

2013

Medi-Cal Payment Error Study

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



Fee-For-Service Program



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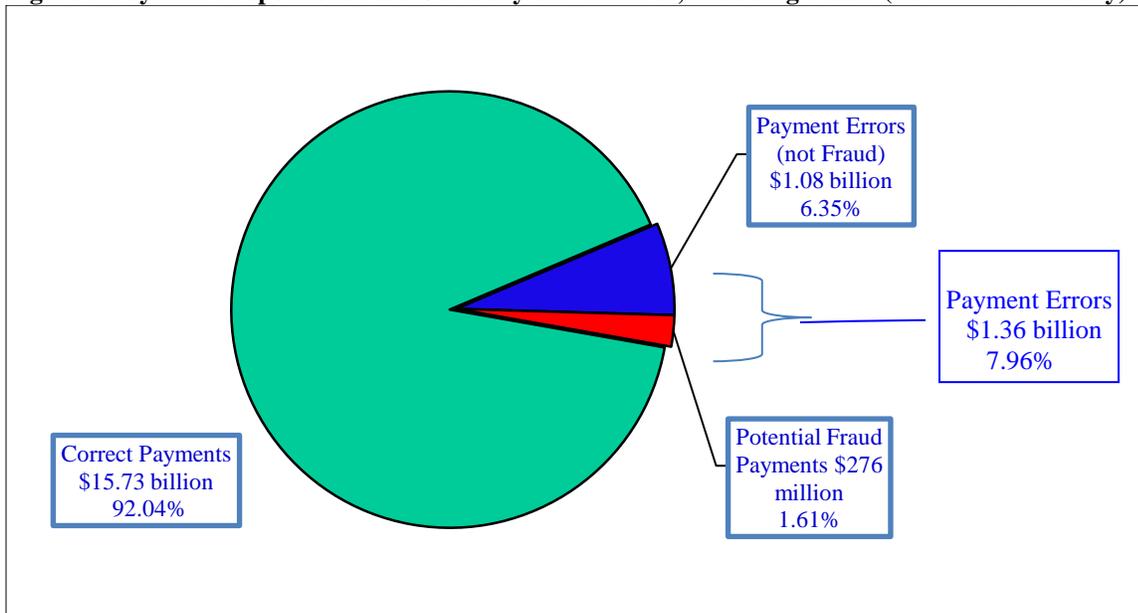
I. Executive Summary

The California Department of Health Care Services has completed its 2013 Medi-Cal Payment Error Study (MPES). The study identifies where the Fee-For-Service (FFS) Medi-Cal program is at greatest risk for payment errors. Furthermore, it allows DHCS to analyze the factors that influence the payment errors and determine what actions and strategies it needs to take in order to reduce the cost associated with those errors.

1) Overall Findings

The MPES 2013 results show that a very large majority of payments, 92.04 percent of total payments made in FFS medical and dental programs, was billed and paid appropriately (Figure 1). In contrast, an estimated 7.96 percent of those payments had some indication of a potential provider payment error (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 for services that were not medically-necessary.

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



Extrapolating from the MPES 2013 sample to the program as a whole, the 7.96 percent error rate equates to a projected \$1.36 billion in total payments at risk of having been made in error for FFS medical and dental services in 2013. This projected amount represents the Medi-Cal program payments at risk of being paid inappropriately. The term “at risk” is used because the \$1.36 billion cannot be considered as actual payments made in error unless all the individual services that are questionable are identified through a complete medical review or audit.

Table 1 shows, for each MPES year since 2005, the payment error rate that was determined through medical review, the corresponding FFS projected payments annualized from Medi-Cal quarterly financial records, and the calculated projected annual payments at risk of being in error.

Table 1 – Error Rates and Projected Payments in Error Across MPES Studies

MPES	Error Rate	FFS Projected Annual payments	Projected Annual Payments in Error	Difference in Projected Payment Errors From Prior MPES Study
MPES 2005	8.40%	\$16,773,590,756	\$1,409,704,505	
MPES 2006	7.27%	\$16,177,256,316	\$1,176,521,646	(\$233,182,859)
MPES 2007	6.56%	\$15,968,390,500	\$1,047,708,877	(\$128,812,769)
MPES 2009	5.45%	\$19,636,308,388	\$1,070,041,382	\$22,332,505
MPES 2011	6.05%	\$20,718,001,080	\$1,252,789,452	\$182,748,070
MPES 2013	7.96%	\$17,090,496,599	\$1,360,841,521	\$108,052,069

Note: Numbers and percentages in table are rounded off as they derive from formulas.

Cumulatively, there are \$108 million more projected payments at risk of being in error in MPES 2013 than were in MPES 2005.

The 7.96 percent payment error rate represents an increase, compared to the 6.05 percent rate of the 2011 study, but is somewhat lower than the 8.40 percent rate found in the benchmark 2005 study. The projected annual payments in error are reflections of the error rate of the MPES year and the FFS annual payments for that year, which fluctuate according to services per beneficiary. The MPES 2013 projected annual payments at risk of being in error was \$1.36 billion, compared to \$1.25 billion in 2011, and \$1.40 billion in 2005.

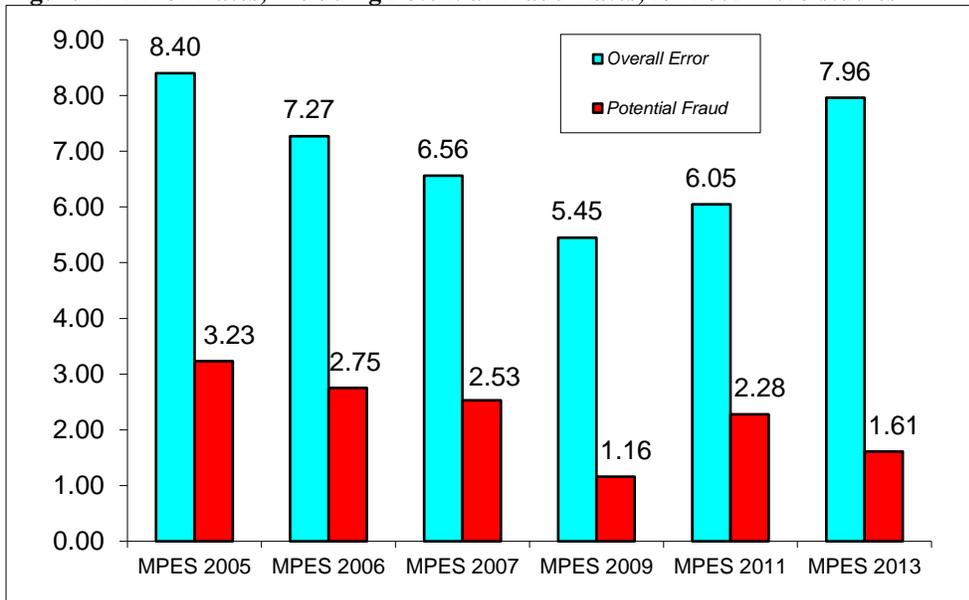
2) Potential Fraud Error

To commit fraud involves malicious intent on the part of the provider. MPES takes the approach of identifying potential fraud, since proving actual fraud typically involves full criminal investigation. The potential fraud estimate is an important aspect of the study because the findings have implications for the Medi-Cal program as a whole. Follow-up analysis of the portion of the overall payment error ascribed to potential fraud facilitates the development of systems for the prevention of fraud, plus it facilitates the detection of actual fraud.

MPES 2013 findings indicate that 1.61 percent of the total payments in the Medi-Cal FFS medical and dental programs was for claims that disclosed characteristics of potential fraud. The 1.61 percent is equivalent to an estimated annual amount of \$276 million in potential fraud.

Notably, the potential fraud rate declined in MPES 2013, compared to the MPES 2011 fraud amount of 2.28 percent. The 2013 rate is the second lowest among all MPES studies, behind the 2009 fraud rate (Fig.2). The average fraud rate for the 2005-2013 studies is 2.56 percent and continues to trend down.

Figure 2 - Error Rates, Including Potential Fraud Rates, for 2005- 2013 studies



The largest contributors to the potential fraud rate include Pharmacy (44 percent), Other Services (26 percent), and Durable Medical Equipment (nearly 11 percent).

3) Sampling Overview

The MPES 2013 random sample includes 1,117 Medi-Cal claims paid during the fourth quarter of 2013, and is organized by major provider type (stratum). There are eight provider types in the sample: Dental, Durable Medical Equipment (DME), Inpatient Services, Laboratory (referred to as Lab), Local Education Agencies (LEA), Physician Services, Other Services and Supplies (referred to as Other Services), and Pharmacy. The 2013 strata are comparable to those in the 2011 MPES, except that the Adult Day Health Care (ADHC) stratum was retired, due to reorganization of the Medi-Cal program, and an LEA stratum was created as its replacement.

The sample claims were apportioned as follows: 50 each in DME, Inpatient Services and Other Services strata; 69 in the Lab stratum, 70 in Dental, 87 in LEA, 291 in Pharmacy, and 450 in Physician Services. Each sample claim was reviewed for errors, and primary and secondary error codes from a pre-set list were assigned to the rendering provider and to the referring provider, when applicable.

Sample claims with any payment error were the basis of the calculation of the payment error percent. Per the MPES methodology, the payment error percent is a function of the dollar amounts of the component claims. High-dollar claims have a greater impact than low-dollar claims. Based on Medi-Cal claims data obtained from the fourth quarter of 2013, the stratum with the highest average amount per claim was Inpatient Services, which accounted for about 50.4 percent of the payment share in that universe (Table 2). On the other end of the spectrum were the Dental, DME, Lab, LEA, and Other Services strata.

Table 2 - Paid Claims in the Universe by Stratum (Oct.1 – Dec. 31, 2013)*

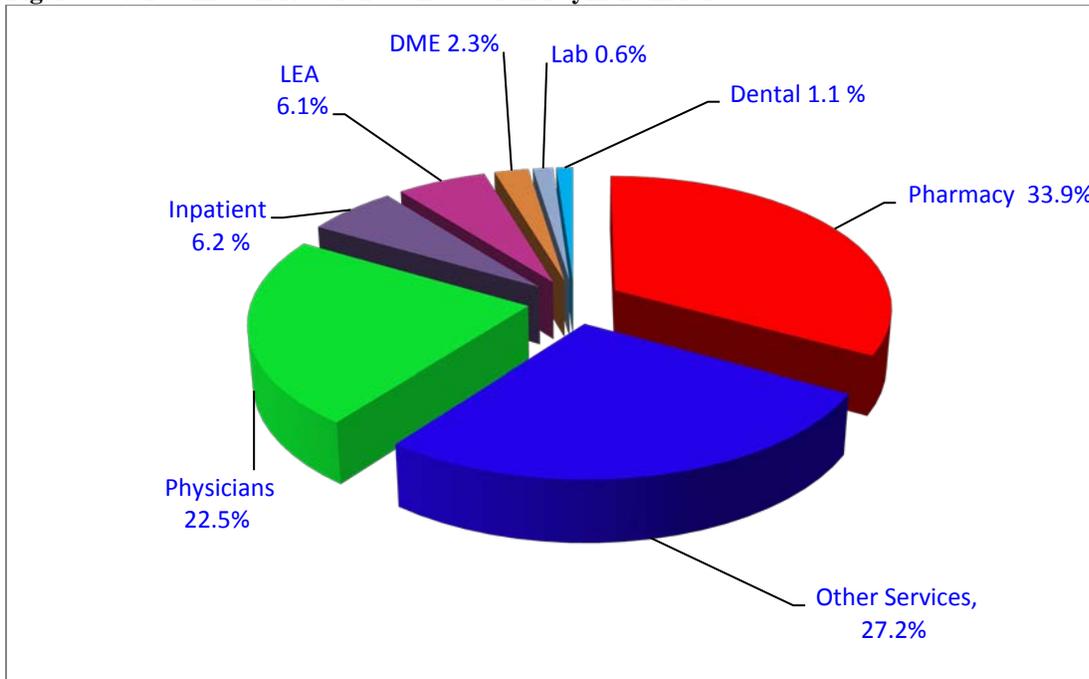
Stratum	Number of claims	Payments	Percent of Claims Volume	Percent of Payments Volume
Dental	1,196,898	\$133,895,556	6.53%	3.13%
DME	217,338	\$23,800,089	1.19%	0.56%
Inpatient	812,931	\$2,152,561,037	4.44%	50.38%
Lab	1,171,837	\$52,632,550	6.39%	1.23%
LEA	1,479,644	\$34,337,494	8.07%	0.80%
Physicians	7,717,668	\$908,675,365	42.12%	21.27%
Other Services	752,378	\$216,141,065	4.11%	5.06%
Pharmacy	4,976,125	\$750,580,993	27.16%	17.57%
Total	18,324,819	\$4,272,624,150	100%	100.00%

*Data obtained from the Research Analysis and Statistics Division

4) Error Analysis – Payment

The Figure below displays the contribution each provider type made of the overall 7.96 percent payment error rate.

Figure 3 - Stratum Contribution to the Overall Payment Error



The Pharmacy stratum was responsible for more than a third (33.9 percent) of the overall payment error, followed by Other Services, with a 27.2 percent share, and Physician Services, with a 22.5 percent share.

The Inpatient Services stratum had only one claim in error; however, it carried a disproportionate 6.2 percent share of the overall payment error, resulting in an estimated \$84 million at risk of having been paid in error.

LEA, the stratum that replaced ADHC in the MPES 2013 sample, contributed 6.1 percent to the overall payment error. LEA's error is significantly high when compared to its share of the payment volume in the universe (0.80 percent).

The remaining three strata (Dental, DME, and Lab) combined for a share of 4.0 percent of the payment error rate.

While Pharmacy and Physician Services historically have been responsible for large portions of the overall error rate, the comparably high share attributable to Other Services represents a significant change. It increased from 16.7 percent in the 2011 MPES to 27.3 percent. A focused review of the stratum's 2013 error claims shows that they involved a wide variety of services (transportation, therapy, genetic testing, hearing aid dispensers, etc.). A common feature was that the errors in this stratum were accompanied with high dollar amounts.

In terms of potential payments at risk of having been paid in error, the Other Services stratum incurred nearly \$371 million, second only to Pharmacy (\$461 million).

5) Error Analysis – Claim Count

Examining the sample in terms of number of claim errors provides supplemental information and adds perspective to the payment errors analysis.

There were 181 claim errors, out of the 1,117 sample claims, accounting for a 16.2 percent claim error rate. This is higher than the 10.5 claim error rate of MPES 2011, but lower than lower than the 18.5 percent claim error rate of MPES 2009

The Pharmacy stratum ranked first, with 55 claim errors (30.4 percent). Physician Services came in second with 54 errors (29.8 percent). LEA came in third in number of errors in the sample, with 45 errors (24.9 percent), and Other Services fourth, with 14 errors (7.7 percent).

The four remaining strata, Dental, DME, Lab, and Inpatient Services, contributed the fewest numbers of claims in error with 6, 3, 3, and 1 claim errors, respectively. However, the one Inpatient Services error caused an estimated \$84 million in potential payments at risk of having been paid in error, when extrapolated annually.

LEA had one of the highest proportions of claims in error. Fifty-two percent of LEA claims were found to be in error (45 out of 87 claims in that stratum). That is more than half of the 87 LEA

claims reviewed. In comparison, Physician Services, which had the second highest percentage, had 28 percent error rate in claims reviewed.

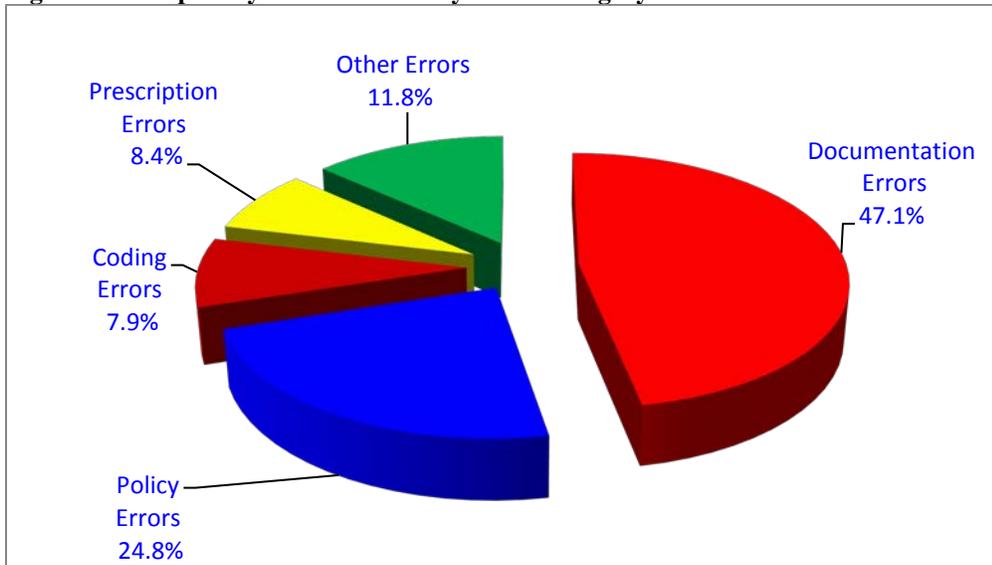
When the claims in error are analyzed according to whether the rendering or referring provider was responsible for the error, we found that most are attributable to the rendering provider, but some are caused by the referring provider. For example, a portion of the Pharmacy stratum errors (6 of 55) were actually attributable to the referring (prescribing) provider and did not involve the rendering (dispensing) provider. If rendering provider errors are categorized as Physician Services errors, then the Physicians Services stratum becomes the one with the greatest vulnerability (or monetary risk).

Drug diversion continues to be an issue in the Medi-Cal program. Three pharmacy claims in error, out of 55, were related to possible drug diversion schemes. Claims of this type are generally associated with narcotic or other pain medication that is used for non-medical or recreational reasons. Drug diversion products are also known to be acquired for street resale.

6) Error Analysis – Type of Error

The pre-set specific error types were grouped into five general categories (coding, documentation, policy, prescription, and other). Below is the breakdown of sample payment errors by category, utilizing the single main specific error type determined for each of the 181 claims with payment errors.

Figure 4 – Sample Payments in Error by Error Category



The largest payment error category was documentation errors, with 47.1 percent. Policy errors ranked second in sample payment errors with a 24.8 percent share of all payment errors. Coding errors accounted for 7.9 percent, and errors linked to Pharmacy prescriptions, 8.4 percent.

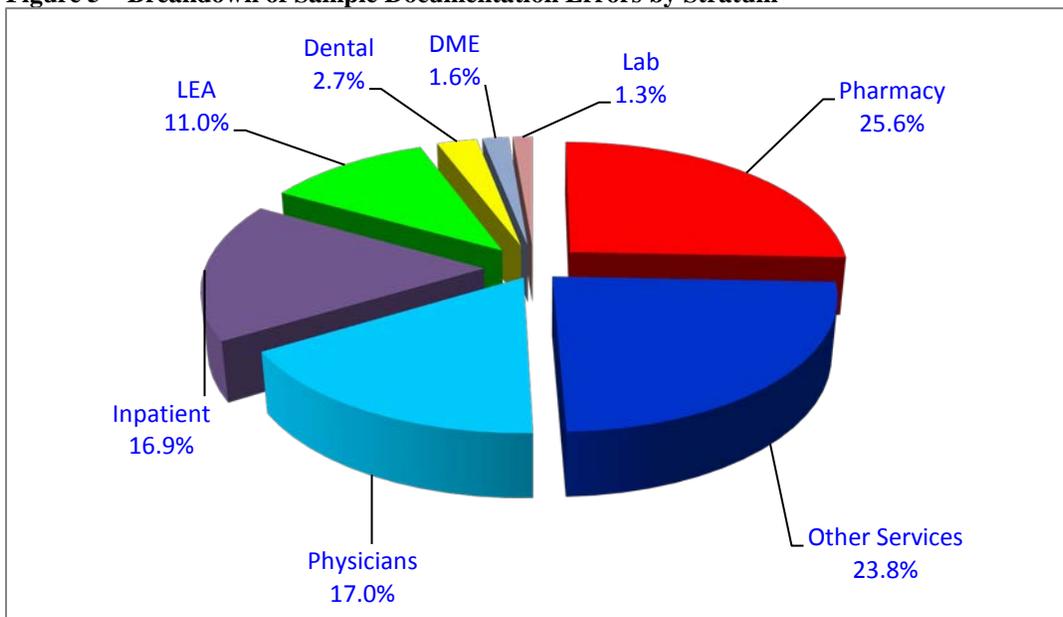
When MPES 2013 results are compared to those of MPES 2011, medical necessity errors are much less prominent. In fact, for MPES 2013, medical necessity errors were attributed to the Other Errors category. In part, the reduction is related to the absence of the ADHC stratum, as that stratum had previously been associated with a high number of medical necessity errors. In addition, more medical necessity errors may have been found if documentation errors had not been so prevalent.

7) Error Analysis – Documentation Errors

Documentation errors are assigned when no documentation at all is submitted by the provider, or when the documentation submitted is incomplete, or when the documentation submitted is inadequate. Without documentation for review, determination of more specific types of errors is precluded.

In terms of payment errors, Figure 5, below, illustrates the breakdown of sample documentation errors by stratum.

Figure 5 – Breakdown of Sample Documentation Errors by Stratum



It shows that Pharmacy accounted for more than a fourth of all documentation payment errors in the sample (25.6 percent), followed by Other Services that had about a 24 percent share. Physician Services came in third with a 17 percent share of the documentation payment errors in the sample.

In terms of error claim count, 102 claims are in error in the documentation error category (out of 181 errors), accounting for 56.4 percent of all the claims in error in the sample. Looking closely at these 102 errors by provider type in the sample, we note that LEA accounted for 36 of them; that is more than a third of all documentation errors in the sample. Physicians came in second with 24 claim errors, followed by Pharmacy (21), and Other Services (10). Other remaining strata had very few documentation errors.

Documentation payment errors were significantly higher in the 2013 MPES than in the 2011 study. The estimate of the potential payments at risk of having been made in error is nearly \$641 million. Improvements in the area of documentation would at a minimum contribute to more complete and accurate case review, and potentially result in significant programmatic savings to DHCS.

8) Key Findings

MPES continues to assist DHCS in maintaining Medi-Cal program integrity, including by identifying emerging fraud practices among providers and provider types, and ensuring that our Department's anti-fraud activities are focused on the areas of highest risk for fraud, waste, and abuse.

MPES 2013 has identified the following:

- Although the overall payment rate has increased with respect to MPES 2011 (from 6.05 percent to 7.96 percent), it is still lower than the highest rate on record (8.40 percent in MPES 2005).
- Findings indicate that 1.61 percent of the total payments in the Medi-Cal FFS medical and dental programs was for claims that disclosed characteristics of potential fraud. This rate is among the lowest of those ascertained through the MPES process, and may represent evidence of progress in the on-going endeavor to assure all Medi-Cal resources are utilized in an optimal fashion.
- The Pharmacy stratum continues to be among the highest contributors to the overall payment error, at nearly 34 percent. When the services of both the rendering and referring providers are considered, Pharmacy has the highest number of claims in error in the sample (55 out of a total of 181 errors) and the highest number of potentially fraudulent claims (13 out of 37).
- The Other Services stratum is the second highest contributor to the payment rate, at 27 percent, behind Pharmacy. The 2011 figure for this stratum was already substantially high, at almost 17 percent. This stratum's 27 percent share of the overall payment error is significantly more than its share of the volume in the payment universe (5.1 percent), suggesting the claim amounts were high. Compared to the results from the 2011 study, the 2013 contribution to the payment error rate is about 10 percentage points higher. It is unclear if this represents a true change or a reflection of the diverse nature of the stratum.
- Physician Services had the third highest share of the payment error, with nearly 23 percent; this share is lower than that of the 2011 study (32 percent). If referring provider errors detected in other strata are included with the rendering provider errors detected in this stratum, then the Physician Services stratum becomes the one with greatest vulnerability.
- LEA replaced the ADHC stratum this time around; in previous studies, the LEA sample claims were part of the Other Services stratum. In 2013, LEA contributed six percent to the overall payment error, disproportionately higher than the 0.80 percent it represented in the MPES 2013 payment universe.

- The number of documentation errors more than doubled in MPES 2013, compared to MPES 2011 (102 errors vs. 45 errors). LEA was the largest contributor, with 36 documentation errors (or 35 percent).
- There were noticeably fewer medical necessity errors in MPES 2013 than were in MPES 2011 (11 errors vs. 37 errors). Two factors likely contributed to this shift:
 - First, the ADHC stratum, which was part of the 2011 MPES sample, had 15 medical necessity errors identified, while the replacement stratum (LEA) had only two identified.
 - Second, there were more issues with documentation in MPES 2013, including problems in obtaining any documentation from providers, obtaining specific documentation for the service claimed, or obtaining quality documentation. It seems likely that some of these cases were potentially medical necessity errors, but were instead categorized as documentation errors.

