actual rendering provider. This error is calculated as the difference between the amount that was paid for the level four office visit and the amount that would have been paid for a level three office visit for an existing patient. CPT Code 99213.	$92.97	$61.06	$31.91
0512	Other Practices & Clinics	MR2B	No documentation	This claim is for a level one office visit for an established patient. The clinic was unable to provide any records for review. According to clinic staff the record was sent to a scanning company to upload into their computer system. After a month's time and seven contacts with the clinic they were still unable to provide the record. This error is calculated as the total amount paid for this claim.	$28.37	$0.00	$28.37
0515	Other Practices & Clinics	MR7	Policy violation	This claim is for a level one office visit for an established patient, contraceptive supplies, plan B contraceptive, Family PACT education and oral contraceptive pills (OCP). The OCP was prescribed by an RN and there was no counter signature by a provider authorized to prescribe medications such as a physician, physician assistant or nurse practitioner. This error is calculated as the difference between the total amount paid for this claim and the amount paid for the OCPs. (X7706)	$256.46	$100.46	$156.00
0521	Other Practices & Clinics	MR2A	Poor/insufficient documentation	This claim is for a level three office visit for a new patient, Family PACT family planning education and Zithromax, an antibiotic for infection. The office visit claim was correctly documented. The medical need for the antibiotic was present. The documentation for the Family PACT education lacked details of the education and the time spent providing the education. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the Family PACT education. Z9751.	$152.98	$140.26	$12.72
0533	Other Practices & Clinics	MR3	Coding error	This claim is for an Obstetrical (OB) ultrasound. This level ultrasound includes fetal and maternal evaluation for single fetus. The ultrasound review consisted of a limited fetal and placental review. This error is	$37.35	$25.18	$12.17

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				calculated as the difference between the amount that was paid for the CPT Code 76805 and the amount that would have been paid for CPT Code 76815.			
0536	Other Practices & Clinics	P2	Non-covered service	This claim is for chiropractic manipulation of the spine. The service was provided in September 2009. Chiropractic services were discontinued as a Medi-Cal benefit effective July 1, 2009. This patient did not meet any of the exceptions to the coverage discontinuation rule. There was no documentation of any manipulation for the date of service. This error is calculated as the total amount paid for this claim.	$16.55	$0.00	$16.55
0547	Other Practices & Clinics	MR3	Coding error	This claim is for a level two office visit for a new patient, Family PACT education and specimen handling. To be a level two office visit for a new patient the following three components must be present: an expanded problem focused history; an expanded problem focused examination and straightforward medical decision making. The documentation provided included a problem focused history and examination and straight forward decision making consistent with a level one new patient office visit. The documentation for Family PACT education did not include any detail of education actually provided or the time spent providing this education. There is a list of education to be provided by the medical assistant in the providers orders. There is also no documentation any specimens were collected or processed to a non-affiliated laboratory by office staff. There was no beneficiary signature verifying any laboratory specimens were collected. This error is calculated as the difference between the total amount paid and the amount that was paid for the Family PACT education, the amount paid for specimen handling and the amount that would have been paid for a level one office visit for a new patient. CPT Code 99201.	$81.83	$43.72	$38.11
0551	Other Practices & Clinics	MR2B	No documentation	This claim is for the dispensing of oral contraceptives and family planning counseling through the Family PACT program. There is documentation the oral contraceptive was dispensed. There is no documentation of any counseling on the date of service. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the family planning counseling. (X9752)	$67.07	$48.00	$19.07
0555	Other Practices & Clinics	MR3	Coding error	This claim is for the professional component for reviewing six laboratory tests for a patient in an acute care hospital. The results for three of the tests were clearly documented. There was no documentation of results for the comprehensive metabolic panel, the C. reactive protein or the blood type. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the three missing tests, CPT Codes 80053, 86140,	$6.43	$2.33	$4.10

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				and 86900.			
0556	Other Practices & Clinics	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for an ultrasound and assessment for nuchal translucency and an ultrasound for fetal and maternal evaluation in the first trimester. There is documentation of necessity for and performance of the nuchal ultrasound. The primary diagnosis used to justify the maternal fetal evaluation (CPT 76801), poor fetal growth, and antepartum care is contradicted by the medical record which shows uterine growth consistent with dates. Medical necessity is not documented. The error is calculated as the difference between the total amount paid for this claim and the amount paid for CPT 76801.	$191.62	$113.98	$77.64
0568	Other Practices & Clinics	MR3	Coding error	This claim is for critical care, first hour, which is a physician service for a hospitalized patient that is critically ill. The provider is an infectious disease specialist and was seeing the patient on consultation. Therefore, inpatient consultation codes should have been billed rather than critical care services. According to the documentation provided, the correct consultation code would have been CPT Code 99251. This error is calculated as the difference between the amount paid for the critical care, first hour and the amount that would have been paid for a level one inpatient consultation code. CPT Code 99251.	$120.38	$92.80	$27.58
0577	Other Practices & Clinics	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for a level three office visit for an established patient and a chest X-ray. The wrong rendering provider was listed on the claim. The actual rendering provider is not an active Medi-Cal provider so is ineligible to provide office visit services for Medi-Cal patients. The patient's diagnoses were listed as high blood pressure and high cholesterol. There is no medical indication in the record for the chest X-ray. Since the actual rendering provider was not eligible to provide the office visit service and there was no indication of medical need for the chest X-ray this error is calculated as the total amount paid for this claim.	$49.48	$0.00	$49.48
0583	Other Practices & Clinics	MR2B	No documentation	This claim is for six different laboratory tests, use of an emergency room and 1000 cc of intravenous fluid. There were no errors with the laboratory tests and use of an emergency room claim. There is no documentation the intravenous fluids were administered. There is a notation that an IV site was obtained and a saline lock was placed for use in administering medications and fluids if necessary. There is no documentation the fluids were actually administered. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the intravenous fluids. (HCPCS Code X7700).	$97.11	$78.46	$18.65
0589	Other Practices & Clinics	MR5	Medically unnecessary service	This claim is for the technical and professional components for an obstetrical ultrasound completed by a radiologist by referral from the provider providing the obstetrical care for this patient .There were no	$93.38	$0.00	$93.38

