

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

Medi-Cal Payment Error Study

Fee-For Service and Dental
Programs

2005



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EXECUTIVE SUMMARY

Consistent with its continuing efforts to detect, identify and prevent fraud and abuse in the Medi-Cal program, gauge the seriousness of the problem, and develop appropriate fraud control strategies, the California Department of Health Services (CDHS) has completed the second annual Medi-Cal Payment Error Study (MPES). Controlling fraud, waste, and abuse in publicly-funded health care programs requires continuous assessment to monitor emerging trends and inform decisions on the allocation of fraud control resources. Fraud, waste and abuse can have a significant impact on the Medi-Cal program which had an annual benefits budget of approximately \$31 billion in Fiscal Year 2004/05.

The primary objective of the MPES is to identify where the Medi-Cal program is at greatest risk for payment errors. To this end, an estimate of the potential dollar loss due to payment errors, including potential loss due to fraud, waste and abuse is computed. The results of the MPES assist in the development of new fraud control strategies and determine how best to deploy Medi-Cal anti-fraud resources.

Due to the inherent difficulties in measuring payment errors associated with medical claims, very few states have attempted to scientifically determine a percentage of error in their health care program payments.¹ California's MPES is the only study conducted by a state or federal entity that includes an estimate of potential fraud². The identification of risk is critical to guiding the development of fraud control strategies and the allocation of resources to those areas of the Medi-Cal program most vulnerable to fraud, waste and abuse, and more importantly, where Medi-Cal beneficiaries may be at risk of receiving inappropriate medical services, drugs and/or supplies.

CDHS uses findings from the MPES to improve anti-fraud efforts and looks for ways to strengthen the study methodology. The MPES 2004 was the first CDHS study of this type; modifications were made in 2005 to improve the MPES design and review procedures. For example, although the sampling methodology utilized in the MPES 2004 provided statistically valid estimates of the overall dollar error, it was not refined enough to infer statistically valid conclusions of the Medi-Cal program's vulnerability for some strata³. Thus, the MPES 2005 design included some modifications in the sampling. In addition, as is the case with most repeated studies using sampling methods, the review processes involved in MPES 2005 were strengthened from MPES 2004.

¹ Kansas, Texas, Illinois, and Florida are the other states that have conducted payment error rate studies.

² Shortage of resources in terms of both time and money, difficulties involved in scientific measurement and definitional ambiguities are some of the most commonly cited reasons for not conducting such studies.

³ A stratum is defined as a subset of the population of all claims paid in the 4th quarter of the calendar year 2004 and may comprise one or more provider type(s); e.g. "Other Services and Supplies" stratum is composed of Local Education Agencies (LEA), Non-emergency Medical Transportation, Medical Supplies, Home Health etc.

The specific modifications included changes to both the sampling strategy and the claim review process. The sampling strategy changes included an increase in the sample size of claims from 800 in the MPES 2004, to 1,123 claims in the MPES 2005. The sample size increase allowed for inclusion of a minimum of 50 claims from each stratum to ensure that statistically valid conclusions could be drawn. This resulted in the addition of three separate strata for Durable Medical Equipment (DME), Laboratory (Lab) and Adult Day Health Care (ADHC) claims. These three additional strata were identified as the provider types of most concern for fraud, waste and abuse in MPES 2004 and related investigations. The MPES 2004 also identified areas and opportunities where staff conducting the study could be more comprehensively trained to identify errors in a more standardized manner so as to improve study results. Also added to the review process in the MPES 2005 was reviewing for vulnerabilities in the eligibility process for both Fee-For-Service (FFS) and Medi-Cal Managed Care.

The MPES 2005 indicates that 91.60 percent of total dollars paid in the FFS medical and dental programs were billed appropriately and paid accurately. In contrast, 8.40 percent of the total dollars paid had some indication that they contained a provider error, see Figure 1 on the following page. Claim errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided. MPES 2005 again identified insufficient documentation by providers as one of the most significant factors contributing to the overall dollar error. However, the single largest factor in the overall dollar errors in MPES 2005 was the lack of medical necessity for the service provided, which means the documentation showed the services were not medically necessary.

Included in the claim errors are those attributable to compliance issues, i.e., providers failed to comply with one or more required claiming regulations, policies and/or procedures, but based on the examination of other available information, reviewers determined that the services billed were medically necessary and were provided to the patient. The dollars associated with such claims are not considered "at risk" of having been paid inappropriately by the Medi-Cal program.

These compliance errors are a subset (representing 0.97 percent of the total dollars paid) of the 8.40 percentage of payment error. The remaining 7.43 percent represents the percentage of payment error attributable to Medi-Cal program dollars "at risk" of being paid inappropriately. The 8.40 percent equates to \$1.4 billion of the total \$16.8 billion annual payments made for FFS medical and dental services in calendar year 2004. Of the \$1.4 billion in annual payments \$1.25 billion are viewed as being "at risk" of being paid inappropriately. The \$1.25 billion represents payments for claims with errors, such as a lack of medical necessity, abuse, or fraud. It does not include payments for claims with compliance errors.

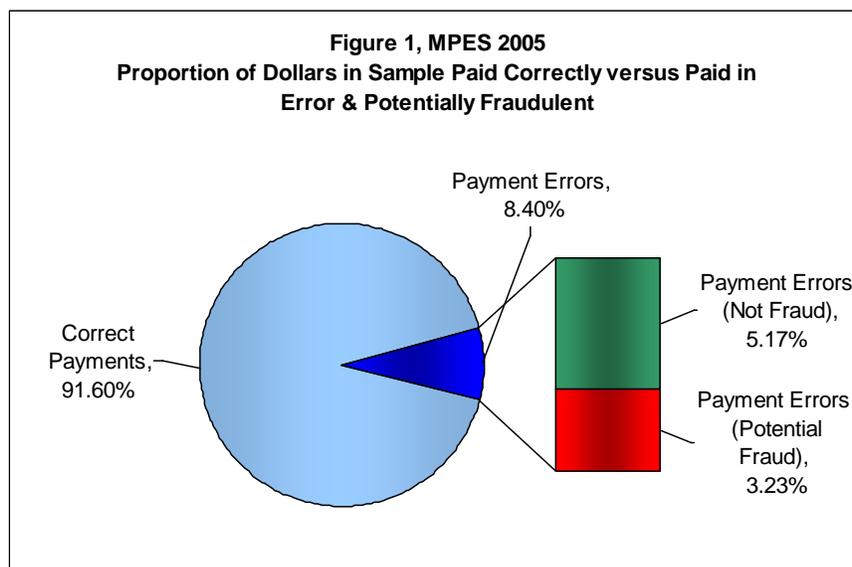
The term "at risk" is used because this dollar figure is derived by applying the 7.43 percent rate to the program's annual expenditure level. This figure cannot be considered as payments made in error unless all of the individual services that are

questionable are identified through a complete medical record review or audit of all services submitted for payment and found to be medically unnecessary.

Of the total payments, 3.23 percent, or \$542 million, were for claims submitted by providers that disclosed characteristics of potential fraud. To determine exactly how much of the payment errors identified were indeed attributable to fraud requires a complete criminal investigation.

An additional examination of those providers who submitted potentially fraudulent claims was performed to validate the study's preliminary findings of potential fraud. The billing patterns of each of these providers were reviewed subsequent to completion of the MPES 2005 study but prior to issuance of the MPES 2005 report. Some claims that were initially considered to be potentially fraudulent were determined not to be fraudulent, but simply in error. This subsequent analysis of claims did not change the overall 8.40 percentage of payments to claims with errors. It did, however, reduce the percentage of payment errors for potentially fraudulent claims from 5.04 percent to 3.23 percent.

This additional analysis was not part of the MPES 2005 review protocols or sampling and estimation methodology. However, because one of the main objectives in performing the MPES is to estimate the potential dollar loss due to the payment of claims that are potentially fraudulent, the additional analysis provides the most accurate estimate of the potential Medi-Cal funds at risk due to fraud. (See Appendix XVI for additional details.)



Due to the dynamic nature of health care-related fraud schemes and changes in provider behavior, the focus of anti-fraud efforts and the percentage of payment error are expected to vary from year-to-year.

A newly emerging trend identified by MPES 2005 is that some pharmacies appear to have changed their billing behavior in response to the changes in reimbursement for prescription refills. In 2004, a statutory change increased dispensing fees concurrent with state actions to more tightly control ingredient costs. Some pharmacists provided less medication than prescribed on the initial prescription. This enabled the pharmacist to refill the prescription more frequently to obtain additional reimbursement.

The major factors that may have contributed to changes in the overall percentage of payment error between the MPES 2004 and the 2005 MPES are:

1. Review Process

The reviewers' knowledge, skill and experience in identifying and evaluating claim errors gained from MPES 2004 resulted in more effective interviewing, data collection and evaluation techniques in MPES 2005. In addition, the MPES 2005 medical review process was more controlled because a more comprehensive and standardized training program was used to prepare staff in the review of claims. The reason that both of these factors are important is because they may have resulted in an increase in the number of errors identified in the MPES 2005.

2. Impact of Each Stratum On the Overall Percentage of Error

The overall error rate takes into account the proportional relevance of each stratum, rather than treating each stratum equally. For example, a 10 percent error rate in the ADHC stratum would result in an overall payment error rate of .21 percent, assuming no other errors in the study. But a 10 percent error rate in the pharmacy stratum would result in an overall payment error rate of 3.12 percent, assuming no other errors in the study. This is because the percentage of payment error rate is weighted by the total dollars paid by provider type (stratum). The 2005 MPES pharmacy stratum disclosed a percentage of payment error that was 6 percentage points higher than the 2004 MPES (i.e., 14 percent MPES 2005 vs. 8 percent MPES 2004). Since the pharmacy stratum was the largest stratum in dollars paid, this finding contributed to the increased percentage of payment error.

3. Cost per Error

A higher cost per error in a stratum may increase the overall payment percentage of payment error. For instance, the errors found in the pharmacy stratum were associated with a relatively high average dollar cost per error of \$70.00 in MPES 2005 which is significantly higher than the average dollar cost per error of \$50 in MPES 2004. Additionally, pharmacy was the largest stratum of the sample thus contributing the largest portion of the overall percentage of payment error, see Figure 2 below. In comparison, the average error cost per laboratory claim was \$19.00 and therefore had less of an impact on the overall percentage of payment error. Additionally, the number of claims identified with payments completely in error versus partially in error increased significantly from MPES 2004 to MPES 2005. Because the total dollar amount of the claim is in error, there are more dollars in error directly affecting the percentage of payment error.

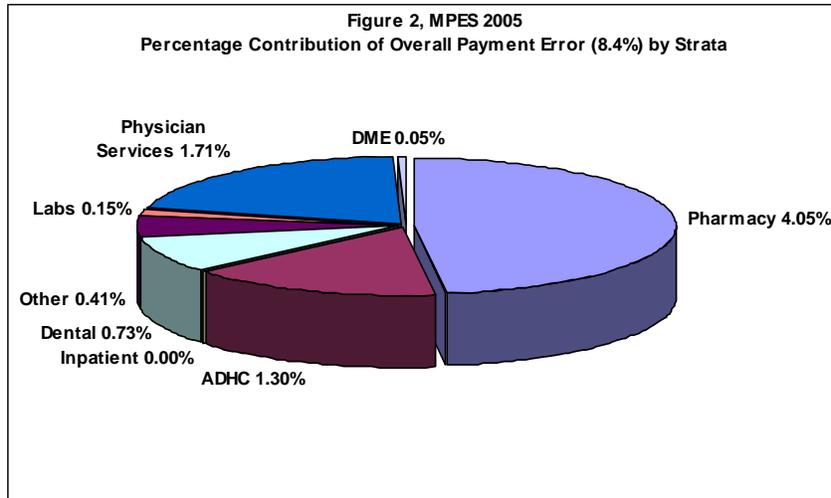
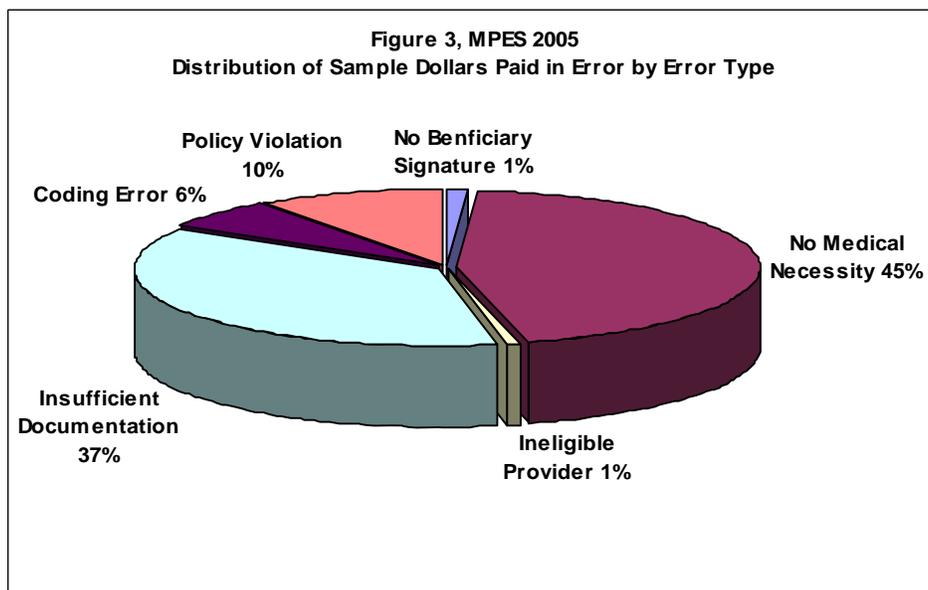


Figure 3 summarizes the percent of total dollars potentially paid in error by error type in the MPES 2005. The single largest factor in the overall dollar errors in MPES 2005 was the lack of medical necessity, which means Medi-Cal providers submitted claims for services that were not medically necessary.

MPES 2005 identified insufficient documentation by providers as the second largest factor contributing to the overall dollar error. This means that the documentation presented by the provider did not support the services claimed. It does not mean that the services were not provided or not medically necessary, and therefore, may not represent an overpayment.



The MPES 2005 found no errors in claims submitted by institutional providers. These providers generally have strong internal controls. Medi-Cal's most rigorous prior authorization processes are used to review the medical necessity for institutional

services. All claims from institutional providers were determined to be for medically necessary services and to contain sufficient documentation to support the claim.

No processing errors were identified in MPES 2005. This indicates that the prepayment edits and audit methods employed by fiscal intermediaries, Electronic Data Systems (EDS) and Delta Dental, appear to be working effectively. In addition, no pricing errors⁴ were found.

The MPES 2005 reviewed all 1,123 claims within the sample study design to determine if the FFS beneficiary (1,026 unduplicated beneficiaries) was eligible for Medi-Cal at the time he/she received services. These beneficiaries were divided into two groups-- "linked cases" (i.e., Medi-Cal eligibility is contingent on eligibility for another public assistance program) and "Medi-Cal only" cases (i.e., Medi-Cal eligibility is not linked to eligibility for other public assistance programs for which they receive a cash grant such as SSI/SSP, CalWORKS, etc). The review of claims found that 5.5 percent of "Medi-Cal only" beneficiaries within the MPES sample were in error due to the beneficiary being ineligible. Note that the sample reviewed was not a random sample of FFS beneficiaries but rather the sample of 1,123 FFS claims reviewed as part of MPES. The eligibility errors are not included in the 8.40 percentage of payment error calculation since the MPES focuses on payment errors due to provider behavior rather than due to errors in the eligibility determination process. In addition, a different methodology would need to be developed to derive a statistically valid estimate of the annual costs of FFS claims that are paid on behalf of ineligible "Medi-Cal only" FFS beneficiaries, as the MPES 2005 sample design methodology was not developed to provide this type of information. (See Appendix XIII for additional details.)

The MPES also included a review of the eligibility of 1,000 managed care beneficiaries and found 56 eligibility errors, or 5.6 percent. Forty-four of these errors occurred in cases from Los Angeles County, with the majority due to failure to redetermine beneficiary eligibility annually. Of the 1,000 managed care cases, 394 cases were "linked" and the remaining 606 were "Medi-Cal only." The review found a 9.2 percentage of payment error for "Medi-Cal only" beneficiaries. Based on this review, the potential risk of payment made in error to Medi-Cal managed care plans for ineligible Medi-Cal only beneficiaries is estimated at \$210 million annually. This estimate is the high end of potential inappropriate program expenditures, as many of these beneficiaries potentially could have been Medi-Cal eligible even though there was a County eligibility determination error. Examples of errors that cannot be assumed to have resulted in inappropriate program expenditures include cases in which the County: (1) failed to redetermine eligibility annually and CDHS reviewers were unable to contact the beneficiary to determine if they would have been eligible at the time the payments were made; (2) incorrectly determined the beneficiary to be eligible for full-scope services, but the beneficiary was only eligible for restricted scope of benefits and not eligible for managed care and; (3) incorrectly determined the share-of-cost that a beneficiary must pay for medical services before being eligible for Medi-Cal coverage

⁴ Pricing errors represent payment for a service(s) that do not correspond with the established pricing schedule, contract, and reimbursable amount.

and the beneficiary was otherwise eligible for Medi-Cal. As previously indicated, the County eligibility determination errors are not included in the 8.40 percentage of payment error.

The MPES 2005 indicates that CDHS' current focus on non-institutional providers, specifically physicians and pharmacies, is targeting the area of highest risk for payment errors. In fact, some errors discovered in the MPES 2005 had already been identified by CDHS. Actions are currently being taken to stop these types of errors from continuing.

The MPES 2005 did identify newly emerging fraud and abuse patterns. CDHS has initiated corrective actions for all providers identified in the study against which actions are warranted.

In addition, CDHS will take additional actions to focus anti-fraud efforts on those areas identified by the study as most vulnerable to fraud and abuse. These additional actions include: on-site reviews of 2,000 pharmacies, expanded use of new technology to better identify potential fraud schemes, reform of the ADHC program, an increase of the number of investigational and routine field compliance audits, and development of a joint action plan with provider regulatory boards and provider associations to address provider claiming errors identified as potential fraud and abuse.

The annual MPES provides opportunities for identifying new patterns of payment errors and areas of potential fraud, waste and abuse in the Medi-Cal program. The MPES findings reinforce the need to continuously and systematically identify those areas of the program most vulnerable to fraud and abuse and to use these findings to guide CDHS in its allocation of fraud control resources and its development of innovative anti-fraud strategies and fraud prevention tools.

MEDI-CAL PAYMENT ERROR STUDY 2005

BACKGROUND

CDHS places significant priority on combating fraud, waste and abuse in California's largest publicly funded health care program, Medi-Cal. A systematic study of program payment accuracy, such as the Medi-Cal Payment Error Study (MPES), assists CDHS in determining where the Medi-Cal program is at greatest risk for payment errors and provides an estimate of the potential dollar loss to the program, including potential loss due to fraud, waste and abuse. The primary goal of the MPES is to identify emerging fraud practices and help to ensure that CDHS' anti-fraud activities are focused in the areas of highest risk for fraud, waste and abuse.

The study: (1) identifies where Medi-Cal is at greatest risk for paying provider claims that are in error, and thus establishes how best to deploy Medi-Cal anti-fraud resources and (2) computes the amount of potential loss to Medi-Cal due to billing or payment errors, including potential loss due to fraud, waste and abuse. MPES is currently the only study conducted by a state or federal entity that includes an estimate of potential fraud.

The Medi-Cal program serves over 6.6 million beneficiaries. Approximately 3.4 million beneficiaries (52 percent) are served by providers who are reimbursed through the Fee-For-Service (FFS) system. This means that providers are paid a fee for each service provided. An additional 3.2 million beneficiaries (48 percent) are enrolled in Medi-Cal Managed Care plans. Medi-Cal pays these plans a flat fee per month. The plans, in turn, reimburse individual providers for services rendered to Medi-Cal beneficiaries.

The total Medi-Cal benefits budget for Fiscal Year 2004-2005 was approximately \$31 billion. The MPES 2005 reviewed claims paid through the FFS system in calendar year 2004. These claims total approximately \$16.8 billion and are a subset of the total \$31 billion. The primary focus and expansion of the Medi-Cal anti-fraud efforts over the past several years have been in the non-institutional FFS and Dental programs as these programs are considered to be at greatest risk for payment errors as well as at highest risk for fraud, waste and abuse. In calendar year 2004 approximately 231 million claims were paid through the FFS system. CDHS focused the MPES in both 2004 and 2005 on the non-institutional Medi-Cal FFS program including FFS dental services.

The MPES 2005 is based on a sample of claims paid in the fourth quarter of calendar year 2004. The MPES 2005 reviewed the same types of medical and dental payments as did the MPES 2004. Claims paid to or by Medi-Cal Managed Care contractors, Medi-Cal claims paid for services administered by other state departments, and supplemental payments made to disproportionate share hospitals were not included in MPES 2004 or 2005.

MPES 2005 is the second annual Medi-Cal payment error study to be conducted by CDHS. The design and results of these first two studies do not yet provide a benchmark against which to measure and compare future studies. Studies of this type typically take three to five years to establish a benchmark. The methodology for MPES 2006 will be refined and improved based upon what was learned from MPES 2004 and MPES 2005 in order to enhance the effectiveness of both the MPES 2006 as well as CDHS' fraud control activities.

The MPES 2005 sampling design, medical and eligibility review processes, analysis of factors, discussion of findings, and follow-up recommendations are described in the following sections.

SAMPLING METHODOLOGY

The MPES 2005 sampling strategy used proportional stratified random sampling to generate estimates of payment and fraud error. These estimates were then extrapolated to estimate the potential dollar loss to the program due to provider claiming errors. This is a widely accepted standard statistical technique used to measure sample estimates¹.

Other states and federal payment error studies also employ random sampling and extrapolation techniques to measure medical payment error. These studies have reported payment errors ranging from 4.72 percent to 24 percent. Based on the lessons learned from their prior experiences, those states that have undertaken subsequent studies have modified and refined their sampling and review methodologies to broaden the scope of the analysis and to improve the standardization of the claims review process as much as possible. In performing subsequent studies, some states, including Texas², have reported a significantly higher percentage of payment error than their own earlier studies.

STUDY DESIGN AND REFINEMENTS

The sampling methodology utilized in the MPES 2004 provided statistically valid estimates of the overall dollar error for the FFS system as a whole. The study design was not refined enough to infer statistically valid conclusions of the program's vulnerability for some specific strata of providers³. The MPES 2005 design was modified and improved. Improvements in study design and review procedures are common in these types of evaluations as each MPES provides opportunities for refinement and modification. Refinements included: (1) an increase in the sample size from 800 to 1,123 claims, (2) inclusion of a minimum of 50 claims from each stratum to

¹ See Appendix III for sample plan details.