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 administered by 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. As such, it is California's largest publicly-funded health care program and its largest health care purchaser.

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, and 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 rendered.

The calendar year 2013 enrollment figures show there were almost 12.5 million beneficiaries enrolled in Medi-Cal. Of those, about 5.2 million (41.6 percent) were enrolled in FFS, while nearly 7.3 million (58.4 percent) were enrolled in MMC (these numbers were obtained from MIS/DSS).

In terms of expenditures, FFS and MMC combined for a total of \$33.7 billion in 2013; of that amount, \$17.2 billion (51 percent) was for FFS and \$16.6 billion (49 percent) for MMC (numbers obtained from MIS/DSS).

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.

3) MPES Overview

MPES has been an important part of DHCS' program integrity efforts for the last several years. Specifically, 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 Types

MPES is based upon claims paid to the following list of eight Medi-Cal provider types:

- Dental

- Durable Medical Equipment (DME)
- Inpatient
- Clinical Laboratory Services (referred to as Lab)
- Local Education Agencies (LEA)
- Other Services and Supplies (referred to as Other Services)
- Physicians Services and Physician Services Groups (referred to as Physician Services)
- Pharmacy

5) Main Payment Error Types

MPES measures “payment errors.” A payment error occurs when DHCS reimburses a provider for a Medi-Cal claim for which, unknown to DHCS, that provider either accidentally billed Medi-Cal incorrectly, or by which the provider intended to commit fraud, waste, or abuse. It is important to note that most payment errors are not attempts to defraud, abuse Medi-Cal or waste its resources.

The five most significant categories of payment errors among the many types used and reported by MPES 2013 are:

- *Documentation: This occurs when 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.*
- *Policy Violation: Violation of Medi-Cal policy.*
- *Coding errors: The procedure was performed, but insufficiently documented and billed using an incorrect procedure code. This error includes up-coding for office visits.*
- *Prescription-related errors: The prescription was either missing from the medical record or lacked important information required, such as the quantity to be dispensed, instructions for use, or a legal signature.*
- *Other errors: Payment errors that do not fall into the major categories listed above.*

6) MPES 2011 Findings

The previous study (MPES 2011) reported that 93.95 percent of all Medi-Cal FFS payments were correct, with a payment error rate of 6.05 percent. The 6.05 rate represented an increase in payment errors since the MPES 2009 rate of 5.45. It further stated that DHCS remained concerned mostly about payment errors for medically-unnecessary services, as it was in the MPES 2009 report.

III. MPES Design and Methodology

MPES 2013 reviews Fee-For-Service (FFS) claims only. The Medi-Cal Managed Care plans and programs are currently excluded from this study.

Prior to 2009, MPES had been conducted annually, but DHCS now performs the study every odd year (2009, 2011, 2013, etc.). The methodology continues to be refined and improved to enhance the effectiveness of DHCS' monitoring of payment errors, as well as waste, fraud, and abuse.

1) Process

MPES follows a multiple-stage process:

- a) Draw a Sample of Claims: Using the same statistical sampling design as in previous studies¹, DHCS began by sampling 1,117 FFS claims paid in the fourth quarter of 2013; it further refined the review processes for minimizing the non-sampling errors and improving the reliability of the review process between auditors and the medical reviewers.
- b) Conduct Review of Medical Records to Validate the Sampled Claims: To ensure the integrity of the study, Medical Review Branch (MRB) auditors and medical staff conducted onsite visits at the provider's location, 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 Medi-Cal regulations,
 - 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) Perform a Second Review to Confirm the First Review Findings: After the first-level reviews, MRB medical staff performed a second-level review to validate the first review findings and identify claims that may show possible characteristics of fraud, waste, or abuse.² Their findings are compiled into a database for analysis.
- d) Refer selected Cases: MRB sent claims determined to be potentially fraudulent to the California Department of Justice's Medicaid Fraud Control Unit for validation, according to their fraud protocols. MRB then reevaluated its findings based upon DOJ's review. In addition,

¹ The MPES 2013 sampling strategy uses a widely-accepted proportional stratified random sampling to generate estimates of overall payment and fraud errors; it uses a ratio estimator to determine the potential dollar loss to the program, due to provider claiming errors.

² Common indicators of fraud are provided in Appendix I.

MRB sent selected claims to the DHCS' Medi-Cal Policy Division, Pharmacy claims to DHCS' Pharmacy Division, and LEA claims to the State Controller's Office.

e) Analyze Data and Draft the MPES Report.

f) Issue Final Report: DHCS Executive Staff review/approve the final draft before publication.

2) Data Universe and Sample

The sampling universe for MPES 2013 consisted of Medi-Cal fee-for-service claims paid through the Fiscal Intermediary Xerox, during the period of October 1, 2013, through December 31, 2013. (Table III.1).

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

Stratum	Number of claims	Payments	Percent of Claims Volume	Percent of Payments Volume
Dental	1,196,898	\$133,895,556	6.53%	3.13%
DME	217,338	\$23,800,089	1.19%	0.56%
Inpatient	812,931	\$2,152,561,037	4.44%	50.38%
Lab	1,171,837	\$52,632,550	6.39%	1.23%
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Pharmacy	4,976,125	\$750,580,993	27.16%	17.57%
Total	18,324,819	\$4,272,624,150	100%	100.00%

The 1,117 claims sampled for this study represent eight major provider types and are distributed as follows:

- 450 Physician Services claims
- 291 Pharmacy claims
- 87 LEA claims
- 70 Dental claims
- 69 Lab claims
- 50 DME claims
- 50 Inpatient claims
- 50 Other Services claims.

The ADHC stratum was removed from the 2013 study, as DHCS replaced that program in 2012 by the Community Based Adult Services (CBAS), a Medi-Cal Managed Care benefit. The LEA stratum has been substituted for ADHC in the MPES 2013 sample.

Each claim in the sample 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.

The sample size was extracted from a universe of 18,324,819 Medi-Cal FFS and Dental paid claims. It was used to ensure a 95 percent confidence level with a ± 3 percent 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. Simple random sampling without replacement was used in each stratum for the overall the sample selection.³

3) Sample Stratification

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

- Stratum 1: Dental, plan code equal to 0 and claim type equal to 5 and vendor code equal to 27.
- Stratum 2: Durable Medical Equipment (DME) services, [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 services, claim type = 2 (Inpatient), and with the following 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: Laboratory services, with the following vendor code list:

11	Fabricating Optical Labs
19	Portable X-ray Laboratory

³ This sampling methodology, also used for MPES 2006- 2007, MPES 2009, MPES 2011, and MPES 2013, was reviewed and approved by Dr. Geetha Ramachandran, Professor of Statistics at California State University, Sacramento.

23	Lay-owned Laboratory Service
24	Physician Participated Lab Service

- Stratum 5: Local Education Agency (LEA), with vendor code = 55.
- Stratum 6: Other Practices and Clinics (Physician Services), vendor code list:

5	Certified Nurse Midwife
7	Certified Pediatric Nurse Practitioner
8	Certified Family Nurse Practitioner
9	Respiratory Care Practitioner
10	Licensed Midwife
12	Optometric Group Practice
13	Nurse Anesthetists
20	Physicians
21	Ophthalmologist
22	Physicians Group
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	Surgi-center
75	Organized Outpatient Clinics
77	Rural Health Clinics / FQHCs
78	Community Hemodialysis Center
91	Outpatient Heroin Detox

*Not all the vendor codes listed above are represented in the MPES 2013 sample

- Stratum 7: Other Services and Supplies, all other claims that do not meet the criteria for the other strata.
- Stratum 8: Pharmacy Services, with 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, 2013 through December 31, 2013. 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 and their descriptions that could be assigned to a claim in error. Twenty-three errors were found in the MPES 2013 sample. MRB grouped these 23 error codes into the five most prevalent categories (or types), in Table III.2 below.

Table III.2 – Major Errors Found in MPES 2013 Sample

Error Category	Error Code	Error Description
Documentation	MR1	No documents were submitted with the claim
	MR2A	Poor/insufficient documentation
	MR2B	Documentation of the procedure claimed was not provided
Policy	MR7	Policy Violation
	MR8	Other medical error
	PH10	Other pharmacy policy error
Coding	MR3	Coding error
	MR4	Unbundling error
Prescription errors	PH2	No legal prescription for date of service
	PH3	Prescription missing essential information
	PH5	Wrong Information on label
	PH7B	Prescription split
Other	MR5	Medical necessity
	P1	Duplicate item
	P2	Non-covered service
	P3	Medicaid Managed Care Organization covered service
	P5	Pricing error
	P6	Logical edit
	P7	Ineligible recipient
	P9A	Billing provider ineligible to bill for claimed services/supplies
	P9B	Rendering provider ineligible to bill for services/supplies
	WPIA	Wrong rendering provider identified on the claim
	O	Other error

5) Estimation

DHCS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits.⁴ 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 eight strata. The payment error rate for each stratum was calculated by subtracting the accuracy rate from 100 percent (see Table III.3 below).

Table III. 3 - 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
Dental	70	\$8,475	\$8,231	97.11%	2.89%
DME	50	\$7,405	\$4,953	66.88%	33.12%
Inpatient	50	\$218,487	\$216,353	99.02%	0.98%
Labs	69	\$3,102	\$2,980	96.07%	3.93%
LEA	87	\$2,215	\$877	39.57%	60.43%
Physicians	450	\$54,966	\$50,333	91.57%	8.43%
Other Services	50	\$8,182	\$4,673	57.12%	42.88%
Pharmacy	291	\$35,859	\$30,348	84.63%	15.37%
Total	1,117	\$338,692	\$318,748	92.04%	7.96%

- Second, each of the accuracy rates for the eight strata was weighted by multiplying the payments made for services in the corresponding universe stratum. These products were 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.

The projected annual payments made correctly were calculated by multiplying three quantities: 1) the payment accuracy rate, 2) the 4th quarter 2013 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.4)

⁴ William G. Cochran, Sampling Techniques (John Wiley & Sons, 1977), p. 164.

Projected annual payments made in error = payment error rate X (times) 4th quarter 2013 Medi-Cal FFS payments universe subject to sampling X 4 (number of quarters). Table III.4 below lists those overall estimates.

Table III.4 - 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	Annualized Overall Incorrect Payments
Dental	97.11%	\$133,895,556	\$130,030,573	\$3,864,983	\$15,459,932
DME	66.88%	\$23,800,089	\$15,916,915	\$7,883,173	\$31,532,693
Inpatient	99.02%	\$2,152,561,037	\$2,131,533,463	\$21,027,574	\$84,110,296
Labs	96.07%	\$52,632,550	\$50,566,343	\$2,066,207	\$8,264,830
LEA	39.57%	\$34,337,494	\$13,588,356	\$20,749,138	\$82,996,551
Physicians	91.57%	\$908,675,365	\$832,084,358	\$76,591,007	\$306,364,028
Other Services	57.12%	\$216,141,065	\$123,461,968	\$92,679,098	\$370,716,390
Pharmacy	84.63%	\$750,580,993	\$635,231,793	\$115,349,200	\$461,396,801
Total	92.04%	\$4,272,624,150	\$3,932,413,770	\$340,210,380	\$1,360,841,521

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

$$\hat{Y} = \sum_{h=1}^8 (y_h / x_h) X_h$$

(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:

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

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

$$\hat{Y} \text{ lower limit} = \sum_{h=1}^8 (y_h / x_h) X_h - 1.96S$$

$$\hat{Y} \text{ upper limit} = \sum_{h=1}^8 (y_h / x_h) X_h + 1.96S, \text{ and}$$

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

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

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

$$\text{where } R_h = y_h / x_h$$

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

IV. Findings

Overall, the MPES 2013 results indicate that, of the estimated \$17.1 billion in all Medi-Cal FFS and Dental payments made in 2013, a very large majority, \$15.7 billion (or 92.04 percent), were appropriately and correctly billed and paid. In contrast, about \$1.36 billion (7.96 percent) was for erroneous payments to Medi-Cal providers.

1) Summary Statistics

The following three tables summarize the main MPES 2013 findings, including the overall payment error rate, the potential fraud rate, the error rates for each stratum (provider type), and the payments amounts in error, projected annual payments in error. In addition, the first two tables show the computed margins of error and confidence intervals for each stratum. A detailed explanation of how these amounts were computed and the statistical methodology used in MPES are described in Section III of this report.

**Table IV.1 - Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Fourth Quarter of 2013)**

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	4th Quarter 2013 Payments in Error	Projected Annual Payments in Error, Including Fraud
Dental	2.89% ± 3.07%	\$133,895,556	\$3,864,983	\$15,459,932
DME	33.12% ± N/A	\$23,800,089	\$7,883,173	\$31,532,693
Inpatient	0.98% ± 2.98%	\$2,152,561,037	\$21,027,574	\$84,110,296
Lab	3.93% ± 5.27%	\$52,632,550	\$2,066,207	\$8,264,830
LEA	60.43% ± 15.77%	\$34,337,494	\$20,749,138	\$82,996,551
Physicians	8.43% ± 4.14%	\$908,675,365	\$76,591,007	\$306,364,028
Other Services	42.88% ± 14.65%	\$216,141,065	\$92,679,098	\$370,716,390
Pharmacy	15.37% ± 6.56%	\$750,580,993	\$115,349,200	\$461,396,801
Overall Payment Error Rate	7.96% ± 2.20%			
Totals		\$4,272,624,150	\$340,210,380	\$1,360,841,521

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 7.96%, plus or minus 2.20%, or that the true error rate lies within the range of 5.77% and 10.16%.

The projected annual payments in error are computed by multiplying the following quantities: 1) the payment error rate, 2) the 4th quarter 2013 Medi-Cal FFS payments universe included in the sampling, and 3) the number 4 (for four quarters).

**Table IV.2 - Potential Fraud Rates and Projected Annual Fraudulent Payments by Stratum
(Using Claims Paid in Fourth Quarter of 2013)**

Stratum	Potential Fraud Rate and Confidence Interval	Payments in Universe	4th Quarter 2013 Fraudulent Payments	Projected Annual Fraudulent Payments
Dental	0.27% ± 0.57%	\$133,895,556	\$355,455	\$1,421,821
DME	30.97% ± 61.65%	\$23,800,089	\$7,370,822	\$29,483,289
Inpatient	0.00% ± N/A	\$2,152,561,037	\$0	\$0
Lab	0.00% ± N/A	\$52,632,550	\$0	\$0
LEA	15.80% ± 14.98%	\$34,337,494	\$5,426,197	\$21,704,787
Physicians	0.78% ± 0.89%	\$908,675,365	\$7,071,386	\$28,285,545
Other Services	8.40% ± 7.32%	\$216,141,065	\$18,163,856	\$72,655,425
Pharmacy	4.08% ± 2.30%	\$750,580,993	\$30,601,755	\$122,407,022
Overall Potential Fraud Rate	1.61% ± 0.68%			
Totals		\$4,272,624,150	\$68,989,472	\$275,957,889

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 1.61% plus or minus 0.68, or that the true potential fraud rate lies within the range of 0.93% and 2.3%.

The projected annual fraudulent payments are computed by multiplying the following quantities:

- 1) the potential fraud rate for the 4th quarter of 2013, and*
- 2) Medi-Cal FFS payments universe included in the sampling,*
- 3) the number 4 (four quarters).*

The Table below displays the 2013 total Medi-Cal FFS and Dental payments. These payments are broken down by stratum and by each quarter of 2013. These are actual amounts, not estimated; they were obtained from DHCS' Research Analysis and Statistical Division

Table IV.3 – Calendar Year 2013 Medi-Cal FFS Payments by Quarter
Data obtained from the Research Analysis and Statistics Division

Stratum	First Quarter	Second Quarter	Third Quarter	Fourth Quarter	Stratum Total
Dental	\$122,599,702	\$145,805,345	\$148,728,182	\$133,895,556	\$551,028,785
DME	\$28,094,527	\$22,813,878	\$31,746,370	\$23,800,089	\$106,454,863
Inpatient	\$2,268,881,331	\$1,839,953,948	\$2,579,762,659	\$2,152,561,037	\$8,841,158,975
LEA	\$30,006,992	\$43,767,499	\$42,719,006	\$34,337,494	\$150,830,991
Lab	\$52,412,516	\$45,286,054	\$59,102,887	\$52,632,550	\$209,434,007
Other Services	\$205,946,063	\$180,122,250	\$257,763,209	\$216,141,065	\$859,972,587
Pharmacy	\$759,336,936	\$652,150,375	\$900,162,458	\$750,580,993	\$3,062,230,762
Physicians	\$908,355,379	\$800,003,865	\$1,058,276,962	\$908,675,365	\$3,675,311,571
Quarter Total	\$4,375,633,446	\$3,729,903,214	\$5,078,261,732	\$4,272,624,150	\$17,456,422,542

2) Claims Processing Errors

In MPES 2013, no claims processing errors directly attributable to the fiscal intermediaries of Xerox and Delta Dental were identified. However, there were a few cases in which questions arose regarding supporting claims documents and appropriate edits for some restricted benefits.

3) Payment Errors

Payment errors, as defined in Section II, are identified as potential dollar value losses, due to payment or billing errors, including potential losses due to fraud, waste, and/or abuse. The MPES 2013 findings identified \$340 million in Medi-Cal FFS payments made during the 4th quarter of 2013 (universe) at risk of having been made in error. This amount extrapolates to nearly \$1.36 billion, annually, in payments at risk for potential error. Of the \$1.36 billion annualized payments potentially made in error, nearly \$276 million (or 1.61 percent) was for potentially fraudulent claims. The projected \$1.36 billion in payments at risk for error is higher than the projected \$1.25 billion payments at risk for error found in the 2011 study.

There were 165 unique providers represented in the 181 claims in error in the MPES 2013 sample. Of those 165 unique providers, one had 5 errors, three 3 errors, and four had 2 errors.

a) Payment Errors by Type⁵

Claim errors in MPES 2013 ranged from simple mistakes to more serious findings indicative of potential fraud. Notable errors often involved lack of documentation, insufficient documentation, the lack of medical necessity, not meeting legal requirements, policy violations, coding errors, and ineligibility of providers.

⁵ See Section II for a definition of “payment error” and a description of the various error types.

Error type assignment was based on the problems identified and the degree of potential significance. Please see Appendix 3 for a complete description of the error codes and Appendix 4 for a detailed explanation of each error.

Among the error types in the sample, documentation errors accounted for nearly the majority (47.1 percent) of all the payment errors in MPES 2013 (Table IV.5). This finding contrasts with the 2011 study in which medical necessity errors were the most prominent errors in the sample, and makes documentation errors the most significant type of errors this time around. Policy errors ranked second, with nearly 25 percent, and prescription-related errors were third, with 8.4 percent. Medical necessity errors ranked the lowest, with 3.4 percent, of payment errors in the sample.

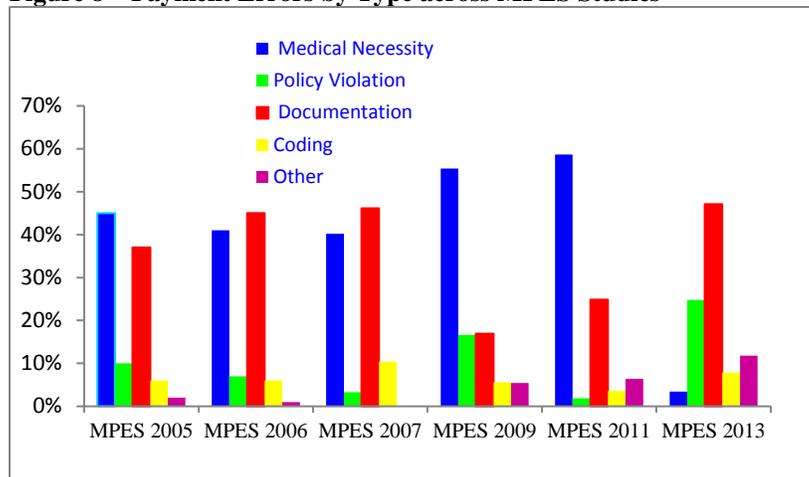
Table IV.5 – Sample Payments Made in Error by Error Type

Payment Error Type	Percent
Documentation	47.10%
Policy	24.78%
Prescription-related Errors	8.44%
Coding	7.85%
Medical Necessity	3.41%
All Other Errors	8.42%

The breakdown of documentation errors in the sample shows LEA accounted for 36 out of 102 (more than a third) total claims in error in the sample. Physician Services and Pharmacy ranked second and third, respectively, with 24 and 21 claims in error.

Figure 8, below, shows the trend of payment error by type, from MPES 2005 through MPES 2013. The chart shows that medical necessity declined to their lowest levels, and documentation errors increased to their highest levels. It is to be noted that documentation errors levels have always been in double digits.

Figure 8 – Payment Errors by Type across MPES Studies



b) Payment Errors by Stratum

Table IV.6, below, shows the breakdown of the 181 errors by stratum and by error type.

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

Error Type	Dental	DME	Inpatient	Lab	LEA	Physicians	Other Services	Pharmacy	Type Total
MR1- No documents submitted					6	1	2	5	14
MR2A - Poor/insufficient documentation		1		1	17	13	7	13	52
MR2B - No documentation	6		1	2	13	10	1	3	36
MR3 - Coding error					1	8			9
MR4 - Coding error (unbundling)						1			1
MR5 -Medical necessity					2	2	1	6	11
MR7- Policy Violation		1			1	11	1	1	15
MR8 – Other medical error					3	2			5
P1 – Duplicate item						1	1		2
P2 - Other (non-covered service						1			1
P3 - Medicaid MCO covered service						1			1
P5 - Pricing error						1			1
P6 - Logical edit							1		1
P7 - Ineligible recipient								2	2
P9A - Billing provider ineligible to bill for claimed service						1			1
P9B - Rendering provider not eligible to bill for service					2	1			3
PH10 – Other (policy violation)								8	8
PH2 -No legal prescription for date of service		1						9	10
PH3 - Prescription missing essential information								1	1
PH5 - Wrong information on label								3	3
PH7B – Prescription split								4	4
Stratum Total	6	3	1	3	45	54	14	55	181

Error types are assigned depending upon the error and the most potentially costly errors. The most serious errors are: lack of documentation, insufficient documentation, lack of medical necessity, which represents a legal requirement not met by the provider, coding errors, ineligible providers, and policy violation errors. The breakdown of documentation

errors in the sample shows LEA accounted for 36 out of 102 (more than a third) total claims in error in the sample. Physician Services and Pharmacy ranked second and third, respectively, with 24 and 21 claims in error.

Examples of the types of error within each stratum follow.

Dental Services

Six Dental Services claims were found in error. All six claims had documentation errors. Below is an example of such errors:

No Documentation - This dental claim is for 4 bitewings, general anesthesia, hospital services, and medications. Documentation did not mention bitewings being done. Dental office staff stated that they were not done and should not have been claimed. The error is calculated as the amount that was paid for the bitewings.

Durable Medical Equipment

Three DME claims had payment errors in the MPES 2013 sample. One error was due to poor/insufficient documentation, one claim had a policy violation error, and one claim had no legal prescription for the appropriate date of service.

Poor/Insufficient Documentation - This claim is for enteral feeding supplies. Based on the patient's diagnosis and notes in the medical record, the items were medically necessary. The prescription renewal was written by a rendering physician for the group, but there are no notes by this physician to validate the order. Based on lack of documentation for the date of service, an error code MR2A is assigned. This error was calculated as the total amount paid for this claim.

Policy Violation – This claim is for ventilator rental for a 21-year old being discharged to home from a Subacute facility, for two service dates one month apart. Documentation justifies medical necessity for ventilator equipment. A physician order specifies two ventilators, but the available approved TAR covers only one. On the CDR, there are three claims and payments for ventilator monthly rental; one is in the first month and two are in the following month, separated by one day. All use the number of the aforementioned TAR. Therefore, the payment of the third service is not authorized. The DME rendering provider's NPI number listed on the claim is for a different location than the NPI number listed on the TAR. The error is calculated as the amount paid for the third service.

No Legal Prescription for Date of Service - This claim is for oxygen probes to be used with an oximeter in a patient with chronic respiratory failure. The billing provider does not have an approved Service Authorization Request (SAR) for the date of service on the claim. The probes were mailed and there was not a signature to verify beneficiary receipt. There was no valid MD order for the probes (PH2). Instead, there was a copy of an unsigned pre-prepared prescription that had been faxed to the PCP with a reply on it that the patient's pulmonologist should be contacted instead. The error is calculated as the total amount paid for this claim.