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				errors identified in the documentation provided by the radiologist. The referring provider's records did not support a medical need for the ultrasound. There is no indication of any complicating factors, conditions, symptoms or other medical reasons other than routine for doing this ultrasound. Therefore, this error is calculated as the total amount paid for this claim.			
0605	Other Practices & Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit two of the following three components must be present: expanded problem focused history; expanded problem focused examination and medical decision making of low complexity. The documentation provided has a problem focused history, problem focused examination and straightforward medical decision making. These components are consistent with a level two office visit for an established patient. This error is calculated as the difference between the amount that was paid for the claim and the amount that would have been paid for a level two office visit for an established patient. CPT Code 99212.	$23.76	$17.92	$5.84
0630	Other Practices & Clinics	P7	Ineligible recipient	This claim is for physician services for a patient in an acute care hospital. An approved Treatment Authorization Request (TAR) must be obtained for inpatient services to be billable. The TAR request for this patient was denied since the patient is eligible for emergency and obstetrical services only and this was deemed to not be an emergency admission. Without an approved TAR none of the services rendered to the patient in the hospital for these dates of service are reimbursable. This includes physician services. Therefore, this error is calculated as the total amount paid for this claim.	$136.10	$0.00	$136.10
0646	Other Practices & Clinics	P9B (Potential for fraud or abuse noted)	Rendering provider not eligible to bill for services/ supplies	This claim is for a level three office visit for an established patient. The incorrect rendering provider was listed on the claim. The actual rendering provider had been suspended from the Medi-Cal program five months before this date of service and is listed as such on the public suspended an ineligible list. Therefore, this information is readily available to the billing providers. This error is calculated as the total amount paid for this claim.	$64.52	$0.00	$64.52
0650	Other Services & Supplies	MR7	Policy violation	This claim is for ambulance service, an electrocardiogram and mileage to transport a patient. The ambulance service was medically appropriate as was the electrocardiogram. There were no odometer readings documented to verify the miles traveled during the transport. The provider moved their place of business several years ago but Medi-Cal had no record of the change of business site. This error is calculated as the difference between the amount paid for this claim and the amount that would have been paid for the mileage.	$153.25	$142.71	$10.54

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0651	Other Services & Supplies	MR2B	No documentation	This claim is for mileage for a local education agency (LEA) student. The service was medically appropriate. However, there was no transportation trip log provided that indicated the number of miles the child was transported as required by Medi-Cal policy. This error is calculated as the total amount paid for this claim.	$28.80	$0.00	$28.80
0654	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for one increment health/nutrition assessment through a LEA. One increment is for fifteen minutes. Any service time that is at least seven minutes can be counted as an increment. The documentation provided includes a blood pressure, height, weight and Body Mass Index (BMI). This limited documentation does not support a minimum of seven minutes, as required. This error is calculated as the total amount paid for this claim.	$10.85	$0.00	$10.85
0661	Other Services & Supplies	MR2B	No documentation	This claim is for individual counseling through an LEA. There was no documentation provided to support the claimed service was provided. The provider stated they could not locate any paperwork or documentation relative to the claimed service. The error is calculated as the total amount paid for this claim.	$11.28	$0.00	$11.28
0670	Other Services & Supplies	MR5	Medically unnecessary service	This claim is for incontinence supplies. There were no errors identified in the documentation provided by the Durable Medical Equipment (DME) provider. There was no documentation in the referring provider's records to indicate the patient had incontinence and was in need of incontinence supplies. The error was calculated as the total amount paid for this claim.	$42.74	$0.00	$42.74
0671	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for two days of medical transportation with associated mileage and night call differential. The night differential identifies a quantity of two on each day for a total of four units. The transportation logs do not indicate whether the times are AM or PM. However, at least one of the transportation trips on each day did not fall within the 12 hour period authorized for night call. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for one of the night call units for each of the two days on the claim.	$130.22	$118.08	$12.14
0676	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for four different occupational therapy services on three different days for a beneficiary through the California Children's Services (CCS). The services for the first day of the claim are for occupational therapy treatment. The only documentation provided is a brief note reflecting assessment/evaluation. There was no treatment documented. All four services were timed services but no indication of time spent was documented. The documentation for the second and third dates of service was appropriate for evaluation which was claimed. The documentation tends to support the expected amount of	$103.54	$68.98	$34.56

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				time for the claim was used to provide the evaluation. This error was calculated as the difference between the total amount paid for this claim and the amount paid for the two services on the first date of the claim.			
0678	Other Services & Supplies	MR3	Coding error	This claim is for six transportation services on two different dates of service. The claim is for wheelchair transport, mileage, and night call for both dates. There is no problem with any of the documentation except the night call on the second date of service. Records show the patient was picked up at 8:45 AM. Night call is from 7:00 PM to 7:00 AM. This error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the one night call on the second date of service.	$107.78	$101.71	$6.07
0683	Other Services & Supplies	MR3	Coding error	This claim is for speech therapy through an LEA. This claim is for an incremental service of 15 minutes which can be claimed after three 15 minute increments of initial services are provided on the same date of service. The documentation provided by the school demonstrates the student attended 30 minutes of speech therapy or two increments of initial service. Therefore the school did not provide the necessary initial services to authorize the additional increment. This error is calculated as the total amount paid for this claim.	$3.87	$0.00	$3.87
0685	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for three 15 minute increments of speech therapy to a student through the LEA. The documentation provided to support this service is a brief summary of activities emailed to the auditor over a year after the service was provided. There was no documentation of the type and extent of services provided to this beneficiary in the beneficiary's record. There also was no documentation of the time spent providing these services. This error is calculated as the total amount paid for this claim.	$14.19	$0.00	$14.19
0691	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for nursing assessment for a child through the LEA. The assessment that was provided had not been signed by anyone. Therefore, it is not possible to determine if it was in fact the nursing assessment. There was a vision and hearing screening. The assessment states the child is overweight. However, there is no documentation of height or actual weight or BMI to objectively determine the significance or accuracy of this comment. This error is calculated as the total amount paid for this claim.	$75.92	$0.00	$75.92
0694	Other Services & Supplies	MR3	Coding error	This claim is for ambulance service, basic life support with mileage, oxygen and an electrocardiogram. The patient's vital signs and general medical condition were stable when the ambulance arrived so the emergent situation had passed. The mileage, oxygen and electrocardiogram were appropriate. The ambulance service should have been claimed as non-emergency ambulance service. This error is	$149.74	$138.81	$10.93