² A detailed discussion of the studies conducted and methodologies utilized by other states and the U.S. DHHS is provided in Appendix XII.

³ A stratum is defined as a subset of the population of all claims paid in the fourth quarter of the calendar year 2004 and may comprise one or more provider type(s); e.g. "Other Services and Supplies" stratum is composed of Local Education Agencies, Non-emergency Medical Transportation, Medical Supplies, Home Health care, etc.

ensure that statistically valid conclusions could be drawn, and (3) inclusion of Durable Medical Equipment (DME), Laboratory (Lab), and Adult Day Health Care (ADHC) as three separate strata. These three areas were identified in the MPES 2004 as the provider types of potential concern for fraud, waste and abuse. Also added to the review process in the MPES 2005 was an analysis of vulnerabilities in the eligibility process for both FFS and Medi-Cal Managed Care.

Additionally, the MPES 2005 medical review process was more controlled than that of the MPES 2004. A more comprehensive and standardized training program was used to prepare all staff in the review of claims and related supporting medical records and documentation in order to provide for a consistent and methodical evaluation of all claims.

CDHS' review processes are generally accepted standard review procedures that other states conducting similar studies have used⁴. A multidisciplinary team of medical professionals, auditors, analysts and researchers conducted the MPES. To ensure the integrity of the study, claims data were collected from an on-site review at the providers' offices. There were six components of the claims review process to confirm the following: (1) that the beneficiary received the service, (2) that the provider was eligible to render the service, (3) that the documentation was complete and included in the medical files as required by statute or regulation, (4) that the services were billed in accordance with applicable laws and regulations and policies, (5) that the claim was paid accurately, and (6) that the documentation supported the medical necessity of the service provided. After the multidisciplinary team completed its review, findings were validated by the appropriate CDHS medical policy specialist.

Using the six review components and the characteristics⁵ of potentially fraudulent activities, CDHS identified claims that included characteristics of being potentially fraudulent. The California Department of Justice (DOJ) reviewed these claims further to validate CDHS' findings.

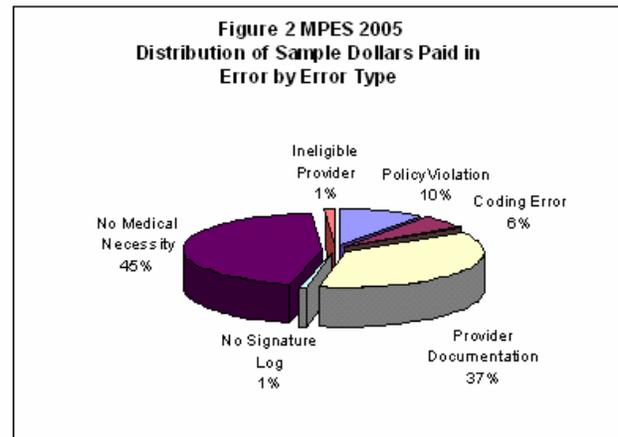
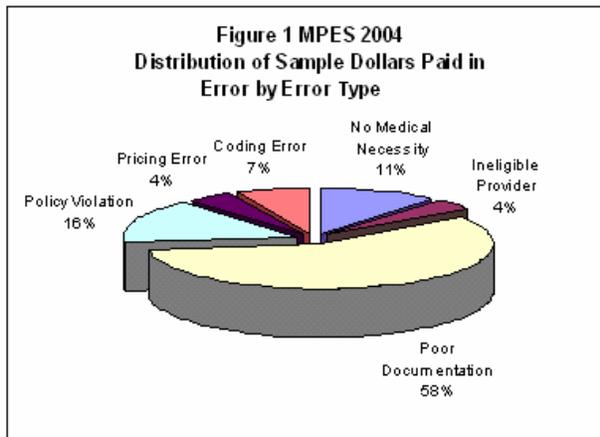
BENEFICIARY ELIGIBILITY REVIEW

In addition to the overall assessment of payment error, the MPES 2005 included reviews of both the FFS and Medi-Cal Managed Care programs to determine if beneficiaries were eligible for Medi-Cal at the time services were rendered. The Managed Care eligibility review was a random sample of 1,000 beneficiaries enrolled in managed care from the fourth quarter of 2004. The FFS eligibility review was conducted on the 1,123 claims from the MPES 2005 sample. Both reviews were limited to the accuracy of the determination of beneficiary eligibility for "Medi-Cal only." The eligibility errors identified were not included in the overall percentage of payment error because the payment error calculation focused on payment errors due to provider behavior rather than the errors in the county eligibility determination process. (See Appendix XIII for additional details.)

⁴ Appendices IV and XII for details regarding review processes.

⁵ Common indicators of fraud are provided in Appendix VI

FINDINGS: PERCENTAGE OF PAYMENT ERROR



The MPES 2005 indicates that 91.60 percent of total dollars paid in the FFS medical and dental programs were billed appropriately and paid accurately. In contrast, 8.40 percent of the total dollars paid had some indication of a provider error. Claim errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided.

The single largest factor in the overall dollar errors in MPES 2005 was the lack of medical necessity, which means Medi-Cal providers submitted claims for services that were not medically necessary.

MPES 2005 identified insufficient documentation by providers as the second largest factor contributing to the overall dollar error. This means that the documentation presented by the provider did not support the services claimed. It does not mean that the services were not provided or not medically necessary, and therefore, may not represent an overpayment.

Included in the errors are those attributable to compliance issues, i.e., providers failed to comply with one or more required claiming regulations, policies and/or procedures. Claims with compliance errors were reviewed to determine if the services/supplies on the claim were for medically necessary services. For example, if a prescription was refilled without the appropriate prescriber's documentation on file, but the prescription was consistent with previously approved prescriptions for the same medication and receipt of the prescription was acknowledged by the beneficiary, then the payment was determined to be appropriate. Because such claims were for necessary medical services that were appropriate to provide, the payments associated with such claims are not considered "at risk" of having been paid inappropriately by the Medi-Cal program.

Compliance errors are a subset (representing 0.97 percent of the total dollars paid) of the 8.40 percentage of payment error. The remaining 7.43 percent represents the percentage of payment error attributable to Medi-Cal program dollars "at risk" of being paid inappropriately due to findings related to such factors as a lack of medical

necessity, abuse, or fraud. The 8.40 percent equates to \$1.4 billion of the total \$16.8 billion in annual payments made for FFS medical and dental services in calendar year 2004. Of the \$1.4 billion in annual payments, \$1.25 billion is viewed as being “at risk” of being paid inappropriately because it represents payments for claims with errors such as a lack of medical necessity, abuse, or fraud. It does not include payments for claims with compliance errors.

The term “at risk” is used because this dollar figure is derived by applying the 7.43 percent to the program’s annual FFS expenditure level. This figure cannot be considered as payments made in error unless all of the individual services that are questionable are identified through a complete medical record review or audit of all services submitted for payment and found to be medically unnecessary.

Of the total payments, 3.23 percent, or \$542 million, were for claims that contained characteristics of potentially fraudulent billing. To determine exactly how many and the dollar value of the payment errors identified that are attributable to fraud requires complete criminal investigations.

Additional examination of the billing practices of providers who were identified as submitting potentially fraudulent claims was performed to validate the study’s preliminary findings. The billing patterns of each of these providers were reviewed subsequent to completion of the MPES 2005 study but prior to issuance of the MPES 2005 report. Some claims that were initially considered to be potentially fraudulent were determined not to be fraudulent, others remain under review. This analysis of claiming patterns did not change the overall 8.40 percentage of payments to claims with errors. It did, however, reduce the percentage of payments for potentially fraudulent claims from 5.04 percent to 3.23 percent.

This additional analysis was not part of the MPES 2005 review protocols or sampling and estimation methodology. However, because one of the main objectives in performing the MPES is to estimate the potential dollar loss due to the payment of claims that are potentially fraudulent, the additional analysis provides the most accurate estimate of the potential Medi-Cal funds “at risk” due to fraud. (See Appendix XVI for additional details.)

FACTORS CONTRIBUTING TO THE OVERALL PERCENTAGE OF PAYMENT ERROR

Due to the dynamic nature of health care-related fraud schemes and changes in provider behavior, the focus of anti-fraud efforts and the percentage of payment error are both expected to vary from year-to-year.

A newly emerging trend identified by MPES 2005 indicates that some pharmacies changed their billing behavior in response to the changes in reimbursement for prescription refills. In 2004, a regulatory change increased dispensing fees, concurrent with state actions to more tightly control ingredient costs. Some pharmacists provided

less medication than prescribed on the initial prescription. This enabled the pharmacist to refill the prescription more frequently to obtain additional reimbursement.

The major factors that may have contributed to the overall percentage of payment error from the MPES 2005 are:

1. Review Process

The reviewers' knowledge, skill and experience in identifying and evaluating claim errors gained from MPES 2004 resulted in more effective interviewing, data collection and evaluation techniques. In addition, the MPES 2005 medical review process was more controlled because a more comprehensive and standardized training program was used to train staff in the review of claims. These factors are important because they may have resulted in an increase in the number of errors identified in the MPES 2005.

2. Impact of Each Stratum On the Overall Percentage of Error

The overall percentage of payment error takes into account the proportional relevance of each stratum, rather than treating each stratum equally. For example, a 10 percent error rate in the ADHC stratum would result in an overall payment error rate of .21 percent, assuming no other errors in the study. But a 10 percent error rate in the pharmacy stratum would result in an overall payment error rate of 3.12 percent, assuming no other errors in the study. This is because the percentage of payment error rate is weighted by the total dollars paid by provider type (stratum). The 2005 MPES pharmacy stratum disclosed a percentage of payment error that was 6 percentage points higher than the 2004 MPES (i.e., 14 percent MPES 2005 vs. 8 percent MPES 2004). Since the pharmacy stratum was the largest stratum in dollars paid, this finding contributed to the increased percentage of payment error.

3. Cost per Error

A higher cost per error in any given stratum may increase the overall percentage of payment error. For instance, the errors found in the pharmacy stratum were associated with a relatively high average dollar cost per error of \$70.00 in MPES 2005 which is significantly higher than the average dollar cost per error of \$50.00 in MPES 2004. Additionally, pharmacy was the largest stratum in the sample thus contributing the largest portion of the overall payment percentage of payment error. In comparison, the average error cost per laboratory claim was \$19.00 and therefore had less of an impact on the overall percentage of payment error. Additionally, the number of claims identified with payments completely in error versus partially in error increased significantly from MPES 2004 to MPES 2005. Because the total dollar amount of the claim is in error, there are more dollars in error directly affecting the percentage of payment error.

KEY MPES FINDINGS

Findings:

- Payments for claims that were billed appropriately, paid appropriately, for medically necessary services rendered by an eligible Medi-Cal provider represent 91.60 percent of total dollars paid through the Medi-Cal FFS system. Of the \$16.8 billion in payments made through the FFS system in calendar year 2004, 7.43 percent (\$1.25 billion) were identified as “at risk” of being paid inappropriately.
- The amount of payments for claims that were potentially fraudulent was projected to be \$542 million, or 3.23 percent of the total FFS payments. Determination of exactly how much of the payments are for claims that are indeed fraudulent requires complete criminal investigations.

Types of Errors:

- Of the payments for claims with errors, 45 percent were for claims in which the provider’s documentation did not support medical necessity for the services billed, meaning the services did not need to be provided. This type of error was the most costly to the program.
- A total of 37 percent of all payments for claims with errors were for claims with insufficient documentation. This means that the documentation presented by the provider did not support the services claimed.
- No claims processing errors were identified. This indicates that the prepayment edits and audit methods employed by fiscal intermediaries, Electronic Data Systems (EDS) and Delta Dental, appear to be working effectively. This also means that claims submitted by providers contained the required information to be adjudicated and paid.

Errors by Provider Type:

- Institutional providers had the highest payment accuracy rates. No billing or payment errors were associated with claims from hospital or nursing facility services. Payments to Medi-Cal institutional provider types (e.g., hospitals, nursing facilities) involve the largest Medi-Cal expenditures per service and have more Medi-Cal programmatic oversight, such as authorization by the Medi-Cal field offices of the services being rendered, routine financial audits, licensing and certification reviews, and strong internal control systems.
- Payments to pharmacies and physicians disclosed the highest percentage of payments made to claims with errors among non-institutional providers. Non-institutional providers are the largest group of Medi-Cal providers, have more

services provided at a lower cost per service and have less internal and external control systems, such as fewer services requiring prior authorization and fewer audits. This finding is consistent with risk assessment in CDHS' Medi-Cal Fraud Control Strategic Plan and the current focus of anti-fraud efforts.

- ADHCs had the highest percentage of claims completely in error and the greatest number of errors due to no medical necessity. ADHCs are reimbursed on a bundled daily rate and normally submit claims for more than a single day of service. The average cost of ADHC claims (\$166 per claim) is generally higher than other services; this higher average cost impacts on the amount of dollars found to be in error. In response to the troubling findings related to ADHC claims, CDHS took immediate steps. Utilizing a multidisciplinary interdepartmental task force, unannounced visits were made to 16 ADHC providers identified as having submitted erroneous claims. Although investigations are continuing, all 16 providers were found to have pervasive problems. All 16 have been placed on administrative control(s), such as withhold, special claims review, etc.
- Pharmacy errors accounted for almost half of the overall percentage of payment error (4.05 percent of the 8.40 percent). Most pharmacy claim errors are a result of absent or inadequate documentation, such as not having a valid prescription in the file or the provider violated the requirement to obtain an approved Treatment Authorization Request before dispensing a drug.
- Physician services errors accounted for 20 percent of the overall percentage of payment error (1.71 percent of the 8.40 percent). Physician claim errors involved miscoding, no documentation or insufficient documentation. Physicians also accounted for errors in other strata (DME, Lab, and pharmacy). Lack of documentation of medical necessity by a physician leads to errors in these ancillary services.
- Dental services errors accounted for almost 9 percent of the overall percentage of payment error (0.73 percent of the 8.40 percent). Among these claims with errors, two revealed substandard and/or abusive patient care involving lack of anesthesia when warranted and claims for anesthesia that was not provided to the patient.
- Two claims with errors in physician and pharmacy services revealed substandard care. Both errors led to subsequent hospitalizations and human suffering, and increased costs to the Medi-Cal program.
- Within the "Other Services and Supplies" stratum, the Local Education Agency (LEA) claims comprised the largest number of errors for this stratum (eight of the fifty claims). The LEA claim errors resulted from insufficient documentation to support that services were provided.

Eligibility Errors:

- CDHS' Medi-Cal Eligibility Branch performed a review of the eligibility status of beneficiaries who received Medi-Cal services in FFS as well as under Medi-Cal Managed Care. The review consisted of an analysis of eligibility data, income verification, review of county case records and other procedures as required. The beneficiaries for both FFS and Managed Care were divided into two groups: "linked" (i.e., Medi-Cal eligibility is contingent on eligibility for another public assistance program) and "Medi-Cal only" beneficiaries (i.e., Medi-Cal eligibility is not linked to eligibility for other public assistance programs for which they receive a cash grant such as SSI/SSP, CalWORKS, etc.). Medi-Cal eligibility is automatic for "linked" beneficiaries; they are deemed to be eligible by virtue of their enrollment in the "linked" program. The eligibility reviews focused on "Medi-Cal only" beneficiaries and are summarized as follows:

CDHS reviewed all 1,123 claims representing 1,026 unduplicated beneficiaries within the sample study to determine if the FFS beneficiary was eligible for Medi-Cal at the time he/she received services. The review of claims found that 5.5 percent of "Medi-Cal only" beneficiaries in the sample were ineligible. The sample reviewed was not a random sample of FFS beneficiaries but rather the beneficiaries associated with the sample of 1,123 FFS claims reviewed as part of MPES, therefore these results can not be extrapolated to draw conclusions about eligibility error rate. The next study (MPES 2006) will utilize a different method to measure FFS eligibility and allow for estimating the annual costs of FFS claims that are paid on behalf of ineligible "Medi-Cal only" beneficiaries. (See Appendix XIII for additional details.)

CDHS conducted a separate review of the eligibility of 1,000 managed care beneficiaries, using a random sample of managed care beneficiaries, and found 56 eligibility errors, or 5.6 percent of the total. Forty-four of these errors occurred in beneficiaries from Los Angeles County. The majority of the errors were due to the County's failure to redetermine beneficiary eligibility annually. Of the 1,000 Managed Care beneficiaries, 394 were "linked" and the remaining 606 were "Medi-Cal only." The review found a 9.2 percent eligibility determination error rate for "Medi-Cal only" beneficiaries. Based on this review, the potential risk of payment made in error to Medi-Cal managed care plans for ineligible "Medi-Cal only" beneficiaries is estimated at \$210 million annually. This estimate overstates the risk of payments made in error for ineligible beneficiaries because some of these beneficiaries potentially could have been Medi-Cal eligible irrespective of whether the County performed the annual eligibility determination. Examples of errors that cannot be assumed to have resulted in inappropriate program expenditures to plans include beneficiaries for whom the County: (1) failed to redetermine eligibility annually and CDHS reviewers were unable to contact the beneficiaries to determine if the beneficiary would have been eligible at the time the capitation

payments were made; (2) incorrectly determined the beneficiary to be eligible for full-scope services, but the beneficiary was only eligible for restricted scope of benefits and not eligible for managed care; and (3) incorrectly determined the share-of-cost that a beneficiary must pay for medical services before being eligible for Medi-Cal coverage and the beneficiary was otherwise eligible for Medi-Cal. The County eligibility determination errors are not included in the 8.40 percentage of payment error. (See Appendix XIII for additional details.)

CONCLUSION

The MPES 2005 demonstrates that the vast majority of Medi-Cal providers are billing correctly and being paid accurately. It also shows that CDHS' current focus on non-institutional providers, specifically physician services, pharmacies, and ADHCs, is targeting the areas of highest risk for payment errors and potential billing fraud.

The MPES 2005 did not reveal any claims processing errors. This finding indicates that the prepayment edits and audit methods employed by Electronic Data Systems (EDS) and Delta Dental, CDHS' fiscal intermediaries, appear to be working effectively. There were also no pricing errors found which indicates that EDS pays claims consistent with Medi-Cal policy.

The MPES 2005 identified newly emerging fraud and abuse patterns that were previously undetected, such as multiple prescription refills from pharmacists following a change in the state's dispensing fee reimbursement rate. CDHS has initiated corrective actions against all providers identified in the MPES for which actions are warranted.

The MPES studies are a valuable tool to assist CDHS in identifying those areas of the Medi-Cal program most at risk for fraud, waste and abuse. These systematic studies help guide the allocation of fraud control resources to ensure that CDHS focuses its fraud control efforts in the most effective and appropriate manner. As such, in response to the MPES 2005 findings, a number of actions have been taken or are in the process of being taken. In addition, the Governor has directed CDHS to arrange for an independent, top-to-bottom evaluation of the Department's anti-fraud program and identify any gaps in its efforts to protect the fiscal integrity of Medi-Cal. This assessment is intended to ensure that CDHS is taking every appropriate action to prevent Medi-Cal fraud and payment error. The results of the evaluation would be due no later than July 2007.

The following actions already have been taken to focus anti-fraud efforts on those areas most vulnerable to fraud and abuse:

- Expanded the number of investigational and routine field compliance audits of ADHCs to identify provider claim errors as identified in the MPES 2005 and take appropriate corrective actions and apply appropriate sanctions. More than 50

ADHCs received on-site reviews during November 2005 and June 2006. Forty of these ADHCs received one or more sanctions.

- CDHS has previously proposed legislation to reform the ADHC program. While this legislation was being considered, CDHS placed a moratorium on the enrollment of any additional ADHCs into the Medi-Cal program. Although the previously proposed legislation was not approved, CDHS continues to work with the Legislature to enact reform of ADHC services.
- Effective June 2006 CDHS increased the number of claims examined randomly each week from 100 to 200 claims with a focus on physician and pharmacy provider claims. The random claims sampling process is an additional layer of review beyond the automated edits and audits in the claims processing system. This sampling method allows all claims paid to have an opportunity to be selected for review. This random claims review process is a best practice that detects current Medi-Cal billing fraud and prevents future fraud via a deterrent effect.
- A total of 141 different sanctions have already been placed on 54 billing and/or referring providers identified in the study as submitting claims with errors or characteristics of fraud. A total of 187 providers were identified with claim errors in the study. Additional examination continues on 107 providers, and 26 providers have already received a review and been closed with no action required. Cases will be developed on those determined to have submitted claims with errors or characteristics of fraud and appropriate sanctions will be implemented.
- Beginning in FY 2003-04 letters were sent on a periodic basis to providers to inform them of their billing practices when billing patterns changed beyond their normal billing history or when billing patterns changed beyond the expected range of other similar providers. The providers are identified as a result of ongoing audits and reviews. In FY 2004-05, 1,314 letters were mailed to specific providers. The letters provide feedback to providers on their billing practices and send the signal that CDHS is monitoring provider billing activity.
- CDHS performs monthly Medi-Cal eligibility quality control reviews to identify error trends by category and county, and target future reviews of selected counties to examine specific problem areas. The reviews are performed by randomly sampling approximately 225 cases per month to determine compliance with current county eligibility requirements. Follow-up with counties is done to develop corrective action plans. Corrective actions will be taken against those counties who failed to comply with eligibility requirements.

CDHS is in the process of implementing the following action steps that address findings from MPES 2005:

- CDHS will conduct on-site reviews of approximately 2,000 pharmacies by a temporary redirection of staffing resources to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse. This will be a significant effort to respond to one of the primary findings of the MPES. Appropriate actions will be taken against those pharmacies submitting inappropriate claims.
- CDHS has initiated steps to utilize a new automated technology tool to better identify potential fraud schemes. This is a significant new development that will permit CDHS to identify patterns of potential fraud and abuse that CDHS has not previously been able to identify without on-site visits to providers. This new technology captures data, both current and historical, about patients relevant to the claims submitted by providers. The technology gathers data from many sources, including data related to other patients with similar health issues who should be treated the same way, and is capable of performing analysis very rapidly and identifying claims determined to be outside of normal ranges for similar services and claims. Identification of the patterns of fraud and abuse at the earliest possible point will allow CDHS to take the appropriate punitive actions and avoid potential loss of program dollars. These newly identified fraud schemes may also provide the basis for modifying existing regulations, policies and/or claims processes to prevent future payment of fraudulent claims. Utilization of this new tool is expected to begin in January 2007.
- Expansion of joint efforts with the Department of Justice to send letters to Medi-Cal beneficiaries to verify that the beneficiaries actually received the services or products claimed by providers. This will assist in detecting those providers who submit claims for services and/or products not actually provided.
- Expansion of the provider self-verification system to permit CDHS staff to focus their efforts on those providers who are submitting claims with characteristics of potential fraud. The self-verification system allows providers who have not submitted claims in a fraudulent or abusive manner, but who have submitted claims in error, to self-identify and self-correct system problems within their organizations and remit any inadvertent overpayments they may have received.