Inpatient Services

Inpatient Services had one error:

No Documentation – This claim is for 9 days at a skilled nursing facility for an 86-year-old. The documentation collected antedated the claimed service. The medical record verified services provided were medically necessary, consistent with diagnosis and generally accepted medical standards. However, there was no indication that the patient was there during the dates at issue. This error was calculated as the total amount paid for this claim.

Laboratory Services

There were three errors in this stratum, each related to documentation:

Poor/Insufficient Documentation – This is a claim for DNA testing of a cervical specimen. The lab requisition does not clearly state which test is requested. The beneficiary's signature is missing or blocked by the label. There are no instrument printouts from the lab. However, the test result was documented in the medical record. The medical note lacked important components for the patient's history and contained no exam whatsoever. Medical necessity cannot be established based on these records. Poor documentation is assigned as numerous documentation deficiencies are noted. This error was calculated as the total amount paid for this claim.

No Documentation - This claim is for a Complete Blood Count (CBC) automated lab test. This four year-old has no elements of history or physical exam findings indicating risk factors for anemia or other hematologic problem. There is no documentation in the record of intent for a CBC or any results of it being done. This error was calculated as the total amount paid for this claim

Local Education Agencies

This stratum displayed a total of 45 errors, mostly documentation errors. Representative examples are listed below.

No Documents Submitted - This claim is for group speech/language therapy through the LEA Medi-Cal Billing Option Program. According to the school secretary this student is not in their computer system. There are no school records to review. Per the Claims Detail Report there are multiple paid claims to this school district for this child. The error is calculated as the total amount paid for this claim.

Poor/Insufficient Documentation - This claim is for occupational therapy services. There is documentation that the student was assisted on the playground. However, the document is unsigned and does not state who provided the service. It cannot be verified that an appropriately licensed therapist provided the service. The error is for the total amount of the claim.

No Documentation - This claim is for group speech/language treatment through the LEA Medi-Cal Billing Option Program. The LEA Medi-Cal Billing Option Program covers only speech therapy treatment services per a written referral by a physician or dentist, or per a written referral by a licensed speech-language pathologist when supported by a valid Physician-Based Standards protocol. The record contained no referral for speech/language treatment services from a physician or speech-language pathologist. There was no record of the actual service provided. Although the LEA provider stated the speech therapist that provided the service is no longer

employed by them and took the working file, the LEA is responsible for maintaining all records pertaining to billed services. The error is calculated as the total amount paid for this claim.

Coding Error - This claim is for registered nurse (R.N.) services, up to 15 minutes for this 16-year-old. The beneficiary requires G-tube feeding and tracheostomy care. The record showed services were provided by a licensed vocational nurse (LVN) rather than an R.N., and there is a date disparity, as well. According to the business services manager, the billing was outsourced; there might have been "keying in" errors. Available MD orders are limited to those for trach care. This error was calculated as the total amount paid for this claim.

Medical Necessity - This claim is for non-emergency transportation; encounter/trip. Transportation services are outlined in the Individualized Education Plan (IEP), and are technically reimbursable. However, the student receives wheelchair transportation and there is no documentation as to why it is needed. According to his IEP, he is "able to walk, run and jump independently. He is able to navigate through the playground apparatus and climb stairs with ease. He is able to climb a curved ladder, as well." It is unclear why such a child would require wheelchair or litter van transportation to and from school, as outlined in the IEP. Per the Medical Provider Manual, litter van transportation is appropriate and reimbursable when the student's medical and/or physical condition requires specialized equipment and more space than available in passenger cars, taxicabs or other forms of public transportation. Wheelchair van transportation is appropriate and reimbursable when the student's medical and/or physical condition renders the student unable to sit in a private vehicle, taxicab or other form of public transportation for the time needed for transport. These situations do not seem applicable to this student, as documented in his IEP. An MR5 error, medically unnecessary service, is assigned. This error was calculated as the total amount paid for this claim.

Policy Violation - This claim is for group speech therapy for a 21 year-old with multiple disabilities. The Individualized Education Plan (IEP) states speech therapy is for once a week, 30 minutes per session. The flow sheet indicates initial service time was 30 minutes and continued to 45 minutes. The provider billed for 3 units of continuous speech therapy (second modifier TM) which is not covered on the IEP. This error is the difference between the 30 minutes as planned in the IEP and the 45 minutes claimed.

Rendering Provider Not Eligible to Bill for Services/Supplies - This is a claim for group speech therapy. There is evidence that the student was in class, but no evidence that a licensed speech language therapist provided this service. The staff member that led the group therapy was credentialed in "multiple subject teaching and reading" and was not a licensed speech therapy professional (P9B error). This error was calculated as the total amount paid for this claim.

Other Services and Supplies

Included in this category are transportation claims, medical supply claims, etc. The major error types in this stratum were those related to documentation.

No Documents Submitted - This claim is for response to call non-litter transportation, and mileage. The rendering provider was not at the place of business listed; the provider had moved but PED was not notified. The provider visited denied the claim. No documents were available. This error was calculated as the total amount paid for this claim.

No Documentation – This claim is for 6 physical therapy treatments for a 2 year-old with multiple birth defects. The documentation validates the medical necessity. However, for one date the mother cancelled the treatment. The documentation states a consult was done but nothing as to treatment. The error is calculated as the amount that was paid for therapy on the one date.

Medical Necessity - This claim is for adult size briefs/diapers. The documentation in the medical record does not mention incontinence. Bowel symptoms were discussed without mention of incontinence. Urinary tract infection symptoms were reviewed without mention of incontinence. There was no evidence in the medical record of medical necessity for these supplies. The prescription does not have a diagnosis listed. The provider has changed location. This error was calculated as the total amount paid for this claim.

Duplicate Item - This claim is for medical ambulance mileage, one way, and the use of an oxygen tank. The services were medically necessary. This claim is a duplicate claim. The provider was previously paid for the same patient, same date of service. The error is calculated as the total amount paid for this claim.

Logical Edit – This claim is for EPSDT/LVN services through a Home Health Agency, covering 5 dates in 2013, 8 units each. This 12 year-old is actively enrolled in CalOptima and is an open case with CCS Orange. There was an approved Service Authorization Request which covered the applicable service code and dates. This error was calculated as the total amount paid for this claim.

Physician Services

Physician Services recorded 54 payment errors in the study sample, most of which were documentation errors and policy violation errors. This provider type includes physicians, clinics, emergency room visits and other licensed providers. Examples of errors are:

Poor/Insufficient Documentation – This claim is for X7722-UD, Plan B Emergency Contraceptive, 1 unit. The patient was seen in a Family PACT clinic. As part of the office visit, Plan B One-Step was prescribed in the quantity of 2. The available paperwork does not show that the prescription was dispensed and the medication received by the patient (MR2A error). The error was calculated as the total amount paid for the claim.

No Documentation - This claim is for an office visit for an established patient, ceftriaxone injection, and Family PACT individual education. This 20 year-old was seen for gonococcal pharyngitis and services were medically necessary. Documentation justifies the level of the office visit and that the medication was administered. There is no documentation to substantiate the Family PACT education. The error is calculated as the amount that was paid for the Family PACT individual instruction.

Coding Error - This claim is for an office/outpatient visit for a 22-year old established patient. The documentation is for dispensing education for contraceptives. There is adequate documentation for a level-3 visit for family planning, but the visit was coded as a 99214. The error is calculated as the difference between the total amount paid for the 99214 visit and the amount that should be paid for a 99213 visit.

Medical Necessity - This claim is for a tissue examination by a Pathologist. The source of the specimen is a placenta from a C-section. There is no order by the delivery physician for an examination of the placenta, but there may have been a standing order. In the operative report there is not a reason given for why the placenta should be sent for this examination. The lack of a

documented reason for the test renders the exam not medically justified. The error is calculated as the total amount paid for this claim.

Policy Violation - *This claim is for initial newborn per day/hospital & hospital discharge day management: 30 minutes or less, and refers to 2 services. The first claim was for evaluation and management of a normal newborn. This claim was justified by the documentation in the medical record. The second claim was for the second day and was for management of discharge. The medical record at the hospital shows a telephone discharge order and nothing documented for that day. The doctor's assistant at his office stated that they do not keep medical records at the office for deliveries. CPT 99460 was appropriately billed for newborn care. During the same hospital stay, code 99238 was also billed for discharge day management. The Medi-Cal Provider Manual specifically states that these two codes cannot be claimed for the same hospitalization. The error is the amount paid for CPT 99238.*

Non-covered Service - *This claim is for a Medi-Cal Per Visit Code 01 for a chiropractic service provided to a 10-year old patient. The chiropractic service provided at the RHC on the date of service claimed was not covered by Medi-Cal (P2 error - non-covered service). The date of service was not within the effective date of the reinstatement of chiropractic services. Per the Medi-Cal Provider Manual, the optional benefit of chiropractic service provided by FQHCs/RHCs was excluded from coverage under the Medi-Cal program effective July 2009. In accordance with the US Court decision, effective for dates of service on or after September 2013, adult dental, chiropractic, and podiatric services are reimbursable Medi-Cal services when provided by FQHCs and RHCs. Other than the chiropractic service not being a covered service, the documentation does not support the definition of an encounter. The nature and extent of the service were not documented. For this claim, the error was calculated as the total amount paid.*

Billing Provider Ineligible to Bill for Claimed Services/Supplies - *This claim is for screening mammography. Although the service was medically necessary, the provider has been suspended by the Franchise Tax Board. This error was calculated as the total amount paid for this claim.*

Pharmacy

This stratum was the largest in the sample; it registered the highest number of errors (55). Claim errors in pharmacy were due to both the pharmacies making errors and errors found in the prescriber's documentation. Medical necessity errors are the fault of the prescribing provider, not of the pharmacy.

Error Examples:

No Documentation Submitted - *This claim is for slow release Oxycodone, an opioid used to treat moderate to severe pain that is expected to last for an extended period of time. This medication has high risks of overdose, addiction and diversion for other than intended use. The written prescription noted a diagnosis of neuropathic pain secondary to spinal cord injury not effectively treated with lower risk medication. The referring physician's office refused to provide records, so the claim is unsupported due to lack of cooperation from the referring provider. The error is calculated as the total amount paid for this claim.*

Poor/Insufficient Documentation – *This pharmacy claim is for Lexapro in this 29 year-old with an apparent history of depression and chronic pain. The beneficiary is prescribed Ambien (for insomnia, per the prescription), Wellbutrin (for anxiety, per the prescription), Ultram, and*

Percocet. The chart documents a history of depression and chronic pain/artralgias at many sites. There is no further characterization of either diagnosis, other than a mention of an assault with minor injuries five days before the date of service. The physical exam consists of vital signs, a skin exam and a psychiatric exam ("attitude not uncooperative; affect abnormal"). There is no assessment of the beneficiary's depression or chronic pain, and how either might be improving or not, on the refilled medications. An MR2A error for poor documentation is assigned. All pharmacy data is supportive of the claim. The error is calculated as the total amount paid for this claim.

Medical Necessity - This claim is for Hydrocodone-Acetaminophen 10-325 (Norco), a medication used to relieve moderate to severe pain. There is no error with the pharmacy claim. The medical record documents the physician's order for the medication on a round-the-clock dosage schedule, citing chronic pain in the order. The medical record documentation does not support medical necessity. The physician's note does not mention a history of chronic pain or a condition that would reasonably be expected to cause chronic pain requiring continuous medication. The error is calculated as the total amount of the claim.

Policy Violation - This claim is for blood sugar diagnostics. The pharmacy is a closed door pharmacy that delivers to long term care (LTC) facilities. Diabetic test strips are kept with the central medications in the medication room at the LTC. The nurse uses the same bottle for every patient. There are no patient labels on any of the strip bottles in the central location. This error was calculated as the total amount paid for this claim.

Ineligible Recipient - This claim is for lancets, which are disposable medical supplies used by diabetics to obtain drops of blood for checking blood sugars. In beneficiaries who are not on insulin, Medi-Cal restricts the supply of lancets without prior authorization to any more than 100 in a 90-day period. This beneficiary uses only oral medication; following the physician's instructions would require 1-2 lancets per day. For the 90 days prior to and including this date of service, the beneficiary received 300 lancets. The medical record contains no justification for the quantity of lancets supplied and no record of request for prior authorization. This beneficiary has Medicare. For beneficiaries eligible for Medicare, the provider must bill Medicare prior to billing Medi-Cal. The overreaching issue, however, is that the patient has a Nevada address to which the provider ships the supplies. Out of state residents are not eligible for Medi-Cal. The error is calculated as the total amount paid for this claim.

Other Pharmacy Policy Error - This claim is for Calcium Carbonate, necessary for many normal functions of the body, especially bone formation and maintenance. This medication was a program benefit at the time of the dispensing at the dosage of 500 mg calcium (1250 mg of calcium carbonate). Although #60 tablets were prescribed as a one-month supply, #180 were dispensed. No authorization for this change was provided. The error is calculated as the total amount paid for this claim.

Wrong Information on Label - The claim is for Amlodipine Besylate (Norvasc), a long-acting calcium channel blocker used to lower blood pressure and to treat other cardiovascular conditions. This was a telephone prescription from the physician. It was for 10 mg, one q pm, #90. Directions on the label of the prescription read, "one tablet by mouth two times a day, #60." The pharmacy claim shows that #90 were dispensed for the date of service and then again approximately three months later, suggesting the patient was taking the medication as indicated on the ordering prescription. The prescriber documentation was extremely difficult to read, but no notation of the telephone order was found. This error was calculated as the total amount paid for this claim.

Prescription Split – This claim is for Hydroxyurea, which is used in the treatment of certain neoplastic diseases and sickle cell disease. This beneficiary has sickle cell disease and was seen in clinic. The original prescription for this medically appropriate medication was for a quantity of 90 pills; the prescription had 2 refills. The pharmacy split the prescription and dispensed only 30 pills at a time, including on the date of service. The patient name on the medical records and prescription was different than the name on the Medi-Cal CDR and MPES summary of the claim. The reason for the discrepancy is unclear. This error was calculated as the total amount paid for this claim.

c) Potential Fraud Errors

One of the most substantial goals of MPES is to identify potentially fraudulent claims. The Medical Review Branch found 37 such claims out of 181 (20 percent) payment error claims in the sample. While this finding appears significant, it needs to be interpreted with caution as a single claim carrying suspicion of fraud does not prove actual fraud. Without a full criminal investigation of the actual practice of the provider, there is no certainty that actual fraud has occurred.

The 20 percent amount in fraudulent claims is about half the amount of potential fraud found in the 2011 study.

The number of claims identified as having characteristics for potential fraud occurred in dental, DME, LEA, Other Services, Physician Services, and Pharmacy. Laboratory and inpatient claims did not contain any potential fraud. Documentation (16), medical necessity (7), and policy violation (5) errors, accounted for the vast majority of the potentially fraudulent claims in MPES 2013.

The table below displays the breakdown of potential fraud errors by stratum.

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

Error Type	Dental	DME	LEA	Physicians	Other Services	Pharmacy	Type Total
MR1 - No documents submitted			6		2	4	12
MR2A - poor/insufficient documentation			1				1
MR2B - No documentation	1		2				3
MR5 - Medical necessity			2	1	1	3	7
MR7 - Policy violation		1		3		1	5
P1 - Duplicate item					1		1
P7 - Ineligible recipient						1	1
P9A - Billing provider not eligible to bill for claimed services				1			1
P9B - Rendering provider not eligible to bill for claimed services				1			1
PH10 - Other						1	1
PH2 - No legal prescription for date of service		1					1
PH7B - Prescription split						3	3
Stratum Total	1	2	11	6	4	13	37

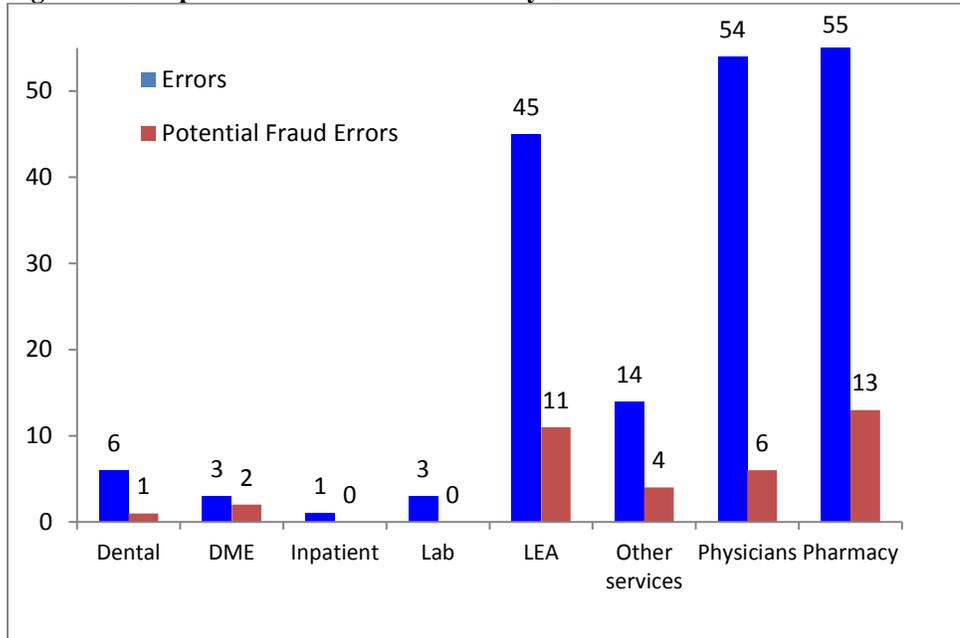
MPES review protocols call for the medical review team to examine each claim for potential fraud, waste, and/or abuse. Appendix 1 discusses the steps utilized during each level of the review process in regard to potential fraud.

MPES 2013 consists of 938 unique providers represented in the sample of 1,168 claims.

A total of 37 claims, submitted by 37 unique providers, were found to be potentially fraudulent. These claims were confirmed as potentially fraudulent by the California Department of Justice (DOJ). Figure 9, on the next page, displays the breakdown of potentially fraudulent claims by stratum.

A comparison of total claims in error and potentially fraudulent claims in error is shown on the chart below.

Figure 9 – Sample Errors and Fraud Errors by Stratum



The following table describes, for each error type, examples of potentially fraudulent claims juxtaposed to claims that have been determined to be in error, but that did not show characteristics of potential fraud.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
No documents submitted MRI	Dental Claim The claim is for fluoride dental prophylaxis provided for a child at a school. The dental hygienist was appropriately licensed and treatment authorization request approved for the service. No documentation of the service was received to support the claim. The provider's phone number was disconnected and the pay to address found to be a Copy Pack and Ship business. The error is calculated as the total amount paid for this claim.	Dental Claim The claim is for a dental office visit with X-rays and a fluoride treatment for a juvenile male beneficiary. The dentist did not respond to a request for records, his telephone number is disconnected and his dental office closed. The provider is voluntarily inactivated from the Denti-Cal program and a sign on the door of his closed dental office indicates that he has retired. The error is calculated as the total amount paid for this claim.
Poor/Insufficient Documentation MR2A	The claim is for a comprehensive chemistry panel for an adult male beneficiary with Diabetes. The beneficiary had a prior Chemistry panel ordered by his regular physician two months prior. The beneficiary was out of town and saw an alternate MD who ordered the chemistry panel claimed for. The laboratory conducted, interpreted and reported the test results appropriately and no error is assigned to this laboratory. An error is assigned to the referring provider because of the repetition of the testing within a short period. There is no documentation to	The claim is for a tub stool for a male Medicare/Medi-Cal beneficiary. The tub stool is not a Medicare benefit. The beneficiary requested a tub stool and one was ordered. Two months prior to the order the record showed the beneficiary complained of left knee pain but the record described the examination as unremarkable. The documentation submitted to support the claim does not adequately describe the need for this equipment. The error is calculated as the total amount paid for this claim.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	<p>indicate that the second MD contacted the beneficiary's regular MD prior to ordering the lab tests. Several of the test results for the claimed service were abnormal. The error is assigned as the total cost of the laboratory test.</p>	
<p>No documentation MR2B</p>	<p>Physicians Claim The claim is for ophthalmic biometry on the same date of service as documented cataract surgery. The operative report does not mention biometric measures. The medical record contains a report dated 3 months prior to the date of service of the claim on which the provider was observed adding a date 1 year later than the date of service at the onsite visit. No documentation of the service for the claimed date was provided. The error is calculated as the total amount paid for this claim.</p>	<p>Other Services Claim The claim is for three days of medical transportation via wheel chair van for a male beneficiary with end stage renal disease. The transportation occurred three times weekly for hemodialysis. The service was medically appropriate; however, there was no transportation trip log for one of the three dates of service. The error is calculated as the amount reimbursed for 1 trip.</p>
<p>Coding error MR3</p>	<p>Physicians Claim This claim is for a level 3 emergency department visit for a 14-year-old with a chief complaint of sore throat. A level 3 visit requires an expanded problem focused history, expanded problem focused examination and medical decision making of moderate complexity. The documentation contains a brief history, an examination that contains multiple elements but lacks findings of an examination of the symptomatic area, the throat, and straightforward decision making which supports a level 1 visit. The error is calculated as the difference between the two codes.</p>	<p>Physicians Claim The claim is for an inpatient level 5 oncology consult for a beneficiary with esophageal cancer. Requirement for all inpatient consultation codes include a physical examination of the patient and communication by written report to an appropriate source of the request for the consultation. Documentation for this claim is brief and includes no physical examination or written report. The most appropriate code for the service would be level 1 subsequent hospital care 99231. The error is calculated as the difference between the two codes.</p>
<p>Other policy violation MR8</p>	<p>Other Services Claim The claim is for nursing aide services for a male student beneficiary at a Local Education Agency (LEA). The documentation submitted indicates that the services were provided by a classroom teacher. Nursing aide services for LEA students are mandated by Medi-Cal to be provided by trained health care aides, supervised by a licensed health professional, thus this claim should not have been reimbursed. The error is calculated as the total amount paid for this claim.</p>	<p>Other Services Claim There is no example of this type because no such error was found in the MPES 2011 sample that was not potentially fraudulent.</p>

Error Type	Potential Fraud Identified	No Potential Fraud Identified
Other non-covered service P2	<p>Other Services Claim</p> <p>The claim is for nursing aide services for a student beneficiary at a Local Educational Agency. The child complained of a stomach ache. Her temperature was taken and her parents were called to take her home from school. The claim is invalid because this is not a Medi-Cal covered service. The service would be provided to any child at the school in a similar situation and thus does not qualify for Medi-Cal reimbursement. There is no documentation as to who provided the services or if there was supervision by an appropriately licensed health professional. The error is calculated as the total amount paid for this claim.</p>	<p>Physicians Claim</p> <p>The claim is for dental services for an adult female beneficiary at a Federally Qualified Health Center. The documentation submitted to support the claim does not provide evidence that the beneficiary's dental problems involve trauma, pain, or infection, nor is the beneficiary described as being pregnant. The criteria for exemption from the elimination of dental services for adults from Medi-Cal optional services are not met and the beneficiary is not eligible for the service. The error is calculated as the total amount paid for this claim.</p>
Pricing error P5	<p>DME Claim</p> <p>The prescribed item, a tub stool was appropriately ordered and supplied for female beneficiary with quadriplegia. The Pharmacy overbilled for the equipment. The cost to the Pharmacy was \$19.25, with the 100% markup in cost permitted by Medi-Cal policy, the provider could bill for \$38.50. The provider billed for \$75 and was reimbursed \$59.01. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.</p>	<p>DME Claim</p> <p>The claim is for Wheelchair components and accessories for a male beneficiary. The equipment was medically necessary and appropriately ordered and provided to the beneficiary. The Assistive Device dealer over billed Medi-Cal for two of five components of the ordered equipment. Medi-Cal Upper Limit Policy permits billing a markup of no more than 100% of the suppliers' cost. The dealer markup exceeded the 100% limit for both a custom-built wheelchair cushion and back cushion. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.</p>
Other rendering provider not eligible to bill for claimed services/supplies P9B	<p>Physicians Claim</p> <p>The claim is for an office visit for an adult female beneficiary. The claim lists an MD as the rendering and billing provider. The services were actually provided by a Non-Medical Practitioner (NMP), who is an appropriately licensed Physician's Assistant (PA); however, the PA is not enrolled in the Medi-Cal program and her services may not be billed to Medi-Cal. The error is calculated as the total amount billed for this claim.</p>	<p>Physicians Claim</p> <p>The claim was for an office visit for an adult female beneficiary. The visit was medically necessary and conducted appropriately. The service was provided by a Nurse Practitioner who, while licensed to practice in the State of California, is not enrolled as a Medi-Cal provider and her services could not be billed to the Medi-Cal program. The modifier required for the services of a non-physician medical practitioner was not utilized on the claim. The error is calculated as the total amount paid for this claim.</p>
Other –no legal prescription for date of service PH2	<p>Pharmacy Claim</p> <p>The claim is for a prescription for Solifenacin, a medication for the treatment of overactive bladder, for an elderly male</p>	<p>Pharmacy Claim</p> <p>The claim is for a prescription for docusate sodium, a stool softener, for an adult female beneficiary. The original</p>

