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Status of Medi-Cal Fraud  
Control Initiatives

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Prepared by the  
California Department of Health Care Services  
Audits & Investigations Division

Fiscal Years 2012-13 and 2013-14

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## Executive Summary

The anti-fraud initiatives in this report demonstrate the Department of Health Care Services' (DHCS) continued success in reducing fraud and abuse in the Medi-Cal program. These initiatives establish a positive Return on Investment (ROI) on the resources used to the dollars saved. For Fiscal Years (FY) 2012-2014, the Audits and Investigations (A&I) Division Medical Review Branch (MRB) achieved a Return on Investment (ROI) of **\$5.17** for every \$1 spent on anti-fraud activities.

### Medi-Cal Payment Error Study (MPES)

The MPES systematically studies Medi-Cal's accuracy in paying claims submitted by providers. The MPES assists DHCS in determining the greatest payment-error risk areas within the Medi-Cal program. The study also provides an estimate of potential dollar loss to the program, including potential loss due to fraud, waste, and abuse. The study reviews Fee-for-service (FFS) and dental services only. The MPES for the reporting period is still being prepared.

### Random Claims Review (RCR)

DHCS reviews approximately 120 random provider-submitted claims per week, prior to payment. The RCR process places Medi-Cal providers on notice that all claims are at risk for review. When a claim is selected for review, providers are required to submit documentation to support the claim prior to payment.

### Strengthening the Pre-Enrollment/Enrollment Process

Preventing fraudulent providers from enrolling or re-enrolling in the Medi-Cal program is a key component in the fight against Medi-Cal fraud. DHCS's Provider Enrollment Division (PED) thoroughly reviews all enrollment applications. During this review period, PED reviewed 43,134 enrollment applications from providers seeking admission to the Medi-Cal program. Of the 43,134 applications submitted, PED denied 7,202 applications for not meeting Medi-Cal program requirements.

## Payment Error Rate Measurement Study (PERM)

The federal government mandates that each state complete a PERM review of the Medicaid and Children's Health Insurance Program (CHIP), managed care capitation and FFS payments, as well as eligibility determinations. The Centers for Medicare and Medicaid Services (CMS) administers this review pursuant to the Improper Payments Information Act of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) with the goal of measuring improper payments and calculating error rates.

## Individual Provider-Claims Analysis (IP-CAR) Project

MRB released the first IP-CAR report for 2012 (IP-CAR-Rx) to providers in June 2012. The IP-CAR report is released on an as-needed basis, as it is generated as part of MRB's practice of program integrity. MRB established the IP-CAR project with four goals:

1. Encourage providers to become more conscientious about billing.
2. Give providers peer billing information for self-comparison.
3. Encourage providers to bill accurate diagnosis codes.
4. Educate providers on the technique of performing a self-audit.

## Medi-Cal Managed Care Plan Audits

CMS requires annual medical audits of each contracting Medi-Cal managed care plan, specifically for contract compliance. MRB previously focused on FFS providers, specifically for financial and medical necessity. MRB reviews Managed Care providers for contractual compliance.

## Recovery Audit Contractor (RAC)

The RAC program identifies and corrects improper payments through the efficient detection and collection of overpayments and enumeration of underpayments made to Medi-Cal providers. During 2014, the RAC completed its review of Podiatrists, Optometrists, Speech Therapists, and Ambulance Services provider claims for the years 2011-2014 with no findings.

## Special Investigations Unit (SIU)

In July 2013, the Centers for Investigative Reporting published a three part series of reports in regards to the Drug Medi-Cal program and alleged fraud, asserting that lax oversight left California drug rehabilitation funding vulnerable to fraud. In response, A&I quickly mobilized what became known as the Special Investigations Unit, (SIU) made up of redirected staff to commence targeted reviews of all Drug Medi-Cal Certified provider sites that were actively billing.

The SIU's approach to combating fraud and abuse has been remarkably successful. Over the FY 2013-14, the SIU visited over 275 providers totaling approximately 550 individual sites. As a result of these investigations, approximately 75 providers were suspended due to a Credible Allegation of Fraud (CAF), and approximately 90 CAF referrals to the State Department of Justice (DOJ) were completed. Based on the success of this team, A&I is permanently establishing the SIU and expanding it to include a wide range of programs within DHCS, and no longer limited to the Drug Medi-Cal program.