The following action steps will be taken to address the findings of the MPES 2005:

- Develop a joint plan of action with regulatory boards such as the Medical Board, Dental Board and Board of Pharmacy, and provider associations, such as the California Medical Association, to address the provider claiming errors identified as potential fraud and abuse. The plan will include extensive education of providers, utilizing training sessions and detailed Medi-Cal provider bulletins, on how to provide justification for the medical necessity of the services or products

provided as well as the maintenance of documentation requirements. CDHS will conduct education of physicians, optometrists and dentists based on the plan of action resulting from this work.

- CDHS will propose legislation to enact changes to increase county compliance and accountability standards for completing timely determinations and redeterminations of beneficiary eligibility. Statutory performance standards enacted in 2004 require counties to meet a 90 percent compliance rate for timely eligibility determinations and annual redeterminations. These standards also require prompt disenrollment of beneficiaries who become ineligible for Medi-Cal. Failure to meet the standards puts counties at risk for a fiscal penalty. In light of the number of errors identified in the eligibility review and the potential significant fiscal impact to the Medi-Cal program, CDHS proposes that these determination and redetermination standards be increased to 95 percent.
- CDHS will propose additional budget resources to increase and strengthen comprehensive monitoring of county compliance with eligibility determination performance standards. If the errors identified in the county eligibility review process are not addressed with increased resources to monitor counties, it may result in potential significant fiscal impact to the Medi-Cal program. These resources should include a third-party contract to monitor county compliance
- Explore implementation of a “Provider Report Card” (PRC) for all Medi-Cal providers similar to a system utilized in Australia. This would be a significant expansion of a similar process described above for providing feedback letters to a select number of providers and require the accumulation of data regarding payments and services for all providers. The PRC would provide all (100 percent) Medi-Cal providers with detailed service information that shows how each practitioner compares with services and claims by similar practitioners. This process will also require development of a reporting system to notify all providers and the ability to monitor and follow-up on providers that demonstrate claiming and service patterns significantly different than that of their respective peers. CDHS will work with the various provider associations to explore the development of a PRC for California.

MEDI-CAL PROGRAM OVERVIEW

In California, the California Department of Health Services (CDHS) administers the Medicaid (Medi-Cal) program. The Medi-Cal program serves over 6.6 million¹ beneficiaries of which approximately 3.4 million (52 percent) are in the Fee-For-Service (FFS) system and 3.2 million are enrolled in Medi-Cal Managed Care plans. The total Medi-Cal benefits budget for FY 2004/05 is approximately \$30.9 billion, of which \$19.8 billion is allocated to the FFS and Dental programs, making it one of the largest programs in the nation.

Medi-Cal eligibility is determined, on an as-needed basis, at the county level based upon State requirements or by meeting other requirements outside the State's control, such as disability actions determined by the Federal Social Security Administration (SSA). Once beneficiaries meet the eligibility requirements, they have access to a variety of Medi-Cal programs, including FFS, Managed Care, dental, and vision.

Eligibility determinations are processed at the County Departments of Human Assistance. Eligibility is confirmed and established on the State Medi-Cal eligibility database (VSAM), maintained at the Health and Human Services Data Center. CDHS also conducts bi-annual Medi-Cal eligibility quality control (MEQC) reviews to assure the authorizing County agencies have correctly determined eligibility for Medi-Cal beneficiaries based on the regulations and policies in effect for the month of medical service.

Managed Care payments are made through capitated contracts with health plans. Payments made in the FFS system are made through the fiscal intermediary, Electronic Data Systems (EDS), and dental services are paid via a capitated contract with Delta Dental who pays claims on a FFS basis. These entities process and adjudicate claims against State-established audit, edit, and payment guidelines. California also employs an extensive prior authorization system in the FFS program to grant service approval before a claim can be submitted for payment of services, such as hospital care and many outpatient services. Payments to providers are also subject to pre- and post-payment reviews, special claim reviews, annual cost report audits, and rate setting audits.

Over the past five years there has been significant focus placed on combating fraud, waste, and abuse in Medi-Cal. Through changes in laws, regulations and policies, as well as, several successful anti-fraud initiatives which increased staffing, CDHS has been able to achieve significant savings to Medi-Cal and has created new systems to prevent fraud from occurring. CDHS' current anti-fraud efforts focus on physicians, physician groups, pharmacies, and other provider types and services in the Medi-Cal FFS program. This focus is based on the assessment that these providers comprise the highest risk for potential fraud and abuse because: (1) they are generating directly

¹ Annual Statistical Report Calendar Year 2004, CDHS Medical Care Statistics Section

or indirectly the largest expenditures and have fewer internal management controls; (2) they are not routinely audited by Medi-Cal, and (3) they have fewer services subject to prior authorization. The following are key elements of CDHS' current anti-fraud efforts.

- Enrollment/Re-enrollment

To prevent fraudulent providers from being enrolled, or re-enrolled in Medi-Cal, CDHS tightened the enrollment process by developing new regulations, applications, provider agreements, and internal security protocols to assure the integrity of the provider enrollment process. One of the key elements of the enrollment and re-enrollment efforts is a detailed background check, including an on-site review at each service location by CDHS' Audits and Investigations.

- Moratoriums

Because of the high risk for fraud, CDHS has placed moratoriums on new enrollments for durable medical equipment (DME) providers; non-chain laboratories (Labs); non-chain and non-pharmacist owned pharmacies in Los Angeles County. Additionally a moratorium was placed on Adult Day Health Care (ADHC) facilities in collaboration with California Department of Aging (CDA) and the ADHC provider community to contain growth and costs in the ADHC program.

- Administrative Sanctions

Administrative sanctions include the following: withhold of payments; temporary suspension from Medi-Cal; special claims review; prior authorization for services; and, procedure code limitations. Sanctions are placed on a provider as a result of field reviews and preliminary investigations.

- Field Audit Reviews

A&I, in concert with EDS' Provider Review Unit, monitor provider billing patterns and payments made for abnormal changes, such as a large percentage increase in payments or other outliers in comparison with peer groups. The purpose is to detect fraudulent schemes, suspicious providers, and stop inappropriate payments as quickly as possible. From this analysis, A&I field staff conduct on-site reviews of suspicious providers, which may result in administrative sanctions or stopping the payment on a check. In 2004, legislation was passed which delayed the Medi-Cal check-writes by one week to allow more time to review provider claims prior to checks being issued. This one week delay is still in effect.

- Procedure Code Limitation

Medi-Cal and non-Medi-Cal providers that are suspected of abusing certain procedure codes are advised they may no longer utilize particular codes, and denied payment when billing those codes.

- Random Claims Sample

A key element in an effective anti-fraud control strategy is the awareness by providers that every claim submitted for payment has some risk of review prior to payment. In

April 2004, CDHS began randomly selecting 100 claims per week for review prior to payment. The random claim review is a real time look into services and trends in Medi-Cal billing. A&I, in cooperation with EDS, developed a systematic process for randomly selecting the claims. When a claim is selected, providers are required to submit documentation to support the claim prior to payment approval. Any claim that is not supported is denied. In addition to preventing improper claims from being paid, the review results are used to further enhance the case detection and development process. To further increase the integrity and effectiveness of the random claims review process, A&I has directed EDS to monitor for re-submission of claims previously denied to ensure that providers do not attempt to re-submit the claims for payment.

- **Beneficiary Identification Card Re-Issuance**

The Beneficiary Identification Card (BIC) replacement project consists of replacing all BICs, statewide. These new BICs have removed the beneficiary's social security number and replaced it with a pseudo Social Security number. In addition, the cards are issued randomly during the course of a month to produce random issue dates. Providers are then required to use the new pseudo numbers and correct issue dates to have their claims adjudicated. In FY 2003/04, this expanded effort saved the Medi-Cal program \$29,188,000. CDHS will continue evaluating beneficiaries for BIC re-issuance as cards are identified as being misused. The process will involve continued evaluation to identify new and evolving fraud schemes and sharing patterns (e.g., identity theft, collusion, etc.).

- **Research and Development**

In cooperation with external partners, EDS and Medstat, A&I has developed state-of-the-art fraud detection systems for case development and identification of new fraud schemes. These systems are key in focusing on anti-fraud efforts.

- **Medicare Data Match Agreement**

California has a data match agreement with the federal Centers for Medicare & Medicaid Services (CMS) to share Medicare/Medi-Cal data. This project is 100 percent federally funded and allows both programs to identify fraudulent providers and fraud schemes that might otherwise go undetected.

- **Criminal Fraud Referrals**

Because of the expanded focus on Medi-Cal provider fraud, A&I increased the number of fully developed criminal fraud referrals to the California Department of Justice (DOJ), the Federal Bureau of Investigations (FBI), and the U.S. Attorney. A&I Fraud Investigators work closely with these law enforcement agencies, and have an investigator assigned to the Health Authority Law Enforcement Team (HALT) in Los Angeles.

- **Beneficiary Investigations**

The Beneficiary Care Management Project was developed to identify beneficiaries abusing the Medi-Cal program by seeking more services than medically necessary.

Beneficiaries found abusing the program are assigned to a primary provider and/or pharmacy for a two-year period. The intent is to decrease physician/pharmacy shopping and improve the continuity and quality of care and services the beneficiary both needs (i.e. is medically necessary) and receives.

APPENDIX II

COMPARISON OF MPES 2004 WITH MPES 2005

	MPES 2004	MPES 2005
Results	<ul style="list-style-type: none"> • Billing or Payment Errors = 3.57% • Potential Fraud Billing or Payment Errors = 1.57% 	<ul style="list-style-type: none"> • Billing or Payment Errors = 8.40% • Potential Fraud Billing or Payment Errors = 3.23%
Funding	50% State Funds / 50% Federal Funds	50% State Funds / 50% Federal Funds
Project Designed By	California Department of Health Services, Audits & Investigations	California Department of Health Services, Audits & Investigations
Sampling Plan Designed By	California Department of Health Services, Medical Care Statistics Section	California Department of Health Services, Medical Care Statistics Section
Objective	<p>The objectives of the project are:</p> <ol style="list-style-type: none"> 1. Measure the amount of errors in the Medi-Cal FFS claims payment system; 2. Identify the amount of potential fraud or abuse in Medi-Cal; and 3. Identify the vulnerabilities of the Medi-Cal program. 	<p>The objectives of the project are:</p> <ol style="list-style-type: none"> 1. Measure the amount of errors in the Medi-Cal FFS claims payment system; 2. Identify the amount of potential fraud or abuse in Medi-Cal; and 3. Identify the vulnerabilities of the Medi-Cal program.
Universe	FFS claims paid between October 1, 2003 and December 31, 2003, inclusive.	FFS claims paid between October 1, 2004 and December 31, 2004, inclusive.
Method of Allocating Sampling Units to Strata	The proportion of <u>total claims</u> paid for the line items represented by each stratum in the sampling period October 1, 2003 through December 31, 2003, inclusive.	The proportion of <u>total claims</u> paid for the line items represented by each stratum in the sampling period October 1, 2004 through December 31, 2004, inclusive.
Sample Size	800 FFS (medical & dental) claims	1,123 FFS (medical & dental) claims
Sampling Unit	Entire claim	Entire Claim
Confidence Level	95%	95%
Level of Precision	+/-3%	+/-3%
Sampling Methodology	Proportional stratified random sampling	Proportional stratified random sampling
Study Design	Fee-for-service and dental claims with beneficiary confirmation of services.	Fee-for-service and dental claims. Added statistically valid number of

	MPES 2004		MPES 2005	
			claims with three additional stratum: <ul style="list-style-type: none"> • DME • Lab • ADHC Increased the number of claims for dental and inpatient services to provide statistically valid number of claims. Beneficiary eligibility was reviewed for fee-for-service and managed care programs.	
Factors Impacting Error Rate	Volume of claims Number of errors Dollar value of errors		Volume of claims Number of errors Dollar value of errors	
Strata & Sampling Unit Differences	FFS/DENTAL 1. Inpatient 22 2. Physician Services 204 3. Pharmacy 426 4. Other Services & Supplies 116 5. Dental 32 Total <u>800</u>		FFS/DENTAL 1. Inpatient 50 2. Physician Services 262 3. Pharmacy 561 4. Other Services & Supplies 50 5. Dental 50 6. DME 50 7. ADHC 50 8. Laboratory 50 Total <u>1,123</u>	
Attempt to Estimate Error Rate Related to Potential Fraudulent Claims	Yes		Yes	
Review Beneficiary Eligibility	No		Yes	
Sample Size for Beneficiary Eligibility	Not reviewed		FFS Cases (taken from 1,123 FFS sample claims) Managed Care Cases	1,026 1,000
Beneficiary Confirmation of Product	Yes		Yes - in select instances to verify receipt of pharmacy services	
Validate medical necessity	Yes		Yes	
Key Findings	<ul style="list-style-type: none"> • A total of 96.43 percent of the dollars in the study sample of 800 claims was billed appropriately and paid accurately, were medically necessary and delivered by an eligible Medi-Cal provider to an eligible Medi-Cal 		<ul style="list-style-type: none"> • A total of 91.60 percent of the dollars in the study sample of 1,123 claims were billed and paid appropriately, were medically necessary and delivered by an eligible Medi-Cal provider to an 	

	MPES 2004	MPES 2005
	<p>beneficiary.</p> <ul style="list-style-type: none"> • A total of 3.57 percent of the dollars in the sample had some indication of billing or payment error, which equates to \$568 million in annual payments that are “at risk” of being paid inappropriately. • Of the 3.57 percent, 1.57 percent disclosed characteristics of potential fraud, which equates to \$253 million annually that are “at risk” to potential loss due to fraud. • The MPES results compare favorably to (1) the GAO’s fraud, waste and abuse estimate of 10 percent, (2) Medicare Program’s 2004 report estimate of 9.3 percent and the study conducted by Illinois in 1998 that reported 4.72 percent. • A comparison to other studies relating to the estimated loss due to potential fraud cannot be made because California is the first state to conduct a study that includes an estimate of potential fraud. • Errors ranged from simple mistakes such as coding errors, to potential fraud such as forged physician signatures and filling prescriptions in excess of the prescribed amount. • All errors were found in the non-institutional providers (Physicians, Pharmacies, DME, etc.) category, of which 71 percent were in the Pharmacy and Physician service category. • Over half of the errors related to no documentation or insufficient documentation either at the billing provider or at the referring provider. • Some errors identified in the MPES had already been identified by DHS independent of the study and corrections were being implemented. • Six of the 41 providers identified as submitting claims suspicious of fraud had already been identified by DHS and administrative sanction had been taken. • Findings from the beneficiary confirmations were deemed unreliable and not used in computing the results of the MPES. 	<p>eligible Medi-Cal beneficiary.</p> <ul style="list-style-type: none"> • A total of 8.40 percent of the dollars in the sample had some indication of billing or payment error, which equates to \$1.4 billion in annual payments. Of the 8.40 percent, 0.97 percent were compliance errors. These resulted from providers failing to comply with one or more required claiming regulations, policies or procedures, but it was appropriate for the service to be provided. • Of the 8.40 percent, 7.43 percent represents the payment error rate attributable to Medi-Cal program dollars “at risk” of being paid inappropriately which are approximately \$1.25 billion. • Of the 8.40 percent, 3.23 percent had characteristics of potential fraud, which equates to \$542 million annually that are “at risk” for loss due to fraud. • Of the 113 unique providers submitting potentially fraudulent claims, 21 had already had been independently identified by CDHS and were in case development or on administrative sanctions when the study was conducted. • Errors ranged from simple mistakes such as coding errors, to potential fraud such as forged physician signatures and filling prescriptions in excess of the prescribed amount. • A comparison to other studies relating to the estimated loss due to potential fraud cannot be made because California is the only state to conduct a study that includes an estimate of potential fraud. • No billing or payment errors were identified in the MPES relative to hospital or nursing facility services. • All errors were found in the non-institutional providers (Physicians, Pharmacies, DME, etc.) category. • Payments to pharmacies, physician services and ADHCs

	MPES 2004	MPES 2005
		<p>disclosed the highest error rates.</p> <ul style="list-style-type: none"> • ADHCs had the highest percentage of claims completely in error and the greatest number of errors with no medical necessity. • The single largest error type of all payment errors, 45 percent, was that the documentation did not support medical necessity for the services billed. • The second largest error type for payment errors, 37 percent, resulted from insufficient documentation either by the billing provider or the referring provider. • Pharmacy errors contribute almost half of the overall MPES 2005 error rate (4.05 percent of the 8.40 percent). Most of the pharmacy errors were compliance errors. • Physician services errors were the second highest contributing stratum. Physician errors involved miscoding, no documentation or insufficient documentation. • Two dental claims were found to be in error. These two claims revealed substandard and/or abusive patient care involving lack of anesthesia when warranted and billed but not delivered. • Also identified were two errors in physician and pharmacy services which identified substandard care. Both errors led to subsequent hospitalizations, and human suffering, and therefore, increased costs to the Medi-Cal program. • Review of 1,000 Managed Care beneficiaries found 56 eligibility errors, or 5.6 percent. Forty four of these errors were from Los Angeles County, with the majority due to incomplete redeterminations. • The eligibility errors for full scope FFS reviews was 5.5 percent although, the sample was not a random sample of beneficiaries. The errors associated with eligibility

	MPES 2004	MPES 2005
		for managed care and FFS are not included in the 8.40 percentage of claims error calculation, however, these eligibility errors do result in a fiscal impact to the program.
Potential Fraud Claims	45	124
High-Risk Provider Groups	<ul style="list-style-type: none"> • Physician Services • Pharmacies 	<ul style="list-style-type: none"> • ADHCs • Physician Services • Pharmacies • Dental (patient abuse)
Recommendations	<ul style="list-style-type: none"> • Complete the development of cases on the providers identified as potentially fraudulent and take the appropriate action, such as an administrative sanction and/or referral to DOJ. • Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted. • Expand the number of investigational and routine compliance audits, (specifically in the area of physicians, physician groups and pharmacies); to provide a more in-depth look at billing code abuses that may not be identifiable through the pre-payment edits and audits. • Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclosure information. • Develop a plan for educating providers on appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins. • Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses. • Evaluate the results of the study to 	<ul style="list-style-type: none"> • Complete the development of cases on the providers identified as potentially fraudulent and take the appropriate action, such as an administrative sanction and/or referral to DOJ. • Conduct on-site reviews of approximately 2,000 pharmacies to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse. • Expand use of new automated technology to better identify potential fraud schemes. This is a significant new development that will permit CDHS to identify patterns of potential fraud and abuse that CDHS has not previously been able to identify without on-site visits to providers. • Expand the number of investigational and routine field compliance audits in the areas of ADHCs, physicians and pharmacies to identify provider claim errors as identified in the MPES 2005 and take appropriate corrective actions and apply appropriate sanctions. • Work with the Legislature to enact reform of ADHC services as proposed by the California Department of Aging and CDHS. Reforms include revising the payment methodology and implementing more intensive monitoring of ADHCs. CDHS will

	MPES 2004	MPES 2005
	<p>identify where Medi-Cal laws, regulations and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors.</p> <ul style="list-style-type: none"> • Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software. • Use the study findings to develop the methodology and focus of the 2005 MPES. 	<p>perform additional unannounced visits to ADHC providers identified as having submitted erroneous claims and place administrative controls on these providers as appropriate.</p> <ul style="list-style-type: none"> • Increase the number of claims examined randomly each week from 100 to 200 claims. This claims review process will focus on the physician and pharmacy provider claims. • CDHS is partnering with professional licensing boards and provider associations to educate the various providers as to the types of documentation issues identified in MPES 2005 in order to focus on those parts of the Medi-Cal program at greatest risk for fraud, waste and abuse. • To focus on resolution of the findings related to beneficiary eligibility issues: CDHS will continue its ongoing program for county Medi-Cal eligibility quality control reviews that includes a monthly random sample of approximately 225 cases to identify error trends by category and county, and targeted reviews of selected counties to examine specific problem areas. CDHS will work with the Legislature to enact changes to the statute to increase county compliance and accountability standards for completing timely determinations and redeterminations of eligibility. CDHS will work with the Legislature to obtain additional budget resources to increase and strengthen comprehensive monitoring of county compliance with eligibility determination performance standards. • Provide feedback to providers regarding their billing practices when billing patterns change beyond the providers' normal billing history or when billing patterns are beyond the expected range of other similar providers.

	MPES 2004	MPES 2005
		<p>As part of the ongoing feedback to providers, 1,114 letters describing their billing patterns and any areas of concern are being mailed to various providers.</p> <ul style="list-style-type: none"> • A self –verification system is underway and will be expanded to allow providers, who have not submitted claims in a fraudulent or abusive manner, to self-identify and self-correct system problems within their organizations and remit any inadvertent overpayment(s) they may have received. Providers can identify and correct internal system errors more efficiently than outside auditors. The self-verification process is a team approach between CDHS and providers to identify problems and initiate corrective actions more expeditiously. CDHS will verify the results of self-verifications as appropriate. The goal is to allow CDHS staff to perform more difficult audits as well as to perform an increased number of field audits. • Review claiming patterns, develop cases, and place sanctions on those providers identified as having claims with errors including those that are potentially fraudulent. To this end, the claiming patterns for 138 of the 203 providers with errors were reviewed. Of those reviewed, 68 have been assigned for field review. An additional 44 have been referred for audit. A total of 65 different controls have been placed on billing and/or referring providers related to the claims in error. • Use the MPES 2005 findings to assist in developing the methodology and focus of the MPES 2006.

APPENDIX III

SAMPLING AND ESTIMATION METHODOLOGY

In the two sections that follow, this appendix describes how the Error Rate Study sample was selected and the error rate was estimated.

Sampling Plan

Sampling Unit

Sampling was done at the claim level. That is, a sampling unit included all detail lines of the claim.

Universe of Claims Paid In Study

The sampling universe consisted of Medi-Cal fee-for-service claims paid through the fiscal intermediary, Electronic Data Systems, as well as dental claims paid during the months of October 1, 2004 through December 31, 2004 inclusive (Table I). Claims with zero payment amounts and adjustments were excluded from the universe. However, all adjustments to a sampled claim that occurred within 60 calendar days of the original adjudication date were included. Dental claims do not report the adjudication date. Therefore, the check date was used as a substitute for the adjudication date for dental claims.