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	beneficiary. The pharmacy was unable to provide appropriate documentation for a refill for the medication. The prescribing provider had previously ordered the medication, but had no record of authorizing a refill for the date on which the medication refill was dispensed. The error is calculated as the total amount paid for this claim.	prescription was three years old and there was no documentation that a current refill was authorized. The beneficiary had not seen the prescribing physician for two years and requests for refill authorization had been declined by the physician because of poor beneficiary compliance and a lack of a recent evaluation by the physician. The error is calculated as the total amount paid for this claim.
Other - prescription split PH7B	<p>Pharmacy Claim</p> <p>The claim is for a prescription for Vicodin, a controlled substance utilized for pain control, for an adult male beneficiary. The prescription was a refill of the original prescription for 40 tablets. The pharmacy dispensed 30 tablets initially, and another 10 tablets three days later. This resulted in an additional dispensing fee, and there is no evidence that the pharmacy discussed the change in the prescription with the prescribing provider. The same dispensing practice occurred with the original prescription. A treatment authorization request would have been necessary had the prescribed amount been dispensed. The error is calculated as the amount paid for the dispensing fee for this claim.</p>	<p>Pharmacy Claim</p> <p>The claim is for a prescription for Risperidone, an atypical anti-psychotic medication, for an adult female beneficiary. The prescription was written for 30 tablets. The pharmacy dispensed the appropriate number of pills over several months; however, they dispensed the medication 13 pills at a time, resulting in excessive dispensing fees charged to the Medi-Cal program. The error is calculated amount paid for the dispensing fee for this claim.</p>

4) MPES Study Comparison of Significant Items (MPES 2005 – MPES 2013)

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

Study Objective	The study objectives remained the same for 2005-2013: <ol style="list-style-type: none"> 1. Measure the payment amount due to payment errors in Medi-Cal FFS program; 2. Identify the amount of potential fraud in Medi-Cal; 3. Identify the vulnerabilities specific provider types of the Medi-Cal program. 				
Study Universe	The universe changed from the second quarter paid claims data in 2011 to the last quarter paid claims data.				
Sampling Design	Methodology is unchanged: proportioned stratified random sampling which is <u>dollar-weighted</u> . This means a hospital claim in error has more of an impact than a DME claim in error 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. ADHC stratum was replaced by LEA.				
Error Rate & Fraud Error	The payment error rate increased, but its subset, the fraud rate, declined in 2013: <table border="1" style="width: 100%; border-collapse: collapse;"> <thead> <tr> <th style="text-align: left;"><u>Error Rate</u></th> <th style="text-align: left;"><u>Fraud Error Rate</u></th> </tr> </thead> <tbody> <tr> <td>2005 – 8.40%</td> <td>2005 – 3.23%</td> </tr> </tbody> </table>	<u>Error Rate</u>	<u>Fraud Error Rate</u>	2005 – 8.40%	2005 – 3.23%
<u>Error Rate</u>	<u>Fraud Error Rate</u>				
2005 – 8.40%	2005 – 3.23%				

	<p>2006 – 7.27% 2006 – 2.75%</p> <p>2007 – 6.56% 2007 – 2.53%</p> <p>2009 – 5.45% 2009 – 1.16%</p> <p>2011 – 6.05% 2011 – 2.28%</p> <p>2013 – 7.96% 2013 – 1.61%</p>
Trends	<p>The MPES studies have been successful in identifying vulnerabilities in the Medi-Cal program and in redeploying resources to reduce their impact.</p> <p>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.</p> <p>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).</p> <p>MPES 2007 identified the following areas of risk:</p> <ul style="list-style-type: none"> • 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. <p>MPES 2009 identified the following areas of risk</p> <ul style="list-style-type: none"> • 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 2.0 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. <p>MPES 2011 identified the following areas of risk:</p> <p>MPES 2011 estimated 6.05 percent of all FFS and dental payments had indication of provider payment error, and 2.28 percent of all FFS payments had indications of potential fraud.</p> <p>Payment errors ranked by provider type:</p> <ul style="list-style-type: none"> • Physician services: 32 percent; • Pharmacy payment: 28.6 percent;

	<ul style="list-style-type: none"> • Other Services: 16 percent. This was a nearly six-fold increase from MPES 2009; • ADHC: 11.6 percent; • Inpatient: 7.6 percent. Though this provider type had no payment errors in MPES 2009, it contributed nearly \$95 million to the overall payment error this time around; • DME: 1.6 percent; • Lab: 0.6 percent. <p>Consistent with previous years, 58.7 percent of all the payments in error in the sample were for claims that lacked medical necessity, ADHCs accounted for nearly half (47.6 percent) of all the medical necessity payment errors in the sample.</p> <p>MPES 2013 identified the following areas of risk:</p> <p>An estimated 7.96 percent of all FFS and dental payments had indication of provider payment error, and 1.61 percent of all FFS payments had indications of potential fraud.</p> <p>Stratum contribution to the overall payment error:</p> <ul style="list-style-type: none"> • Pharmacy 33.9 percent, an increase of 5 percent from 2011; • Other Services: 27.2 percent, an increase of 10 percent from 2011; • Physicians: 22.5 percent, a decrease of 10 percent from 2011; • Inpatient: 6.2 percent; • LEA: 6.1 percent; • DMD: 2.3 percent; • Dental: 1.1 percent; • Lab 0.6 percent, unchanged from 2011. <p>The number of 2013 documentation errors more than doubled since 2011, from 45 to 102 errors.</p> <p>Medical necessity error claims declined from 37 in 2011 to 11 in 2013.</p>
	<ul style="list-style-type: none"> • The 2011 trend reversed in 2013, with documentation errors more than doubling and medical necessity errors declining by more than two-thirds.
<p>Fraud Trends</p>	<ul style="list-style-type: none"> • 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. • MPES 2011 revealed that Pharmacy contributed more than half (52 percent) of the potential fraud rate. ADHC came in second with a 27 percent contribution. • MPES 2013 saw ADHC being replaced by LEA in the study sample. • There were 37 potential fraudulent claims in MPES 2013; Pharmacy had the most (13) and LEA came in second with 11 potentially fraudulent claims. • Pharmacy had the largest share of the potential fraud rate, with 44.4 percent; it was followed by Other Services, with 26.3 percent, and DME, with 10.7 percent.
<p>Conclusion</p>	<p>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.</p>

V. Significant Actions Taken After MPES Studies

One of MPES's most important features 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 because determining 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 DOJ for a preliminary review pertaining to potential fraud. All cases DOJ determines to be 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 may be placed on providers, depending on the audit findings. In addition, 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 multiple MPES studies:

- MPES 2005 identified 124 potentially fraudulent claims, out of the 1,123 sampled claims. Audits of those 124 claims resulted in 147 actions and 58 referrals. MRB audits identified issues common to several ADHC providers. MRB developed training seminars which were presented to all ADHC providers in California. MRB staff was made available, via telephone, to answer provider questions. Based on further investigations, five providers closed their practices.
- Eighty of the 1,147 claims in the MPES 2006 sample were identified as potentially fraudulent, resulting in 106 actions and 40 referrals. Based on referrals to DOJ, six providers were suspended from Medi-Cal. Documentation errors were dominant among the potentially fraudulent claims. This may indicate unorganized or incomplete record-keeping, or possible serious fraudulent activity. Detailed investigations were conducted on the providers' claiming patterns, as well as their business practices.
- Eighty of the 1,148 claims in the MPES 2007 sample were identified as potentially fraudulent. The field audits of these 80 providers resulted in 125 actions taken and 24 referrals to other agencies and/or licensing boards made. Claims noted as medically-unnecessary dominated the potentially fraudulent claims in this study, with 63 percent of them being pharmacy claims.
- The 2009 MPES sample had 40 potentially fraudulent claims, out of the 1,148 claims in that sample. DOJ reviewed those 40 cases and concluded that all of them contained characteristics of potential fraud. Focused onsite field audits were conducted on 55 unique

providers. If the claims are for any type of prescription, the provider that wrote the prescription was also reviewed. No dental claims were reviewed for this study. The field audits conducted resulted in 86 actions and five referrals. Audits are continuing on a few of those cases due to appeals.

- The 2011 MPES sample had 58 claims potentially fraudulent claims, out of the 1,168 claims included in the study. The potential fraud characteristics were identified by DOJ. The field audits conducted on these 58 providers resulted in 89 sanctions and 11 referrals to other agencies. One provider was permanently suspended from the Medi-Cal program. Appeals by two separate providers have resulted in temporary suspensions after the 2011 report was published.
- MPES 2013 originally determined that, out of the 181 errors in the sample, 42 were potentially fraudulent; however, DOJ reviewed that list and agreed that only 37 of the 42 were actually potentially fraudulent claims. A field audit review was conducted on a claim from an MPES provider resulting in a temporary suspension and an audit for recovery demand of \$1.8 million. This study also reported that 45 LEA claims had been identified as error claims. Of these 45 LEA errors, 11 were identified as being potentially fraudulent by DOJ. With this high number of claims in error and potentially fraudulent claims identified, a special project involving an onsite review of LEA providers will soon be undertaken by MRB. In addition, two actions have already been taken, and one referral has been made.

To date, there have been 558 sanctions/actions placed on potentially fraudulent providers, based on data collected and analyzed, as a result of MPES studies, and 144 referrals have been processed and referred for further investigations by various agencies. This does not account for the claims that found in error, but not show characteristics of potential fraud.

Table V.1, on the next page, shows the number and types of all actions taken as a result of further review and audits originating from the MPES 2005 –MPES 2013 studies. Based on appeal actions and investigations by other agencies, it may take several years to complete adjudicate all cases.

Table V.1- MPES 2005 through 2013 Sanctions and Referral

Type of Sanction/Referral	Number of Sanctions/Referrals					
	2005	2006	2007	2009	2011	2013
Sanctions/Actions						
Withholds	12	4	3	3	2	
Temporary Suspensions	6	7	8	5	5	1
Civil Money Penalty Warning Letters	63	60	78	42	58	
Prepayment Post Service Reviews		12	4	4	1	
Audits for Recovery	8	9	16	16	15	1
Special Claims Review	37	This sanction has been replaced by the Post-Service Pre-Payment Audit (PPM).				
Procedure Code Limitations	11	1	4	2	0	
Minor Problem Letters	4	6	9	14	7	
Permissive Suspension	1	1			1	
Prior Authorization		1			0	
Business Closed - Deactivated	5	5	3		3	
Total	147	106	125	86	92	2
Referrals						
Investigations Branch	18	8	12	5	3	
Department of Justice	11	8	9		2	
Board of Pharmacy		3	2	4		
Denti-Cal (Delta Dental)	4	12			2	1
Department of Aging	9	4				
Financial Audits Branch - A&I			1			
Licensing & Certification	9	2				
Board of Registered Nursing	2	1			1	
California Medical Board		2	1		1	
Center for Medicare & Medicaid	2					
Occupational Therapy Board	1					
Physical Therapy Board	1					
Physician Assistant Committee					1	
Provider Enrollment Branch			1		1	
Vaccines for Children	1					
Total	58	40	26	9	11	1

VI. Payment Error Rate Measurement

The Improper Payments Information Act (IPIA) of 2002, amended in 2010 by the Improper Payments Elimination and Recovery Act (IPERA), requires Federal agencies to review programs at risk for improper payments and submit estimates of improper payments and corrective actions to Congress. Because the Office of Management and Budget (OMB) identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk of significant improper payments, the Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with IPIA, the Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009 and related guidance issued by OMB.

For the federal Fiscal Year under review, the PERM program measures payments that did not meet statutory, regulatory or administrative requirements for both Medicaid and CHIP. The error rate is based on reviews of the fee-for-service (FFS), managed care, and eligibility components. It is important to note that the purpose of PERM is to measure improper payments made by the State to providers and health care plans, not to develop a "fraud rate." At the conclusion of the review, states are required to remit all identified overpayments to CMS and submit a corrective action plan indicating how future overpayments will be prevented.

Beginning in FY 2005-06, CMS implemented PERM by reviewing seventeen states per year, or cycle, on a three-year rotational basis. California is a cycle two state, participating in PERM in FY 2006-07, FY 2009-10 and FY 2012-13. The focus of PERM includes Medi-Cal FFS paid claim medical record reviews, data processing reviews of Medi-Cal paid and denied FFS claims and managed care capitation payments, and reviews of Medi-Cal eligibility determinations. FY 2007-08 was the first year in which CMS reported Medicaid and CHIP error rates for cycle two states to Congress.

All FFS paid claims randomly sampled undergo a medical record review to ensure that medical services were rendered as needed and that the state correctly paid for the services billed. In order to complete the medical record review, Medi-Cal providers are required to submit copies of patient medical records to PERM reviewers. Data processing reviews are conducted on site by PERM reviewers for FFS paid and denied claims, as well as managed care capitation payments, to validate that payment was made correctly by the State to providers and health care plans. A review of the state's eligibility determination and enrollment activities is also conducted to ensure that payments were accurately made for services to beneficiaries.

For FY 2012-13 PERM, CMS calculated California's overall error rate at 9.72 percent for Medicaid and 2.12 percent for CHIP. The overall national average for Medicaid was 6.7 percent and for CHIP was 6.5 percent. In comparison, California's overall Medicaid error rate for FY 2009-10 PERM was 1.63 percent, which was much lower than the overall national error rate of 6.7 percent. The FY 2009-10 PERM review did not include reviews of CHIP.

The review of the managed care component for both Medicaid and CHIP resulted in no errors for FY 2012-13 PERM. The successful outcome of the reviews was directly attributed to process enhancements that increased the accuracy of payments to health care plans. Reviews of the

eligibility component resulted in an error rate of less than two percent for Medicaid and less than one half percent for CHIP, a clear indication that county staff exhibited a high level of accuracy determining eligibility for those receiving benefits in the Medi-Cal program.

California's FY 2012-13 PERM overall error rates were largely affected by the State's challenges in implementing Title 42 of the Code of Federal Regulations, Section 455.410, the Enrollment and Screening of Providers. While these regulations became effective March 25, 2011, an approved State Plan Amendment (SPA) gave California an extension to implement provisions of the new regulations until January 1, 2013. However, due to the complex nature of implementing these regulations, not all of the issues outlined in the SPA have been resolved, and California's implementation schedule continues to be impacted. A majority of the data processing review errors for the FFS review component were due to these delays, which caused an upsurge in California's overall error rates.

VII. Conclusions

MPES continues to assist in the identification and reduction of fraud, waste, and abuse in the Medi-Cal program. It also continues to assist DHCS in maintaining that program's integrity. Since MPES 2005, the overall payment error rate and the potential fraud rate have been declining –from the high of 8.40 percent for the overall estimated error rate and from the high of 3.23 percent for the potential fraud rate. These trends attest to the value of sustained efforts within DHCS to reduce and minimize payment errors in Medi-Cal.

Overall, the 2013 study results indicate that, of the estimated \$17.1 billion in Medi-Cal FFS and Dental payments made in 2013, a very large majority, \$15.7 billion (92.04 percent), was appropriately and correctly billed and paid. In contrast, about \$1.36 billion (7.96 percent) was for payments to Medi-Cal providers that were at risk of being erroneous.

In addition, the 2013 findings reveal that 1.61 percent of the total payments in the Medi-Cal FFS medical and dental programs was for claims that disclosed characteristics of potential fraud. The 1.61 percent is equivalent to an estimated annual amount of \$276 million in potential fraud. This amount represents an improvement compared to the estimated \$473 million in potentially fraudulent payments in MPES 2011.

Pharmacy had the highest contribution (34 percent) of the 7.96 percent overall payment error. It was followed by the Other Services, which accounted for 27 percent, and by Physician Services, with 23 percent, of the overall payment error.

In terms of sample claims in error, Physician Services, which had the second highest claims in error (54), behind Pharmacy (55), were also involved in six Pharmacy errors, those committed by prescribers. These six errors were due to lack of medical necessity; they dealt with non-needed prescriptions or referrals by physicians. Combining the 54 Physicians errors with the six prescriber errors in the Pharmacy stratum adds up to 60 total Physicians errors. That represents a third (33.2 percent) of all the sample errors and makes Physician Services still, the stratum the most vulnerable in the Medi-Cal program.

Documentation payment errors were significantly higher in the 2013 MPES than in the 2011 study. The estimate of the potential payments shown to be at risk of having been made erroneously is nearly \$641 million. Improvements in the area of documentation would at a minimum contribute to more complete and accurate case review, and potentially result in significant programmatic savings.

Because of the high number of errors in Physician Services, DHCS will continue to target its efforts to curb errors in that provider type. To that effect, it first implemented the Individual Provider Claims Analysis Report in 2010. The purpose was to develop a more collaborative partnership among the physician community in California. IP-CAR 2010 supplied primary care providers with information about their billing patterns to compare with that of similar providers. Those who billed a higher percentage of the most expensive office visits were selected to receive reports. The estimated savings was about \$2 million for the second half of 2011 (See MPES 2011 for details).

In 2011, MRB developed another version of IP-CAR that focused on prescribing for children. Providers were selected based on their high prescribing of specific drugs; they were sent a letter informing them that they had been prescribing specific drugs at a higher rate than other physicians had. Data were gathered for the numbers of prescriptions per beneficiary and the cost associated with those prescriptions, including over-the-counter drugs. In 2013, the same data were collected and compared with 2011 data. MRB found that the cost of prescriptions per beneficiary decreased for those providers that received a letter, and increased for those that did not receive a letter, as shown in Table VII.1 below:

Table VII.1 – IP-CAR Focus on Prescribing for Children – 2011 vs. 2013

Measure	Providers That Received Letter	Providers That Did Not Receive Letter
Change in Prescription Cost per Beneficiary	(\$1.45)	\$1.31
Savings to State	About \$1million	
Increase Cost to State		About \$3.8 million

MRB has concluded that the IP-CAR letters may have had an impact on unnecessary prescribing, saving the state almost \$1 million. Expanded IP-CAR projects in the future may influence prescribers to be more careful about prescribing. Fewer unnecessary prescriptions across larger numbers of prescribers have the potential to result in large savings to the state.

The Other Services stratum saw its contribution to the overall payment error increase substantially, when compared to MPES 2011 (27 percent vs. 16 percent). Even though this stratum had only 14 claims in error – which ranks fourth behind Pharmacy, Physicians, and LEA, some of those errors carried high dollar amounts. In particular, a Home Health Agencies claim had a \$1,165 payment error. Other claims related to Hearing Aid Dispensers, AIDS Waiver Services, and Genetic Disease Testing had high value errors, as well.

It remains to be seen whether the significant increase of this stratum’s share in the overall payment error constitutes a trend or is just a one-time occurrence. MRB will pay close attention to this provider type and continue to look for anomalies and spikes in its billing and payment patterns.

Inpatient Services had only one claim in error, which resulted in a share of 6.2 percent of the overall payment error rate. That one claim in error incurred an estimated \$84 million in potential payments that were at risk of having been made in error.

LEA showed a 6.1 percent share of the overall payment error rate. While it is not significantly high, this share is higher than the stratum’s share of the payment volume in the MPES 2013 universe (0.80 percent). Moreover, LEA had 45 out of 87 claims in error (52 percent), and the 45

errors represent nearly 25 percent of the 181 total errors in the sample. Most of the LEA errors are documentation errors (36 of 45, or 80 percent).

LEA has historically been a high-risk provider. In MPES 2006, 23 out of 32 sample claims (72 percent) were in error; in MPES 2007, 16 out of 32 (50 percent) LEA claims reviewed had errors; and in MPES 2011, 24 out of 25 (96 percent) LEA claims in the sample had errors.

DHCS has worked closely with the State Controller's Office to address various issues with this provider type, and offered to LEA providers multiple training sessions on Medi-Cal requirements, including focus on providing adequate documentation. DHCS will also increase its oversight of the LEA program. For instance, as a direct result of MPES 2013 findings, MRB will conduct an onsite review of several LEA providers that were selected based on their high billings and other criteria.

The Medi-Cal program registered a major transformation in 2013, as it shifted most enrollees to the Managed Care plans. It also prepared for a large expansion, due to the Patient Protection and Affordable Care Act.

The year 2013 saw the Medi-Cal program surge, as more than 850,000 children transitioned to Medi-Cal from the Healthy Families Program. As a result, Medi-Cal was estimated to increase by at least one million enrollees, due to ACA, including about 680,000 people in 2014, the first year of Medi-Cal expansion under the health care reform.

Appendix 1 - Review Protocols

Statistically valid and reliable MPES results are contingent upon the methodical evaluation of claim payments by well-qualified and comprehensively-trained medical reviewers. Correct and reproducible results are important. This review protocol is intended as a description of, and reference for, a consistent and understandable process that furthers inter-rater reliability.

At all stages of the medical review, an electronic audit trail of each claim is retained. With respect to each claim's error status at each stage in the review, the audit trail specifies the decision made, the 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 is available for subsequent analysis.

1. Protocol for Comprehensive Review

a) Documentation Retrieval

To achieve integrity in the information base available for review, the multidisciplinary staff attends training sessions on the procedures for the uniform collection of data. Once the MPES timeline begins, claims are assigned to each Audits and Investigations' Field Office. A designated team then goes into the field and collects documentation supporting the ordered services from the rendering and referring providers. If needed, follow-up requests are done, typically by telephone or fax. Communications are logged. If the supporting documentation is not forthcoming and all reasonable avenues have been explored, the effort is suspended.

b) Medical Review

Level One Review

- Claims are reviewed in a sequence of three stages designed to arrive at the correct determination regarding payment errors.
 - Initial review of claims is conducted by field office staff, using standardized audit program guidelines specific to each provider type. The assigned reviewer personally collects the data, conducts the initial review, and completes the data entry form.
 - Physician consultants (medical consultants) perform secondary review of the preliminary findings.
 - Supervisors conduct a third review and record the determination.
- Components of each review include verifying compliance with the following:
 - Provider is eligible to render the service
 - Documentation is complete
 - Service is accurately documented
 - Documentation supports medical necessity

- Claim is billed in accordance with laws and regulations
- Payment of the claim is accurate.

A claim in error is any claim submitted and paid because a provider associated with the claim did not comply with a statute, regulation, or instruction in the Medi-Cal manual. Noncompliance with one or more of the above elements equates to a claim with a payment error.

Level Two Review

- For claims with errors related to medical necessity, a special fourth review is conducted. It is to determine the reliability of the first-level review process and to ensure consistency and accuracy of the findings. All such cases plus 10 percent of claims without errors are intermixed and reviewed by teams of two medical consultants. The reviewers look at the same documentation and background information available to the Level One reviewers, but are not aware of the error status of the claim. This “blinded” review is intended to address whether the dollar error identified truly reflects dollars at risk of being paid inappropriately and to minimize inter-rater variability and inaccuracy. If all independent reviewers reach the same conclusion, the error status of the claim is upheld. If there is a difference of opinion, the Second Level reviewers discuss the claim and reach a consensus.
- For claims identified as having errors not related to medical necessity, a similar but less formal review process is conducted by clinical staff.

Level Three Review

- DHCS’ Medi-Cal policy specialists conduct a supplemental review of selected claims. The main purpose is to ensure that errors identified thus far are correctly classified as not allowable according to the Medi-Cal policy in effect at the time of the claim. The process also provides feedback to the Policy section regarding possible adherence issues with specific policies.

2. Protocol for Identifying Potentially Fraudulent Claims

Level One and Level Two reviews include contextual analysis of all aspects of the claim and evaluation for characteristics associated with fraud. Often suspicious cases have more than one.

Some of the characteristics for potential fraud include:

- Medical records were submitted, but documentation of the billed service does not exist and service is out 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 was 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.

For claims identified as having characteristics of potential fraud in the First Level and Second Level review process, there is further scrutiny:

- Within DHCS - directed review is done of provider billing patterns and presence of stereotyped errors or other suspicious activity not necessarily apparent on the claim under review.
- Department of Justice – claims are selected for referral and full review is conducted. On a case-by-case basis, the findings of DOJ attorneys are relayed back to DHCS. Further actions are taken, as needed.