## Introduction

In 2003, the California Legislature enacted legislation which authorized additional resources and staffing to the DHCS to combat fraud and waste in the Medi-Cal program. Assembly Bill 1765 (Oropeza, Chapter 157, Statutes of 2003) created 161.5 positions, with 154.5 reserved for implementing and expanding DHCS anti-fraud programs and seven (7) positions reserved for program support.

The legislation required DHCS to report results of specific anti-fraud activities to the Legislature. DHCS submitted the report to the chairperson of the Committee on Appropriations and to the chairperson of the Joint Legislative Budget Committee. This report covers the fiscal period from July 1, 2012 through June 30, 2014.

DHCS continues to make strides in reducing fraud, waste, and abuse in the Medi-Cal program. The anti-fraud initiatives in this report include RCR, Expansion and Strengthening of the Pre-Check Write, Expansion and Strengthening of the Pre-Enrollment/Enrollment Process, and ongoing anti-fraud achievements. These initiatives continue to play a significant role in the anti-fraud program.

### Return on Investment (ROI)

MRB calculates ROI based on cost recovery, savings, and avoidance activity during the period July 1, 2012 to June 30, 2014. MRB's program integrity efforts resulted in an average ROI of \$5.17 in savings and avoidance for every \$1 invested in the effort. The table below identifies the ROI for each activity.

Anti-Fraud Activity	ROI	Ratio
Audits for Recovery	\$24.31	1.00:24.31
Field Audit Review	\$6.72	1.00:6.72
Pre-Enrollment	\$10.74	1.00:10.74
Overall ROI	\$5.17	1.00:5.17

The table below shows the cost savings, cost avoidance and Demands.

Cost Savings	Cost Avoidance	Demands
\$86,933,568	\$50,072,856	\$43,996,367

## Anti-Fraud Savings

During FY's 2012-2013 and 2013-2014, the total savings were \$181,002,791

During this reporting period, DHCS continued to achieve significant monthly savings as a result of its anti-fraud initiatives. The table below demonstrates the average savings per each action.

Actions:	Monthly Savings per Action:
Audit for Recovery	\$67,873
Payment Suspension (Withhold)	\$37,972
Temporary Suspension	\$37,972
Procedural Code Limitation	\$28,103
Civil Money Penalty (CMP)	\$25,391
Denied Enrollment	\$83,706

## Production Activity

Production Activity	FY 2012-13	FY 2013-14	Total
Audits for Recovery	177	48	225
Desk Audits	2	2	4
Self Audits	11	54	65
Field Audit Review	263	226	489
CMP Assessments	3	1	4
Post-Enrollment	0	49	49
Re-Enrollment	0	0	0
Pre-Enrollment	579	526	1,105
Random Claims Review	4480	3,716	8,196
Managed Care	2	5	7
Bureau of State Audits	105	0	105
All Other Type Codes	259	5	264
Total	5,881	4,632	10,513

## Actions Taken

Actions Taken	Actions Imposed FY2012-13	Actions Imposed FY 2013-2014	Total
Withholds & Temporary Suspensions	271	186	457
Issued Demands	162	91	253
Post Service Prepayment Audit	28	0	28
Procedure Code Drug Limits	19	3	22
CMP (1 <sup>st</sup> , 2 <sup>nd</sup> , 3 <sup>rd</sup> )	186	91	277
Other	251	0	251

### Key Accomplishments

- MRB recoveries during the reporting periods totaled \$31,790,074.
- MRB issued 504 Demand Letters during the two reporting periods totaling \$43,996,367.

### Expansion and Strengthening of the Pre-Check Write

A&I uses auditing and investigative procedures to monitor the practices and billing activity of providers. Working with the Fiscal Intermediary, A&I monitors abnormal changes in the payments made to providers, such as large payment increases from previous weeks. This process assists in detecting fraudulent schemes and suspicious providers. Using the information gained from monitoring billing activity, A&I staff conducts on-site Field Audit Reviews (FAR) or an Audit for Recovery (AFR) of the identified suspicious providers. As a result of the FAR/AFR, MRB can place an administrative sanction on a provider, or contact the State Controller to stop the payment on a check.