Table I – Claims Paid In Universe By Stratum

Strata	Claims	Dollars Paid	% of Total Claims Volume
ADHC	406,294	\$87,655,628	1.25%
Dental	1,419,656	\$154,041,783	4.38%
Durable Medical Equipment	306,887	\$29,558,596	0.95%
Inpatient	882,451	\$1,656,440,246	2.72%
Labs	1,377,397	\$46,185,003	4.25%
Other Practitioners & Clinics	8,562,229	\$744,417,656	26.39%
Other Services & Supplies	1,380,569	\$166,695,184	4.26%
Pharmacy	18,105,709	\$1,308,403,593	55.80%
Total	32,441,192	\$4,193,397,689	100.0%

Sample Size

The sample size selected was 1,123. The sample size was estimated to ensure a 95% confidence level with a +/-3% precision relative to the overall payment error rate. To

ensure that sample size generated results that were sufficient for “decision making”, each stratum contained a minimum sample size of 50.

Sample Stratification

A proportional stratified random sample was drawn. The sample observations were divided into eight strata. Below is a list of the strata, including the vendor codes associated with each stratum.

- **Stratum 1 – Adult Day Health Care (ADHC)**, vendor code = 01 (ADHC)
- **Stratum 2 – Dental**, plan = 0, claim type = 5 (Medical), and vendor code = 27 (Dentists)
- **Stratum 3 – Durable Medical Equipment**, provider type = 02 (DME)
- **Stratum 4 – Inpatient**, claim type = 2 (Inpatient), and vendor codes in list:

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

- **Stratum 5 – Labs**, vendor code in list:

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

- **Stratum 6 – Other Practices and Clinics**, vendor code in list:

5	Certified Nurse Midwife
7	Certified Pediatric Nurse Practitioner
8	Certified Family Nurse Practitioner
9	Respiratory Care Practitioner
12	Optometric Group Practice
13	Nurse Anesthetists
20	Physicians Group
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 Dialys
72	Surgicenter
75	Organized Outpat Clinics
77	Rural Health Clinics / FQHCs
78	Comm Hemodialysis Center
91	Outpat Heroin Detox

- **Stratum 7 – Other Services and Supplies**, all other claims that do not meet the criteria for the other strata.
- **Stratum 8 – Pharmacy**, vendor code equal to 26 (Pharmacies)

The sample sizes within each stratum were determined using the proportion of the total number of claims represented by each stratum for claims paid between the dates of October 1, 2004 through December 31, 2004 inclusive (Table I). The sampling strata and calculated stratum sizes are depicted in Table II.

Table II – Sample Size By Stratum

Strata	Sample Size	Dollars Paid
ADHC	50	\$8,290.46
Dental	50	\$5,635.25
Durable Medical Equipment	50	\$7,735.37
Inpatient	50	\$63,817.09
Labs	50	\$1,103.80
Other Practitioners & Clinics	262	\$27,611.20
Other Services & Supplies	50	\$2,414.78
Pharmacy	561	\$41,396.89
Total	1,123	\$158,004.84

ESTIMATION

Payment Error Rate

CDHS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits¹. To calculate the payment error rate, the following steps were utilized. First, dollars 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. Second, each of the accuracy rates for the eight strata were weighted by multiplying the payments made for services in the corresponding universe stratum and summed to arrive at an overall estimate of payments that were made correctly. Third, this estimate of the correct payments was divided by the total payment made for all services in the universe to arrive at the overall payment accuracy rate. The projected annual payments made correctly was calculated by multiplying three quantities: 1) the payment accuracy rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the year). Finally, the error rate and projected annual dollars paid in error were calculated as follows:

- 100 Percent Minus the Overall Accuracy Payment Rate = Payment Error Rate
- (Payment Error Rate X 4th Quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling) X 4 Quarters = Projected Annual Payments Made In Error

Table III- Calculation of Payment Accuracy Rate By Stratum

Stratum	Dollars Paid in Sample Stratum	Dollars Found to be Paid correctly After Review	Payment Accuracy Rate by Stratum	Payment Error Rate
ADHC	\$8,290.46	\$3,131.31	37.77%	62.23%
Dental	\$5,635.25	\$4,511.02	80.05%	19.95%
Durable Medical Equipment	\$7,735.37	\$7,154.44	92.49%	7.51%
Inpatient	\$63,817.09	\$63,817.09	100.00%	0.00%
Labs	\$1,103.80	\$951.48	86.20%	13.80%
Other Practitioners & Clinics	\$27,611.20	\$24,946.72	90.35%	9.65%
Other Services & Supplies	\$2,414.78	\$2,170.16	89.87%	10.13%
Pharmacy	\$41,396.89	\$36,023.57	87.02%	12.98%

¹ William G. Cochran, Sampling Techniques (John Wiley & Sons, 1977), 164.

Table IV – Overall Estimate of Payments Made Correctly

Stratum	Total Dollars Paid for Services in Stratum Universe (4th Q 2004 FFS Medi-Cal/ Dental and Paid Claims)	Payment Accuracy Rate By Stratum	Overall Estimate of Payments Made Correctly By Stratum	Overall Estimate of Payments Made Incorrectly By Stratum in 4th Q 2004
ADHC	\$87,655,628	37.77%	\$33,107,531	\$54,548,097
Dental	\$154,041,783	80.05%	\$123,310,447	\$30,731,336
Durable Medical Equipment	\$29,558,596	92.49%	\$27,338,745	\$2,219,851
Inpatient	\$1,656,440,246	100.00%	\$1,656,440,246	\$0
Labs	\$46,185,003	86.20%	\$39,811,473	\$6,373,530
Other Practitioners & Clinics	\$744,417,656	90.35%	\$672,581,352	\$71,836,304
Other Services & Supplies	\$166,695,184	89.87%	\$149,808,962	\$16,886,222
Pharmacy	\$1,308,403,593	87.02%	\$1,138,572,807	\$169,830,786
Total	\$4,193,397,689	91.60%	\$3,841,152,283	\$352,245,406

Confidence Intervals

Confidence limits were calculated for the payment accuracy rate at the 95% 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.

Formulas

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} = estimate of dollar value of accurate payments

X = known dollar value of total payments in the universe

Xh = known dollar value of total payments in the universe for stratum h

y_h = sample estimate of the dollar value of accurate payments for stratum h

x_h = sample estimate of the dollar 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 above formula is equation 6.44 from Cochran, found on page 164.)

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

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

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

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

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

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

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

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

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

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

REVIEW PROTOCOLS

Processing Review Protocol

Validation of claims processing focused on correct submission of claim data to EDS and Delta Dental and accurate claim adjudication resulting in payment. The claim processing systems were reviewed by comparing the provider's billing information and medical/dental records to the adjudicated claims. Prescribed audits and edits within the EDS and Delta Dental adjudication process were reviewed in conjunction with medical review of the sample claims.

Medical Review Protocol

Documentation Retrieval for Claim Substantiation

To ensure the integrity of documentation, the multidisciplinary staff attended comprehensive standardized training sessions on the data collection and evaluation process. This multidisciplinary team then collected documentation supporting ordered services from prescribing or referring providers in person, or by telephone or fax. In some cases, many requests were necessary to obtain the documents needed to complete the claim review. These efforts occurred at multiple levels of the medical review process.

First Level Medical Review

Initial review of claims was conducted at multiple field offices by CDHS staff, using standardized audit programs specific to each provider type, who collected the data and a second review was performed by supervisors and licensed medical staff (e.g. physicians, dentists, and registered nurses).

All claims were reviewed for the following six components:

1. Episode of treatment was accurately documented;
2. Provider was eligible to render the service;
3. Documentation was complete;
4. Claims were billed in accordance with laws and regulations;
5. Payment of the claim was accurate; and
6. Documentation supported medical necessity.

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

Second Level Medical Review

To ensure consistency and accuracy of the first level review findings, a Peer Review Committee (Committee) of medical, dental, and pharmacy consultants subjected all

claims with dollar errors to second level review. The Committee gave a consensus opinion on all aspects in the first level review, and consulted with other specialists, such as optometrists and psychiatrists, when necessary. In addition, Medi-Cal program specialists were also consulted to ensure accuracy. For example, pricing errors were discussed with fiscal intermediaries (EDS or Delta Dental) and provider eligibility errors were referred to CDHS' Provider Enrollment Branch (PEB).

Third Level Medical Review

The third level review consisted of all claims identified as potentially fraudulent to be reviewed and confirmed as fraudulent by the Department of Justice. Medical consultants, pharmacy consultants, and an ADHC expert nurse consultant reviewed these claims to ensure that all errors were established through Medi-Cal policy.

Quality Assurance of Non-Errors Protocol

A sample of claims found to have no errors in the initial review were reviewed a second time for quality assurance. The second review of the sample did not find any inaccuracies.

Medical Review Protocol For Assessing Potentially Fraudulent Claims

Level I Review

Presence or absence of medical documentation and provider cooperation with documentation requests.

Level II Review

Service medically necessary or not.

Level III Review

Contextual analysis of all aspects of the claim and evaluation for characteristics associated with fraud and abuse. Often suspicious cases would have more than one characteristic. Some of the characteristics for potential fraud were:

1. Medical records were submitted but documentation of the billed service does not exist and is out of context with the medical record.
2. Context of claim and course of events laid out in the medical record did not make medical sense.
3. No record that the beneficiary ever received the service.
 - Contacting beneficiaries to verify receipt of services was not a part of the study protocol. This was done in 2004 with all the claims but the process was deemed unreliable. The negative beneficiary responses were determined through further investigation to be invalid.
 - The review of errors in MPES 2005 identified several pharmacies were not in compliance with new statute regarding signature of receipt of pharmaceutical products
 - As many as possible of the beneficiaries attached to these claims were contacted to verify receipt of pharmaceutical products

4. No record to confirm the beneficiary was present on the day of service billed.
5. Direct denial that the service was ever ordered by the listed referring provider.
6. Cooperation and attitude of providers and their office staff when contacted by CDHS.
7. Level of service billed was markedly outside of the level documented.
8. Policy violations that were illegal or outside accepted standards of ethical practice or contractual agreements.
9. Medical record discrepancies coupled with a failure to run a legal business and fulfill licensing requirements.
10. Medical record discrepancies coupled with the fact that the provider had a prior negative record of sanctions with CDHS.
11. Medical record discrepancies for services with a historical record of abuse.
12. Multiple types of errors on one claim.
13. Billing for a more expensive service than what was documented as rendered.
14. No actual place of business at the provider site listed.

Level IV Review

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

Level V Review

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

Beneficiary Eligibility Selected Sample Methodology For Fee-For-Service

In addition to the overall assessment of payment error, the MPES 2005 also included reviews of both the FFS and Medi-Cal Managed Care programs to determine if beneficiaries were eligible for Medi-Cal at the time services were rendered. This review process was conducted by CDHS' Medi-Cal Eligibility Branch, Program Review Section (PRS). See Appendix XIII for additional information.

SUMMARY OF PAYMENT ERRORS

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

There were 191 Fee-For-Service (FFS) medical provider errors and 12 dental provider errors for a total of 203 errors in the 1,123 claims sampled. These errors were also used to identify the program vulnerabilities to determine the areas of greatest risk for loss to the Medi-Cal program. A summary of the findings by type and strata is presented below. See Appendix VII for explanation of each error and Appendix VIII for explanation of the error reason codes.

Medical Provider Errors

There were a total of 203 errors identified in the MPES 2005 for medical providers. Errors were placed into two categories, processing errors (3), and medical review errors (200). Of the 203 errors 124 were identified as having a potential for fraud, waste, and/or abuse and were referred to the Department of Justice for review. Attachment VI is a summary of the potentially fraudulent claims.

Number of Medical Errors by Provider Type

Error Type	Inpatient Hospital	Adult Day Health Care	Dental	Durable Medical Equipment	Laboratory	Physician Services	Pharmacy	Other Services	Total FFS
Processing Errors									
Ineligible provider (P9)							1	2	3
Medical Review Errors									
No Documents Submitted (MR1)						1			1
Insufficient Documentation (MR2)		3	9	2	1	20		5	40
Coding Errors (MR3)(PH4)			3			20			23
Medically Unnecessary (MR5)		28		5	4	9	22		68
Policy Violation (MR7)(PH10)						4	11	4	19
No Beneficiary Signature of Receipt (MR9) (PH1)					3		1		4
No Legal Prescription (PH2)				2		1	22		25
Prescription Missing Essential Information (PH3)							9		9
No Record of Drug/Supply Acquisition (PH6)							2		2
Refills too frequent (PH7)							9		9
TOTAL	0	31	12	9	8	55	77	11	203

SUMMARY OF NOTABLE FINDINGS BY REVIEW TYPE

Processing Errors

Processing errors are claims incorrectly submitted and/or paid because they did not trigger one of the many audits and edits built into the claim processing system. Processing errors may meet one the following eight identified criteria: non-covered services; Managed Care covered services; third party liability; pricing errors; logical edit; ineligible recipient; ineligible provider; and, data entry errors. There is a complete description of processing errors in Appendix VIII.

Examples:

Although there were three ineligible providers identified, they were rendering/referring providers and the claims processing system evaluates only billing providers.

Medical Review Errors

Medical review errors were comprised of claims with no documentation, claims with insufficient documentation, coding errors (i.e. up-coding), claims where the documentation did not support medical necessity of the service, missing signature of the recipient, and claims paid which were in conflict with Medi-Cal policy. Error types are assigned depending on the error and the most potentially costly errors. The most serious errors are: a lack of medical necessity, a legal requirement not met by the provider, insufficient or no documentation, coding errors, ineligible providers and policy errors. Examples follow per strata. There is a complete description of medical review errors in Appendix VIII.

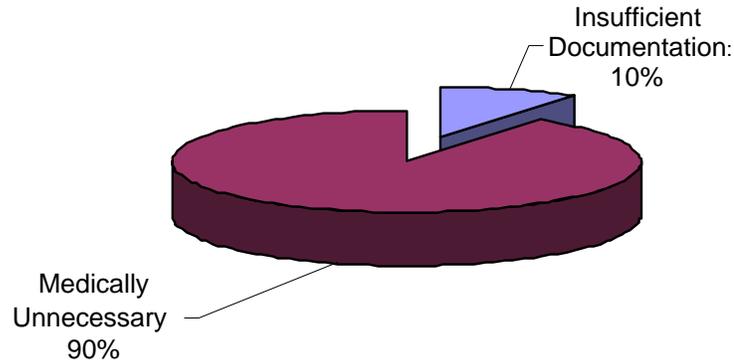
Inpatient Hospital and Nursing Facilities

No errors were identified in this stratum made up of hospitals and long-term care facilities.

Adult Day Health Care

Thirty-one Adult Day Health Care claims were noted as having errors. Adult Day Health Care errors were in the following types:

Adult Day Health Care Errors by Type



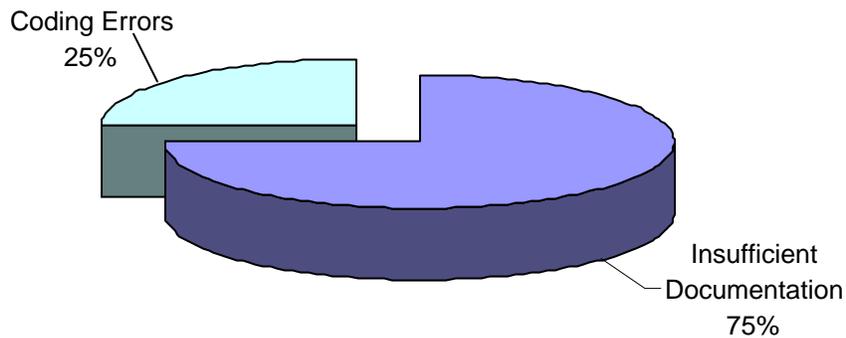
Examples:

- Insufficient/Poor Documentation: Records reveal diagnoses and functional problems for a beneficiary, which justifies ADHC services. However, documentation of activities and or progress was not noted in the record.
- Medically unnecessary: This claim was for a patient who resides in a board and care facility and according to the primary physician, the patient is independent except for assistance with taking medications. This service is provided by the board and care facility where the patient resides. The patient is able to leave the residential care facility unassisted; therefore, there is not a high potential for deterioration according to the patient's primary care physician. This makes ADHC services medically unnecessary.

Dental Provider Errors

Twelve dental claims were noted as having errors. Dental errors were in the following types:

Dental Errors by Type



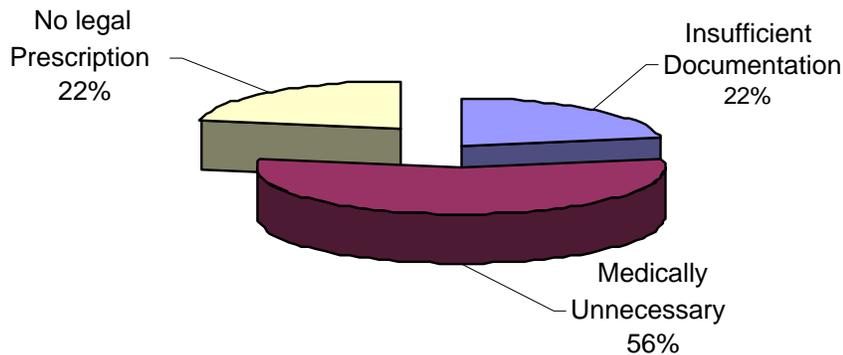
Examples:

- Insufficient documentation: There is no documentation in the dental record the services were provided.
- Coding errors: A provider billed for surgical extraction of a tooth, which is procedure code 202. The documentation is insufficient to support surgical extraction so should have been billed as a simple extraction, which is procedure code 200.
- Medically unnecessary services: There were no errors based on medically unnecessary services.
- Substandard dental care:
 - Tooth extraction without documentation of anesthesia.

Durable Medical Equipment

Nine Durable Medical Equipment (DME) claims were noted as having errors. DME errors were in the following types:

Durable Medical Equipment Errors by Type



Examples:

- Insufficient Documentation: A claim was submitted for an alternating pressure pad for the bed, which is used to help prevent skin breakdown. The item was shipped from the DME provider to the skilled nursing facility via United Parcel Service (UPS). There was no signature obtained to verify receipt. The tracking information available via the tracking number shows the item was delivered on the day of the claim; however, there is no documentation at the skilled nursing facility the mattress was ever placed on the resident's bed. The telephone order slip was completed by the facility staff and forwarded to the DME provider. However, the order was not transcribed to the physician orders in the medical record.
- Medically unnecessary: A claim was submitted for an electric heating pad. The physician's records do not document any plan for a heating pad, nor any

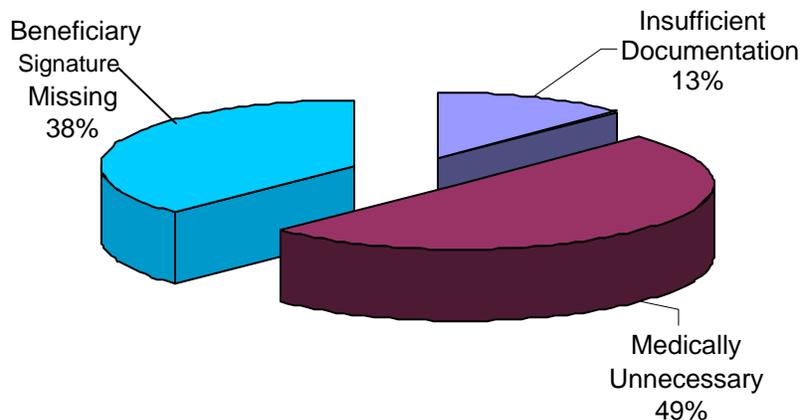
instructions for use, i.e. which part of body to apply it to, duration, etc. The DME provider failed to put the referring physician's license number or name on the claim. This claim should not have been paid by EDS (second error WPI-B). On the same date of service, the same DME provider also dispensed urinary incontinence supplies without meeting code I (one) restrictions, and the physician signed a prescription for the supplies even though his records documented that the patient had no urinary incontinence.

- No legal prescription: A claim was submitted for liquid Oxygen. No prescription could be found. The DME provider moved to another location without notifying Medi-Cal. The owner refused to provide a purchase invoice for this product. The owner stated a "sister company" provided this service. Since the billing provider did not provide the service, this is a violation of the California Code of Regulations, title 22, section 51470(a), which states "A provider shall not bill or submit a claim ...for Medi-Cal benefits not provided to a Medi-Cal beneficiary."
- No record of acquisition of supplies: This is a claim for an oxygen concentrator. The provider informed reviewers that the company acquired approximately 5,000 concentrators from secondary markets, such as financial institutions and business closures. However, the provider was unable to provide documentation of the purchase of the oxygen concentrators. There was also no patient signature to document receipt of this equipment on or near this date of service.

Laboratory

Claims from eight laboratories were noted as having errors. The claim errors were attributed to the referring provider. Laboratory errors were in the following types:

Laboratory Errors by Type



Examples:

- Insufficient Documentation: A claim was submitted for single vision lenses. The medical record was largely illegible, except the prescription plan for glasses, which specifies bifocal lenses, not single vision. Two prescriptions were written for glasses, one for distance and one for near. There is no documentation to

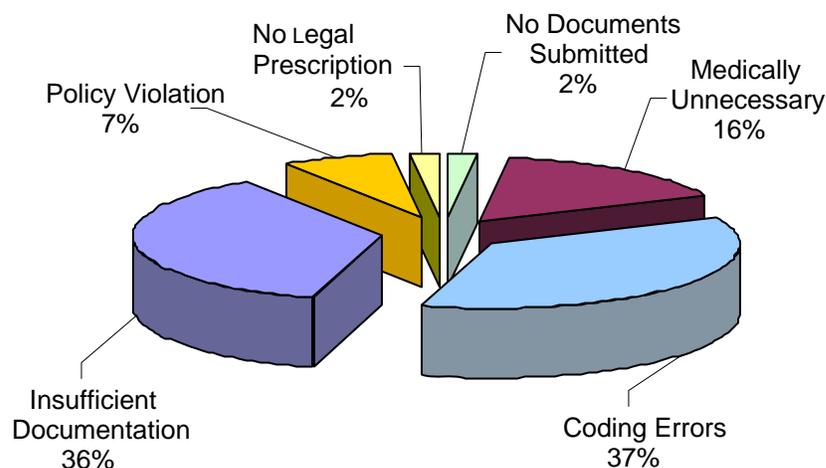
justify single vision lenses in lieu of bifocals. Only one pair of lenses was actually made and billed, however, there is no evidence that glasses were dispensed to the patient.