Appendix 2 – Previous Studies Statistics
MPES 2011 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2011)

Stratum	Payment Error Rate and Confidence Interval	Payments in Universe	Payments in Error (Including Potential Fraud)	Projected Annual Payments in Error
Stratum 1 - ADHC	39.55% ± 22.06%	\$91,863,971	\$36,330,384	\$145,321,537
Stratum 2 - Dental	4.36% ± 5.11%	\$121,889,944	\$5,309,455	\$21,237,819
Stratum 3 - DME	13.18% ± 10.65%	\$37,026,707	\$4,878,555	\$19,514,221
Stratum 4 - Inpatient	0.97% ± 2.77%	\$2,446,871,902	\$23,717,697	\$94,870,787
Stratum 5 - Lab	2.59% ± 3.26%	\$78,306,224	\$2,025,684	\$8,102,736
Stratum 6 - Physicians	8.72% ± 7.59%	\$1,149,632,777	\$100,229,679	\$400,918,716
Stratum 7 - Other Services	18.98% ± 4.85%	\$269,565,934	\$51,153,430	\$204,613,722
Stratum 8 - Pharmacy	9.10% ± 8.48%	\$984,342,811	\$89,552,479	\$358,209,915
Overall Payment Error Rate	6.05% ± 2.72%			
Totals*		\$5,179,500,270	\$313,197,363	\$1,252,789,452

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.

MPES 2009 Summary Statistics
MPES 2009 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 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.

**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 2011 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2011)**

Stratum	Potential Fraud Rate and Confidence Interval	Payments in Universe	Fraudulent Payments	Projected Annual Fraudulent Payments
ADHC	35.03% ± 21.52%	\$91,863,971	\$32,178,340	\$128,713,361
Dental	0.53% ± 1.11%	\$121,889,944	\$643,014	\$2,572,054
DME	0.00% ± 162.37%	\$37,026,707	\$0	\$0
Inpatient	0.00% ± N/A	\$2,446,871,902	\$0	\$0
Lab	0.98% ± 2.10%	\$78,306,224	\$771,179	\$3,084,715
Physicians	1.28% ± 1.48%	\$1,149,632,777	\$14,746,285	\$58,985,139
Other Services	3.45% ± 1.59%	\$269,565,934	\$9,308,730	\$37,234,920
Pharmacy	6.15% ± 6.26%	\$984,342,811	\$60,524,684	\$242,098,735
Overall Potential Fraud Rate	2.28% ± 1.74%			
Totals*		\$5,179,500,270	\$118,172,231	\$472,688,924

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 2.28 %, plus or minus 1.74%, or that the true error rate lies within the range of 0.54 and 4.02%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the 2nd quarter 2011 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.

**MPES 2009 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 2009)**

Stratum	Potential Fraud Rate and Confidence Intervals	Payments in Universe	Potential 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 potential fraud 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).

*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 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	Potential Fraud Payments	Projected Annual Fraud Payments
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	Potential Fraud Rate and Confidence Interval	Payments in Universe	Potential Fraud Payments	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	Potential Fraud Rate and Confidence Interval	Payments in Universe	Potential Fraudulent Payments	Projected Annual Potential Fraudulent Payments
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 2011 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	First	Second	Third	Fourth	Stratum Totals
ADHC	\$94,583,397	\$91,863,971	\$84,687,428	\$84,954,792	\$356,089,589
Dental	\$115,691,357	\$121,889,944	\$125,130,713	\$113,808,548	\$476,520,562
Durable Medical Equipment	\$42,417,181	\$37,026,707	\$34,499,042	\$31,621,366	\$145,564,295
Inpatient	\$2,466,772,836	\$2,446,871,902	\$2,290,897,009	\$2,232,032,265	\$9,436,574,013
Lab	\$47,584,613	\$78,306,224	\$63,003,239	\$55,364,652	\$244,258,728
Other Services	\$253,754,656	\$269,565,934	\$228,202,644	\$229,559,859	\$981,083,094
Pharmacy	\$996,058,283	\$984,342,811	\$833,459,278	\$844,477,988	\$3,658,338,360
Physicians	\$1,073,810,619	\$1,149,632,777	\$904,695,141	\$926,502,058	\$4,054,640,595
Quarter Totals	\$5,090,672,942	\$5,179,500,271	\$4,564,574,494	\$4,518,321,528	\$19,353,069,235

Calendar Year 2009 Medi-Cal Fee-for-service Payments by Quarter

Stratum	CY 2009 Fee-for-Service (FFS) Payments by Quarter				
	First	Second	Third	Fourth	Stratum Totals
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

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

Stratum	CY 2007 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.

PH4 – Wrong NDC Label

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.

PH6 – No Record of Drug Acquisition

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 Claims in Error

ID	Stratum	Primary Error	Error Description	Paid Amount	Correct Amount	Payment Error	Detailed Description of Error
0002	Dental	MR2B	No Documentation	\$79.20	\$52.80	\$26.40	This dental claim is for a periodic oral evaluation with x-rays and fluoride treatment. The documentation for the service claimed showed 4 periapical x-rays (PAs) were performed whereas 6 were claimed. The error is calculated as the difference between the total amount paid for PAs noted on the claim and the number of PAs that were documented as being done.
0008	Dental	MR2B	No Documentation	\$308.55	\$290.55	\$18.00	This dental claim is for 4 bitewings, general anesthesia, hospital services, and medications. Documentation did not mention bitewings being done. Dental office staff stated that they were not done and should not have been claimed. The error is calculated as the amount that was paid for the bitewings.
0014	Dental	MR2B	No Documentation	\$210.60	\$105.30	\$105.30	This dental claim is for a periodic oral evaluation with x-rays and fluoride treatment. The documentation for the service claimed for 2 periapical x-rays (PAs), whereas the documentation states only one was done. The error is calculated as the difference between the total amount paid for PAs on this claim and the amount paid for the PA that was documented.
0022	Dental	MR2B	No Documentation	\$72.90	\$36.45	\$36.45	This dental claim is for a periodic oral evaluation with x-rays and fluoride treatment. Six periapical x-rays (PAs) were claimed for this date of service. Documentation states that only 3 PAs were done. The error on this claim is difference between the total amount paid for PAs noted on the claim and the amount paid for the 3 PAs that were done.

0032	Dental	MR2B	No Documentation	\$45.00	\$22.50	\$22.50	This dental claim is for a comprehensive dental evaluation, a first intraoral/periapical x-ray, and 5 additional intraoral/periapical images. The dental evaluation is documented. A photograph of the surface of a tooth labelled with the date of service is documented. The only x-rays documented were dated 6 months after the date of service billed. The error is calculated as the amount paid for the undocumented x-rays.
0035	Dental	MR2B	No Documentation	\$62.10	\$26.10	\$36.00	This dental claim is for a periodic oral evaluation, intraoral additional film (x-ray) bitewings, prophylaxis, and fluoride treatment. There were no radiographs found in the record or at the dental office. The error is calculated as the amount that was paid for the radiographs.
0077	DME	MR7	Policy Violation	\$2,227.70	\$0.00	\$2,227.70	This claim is for ventilator rental for a 21-year old being discharged to home from a Subacute facility, for two service dates, one month apart. Documentation justifies medical necessity for ventilator equipment. A physician order specifies two ventilators, but the available approved TAR covers only one. On the CDR, there are three claims and payments for ventilator monthly rental. One is in the first month and two are in the following month, separated by one day. All use the number of the aforementioned TAR. Therefore, the payment of the third service is not authorized. The DME rendering provider's NPI number listed on the claim is for a different location than the NPI number listed on the TAR. The error is calculated as the amount paid for the third service.
0098	DME	PH2	No Legal Prescription for Date of Service	\$65.76	\$0.00	\$65.76	This claim is for oxygen probes to be used with an oximeter in a patient with chronic respiratory failure. The billing provider does not have an approved Service Authorization Request (SAR) for the date of service on the claim. The probes were mailed and there was not a signature to verify beneficiary receipt. There was no valid MD order for the probes (PH2). Instead, there was a copy of an unsigned pre-prepared prescription that had been faxed to the PCP with a reply on it that the patient's pulmonologist should be

							contacted instead. The error is calculated as the total amount paid for this claim.
0103	DME	MR2A	Poor/Insufficient Documentation	\$159.41	\$0.00	\$159.41	This claim is for enteral feeding supplies. Based on the patient's diagnosis and notes in the medical record, the items were medically necessary. Approximately two weeks before the prescription renewal date, a physician documented an order for the items listed for this date of service. The prescription renewal was written by a different rendering physician for the group, but there are no notes by this physician to validate the order. Based on lack of documentation for the date of service, an error code MR2A is assigned. This error was calculated as the total amount paid for this claim.
0169	Inpatient	MR2B	No Documentation	\$1,534.32	\$0.00	\$1,534.32	This claim is for 9 days at a skilled nursing facility for an 86-year-old. The documentation collected antedated the claimed service. The medical record verified services provided were medically necessary, consistent with diagnosis and generally accepted medical standards. However, there was no indication that the patient was there during the dates at issue. This error was calculated as the total amount paid for this claim.
0212	Lab	MR2A	Poor/Insufficient Documentation	\$42.62	\$0.00	\$42.62	This is a claim for DNA testing of a cervical specimen. The lab requisition does not clearly state which test is requested. The beneficiary's signature is missing or blocked by the label. There are no instrument printouts from the lab. However, the test result was documented in the medical record. The medical note lacked important components for the patient's history and contained no exam whatsoever. Medical necessity cannot be established based on these records. Poor documentation is assigned as numerous documentation deficiencies are noted. This error was calculated as the total amount paid for this claim.

0215	Lab	MR2B	No Documentation	\$72.01	\$0.00	\$72.01	This claim is for a blood test for tuberculosis (TB) and a blood test for hemoglobin A1C on a pregnant patient. Although the lab documentation supports claims for many other blood tests, these tests are not documented (MR2B). There is no order for the tests as claimed. Both tests were only noted in the treatment plan without any medical justification. Based on medical records, this patient had normal pregnancy, no history of diabetes, nor history of exposure to TB or previous BCG vaccination. There is no documentation to support that the blood TB test was medically necessary. Hemoglobin A1C may have been reasonable to screen for gestational diabetes. This error was calculated as the total amount paid for this claim.
0230	Lab	MR2B	No Documentation	\$6.44	\$0.00	\$6.44	This claim is for a Complete Blood Count (CBC) automated lab test. This 4-year-old has no elements of history or physical exam findings indicating risk factors for anemia or other hematologic problem. There is no documentation in the record of intent for a CBC or any results of it being done. This error was calculated as the total amount paid for this claim
0240	LEA	MR5	Medical Necessity Error	\$12.22	\$0.00	\$12.22	This claim is for group speech/language treatments. There is no documentation that a licensed speech pathologist provided speech therapy services on the date of service claimed. Notes were not signed and they gave no indication of who did the services (MR2A, poor documentation). The beneficiary can retell a story in Spanish; was he learning English or getting therapy? The characteristics of this case suggest the possibility of fraud or abuse of Medi-Cal funds. This error was calculated as the total amount paid for this claim.
0248	LEA	MR2B	No Documentation	\$32.74	\$0.00	\$32.74	This is a claim for individual speech therapy. There is no evaluation by a speech pathologist and no physician's prescription or protocol. There is no progress note of any kind on the date of service claimed. This patient has cerebral palsy and so is reasonable for services. This error was calculated as the total amount paid for this claim.

0254	LEA	MR2A	Poor/Insufficient Documentation	\$24.44	\$0.00	\$24.44	This claim is for speech/language/voice treatment services. They are medically necessary as indicated by the Individualized Education Plan (IEP), and they did occur on the dates of service, as per the attendance log and the speech pathologist's brief progress notes. However, the IEP contained in the chart is not signed, nor is there a written order or a referral from either a physician or a licensed speech-language pathologist for speech therapy treatment services, as required by the Medi-Cal Provider Manual. All that is present is the IEP. Therefore, an MR2A error is assigned for poor documentation. This error was calculated as the total amount paid for this claim.
0255	LEA	MR5	Medical Necessity Error	\$18.54	\$0.00	\$18.54	This claim is for non-emergency transportation; encounter/trip. Transportation services are outlined in the Individualized Education Plan (IEP), and are technically reimbursable. However, the student receives wheelchair transportation and there is no documentation as to why it is needed. According to his IEP, he is "able to walk, run and jump independently. He is able to navigate through the playground apparatus and climb stairs with ease. He is able to climb a curved ladder, as well." It is unclear why such a child would require wheelchair or litter van transportation to and from school, as outlined in the IEP. Per the Medi-Cal Provider Manual, litter van transportation is appropriate and reimbursable when the student's medical and/or physical condition requires specialized equipment and more space than available in passenger cars, taxicabs or other forms of public transportation. Wheelchair van transportation is appropriate and reimbursable when the student's medical and/or physical condition renders the student unable to sit in a private vehicle, taxicab or other form of public transportation for the time needed for transport. These situations do not seem applicable to this student, as documented in his IEP. An MR5 error, medically unnecessary service, is assigned. This error was calculated as the total amount paid for this claim.

0257	LEA	P9B	Billing Provider not Eligible to Bill for Claimed Services/Supplies	\$32.74	\$0.00	\$32.74	This claim is for individual speech/language treatment. It is for an almost 5-year old student with autism and intellectual disability in a special educational program. The person who gave the therapy wrote a therapy note and filled out a speech therapy treatment form. She signed with "SLP" after her name; however, her speech-language pathologist license had been cancelled many years earlier. She does have a life credential in Clinical or Rehabilitative Services - Language, Speech and Hearing. The therapy note was not co-signed by a licensed speech-language pathologist. The document entitled "Supervision of Credentialed Speech-Language Pathologist" did not cover the date of service. The error P9B is assigned, since information suggests the rendering provider is not licensed and is not appropriately supervised. This error was calculated as the total amount paid for this claim.
0258	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language/voice therapy. The LEA Medi-Cal Billing Option Program covers only speech therapy treatment services when there is a written referral by a physician, dentist, or licensed speech-language pathologist. There was no written referral for speech therapy treatment services and no documentation of service for the date of service billed. The error is calculated as the total amount paid for this claim.

0260	LEA	MR8	Other Medical Error	\$12.22	\$0.00	\$12.22	<p>This claim is for group speech/language/voice treatment 2 units, signifying group speech therapy for 30 minutes by a speech pathologist as part of an Individualized Education Plan (IEP). An IEP covering the timeframe of the claim is available and shows Language and Speech, Group, 30 min x 40 sessions as a planned service. The IEP has typewritten names but not signatures (MR8 - lack of signature). The referral for speech therapy treatment services seems to be indirectly established and documented in the student's IEP. There is an accompanying document entitled, Determination of Medical Necessity for Services of Speech and Language Therapists, which probably fulfills the requirement for Physician-based Standards. It is signed by a physician; parenthetically this physician's business card includes the phrase, "Visit Clinic Inside Walmart." The patient was at school on the day of the service per the attendance records. The delivery of the 30-minute group service was documented, including progress. The service was delivered by a licensed speech language pathologist, who was identified by typewritten user name, but the note did not have a handwritten or electronic signature (MR8 - lack of signature). The error is calculated as the total amount paid for this claim.</p>
0261	LEA	MR2A	Poor/Insufficient Documentation	\$16.40	\$0.00	\$16.40	<p>This claim is for nursing aide services 4 units, which signifies four 15-minute increments of school health aide services provided as part of an Individualized Education Plan (IEP). The IEP that is available covers a time period after the claim date. Furthermore, the IEP is partial and does not include a signature page (MR2A - the documentation submitted was insufficient). A School Nurse Health Report is available which is dated 2-3 months after the claim date, and the report lacks a handwritten or electronic signature. It mentions that the beneficiary is incontinent, in a wheelchair, and requires supervision with eating because of cheek-stuffing. A Specialized Healthcare Procedure Log is available and shows provision of services on the claim date, by a health aide identified per another document.</p>

							Information is not available regarding health aide training or supervision. Per check marks on the log, the services included circulation/mobility x2 units and skin check/integrity x2 units, but information is not available regarding clinical findings or interventions (MR2A - the documentation submitted was insufficient). The error is calculated as the total amount paid for this claim.
0264	LEA	MR8	Other Medical Error	\$126.36	\$0.00	\$126.36	The claim is for 26 units of licensed vocational nurse (LVN) services, up to 15 minutes each, on one date of service, through the LEA Medi-Cal Billing Option Program. The LVN provided G-tube feeding and dressing change, and continuous one-on-one monitoring for seizures. The LEA program requires physician orders for nursing treatments. There is no physician order for the administration of G-tube feedings and G-tube nursing care. Seven or more continuous one-on-one treatment minutes must be documented in order to bill for one 15-minute unit of service. The LVN notes for the date of service do not document 6.5 hours of one-on-one care. The provider submitted two contradictory LVN notes for the date and time of service, one stating the student was given G-tube feeding and went back to a school dance, and the other stating the student went to a field trip and was assisted with lunch feeding. One-on-one continuous monitoring for seizure activity was not documented. The error is calculated as the total amount paid for this claim.
0265	LEA	MR2B	No Documentation	\$24.63	\$0.00	\$24.63	This claim is for targeted case management for this 9-year-old at school. Documentation includes a physician's order for the service, however, there is no evidence that any case management activity was done on this date. The error is for the total amount of the claim.

0266	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This is a claim for group speech/language therapy. The billed code includes modifier TM, which means this service was included in the Individualized Education Plan (IEP). However, it was not. There are treatment goals in the IEP that suggest the student has problems with speech, but since the IEP specifies individual speech/language treatment, it is unclear whether this student can benefit from group therapy. There is no evaluation by a speech-language therapist that describes the impairments and need for treatment. There is also no evidence of the nature and extent of either group or individual treatment on the date of service. Documentation does not support the claim, except that the student was present. The error is for the total amount of the claim.
0267	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language therapy for a 6-year-old at school. The child was enrolled in the LEA program for speech learning disability and language impairment based on the Individualized Education Plan (IEP). The IEP is available, but it is not signed. No MD orders were submitted. No Minimum Standard of Medical Necessity was submitted. No treatment record was submitted, and no progress notes/goals were submitted. There is an attendance log for the month of service and a copy of a bill for the date of service for 20 min group therapy. The attendance log did not show proof of attendance for the date of service. The error is for the total amount of the claim.
0268	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language treatment for this 5-year-old student. There is an Individualized Education Plan (IEP) valid for the date of service which documents speech and language impairment. There is no physician order or Determination of Medical Necessity. There is an attendance log to verify the child's presence at school. There is also a Date of Service sheet for small group services; however, the type of service is not specified. The provider identified is a speech-language pathologist with a license that was not issued, per the licensing board, until after the date of service on the claim. There are no progress notes from the date of

							service to verify that the service occurred, so an MR2B error is assigned. A P9B error is considered because the likely rendering provider did not have a verifiable license on the date of service. This error was calculated as the total amount paid for this claim.
0269	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech treatment for 45 minutes by a speech-language pathologist as a part of an Individualized Education Plan (IEP), equating to the maximum of 3 units per day. An IEP for the date of service shows a plan for Language and Speech, one 30-minute group session per week. A document equivalent to the required Physician-Based Standards was not located (MR2A - poor documentation). An attendance record shows the beneficiary's presence on the date of service. A Treatment Detail Log shows weekly 30-minute group sessions in September. A grid shows the treatment time, 10:30-11:00, and briefly describes services provided to each student in the small group. At the top of the grid page is a name, which would seem to identify the provider, but the individual treatment notes are not signed and the grid page itself is not signed. The person providing the service is not licensed, and so should be performing the service under the supervision of licensed personnel; however, supervision was not documented. In view of the areas of insufficient documentation, for this claim the error is calculated as the total amount.

0271	LEA	MR2B	No Documentation	\$27.30	\$0.00	\$27.30	This claim is for A0425-TM, 42 units, ground mileage as part of an Individualized Education Plan (IEP). An IEP that covers the claim is available. It describes the 18-year-old beneficiary as having an academic performance falling into the "moderate to severe ranges for severely developmentally delayed students with cognitive disabilities," but having "no apparent motor limitations and he is able to board and disembark a school bus and school van." The IEP's section for indicating disability shows only intellectual disability as present and not, for example, emotional disturbance or orthopedic impairment. The IEP section on program and services shows Targeted Case Management (TCM) and Transportation Special Ed. For the day of the claim and in general, no TCM records are available for review, no attendance records are available for review, and no transportation records are available for review. Based on the available documentation, it is unclear if the beneficiary is "unable to sit in a private vehicle, taxicab or other form of public transportation for the time needed for transport" (apparently 21 miles one way), and it is unclear if the daily TCM (which apparently is the qualifying Medicaid-covered service) is medically necessary (MR2A - poor documentation). Regarding the ground mileage claimed, no documentation was provided to support that a transportation service occurred (MR2B - no documentation). This error was calculated as the total amount paid for this claim.
0272	LEA	MR2B	No Documentation	\$21.45	\$0.00	\$21.45	This claim is for ground mileage through the LEA Medi-Cal Billing Option Program. Medical necessity for transportation is documented. There is no Transportation Log documenting the service was provided. The error is calculated as the total amount paid for this claim.
0273	LEA	MR2B	No Documentation	\$18.54	\$0.00	\$18.54	This claim is for non-emergency transportation for a 19-year-old student with autism and intellectual disabilities in special educational/vocational programs. The high school district sent no documentation indicating that transportation was provided on the date of service. The representative stated that they do not do individual student Transportation

							Logs. This error was calculated as the total amount paid for this claim.
0274	LEA	MR2A	Poor/Insufficient Documentation	\$18.54	\$0.00	\$18.54	This claim is for non-emergency transportation. This 19-year-old student with intellectual disabilities is in special educational/vocational programs and receiving Transportation and Targeted Case Management (TCM) per the Claims Detail Report. There is no physician order or Minimum Standard of Medical Necessity for the transportation service. However, in the Individualized Education Plan it is stated to be needed. The high school district provided a map of the transportation routes and a daily route outline. There was no indication that the student was on the bus on the date of service; there was no signed Transportation Log. However, there is a TCM Log, which shows attendance and transportation for the month that includes the date of service. The error assigned is MR2A, and the amount of the error is calculated as the amount paid for the claim.
0275	LEA	MR2A	Poor/Insufficient Documentation	\$7.20	\$0.00	\$7.20	This claim is for targeted case management (TCM) for a 19-year-old student in a special educational program. Diagnoses include bipolar disorder and ADHD with emotional disturbances and behavioral difficulties. This student is to be receiving TCM and Transportation. Per the Medi-Cal Provider Manual, there are several components of TCM, including determining needs, developing a plan, linking and consulting coordination, accessing services outside the school system, assisting with crises and reviewing progress. Other than a check mark to note that TCM services occurred on the date of service in question, there are no notes regarding the specifics of what services were needed/provided (MR2A error). This error was calculated as the total amount paid for this claim.

0277	LEA	MR2A	Poor/Insufficient Documentation	\$38.76	\$0.00	\$38.76	This claim is for occupational therapy services. There is documentation that the student was assisted on the playground. However, the document is unsigned and does not state who provided the service. It cannot be verified that an appropriately licensed therapist provided the service. The error is for the total amount of the claim.
0279	LEA	MR2A	Poor/Insufficient Documentation	\$49.20	\$0.00	\$49.20	This claim is for three hours of nursing aide services for a 5-year-old with autism. The services were not indicated on the Individualized Education Plan (IEP) and were not supported by physician's order. Apparently the aide performed daily monitoring by observing the student to prevent self-harm and harm to others, and performed daily skin integrity checks. The nature and extent of the services were not further documented. For poor/insufficient documentation, the error was calculated as the total amount paid for this claim.
0282	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This claim is for the LEA service of 92508-GN-TM, 1 unit, which signifies group speech therapy for 15 minutes by a speech pathologist as part of an Individualized Education Plan (IEP). One page of an IEP that covers the date of service is available. It confirms the diagnosis of speech impairment but does not specify treatment plan, such as frequency and duration of treatment sessions. The IEP signature page is not available. A page entitled Determination of Medical Necessity for Services Provided by SLPs in Solano County Schools is available, and it has an MD signature appropriate for the timeframe. A Speech Services Attendance Register is available, which documents a 25-minute group session on the date of service by a licensed speech pathologist; this attendance register is signed at the bottom. A progress note describing the specifics of the session is not available (MR2A - poor documentation). This error was calculated as the total amount paid for this claim.