### Medical Payment Error Study (MPES)

The most recently-published MPES is the 2011 study, as the MPES 2013 report is still being prepared. The data analysis and report preparation for MPES 2013 are still on-going. There are 1,117 claims randomly selected for this study; they represent eight major provider types (strata) and are distributed as follows:

- 450 Physician Services claims
- 291 Pharmacy claims
- 87 Local Education Agency (LEA) claims

- 70 Dental claims
- 69 Lab claims
- 50 Durable Medical Equipment (DME) claims
- 50 Inpatient claims
- 50 Other Services claims.

In 2012 DHCS replaced the Adult Day Health Care (ADHC) stratum with Community Based Adult Services, a Medi-Cal Managed Care benefit. In 2013, the ADHC stratum was substituted by the LEA stratum for the MPES 2013 sample.

### Random Claims Review (RCR)

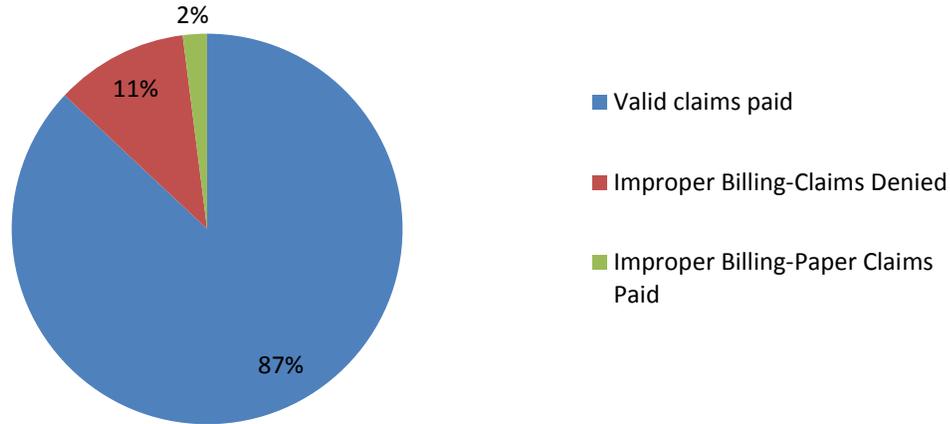
Provider awareness that every claim submitted for payment has some risk of review prior to payment serves as a key element in an effective anti-fraud control strategy. Since August 2012, DHCS randomly selects 120 claims per week for review prior to payment. The RCR facilitates a real-time look into services and trends in Medi-Cal billing. A&I, in cooperation with the Fiscal Intermediary, developed a systematic process for random claim selection. Following claim selection by the RCR process, providers must submit documentation to support the claim prior to payment approval. A&I denies payment for any unsupported claims. A&I continues to improve the process by focusing on claims with the highest potential for error. In addition to preventing improper claims from being paid, staff review results to enhance the case detection and development process. A&I staff tracks billing patterns of the selected providers over time to determine if there is any deterrence factor associated with RCR. Providers with negative RCR outcomes receive in depth evaluations and full scope field reviews may be conducted.

July 1, 2012 – June 30, 2014

- A total of 8,196 claims representing 3,373 unique provider numbers have been reviewed.
- A total of 7,146 claims (87%) were determined to be valid.
- A total of 1,050 claims (13%) were determined to be improper.
- Of the 1,050 claims, 894 claims (85%) have been denied for payment and the remaining 15 % were paid due to being paper claims.
- In order to maintain compliance with section 5001(f) (2) of the American Recovery and Reinvestment Act, paper claims are paid prior

to review and are not subject to the one-week review hold; therefore, DHCS loses the ability to deny these claims. However, after paper claims are paid they are reviewed for potential improper billing and fraud despite our initial inability to deny them. Paper claims constitute approximately 15 percent of the claims received in our sample.

**Results from Random Claim Reviews FY 2012-2014**



### Denied Claims Percentages

The percentages of denied claims are below. DHCS currently defines 15 different reasons for why a claim cannot be verified. DHCS merged several serious, material, or significant reasons into the categories listed above, totaling 86 percent. The remaining less serious reasons represents a very small number of cases, totaling 14 percent. A&I completes an analysis of all RCRs that result in a negative outcome. This resulted in 55 providers with significant errors being referred for further review.