- **Medically Unnecessary:** A claim was submitted for a Chlamydia test. The test was done based on a physician's order, but the test was not medically necessary, since the patient had a negative test for Chlamydia in the same doctor's office earlier, had no new complaints, and no history of a new partner. The physician's office that collected the specimen did not obtain the recipient's signature for this lab test, as required by Welfare and Institutions Code section 14043.341(a). In addition, the laboratory was not eligible to bill at this location.
- **No Signature of Receipt:** A claim was submitted for single vision reading lenses. The medical record does not document a need for these glasses (no complaints, and no near vision test.) The medical record is largely illegible. The claim does not identify the referring provider, or the name and address of the beneficiary. There is no evidence that the glasses were received.

Physician Services

Fifty-five physician services claims were noted as having errors. Physician services provider type includes physicians, clinics, and other licensed providers. Insufficient/poor documentation and coding errors continue to be high, as identified in the MPES 2004, accounting for 46 percent of errors by this provider type identified in that study. In the MPES 2005, 77 percent of the errors were found in these error types. Physician services errors were in the following types:

Physician Services Errors by Type



Examples:

- **Insufficient Documentation:** A claim was submitted for multiple laboratory tests prior to central line placement on a patient with cancer. There was no documentation that the physician ordered the tests. The facility was not able to

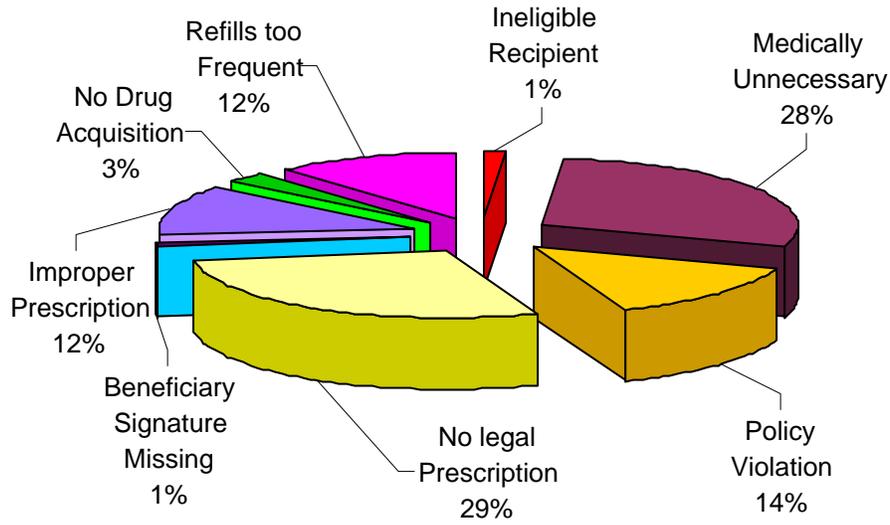
provide evidence of protocol or physician's orders for these tests. An incorrect diagnosis code was used on the claim. A general symptom code was used when there is a specific code for the patient's diagnosis.

- **Coding Errors:** A claim was submitted for a level 5 office visit for an established patient. The medical record documents the patient presented with complaints of "fever, stomach pain, cold, runny nose, and vomiting" written by the medical assistant/ nurse. The office notes have no patient name or physician's name on them. The physician wrote: "Alert, not ill, coop, moist ou, Heart 100, Abd soft non-tender with normal active bowel sounds." There was no diagnosis, and the plan was Tylenol, Dimetapp, and clear liquids. Someone else later wrote "Viral Syndrome 078.89" apparently for billing purposes. None of the criteria for a level 5 office visit were met. The visit would qualify for a level 2 office visit.
- **Medically Unnecessary:** This claim is for a new patient office visit by a podiatrist. The reason given for this podiatry visit is "The patient is a severe asthmatic secondary to drugs [sic]." No problem with the feet was mentioned in the present history by the podiatrist, or by the referring doctor. The podiatrist circled diagnoses related to the feet, but documented no physical findings or history to support the diagnoses. The documentation does not support the medical necessity of this visit.
- **Policy Violation:** This claim is for psychology services in a Federally Qualified Health Center. A beneficiary is entitled to two psychologist visits a month. There is no mechanism in place to authorize an increase in this number. This particular paid claim was for a seventh psychology service for this beneficiary in one calendar month. That is five more than should have been paid.
- **No Legal Prescription:** This claim is for several laboratory tests that were drawn in a physician's office. One of the tests, the sedimentation rate, did not have a physician's order. On follow-up the physician's office stated the test was not intended or medically necessary.

Pharmacy

Errors in pharmacy claims were due to both the pharmacies making errors and errors found in the prescriber's documentation. Twenty seven percent of the pharmacy errors are attributed to the referring physician. Pharmacy errors were in the following types:

Pharmacy Errors by Type



Examples:

- **Insufficient Documentation:** A claim was submitted for medication where there was no medical record documentation to support the need for the medication. The medical records did not mention any problem in this area or that the medication had been ordered.
- **Medically unnecessary:** A claim was submitted for an antibiotic for an 11 year-old patient. The patient's history in the medical record consists of "runny nose sore throat." No physical exam was done. A prescription was written for the antibiotic with no evidence that it was necessary. Unnecessary antibiotics are hazardous both to the patient and to the public health.
- **Policy Violation:** A prescription was written for a six-month supply of medication. The pharmacy would need a TAR to fill this prescription as written. The pharmacy changed the prescription to a 100-day supply to avoid obtaining the TAR, and there is no indication the pharmacy obtained the prescribing provider's permission to change the prescription.
- **No Signature Log:** A claim was submitted for Glucose test strips for diabetes. Test strips were noted as prescribed this date; however, there is no beneficiary signature for receipt of these strips at the pharmacy. Follow-up with the beneficiary revealed that she was not diabetic.
- **No Legal Prescription:** A claim was submitted for a medication to treat high-blood pressure. Medical necessity was documented in the medical record; however, the pharmacy was unable to produce a prescription for this medication. There was no signature log for receipt of this medication.
- **Prescription Missing Essential Information:** A claim was submitted for Singular, a medication for asthma. A new prescription was called in on 7/01/2004 with no refills. On 7/02/2004, the pharmacy's computer data files indicated six refills were

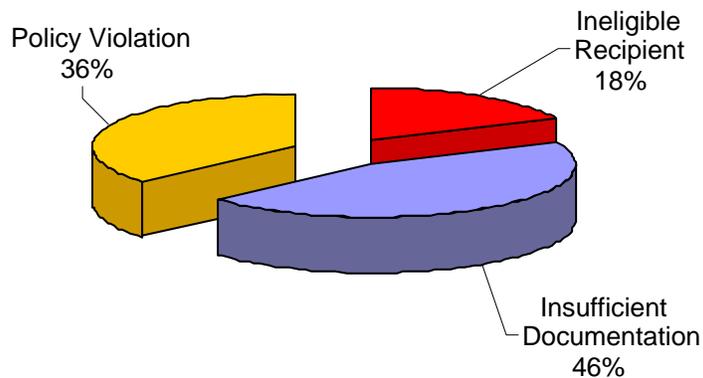
requested via fax. However, there was no documentation at the pharmacy or physician's office to support this.

- **No Record of Drug Acquisition:** A claim was submitted for Flagyl, an antibiotic. The pharmacist stated that he destroyed 2004 drug acquisition invoices. This is in violation of Business and Professions Code section 4081(a) which states "All records of manufacture and of sale, acquisition, or disposition of dangerous drugs...shall be preserved for at least three years from the date of making."
- **Refills Too Frequent:** Claims were submitted for a patient in a long-term care facility where medications are filled on a routine basis, usually monthly. This medication was filled every 15 days, twice as often as the standard. This doubles the dispensing fees the pharmacy can claim.

Other Services and Supplies

Included in this category were transportation, medical supplies, and Local Education Assistance (LEA) programs, among others. Again, the major finding was lack of documentation. Eleven of the claims in this provider type were noted as having errors. Eight were LEA claims, two transportation claims, and one medical supply claim. Other services and supplies errors were in the following types:

Other Services and Supplies Errors by Type



Examples:

- **Insufficient Documentation:** A claim was submitted by a local school for speech therapy services for a student. The Individual Education Plan (IEP) was not written until two months after the service was claimed, and therefore, the school incorrectly billed the procedure code modifier YX. There is neither a physician's prescription, nor a document of minimum standards of medical need signed by a physician. There is no documentation of the nature and extent of services to this individual. There is also no documentation of medical necessity for speech therapy services.

- Policy Violation: A claim was submitted for a tuberculosis skin test given by a school nurse. The test was not given as part of an IEP, and other students who were non-Medi-Cal beneficiaries were not charged for the same test. According to the Medi-Cal provider manual (loc. edu. 9) a school cannot charge Medi-Cal for the services of the school nurse unless non-Medi-Cal students are also charged, unless included in an IEP.

POTENTIAL FRAUD CLAIMS

One of the goals of the MPES 2005 was to identify claims that were potentially fraudulent. Over half of the claims found to have errors were also identified to have characteristics for potential fraud or abuse, such as claiming for services not delivered. While this is significant, it needs to be interpreted with caution. Obviously, a single claim does not prove fraud. Without a full criminal investigation of the actual practice of the provider, there is no certainty that fraud has occurred. The MPES 2005 merely identified the claim as being potentially fraudulent.

The MPES 2005 review protocols called for the medical review team to examine each claim for potential fraud, waste, and/or abuse (Appendix IV). There were 962 unique providers represented in the sample of 1,123 claims. A total of 124 claims, submitted by 113 unique providers, were found to be potentially fraudulent. The Department of Justice (DOJ) reviewed all claims so designated and concurred with CDHS' assessment of potentially fraudulent activity in the 124 claims. The 113 unique providers of these 124 claims are undergoing further review by field audit staff to determine the appropriate actions needed. Of the 113 providers identified as submitting potentially fraudulent claims, 21 had been independently identified by CDHS prior to the MPES 2005 and were already undergoing case development and/or placed on administrative sanction when the study was conducted.

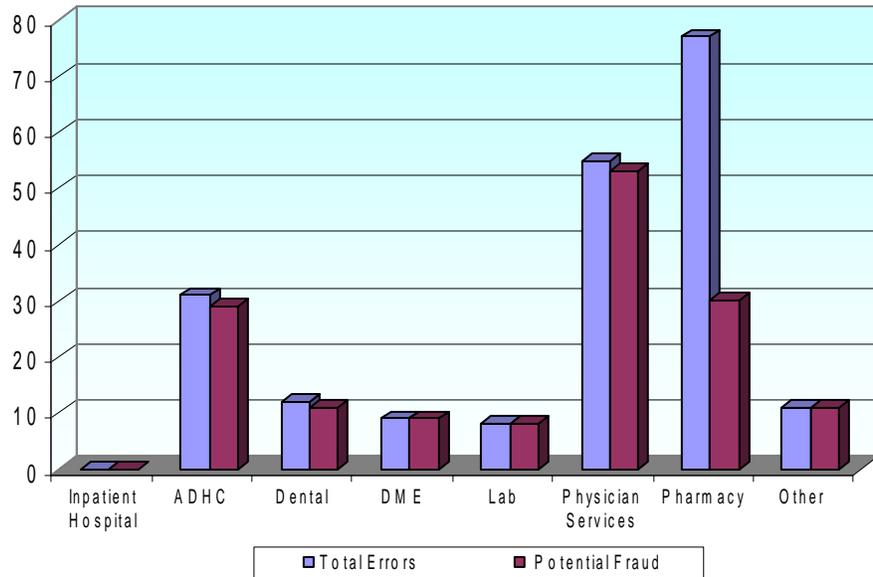
The following table and graph summarizes the types of errors found.

Breakdown of Potentially Fraudulent Claims by Type of Service and Error Code

Provider Type	Number of Potentially Fraudulent Claims	Insufficient Documentation	Coding Error	No Medical Necessity	Policy Violation	Lack of Beneficiary Signature	% Errors by Provider Type ¹
Inpatient Hospital	0	0	0	0	0	0	0.00%
Adult Day Health Care	28	2	0	26	0	0	22.58%
Dental	7	4	3	0	0	0	5.65%
Durable Medical Equipment	5	1	0	3	1	0	4.03%
Laboratory	7	1	0	3	3	0	5.65%
Physician/ Clinic Services	42	14	15	8	1	4	33.87%
Pharmacy	25	0	0	1	24	0	20.16%
Other Services and Supplies	10	5	0	0	2	3	8.06%
Potential Fraud by Primary Errors	124	27	18	41	31	7	
Percent of Errors	100%	21.77%	14.52%	33.06%	25.00%	5.65%	

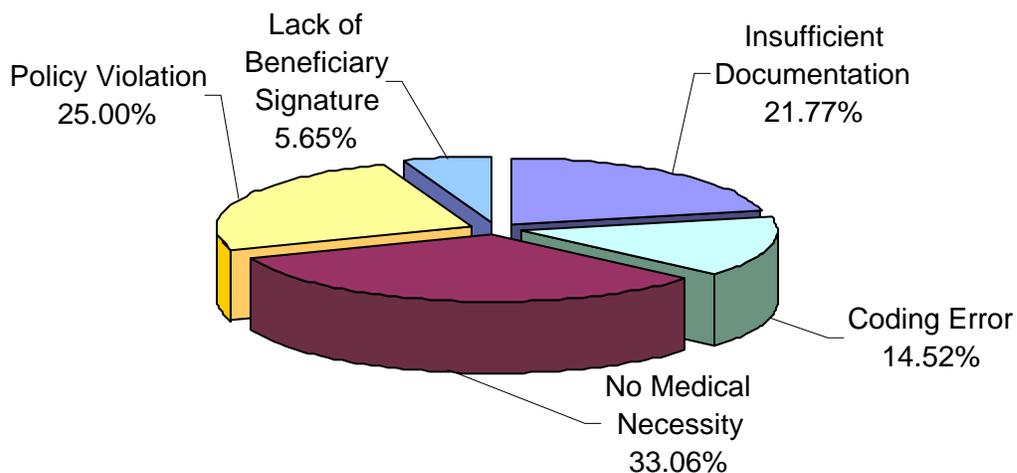
¹ Percentage is calculated using number of claims.

Non-Fraud Errors vs. Potentially Fraudulent Claims by Type of Service



The preceding table and above chart depict that the number of claims identified as having characteristics for potential fraud were concentrated in physician, ADHC and pharmacy services when compared to their respective number of total claims. While pharmacies had many more errors, incidences of claims at risk for fraud were much less.

Summary of Potentially Fraudulent Errors



Documentation Errors

Documentation errors were dominant among potentially fraudulent claims. For twenty-seven (21.77%) claims there was no documentation or insufficient documentation to support the visit or service claimed. Some of these omissions may represent unorganized or incomplete record keeping by providers. Others may be more indicative of serious fraudulent activity that warrants a comprehensive, detailed investigation of the providers claiming patterns.

Unorganized and incomplete record keeping by providers makes the system vulnerable to fraud, waste and abuse, because auditors may be unable to judge whether the service claimed was actually performed. An example of a documentation error identified by MPES 2005 was a provider who billed for three speech and language services, none of which were documented in the record.

Medical Coding Errors

Of the claims with characteristics for potential fraud, there were eighteen (14.52 percent) claims with medical coding errors in the MPES 2005. Although it is not uncommon for documentation to be inadequate or insufficient to justify the level claimed, a few claims had discrepancies that were serious enough to cross the threshold into the potentially fraudulent category. One physician, for example, billed the code 99213 (established patient, level 3, office visit). To bill this code, a provider must document an expanded problem-focused history and/or examination, and medical decision making of low complexity. In this case, the patient was seen for a routine exam. No problems were identified in the patient record and the decision was to have the patient return in six months. Code 99212 (level two) visit would have been the appropriate code for a problem-focused history and/or examination, and straightforward decision-making.

Medically Unnecessary Services

Forty-one (33.06 percent) claims were found to be at risk due to lack of medical necessity. Medical necessity is inherently difficult to judge, as such, only the claims with the most obvious lack of medical need were considered potentially fraudulent. For example, a pharmacy filled a prescription for anti-depressant medication that was over a year old. The prescribing physician's notes contain no documentation for two years regarding the patient's depression or reason for the medication.

Policy Violation

Thirty-one (25.00%) claims fell into the policy violation category. For example, a claim was submitted for an eye examination and glasses. The beneficiary statement regarding loss of prior eyeglasses is inadequate. According to the Medi-Cal Provider Manual (eye app 1), "The statement must certify that a loss, breakage or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the

steps taken to recover the lost item.” In this case the statement included only the words “Lost my glasses.” The wrong rendering provider was identified on the claim. The actual rendering provider is a licensed optometrist employed by this provider and has an inactive Medi-Cal provider number at the same address. The recipient did not sign for receipt of the glasses. The diagnosis code on the claim does not match that in the medical record. Multiple errors suggest the possibility of fraud.

Lack of Beneficiary Signature

The MPES 2005 identified seven claims (5.65%) that did not have a signature or proof that the product or service was dispensed or received. This type of error was more a compliance issue and not counted as an error unless when contacting the beneficiary, the beneficiary denied receiving the product or service. An example of this was a claim that was submitted for test strips for diabetes by a pharmacy. The beneficiary was contacted and denied receiving the product or having diabetes.

Using the protocols in Appendix IV, the following are examples of how errors were classified as fraudulent.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
No Documentation Submitted (MR1)	Pharmacy Claim This claim is for a birth control medication, for 3 cycles with 4 refills. Medical justification is documented in the medical record. However, a signed receipt or delivery log could not be produced by the pharmacy. The pharmacy also could not provide a copy of the dispensing label. The prescription copy from the health center was dated 11/13/03, and the prescription copy from the pharmacy was dated 12/13/03. The prescription was initially dispensed 12/29/03. The prescriptions were identical but different dates of issue were noted. It appears the issue date on one of the prescriptions was altered. If 11/13/03 is the issue date and the refill date is 12/5/04, per the claim history, then this is greater than one year. Receipt of the medication was unable to be confirmed with the recipient.	Providers provided requested documentation to support the claim. Only one provider refused to supply documentation to the reviewers and review of the provider claim patterns did not reveal any further concerns.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
<p>Insufficient Documentation (MR 2-A, MR2-B)</p>	<p>DME Claim This claim is for an oxygen concentrator. The provider informed reviewers that the company acquired approximately 5,000 concentrators from secondary markets such as financial institutions and business closures. However, the provider was unable to provide documentation of purchase of the oxygen concentrators. There was no documentation of receipt of this equipment on or near this date of service.</p>	<p>Physician/Clinic Claim Medical necessity could not be validated because the medical record was illegible.</p>
<p>Coding Error (MR3, PH4)</p>	<p>Physician/Clinic Claim This provider billed a level four office visit for a new patient (reimbursement higher than an established patient). However the patient is documented as being seen 5 days previously. In addition, the detailed level billed was not supported by the documentation.</p>	<p>Dental Claim The provider billed for two procedure code 722 services. This service is an outside laboratory refining of dentures. The dental record documentation shows the provider did the service himself in his office. He should have billed for two procedure code 721 services.</p>

<p>Policy Violation (MR 7, PH10)</p>	<p>Pharmacy Claim This claim is for an over-the-counter antacid, Mylanta. The prescribing physician and the pharmacist are the same person. The drugstore keeps the doctor's prescription pads on hand. According to California Business and Professions Code, section 41111, the pharmacy board shall not issue or renew a license to conduct a pharmacy to a person authorized to prescribe or write prescriptions, or to any person who shares a financial interest with a prescriber. This pharmacist/physician mix of roles constitutes a serious conflict of interest, and is a violation of the law.</p>	<p>Other Services This claim is for 5 sessions of speech and language therapy (X4925) by a special education teacher in a school. The school had neither a physician prescription, nor a protocol of minimum standard for medical need, as required by the Provider Manual ("loc edu" p. 18).</p>
<p>No beneficiary signature (MR9, PH1)</p>	<p>DME Claim There was no signature of receipt for an alternating pressure pad for a bed, which is used to help prevent skin breakdown. The item was shipped from the DME provider to the skilled nursing number information shows the item was delivered on the day of the claim There is no documentation at the skilled nursing facility the mattress was ever placed on the resident's bed.</p>	<p>Pharmacy Claim There were 68 pharmacy claims where no signature was obtained to verify receipt of medication. The requirement for a signature of receipt was a change to the W&I Code 14043.341 in January 2004. Inconsistent compliance with this requirement was found throughout the pharmacy claims reviewed. This lack of verification was tested by contacting beneficiaries to verify receipt. Of those beneficiaries that could be contacted all but one verified receiving the medication. This is a compliance issue and not a program vulnerability issue.</p>

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0005	Dental	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for dental services. The documentation is illegible so the appropriateness of the service claimed could not be determined. The error is calculated as the total amount paid for this claim.	\$116.00	\$0.00	\$116.00
0009	Dental	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for dental services. The provider did not complete the Handicapping Labio-Lingual Deviation (HLD) Form which is a form required for billing for procedure code 551, "Initial Orthodontic Exam and HLD Index." The error is calculated as the total amount paid for this claim.	\$35.00	\$0.00	\$35.00
0015	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. There is no documentation in the dental record the services were provided. The error is calculated as the total amount paid for this claim.	\$87.00	\$0.00	\$87.00
0018	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. The provider billed for procedure code 301 which is for relative analgesia (nitrous oxide and oxygen). There is no documentation in the dental record this analgesia was given to this patient. The error is calculated as the total amount paid for this claim.	\$457.00	\$0.00	\$457.00
0019	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. The provider billed for procedure code 551 which is for initial orthodontic examination. This initial orthodontic exam is not documented in the dental record. The error is calculated as the total amount paid for this claim.	\$17.50	\$0.00	\$17.50
0022	Dental	MR3 - (Coding Error)	This claim is for dental services. The provider billed for surgical extraction of a tooth which is procedure code 202. The documentation is insufficient to support surgical extraction so the service should have been billed as a simple extraction which is procedure code 200. The error is calculated as the difference between procedure code 202 and procedure code 200.	\$95.00	\$55.00	\$40.00
0025	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. The provider billed for procedure code 116, two bitewing X-rays. However, there was no documentation the X-rays were taken. The error is calculated as the total amount paid for this claim.	\$61.75	\$0.00	\$61.75