0284	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for 92508-TM-GN 1 unit, which signifies group speech treatment for 15 minutes by a speech-language pathologist as part of an Individualized Education Plan (IEP). A note indicating group speech treatment on the date of service is not available (MR2B - no documentation). An IEP is available but it covers a time period after the claim date. This IEP includes Language and Speech services, for 50 sessions, each 20 minutes in length. The IEP has typewritten names at the end, although no signatures. A participating speech-language pathologist is identified; licensure was checked for but not found. A document representing Physician-Based Standards is not available. An attendance record is not available. For these reasons, an MR2A error also applies. For this claim, the error was calculated as the total amount paid.
0285	LEA	MR2B	No Documentation	\$122.20	\$0.00	\$122.20	This claim is for group speech/language treatments by a licensed speech pathologist, for 30 minutes, 56 times/year per the Individualized Education Plan (IEP). This 10-year-old student has a specific learning disability per this IEP. The school district did not provide the physician order, the Minimum Standard of Medical Necessity for the Speech/Language Treatments, or the Determination of Medical Necessity for Services of the Speech/Language Pathologist. In addition to this insufficient documentation (MR2A error), there are no progress notes submitted (MR2B - no documentation). For this claim, the error was calculated as the total amount paid.
0286	LEA	MR7	Policy Violation	\$12.22	\$8.08	\$4.14	This claim is for group speech therapy for a 21-year-old with multiple disabilities. The Individualized Education Plan (IEP) states speech therapy is for once a week, 30 minutes per session. The flow sheet indicates initial service time was 30 minutes and continued to 45 minutes. The provider billed for 3 units of continuous speech therapy (second modifier TM) which is not covered on the IEP. This error is the difference between the 30 minutes as planned in the IEP and the 45 minutes claimed.

0287	LEA	MR1	No Documents Submitted	\$12.22	\$0.00	\$12.22	This claim is for group speech/language/voice treatment for a 6-year-old at the school. Although requested, no documentation was submitted. This error was calculated as the total amount paid for this claim.
0289	LEA	MR2A	Poor/Insufficient Documentation	\$38.76	\$0.00	\$38.76	This claim is for CPT 97110-GO-TM, Therapeutic Procedure, 2 units, which signifies 30 minutes of Occupational Therapy as part of an IEP. An IEP covering the timeframe of the claim is available and the plan includes Occupational Therapy, individual, 30 minutes, once a week. Other services include Speech/Language, Transportation, and Extended School Year. A signature page was not available. An EMR note is available that is not labeled as Occupational Therapy but can be surmised as such. It documents student present 30 minutes for individual service, and date represented seems to be the date of the claim. The note is brief, "good attention to task; puzzles, tracing with dry eraser marker." The name of the provider is documented, who is a licensed Occupational Therapist, but there is not an official signature. Other available records include an attendance record which verifies presence at school on the day of the claim. Also there is a page from earlier in the year which gives the rationale for Occupational Therapy and it is signed as a physician prescription. The ancillary documentation deficiencies are assigned an MR2A error. This error is calculated as the total amount of the claim.

0290	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language therapy for this 8 year-old. There is one page of an unsigned Individualized Education Plan (IEP) which covers the date of service and which documents that the beneficiary should receive language and speech services for a total of 120 minutes per month. There is neither a Determination of Medical Necessity document nor any other indication as to why the student needs the services. There is an unsigned Speech/Language Therapy Daily Log for the beneficiary, with an unsigned brief progress note from the date of service. There is a Student Treatment Detail Log with the beneficiary's name which identifies a speech therapist; however, it does not apply to the date of service. The speech therapist identified did not have a valid license at the time of the date of service, per the licensing board (likely P9B error). Also, an MR2A error for poor documentation is assigned for the reasons described above. The error was calculated as the total amount paid for this claim.
0291	LEA	MR2A	Poor/Insufficient Documentation	\$67.43	\$0.00	\$67.43	This is a claim for the initial health assessment for the Individualized Education Plan (IEP) of this 3-year-old beneficiary. The IEP from 2013 notes the initial referral date and that the referral was made by "other;" however, the referral is not present for review and "other" is not defined. The IEP notes that the child has receptive and expressive language delays. There is one page available from the IEP from 2014, as well. The initial health assessment is only present in part; not all pages are received. There is an Emergency Care Plan related to Febrile Seizures from 2013 and signed by a registered nurse. Per the Medi-Cal Provider Manual, a referral for the initial IEP assessment must be present in the beneficiary's chart. Only part of the initial IEP was received for review. An MR2A error is assigned for poor documentation. The error was calculated as the total amount paid for this claim.

0293	LEA	P9B	Rendering Provider not Eligible to Bill for Claimed Services/Supplies	\$12.22	\$0.00	\$12.22	This is a claim for group speech therapy. There is evidence that the student was in class, but no evidence that a licensed speech language therapist provided this service. The staff member that led the group therapy was credentialed in "multiple subject teaching and reading" and was not a licensed for speech therapy professional (P9B error). This error was calculated as the total amount paid for this claim.
0294	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language treatment through the LEA Medi-Cal Billing Option Program. The LEA Medi-Cal Billing Option Program covers only speech therapy treatment services per a written referral by a physician or dentist, or per a written referral by a licensed speech-language pathologist when supported by a valid Physician-Based Standards protocol. The record contained no referral for speech/language treatment services from a physician or speech-language pathologist. There was no record of the actual service provided. Although the LEA provider stated the speech therapist that provided the claimed service is no longer employed by them and took the working file, the LEA is responsible for maintaining all records pertaining to billed services. The error is calculated as the total amount paid for this claim.
0295	LEA	MR1	No Documents Submitted	\$18.54	\$0.00	\$18.54	This claim is for non-emergency transportation for a disabled 12-year-old for transport to and from school. Multiple requests were made to the provider for submission of supporting documentation, without response. This error was calculated as the total amount paid for this claim.
0296	LEA	MR2A	Poor/Insufficient Documentation	\$8.12	\$0.00	\$8.12	This claim is for a behavior group session for an 11-year student. According to documentation provided by the provider, the service was provided by a staff member credentialed to provide school psychology service. There was no physician order or documentation for Minimum Standards of Medical Need (MR2A - poor or insufficient documentation). This error was calculated as the total amount paid for this claim.

0299	LEA	MR2B	No Documentation	\$8.20	\$0.00	\$8.20	This is a claim for gastrostomy tube feeding. The student is an 8 year-old with developmental delays and chronic lung disease, status post tracheostomy and gastrostomy button. There is an Individualized Education Plan (IEP) describing the student's needs, and a note that a physician prescription was received by fax, however, no prescription was found. And there is no documentation that the student received the services on the date claimed (MR2B). This error was calculated as the total amount paid for this claim.
0301	LEA	MR2A	Poor/Insufficient Documentation	\$38.76	\$0.00	\$38.76	This is a claim for occupational therapy, 45 minutes, through the LEA Medi-Cal Billing Option Program. Occupational therapy treatment services require a written prescription by a physician or a podiatrist and that it be maintained in the student's file. There is no documentation of an occupational therapy evaluation to support the necessity of the service, and no written prescription as required to bill for occupational therapy services in the LEA program. The error is calculated as the total amount paid for this claim.
0312	LEA	MR1	No Documents Submitted	\$4.10	\$0.00	\$4.10	This claim is for nursing aide services through the LEA Medi-Cal Billing Option Program. No documentation was provided to support the services were provided. The error is calculated as the total amount paid for this claim.
0313	LEA	MR2A	Poor/Insufficient Documentation	\$126.36	\$0.00	\$126.36	This is an LEA claim for licensed vocational nurse (LVN) services, up to 15 min, 26 units for a total of 6.5 hours on the date of service. The LEA program requires physician orders for nursing treatments. No Individualized Education Plan (IEP) or physician order for the service was provided covering the time period of the date of service on the claim. If a nursing service is not listed in the IEP, the LEA Medi-Cal Billing Options Program has service limitations on LEA nursing services of 24 per year, which had been exceeded prior to date of service. Seven or more continuous one-on-one treatment minutes must be documented in order to bill for a unit of service. The nursing note for the date of service documents frequent repositioning and G-tube feeding activities but does not demonstrate that any service provided entailed 7 or more minutes of one-on-one skilled health

							care. The error is calculated as the total amount paid for this claim.
0314	LEA	MR8	Other Medical Error	\$67.43	\$0.00	\$67.43	This claim is for T1001-TM 1 unit, which signifies initial or triennial IEP health assessment by a nurse. An IEP is available; it is from 2013 and it is labeled as initial. A stand-alone nurse health assessment is not available. However, there is a log signed by an RN documenting that she performed a health assessment on this beneficiary. Also, a 17-page evaluation is available and it includes a section entitled, Health Screening and History, submitted by the RN just before the date of the IEP. This section documents a comprehensive assessment. The section ends with the RN's typewritten name, but her handwritten or electronic signature is not evident at this point or elsewhere on the document (MR8 - rendering provider did not sign the medical record). This error was calculated as the total amount paid for this claim.
0316	LEA	MR1	No Documents Submitted	\$12.22	\$0.00	\$12.22	This claim is for group speech/language therapy through the LEA Medi-Cal Billing Option Program. According to the school secretary this student is not in their computer system. There are no school records to review. Per the Claims Detail Report there are multiple paid claims to this school district for this child. The error is calculated as the total amount paid for this claim.
0317	LEA	MR1	No Documents Submitted	\$111.78	\$0.00	\$111.78	This claim is for licensed practical nurse services, 15 minutes, quantity 23 for this 6-year-old LEA student. Although requested, no documentation was submitted. This error was calculated as the total amount paid for this claim.

0320	LEA	MR2B	No Documentation	\$12.22	\$0.00	\$12.22	This claim is for speech/language treatments (92508) by a licensed speech pathologist. This 8-year-old student has a speech and/or language impairment with a medical diagnosis of attention deficit disorder, per the available Individualized Education Plan (IEP). The billed group speech/language treatment on the date of service is not authorized by the IEP since the submitted IEP does not cover speech/language treatments beyond 2012. The school district did not provide the physician order, the Minimum Standard of Medical Necessity for the Speech/Language Treatments, or a Determination of Medical Necessity for Services of the Speech-Language Pathologist (MR2A - poor, insufficient documentation). There are no progress notes for speech therapy submitted (MR2B - no documentation). The number of units rendered/billed and the time documented is in question due to the IEP. This error was calculated as the total amount paid for this claim.
0321	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This claim is for group speech/language/voice therapy through the LEA Medi-Cal Billing Option Program. The LEA Medi-Cal Billing Option Program covers speech therapy treatment services with a written referral by a licensed speech-language pathologist only when supported by a valid Physician-Based Standards protocol which is required to be kept in the student's file. There is a written referral for the speech and language therapy from a licensed speech-language pathologist. There is no documentation of the required protocol in the student's file. There is documentation of therapy on the date of service, but it is not officially signed. The error for this claim is calculated as the total amount paid.

0323	LEA	MR2A	Poor/Insufficient Documentation	\$12.22	\$0.00	\$12.22	This claim is for speech/language therapy. The IEP documents the medical necessity for this 9-year-old student. However, the Determination of Medical Necessity for Services signed by a physician is dated after the date of service on the claim, so it not valid for the claimed services. The speech-language pathologist's name is found on the Individualized Education Plan (IEP), but there is no progress note for the date of service, only an Attendance Log indicating that the child was in school and received the specific service (2 units). An MR2A error is assigned for lack of a note describing the services rendered, plus lack of a signed Medical Necessity Determination valid for the date of service. The error is calculated as the total amount paid for this claim.
0324	LEA	MR1	No Documents Submitted	\$9.63	\$0.00	\$9.63	This claim is for registered nurse services for a Local Education Agency for a 12-year-old. The school district was notified multiple times with requests for documentation to support this claim. No documentation was received. The service could not be justified. This error was calculated as the total amount paid for this claim.
0325	LEA	MR3	Coding Error	\$48.15	\$0.00	\$48.15	This claim is for registered nurse (RN) services, up to 15 minutes for this 16-year-old. The beneficiary requires G-tube feeding and tracheostomy care. The record showed services were provided by a licensed vocational nurse (LVN) rather than an R.N., and there is a date disparity as well. According to the business services manager, the billing was outsourced; there might have been "keying in" errors. Available MD orders are limited to those for trach care. This error was calculated as the total amount paid for this claim.
0328	Other Services	MR2A	Poor/Insufficient Documentation	\$51.44	\$0.00	\$51.44	This claim is for incontinence under pads. The prescribing provider wrote an order for diapers. The supply amount on the claim for diapers did not have an end date or duration of need for this supply. The diagnosis listed did not fulfill the policy requirements for this item. The error is calculated as the total amount paid for this claim.

0333	Other Services	P1	Duplicate Item	\$53.46	\$0.00	\$53.46	This claim is for medical ambulance mileage, one way, and the use of an oxygen tank. The services were medically necessary. This claim is a duplicate claim. The provider was previously paid for the same patient, same date of service. The error is calculated as the total amount paid for this claim.
0334	Other Services	MR1	No Documents Submitted	\$543.96	\$0.00	\$543.96	This claim is for case management per month - AIDS waiver, waiver services not otherwise specified, and home delivered meals. No documents were submitted. According to the provider, the patient registered but was never seen. A statement of "no medical records found" was received. This error was calculated as the total amount paid for this claim.
0337	Other Services	MR7	Policy Violation	\$73.89	\$0.00	\$73.89	This claim is for non-emergency transportation (NEMT), including mileage. This is for a 53year-old with end stage renal disease on chronic dialysis that is being transported to dialysis 3 times a week. Medical necessity for this baseline service is well documented. However, for the week under review, the number of NEMT services for dialysis that were provided was 4, and the approved TAR covered only 3. The reason for the extra transport session was not evident from the available documentation. The referring physician was not listed on the claim. This error was calculated as the total amount paid for this claim.
0342	Other Services	MR2A	Poor/Insufficient Documentation	\$34.56	\$0.00	\$34.56	This claim is for occupational therapy treatment lasting 45 minutes. Although the therapy was appropriate for this 12 year-old with progressive hereditary muscular dystrophy, the documentation is minimal. Services were rendered on the date claimed, as ordered by the physician. The services provided were medically necessary, consistent with diagnosis and generally accepted medical standards. The error is calculated as the total amount paid for this claim.
0343	Other Services	MR1	No Documents Submitted	\$43.47	\$0.00	\$43.47	This claim is for response to call non-litter transportation, and mileage. The rendering provider was not at the place of business listed; the provider had moved but PED was not notified. The provider visited denied the claim. No documents were available. This error was calculated as the total amount paid for this claim.

0344	Other Services	MR2B	No Documentation	\$97.21	\$69.73	\$27.48	This claim is for 6 physical therapy treatments for a 2 year-old with multiple birth defects. The documentation validates the medical necessity. However, for one date the mother cancelled the treatment. The documentation states a consult was done but nothing as to treatment. The error is calculated as the amount that was paid for therapy on the one date.
0346	Other Services	MR2A	Poor/Insufficient Documentation	\$860.06	\$0.00	\$860.06	This claim is for a hearing aid. There is a patient signature of receipt documenting that a hearing aid was dispensed to this beneficiary. The TAR is for a different hearing aid than that identified on the claim. The error is calculated as the total amount paid for this claim.
0350	Other Services	MR5	Medical Necessity Error	\$46.67	\$0.00	\$46.67	This claim is for adult size briefs/diapers. The documentation in the medical record does not mention incontinence. Bowel symptoms were discussed without mention of incontinence. Urinary tract infection symptoms were reviewed without mention of incontinence. There was no evidence in the medical record of medical necessity for these supplies. The prescription does not have a diagnosis listed. The provider has changed location. This error was calculated as the total amount paid for this claim.
0353	Other Services	MR2A	Poor/Insufficient Documentation	\$145.80	\$0.00	\$145.80	This claim is for maternal serum quad screen in this pregnant patient. The consent form is present and signed. The same form is also signed at a later date which corresponds to the date of the blood draw. The same form lists the location of the blood draw, thus fulfilling the requirement that the patient sign for her laboratory specimen. The results of the test are also present, indicating that a 2nd trimester specimen needs to be sent. However, per the CDR and notes on the standardized OB record, the patient had a missed abortion subsequently. The documentation from the referring physician's office is scanty and very difficult to read. The information in the OB record is extremely scanty with 4 out of 5 visits all with the same blood pressure (100/70). The information in the progress notes is also very brief. There is a note on the date of service consisting of one line; there is no entry on the standardized OB record for the date of

							service. A poor documentation error, MR2A, is assigned. This error was calculated as the total amount paid for this claim.
0355	Other Services	MR2A	Poor/Insufficient Documentation	\$145.80	\$0.00	\$145.80	This claim is for a maternal serum quad screen on a 32-year-old pregnant female. The blood is drawn in her physician's office on the date of service for the claim and also on the date of her antepartum visit. There is a signed consent for the blood draw, as well as a signature for the specimen. The results are present, as is the progress note documenting her pregnancy. However, the progress note does not include a physical exam, except for vital signs. There is no measurement of fundal height and no documentation of fetal heart rate. Therefore, an error is assigned for poor documentation. This error was calculated as the total amount paid for this claim.
0356	Other Services	MR2A	Poor/Insufficient Documentation	\$145.80	\$0.00	\$145.80	This claim is for maternal serum quad screen (genetic testing) on a 27-year-old pregnant patient. The blood was originally drawn on the same date of service on the claim and the date of service of her antepartum visit. This blood draw was not appropriate for the test, however, as it was drawn too early in the pregnancy. Furthermore, though the patient signed for the blood draw as a part of the consent for the test, the information about where the blood was drawn was left blank. Another blood sample was drawn and sent approximately one month later (at the appropriate time during the pregnancy), but there was no consent form signed on that date, no patient signature for the blood draw, and no record of the site from which the blood was drawn. No claim was submitted for the second test, thus no duplicate claim. Of note, the pregnancy record is not sent with the progress note from the date of service, so no vital signs are present, no record of fundal height, fetal heart rate, etc. This information may be present in the chart and was just not received. There is a progress note which, though very scanty, does indicate that the patient is pregnant. An MR9 error is assigned for recipient signature missing. An MR2A is assigned for the lack of an OB record with vital signs,

							fundal height, fetal heart, etc., for the date of service. This error was calculated as the total amount paid for this claim.
0361	Other Services	MR2A	Poor/Insufficient Documentation	\$171.16	\$0.00	\$171.16	This claim is for large disposable underpads, adult size briefs, and a bed size under pad. The physician listed on the claim had not seen this patient since 2012 and did not order the incontinence supplies. The current physician had not ordered supplies recently. It is questionable as to who ordered the continuation for these medically necessary supplies. This error was calculated as the total amount paid for this claim.
0365	Other Services	P6	Logical Edit	\$1,164.65	\$0.00	\$1,164.65	This claim is for EPSDT/LVN services through a Home Health Agency, covering 5 dates, 8 units each. This 12 year-old is actively enrolled in CalOptima and is an open case with CCS Orange. There was an approved Service Authorization Request which covered the applicable service code and dates. This error was calculated as the total amount paid for this claim.
0378	Pharmacy	PH2	No Legal Prescription for Date of Service	\$452.12	\$0.00	\$452.12	This claim is for Nexium, used to treat symptoms of gastroesophageal reflux disease (GERD) and other conditions involving excessive stomach acid. The pharmacy could not produce an order for the refill. The documentation at the prescribing provider did not document medical necessity or that a refill order was given. This error was calculated as the total amount paid for this claim.
0383	Pharmacy	MR2A	Poor/Insufficient Documentation	\$9.36	\$0.00	\$9.36	This claim is for Zolpidem (Ambien), a sedative, also called a hypnotic, used to treat insomnia. The pharmacy dispensed as prescribed. The documentation regarding the corresponding visit shows it was to check lab work and has no mention of insomnia. Medical necessity was not documented. This error was calculated as the total amount paid for this claim.
0392	Pharmacy	PH2	No Legal Prescription for Date of Service	\$71.23	\$0.00	\$71.23	This claim is for Amoxicillin, an antibiotic. There is no hard or electronic copy of the order. The physician listed on the medical record denied prescribing the medication and it was not noted in the documentation of the medical record, but he did mention it could have been a phone prescription. This error was calculated as the total amount paid for this claim.

0393	Pharmacy	MR2A	Poor/Insufficient Documentation	\$9.47	\$0.00	\$9.47	This claim is for Calcium Carbonate. There is no error by the pharmacy as all requirements were met. No written documentation was found with the prescriber for this date of service. Error is with the prescribing provider. This error was calculated as the total amount paid for this claim.
0397	Pharmacy	MR2A	Poor/Insufficient Documentation	\$6.49	\$0.00	\$6.49	This claim is for Aspirin. The dispensing label is not available; no other errors were found with the pharmacy. The referring provider has noted the prescription in the medical record for the date of dispensing, however, the documentation did not substantiate medical necessity. This error was calculated as the total amount paid for this claim.
0405	Pharmacy	MR5	Medical Necessity Error	\$127.78	\$0.00	\$127.78	This is a pharmacy claim for incontinence supplies. The documentation at the pharmacy has incontinence on it including the order for it. The medical record doesn't say anything about the patient being incontinent. A recent notation says continue incontinent supplies but not that the patient was incontinent. The error is calculated as the whole amount paid.
0424	Pharmacy	PH5	Wrong Information on Label	\$89.42	\$0.00	\$89.42	This claim is for Humulin, insulin for a diabetic. No signature log was available at the pharmacy and the pharmacy put the wrong prescribing physician on the telephone order and label, plus on the claim. This physician signed a declaration that the patient was not one of his. The patient was actually seen by another physician with same name except that the middle name is different. The medication was medically necessary. This error was calculated as the total amount paid for this claim
0429	Pharmacy	MR7	Policy Violation	\$46.79	\$0.00	\$46.79	This claim is for blood sugar diagnostics. The pharmacy is a closed door pharmacy that delivers to long term care (LTC) facilities. Diabetic test strips are kept with the central medications in the medication room at the LTC. The nurse uses the same bottle for every patient. There are no patient labels on any of the strip bottles in the central location. This error was calculated as the total amount paid for this claim.

0440	Pharmacy	MR5	Medical Necessity Error	\$17.60	\$0.00	\$17.60	This claim is for Sulfamethoxazole-Trimethoprim, used to treat infections such as urinary tract infections, respiratory tract infections, and traveler's diarrhea. The pharmacy did not produce a signature log. The documentation in the medical record regarding possible infection or intent to prescribe this medication is poor, including no mention of the prescription. This error was calculated as the total amount paid for this claim.
0446	Pharmacy	PH2	No Legal Prescription for Date of Service	\$7.89	\$0.00	\$7.89	This claim is for Aspirin EC 325 mg #28. The patient lives in a residential care facility. The patient's medical records support the medical necessity for daily aspirin (ASA). The house supervisor of the care facility has signed that the ASA was received. There is a Monthly Medication Reorder Sheet that shows ASA EC 325 mg daily #30, with 5 refills, was ordered and one of the refills would have covered the claim. The pharmacy has this order in its Order Processing file. However, for this review the pharmacy submitted a document requesting a refill order from the physician and it was signed by the physician, but it was for a time period that preceded the fill date on the claim. (PH2 - no legal prescription for date of service). Apparently the pharmacy dispensed the ASA on a weekly basis, along with several other medications, possibly as a blister pack. Review of the records submitted did not show a document that authorized adjusting the dispensing from #30 per 30 days to #7 each week for four weeks. (PH10 - other pharmacy policy violation). Per the audit team, at the time of record collection the billing provider was at a location that was not the enrollment address. (P9C - the billing provider is a Medical provider, but not at this location). This error was calculated as the total amount paid for this claim.