Reasons Claims Deemed Improper for Payment	Percent
Lack of response from the provider	46%
Documentation insufficient to support the claim	16%
Documentation does not support service/product billed	7%
Documentation does not support level/quantity billed	8%
Service not performed	4%
Documentation does not support Medical Necessity	2%
Beneficiary is not provider's patient	3%
Other	14%
Total	100%

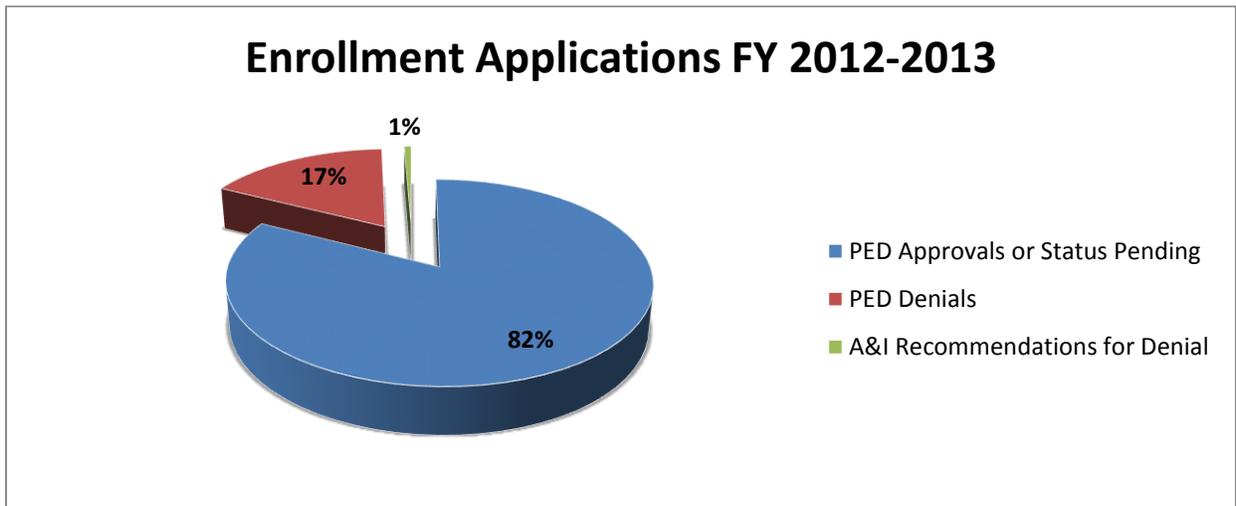
## Strengthening the Enrollment/Pre-Enrollment Process

Medi-Cal's Anti-Fraud enrollment process prevents fraudulent providers from enrolling or continuing enrollment in the Medi-Cal program. PED thoroughly reviews all applications for enrollment. PED uses a number of confidential risk factors to evaluate the information provided on the applications. If an application contains invalid information, PED may deny the application. If an application lacks adequate justification for denial but is graded as high-risk for fraud, it is referred to A&I. A&I performs a more detailed investigation including an on-site review and then makes a recommendation to PED to approve or deny enrollment.

The data below reflects the results of the enrollment process for FY 2012-2013.

- PED received and processed a total of 20,252 Medi-Cal provider enrollment applications. The application types include but are not limited to New Enrollment Applications, Address Change Applications, and Change of Ownership Applications.
- PED denied 3,399 (17%) applications.
- PED determined 966 (5%) applications warranted further analysis and referred the applications to A&I.
- A&I recommended 129 (1%) applications be denied.