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0029	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. The provider billed for procedure code 200, extraction of a single tooth. There is no documentation in the dental record the procedure was performed. The error is calculated as the total amount paid for this claim.	\$25.00	\$0.00	\$25.00
0039	Dental	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for dental services. The provider billed for procedure code 646, fillings for two or more teeth. There is no documentation the provider used any local anesthetic for these fillings. This may be substandard care and abuse of the patient if no anesthetic was used. The error is calculated as the total amount paid for this claim.	\$88.00	\$0.00	\$88.00
0040	Dental	MR3 - (Coding Error)	This claim is for dental services. The provider billed for two procedure code 722 services. This service is an outside laboratory refining of dentures. The dental record documentation shows the provider did the service himself in his office which is procedure code 721. The dentist claimed for and was paid for two procedure code 722 services. The dentist should have claimed two procedure code 721 services. The error is calculated as the difference between two 722 services and two 721 services.	\$280.00	\$140.00	\$140.00
0045	Dental	MR3 - (Coding Error)	This claim is for dental services. The provider billed for ten X-rays. However, only nine X-rays were taken, a \$3.00 overpayment. Also, the X-rays were billed as individual films for \$37.00. They should have been billed as one procedure code 117 at \$18.00 and five procedure code 111 at \$15.00, for a total of \$33.00. The error is calculated at the difference between ten individual films billed, the amount that should have been billed for procedure code 117 and five individual films for procedure code 111 which is \$4.00 and the cost of one film that was not taken at all which is \$3.00.	\$92.00	\$85.00	\$7.00
0046	Dental	MR2-B - (Service Claimed is not Documented)	This claim is for dental services. The provider billed for procedure code 061, a child dental prophylaxis and fluoride treatment. There is no documentation to support the service was performed. The error is calculated as the total amount paid for this claim.	\$50.00	\$0.00	\$50.00

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0051	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for the initial three day assessment period for ADHC services. The patient resides in a board and care facility and according to her primary physician she functions independently except for assistance with taking medications. This service is provided by the board and care facility where she resides. The patient is able to leave her residential care facility unassisted. Therefore, there is not a high potential for deterioration according to the patient's primary care physician. This makes ADHC services medically unnecessary according to Medi-Cal regulation. The error is calculated as the total amount paid for this claim.	\$219.18	\$0.00	\$219.18
0052	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for two days of ADHC services for a 44-year-old male with diagnoses of paranoid schizophrenia, and depression, verified only by the ADHC staff physician. There is no evidence of any communication with a primary care physician or psychiatrist. The ADHC records reveal that the patient lives in a board and care home, and is independent in bathing, dressing, ambulation, etc. There is no indication of medical necessity for ADHC services, as required by Medi-Cal regulation. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$139.16	\$0.00	\$139.16
0054	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim for three days of ADHC services for a 71-year-old female with diabetes and hypertension, which are stable, who uses a walker to decrease discomfort in knees. The beneficiary lives with her family and needs supervision with Activities of Daily Living (ADLs), according to the Individual Plan of Care (IPC). The beneficiary has an in home support services care giver that assists with needs as required. The beneficiary is independent in medication administration. ADHC documentation does not support medical need for ADHC services. The error is calculated as the total amount paid for this claim.	\$208.74	\$0.00	\$208.74
0055	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for three days of ADHC services. The patient's primary physician's records do not document medical necessity for ADHC services as required by Medi-Cal regulation. There is very little documentation in the medical record to substantiate medical necessity for anything other	\$208.74	\$0.00	\$208.74

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			<p>than occasional supervision. He is able to self administer medications and according to documentation at the ADHC, his primary problem is depression. The assessments completed by the different professional services are inconsistent, describing the beneficiary at different levels of independence. The nursing assessment and psychological assessment is the same assessment and neither address his depression. There is no indication the beneficiary was seen by a psychologist or psychiatrist for his depression. The current IPC says the beneficiary needs supervision in ADLs except assistance with bathing. The next page of the current IPC states he is unable to provide himself with daily routines and requires increased assistance with ADLs. This inconsistent documentation makes assessing medical necessity very difficult. The error is calculated as the total amount paid for this claim.</p>			
0057	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for two days of ADHC services for a 77-year-old female. The information reported on the Treatment Authorization Request was inconsistent with the documentation in the patient's record. The IPC states she needs assistance/supervision with ADSL. Beneficiary lives alone without apparent problems according to home assessment and uses public transportation as needed. The beneficiary's current primary care physician was unaware his patient was attending ADHC. There was no indication in his records of any health needs requiring ADHC services. The error is calculated as the total amount paid for this claim.</p>	\$139.16	\$0.00	\$139.16
0058	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for two days of ADHC services. There is no evidence that there is a high potential for deterioration and probable institutionalization. The ADHC records list rheumatoid arthritis as the primary diagnosis. The participant's personal physician's records indicate workup for rheumatoid arthritis was negative and the patient given the diagnosis of fibromyalgia in January 1999 and condition was stable. The participant's ADHC care plan states he needs transportation services, yet there is no evidence this service was provided. The ADHC is billing for services which</p>	\$139.16	\$0.00	\$139.16

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			the documentation does not support as medically necessary, and were not requested by his personal physician, and for an inaccurate diagnosis. The error is calculated as the total amount paid for this claim.			
0059	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for two days of ADHC services for a 66-year-old female with arthritis and diabetes with a history of poorly controlled blood sugars. On the ADHC referral form, the referring physician states the diabetes is stable on medications. The physician describes the beneficiary as ambulatory with no assistive devices needed. The beneficiary lives with her husband and provides self care at home. The nursing assessment describes the beneficiary as alert, oriented and independent in ambulation. She also self administers her medications. According to the IPC, the beneficiary is independent in most ADLS except bathing which she needs assistance with. The minimal, inconsistent documentation makes determining medical necessity difficult. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$139.16	\$0.00	\$139.16
0060	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for three days of ADHC services. The ADHC assessment reflects he performs all ADLs independently and the care plan reflects he is able to take public transportation to the center. Medical necessity is not demonstrated. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$208.74	\$0.00	\$208.74
0063	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services. The beneficiary is a 56-year-old female with developmental delay and non-insulin dependent diabetic, who lives with her mother in a Board and Care facility where supervision and assistance in Activates of Daily Living and medication administration is provided as needed. There is no evidence that ADHC services are necessary for this patient, and there is no evidence that the ADHC is coordinating care with the patient's primary physician. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0067	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services. The medical records and nursing assessments indicate that this patient walks 30 minutes 3 times per week without the need for assistive devices, and can take her medications independently. The Individual Care Plan that accompanied the Treatment Authorization Request has medical information that is inconsistent with the assessments done by the ADHC staff. The patient's physician ordered a low sodium diet, but was placed on a regular diet in the ADHC. According to the facility administrator, nutritional counseling and assessment is only provided for diabetics. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0070	ADHC	MR2-A – (Documentation problem errors – poor documentation)	This claim is for one regular day of services at the ADHC for an 80-year-old male with arthritis and cirrhosis. There is no evidence some of the services in the Treatment Authorization Request/Individual Care Plan was provided. One of the "goals" of medical/nursing listed in the patient's care plan was to measure abdominal girth and edema at each attendance. This was not done. The documentation by the different services is inconsistent. There is no evidence of communication with the primary care provider. The IPC describes the beneficiary as independent in eating and toileting and needing supervision or assistance with other ADSL. The nursing assessment flow sheet shows no assistance provided for ADSL. The beneficiary has IHSS care giver to provide assistance as needed at home. The error is calculated as the total amount paid for this claim.	\$208.74	\$0.00	\$208.74
0073	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for four days of ADHC services. According to the Individual Plan of Care, the beneficiary lives at home with a care giver who provides assistance with medications and any other needs. Documentation fails to establish medical necessity for admission to the ADHC. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$278.32	\$0.00	\$278.32

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0075	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for 14 days of ADHC services for a 40-year-old male who is independent in his activities of daily living, and lives at home with his parents due to schizophrenia and mild mental retardation. He is able to use public transportation independently. Medical necessity for ADHC services is not established. According to Medi-Cal regulation, ADHC services may be granted only if there are mental or physical impairments which handicap activities of daily living, and when there is a high potential for further deterioration and probable institutionalization without ADHC services. There was no documentation that the patient's nutritional, grooming, or social problems described in the Individual Care Plan were addressed on any of the dates of service claimed. The ADHC took the patient, along with several other patients, to a doctor who filled out an authorization for the ADHC without taking a complete history or obtaining medical records. The doctor wrote "astigmatism" for exam results under HEENT. There was no documentation of the eye exams needed to make this diagnosis. The history included "abdominal pain after meal" but with no further Gastrointestinal history. The diagnosis was peptic ulcer disease, and Prevacid was prescribed on a monthly basis with no follow-up visit planned. In addition, the ADHC later altered the doctor's report by adding chest X-ray results. There is no evidence that the patient's primary care physician or psychiatrist requested any specific ADHC services or was involved in coordinating care for this patient, as required by Medi-Cal regulation. The error is calculated as the total amount paid for this claim.</p>	\$974.12	\$0.00	\$974.12
0077	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for three days of ADHC services. The beneficiary has a caretaker at home who administers medication and provides assistance as needed. Documentation fails to establish medical necessity for admission to the ADHC. There is no evidence that the patient's primary care physician was involved in coordinating care for this patient. The ADHC center's physician, who is under utilization controls by DHS, wrote patient diagnoses</p>	\$208.74	\$0.00	\$208.74

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			and orders for numerous medications with no instructions for administration. The error is calculated as the total amount paid for this claim.			
0078	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	The claim is for one day of ADHC services. The beneficiary was referred by the ADHC center's physician and all orders were written by this physician. The medication orders are a list of medications with no directions for administration. The beneficiary has a care giver at home who administers medications and provides assistance with ADLs, home care and community access if needed according to the center's discharge plan. The beneficiary is independent in most ADLs and self administers medications according to center's documentation. There are inconsistencies within the documentation in the TAR/IPC. The nursing assessment states the beneficiary's blood pressure is unstable. However, the blood pressures taken at the center are stable and well within the parameters set by the physician referring the beneficiary. There is no evidence the patient's primary care physician was informed of the participant's status and progress, as required by Medi-Cal regulation. Documentation fails to establish medical necessity for admission to the ADHC. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0079	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services for a 48-year-old female with psychotic disorder who lives in a board and care facility. There is no history of psychiatric hospitalization. The participant is capable in ADSL with supervision which is provided by the board and care facility. Her personal psychiatrist's records reflect she is medication compliant. There is no evidence that there is a high potential for further deterioration and probable institutionalization without ADHC services, as required by Medi-Cal regulation. There are no medically necessary services identified that should not already be provided by the board and care facility. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0080	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for ADHC services for a 59-year-old male with schizophrenia living in a board and care facility. While the ADHC Individual Plan of Care (IPC) documented medical necessity for services, no physician documented history or limitations to substantiate this claim. There were two physicians listed as the primary care physician. Neither of them requested services or were involved in coordinating care for this patient. The ADHC physician prescribed physical and occupational therapy which was not done. There is no documentation of coordination of ADHC social services with family, home, or other agencies; and no provider signature for social services. There is no documentation of coordination of care with the patient's attending psychologist or psychiatrist as required by Medi-Cal regulation. There are numerous inconsistencies between the Individual Care Plan, and the individual evaluations. For example, the intake interview by the ADHC physician makes no mention of Schizophrenia. There were also discrepancies regarding patient's family situation, medications, work history, toileting, etc. The physician who prescribes the patient's antipsychotic medication is listed with the medical board as living in Kentucky, and has an expired license. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0081	ADHC	MR2-A – (Documentation problem errors – poor documentation)	This claim is for one day of ADHC services. The patient's primary care physician (PCP) approved ADHC services, but has since closed his practice. Attempts to contact the medical group with the records were unsuccessful. The patient has conditions that make ADHC services medically necessary. The TAR/IPC notes many medical issues that need to be addressed by a physician such as daily knee pain at a level of 6-7. There is a documented 15 pound weight loss over 6 months that is not documented as intentional. There is no documentation of any intervention to manage this unintended weight loss. There is no documentation that the ADHC made any referrals for medical evaluation or intervention for the weight loss or	\$69.58	\$0.00	\$69.58

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			continued pain. The ADHC did not provide the medical services which appeared to be needed. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.			
0082	ADHC	MR5 – (Documentation does not support medical necessity)	This claim is for one day of ADHC services for a 72-year-old female with cardiomyopathy and rheumatoid arthritis which appear to be stable and well managed by her primary physician. Her physician noted she was independent in activities of daily living. Therefore, the beneficiary does not meet all of the criteria for ADHC admission. The Physical Therapy goals that were set by the ADHC were not met due to poor attendance but there are no changes in interventions to meet the beneficiary's needs. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0084	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services for a 79-year-old female. According to Medi-Cal regulation, ADHC services may be granted only if there are mental or physical impairments which handicap activities of daily living, and when there is a high potential for further deterioration and probable institutionalization without ADHC services. According to the primary care physician, this patient is ambulatory, independent for all activities of daily living and medical conditions are stable. Therefore, the documentation does not support medical necessity. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0085	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for three days of ADHC services. The beneficiary has diagnoses of arthritis and knee pain, but does not require any assistive devices for ambulation. There is no evidence in the medical record that this patient has any limitations of activities of daily living, or requires ADHC services to prevent deterioration. Therefore, the beneficiary does not meet all of the criteria for ADHC admission. The patient attends primarily to be with spouse who also attends the ADHC. The facility submitted a service area waiver request with the primary care physician's signature to the Department of Aging. However, the primary care physician	\$208.74	\$0.00	\$208.74

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			denies that this is his signature. There is no evidence that the patient's primary care physician requested any specific ADHC services or goals or was involved in coordinating care for this patient. The error is calculated as the total amount paid for this claim.			
0086	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for two days of ADHC services. The beneficiary is independent or needs supervision for all ADLs. The beneficiary self administers medications. The beneficiary has no special diet requirements. Therefore, the beneficiary does not meet one of the criteria for ADHC admission. The patient's diagnoses are anemia, hypertension and Addison's Disease which he has had for ten years and appears stable. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$139.16	\$0.00	\$139.16
0087	ADHC	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for two days of ADHC services. Records reveal diagnoses and functional problems for this patient that justify ADHC services. However, conflicting documentation on the assessments and IPC made medical necessity difficult to assess. The patient's Primary Care Physician (PCP) requested to be notified if the patient's blood pressure was elevated, and there is no evidence that the ADHC center checked the patient's blood pressure. The error is calculated as the total amount paid for this claim.	\$139.16	\$0.00	\$139.16
0089	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services for a 50-year-old male with diagnoses of schizophrenia and polysubstance abuse. The IPC states the participant is independent or needs supervision with ADLs and medication administration. The beneficiary lives at a board and care facility where these services are available. Through out his stay at the ADHC there is no evidence he is benefiting from this supervision or other interventions since his appearance remains disheveled and dirty. There is no documentation to support medical necessity for ADHC services. The report completed by the physician who signed the "Request for ADHC Services" lacked any details, giving only the diagnoses listed above. No medications were listed. No mental status examination was done. The physical exam	\$69.58	\$0.00	\$69.58

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			<p>documented normal extremities, back, and neck. Despite the lack of a history of medical or orthopedic problems, the referring physician prescribed skilled nursing, physical therapy, occupational therapy, and consultation with a dietitian. There were services documented for these specialties with little or no response to the interventions planned. The ADHC stated on their Individual Plan of Care that the patient had multiple medical and psychiatric conditions for which he takes multiple medications. Throughout the patient's stay at the ADHC, the beneficiary continued to be paranoid and suspicious, having hallucinations, disorganized and confused speech, restlessness, etc. He was noted not to participate in classes. There is no evidence that the ADHC altered any of their planned interventions to improve this patient's health status. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.</p>			
0090	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for one day of ADHC services for a beneficiary diagnosed with schizophrenia. The intake assessments and Individual Plan of Care state the beneficiary is independent in self care but needs supervision with eating. The medication assessment states the beneficiary also needs supervision with taking medications. This beneficiary resides in a board and care facility where supervision with eating and taking medications is provided. The record provided showed many inconsistencies in documentation. Several of the occupational therapy and social service notes are unsigned. Records for different services seem to be written in the same handwriting such as, activity services assessment, social service assessment, nursing quarterly progress notes, referral notes and the initial screening form. Social service notes for a month are in the same handwriting but different notes have different initials. The error is calculated as the total amount paid for this claim.</p>	\$69.58	\$0.00	\$69.58

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0091	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services for a 57-year-old male diagnosed with paranoid schizophrenia that lives in a board and care home. He is independent in ADLs. He has been stable long term on his medication. He receives psychiatric care from the county. There is no evidence there is a high potential for further deterioration and probable institutionalization without ADHC services. The history and physical are entered by the medical consultant for the ADHC and there is no evidence of any communication with the participant's personal psychiatrist, a violation of Medi-Cal regulation. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0092	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for one day of ADHC services for a 74-year-old female with severe mental retardation, post traumatic left hemiparesis, non insulin dependent diabetes, and history of cerebrovascular accident, myocardial infarction, hypertension, schizophrenia, and congestive heart failure. These conditions appear stable. The beneficiary lives in an intermediate care facility (ICF/DD-H). Intermediate care facilities for the developmentally disabled- habilitative furnish 24 hour personal care, developmental training, habilitative and supportive health services to residents with developmental disabilities. The Physical Therapy evaluation states patient is within normal functional limits. The ADHC nursing records show blood sugars which are sometimes in the high 200's range. There is no record that the personal physician was contacted concerning these elevated blood sugars and the participant is on a "regular diet". Progress reports state patient is compliant with psychotropic medication. Elsewhere in the record, it is stated that complete remission of schizophrenia without medication has been achieved. The error is calculated as the total amount paid for this claim.	\$69.58	\$0.00	\$69.58
0093	ADHC	MR5 - (Documentation Does not Support	This claim is for four days of ADHC services for a 22-year-old participant with bipolar and schizophrenic disorders, asthma, and obesity, who lives under court order in a sober	\$278.32	\$0.00	\$278.32

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
		Medical Necessity)	living facility. Diagnoses on the claim are schizophrenic disorder and peripheral vascular disease. The participant is independent in ADLs. There is no evidence that the ADHC is providing medically necessary services that are not available through sober living or the participant's personal psychiatrist. The ICP states that patient will attend addictions group and actively work a 12 step program. There is no documentation this service was provided. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.			
0094	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for three days of ADHC services for an 87-year-old male with diagnoses of hypertension and arteriosclerotic heart disease. There is no evidence that a primary care physician requested ADHC services for this patient. Patient's intake form indicates that he was referred by "TV". The beneficiary lives with his son, performs ADLs with supervision and uses a cane for ambulation. The IPC states the beneficiary has no personal care problems. According to the primary care physician's records and the ADHC nursing flow sheet, the patient's blood pressure is stable on medication and does not demonstrate a potential for decline. He also has no signs or symptoms of ASHD such as dizziness and shortness of breath according to the ADHC nursing flow sheet. There is no documentation to support medical necessity for ADHC services. There is no evidence that the ADHC provided a home visit as required by Medi-Cal regulation. There is no evidence of coordination of care with a primary care physician. The error is calculated as the total amount paid for this claim.	\$208.74	\$0.00	\$208.74
0096	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for two days of ADHC services for a 62-year-old female who according to her primary care physician has depression and joint pain. There is no physician's request for ADHC services. The ADHC records reveal severe pain, gait imbalance, vertigo, severe insomnia, disorientation, uncontrolled grief and a history of hallucinations. The IPC	\$139.16	\$0.00	\$139.16

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			<p>identifies knee pain as a problem. The Physical Therapy assessment states the beneficiary has gait problems because of pain, at a 7-10 on a scale of 1-10, in knee. The IPC states patient walks to center because she lives very close. Map Quest shows the address of record, at the ADHC, as 1.03 miles from the center. The nursing flow sheet describes the knee pain as a 3 on a scale of 1-10. The psychiatric care plan identifies the beneficiary's depression with a plan for the LCSW to have a 1:1 session with the beneficiary in three months. The Social Service section of the same IPC states the LCSW will meet with the patient four times a month. The beneficiary is independent in ADLs. There is no evidence of coordination of care with a primary care physician. The inconsistent documentation and independence in ADLs question the medical need for ADHC services. The error is calculated as the total amount paid for this claim.</p>			
0100	ADHC	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for two days of ADHC services. According to Medi-Cal regulation, ADHC services may be granted only if there are mental or physical impairments which handicap activities of daily living, and when there is a high potential for further deterioration and probable institutionalization without ADHC services. This patient lives with her family and there is no evidence that she requires any assistive services. She was referred to the facility by her son for "socialization." The physician's report states that she is independent for ambulating without assistive devices, and for meals, bathing, dressing, and toileting. The error is calculated as the total amount paid for this claim.</p>	\$139.16	\$0.00	\$139.16
0151	DME	MR5 - (Documentation Does not Support Medical Necessity)	<p>This claim is for an electric heating pad. The physician's records do not document any plan for a heating pad, or any instructions for use, i.e. which part of body to apply it to, duration, etc. The DME provider failed to put the referring physician's license number or name on the claim. The referring physician was on Special Claims Review at the time of this prescription. The error is calculated as the total amount paid for this claim.</p>	\$2.15	\$0.00	\$2.15

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0156	DME	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for rental of a hospital bed. Neither the DME provider, nor the prescribing physician could provide any evidence that the service was needed or rendered. The error is calculated as the total amount paid for this claim.	\$33.59	\$0.00	\$33.59
0173	DME	PH2 - (No Rx for date of Service)	This claim is for rental of a home oxygen concentrator and gaseous oxygen for a patient with severe COPD requiring constant oxygen use since 1997. Current medical treatment and medical necessity are documented, but the most recent prescription was written in 1999 (for lifetime duration.) The DME provider could not document delivery of oxygen during the month of service claimed, nor provide an invoice for its purchase. The error is calculated as the total amount paid for this claim.	\$15.63	\$0.00	\$15.63
0174	DME	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a wheelchair rental for two months (7/04 and 8/04) for a 77-year-old diabetic female attending ADHC. The physician who prescribed the chair did not document its need in the patient's medical record. The patient did sign a request to continue renting the chair on 4/12/04, but her husband called 9/20/04 and demanded the chair be picked up as she was not using it. Despite this call, the physician signed another prescription for a wheelchair on 10/7/04, with a duration of 99 months (lifetime use.) Also, no referring provider was listed on the claim, and therefore it should not have been paid. The wrong referring provider was identified on the claim. The error is calculated as the total amount paid for this claim.	\$16.38	\$0.00	\$16.38
0186	DME	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for rental of a nebulizer with compressor (used for asthma). The prescribing physician's records fail to document the need for this equipment. The error is calculated as the total amount paid for this claim.	\$2.96	\$0.00	\$2.96
0187	DME	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a tub stool or bench. The prescribing physician's records failed to document medical necessity for this item. The error is calculated as the total amount paid for this claim.	\$59.61	\$0.00	\$59.61