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				calculated as the difference between the amount paid for ambulance service, basic life support and the amount that would have been paid for non-emergency ambulance service. HCPCS Code X0032.			
0697	Other Services & Supplies	MR2A	Poor/insufficient documentation	This claim is for speech therapy through the LEA. There is documentation that services were provided. This is a timed service with each unit representing fifteen minutes of service. There is no documentation of the time spent providing the service so two units of service cannot be supported. Furthermore, there is no signature or other identification of the person providing the service so their qualifications to provide the service cannot be verified. This error is calculated as the total amount paid for this claim.	$14.19	$0.00	$14.19
0713	Pharmacy	PH10	Other pharmacy policy error	This claim is for Mobic, a medication for pain. This medication has a Code 1 restriction and can be only be prescribed for patients with arthritis. There was no mention of arthritis in the pharmacy or the prescribing provider's records. The prescriber's records did mention pain but it was not evaluated and determined to be from arthritis. The error is calculated as the total amount paid for this claim.	$13.53	$0.00	$13.53
0715	Pharmacy	MR5	Medically unnecessary service	This claim was for two types of incontinence supplies, diapers and under pads. After many attempts no documentation was obtained to support that the patient had a problem with incontinence and needed these items. There is no signature verifying receipt of these products. This error is calculated as the total amount paid for this claim.	$161.47	$0.00	$161.47
0717	Pharmacy	MR2B	No documentation	This claim is for Amitriptyline, a medication used to treat depression. There were no errors identified in the documentation provided by the pharmacy. The prescriber's place of business is closed. The available phone numbers were disconnected. The prescribing provider could not be located. Since no medical records could be obtained medical necessity could not be determined. This error is calculated as the total amount paid for this claim.	$9.21	$0.00	$9.21
0721	Pharmacy	MR5	Medically unnecessary service	This claim is for Acetaminophen, an over the counter medication used for mild to moderate pain. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider's records had no documentation to support the need for this medication. This error is calculated as the total amount paid for this claim.	$10.42	$0.00	$10.42
0731	Pharmacy	PH10	Other pharmacy policy error	This claim is for Jolessa, a birth control pill through the Family PACT program. The prescription was written for two months' supply, the pharmacy dispensed one month's supply. There is no indication that authorization for this change was obtained from the prescribing provider as required. The prescribing provider's DEA number was used on the claim instead of his NPI or license number as required. This error is calculated as the total amount paid for this claim.	$140.60	$0.00	$140.60

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0735	Pharmacy	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for 200 test strips for testing blood sugar for a diabetic patient. The test strips are delivered to the ADHC where the beneficiary goes twice a week. According to the beneficiary, and verified by the ADHC, she does not take the strips home and her blood sugar is tested only at the ADHC twice a week. Therefore she only needs 8 strips per month or 16 for two months. Her primary care provider has not ordered these strips for her for three years. They are being ordered by the ADHC staff physician. The prescription was for 100 test strips and the pharmacy dispensed 200 test strips as a two month order. At the rate this beneficiary's blood sugar is being tested, these 200 test strips would last over a year. However, the same number was dispensed less than four months before this date of service and again six weeks after this date of service. Since 200 test strips were dispensed to the patient less than four months before this date of service, there is no need for two hundred more test strips on this date of service. There is no indication the pharmacy had authorization from the prescribing provided to change the quantity on the prescription. The date of service and the prescription date are two days after the test strips were delivered to the ADHC. Therefore, there was no legal prescription at the time of dispensing. This error is calculated as the total amount paid for this claim.	$198.75	$0.00	$198.75
0736	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Tramadol, a medication used to treat moderate to severe pain. The pharmacy was unable to provide an original prescription or signature of receipt for this claim. There had been a water leak at the pharmacy and several documents were not available due to restoration work being done. The prescribing provider stated he remembered calling the prescription in but was unable to provide documentation to that effect since he had recently moved and was unable to locate record. The limited records available from the prescribing provided prior to the day the prescription was filled did not include a medical reason for the medication. The date of service on the claim is two days after the date the medication was dispensed to the patient. This error is calculated as the total amount paid for this claim.	$16.25	$0.00	$16.25
0748	Pharmacy	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for Docusate Sodium, a medication used to treat constipation. There were no identified errors with the documentation provided by the pharmacy. There is no documentation in the prescribing provider's records to support the need for this medication or the intent for the patient to have the medication. This error is calculated as the total amount paid for this claim.	$8.89	$0.00	$8.89
0759	Pharmacy	PH10	Other pharmacy policy error	This claim is for Rifampin, a medication used to treat tuberculosis. The prescription was written for two 300mg capsules twice a week with a	$63.83	$37.43	$26.40

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				quantity of one month's supply. That would be 16 capsules. The pharmacy dispensed 30 capsules. The label for the medication had different directions than were on the prescription. The directions on the label were two capsules twice daily a week. This could cause the patient to take the medication incorrectly. This error is calculated as the difference between the amount that was paid for 30 capsules and the amount that should have been paid for 16 capsules.			
0760	Pharmacy	MR2A (Potential for fraud or abuse noted)	Poor/insufficient documentation	This claim is for lancets used to collect blood for glucose testing. The instructions on the prescription instruct the patient to test two times a day. The instructions given to the patient on the prescription label was to test four times a day. The pharmacy did not obtain signature of receipt from the beneficiary. There was no documentation to support the prescribing provider authorized this change. The records provided by the prescribing provider did not contain any information to support the patient is actually using the lancets or that the blood sugar results are being reviewed by the provider. This error is calculated as the total amount paid for this claim.	$11.40	$0.00	$11.40
0767	Pharmacy	PH10	Other pharmacy policy error	This claim is for morphine capsules, a medication used to manage pain. The prescription was written for 120 tablets but the pharmacy dispensed only 60 tablets. There is no indication this change was authorized by the prescribing provider as required. This error is calculated as the total amount paid for this claim.	$412.68	$0.00	$412.68
0769	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Prozac a medication used to treat depression for a patient in a skilled nursing facility. The wrong referring provider was listed on the claim. There is limited documentation mostly by the nursing staff at the skilled nursing facility to support the patient's need for an anti-depressant. The referring provider documentation lacks detailed information about the patient's symptoms, the effects of the medication, and any need for dose adjustments. This error is calculated as the total amount paid for this claim.	$12.36	$0.00	$12.36
0772	Pharmacy	PH10 (Potential for fraud or abuse noted)	Other pharmacy policy error	This claim is for Hydrocodone, a medication for pain. The prescription was written for 35 tablets. The pharmacy claimed for 30 tablets to avoid the Code 1 restriction of only 30 tablets per dispensing. The dispensing label stated 35 tablets and the claim was for only 30 tablets. The pharmacist states the five additional tablets were purchased separately for cash since Medi-Cal only authorized 30 tablets without prior authorization. The pharmacy had no documentation to support this cash purchase. Providers are not allowed to charge Medi-Cal patients for services covered by Medi-Cal. The pharmacy only needed authorization to claim for the additional medication. This error is calculated as the total amount paid for this claim.	$10.46	$0.00	$10.46