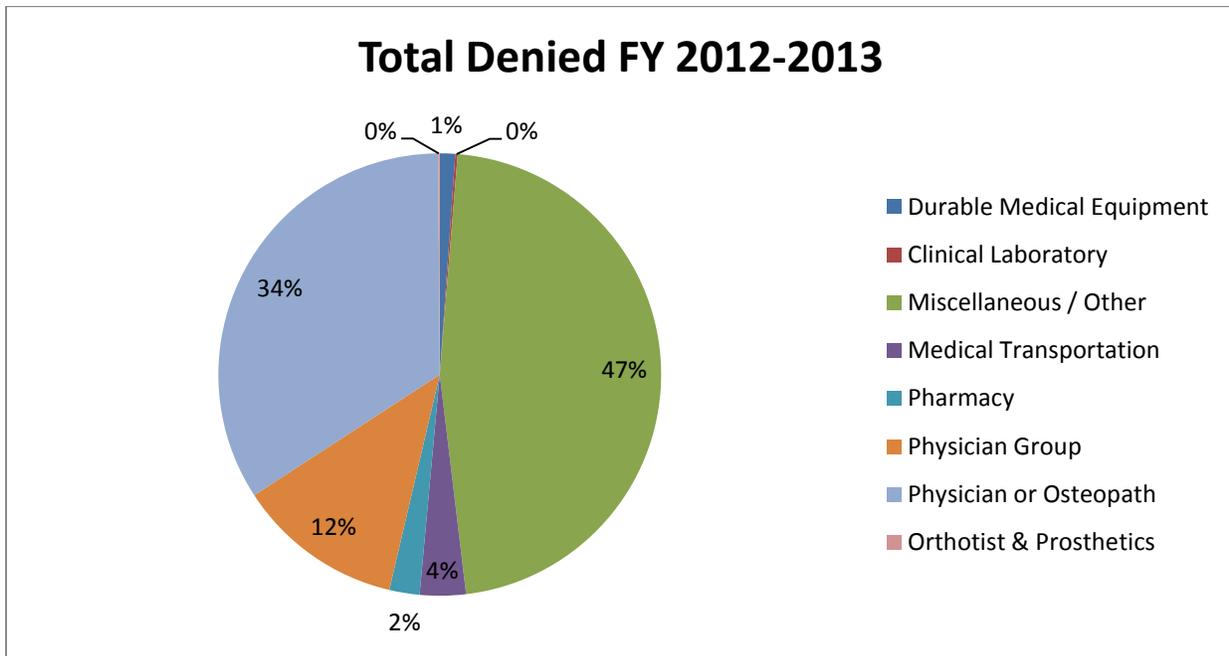
## FY 2012-2013 Enrollment Process Results



Through the combined reviews, PED and A&I denied a total of 3,528 applications (18%), including 26 denials resulting in a three-year debarment. The majority of the applications denied were from physicians, with lower denials for DME, medical transportation, and pharmacy providers. The large proportion of physician denials resulted from: (1) the majority of the applications submitted are from physicians, and (2) there are moratoria in place on DME applications in Los Angeles, Orange, Riverside and San Bernardino Counties and for non-chain pharmacies in Los Angeles County, thus the lower submission rate for these providers. Failure to correct application deficiencies to improprieties found during an on-site review by A&I resulted in several denials. Improprieties range from not meeting Medi-Cal established place of business requirements to ownership structure not being disclosed thoroughly or accurately.

Provider Type	Denied PED	Denied A&I	Total Denied
Durable Medical Equipment	38	6	44
Clinical Laboratory	6	0	6
Miscellaneous / Other	1591	32	1623
Medical Transportation	114	19	133
Pharmacy	75	18	93
Physician Group	413	34	447

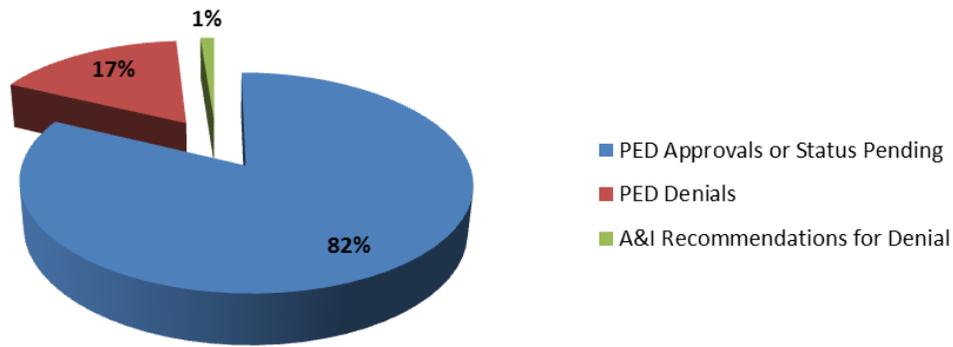
Provider Type	Denied PED	Denied A&I	Total Denied
Physician or Osteopath	1158	20	1178
Orthotists & Prosthetics	4	0	4
<b>Total</b>	<b>3399</b>	<b>129</b>	<b>3528</b>