0447	Pharmacy	PH2	No Legal Prescription for Date of Service	\$193.99	\$0.00	\$193.99	<p>This claim is for Atorvastatin Calcium (Lipitor), used to treat high cholesterol, and to lower the risk of stroke, heart attack, or other heart complications in people with type 2 diabetes, coronary heart disease, or other risk factors. This 61-year-old with a history of hyperlipidemia, congestive heart failure secondary to alcohol, atrial fibrillation, hypertension, osteoarthritis, obesity, and chronic obstructive pulmonary disease, was residing in a convalescent home (SNF-B). Admission orders, as well as a progress note from three days prior to the date of service, are present; however, the pharmacy could not produce a paper or electronic prescription for the medication (PH2 error). Numerous delivery reports from the pharmacy to the convalescent home are present, however, the only ones that are signed are from after the date of service; those which would pertain to the prescription in question are not signed (PH1 error). Lab results from one month are also present, noting cholesterol levels, including HDL and LDL, which are all therapeutic to low (cholesterol 96, HDL 24, LDL 49). There is no notation on the lab results report or in the progress note from the following month commenting on these values. The patient may have been prescribed atorvastatin as a lipid lowering agent and/or as an adjunct for treatment of cardiovascular disease, but this is not apparent in the progress note or admitting orders. Because of the patient's diagnosis of hyperlipidemia and the lack of documentation surrounding the lower cholesterol levels, an MR2A error for poor documentation is assigned. For this claim, this error was calculated as the total amount paid.</p>
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0448	Pharmacy	MR2A	Poor/Insufficient Documentation	\$141.64	\$0.00	\$141.64	<p>This claim is for a prescription for adult sized briefs, size large, for a 34-year-old resident of a group care home with severe mental retardation and incontinence of bladder and bowel. The prescription is for 216 briefs for a 27-day period, which is the Medi-Cal quantity limit. However, there were 3 variations of the physician signature: from the prescription, from a home visit note, and from a signature on a progress note. There is a signed Certificate of Medical Necessity (CMN) from the patient's physician from the same calendar year as the date of service; the CMN indicates that 7 briefs are needed per day. The pharmacy has a copy of the medical indications for the briefs, and for how often the briefs are to be changed (prn). Medical necessity is demonstrated by the CMN and the pharmacy records, though the physician's progress note just prior to the date of service does not specifically discuss incontinence. There is a signature log from the pharmacy, indicating the delivery and receipt of the briefs. However, the quantity delivered is listed as 3, for a total amount of 143.07. In parentheses is the number 47.69, which likely indicates that the briefs were delivered and received in 3 boxes, at 47.69 each. But there is no indication on the delivery ticket of the absolute number of briefs delivered and received. Therefore, an MR2A error is assigned, as no other error code seemed to apply. In addition, a P9C error is assigned because the business had changed location. For this claim, the error was calculated as the total amount paid.</p>
0449	Pharmacy	MR2A	Poor/Insufficient Documentation	\$4.00	\$0.00	\$4.00	<p>This claim is for Cephalexin or Keflex, an antibiotic. The order is for cephalexin 500 mg tid x 10 days, no refill. The electronic prescription gave the last name and not the title of the prescribing Physician Assistant (PA); on the pharmacy label the PA was identified as an MD. The patient was a 49 year-old who presented with pain at the right great toe, history of gout, and recent fracture of the second toe following dropping a weight on that foot. On exam the PA found a small degree of redness and tenderness in the vicinity of the great toe. Presumably the Keflex was for the</p>

							possibility of infection, but this was not stated in the note; the assessment consisted of “gout.” This error was calculated as the total amount paid for this claim.
0455	Pharmacy	MR1	No Documents Submitted	\$171.09	\$0.00	\$171.09	This claim is for Montelukast Sodium (Singular), a medication used for the treatment of symptoms of allergies. The prescribed amount was 30 tablets; the pharmacy dispensed 28, with no documentation of an explanation or authorization for the change. The referring physician, self-reported as a psychiatrist on the California Medical Board website, provided no medical records to support medical necessity for this medication. The error is calculated as the total amount paid for this claim.
0467	Pharmacy	MR1	No Documents Submitted	\$163.31	\$0.00	\$163.31	This claim is for blood sugar diagnostics. No errors found with the pharmacy. Medical necessity could not be determined due to no documentation available to review. The error is calculated as the total amount paid for this claim.
0468	Pharmacy	PH10	Other Pharmacy Policy Error	\$21.71	\$0.00	\$21.71	This claim is for lancets for a pregnant female with type 2 diabetes. This supply of lancets was mailed to the wrong address and returned to the pharmacy. It was re-sent over a month later, along with another supply. The item was medically necessary, however, it was not provided in a timely manner, the claim was not reversed as required, and an over-supply resulted when the refill schedule was not adjusted. The error is calculated as the total amount paid for this claim.
0478	Pharmacy	PH10	Other Pharmacy Policy Error	\$8.45	\$0.00	\$8.45	This claim is for Loratadine, which is used to treat the symptoms of allergies, such as sneezing, watery eyes, and runny nose. This 69 year-old lives in assisted living and was seen for allergic rhinitis. In assisted living, medications are often filled according to a set cycle. The documentation establishes medical necessity for the service claimed. However, the prescription was written for 30 pills and initially only 21 were dispensed; 30 pills were dispensed 15 days later, and then on a monthly basis. This error was calculated as the total amount paid for this claim.

0482	Pharmacy	PH2	No Legal Prescription for Date of Service	\$173.90	\$0.00	\$173.90	This claim is for Dexlansoprazole, a proton pump inhibitor. It decreases the amount of acid produced in the stomach and is used to treat conditions such as heartburn caused by gastroesophageal reflux disease (GERD). The pharmacy did not have copies of the order or any documentation regarding dispensing this medication. One-month prior, the referring practitioner prescribed 120 tabs, no refill; only 30 were dispensed. This error was calculated as the total amount paid for this claim.
0485	Pharmacy	PH10	Other Pharmacy Policy Error	\$3.15	\$0.00	\$3.15	This claim is for Calcium Carbonate, necessary for many normal functions of the body, especially bone formation and maintenance. This medication was a program benefit at the time of the dispensing at the dosage of 500 mg calcium (1250 mg of calcium carbonate). Although #60 tablets were prescribed as a one-month supply, #180 were dispensed. No authorization for this change was provided. The error is calculated as the total amount paid for this claim.
0489	Pharmacy	MR2A	Poor/Insufficient Documentation	\$12.66	\$0.00	\$12.66	This claim is for Fluconazole, an antifungal medicine. It is available to Family PACT beneficiaries for the treatment of vaginal candidiasis, commonly referred to as yeast infection. The prescribing provider's documentation does not have pertinent history or pelvic exam (patient refused) but vaginitis is check-marked as a diagnosis. The clinic is no longer open. The prescription was not written on a tamper resistant prescription pad as required. For this claim, the error was calculated as the total amount paid.
0492	Pharmacy	MR2A	Poor/Insufficient Documentation	\$1,134.70	\$0.00	\$1,134.70	This claim is for Quetiapine Fumarate (Seroquel), for the treatment of schizophrenia. The pharmacy records were reviewed. No errors were found except there was no referring provider listed on the claim (WPI-B, Compliance error). Medical documentation from the prescriber is poor, with no justification for use of the prescribed medication other than the diagnosis from the previous office visit. (MR2A error for the prescriber). The error is calculated as the total amount of the claim.

0498	Pharmacy	MR2A	Poor/Insufficient Documentation	\$8.61	\$0.00	\$8.61	This claim is for low dose Aspirin (ASA). The nurse practitioner's name was not listed on the prescription. The documentation did not contain a clear indication for prescribing the ASA; side effects are possible. The error is with the referring/prescribing provider. The error is calculated as the total amount paid for this claim.
0500	Pharmacy	PH2	No Legal Prescription for Date of Service	\$15.65	\$0.00	\$15.65	This pharmacy claim is for Warfarin in a 52-year-old woman with a closed head injury dating back to 2004, residing in a long term care facility. She is noted to have a carotid cavernous sinus fistula, requiring anti-coagulation. The original prescription does not appear to be present in the file; the only prescription present is dated one month after the date of service. The error is calculated as the total amount paid for this claim.
0514	Pharmacy	MR1	No Documents Submitted	\$9.00	\$0.00	\$9.00	This claim is for Chlorpheniramine, an antihistamine used to treat symptoms caused by allergies or the common cold. The pharmacy had all the required documentation. The referring provider did not respond to attempts to locate him. The phone was disconnected and the office was locked with no signage. It was not possible to verify medical necessity or script validity. The error is calculated as the total amount paid for this claim.
0517	Pharmacy	MR2A	Poor/Insufficient Documentation	\$9.29	\$0.00	\$9.29	This claim is for Docusate Sodium (Colace), a stool softener. The pharmacy produced documentation of a valid prescription, appropriate label, and signature of receipt by the beneficiary. No error on the pharmacy. There was no documentation by the prescribing practitioner to indicate the reason for prescription. The patient has a history of neck and back pain but is not on narcotics to justify the Colace. Although this is an over-the-counter medication, the documentation does not support the order for dispensing. This error was calculated as the total amount paid for this claim.

0533	Pharmacy	PH10	Other Pharmacy Policy Error	\$8.28	\$0.00	\$8.28	This claim is for Sulfamethoxazole/Trimethoprim 800/160 mg, a combination medication that treats different types of infection. It is available to Family PACT beneficiaries for the qualifying diagnosis of urinary tract infection, with the restrictions of 6 tablets per dispensing and one dispensing in 15 days. The prescriber ordered 12 pills by telephone; the pharmacy split the quantity and filled twice within 15 days without a TAR: 6 tablets on the first date and 6 tablets just four days later. The referring provider documentation did not document any reason for prescribing the medication, although urine tests were ordered in the same timeframe. This error was calculated as the total amount paid for this claim.
0537	Pharmacy	PH7B	Prescription Split	\$39.06	\$0.00	\$39.06	This claim is for Hydroxyurea, which is used in the treatment of certain neoplastic diseases and sickle cell disease. This beneficiary has sickle cell disease and was seen in clinic. The original prescription for this medically appropriate medication was for a quantity of 90 pills; the prescription had 2 refills. The pharmacy split the prescription and dispensed only 30 pills at a time, including on the date of service. The patient name on the medical records and prescription was different than the name on the Medi-Cal CDR and MPES summary of the claim. The reason for the discrepancy is unclear. This error was calculated as the total amount paid for this claim.
0541	Pharmacy	PH5	Wrong Information on Label	\$98.29	\$0.00	\$98.29	This claim is for Risperidone, an atypical antipsychotic. Risperidone has been used to treat this 55-year-old patient at a dosing schedule of 1 mg per day, #30 per month. Several renewals with failure to pick up are documented by the pharmacy. A signature log was not available and the pharmacy's system could not reproduce a label. The office visit prior to the date of service was three months earlier. The note was poorly legible; however, overall documentation by the referring physician verified medical necessity. The error was calculated as the total amount paid for the claim.

0544	Pharmacy	PH7B	Prescription Split	\$10.00	\$0.00	\$10.00	This claim is for Diphenhydramine, an antihistamine. The patient is a 77 year-old who lives at home. The patient has Medicare and Medi-Cal coverage, but this claim was not covered by Medicare. The original prescription was an electronic prescription; the claim represented a refill. The prescription was for "Benadryl 25 mg tabs, quantity 120, take one (1) tablet by mouth twice a day. Refs: 3." Although the quantity ordered was #120, #60 capsules were dispensed. Per the Pharmacist In-Charge (PIC), they dispensed #60 because medications were packed in a blister pack. The PIC reminded the physician multiple times to change the order from #120 to #60, but the physician kept on ordering #120. Medical records support the need for the medication. For this claim, the error was calculated as the total amount paid.
0554	Pharmacy	MR2A	Poor/Insufficient Documentation	\$105.69	\$0.00	\$105.69	This claim is for blood sugar diagnostics, the fourth refill of a prior prescription. Essential information was missing on the label/prescription (PH3 error), and there was no signature log (PH1 error). The documentation received from the referring provider's place of business did not include a corresponding office visit note and did not contain a plan of care for diabetes or a mention of the need for these supplies (MR2A error). For this claim, the error is calculated as the total amount.
0570	Pharmacy	MR1	No Documents Submitted	\$46.79	\$0.00	\$46.79	This claim is for 100 blood sugar diagnostic test strips. Used as ordered, 100 strips should have lasted about 33 days. Claims were submitted for 100 strips four times in the 3 months preceding this claim. This exceeds the prescribed amount by over 100 strips. The referring physician retired and current staff of the clinic from which his prescription originated would not provide medical records to support medical necessity. The error is calculated as the total amount paid for this claim.

0571	Pharmacy	MR5	Medical Necessity Error	\$144.07	\$0.00	\$144.07	This claim is for disposable liners/diapers/shield/pad and adult size pull-ons. The pharmacy faxes an annual order for incontinence supplies to the physician. The physician signs the refill order and faxes it back to the pharmacy. There is no documentation in the medical record regarding these supplies. Medical necessity for the supplies is not documented. The error is calculated as the total amount paid for this claim.
0577	Pharmacy	PH3	Prescription Missing Essential Information	\$92.07	\$0.00	\$92.07	This claim is for Fluticasone Propionate (Flonase Nasal Spray), a medication used to treat allergic rhinitis. The pharmacy documented a telephone prescription with Nasonex NS crossed out and replaced with Flonase. The telephone prescription did not identify the name of the person calling in the prescription or that the change was approved by the prescriber. The referring physician's record documented a discussion with the beneficiary's father about starting Flonase and added Nasonex to the medication list, suggesting intent to prescribe, but did not document symptoms, physical exam findings, a past medical history, or diagnosis that would support medical necessity. The error is calculated as the total amount of the claim.
0587	Pharmacy	MR5	Medical Necessity Error	\$77.61	\$0.00	\$77.61	This claim is for Hydrocodone-Acetaminophen 10-325 (Norco), a medication used to relieve moderate to severe pain. There is no error with the pharmacy claim. The medical record documents the physician's order for the medication on a round-the-clock dosage schedule, citing chronic pain in the order. The medical record documentation does not support medical necessity. The physician's note does not mention a history of chronic pain or a condition that would reasonably be expected to cause chronic pain requiring continuous medication. The error is calculated as the total amount of the claim.

0598	Pharmacy	MR2A	Poor/Insufficient Documentation	\$162.12	\$0.00	\$162.12	This pharmacy claim is for Lexapro in this 29 year-old with an apparent history of depression and chronic pain. The beneficiary is prescribed Ambien (for insomnia, per the prescription), Wellbutrin (for anxiety, per the prescription), Ultram, and Percocet. The chart documents a history of depression and chronic pain/artralgias at many sites. There is no further characterization of either diagnosis, other than a mention of an assault with minor injuries five days before the date of service. The physical exam consists of vital signs, a skin exam and a psychiatric exam ("attitude not uncooperative; affect abnormal"). There is no assessment of the beneficiary's depression or chronic pain, and how either might be improving or not, on the refilled medications. An MR2A error for poor documentation is assigned. All pharmacy data is supportive of the claim. The error is calculated as the total amount paid for this claim.
0606	Pharmacy	P7	Ineligible Recipient	\$10.21	\$0.00	\$10.21	This claim is for lancets, which are disposable medical supplies used by diabetics to obtain drops of blood for checking blood sugars. In beneficiaries who are not on insulin, Medi-Cal restricts the supply of lancets without prior authorization to no more than 100 in a 90-day period. This beneficiary uses only oral medication; following the physician's instructions would require 1-2 lancets per day. For the 90 days prior to and including this date of service, the beneficiary received 300 lancets. The medical record contains no justification for the quantity of lancets supplied and no record of request for prior authorization. This beneficiary has Medicare. For beneficiaries eligible for Medicare, the provider must bill Medicare prior to billing Medi-Cal. The overreaching issue, however, is that the patient has a Nevada address to which the provider ships the supplies. Out of state residents are not eligible for Medi-Cal. The error is calculated as the total amount paid for this claim.

0616	Pharmacy	PH2	No Legal Prescription for Date of Service	\$9.87	\$0.00	\$9.87	This is a pharmacy claim for a refill of Pyridoxine. A refill request showing filling of the prior prescription is present, but the original prescription could not be produced (PH2 error). The beneficiary resides in a long term care facility. There are three prescription receipt logs, one for the date of service and two for the weeks after the date of service, but none have the medication on the claim listed (PH1 error). There is no discussion of this medication in the progress notes supplied (two prior to the date of service and one after the date of service). There is no notation of the refill in any type of chart note. The beneficiary may have been on the medication long term, but the start date of the prescription is unknown because the original prescription was not supplied. An MR2A error is assigned for the lack of documentation in the chart regarding the medical necessity of the medication and its refill. For this claim, error was calculated as the total amount paid.
0619	Pharmacy	MR2B	No Documentation	\$93.89	\$0.00	\$93.89	This claim is for Levonorgestrel plus Ethinyl Estradiol, an oral contraceptive. The pharmacy had documentation to support the claim, except for the signature log, which was in storage and staff were unable to locate it (PH1 error). The referring provider did not have supporting documentation (MR2B error). The error is calculated as the total amount paid for this claim.
0620	Pharmacy	PH7B	Prescription Split	\$273.95	\$0.00	\$273.95	This claim is for Erythromycin Ethyl Succinate suspension (EES), an antibiotic being used for management of intestinal bacterial overgrowth. The physician prescribed 400mg/5ml suspension 100 ml, take 0.75 ml orally twice a day. The pharmacy dispensed EES 200mg/5ml 100 ml, take 1.5 ml via G-tube twice a day, without obtaining approval from the physician for the changes in concentration and route of administration. Also, the pharmacy dispensed a 33-day supply instead of the 67 days as prescribed. For this claim, the error is calculated as the total amount.

0626	Pharmacy	MR2B	No Documentation	\$14.89	\$0.00	\$14.89	This is a claim for Carbamazepine, a medication used to treat various conditions, such as seizure disorder, nerve pain due to trigeminal neuralgia and diabetic neuropathy, and bipolar disorder. No medical records could be obtained. The referring provider stated there were no records for that date of service or the preceding month for said patient. Medical necessity could not be verified. From the standpoint of the pharmacy service, there was no signature for the pickup of the medication. For this claim, the error is calculated as the total amount paid.
0630	Pharmacy	PH5	Wrong Information on Label	\$9.99	\$0.00	\$9.99	The claim is for Amlodipine Besylate (Norvasc), a long-acting calcium channel blocker used to lower blood pressure and to treat other cardiovascular conditions. This was a telephone prescription from the physician. It was for 10 mg, one q pm, #90. Directions on the label of the prescription read, "one tablet by mouth two times a day, #60." The pharmacy claim shows that #90 were dispensed for the date of service and then again approximately three months later, suggesting the patient was taking the medication as indicated on the ordering prescription. The prescriber documentation was extremely difficult to read, but no notation of the telephone order was found. This error was calculated as the total amount paid for this claim.
0632	Pharmacy	MR2A	Poor/Insufficient Documentation	\$10.69	\$0.00	\$10.69	This is a claim for Loratadine, an antihistamine used to treat the symptoms of allergies. No errors were found in the pharmacy documentation. The prescribing physician has no documentation explaining why the prescription was given to this patient. There was no documentation regarding allergies. This error was calculated as the total amount paid for this claim.
0634	Pharmacy	PH10	Other Pharmacy Policy Error	\$261.71	\$0.00	\$261.71	This claim is for pediatric nutrition with iron. The pharmacy did not dispense exactly what was ordered. The order specifies Vanilla. The prescriber on the claim does not match the prescriber on the prescription. The prescription number is missing in the pharmacy records. The services provided were medically necessary, consistent with diagnosis and

							generally accepted medical standards. The error is calculated as the total amount paid for this claim.
0635	Pharmacy	MR5	Medical Necessity Error	\$182.07	\$0.00	\$182.07	This claim is for adult size briefs, disposable underpads, and a reusable waterproof bed sheet for an adult diagnosed with autism. The DME supplier's order for the items lists qualifying diagnoses and verifies medical necessity, but is signed by the referring physician one week after the date of service. There is no notation of a verbal or telephone order. The most recent note by the referring provider, dated a little over two months prior to the date of service, indicates no problem with incontinence in the review of symptoms. Medical necessity for these items is not supported. The error is calculated as the total amount paid for this claim.
0642	Pharmacy	MR2B	No Documentation	\$12.40	\$0.00	\$12.40	This claim is for Penicillin V Potassium, an antibiotic, for a 57-year-old beneficiary. The claim involves a refill that was dispensed approximately three months after the original prescription was written. It was not possible to determine medical necessity due to lack of documentation in the timeframe of the refill. This error was calculated as the total amount paid for this claim.
0644	Pharmacy	MR5	Medical Necessity Error	\$11.78	\$0.00	\$11.78	This claim is for Clotrimazole, an antifungal cream commonly used in the treatment of topical fungal infections. This medication is available for purchase without a prescription, but requires a physician's prescription for Medi-Cal reimbursement. The pharmacy records included a telephone order for the medication without an order for refills (which was filled the month prior to the date of service of this claim) and a refill authorization request with the prescribing physician's name printed on it. The prescribing physician's office receptionist stated that she entered the physician's name on the authorization for refill, but neither she nor the pharmacy noted that the refill was transmitted by someone other than the named prescribing physician. Review of the prescribing physician's records contained no copy of the original prescription and no mention of a localized fungal infection in the documentation of the history or physical exam for the 3 office visits prior to the

							prescription refill, although the prescription was refilled on a monthly basis for the 6 months up to and including the date of service on the claim. No medical necessity is documented. The error is calculated as the total amount paid for this claim.
0645	Pharmacy	PH2	No Legal Prescription for Date of Service	\$7.67	\$0.00	\$7.67	This claim is for Sulfamethoxazole-Trimethoprim, used to treat infections. In this case, it was a discharge medication for a patient who had been hospitalized with cellulitis. Apparently the prescription had been submitted as an electronic order. The hospital pharmacy was unable to produce a copy of the prescription and instead provided a discharge medication list, which did include this medication but did not include the elements of a valid prescription, such as the signature of the prescribing practitioner. Additionally, on the claim the prescription number did not match the label number; no rendering provider was listed, and the referring provider was not the correct physician. The error is calculated as the total amount paid for this claim.
0646	Pharmacy	PH10	Other Pharmacy Policy Error	\$570.44	\$0.00	\$570.44	This claim is for Cyclophosphamide, a medication that interferes with the growth and spread of certain types of cancer cells in the body. The prescriber failed to sign the prescription. The pharmacy dispensed this drug and it was administered to the patient at the physician's office. As required, the drug should have been claimed by the physician, and not the pharmacy. Reimbursement to the physician may have been different. The Oncology progress notes were not signed. This error was calculated as the total amount paid for this claim.
0647	Pharmacy	MR1	No Documents Submitted	\$198.36	\$0.00	\$198.36	This claim is for slow release Oxycodone, an opioid used to treat moderate to severe pain that is expected to last for an extended period of time. This medication has high risks of overdose, addiction and diversion for other than intended use. The written prescription noted a diagnosis of neuropathic pain secondary to spinal cord injury not effectively treated with lower risk medication. The referring physician's office refused to provide records, so the claim is unsupported due to lack of cooperation from the referring

							provider. The error is calculated as the total amount paid for this claim.
0654	Pharmacy	PH7B	Prescription Split	\$13.16	\$0.00	\$13.16	This claim is for Hydrocodone/Acetaminophen, a narcotic used for relief of moderate to moderately severe pain. The medical record documents a fractured thumb and avulsed tendon to support medical necessity. There is a Code 1 restriction for quantities over #30 of this medication without obtaining TAR approval; #90 tablets were ordered. The pharmacy did not obtain a TAR and dispensed #30. Two months later the pharmacy dispensed another #30. The pain medication quantity ordered seems high and the patient also received prescriptions for Tylenol with codeine and ibuprofen. Review of this prescriber's patterns of opioid prescribing may be warranted. The error is calculated as the total amount paid for this claim.
0656	Pharmacy	PH2	No Legal Prescription for Date of Service	\$7.59	\$0.00	\$7.59	This claim is for low dose Aspirin. The pharmacy dispensed a refill for a prescription with no refills ordered. The name on the label was different than the prescribing physician. The services provided were medically necessary, consistent with diagnosis and generally accepted medical standards. The error is calculated as the total amount paid for this claim.
0660	Pharmacy	P7	Ineligible Recipient	\$10.23	\$0.00	\$10.23	This claim is for Doxycycline Hyclate, a tetracycline antibiotic, prescribed for a patient with bronchitis. The patient has AID Code 8H, which covers family planning program services only: treatment with this antibiotic is restricted to diagnoses involving sexually transmitted infections. Therefore, in this case doxycycline was not a covered benefit. This error was calculated as the total amount paid for this claim.