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
0773	Pharmacy	MR2B	No documentation	This claim is for Nora-Be tablets, an oral contraceptive pill (OCP). The prescription was written for three cycles. The pharmacy dispensed one cycle each month for three months. This allowed the pharmacy to subsequently collect two additional dispensing fees. The pharmacy had no documentation to support prescribing provider authorization for this change in this prescription. The prescribing provider was unable to find any medical records for this patient. Therefore, the medical appropriateness and intent for the prescription could not be verified. This error is calculated as the total amount paid for this claim.	$37.89	$0.00	$37.89
0776	Pharmacy	MR5	Medically unnecessary service	This claim is for Vicodin, a medication for severe pain. There were no errors identified in the documentation provided by the pharmacy. There was no documentation in the referring provider's record to support the need for this level of pain medication. This error is calculated as the total amount paid for this claim.	$59.46	$0.00	$59.46
0777	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for chewable Foaming Antacid Tablets used to manage gastritis. There were no errors identified in the documentation provided by the pharmacy. The referring provider records have gastritis listed as a chronic problem, There is no recent documentation to indicate the status of this problem or the need for continued medication. This error is calculated as the total amount paid for this claim.	$10.05	$0.00	$10.05
0778	Pharmacy	MR5	Medically unnecessary service	This claim is for Famotidine, a medication used to treat ulcers and gastro esophageal reflux disease (GERD). It is used over the counter for heartburn. There were no errors identified in the documentation provided by the pharmacy. There was a note saying dyspepsia in the margin of the progress note but no indication of gastric problems in the history and examination done as part of the visit. The limited documentation in the medical record does not support the medical need for this medication. This error is calculated as the total amount paid for this claim.	$16.25	$0.00	$16.25
0781	Pharmacy	MR5	Medically unnecessary service	This claim is for Glipizide, a medication used to manage type II diabetes. There is no error identified in the documentation provided by the pharmacy. The only documentation provided by the referring provider does not mention diabetes in the progress and the laboratory results were for many months after this date of service. This error is calculated as the total amount paid for this claim.	$21.55	$0.00	$21.55
0786	Pharmacy	MR5	Medically unnecessary service	This claim is for Clonazepam, a medication used to treat seizures and panic disorders. This is a Code 1 restricted drug requiring a TAR for prescriptions after 90 days from the first prescription. There is no indication there is a TAR for this date of service. However, there was a TAR six months earlier and the same TAR number is listed on the	$9.59	$0.00	$9.59

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				claim for this medication one month after this date of service. There is no documentation in the medical record provided by the referring provider of any symptoms or conditions that would require this medication. The error is calculated as the total amount paid for this claim.			
0788	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Tamaflu, a medication used to prevent/treat influenza. This drug is restricted by Medi-Cal for use in treatment of individuals with confirmed, probably or highly suspected H1N1 influenza of as prevent for H1N1 influenza or for treatment of influenza in patients at high risk of complication from influenza virus. This patient has a history of Congestive Heart Failure which puts him at risk. There were no errors found with the documentation provided by the pharmacy. The referring provider had limited documentation to support the patient had influenza. No influenza swab tests were done. The patient had generalized symptoms which could have been influenza or an upper respiratory infection. This error is calculated as the total amount paid for the claim.	$85.46	$0.00	$85.46
0800	Pharmacy	MR5	Medically unnecessary service	This claim is for Nexium, a medication used to treat GERD. There were no errors identified in the documentation provided by the pharmacy. The referring provider's documentation does not include any medical need for this medication. This error is calculated as the total amount paid for this claim.	$469.78	$0.00	$469.78
0802	Pharmacy	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for Amoxicillin an antibiotic used to treat bacterial infections. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the referring provider does not support the need for antibiotics. There is an impression of upper respiratory infection. However, there are no signs or symptoms included in the documentation that address that impression. This error is calculated as the total amount paid for this claim.	$10.83	$0.00	$10.83
0806	Pharmacy	MR5	Medically unnecessary service	This claim is for Cephalexin, an antibiotic used to treat bacterial infections. The person signing for the medication was not the eight year old patient. Their relationship to the patient was not documented. The documentation from the referring provider does not have sufficient information to support the need for antibiotics. It lists some skin conditions but there is no evaluation of these conditions to support they are infections that need treating with antibiotics. This error is calculated as the total amount paid for this claim.	$33.39	$0.00	$33.39
0807	Pharmacy	PH10	Other pharmacy policy error	This claim is for Metoprolol, a medication used to treat high blood pressure. The prescription was written for 100 tablets. The pharmacy dispensed 90 tablets. There is no indication why the pharmacy changed the prescription. There is also no documentation to support the	$11.75	$0.00	$11.75

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				prescriber authorized the prescription alteration. This error is calculated as the total amount paid for this claim.			
0812	Pharmacy	MR5	Medically unnecessary service	This claim is for Phenergan with Codeine cough syrup which is used to treat cough from respiratory infections. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the referring provider makes no mention of any signs or symptoms that may require this medication. There also is no indication of intent to prescribe the medication. This error is calculated as the total amount paid for this claim.	$16.37	$0.00	$16.37
0815	Pharmacy	PH10	Other pharmacy policy error	This claim is for Amitriptyline, a medication used to treat depression. The prescribing provider wrote the prescription for 90 tablets, a 90 day supply. The pharmacy dispensed 31 tablets monthly. There was no documentation the pharmacy obtained an authorization for the change in quantity from the prescriber as required. By dividing the prescription into monthly amounts the pharmacy is able to bill additional dispensing fees. This error is calculated as the total amount paid for this claim.	$9.60	$0.00	$9.60
0818	Pharmacy	PH2	No legal Rx for date of service	This claim is for Adderall, a medication used to manage attention deficit disorder. This is a schedule II controlled substance and a new written prescription is required. The date of service on the claim is one week before the pharmacy received the prescription from the prescriber so there was no legal prescription for the date of service on the claim. The prescription before this date of service was for a 60 day supply but was filled on this date of service after only 39 days. This was filled with a pharmacy over ride in the system. No authorization for the early fill was obtained. There is a pattern of other early refills, as well. Since there was no legal prescription and the prescription was filled earlier than authorized this error is calculated as the total amount paid for this claim.	$365.52	$0.00	$365.52
0820	Pharmacy	PH10	Other pharmacy policy error	This claim is for Clonazepam, a medication used to manage psychiatric problems. The prescription was written for 124 tablets. The pharmacy filled the prescription with 120 tablets. This fill was done without the prior authorization required since the prior authorization on record was for the quantity of 124 tablets. The pharmacy circumvented the prior authorization process to claim for this prescription that was changed by the pharmacy without the prescribing provider's authorization. This error is calculated as the total amount paid for this claim.	$16.61	$0.00	$16.61
0823	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Lisinopril, a medication used to treat high blood pressure. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the referring provider shows high blood pressure in the health history as	$11.90	$0.00	$11.90