### FY 2013-2014 Enrollment Process Results

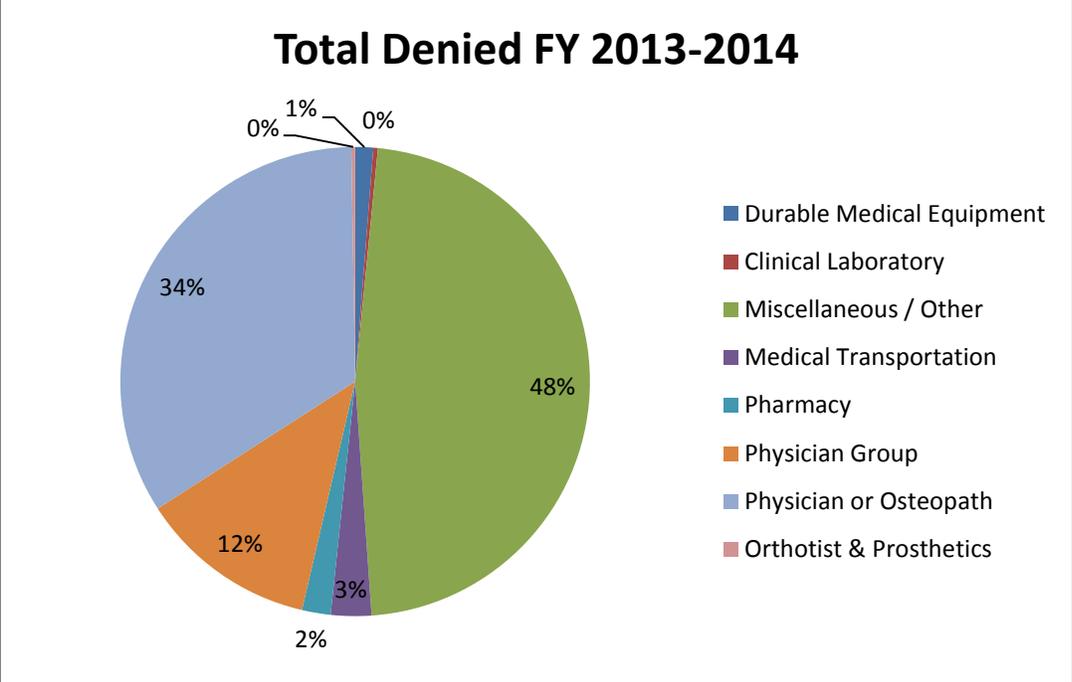
- PED received a total of 22,882 Medi-Cal provider enrollment applications. The application types included, but were not limited to, New Enrollment Applications, Address Change Applications, and Change of Ownership Applications.
- PED denied 3,803 (17%) applications.
- PED determined 870 (4%) of the applications warranted further analysis and referred the applications to A&I.
- A&I recommended 276 (1%) applications be denied.

### Enrollment Applications FY 2013-2014



A total of 4,079 (18%) applicants were denied through the combined reviews of PED and A&I including 29 denials resulting in a three-year debarment. As in the previous fiscal year, the majority of the applications denied were from physicians, with lower denials for DME, medical transportation, and pharmacy providers, for the same reasons.

Provider Type	Denied PED	Denied A&I	Total Denied
Durable Medical Equipment	47	22	69
Clinical Laboratory	12	0	12
Miscellaneous / Other	1800	44	1844
Medical Transportation	106	41	147
Pharmacy	75	19	94
Physician Group	466	92	558
Physician or Osteopath	1287	58	1345
Orthotists & Prosthetics	10	0	10
Total	3803	276	4079



### Re-Enrollment Status – Fiscal Years 2012-2013 and 2013-2014

There were no providers selected to undergo the re-enrollment process for FY 2012-2013 and FY 2013-2014. PED has been unable to accept or participate in any new re-enrollment phases due to the high inventory of pre-enrollment applications. In order for PED to continue to meet the timeliness standards set forth in law, staff has been redirected from the Re-Enrollment Section to focus on the processing of pre-enrollment applications.

However, new program integrity requirements established by CMS under the PPACA require state Medicaid programs to revalidate enrollment of providers at least every 5 years. This includes a requirement that PED revalidate all currently enrolled providers by March 2016. The revalidation requirement compares to our current re-enrollment process. PED is developing an online automated application that will start the process of revalidating providers to meet the new federal requirement.