0662	Pharmacy	MR2A	Poor/Insufficient Documentation	\$9.04	\$0.00	\$9.04	This claim is for Amoxicillin, an antibiotic, prescribed to a beneficiary with a vaginal discharge identified as postmenopausal or bacterial vaginosis (BV, an imbalance in the normal bacteria found in the vagina), and possible urinary tract infection (UTI). At the same visit the referring provider wrote a prescription for another antibiotic, metronidazole, which alone would be adequate treatment for BV. Amoxicillin is not a first line medication for UTI, and so its medical necessity is in doubt. The patient has had chemotherapy and radiation although details are not well documented; these factors could contribute to symptoms of vaginitis/susceptibility to infection. The error is calculated as the total amount paid for this claim.
0664	Pharmacy	PH10	Other Pharmacy Policy Error	\$95.54	\$0.00	\$95.54	This claim is for Benazepril Hydrochloride, an antihypertensive medication for an 88-year-old. A prescription from one month earlier covers the date of service and was issued by the prescribing provider as documented in the medical record. The pharmacy maintained dispensing records which supported the claim; however, there was no documentation that the prescription filled on the claim date was ever received (PH1 error). At the same time, the prescription Pick Up log revealed an unexplained discrepancy in that a prescription filled several months later was documented as picked up by the beneficiary's son on the date of this claim (Other error). For this claim, the error is calculated as the full amount.
0665	Pharmacy	PH10	Other Pharmacy Policy Error	\$14.00	\$0.00	\$14.00	This claim is for Fluconazole, a medicine used to treat or prevent fungal infection. In this case, the patient had a history of rheumatoid arthritis and had been on methotrexate, but methotrexate was being held in anticipation of pregnancy, and fluconazole was prescribed for vaginitis consistent with candidiasis (yeast infection). In the general Medi-Cal population, the Provider Manual restricts the use of fluconazole to treatment of patients with cancer, HIV, and coccidioidomycosis (Valley fever) unless a TAR is obtained. This beneficiary did not have a

							qualifying diagnosis and a TAR was not obtained. This error was calculated as the total amount paid for this claim.
0669	Physicians	MR7	Policy Violation	\$67.08	\$0.00	\$67.08	This claim is for miscellaneous drugs and medical supplies and use of an operating room. The provider gave a patient Botox A injections and spent 40 minutes counseling the patient. The provider incorrectly billed for an operating room rate while counseling. This error was calculated as the total amount paid for this claim.
0670	Physicians	MR7	Policy Violation	\$5.53	\$0.00	\$5.53	This claim is for measurement of blood oxygen level during a routine child exam of an 11-day old infant. The infant was noted as "doing well," and no reason was documented for measurement of oxygen saturation. This code is only reimbursable to physicians when no other services are billed. A well child visit was completed and claimed for the same recipient and date of service. This error was calculated as the total amount paid for the claim.
0676	Physicians	MR2A	Poor/Insufficient Documentation	\$45.43	\$32.71	\$12.72	This claim is for the Family PACT services of office visit, pregnancy test, and education. Documentation supports the office visit and pregnancy test, including medical necessity. However, documentation in the record is poor regarding education code Z9751. The error is calculated as the amount that was paid for code Z9751.
0678	Physicians	MR2B	No Documentation	\$50.75	\$47.12	\$3.63	This claim is for an office visit for a 20-year-old established patient, urine pregnancy test, and handling of specimen. The documentation supports the level of care for the office visit and the urine pregnancy test. However, the handling of specimen code 99000 was not justified since there was no indication blood was drawn and transported to the lab. The error is calculated as the amount that was paid for specimen handling.
0681	Physicians	MR2B	No Documentation	\$49.79	\$0.00	\$49.79	This claim is for EPSDT: case conference physician/dentist-per case, for a 5-year-old with birth defects, including right ear microtia, aural atresia, and a history of laryngomalacia. The patient is followed up by a combination of physicians considering the complex array of diagnoses. Multidisciplinary notes were evident for this date of service. However, for the rendering provider listed on the claim,

							there were not notes in the record or evidence of participation in the conference. This error was calculated as the total amount paid for this claim.
0693	Physicians	MR4	Unbundling Error	\$734.11	\$427.37	\$306.74	The claim is for iliac revascularization with stent, placement of catheter in arteries, artery x-rays arm/legs, and artery x-rays both vessels. This 58-year-old, with a history of diabetes, cerebrovascular accident with residual right hemiparesis and aphasia, below the knee amputation, and an acute ulcer on 2nd digit of left foot, was admitted from the vascular clinic with leg ischemia for Interventional Radiology stent placement. CPT code 37221 was billed properly. CPT codes 36247, 75710, and 75774 represent unbundled services that per CPT guidelines should not be billed separately. The error is calculated as the difference between the total amount paid for this claim and the amount that the payment would be if coded as one test.
0694	Physicians	MR2A	Poor/Insufficient Documentation	\$121.86	\$0.00	\$121.86	This claim is for dental services, filling a cavity, at an FQHC. Documentation does not show that anesthesia was given for filling a tooth of a child. This error was calculated as the total amount paid for this claim.
0703	Physicians	MR8	Other Medical Error	\$231.36	\$0.00	\$231.36	This 2013 claim is for a Medi-Cal per visit code at an FQHC for a 15 month old with a runny nose and fever. The medical record submitted for the review showed a note for the claimed office visit that was dated with a later date. The clinic staff explained that when DHCS requested the particular visit note for the MPES review, they could not locate the note and a late entry was made. Since there was not a note available at the time of the request, the error is calculated as the full amount of the claim.
0718	Physicians	MR2A	Poor/Insufficient Documentation	\$134.73	\$0.00	\$134.73	This claim is for dialysis in a patient with end stage renal disease. The documentation is scarce. For the date of the claim, lab reports were found but nothing else that suggested a dialysis procedure was performed. The service most probably was medically necessary. This error was calculated as the total amount paid for the claim.

0720	Physicians	MR7	Policy Violation	\$91.59	\$50.98	\$40.61	This claim is for initial newborn per day/hospital & hospital discharge day management: 30 minutes or less, and refers to 2 services. The first claim was for evaluation and management of a normal newborn. This claim was justified by the documentation in the medical record. The second claim was for the second day and was for management of discharge. The medical record at the hospital shows a telephone discharge order and nothing documented for that day. The doctor's assistant at his office stated that they do not keep medical records at the office for deliveries. CPT 99460 was appropriately billed for newborn care. During the same hospital stay, 99238 was also billed for discharge day management. The Medi-Cal Provider Manual specifically states that these two codes cannot be claimed for the same hospitalization. The error is the amount paid for CPT 99238.
0721	Physicians	MR3	Coding Error	\$17.05	\$0.00	\$17.05	This claim is for use of an emergency room, for a patient with limited AID code, pregnancy only. Request was for a refill on her seizure medication only, without notation of emergency condition such as seizure activity or pregnancy complication. This error was calculated as the total amount paid for the claim.
0730	Physicians	P9B	Rendering Provider not Eligible to Bill for Claimed Services/Supplies	\$40.50	\$0.00	\$40.50	This claim is for CPT 99214, office visit for an established patient. The patient is a 5 week-old male being seen for colic. The visit note is handwritten and somewhat difficult to read. Assessment was that of reflux and colic, and plan was to switch to Nutramigen plus institute measures for reflux including Ranitidine. The visit was more consistent with CPT 99213 (MR3 - upcoding). The patient was seen by a physician who has an active medical license but is not a Medi-Cal provider (P9B). On the claim, the rendering provider was incorrectly listed as a different physician, who is a Medi-Cal provider (WPIA). It may be this was done intentionally to circumvent the system. This error was calculated as the total amount paid for this claim.

0735	Physicians	MR2A	Poor/Insufficient Documentation	\$15.33	\$0.00	\$15.33	This claim is for X7722-UD, Plan B Emergency Contraceptive, 1 unit. The patient was seen in a Family PACT clinic. As part of the office visit, Plan B One-Step was prescribed in the quantity of 2. The available paperwork does not show that the prescription was dispensed and the medication received by the patient (MR2A error). The error was calculated as the total amount paid for the claim.
0765	Physicians	MR2A	Poor/Insufficient Documentation	\$152.01	\$0.00	\$152.01	This claim is for Managed Care Differential Rate. Documentation for the service on the date for this claim is insufficient. It does not substantiate a one-hour group nutrition counseling session. The provider documented the date of service in a box on the Medi-Cal Billing Perinatal form and one sentence on the Communication Log, "Pt came in Nutrition classes provided as well as referred to WIC office." There was no start and/or stop time documented as required. Content description was not noted. This error was calculated as the total amount paid for this claim.
0779	Physicians	P5	Pricing Error	\$166.48	\$165.16	\$1.32	This claim is for the Managed Care Differential Rate at an FQHC. This 3 year and 5 month-old was seen for a mouth blister on the upper lip. The service was medically necessary. However, payment does not correspond with the pricing schedule; the reimbursable amount is in error and was greater than the contracted amount. For this claim, the error is the difference between the two figures.
0783	Physicians	MR7	Policy Violation	\$254.89	\$0.00	\$254.89	This claim is for the Managed Care Differential Rate. There is no documentation that indicates there was a qualifying visit. Per the Medi-Cal Provider Manual, a visit is defined as a face-to face encounter between an RHC or FQHC recipient and a physician, physician assistant, nurse practitioner, certified nurse midwife, clinical psychologist, licensed clinical social worker or visiting nurse. This 30 year-old was seen by a technician for performance of an ultrasound. The service is not reimbursable as claimed. This error was calculated as the total amount paid for this claim.
0800	Physicians	P1	Duplicate Item	\$28.62	\$0.00	\$28.62	This is a claim for fit spectacles bifocal, for a 62-year-old. Per the CDR this service was claimed and paid twice. This error was calculated as the total amount paid for this claim.

0801	Physicians	P3	Medicaid Managed Care Organization-covered Service	\$118.81	\$0.00	\$118.81	This claim is for newborn services post C-section. Documentation supports medical necessity. However, the mother is covered by a Managed Care plan and therefore the baby would also be covered. This error was calculated as the total amount paid for this claim.
0816	Physicians	MR7	Policy Violation	\$153.22	\$0.00	\$153.22	This is a claim for an inpatient newborn assessment. One of the requirements of billing an encounter visit code for services provided outside the FQHC is that the patient has to be an established patient of the FQHC. Although services were appropriate and documented, the newborn is not an established patient of the FQHC. Because of this, the clinic has not met criteria for billing for an FQHC encounter. This error was calculated as the total amount paid for the claim.
0825	Physicians	MR2A	Poor/Insufficient Documentation	\$221.38	\$0.00	\$221.38	This claim is for dental services at an FQHC. The provider did not supply radiographs to determine the medical necessity of services rendered. This error was calculated as the total amount paid for this claim.
0831	Physicians	P2	Non-covered Service	\$77.10	\$0.00	\$77.10	This claim is for a Medi-Cal Per Visit Code 01 for a chiropractic service provided to a 10-year-old patient. The chiropractic service provided at the RHC on the date of service claimed was not covered by Medi-Cal (P2 error - non-covered service). The date of service was not within the effective date of the reinstatement of chiropractic services. Per the Medi-Cal Provider Manual, the optional benefit of chiropractic service provided by FQHCs/RHCs was excluded from coverage under the Medi-Cal program effective July 2009. In accordance with the US Court decision, effective for dates of service on or after September 2013, adult dental, chiropractic, and podiatric services are reimbursable Medi-Cal services when provided by FQHCs and RHCs. Other than the chiropractic service not being a covered service, the documentation does not support the definition of an encounter. The nature and extent of the service were not documented. For this claim, the error was calculated as the total amount paid.

0835	Physicians	MR7	Policy Violation	\$6.85	\$0.00	\$6.85	This claim is by an emergency medicine physician for reading a chest x-ray. On the basis of an order by this physician, the x-ray was performed, read, and claimed by the radiology section. In the ER note, the emergency medicine physician included additional chest x-ray findings but a separate report was not generated. Therefore, this supplemental x-ray reading is regarded as part of the ER visit and does not qualify for separate billing. This error was calculated as the total amount paid for this claim.
0839	Physicians	MR2B	No Documentation	\$46.86	\$34.14	\$12.72	This claim is for an office visit for an established patient, ceftriaxone injection, and Family PACT individual education. This 20 year-old was seen for gonococcal pharyngitis and services were medically necessary. Documentation justifies the level of the office visit and that the medication was administered. There is no documentation to substantiate the Family PACT education. The error is calculated as the amount that was paid for the Family PACT individual instruction.
0847	Physicians	MR5	Medical Necessity Error	\$3.58	\$0.00	\$3.58	This claim is for a random glucose measurement. No error on the part of the lab noted, but there is not documentation from the referring provider to medically justify this lab test. The error is calculated as the total amount of the claim.
0861	Physicians	MR2B	No Documentation	\$34.01	\$0.00	\$34.01	This claim is for subsequent hospital care. There is no documentation for the date of service listed on the claim. This error was calculated as the total amount paid for this claim.
0865	Physicians	MR2A	Poor/Insufficient Documentation	\$44.14	\$0.00	\$44.14	This claim is for miscellaneous drugs and medical supplies. The documentation submitted only had a date stamp on it and what appeared to be an OB history. The documentation submitted did not include a procedure note or other reference as to what might be the basis for the claim. This error was calculated as the total amount paid for this claim.

0869	Physicians	MR2B	No Documentation	\$65.46	\$0.00	\$65.46	This is a claim for a sigmoidoscopy with biopsy, along with IV fluids, and lab tests (CMP, CBC, and ESR). This 51-year-old had recently undergone colonoscopy, and colitis had been identified in a segment of the sigmoid colon. The current procedure was a medically necessary planned follow-up. Documentation shows the procedure was performed and IV fluids given. The lab tests were documented as ordered and sent, but no results are available. This error was calculated as the total amount paid for the labs.
0871	Physicians	MR7	Policy Violation	\$2.80	\$0.00	\$2.80	This claim is for prenatal vitamins. The patient was given prenatal vitamins on 2 occasions. The Provider Manual states that there is a 300-day maximum supply allowable per pregnancy. The maximum allowable was exceeded. This error was calculated as the total amount paid for this claim.
0879	Physicians	MR2B	No Documentation	\$12.85	\$0.00	\$12.85	This claim is for 2 x-rays. There is no documentation for the billed service date. It appears that there are duplicate claims. This error was calculated as the total amount paid for this claim.
0892	Physicians	MR2A	Poor/Insufficient Documentation	\$1.72	\$0.00	\$1.72	This claim is for 2 lab tests, a blood cholesterol assay and a syphilis test on a 26-year-old. There are no noted errors with the lab. The medical documentation does not reveal why the two tests were run. The patient presented for an IUD check. Progress notes do not mention why a cholesterol level was ordered or who even ordered it. There were no symptoms noted or other indication as to why the STD test was done. This error was calculated as the total amount paid for this claim.
0902	Physicians	MR2B	No Documentation	\$128.87	\$88.98	\$39.89	This claim is for an office/outpatient visit for a new patient, Family PACT individual education, urine pregnancy test, other contraceptive supplies, and Plan B emergency contraceptive. The Plan B contraception was of uncertain medical necessity based on the documentation. The rendering practitioner was not noted on the claim. Z9751 FPACT individual education was not documented. The error is calculated as the amount that was paid for the individual education services.

0908	Physicians	MR7	Policy Violation	\$14.34	\$0.00	\$14.34	This is a claim for destruction of vulvar warts. The procedure was documented one week prior to the date of service of this claim and reimbursed. The progress note for the date of service describes a normal appearing vulva and perineum with no lesions present after the last treatment. The service documented is a follow-up visit and included in the fee for the original procedure. The error is calculated as the total amount paid for this claim.
0933	Physicians	MR2A	Poor/Insufficient Documentation	\$93.57	\$86.57	\$7.00	This claim is for oral contraceptive medications, other contraceptive supplies (condoms and foam) and State Only Family Planning counseling (SOFP). The encounter and dispensing of oral contraceptives are documented and medically necessary. The record indicates condoms and foam were offered, but does not specify if any were given. The error is calculated as the amount paid only for contraceptive supplies.
0943	Physicians	MR3	Coding Error	\$1,107.20	\$203.45	\$903.75	This claim is for CPT code 63047 (remove spine lamina 1; lumbar) and CPT code 63048 (remove spinal lamina add-on; cervical, thoracic, or lumbar). Per the available medical information, this 82-year old was diagnosed with cervical spine stenosis and underwent cervical rather than lumbar spinal decompressive surgery. The error is calculated as the amount paid for the lumbar surgery code.
0944	Physicians	MR5	Medical Necessity Error	\$17.35	\$0.00	\$17.35	This claim is for a tissue examination by a Pathologist. The source of the specimen is a placenta from a C-section. There is no order by the delivery physician for an examination of the placenta, but there may have been a standing order. In the operative report there is not a reason given for why the placenta should be sent for this examination. The lack of a documented reason for the test renders the exam not medically justified. The error is calculated as the total amount paid for this claim.

0961	Physicians	MR3	Coding Error	\$25.92	\$13.09	\$12.83	This claim is for an 8-year-old child seen by a nurse practitioner (NP) for a brief check before receiving Flumist. There were no past issues or active problems. Claimed at the level of CPT 99213, the service was more consistent with a 99211 visit (MR3 - upcoding). While the NP has a license in good standing and she is enrolled as a Medi-Cal provider, she is not listed on the Medi-Cal Provider Group Application. The CDR identifies the rendering provider as a physician, who presumably is the physician supervisor, but does not show a non-physician medical provider modifier with the CPT code (WPIC). The error is calculated as the difference between the total amount paid for the 99213 visit and the amount that should be paid for a 99211 visit.
0966	Physicians	MR2A	Poor/Insufficient Documentation	\$140.45	\$0.00	\$140.45	This claim is for dental services at an FQHC. Copies of radiographs taken on the date of service were not diagnostic. Medical necessity could not be determined. This error was calculated as the total amount paid for this claim.
0969	Physicians	MR3	Coding Error	\$86.10	\$24.00	\$62.10	This claim is for office/outpatient visit established for a 22-year-old patient. The documentation is for dispensing education for contraceptives. There is adequate documentation for a level 3 visit for family planning, but the visit was coded as a 99214. The error is calculated as the difference between the total amount paid for the 99214 visit and the amount that should be paid for a 99213 visit.
0983	Physicians	MR2B	No Documentation	\$64.47	\$0.00	\$64.47	This claim is for an office consultation in an outpatient hospital. No records were located that would support this claim for CPT 99244, Office Consultation, with the rendering provider or the billing provider. The two contact persons denied that they have the beneficiary on record. Parenthetically, on this same date this beneficiary with Restricted Aid Code 3V was seen in a local emergency room. This error was calculated as the total amount paid for this claim.

1002	Physicians	MR2A	Poor/Insufficient Documentation	\$98.74	\$0.00	\$98.74	This claim is for Medi-Cal Per Visit Code 01 by the FQHC. The patient is a 5-year-old brought to clinic with the problem of infection of bilateral lower legs for 2 days with no fever. The diagnosis of bilateral leg cellulitis was documented. The treatment plan included use of the antibiotic Amoxil and warm compresses. The available documentation does not show evidence that the rendering provider performed a physical examination to support the nature of the presenting problem and basis of the clinical judgment. Per the Medi-Cal Provider Manual, documentation for all RHC and FQHC daily rate encounters must be sufficiently detailed as to clearly indicate the medical reason for the visit. This error was calculated as the total amount paid for the claim.
1026	Physicians	P9A		\$77.62	\$0.00	\$77.62	This claim is for screening mammography. Although the service was medically necessary, the provider has been suspended by the Franchise Tax Board. This error was calculated as the total amount paid for this claim.
1029	Physicians	MR7	Policy Violation	\$212.68	\$0.00	\$212.68	This claim is for prenatal ultrasound, with a detailed fetal anatomical exam and a fetal umbilical Doppler exam. Ultrasound during pregnancy is reimbursable only when used for the diagnosis or treatment of specific medical conditions. The specific medical conditions listed on the claim for these ultrasounds are not supported by clinical documentation in the medical record. The medical record identifies the ultrasound as fetal anatomy evaluation, a routine screening that is not separately reimbursable. There also is a payment issue: the beneficiary paid for the service as a co-pay for a second insurance. If Medi-Cal is accepted as payment, then payment cannot be accepted from the patient and there cannot be balance billing. The patient should have been refunded what she paid for services that were later billed to Medi-Cal. The error is calculated as the total amount paid for this claim.

1035	Physicians	MR7	Policy Violation	\$125.24	\$0.00	\$125.24	This claim is for Medi-Cal Per Visit Code 01 for immunization. The documentation does not support the requirements for billing an encounter. This 6 year-old received ProQuad (vaccine indicated for active immunization for the prevention of measles, mumps, and varicella in children 12 months through 12 years of age). The immunization was administered by a medical assistant. The provider documentation shows a physician ordered the ProQuad and signed electronically. The documentation does not indicate that a face-to-face encounter occurred between this physician and the patient. This error was calculated as the total amount paid for this claim.
1043	Physicians	MR1	No Documents Submitted	\$59.40	\$0.00	\$59.40	This claim is for surgical supplies, miscellaneous. The practice has been closed, and therefore is no longer at the address on the claim. This error was calculated as the total amount paid for this claim.
1048	Physicians	MR3	Coding Error	\$120.27	\$24.00	\$96.27	This claim is for an office/outpatient visit for a new patient. According to the medical record, this patient had been seen in the office prior to this visit and should have been classified as established. Also, the provider listed on the claim is not the one who rendered the services. For this claim, the error was calculated as the difference between the amount paid for the visit at the new patient level and what should have been paid for an established patient at the same level.
1050	Physicians	MR3	Coding Error	\$45.26	\$24.00	\$21.26	This claim is for a level 4 office/outpatient visit (99214). Physical examination and medical decision making did not justify this level of care. The error is calculated as the difference between the total amount paid for this claim and the amount of the next lower level of visit (99213).
1052	Physicians	MR2B	No Documentation	\$6.00	\$0.00	\$6.00	This claim is for oral contraceptive medication for a 31 year-old. There is no encounter data in the medical record for the date of service on the claim. Specifically, there is no documentation to determine medical necessity or to verify the medication was dispensed. The first name of the beneficiary on the claim and the records at the clinic are different, however, the date of birth and other identifying

							information are the same. This error was calculated as the total amount paid for this claim.
1059	Physicians	MR2B	No Documentation	\$142.08	\$0.00	\$142.08	This claim is for Pediatric Intensive Care Subsequent CAT 1. Neonatal and Pediatric Intensive Care Unit global HCPCS Z0100-0108, CCS codes, are reimbursed only for physician services. This 17-year-old patient was admitted to the hospital with cardiomyopathy, decompensated congestive heart failure, and multiple other medical problems. A CCS client, numerous pediatric teams were involved in the care, including infectious disease, cardiology, and critical care services. The two progress notes from that date of service are from cardiology and infectious disease teams, and the records do not show documentation from the physician on the claim on the date of service billed. Assuming an incorrect physician name was not entered on the claim, this represents an MR2B error. The error was calculated as the total amount paid for this claim.
1061	Physicians	MR3	Coding Error	\$28.29	\$0.00	\$28.29	This claim is for a 99214 office visit for an established patient. This 15 year-old with torticollis, cerebral palsy, and cleft palate repair years ago is followed by CCS and Contra Costa Health Plan. No physical exam was recorded; a problem focused history and low complexity medical decision making were documented. The service was medically necessary but upcoded; it should have been billed as a 99212 instead of the 99214. The error was calculated as the difference between the two.
1081	Physicians	MR2A	Poor/Insufficient Documentation	\$90.68	\$0.00	\$90.68	This claim is for two subsequent hospital inpatient days for this 74-year-old with a history of hypertension, atrial fibrillation, and alcohol abuse. The beneficiary's name was spelled differently on the chart and on the claim. The rendering provider's documentation does not support the level of care claimed; it is insufficient and difficult to decipher. This error was calculated as the total amount paid for this claim.

1085	Physicians	MR7	Policy Violation	\$65.26	\$0.00	\$65.26	This claim is for an OB ultrasound on a 29 year-old that underwent medical abortion. This ultrasound was done approximately 1 week after the medical abortion. The code claimed for the abortion is a global code which would include this service. This error was calculated as the total amount paid for this claim.
1100	Physicians	MR8	Other Medical Error	\$69.40	\$0.00	\$69.40	This claim is for a Z1034 antepartum visit. The services provided were medically necessary. There is a progress note, written by a medical resident (who is not yet licensed in California, but who is part of a residency training program). The note has a co-signature, but no additional information. The co-signature is illegible. The physician identified on the claim as the rendering provider is an attending physician in the residency program. An MR8 error is assigned because the rendering provider's identity and role in the care was not clearly identified in the medical record. The error is calculated as the total amount of the claim.
1114	Physicians	MR3	Coding Error	\$45.82	\$24.00	\$21.82	This claim is for an office visit, new patient, seeking Family PACT services. By definition, a new patient is one who has not received any professional service from the physician or another physician in the group of the same specialty within the last three years. This patient had been seen by the same physician within the last 3 years. The error is calculated as the difference between the amount paid for a level 4 new patient visit and the amount payable for a level 4 established patient visit.
1116	Physicians	MR2A	Poor/Insufficient Documentation	\$6.85	\$0.00	\$6.85	This claim is for an x-ray, 1 view frontal, for a 23 year-old in labor. History of PPD reactivity or other pertinent factors are not clear in the documentation. This provider moved to a different location in 2010 and has not reported the move to Medi-Cal. This error was calculated as the total amount paid for this claim.

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
CBAS	Community-Based Adult Services
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