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				well as a diagnosis listed on the progress notes. The blood pressure documented is within normal limits and there is a medication for high blood pressure listed on the progress note but not this medication. There is no evaluation of the blood pressure and no mention of an intent for this medication. The error is calculated as the total amount paid for this claim.			
0827	Pharmacy	PH10	Other pharmacy policy error	This claim is for Clonazepam, a medication used to treat psychosis. This medication has a code 1 restriction on its use. The therapy is restricted to up to 90 days from the dispensing date of the first prescription. Any additional prescriptions require a TAR. This claim is for medication past the 90 day limitation. The TAR that was obtained prior to this claim had expired. There was no indication a current TAR had been obtained. This error is calculated as the total amount paid for this claim.	$10.85	$0.00	$10.85
0833	Pharmacy	MR2B	No documentation	This claim is for DiCal-D, a calcium supplement used to prevent and treat osteoporosis. The pharmacy did not have a signature to verify receipt of the medication. The prescribing provider could not locate the medical records for this patient. Therefore, there is no documentation to support the need for the medication or the intent to prescribe the medication. This error is calculated as the total amount paid for this claim.	$23.82	$0.00	$23.82
0834	Pharmacy	MR5	Medically unnecessary service	This claim is for Clonazepam, a medication used for seizures, and panic disorder, This is a Code 1 restricted drug and is limited to prescription for 90 days from first prescription without prior authorization. The pharmacy changed the prescription number to create a new prescription to circumvent the need for prior authorization. This patient has many medical conditions. The referring provider's records do not contain a clear indication why this medication is being used. This error is calculated as the total amount paid for this claim.	$16.97	$0.00	$16.97
0835	Pharmacy	PH10	Other pharmacy policy error	This claim is Coreg, a medication with a Medi-Cal Code 1 restriction for use in the treatment of heart failure only. There is no documentation in the pharmacy or prescribing provider records that the patient has heart failure. The medication seems to be used to treat high blood pressure. This error is calculated as the total amount paid for this claim.	$15.80	$0.00	$15.80
0836	Pharmacy	PH10	Other pharmacy policy error	This claim is for Abilify, a medication used to treat different psychiatric problems. The prescription was written for a quantity of 60 tablets. The pharmacy dispensed 45 tablets. Subsequent fills for this prescription were for 30 tablets for refills from this same prescription for 60 tablets. There is no indication the pharmacy obtained authorization from the prescriber to change the prescription. Since this	$610.98	$0.00	$610.98

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				claim was for the first fill from this prescription, there is no error for split prescription to obtain additional dispensing fees on this claim. Since the prescription was changed without authorization, the error is calculated as the total amount paid for this claim.			
0838	Pharmacy	WCI	Wrong client identified	This claim was for intravenous tubing. The claim was billed to the wrong patient and should not have been submitted. This error is calculated as the total amount paid for this claim.	$2.99	$0.00	$2.99
0848	Pharmacy	MR5	Medically unnecessary service	This claim is for Fluocinonide cream which is used to treat the inflammation and itching caused by a number of skin conditions such as allergic reactions, eczema, or psoriasis. The pharmacy identified the wrong referring provider on the claim. The same incorrect referring provider was used as the prescriber on the medication label. The medical record documentation from the actual referring provider did not address rationale for the cream. The skin examination was normal. There was no medical indication for the medication. The error is calculated as the total amount paid for this claim.	$10.86	$0.00	$10.86
0853	Pharmacy	MR5	Medically unnecessary service	This claim is for Acetaminophen drops for an infant. This medication is used for fever and mild pain. The medication was signed for at the pharmacy but the relationship to the patient is not annotated. There is no documentation in the medical record provided that the infant needed this medication or that the provider intended the patient have it. This error is calculated as the total amount paid for this claim.	$9.97	$0.00	$9.97
0856	Pharmacy	MR5	Medically unnecessary service	This claim is for Claritin, an antihistamine for allergies. The prescription was not written on a tamperproof prescription form as required. There is no documentation the pharmacy verified the prescription with the prescriber as required when a non-tamperproof form is used. There is no documentation in the medical record provided by the referring provider to support the need for this medication. There is no mention of allergy type symptoms in the record provided by the referring provider. This error is calculated as the total amount paid for this claim..	$11.00	$0.00	$11.00
0858	Pharmacy	PH10	Other pharmacy policy error	This claim is for Risperidone, a medication used to manage schizophrenia. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the referring provider addressed numerous medical problems but there was no mention of services or assessment for schizophrenia. Mood disorder was listed in assessment. There was no evaluation of the patient for such a condition. Therefore, medical necessity for this medication cannot be substantiated. This error is calculated as the total amount paid for this claim.	$96.60	$0.00	$96.60
0865	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Vicodin, a medication used for pain. The person signing for receipt of the medication was not the patient. There is no	$18.95	$0.00	$18.95

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				notation of this person's relationship to the patient as required. This is a prescription called in at the time the patient was discharged from the hospital. There is no physician progress note, discharge summary or order in the inpatient record that addresses the need or intent for this medication. Non-dollar error			
0867	Pharmacy	MR5	Medically unnecessary service	This claim is for Aricept, a medication restricted by Medi-Cal for the treatment of mild to moderate dementia of the Alzheimer's type. The prescription was a telephone prescription and lacked the date, quantity, directions for use and dose of the medication. The referring provider's documentation includes “memory problems” as a presenting problem by the patient. There is no evaluation or work up of the patient to determine extent and cause of memory problems. Without this evaluation it is not possible to determine the extent or cause of the memory problem. Furthermore, without this work up there is no medical indication for this medication. This error is calculated as the total cost of this claim.	$193.19	$0.00	$193.19
0872	Pharmacy	MR5	Medically unnecessary service	This claim is for Miconazole cream a medication used to treat vaginal yeast infections. There were no errors identified in the documents provided by the pharmacy. The documents provided by the referring provider did not address any assessment or evaluation to support a yeast infection necessitating the prescribing of this medication. This error is calculated as the total amount paid for this claim.	$17.89	$0.00	$17.89
0876	Pharmacy	MR5	Medically unnecessary service	This claim is for Famotidine, a medication used to treat gastric ulcers, GERD or heartburn. The original prescription did not include the date it was written as required. The documentation provided by the referring provider does not address any issues or symptoms that indicate this patient has a need for this medication. This error is calculated at the total amount paid for this claim.	$16.25	$0.00	$16.25
0889	Pharmacy	MR5	Medically unnecessary service	This claim is for Lorazepam, a medication used to manage anxiety. The pharmacy could not provide a signature verifying the medication was received. The documentation provided by the prescribing provider did not include any indication why the medication was prescribed. This error is calculated as the total amount paid for this claim.	$9.47	$0.00	$9.47
0894	Pharmacy	MR5	Medically unnecessary service	This claim is for Calcium Carbonate, a medication used to treat osteoporosis. There were no errors identified in the documentation provided by the pharmacy. The documentation from the referring provider does not indicate why the medication is being prescribed. There is indication from X-ray the patient may have osteoporosis but this is not addressed in the documentation provided. This error is calculated as the total amount paid for this claim.	$8.04	$0.00	$8.04
0896	Pharmacy	MR5	Medically unnecessary	This claim is for glucose test strips used by diabetics to test blood sugar levels. There were no errors identified in the documents	$206.75	$155.06	$51.69