### Payment Error Rate Measurement Study (PERM)

PERM is a federally mandated review of the Medicaid and CHIP managed care capitation and FFS payments, as well as eligibility determinations. CMS administers this review pursuant to the Improper

Payments Information Act of 2002 (amended in 2010 by the Improper Payments Elimination and Recovery Act or IPERA) with the goal of measuring improper payments and calculating error rates.

CMS calculates improper payments by reviewing all 50 states every three years on a 17-state-per-year rotational basis. The PERM attributes a majority of the Medicaid and CHIP improper payment errors in FY 2013 to state claims processing systems not being fully in compliance with new federal regulations. The table below shows the FY 2013 PERM overall national improper payment error rates for Medicaid and CHIP as reported by the U.S. Health and Human Services in the FY 2014 Agency Financial Report.

Program	FFS	Managed Care	Eligibility
Medicaid	5.1 percent	0.2 percent	3.1 percent
CHIP	6.2 percent	0.2 percent	4.2 percent

California's third PERM review, FY 2013, attributes the majority of FFS findings to the State's payment systems not being in full compliance with new federal regulations; specifically ordering, referring and prescribing provider screening and enrollment. California scored an overall improper payment error rate of 9.72 percent for Medicaid and 2.12 percent for CHIP. The table below illustrates the improper payment error rates by review component.

Program	FFS	Managed Care	Eligibility
Medicaid	11.19 percent	0.0 percent	1.83 percent
CHIP	6.21 percent	0.0 percent	0.49 percent

DHCS and all PERM stakeholders commit to reducing improper payments actively, and to work internally and with CMS to address all error findings through corrective actions.

## Individual Provider-Claims Analysis Report (IP-CAR)

### IP-CAR Project

MRB released the first IP-CAR report for 2012 (IP-CAR-Rx) to providers in June 2012. The IP-CAR report is released on an as-needed basis, as it is generated as part of MRB's practice of program integrity. The first IP-CAR report focused on pediatric drug prescriptions. The number of prescriptions per beneficiary overall, as well as specific categories determined who received reports. Providers with substantially more prescriptions than the norm received reports from MRB describing their prescribing pattern. Some physicians reported that pharmacists erroneously used their National Provider Identification numbers. They were advised to notify the pharmacists to correct the errors. Some providers reported that it was appropriate for their prescribing to rise above the norm due to subspecialty practices. Others called to discuss their reports and volunteered to be more careful about their prescribing in the future.

IP-CAR – The IP-CAR project was on hold FY 2013-14, due to overriding required audits, such as the Medi-Cal Managed Care audits. However, staff will be dedicated to the IP-CAR project in the future.

### Medi-Cal Managed Care Plan Audits

The MRB continues to fulfill its statutorily-mandated responsibility to conduct an annual medical audit of each contracting managed care plan for contract compliance. This requirement has been in place since 1975, but staff was diverted to other priorities in 2010. In 2012, MRB resumed auditing managed care plans. MRB commenced contract compliance audits in December 2012 and has continued them on a rotational basis in coordination with the Department of Managed Health Care (DMHC) survey teams and Managed Care Quality and Monitoring Division (MCQMD) staff. The audit planning, analysis of plan documents, onsite reviews, report writing, and quality review procedures require a minimum of four months to complete.

These annual audits focus on six categories of concern:

1. Utilization Management
2. Continuity of Care
3. Availability and Accessibility
4. Member's Rights
5. Quality Management

## 6. Administrative and Organizational Capacity.

MRB submits the audit reports to the auditee and MCQMD. MCQMD works with the plan to develop the corrective action plan.

Since MRB bases the audits on contractual compliance, they do not result in audits for recovery.

### Recovery Audit Contractor (RAC)

Section 6411(a) of the Patient Protection and Affordable Care Act (PPACA) requires states to establish a RAC. DHCS contracts with Health Management Systems, Inc. (HMS) to act as the RAC for California. The RAC program enables CMS to implement actions that will prevent future improper payments in all 50 states. During 2014, the RAC completed its review of Podiatrists, Optometrists, Speech Therapists, and Ambulance Services provider claims for the years 2011-2014 with no findings.