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0193	DME	PH6 – (No record of drug acquisition)	This claim is for an oxygen concentrator. The provider informed reviewers that the company acquired about 5000 concentrators from secondary markets such as financial institutions and business closures. However, the provider was unable to provide documentation of purchase of oxygen concentrators. There was also no patient signature to document receipt of this equipment on or near this date of service. The patient has health conditions making oxygen therapy medically appropriate. The error is calculated as the total amount paid for this claim.	\$183.04	\$0.00	\$183.04
0195	DME	PH2 - (No Rx for date of Service)	This claim is for liquid Oxygen. Reviewers found multiple policy violations with this claim. No prescription could be found. The DME company moved to another location without notifying Medi-Cal. The owner refused to provide a purchase invoice for this product. The owner stated a "sister company" provided this service. Since the billing provider did not provide the service, this is a violation of Title 22, section 51470(a) which states "A provider shall not bill or submit a claim ...for Medi-Cal benefits not provided to a Medi-Cal beneficiary. The patient has health conditions making oxygen therapy medically appropriate. The error is calculated as the total amount paid for this claim.	\$168.47	\$0.00	\$168.47
0198	DME	MR2-A – (Documentation problem errors – poor documentation)	This claim is for an alternating pressure pad for the bed which is used to help prevent skin breakdown. The resident was identified as at risk for skin breakdown. The item was shipped from the DME provider to the skilled nursing facility via UPS. There was no signature obtained to verify receipt. The tracking information available via the tracking number shows the item was delivered on the day of the claim There is no documentation at the skilled nursing facility the mattress was ever received or placed on the resident's bed. The telephone order slip was completed by the facility staff and forwarded to the DME provider. However, the order was not transcribed to the physician orders in the medical record. The error is calculated as the total amount paid for this claim.	\$99.25	\$0.00	\$99.25

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0202	Labs	MR5 - (Documentation Does not Support Medical Necessity)	This is a lab claim for 2 blood tests (glucose, and complete blood count). There is no documentation in the medical record that the CBC was necessary or ordered by the physician. There is no beneficiary signature for obtaining a biological specimen, which is required by Welfare and Institutions Code 14043.341. The lab was not eligible to bill at this location. The error is calculated as the total amount paid for this claim.	\$13.65	\$0.00	\$13.65
0204	Labs	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a Chlamydia test. The lab test was done based on a physician's order, but the test was not medically necessary, since the patient had a negative test for Chlamydia in the same doctor's office two months earlier, had no new complaints, and no history of a new partner. The physician's office who collected the specimen did not obtain the recipient's signature for this lab test, as required by W&I Code 14043.341. In addition, the lab was not eligible to bill at this location. Therefore the error is calculated as the total amount paid for this claim.	\$38.80	\$0.00	\$38.80
0223	Labs	MR9 - (No Recipient Signature)	This claim is for single vision lenses. The error was not with the optical lab. The optometrist prescribing and dispensing the glasses did not have a signature log verifying receipt of glasses as required by W&I code 14043.341. The error is calculated as the total amount paid for this claim.	\$16.64	\$0.00	\$16.64
0224	Labs	MR9 - (No Recipient Signature)	This claim is for single vision lenses for a six-year-old patient. The error was not with the optical lab. The optometrist prescribing and dispensing the glasses did not have a signature log verifying receipt of glasses as required by W&I code 14043.341. The error is calculated as the total amount paid for this claim.	\$16.64	\$0.00	\$16.64
0226	Labs	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for single vision plastic lenses. The error was not with the optical lab. The referring ophthalmologist's records did not legibly document the medical necessity for single lens glasses one month after prescribing bi-focal lenses. The optometrist listed on the lens order denied having any record of service for this beneficiary after September 2003. The optometrist prescribing and dispensing the glasses did not have a signature log verifying	\$16.64	\$0.00	\$16.64

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			receipt of glasses as required by W&I code 14043.341.The error is calculated as the total amount paid for this claim.			
0227	Labs	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for single vision lenses for a 70-year-old patient. The error was not with the optical lab. The medical record is largely illegible, except the prescription plan for glasses, which specifies bifocal lenses, not single vision. There is no mention of presence or absence of current glasses. Two prescriptions were written for glasses, one for distance and one for near. There is no documentation to justify single vision lenses in lieu of bifocals as required by the Provider Manual. The optometrist prescribing and dispensing the glasses did not have a signature log verifying receipt of glasses as required by W&I code 14043.341.The error is calculated as the total amount paid for this claim.	\$16.64	\$0.00	\$16.64
0228	Labs	MR9 - (No Recipient Signature)	This claim is for single vision reading lenses. The error was not with the optical lab. The professional signature on the prescription is very different from the signature on the medical record. The optometrist prescribing and dispensing the glasses did not have a signature log verifying receipt of glasses as required by W&I code 14043.341..The error is calculated as the total amount paid for this claim.	\$16.64	\$0.00	\$16.64
0229	Labs	MR9 - (No Recipient Signature)	This claim is for single vision reading lenses for a 46-year-old. The error was not with the optical lab. There was no documentation by the prescribing optometrist of necessity for reading glasses other than age. The change in refraction from previous lenses does not meet Medi-Cal requirements for new lenses. The optometrist prescribing and dispensing the glasses did not have a signature log verifying receipt of glasses as required by W&I code 14043.341. The error is calculated as the total amount paid for this claim.	\$16.64	\$0.00	\$16.64
0251	Other	MR2-B - (Service Claimed is not Documented)	This claim is for an Occupational Therapy consultation and report. The record contains no documentation of a consultation on this date of service other than a "1" in a check box, a code which means 1-15 minutes. There is no documentation of consultation, evaluation, treatment, or a	\$21.19	\$0.00	\$21.19

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			report. There is no progress note for this date of service. The error is calculated as the total amount paid for this claim.			
0255	Other	PH10 – (Other pharmacy policy violation)	This claim is for incontinence supplies. The pharmacist failed to document compliance with code I restrictions. The prescribing physician's records do not document any complaint, treatment, or work-up for incontinence. The error is calculated as the total amount paid for this claim.	\$35.10	\$0.00	\$35.10
0269	Other	MR7 - (Policy Violation)	This claim is for night call transport for dialysis services. Night call is from 7:00 P.M. until 7:00 A.M. The documentation from the provider states the pick up time was 5:15 P.M. and the patient declined the transport. The transport is paid as a response to call "dry run" when the patient declines or cancels the transportation after the transport arrives. The night call should not have been claimed since the response to call was before 7:00 P.M. The error is calculated as the total amount paid for this claim.	\$6.13	\$0.00	\$6.13
0270	Other	MR2-B - (Service Claimed is not Documented)	This claim is for transportation services to and from a dialysis center. There is no documentation of the service for the date of service on the claim. The medical record has no services documented for this date either. The documentation of transport services available is for two days before the claimed date of service. The medical record from the dialysis center documents services four days before and one day after the claimed date of transportation service. There is no dialysis service documented for the day the transportation services are documented. The error is calculated as the total amount paid for this claim.	\$17.65	\$0.00	\$17.65
0274	Other	MR2-B - (Service Claimed is not Documented)	This claim is for speech therapy services for a student under an Individual Education Plan (IEP) by a local school. The IEP was not written until two months after the service was claimed, and therefore the school incorrectly used the procedure code modifier YX. There is neither a physician's prescription, nor a document of minimum standards of medical need signed by a physician, as required by the Provider Manual. There is no documentation of the nature and extent of services to this individual as required by the	\$35.64	\$0.00	\$35.64

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			Provider Manual and Medi-Cal regulation. There is also no documentation of medical necessity for speech therapy services. The error is calculated as the total amount paid for this claim.			
0276	Other	P9-B (Rendering provider not eligible to bill for services)	This claim is for Health/Mental Health Evaluation/Education. The specific services provided by the school nurse were a vision test and a hearing screening test. The Medi-Cal Provider Manual states "LEA providers may only bill for LEA services rendered by qualified medical care practitioners within their defined scope of practice." The Manual further states hearing services are claimable when provided by a licensed audiologist, registered school Audiometrist, speech language therapist, physician or psychiatrist. Also, Title 17, section 2951 requires that hearing thresholds must be documented in the student's record. The school nurse is not qualified to provide this test and did not document the hearing thresholds. The routine screening was a medically necessary service. Since the claim includes two services, the error is calculated as the amount paid for one of the two X4900 services.	\$19.14	\$9.57	\$9.57
0280	Other	P9-B (Rendering provider not eligible to bill for services)	This claim is for Occupational Therapy services. There is a "student contact" note stating that the student had difficulty with the putty and pickup sticks activity, but there was no note of any intervention, treatment, or plan. The provider listed is not a Registered Occupational Therapist as required by the provider manual. There is no evidence an Occupational Therapist saw the student on this date. The student has a medical need for OT services The error is calculated as the total amount paid for this claim.	\$18.33	\$0.00	\$18.33
0282	Other	MR7 - (Policy Violation)	This claim is for a TB skin test given by a school nurse. The test was not given as part of an Individual Education Plan, and other students (not Medi-Cal beneficiaries) were not charged for the same test. According to the Medi-Cal provider manual a school cannot charge Medi-Cal for the services of the school nurse unless non-Medi-Cal students are also charged unless the services are part of an IEP. TB	\$9.57	\$0.00	\$9.57

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			testing is a medically necessary routine screening. The error is calculated as the total amount paid for this claim.			
0288	Other	MR7 - (Policy Violation)	This claim is for five sessions of speech and language therapy (X4925) by a special education teacher in a school. The school had neither a physician's prescription, nor a protocol of minimum standard for medical need, as required by the Provider Manual. The error is calculated as the total amount paid for this claim.	\$59.40	\$0.00	\$59.40
0290	Other	MR2-B - (Service Claimed is not Documented)	This claim is for two units of X4900 YX, which means two separate health assessments (psychosocial, health education, nutrition, hearing, vision, or developmental evaluations) were administered in accordance with a student's Individual Education Plan (IEP). A review of the IEP reveals that there are no health issues, so this service was not rendered in accordance with an IEP. No entry was made in the student's health record. None of the specified assessments were done. The only notation for this student on this date was "Sick 97.0 RTC" which was interpreted to mean the student's temperature was normal and he was returned to class. The error is calculated as the total amount paid for this claim.	\$19.14	\$0.00	\$19.14
0292	Other	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for X4925, speech/audiology services. There was no physician's prescription for this service, and the documentation lacked the amount of time spent, the student's name, and the name, title or signature of the person rendering the service. The services were medically necessary. The error is calculated as the total amount paid for this claim.	\$12.91	\$0.00	\$12.91
0301	Physician Services	MR3 - (Coding Error)	This claim is for a level five office visit for an established patient. In order to appropriately bill for this level of service, the CPT 2004 requires at least two of these three key components: 1) a comprehensive history, 2) a comprehensive examination, 3) medical decision making of high complexity. Physicians typically spend 40 minutes face-to-face with the patient and/or family. The medical record documents the patient is a 14yearold with complaints of	\$62.41	\$19.75	\$42.66

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			<p>"fever, stomach pain, cold, runny nose, and vomiting" written by the office staff. The office notes have no patient name or physician's name on them. The physician wrote a few poorly legible words as follows: "Alert, not ill, coop, moist ou, Heart 100, Abd soft non-tender with normal active bowel sounds. There was no diagnosis, and the plan was: Tylenol, Dimetapp, and clear liquids. "Viral Syndrome 078.89" was written in the record in a different handwriting. None of the criteria for a level five office visit were met. The visit qualifies for a level two office visit. The error is calculated as the difference between the amount paid for 99215, and the amount that would have been paid for 99212.</p>			
0302	Physician Services	MR2-B - (Service Claimed is not Documented)	<p>This claim is for 16 vials of cyclophosphamide (chemotherapy injection), but only 5 vials were given to the patient. The provider also billed for five vials of Dexamethasone at eight milligrams per vial. However the patient was actually given vials containing only four milligrams each. The error is calculated as the amount paid for 11 vials of cyclophosphamide (X7524), plus the amount paid for 5 vials of X6008 (8 mg/cc) minus the amount that would have been paid for 5 vials of X6004 (4 mg/cc).</p>	\$1,386.97	\$1,386.67	\$0.30
0303	Physician Services	MR2-B - (Service Claimed is not Documented)	<p>This claim is for six services. One of the services billed is 36410 ZK. According to the CPT, this code represents non-routine venipuncture by a physician. There is no documentation that the physician was involved in this blood draw, or that it was anything other than routine. Therefore the error is calculated as the amount paid for 36410 ZK.</p>	\$103.25	\$89.54	\$13.71
0307	Physician Services	MR2-B - (Service Claimed is not Documented)	<p>This claim is for "epidural opioid follow-up" (Z0310). The previous day, this anesthesiologist billed the code 01961, which according to Current Procedural Technology 2004, represents anesthesia for C-section only. Procedure code 01961 includes "the usual preoperative and postoperative visits." The anesthesiologist visited the patient 12 hours post-op, and documented that she was "doing very well." There was no separately identifiable service documented, and no complications that would explain the extra claim. This is double-billing. The error is calculated as the total amount paid for this claim.</p>	\$20.84	\$0.00	\$20.84

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0312	Physician Services	MR3 - (Coding Error)	This claim is for a colonoscopy. The medical record does not support the diagnoses used on the claim, nor any personal or family history of colon problems. The patient's age, 57-years-old, would warrant a screening colonoscopy if she had not had one for five years, but the medical record does not say whether or not she had a previous colonoscopy. Therefore medical necessity is not established. Incorrect diagnoses were used to bill for this procedure. The error is calculated as the total amount paid for this claim.	\$330.23	\$0.00	\$330.23
0313	Physician Services	MR3 - (Coding Error)	The claim is for a level three office visit. According to Current Procedural Terminology 2004, a level three office visit for an established patient requires at least two of these three key components: an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity. Physicians usually spend 15 minutes face-to-face with the patient or family for a level three office visit. This two-year-old patient was seen for a "cold"/runny nose. The provider did not listen to the patient's lungs, check height or weight, or document any history other than runny nose. The highest level that would have been appropriate to bill is 99212 (level two office visit.) In addition, the rendering provider is not identifiable in the medical record. The error is calculated as the difference between the amount paid for 99213 (level three office visit) and the amount that would have been paid for 99212 (level two office visit.)	\$26.18	\$19.75	\$6.43
0315	Physician Services	MR3 - (Coding Error)	This claim is for a level four office visit. According to the Current Procedural Terminology 2004, a level four office visit for an established patient requires at least two of these three key components: a detailed history, a detailed examination, and medical decision-making of moderate complexity. Physicians usually spend 25 minutes face-to-face with the patient or family for a level four office visit. The physician's notes, which are poorly legible, consist of "cough, runny nose" for history; "tachypnic, chest with	\$40.91	\$19.75	\$21.16

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			diffuse rales" for exam; "pneumonia" for assessment, and plan is illegible. The error is calculated as the difference between the amount paid for 99214 (level four office visit) and the amount that would have been paid for 99212 (level two office visit.)			
0318	Physician Services	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a limited obstetrical ultrasound one day after billing for a detailed OB ultrasound which had no abnormalities. There were no physician's notes to justify another ultrasound. The error is calculated as the total amount paid for this claim.	\$62.95	\$0.00	\$62.95
0331	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for an office visit, level three. The medical record for this date of service was not in the patient's record at the time of the auditor's visit. The physician produced a note for this date of service after 15 minutes. This note was different from all of the other progress notes in the chart in that the date and patient name were written in the physician's handwriting, rather than that of an assistant. Also, the vital signs were missing. The reviewer suspected that the physician generated the progress note at the time of the audit. Additionally, none of the progress notes identified the name of the rendering provider. The error is calculated as the total amount paid for this claim.	\$26.18	\$0.00	\$26.18
0335	Physician Services	PH2 – (No Rx for date of service)	This claim is for several laboratory tests. One of the tests, the sedimentation rate, did not have a physician's order. The physician's office stated the test was not intended or medically necessary. The error is calculated as the total amount paid for this claim.	\$38.91	\$0.00	\$38.91
0340	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for multiple laboratory tests prior to central line placement on a patient with cancer. There was no documentation that the physician ordered the tests. The facility was not able to provide evidence of a protocol or physician's orders for these tests. An incorrect diagnosis code was used on the claim. They used one for general symptoms when there is a specific code for the patient's diagnosis. The error is calculated as the total amount paid for this claim.	\$9.95	\$0.00	\$9.95

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0362	Physician Services	MR3 - (Coding Error)	This claim is for a level three office visit. According to Current Procedural Terminology 2004, a level three office visit for an established patient requires at least two of these three key components: an expanded problem-focused history, an expanded problem-focused examination, and medical decision-making of low complexity. Physicians usually spend 15 minutes face-to-face with the patient or family for a level 3 office visit. The patient was seen for a refill of the patch; she had no complaints. Labs were reviewed; questions were answered and counseled on personal hygiene. No amount of time was documented. Documentation supports a Level two office visit. The error is calculated as the difference between the amount paid for 99213 and the amount that would have been paid for 99212.	\$24.00	\$18.10	\$5.90
0363	Physician Services	MR3 - (Coding Error)	This claim is for a level two office visit. A level two office visit requires the presence of a physician. This patient came in for a pregnancy test and was seen only by a counselor. Since the counselor did not document the amount of time spent with the patient, an education and counseling code is not payable. Therefore, 99211, a brief office visit which does not require the presence of a physician is the appropriate code. The error is calculated as the difference between the amount paid for 99212, and the amount that would have been paid for 99211.	\$26.75	\$19.10	\$7.65
0364	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a level two office visit. According to CPT 2004, a level two office visit for an established patient requires two of these three components: 1) a problem focused history, 2) a problem focused exam, and 3) straightforward medical decision making. In this case, the patient came in to replace a lost laboratory slip. The visit required no history-taking, examination, or medical decision-making. The error is calculated as the total amount paid for this claim.	\$22.41	\$0.00	\$22.41
0366	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for a level three office visit. According to Current Procedural Terminology 2004, a level three office visit for an established patient requires at least two of these three key components: an expanded problem-focused history, an expanded problem-focused examination, and	\$24.00	\$0.00	\$24.00

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			<p>medical decision-making of low complexity. Physicians usually spend 15 minutes face-to-face with the patient or family for a level three office visit. There was no Chief Complaint for this visit. The results of the patient's upper endoscopy and biopsy were noted as positive for H-Pylori. Her abdomen was noted to be soft and non-distended, and the plan was for a medication called Aciphex. The record was signed by a Physician's Assistant, but billed with a physician's name as the rendering provider. The errors include poor documentation, wrong provider identified, and coding for a level three office visit, when only a level two visit was documented. The error is calculated as the total amount paid for this claim.</p>			
0368	Physician Services	MR2-B - (Service Claimed is not Documented)	<p>This claim is for two services, Z7502 (use of emergency room), and X6596 (Morphine). The claim for Morphine was a technical error according to the chief nurse at the emergency room. According to this nurse, the medication should have been billed to another patient's account. The error is calculated as the total amount paid for X6596.</p>	\$40.74	\$34.10	\$6.64
0382	Physician Services	MR3 - (Coding Error)	<p>This claim is for a level three office visit for a new patient. According to Current Procedural Terminology 2004, a level three office visit for a new patient requires three key components: a detailed history, a detailed examination, and medical decision-making of low complexity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. This two month old baby was seen for fever and nasal congestion. The history was very limited and uninformative. The physical exam consisted of height, weight, and normal temperature. Nose and Lungs were circled with no indication of findings (normal or abnormal). The plan was "Podia Care" and "MuJRin." There were no instructions for use of these medications, and the rendering provider was not identified. The error is calculated as the difference between the amount paid for 99203 and the amount that would have been paid for the level of service rendered, 99201.</p>	\$50.00	\$22.90	\$27.10

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0389	Physician Services	MR3 - (Coding Error)	<p>This claim is for a level five office visit. According to CPT 2004, a level five office visit for an established patient requires at least two of these three key components: a comprehensive history, a comprehensive examination, and medical decision-making of high complexity. Usually, the presenting problems are of moderate to high severity. Physicians typically spend 40 minutes face-to face with the patient/family. The medical record documents an established comprehensive general ophthalmologic service (CPT 92014) which includes routine ophthalmoscopy when indicated. The CPT code 92225 was also billed. CPT 2004 defines this code as "Ophthalmoscopy, extended, with retinal drawing (i.e. for retinal detachment, melanoma), with interpretation and report; initial." This patient's vitreous was hazy, so that the retina could not be well-visualized. The patient was referred to a retinal specialist for a possible retinal bleed. Extended ophthalmoscopy (92225) was not documented at all. The error is calculated as the amount paid for 92225, plus the difference between the amount paid for 99215 and the amount that would have been paid for 92014.</p>	\$103.64	\$38.43	\$65.21
0404	Physician Services	MR3 - (Coding Error)	<p>This claim is for two services, a new patient office visit, and family planning counseling. The medical record indicated that the patient had been seen five days before, and therefore was not a new patient. The patient refused breast and pelvic exam at both visits, and there was no documentation that the physician discussed risks and benefits of these examinations with the patient. There was no documentation of family planning counseling at all. The error is calculated as the difference between the amount paid for 99203, and the amount that would have been paid for 99211 (level one office visit); plus, the amount that was paid for Z9751, counseling.</p>	\$69.92	\$12.00	\$57.92
0407	Physician Services	MR2-B - (Service Claimed is not Documented)	<p>This claim is for an office visit billed with CPT Code 99213. This level code requires an expanded problem focused history, expanded problem focused examination, and medical decision making of low complexity. The service</p>	\$26.18	\$13.90	\$12.28

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			documented was a prescription. There was no history, physical or medical decision making of any complexity documented. The medical necessity for the prescription could not be ascertained from this visit. The level of office visit is a CPT Code 99211. Therefore, the error is calculated as the difference between CPT Code 99213 and CPT Code 99211.			
0408	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for dental services performed at a Federally Qualified Health Center. The documentation for the dental service is inadequate. The exam is not described as thoroughly as it should be. Diagnostic information such as gum condition, location of tooth decay and such are missing. The error is calculated as the total amount paid for this claim.	\$216.00	\$0.00	\$216.00
0410	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for speech and language evaluations, and speech therapy. This provider billed for three services, none of which were documented on this date of service, or any date of service. The services claimed were not medically necessary, and there was no referral from a physician as required by Medi-Cal regulation. No plan of care with regard to speech and language was developed for this patient at any time, despite multiple visits. The error is calculated as the total amount paid for this claim.	\$177.34	\$0.00	\$177.34
0411	Physician Services	MR5 - (Documentation does not support medical necessity)	This claim is for a level four office visit, a hepatitis B vaccination, urinalysis, hemoglobin blood test, and collecting and handling fee. The rendering provider failed to sign the medical record and any associated orders. The person who gave the injection was not identified, nor was the site of the injection. The medical record was illegible, and therefore failed to document the nature and extent, and medical necessity for the services claimed, as required by Medi-Cal regulation. There was not enough documentation to support the level of service billed. The record did not contain a signature of the beneficiary verifying the lab specimen was indeed hers as required by W&I Code. These services were medically necessary services. The error is calculated as the total amount paid for this claim.	\$144.87	\$0.00	\$144.87