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
			service	provided by the pharmacy. The order is for 200 test strips a month which is the correct amount for the number of times a day the prescribing provider originally wanted the patient to test her blood sugar level. However, the patient was generally noncompliant and did not test her blood with any regularity. The prescribing provider decreased the frequency of testing but did not change the prescription for the test strips to match this decreased need. The quantity should have been decreased to 150 test strips a month to support the decreased number tests needed. This error is calculated as the difference between the amount paid for 200 test strips and the amount that would have been paid for 150 test strips.			
0901	Pharmacy	MR5	Medically unnecessary service	This claim is for Plavix, a medication used to help prevent blood clots in patents with a history of stroke, heart attack or peripheral artery disease. There were no errors identified in the documentation provided by the pharmacy. There was no indication of medical necessity in the documentation provided by the prescribing provider. This error is calculated as the total amount paid for this claim.	$156.68	$0.00	$156.68
0905	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for an Estrogen/Testosterone compound, a replacement hormone. The date on the label produced by the pharmacy is different than the date on the prescription. The prescriber's handwriting is poor and the date was reported as miss read. If unable to read a prescription, the pharmacy should call the prescriber to verify the information. The prescriber's records are equally illegible. Since the progress note could not be read, medical appropriateness could not be verified. Therefore, this error is calculated as the total amount paid for this claim.	$51.29	$0.00	$51.29
0916	Pharmacy	MR5	Medically unnecessary service	This claim is for Calcitriol a medication used in the treatment of renal disease requiring dialysis and parathyroid disorders. Signature of receipt for the medication was not the patient and the relationship was not documented as required. There is no documentation in the medical record from the prescribing provider that the patient has any conditions to support the need for this medication. This error is calculated as the total amount paid for this claim.	$97.60	$0.00	$97.60
0921	Pharmacy	PH2	No legal Rx for date of service	This claim is for Lipitor, a medication used to treat high cholesterol. The pharmacy had many refills that were called in by the referring provider. However, the pharmacy did not have written documentation of these phoned prescription refills as required. There is no paper or electronic trail to follow the frequent and sometimes over lapping refills reported verbally by the pharmacy. There is medical indication for the medication. Since there is no documentation for the many refills phoned in, the error is calculated as the total amount paid for this claim.	$87.21	$0.00	$87.21
0922	Pharmacy	PH2	No legal Rx for	This claim is for Cozaar, a medication used to treat high blood	$53.80	$0.00	$53.80

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
			date of service	pressure. The pharmacy was unable to provide documentation to support a refill authorization for this date of service. There was no documentation in the prescribing provider's records to support a refill was authorized for the claimed date of service. This error is calculated as the total amount paid for this claim.			
0948	Pharmacy	MR2B	No documentation	This claim is for condoms. The pharmacy has closed and deactivated their license since this claim was submitted. Attempts to find pharmacy records were unsuccessful. Since no pharmacy records were available for review, this error is calculated as the total amount of the claim.	$9.01	$0.00	$9.01
0976	Pharmacy	PH10	Other pharmacy policy error	This claim is for dressings for an abdominal wound. The prescription was written for 128 dressings. The pharmacy dispensed 30 dressings on at least four different occasions. The prescription was changed without authorization from the prescribing provider to avoid the need to obtain prior authorization. This dressing is limited to no more than 30 dressings per wound in a 27 day period without authorization. This error is calculated as the total amount paid for this claim.	$9.37	$0.00	$9.37
0978	Pharmacy	MR1 (Potential for fraud or abuse noted)	No documents submitted	This claim is for Flurazepam, a medication used to treat insomnia. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider, a physician assistant, refused to provide any medical records to support the medical need for this medication. After several visits to the clinic and several phone calls, the provider was served a subpoena and still refused to provide any records. This physician assistant and her supervising physician have been referred to the appropriate agencies for actions as indicated. Since no records could be obtained to be reviewed, this error is calculated as the total amount paid for this claim.	$16.03	$0.00	$16.03
0985	Pharmacy	PH10	Other pharmacy policy error	This claim is for Truvada, a medication used to manage HIV. The prescription was written for 30 doses. The pharmacy dispensed 7 doses at a time. There is no indication the pharmacy obtained authorization from the prescriber to alter the prescription. The pharmacy was also able to collect additional dispensing fees by splitting the prescription. Documentation from the referring provider indicated the medication was justified. This error is calculated as the total amount paid for this claim.	$223.77	$0.00	$223.77
0988	Pharmacy	PH1 (Potential for fraud or abuse noted)	No signature of receipt	This claim is for lancets for checking blood sugar levels in a long term care facility. There is no signature of receipt. Therefore not a dollar error.	$30.55	$0.00	$30.55
0990	Pharmacy	MR2B	No documentation	This claim is for Mi-Acid Liquid, an over-the-counter medication used to manage heartburn. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider	$8.80	$0.00	$8.80

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				could not provide records to support the need for this medication at the time of the date of service. He had recently moved and cannot locate the records for 2009. Since the prescribing provider was unable to locate the needed records, This error is calculated as the total amount paid for this claim.			
0991	Pharmacy	MR5	Medically unnecessary service	This claim is for Zithromax, an antibiotic used to treat bacterial infections. There were no errors identified in the documentation provided by the pharmacy. There was no documentation in the prescribing provider's record of a need for this antibiotic. A progress note written the day before the prescription did not mention an signs or symptoms of an infection. This error is calculated as the total amount paid for this claim.	$26.38	$0.00	$26.38
0995	Pharmacy	PH10	Other pharmacy policy error	This claim is for YAZ, a medication used for birth control. The prescriber wrote the prescription for six months or six cycles. The pharmacy filled it for only three cycles because Family PACT limits the reimbursement to a maximum quantity of three cycles. There is no evidence the pharmacy obtained authorization from the prescribing provider as required when altering prescriptions. This error is calculated as the total amount paid for this claim.	$211.33	$0.00	$211.33
1011	Pharmacy	MR2B (Potential for fraud or abuse noted)	No documentation	This claim is for Methadone, a medication used for narcotic detoxification and severe pain. There is no error identified in the documentation provided by the pharmacy. The referring provider is no longer in practice in the area. His medical records were not available, since medical records were not available, medical need for the medication could not be verified. This error is calculated as the total amount paid for this claim. **Possible Drug Diversion** **Possible drug abuse by patient.**	$17.78	$0.00	$17.78
1017	Pharmacy	MR2B	No documentation	This claim is for Loratadine, a medication used to manage allergies. There were no errors in the documentation provided by the pharmacy. The prescribing provider stated he had no records to support the prescription. Therefore, the error is calculated as the total amount paid for this claim.	$13.25	$0.00	$13.25
1021	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Potassium Chloride, a medication taken to treat low potassium levels. There were no errors identified in the documents provided by the pharmacy. The records obtained from the prescribing provider did not address the need for the medication. There were no laboratory results obtained to support the need for the medication. This error is calculated as the total amount paid for this claim.	$13.51	$0.00	$13.51
1023	Pharmacy	PH10	Other pharmacy policy error	This claim was for condoms for birth control through the Family PACT program .The program restricts the dispensing to 36 condoms in 27 days. The prescription was written for a quantity of 48. The pharmacy changed the RX to comply with Family PACT formulary	$13.62	$0.00	$13.62