Specific objectives:

- The RAC identifies overpayments and underpayments and work with DHCS to recoup overpayments and reimburse underpayments.
- The RAC satisfies PPACA requirements and CMS regulations.
- The RAC protects fiscal integrity of the State Medicaid program resulting in reduced expenditure by preventing future improper payments and increased revenue for the State.
- The RAC creates processes for entities to appeal adverse determinations made by RACs.

### Special Investigations Unit (SIU)

In July 2013, the Centers for Investigative Reporting published a three-part series of reports in regards to the Drug Medi-Cal program and alleged fraud, asserting that lax oversight left California drug rehabilitation funding vulnerable to fraud. The report alleged that, over the prior two fiscal years, the program paid \$94 million to 56 drug and alcohol rehabilitation clinics that have shown signs of deceptive or questionable billing. In September 2013, the Assembly Health Committee and Assembly Accountability and Administrative Review Committee held a joint oversight hearing to examine current oversight of the Drug Medi-Cal program by DHCS. In response, A&I

quickly mobilized an SIU team made up of redirected multi-disciplinary staff to commence targeted reviews of all Drug Medi-Cal certified provider sites who were actively billing.

Over the FY 2013-14, the SIU visited over 275 providers totaling approximately 550 individual sites. As a result of these investigations, approximately 75 providers were suspended due to a CAF, and approximately 90 CAF referrals to the DOJ were completed.

The SIU uses a multi-disciplinary team approach to identify and investigate Medi-Cal fraud, waste and abuse using sophisticated data analysis techniques to identify fraud quickly and target resources efficiently, and develops new tools and techniques to identify fraudulent activity by analyzing suspicious patterns in claims data and social linkages. The SIU's approach to combating fraud, waste and abuse has been remarkably successful. Based on the success of this team, A&I is permanently establishing the SIU and expanding it to include a wide range of programs within DHCS, and is no longer limited to the Drug Medi-Cal program. The permanent SIU will consist of multi-disciplinary A&I staff, to include researchers, auditors, medical professionals, and investigators. Since the inception of the original SIU model, A&I identified an additional 12 provider types for the SIU to investigate pervasive, and likely organized, fraud in the Medi-Cal program. In April 2014, DHCS procured a new data analytics system to supplement the SIU efforts by increasing efficiency and reduce workload turnaround on developing fraud leads. This system fundamentally changes the way A&I operates. With a data analytics system in place, A&I receives continuous leads on providers likely to be engaging in fraudulent practices.

### Ongoing Activities

- Electronic Health Record Incentive (EHR) Program – The Medicare and Medicaid EHR Incentive Programs provides EHR incentive payments to eligible professionals and eligible hospitals as they adopt, implement, upgrade, or demonstrate meaningful use of certified EHR technology. DHCS is required to conduct audits of hospitals and professionals who receive EHR incentive payments as a result of the American Recovery and Reinvestment Act of 2011, Eligible professionals and groups are registering to the program. Office of Health Information Technology (OHIT) then approves the release of incentive funds by XEROX. OHIT conducts prepayment reviews for Adopt Implement and Upgrade (AIU). MRB conducted a risk

assessment and is currently auditing eligible professionals and groups for AIU.

- Hospice Share of Cost Self-Audits – MRB did not perform audits upon Hospices prior to 2004 due to the sensitive nature of the Medi-Cal benefit. MRB noticed a dramatic increase in hospice billing in California compared to prior years. Due to this increase, MRB sampled a provider in Los Angeles and found significant billing problems that led to expanding targets throughout California. MRB identified at-risk hospice providers as targets for medical audits and share of cost audits. A multi-disciplinary team performs audit samples one provider at a time, based on a provider's ranking on a billing trend analysis report for the prior three years. MRB's efforts supported DHCS's goal to reduce waste, fraud, and abuse. For the FY 2012-13, 22 audits identified overpayment amounts of \$5,254,787. In FY 2013-14, 80 audits identified overpayment amounts of \$2,937,255.
- Medi-Cal Managed Care Reviews – MRB continues to perform these reviews as required for consistency regarding performance of updated contracts.
- RAC – The scope of RAC will expand to include Physicians, Hospice, Laboratories, and DME provider claims for the years 2012-2014. HMS currently reviews these provider types for overpayments or underpayments and estimates issuing its findings in 2016.