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				without prescriber authorization. This error is calculated as the total amount paid for this claim.			
1027	Pharmacy	PH3	Rx missing essential information	This claim is for Metoprolol, a medication used to manage high blood pressure. The telephone prescription completed by the pharmacy did not have a date on it so it was not possible to determine when the prescription was obtained. This error is calculated as the total amount paid for this claim.	$8.75	$0.00	$8.75
1028	Pharmacy	MR5	Medically unnecessary service	This claim is for Lomotil a medication used to treat diarrhea. There were no errors identified in the documentation provided by the pharmacy. The records from the prescribing provider indicated there was also a prescription for this medication four months earlier. There is no indication in the record supporting for this date of service that the diarrhea is continuing. There is no medical indication for this new prescription. This error is calculated as the total amount paid for this claim.	$13.53	$0.00	$13.53
1045	Pharmacy	PH10	Other pharmacy policy error	This claim is for Prilosec, a medication used to manage heartburn and GERD. The pharmacy changed the quantity to be dispensed from 30 tablets as written by the prescriber to 28 tablets. This was done to avoid obtaining prior authorization since this medication has a restriction on the number of pills that can be dispensed without prior authorization. There is no documentation the pharmacy obtained authorization form the prescriber to make this change in the prescription. The incorrect prescriber was identified on the claim. This error is calculated as the total amount paid for this claim.	$19.57	$0.00	$19.57
1053	Pharmacy	PH7B (Potential for fraud or abuse noted)	Prescription split	This claim is for Actonel, a medication used to treat osteoporosis. The prescription was written for three tablets, one tablet taken monthly for three months. The pharmacist dispensed one tablet each month. This allows the pharmacy to collect additional dispensing fees for the two additional fills for the prescription. According to the pharmacist and prescribing provider, no authorization to alter the prescription was obtained as required. The pharmacist told the auditor she split the prescription to make money. This error is calculated as the total amount paid for this claim.	$102.06	$0.00	$102.06
1055	Pharmacy	MR2B	No documentation	This claim is for Paroxetine, a medication for depression. The pharmacy has closed and no forwarding information could be found. The license has been canceled and the National Provider Identification number has been suppressed. Since no documentation related to the prescription could be obtained this error is calculated as the total amount paid for this claim.	$17.98	$0.00	$17.98
1062	Pharmacy	MR8	Other medical error	This claim is for Phenergan with Codeine cough syrup, a medication used to suppress cough. There were no errors identified in the documentation provided by the pharmacy. There was no signature on	$16.37	$0.00	$16.37

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				the progress note in the prescribing provider's medical record. All four progress notes provided by the prescribing provider were unsigned. Without a signature it is not possible to determine if the actual prescribing provider is the provider on record at the pharmacy. There is also no way to determine if the prescriber is legally authorized to write a prescription. This error is calculated as the total amount paid for this claim.			
1063	Pharmacy	MR5	Medically unnecessary service	This claim is for Flagyl, an antibiotic used to treat infections. There were no errors identified in the documentation provided by the pharmacy. There is no documentation in the prescribing provider's record to indicate either through examination or laboratory tests the patient had an infection that would be responsive to this antibiotic. This error is calculated as the total amount paid for this claim.	$10.31	$0.00	$10.31
1071	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Voltarin, a non-steroidal anti-inflammatory drug for osteo or rheumatoid arthritis. There were no errors identified in the documentation from the pharmacy. The records provided by the prescriber do not clearly document the indication for ongoing use of an anti-inflammatory drug or address the choice of drug over less costly alternative anti-inflammatory agents.	$35.74	$0.00	$35.74
1075	Pharmacy	PH10	Other pharmacy policy error	This claim is for Xopenex, an inhaler used to manage asthma. The prescriber wrote the prescription for Albuterol, a different medication used to manage asthma. There is no documentation in the pharmacy or prescriber records that this prescription change was authorized. This discrepancy was discussed with the pharmacist in charge who stated the Xopenex may have been dispensed in error. This error is calculated as the total amount paid for this claim.	$52.63	$0.00	$52.63
1078	Pharmacy	MR5	Medically unnecessary service	This claim is for Amoxicillin, an antibiotic. The pharmacy dispensed a different amount of this liquid medication than was prescribed without authorization from the prescriber. The pharmacy was unable to provide a signature for receipt of the medication. There is no indication in the medical record why this antibiotic was prescribed. The documentation in the record included a history of cough and sneezing for one month; a normal examination; and diagnosis of common cold. Antibiotic therapy is not effective against the viruses which cause the common cold. This error is calculated as the total amount paid for this claim.	$66.95	$0.00	$66.95
1079	Pharmacy	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	This claim is for Phenergan with Codeine cough syrup. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider records mentioned dry cough seven months before this date of service. There was no evaluation of this cough. There was no subsequent mention of a need for continued use of this cough syrup. Possible Drug Diversion This error is calculated as the total amount paid for this claim.	$14.09	$0.00	$14.09

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
1087	Pharmacy	PH10	Other pharmacy policy error	This claim is for Aspirin 81mg, a medication used to help prevent heart attacks and strokes. The prescription was written for 100 tablets. The pharmacy dispensed 90 tablets. There is no indication the prescriber authorized this change to the prescription. This error is calculated as the total amount paid for this claim.	$6.49	$0.00	$6.49
1102	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Vicodin, a medication used to manage moderate pain. The pharmacy changed the number of tablets ordered without documentation of authorization from the prescriber. The pharmacy dispensed 30 tablets and then the additional 10 tablets 3 weeks later. The prescription change and split was accomplished to avoid the code 1 restriction which allows a maximum quantity per dispensing of only 30 tablets. By splitting the prescription, the pharmacy was also able to charge two dispensing fees. There was no signature of receipt for this medication. The documentation from the prescribing provider mentions lumbago but there is no examination to support this finding. There also is no indication in the prescribing provider's record of an intention to prescribe this medication. This error is calculated as the total amount paid for this claim.	$19.86	$0.00	$19.86
1103	Pharmacy	PH10	Other pharmacy policy error	This claim is for Simvastatin, a medication to treat high cholesterol. The quantity on the prescription is for 120 day supply. Medi-Cal policy allows for a prescription to cover up to 100 days of medication without authorization. The Pharmacist dispensed 90 tablets. There is no indication the prescribing provider authorized this change to the prescription. Since the pharmacist changed the prescription without authorization, this error is calculated as the total amount paid for this claim.	$26.15	$0.00	$26.15
1112	Pharmacy	MR2A (Potential for fraud or abuse noted)	Poor/insufficient documentation	This claim is for birth control pills. The pharmacy was unable to provide proof of receipt by the patient. The prescribing provider did a pregnancy test prior to prescribing this new medication but the results are not indicated in the record. The counseling, patient assessment and education along with the actual prescribing of the medication was done by the clinic licensed vocational nurse (LVN). This is outside the scope of practice for an LVN. There is no indication there was any evaluation of the appropriateness of this medication by any medical practitioner. This error is calculated as the total amount paid for this claim.	$152.34	$0.00	$152.34
1115	Pharmacy	MR5	Medically unnecessary service	This claim is for Amoxicillin liquid, an antibiotic used to treat bacterial infections. The pharmacy did not have a valid prescription for this date of service. The only prescription the pharmacy had was from five months earlier and that prescription had no refills authorized. The pharmacy could not produce a signature verifying receipt of the medication. The only documentation from the prescribing provider	$11.74	$0.00	$11.74

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				was from three weeks before this date of service and described symptoms of a viral infection. There was no medical indication for this medication. This error is calculated as the total amount paid for this claim.			
1120	Pharmacy	PH10	Other pharmacy policy error	This claim is for Lorazepam a medication used to treat anxiety and insomnia. The prescription was written for 60 tablets. The pharmacy dispensed 30 tablets. There is a Code 1 restriction which limits this medication to 30 tablets per dispensing without prior authorization. There is no indication the prescribing provider authorized this prescription change as required. This error is calculated as the total amount paid for this claim.	$11.65	$0.00	$11.65
1131	Pharmacy	MR5	Medically unnecessary service	This claim is for Cipro, a medication used to treat bacterial infections. This medication is restricted for use in lower respiratory infections for persons 50 or older, osteomyelitis or pulmonary exacerbation of cystic fibrosis. This patient was 46 years old at the time she was seen. The patient complained of symptoms of a viral upper respiratory infection and perhaps a urinary tract infection. There is no indication any further evaluation was done to determine the cause of the symptoms The patient is enrolled in Family PACT services only. None of the symptoms this medication was prescribed for are associated with family planning issues so this beneficiary is not eligible for these services. This error is calculated as the total amount paid for this claim.	$4.00	$0.00	$4.00
1139	Pharmacy	MR5	Medically unnecessary service	This claim is for Vicodin, a medication for pain. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the prescribing provider does not support the need for this medication. There is no complaint of pain and no assessment of a pain problem. There is also no documentation the prescriber intended for the patient to have this medication. This error is calculated as the total amount paid for this claim.	$5.06	$0.00	$5.06
1141	Pharmacy	MR5	Medically unnecessary service	This claim is for Amoxicillin, an antibiotic used to treat bacterial infections. There was no error identified with the documentation provided by the pharmacy. The documentation provided by the prescribing provider did not indicate medical need for this antibiotic. There is no evaluation of the patient's symptoms of upper respiratory infection to indicate it was not a viral infection. This error is calculated as the total amount paid for this claim.	$4.00	$0.00	$4.00
1142	Pharmacy	MR5	Medically unnecessary service	This claim is for Claritin, a medication used to treat allergies. There were no errors identified in the documentation provided by the pharmacy. The records form the prescribing provider did not indicate any assessment related to allergic reaction. The only documentation	$13.25	$0.00	$13.25

ID	Stratum	Primary Error	Error Type Description	Final Comments	Stratum Paid Amount	Stratum Correct Amount	Amount In Error
				was patient complaint of nasal congestion and a request for Claritin. There was no examination or evaluation related to this complaint. This error is calculated as the total amount paid for this claim.			
1144	Pharmacy	MR5	Medically unnecessary service	This claim is for Cilostazol, a medication used to treat intermittent claudication which causes pain due to inadequate arterial blood flow to the extremities. The prescription was written for 100 tablets but the pharmacy dispensed 60. There is no documentation the pharmacy obtained authorization from the prescriber to change the prescription. This is a Code 1 restricted medication limited to use by patients over 65 with intermittent claudication or diabetics of any age with intermittent claudication. There is no documentation provided by the pharmacy or the prescribing provider the beneficiary had intermittent claudication. This error is calculated as the total amount paid for this claim.	$40.10	$0.00	$40.10
1145	Pharmacy	MR5 (Potential for fraud or abuse noted)	Medically unnecessary service	The claim is for Gabapentin, a medication used to treat nerve pain and seizures. There were no errors identified in the documentation provided by the pharmacy. The medical record from the prescribing provider mentions a patient complaint of cervical pain and tingling and intent to prescribe the medication. There was no documentation of an examination or evaluation of the pain to determine its cause. This error is calculated as the total amount paid for this claim.	$14.68	$0.00	$14.68
1146	Pharmacy	MR5	Medically unnecessary service	This claim is for acetaminophen, a medication used for pain and fever. The prescription was not written on a tamper proof prescription and the pharmacy did not verify its authenticity with the prescriber as required. The medical records provided by the prescribing provider contained no mention of an acute or chronic problem that acetaminophen would be prescribed for. This error is calculated as the total amount paid for this claim.	$9.04	$0.00	$9.04

Appendix 5 - Glossary

A&I	Audits and Investigations
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
B&P Code	Business and Professions Code
BIC	Beneficiary Identification Card
CBC	Complete Blood Count
CCR	California Code of Regulations
CDHCS	California Department of Health Care Services
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
CPSP	Comprehensive Prenatal Services Program
CPT	Current Procedural Terminology
CRP	C-Reactive Protein
CVA	Cerebral Vascular Accident
DHHS	U. S. Department of Health and Human Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DOJ	Department of Justice
EDS	Electronic Data Systems
EKG	Electrocardiogram
ER	Emergency Department/Room
FFS	Fee-For-Service
FI	Fiscal Intermediary
FO	Field Office
FPACT	Family Planning, Access, Care and Treatment
FQHC	Federally Qualified Health Centers
GERD	Gastro Esophageal Reflux Disease
HALT	Health Authority Law Enforcement Team
HIV	Human Immunodeficiency Virus
HP	Hewlett Packard
HPES	Hewlett Packet Enterprise Services
IEP	Individual Education Plan
IPC	Individual Plan of Care
IV	Intravenous
Lab	Laboratory
LEA	Local Education Agency
MC	Managed Care
MCE	Managed Care Enrollment
MEQC	Medi-Cal Eligibility Quality Control
MMC	Medi-Cal Managed Care

MMEF	Monthly Medi-Cal Eligibility File
MPES	Medical Payment Error Study
MRB	Medical Review Branch
OB	Obstetrics
OIG	Office of Inspector General
PA	Public Assistance
PEB	Provider Enrollment Branch
PERM	Payment Error Rate Measurement
PIA	Prison Industry Authority
PPM	Post-Service Pre-Payment Audit (formally known as Special Claims Review- SCR)
PRS	Program Review Section of CDHS Medi-Cal Eligibility Branch
RHC	Rural Health Clinic
SCR	Special Claims Review (currently known as Post-Service Pre-Payment Audit- PPM)
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Social Security Income
STD	Sexually Transmitted Disease
STO	State Controller's Office
TAR	Treatment Authorization Request
VSAM	State Medi-Cal eligibility database
W&I Code	Welfare and Institutions Code