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0416	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for an X-ray of the sinuses, and a DEXA scan to look for osteoporosis in a patient complaining of fever, cough, and "allergies of nose for a long time." The medical record was meaningless. This female patient, for example, was noted to have a normal prostate exam. The doctor prescribed an antibiotic, an antihistamine, a medication for ulcers, and Promethazine, a sedative with anti-nausea and antihistamine actions. The DEXA scan was normal showing no osteoporosis, but the doctor prescribed Fosamax, a potentially dangerous drug used to treat osteoporosis. Further checking revealed that this doctor has been on probation with the Osteopathy Board since December of 2001 for insurance fraud, unprofessional conduct, gross negligence, and incompetence. The error is calculated as the total amount paid for this claim.	\$35.56	\$0.00	\$35.56
0432	Physician Services	MR7 – (Other medical error)	This claim is for an eye exam and glasses. The beneficiary statement regarding loss of prior eyeglasses is inadequate. According to the Medi-Cal Provider Manual (eye app 1) "The statement must certify that a loss, breakage or damage was beyond the recipient's control and must include the circumstances of the loss or destruction and the steps taken to recover the lost item." In this case the statement included only the words "Lost my glasses." The wrong rendering provider was identified on the claim. The actual rendering provider is a licensed optometrist employed by this provider. He/she has an inactive Medi-Cal provider number at the same address. The glasses were medically necessary. The provider did not have a signature log verifying receipt of glasses as required by W&I code 14043.341. The diagnosis code on the claim does not match that in the medical record. The error is calculated as the total amount paid for this claim.	\$82.29	\$0.00	\$82.29
0434	Physician Services	MR3 - (Coding Error)	This claim is for 93014. According to the CPT 2004, this code is used for physician interpretation of telephonic post-symptomatic rhythm strips from 24-hour attended EKG monitoring, per 30-day period of time. The medical record reveals that this physician ordered an EKG and the results were transmitted to him on the same day. Since this	\$12.69	\$0.00	\$12.69

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			interpretation was done on the same date of service as the patient's visit, if the physician had billed the procedure code for EKG, it would not have been paid. The error is calculated as the total amount paid for this claim.			
0436	Physician Services	MR7 - (Policy Violation)	This claim is for psychology services in a Federally Qualified Health Center. A beneficiary is entitled to two psychologist visits a month. There is no mechanism in place to authorize an increase in this number. This particular paid claim was for a seventh psychology service for this beneficiary in one calendar month. That is five more than should have been paid. The documentation in the medical record is non-specific regarding current symptoms, response to treatment and need for continued treatment, with no evidence of an evaluation of the patient's mental status. This documentation does not support the necessity of the visit. The wrong service code was used by the FQHC. The service code used, 0012, is for beneficiaries enrolled in managed care plans when the plan does not cover psychological services. This beneficiary is a fee-for-service beneficiary. The wrong rendering provider is listed on the claim. The error is calculated as the total amount paid for this claim.	\$117.30	\$0.00	\$117.30
0437	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for Family Planning Counseling. The nature of the counseling session, and the amount of time spent was not documented as required by CCR Title 22, section 51476. The error is calculated as the total amount paid for Z9751. The error is calculated as the total amount paid for this claim.	\$47.02	\$0.00	\$47.02
0440	Physician Services	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a CAT scan of the brain which was ordered by a physician prior to the patient being seen, since the patient had a history of a stroke two years previously. The medical record mentions no complaints at all. The referral to the radiologist also does not give any reason for the current examination. There is no evidence that this service was necessary. The error is calculated as the total amount paid for this claim.	\$13.10	\$0.00	\$13.10

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0446	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a level three office visit for a new patient. This was the patient's second visit to the provider so should not have been billed as a new patient. The reviewer noted that there were no physician's notes on the record before requesting that the file be copied. When the copies were returned to her, there were illegible physician notes filling in all of the blank areas of the office encounter form. California B&P Code 2262 states "Altering or modifying the medical record of any person, with fraudulent intent, or creating any false medical record, with fraudulent intent, constitutes unprofessional conduct." The error is calculated as the total amount paid for this claim.	\$57.20	\$0.00	\$57.20
0458	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for an injection of Kenalog (a corticosteroid). The medical record documents that the patient has pain in her knees with swelling and inability to walk. No physical examination of the knees is documented. The physician's note is nearly illegible. The plan included "Kenalog 1cc" but does not give the strength of the medication, the location of the injection, or any note that the injection was actually given. This was a medically necessary service. The error is calculated as the total amount paid for this claim.	\$7.65	\$0.00	\$7.65
0461	Physician Services	MR3 - (Coding Error)	This claim is for a level three office visit. The medical record fails to identify both the patient and the rendering provider, and is unsigned. This is in violation of CCR Title 22, section 51476. The record is almost entirely illegible. What can be read reveals a problem-focused history and exam, with straightforward decision-making. According to Current Procedural Terminology 2004, a level three office visit for an established patient requires at least two of these three key components: 1) an expanded problem-focused history, 2) an expanded problem-focused examination, 3) and medical decision-making of low complexity. Physicians usually spend 15 minutes face-to-face with the patient or family for a level three office visit. The error is calculated as the total amount paid for this claim.	\$26.18	\$0.00	\$26.18

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0462	Physician Services	MR5 – (Documentation does not support medical necessity)	This claim is for single vision glasses for near vision use in a patient who already has bifocal glasses. The record does not document the reason two pairs of glasses are needed in lieu of bifocals as required by the Medi-Cal Provider Manual (eye app 2). The medical record also does not document whether the patient's existing glasses are optimum for the patient's distance needs. The provider used modifier 51 on the claim which indicates that the patient's prior frames were lost or destroyed. In reality the patient's glasses were neither lost nor stolen. There is no documentation that glasses were dispensed on this date, though glasses were dispensed six weeks later. The rendering provider was not identifiable in the medical record. The error is calculated as the total amount paid for this claim.	\$42.85	\$0.00	\$42.85
0472	Physician Services	MR3 - (Coding Error)	This claim is for a level three office visit rendered by a nurse practitioner who was not identified on the claim. The NMP modifier was also not used on the claim. The NP is not enrolled as a provider in this group. The visit was brief, with problem-focused history, exam, and straight-forward decision-making, consistent with a level two office visit. Also claimed was collecting and handling of blood specimen (Z5220), whereas the medical record indicates the patient refused blood tests. Errors include: Wrong provider identified, service not documented at all, and coding error. The error is calculated as the total amount paid for this claim.	\$24.00	\$0.00	\$24.00
0473	Physician Services	MR3 - (Coding Error)	The provider billed for a level four office visit. According to the Current Procedural Terminology 2004, a level four office visit for an established patient requires at least two of these three key components: 1) a detailed history, 2) a detailed examination, 3) and medical decision-making of moderate complexity. Physicians usually spend 25 minutes face-to-face with the patient or family for a level 4 office visit. The medical documentation for this visit indicates a brief follow-up visit for asthma, which was stable, and the patient was "doing well." The patient indicated that she felt tired, and a history of anemia was noted. The plan was "check labs." No	\$37.50	\$24.00	\$13.50

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			specific lab test was ordered, and no lab test was reviewed. There was no detailed history or physical examination, and decision-making was straight-forward. The appropriate code would have been 99213. The error is calculated as the difference between the amount that was paid for 99214, and the amount that would have been paid for the appropriate code, 99213.			
0489	Physician Services	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for an office visit, a urine pregnancy test, and a urinalysis. The physician assistant who rendered the service was not enrolled in this group. There was no indication of a reason for the urinalysis. The error is calculated as the amount paid for the urinalysis 81002, plus the amount paid for the office visit 99212.	\$24.70	\$3.74	\$20.96
0491	Physician Services	MR7 - (Policy Violation)	This claim is for drawing blood at the time of a medical visit. There was no visit, so the wrong code was used to bill for this service. In addition, the service was rendered by unlicensed staff without a specific written order by a physician as required by B&P Code 2069. The beneficiary's presumptive eligibility application was not complete. The provider does not have a Medi-Cal number for this location, and was therefore not eligible to bill from this location. The error is calculated as the total amount paid for this claim.	\$3.63	\$0.00	\$3.63
0492	Physician Services	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for the professional component of elbow and shoulder x-rays. The emergency room record does not contain any evidence that x-rays were requested or ordered by the nurse practitioner who examined the patient. Her notes in the "medical decision-making" section of the medical record did not mention x-rays. The X-rays were medically necessary. The error is calculated as the total amount paid for this claim.	\$17.14	\$0.00	\$17.14
0500	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for individual perinatal education, 30 minutes. However, the medical record documents only a Z1034 Obstetrical visit which was billed on a separate claim and paid. There is no documentation of any separate CPSP counseling service. The error is calculated as the total amount paid for this claim.	\$16.82	\$0.00	\$16.82

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0502	Physician Services	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for an EEG. The neurologist's office notes are illegible. It appears that this patient has not had seizures for many years, and is not on medications for seizures. Therefore this test is not medically necessary. The error is calculated as the total amount paid for this claim.	\$81.82	\$0.00	\$81.82
0503	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a medical encounter at a Federally Qualified Health Clinic. The reviewers found no evidence of an established practice and no medical equipment, and no medical records at this site. Reviewers were told that the clinic was taken over by another health center. Attempts to obtain the records from storage were unsuccessful. The error is calculated as the total amount paid for this claim.	\$82.13	\$0.00	\$82.13
0507	Physician Services	MR7 - (Policy Violation)	This claim is for bifocal glasses for a patient post cataract surgery. The refraction was done by the patient's ophthalmologist and the prescription was filled by an optometrist. The optometrist put the following statement on the claim: "Patient broke frame. Affidavit on file." There was no statement on file as required by the Medi-Cal provider manual. The provider did not have a signature log verifying receipt of glasses as required by W&I code 14043.341. The glasses were medically necessary. The error is calculated as the total amount paid for this claim.	\$53.11	\$0.00	\$53.11
0508	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a level five office visit for a new patient. In order to appropriately bill this code, the CPT 2004 requires these three components: 1) a comprehensive history, 2) a comprehensive examination, and 3) medical decision-making of high complexity. The medical record reveals that this patient was diagnosed with pregnancy one week prior to this visit, and filled out a health questionnaire at that time. For this visit under review, the physician used the diagnosis "Absence of Menstruation" instead of pregnancy, when in fact the patient was "here to start OB care." The patient had complaints of normal symptoms of pregnancy, had no medical illnesses, and no abnormalities on examination. The plan included: prenatal care, prenatal vitamins, and prenatal labs. The patient was instructed to return in one week for initial obstetrical exam. The following week, the patient had a follow-up obstetrical evaluation, which should have been	\$56.54	\$0.00	\$56.54

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			billed as Z1034, but was instead billed as a comprehensive initial obstetrical visit. Also billed for this claim was a psychosocial assessment Z6302, and this assessment was not documented. The error is calculated as the total amount paid for this claim.			
0512	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for two dates of service, each one a Z1034, antepartum office visit. For the first claim line, the patient was seen by a nurse practitioner who was not identified on the claim, and the appropriate modifier was not used. For the second line, the medical record does not document that the patient was seen by any provider, except for vital signs. The error is calculated as the total amount paid for this claim.	\$60.48	\$0.00	\$60.48
0514	Physician Services	MR3 - (Coding Error)	This claim is for administration of intravenous solutions and antibiotics. There are seven claim lines, each of which was appropriately documented, except X7700, administration of IV solution, initial. The correct code was X7702, Administration of additional IV solution, since this was an ongoing IV which was started the day before this claim. The error is calculated as the difference between the amount that was paid for X7700, and the amount that would have been paid for X7702.	\$151.04	\$142.43	\$8.61
0518	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a follow-up office visit for pregnancy care, which was documented. Also billed was 15 minutes of perinatal education which was not documented at all. The error is calculated as the total amount paid for this claim.	\$68.89	\$0.00	\$68.89
0519	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for use of hospital exam room and urine pregnancy test. The hospital clinic had no record of service for this patient on the date of service claimed. The error is calculated as the total amount paid for this claim.	\$39.53	\$0.00	\$39.53
0520	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for Family Planning Counseling, 45 minutes. The medical record has no documentation of any counseling done, or of the amount of time spent with the patient. The error is calculated as the total amount paid for this claim.	\$44.51	\$0.00	\$44.51
0523	Physician Services	MR3 - (Coding Error)	The claim is for 99254 (Initial inpatient consultation). According to Current Procedural Technology, this code "requires three key components: 1) a comprehensive	\$65.01	\$46.44	\$18.57

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			history, 2) a comprehensive examination, and 3) medical decision making of moderate complexity. Usually the presenting problems are of moderate to high severity. Physicians typically spend 80 minutes at the bedside and on the patient's hospital floor or unit." The consultant is a chest surgeon, and his report documents an expanded problem-focused history and physical examination, not comprehensive. Since his consultation was simply to rule out a surgically-correctable lesion, his decision-making was of low complexity. Therefore the appropriate code would have been 99253. The error is calculated as the difference between the amount paid for 99254, and the amount that would have been paid for 99253.			
0527	Physician Services	MR3 - (Coding Error)	This claim is for a level three office visit for a new patient. According to Current Procedural Terminology 2004, a level three office visit for a new patient requires three key components: a detailed history, a detailed examination, and medical decision-making of low complexity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. The date of service is wrong. Patient presented for follow-up with no fever, no complaints; brief physical exam. The medical progress note was almost completely illegible. This visit did not meet any of the three components for a Level three office visit. The error is calculated as the difference between the amount that was paid for 99203 and the amount that would have been paid for 99201.	\$57.20	\$34.30	\$22.90
0532	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for a complete doppler echocardiogram of the fetal heart. The medical record documented only an obstetrical ultrasound (which was separately paid) and a doppler exam of the umbilical and middle cerebral arteries of the fetus. The procedure claimed (76827) was not performed. The error is calculated as the difference between the reimbursement for Doppler ultrasound and procedure code 76827.	\$115.25	\$44.61	\$70.64
0550	Physician Services	MR5 - (Documentation Does not Support	This claim is for a level three new patient office visit by a podiatrist. The reason given for this podiatry visit is "The patient is a severe asthmatic secondary to drugs [sic]." No	\$57.20	\$0.00	\$57.20

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
		Medical Necessity)	problem with the feet was mentioned in the present history by the podiatrist, or by the referring doctor (who was on Special Claims Review at the time of this referral.) The podiatrist circled diagnoses related to the feet, but documented no physical findings or history to support the diagnoses. The documentation does not support the medical necessity of this visit. The error is calculated as the total amount paid for this claim.			
0556	Physician Services	MR2-B - (Service Claimed is not Documented)	This claim is for six days of physician services for a dialysis patient. There is no evidence in the medical record that any physician saw the patient on any of the dates of service claimed. Dialysis was a medically necessary service. The error is calculated as the total amount paid for this claim.	\$99.72	\$0.00	\$99.72
0557	Physician Services	MR2-A - (Documentation Problem Error - Poor Documentation)	This claim is for a level four office visit. The patient's medical record documented a chief complaint that was not addressed in any history of present illness at all. A check-list of education topics had 12 topics checked, which were not related to the chief complaint. A check-list of physical findings was circled without comment. For example, the liver was "enlarged" but there was no measurement of its size. For the abdominal exam, both "tender" and "mass" were circled, but there was no description of the location or character of these potentially serious abnormalities. Multiple lab tests were ordered, but the reason for the blood work was not given. The examination was signed by a physician assistant whose name was not identified, and the physician assistant was also not identified on the claim. A non-physician medical provider modifier was not used. The error is calculated as the total amount paid for this claim.	\$24.00	\$0.00	\$24.00
0558	Physician Services	MR2-B - (Service Claimed is not Documented)	This provider billed for family planning counseling (Z9752) and contraceptive supplies (X1500). There is no documentation of any services rendered on this date. The clinic informed DHS that it is their standard procedure to enter condoms and counseling services in the computer billing record only. The error is calculated as the total amount paid for this claim.	\$19.78	\$0.00	\$19.78

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0565	Pharmacy	PH2 - (No Rx for date of service)	This claim is for Benazepril a medication to treat high blood pressure. Medical necessity was documented in the medical record. The Pharmacy was unable to produce a prescription for this medication. There was no signature log for receipt of this medication. This is in violation of W&I Code 14043.431(a). A&I staff was able to verify receipt with the beneficiary. Since there was no prescription, this error is calculated as the total amount paid for this claim.	\$33.39	\$0.00	\$33.39
0588	Pharmacy	PH2 - (No Rx for date of service)	This claim is for Paxil, a medication used to treat depression. This claim is for a refill of an original prescription that is over one-year-old. The signature for receipt of the medication was not that of the patient and there was no printed name or relationship to the beneficiary noted. The label from the pharmacy was for a different date of service. Without the label there is no documentation of what was dispensed to the beneficiary. The prescribing physician's notes contain no documentation for two years regarding the patient's depression or reason for Paxil. The error is calculated as the total amount paid for this claim.	\$224.85	\$0.00	\$224.85
0597	Pharmacy	PH7 - (Refills too frequent)	This claim is for Triamterene/HCTZ, a medication for hypertension. The physician prescribed 30 tablets with three refills. The pharmacist dispensed 100 tablets. This is a violation of B&P Code 4040(a) (B) which requires that a prescription must contain the quantity of the drug to be dispensed. The pharmacist changed the prescribed quantity without obtaining authorization from the physician. The error is calculated as the difference between the amount paid for 100 capsules, and the amount that would have been paid for 30 capsules. (Since this CCN# was voided, and another claim submitted to replace it on the same date of service, the error is calculated based on the paid CCN.)	\$45.69	\$19.34	\$26.35
0625	Pharmacy	PH7 - (Refills too frequent)	This claim is for Tegretol 100mg/5ml suspension used to treat seizures. This patient is in a long term care facility and medications are filled on a routine basis, usually monthly. This medication was filled every 15 days, twice as often as the standard. This doubles the dispensing fees the pharmacy can claim. The error is calculated as the difference between the dispensing fee paid once a month	\$42.38	\$34.38	\$8.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			and the dispensing fee paid twice a month.			
0628	Pharmacy	PH10 _ (Other pharmacy policy violation)	This claim is for incontinence supplies. This was one of six refills of a prescription which did not meet code I restrictions, and was not a complete legal prescription. There were no medical records available to confirm medical necessity, and the prescribing physician has died. The error is calculated as the total amount paid for this claim.	\$119.08	\$0.00	\$119.08
0637	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Hydroxyzine, an antihistamine. The patient's history in the medical record consists of two words: "Pruritis" (itching) and "coughing." No physical exam was done. A prescription was written for a 90-day supply of Hydroxyzine and an antacid. The record is not signed. The provider is not identified in the progress notes, nor is the patient. The error is calculated as the total amount paid for this claim.	\$53.83	\$0.00	\$53.83
0644	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for glucoscan test strips for testing blood sugar levels for someone with diabetes. The product is medically necessary. The pharmacy could not find the original prescription or a refill authorization. This is in violation of B&P Code 4081 (a) which states in part, "All records of ----- sale of -----dangerous devices -----shall be preserved for at least three years from the date of making." It is also a violation of W&I Code 14043.341(a) which states in part, "--- for a drug or device to be covered under the Medi-Cal program, require a written order or prescription----." The error is calculated as the total amount paid for this claim.	\$81.61	\$0.00	\$81.61
0658	Pharmacy	PH2 – (No Rx for date of service)	This claim is for Risperidone, an antipsychotic medication. The patient is on multiple antipsychotic medications with poor documentation of psychiatric problems in the medical record but minimally sufficient to determine medical necessity The pharmacist has refilled this medication for two and one half years, but does not have the original prescription on file. The last refill authorization expired seven months before this refill. The error is calculated as the total amount paid for this claim.	\$369.86	\$0.00	\$369.86
0666	Pharmacy	PH2 – (No Rx for date of service))	This claim is for Cogentin, a medication used to control the side effects of anti-psychotic agents. Medical necessity is documented in the medical record. Pharmacy dispensed	\$26.55	\$0.00	\$26.55

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			100 tablets, 60 tablets were ordered. Authorization from prescribing provider for change in prescription not documented. Refill information is incomplete as there is no documentation that refills were authorized for this prescription which is over one year old. Pharmacy mailed medication to post office box therefore there is no signature log that medication was received. The error is calculated as the total amount paid for this claim.			
0671	Pharmacy	PH2 – (No Rx for date of service))	This claim is for a refill of glucose test strips for home testing of blood sugar. The original prescription for 100 test strips dispensed one month earlier did not specify instructions for use, so days supply could not be calculated. No refill was authorized. The medical record documents a plan for the patient to use glucose test strips, but no home testing values are reported. The error is calculated as the total amount paid for this claim.	\$69.53	\$0.00	\$69.53
0672	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Keflex, an antibiotic for an 11-year-old patient. The patient's history in the medical record consists of "runny nose sore throat." No physical exam was done. A prescription was written for Keflex with no evidence that it was necessary. Unnecessary antibiotics are hazardous both to the patient and to the public health. The provider is not identified in the progress notes. The error is calculated as the total amount paid for this claim.	\$54.32	\$0.00	\$54.32
0678	Pharmacy	PH7 – (Refills too frequent)	This claim is for Valsartan, a medication used to treat high blood pressure. The pharmacy did not obtain a signature to verify receipt of the medication. A&I staff was unable to reach the beneficiary to verify receipt. The prescription was not dated. The prescription was written for 100 tablets. The pharmacy dispensed 30 tablets. There is no documentation, the pharmacy obtained approval for the change from the prescribing provider. By filling the prescription 30 tablets at a time, the pharmacy is able to claim additional dispensing fees. The error is calculated as the amount paid for one dispensing fee.	\$50.93	\$43.68	\$7.25

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0680	Pharmacy	PH7 – (Refills too frequent)	This claim is for Pletal, a medication for intermittent claudication. Medical justification for this Code I drug was not documented. The prescription was written for 100 tablets with three refills. The prescription was refilled early three times, and the pharmacy dispensed 60 tablets each time. This is in violation of Business and Professions Code 4040 which requires a prescription to contain the name and quantity of the drug prescribed, and directions for use. The error is calculated as the total amount paid for this claim.	\$108.21	\$0.00	\$108.21
0690	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Abilify, a medication used for psychosis. The medical record describes cognitive impairments and major depression. Medical necessity for an antipsychotic medication is documented. There is no documentation of a reason for giving this patient a more costly antipsychotic (i.e. failed antidepressant treatment, history of hallucinations, etc.) instead of an older generic medication. The use of Abilify in elderly patients with dementia-related psychosis is known to increase the risk of death from all causes. The pharmacy's shredding company "accidentally shredded" the delivery receipts. The error is calculated as the total amount paid for this claim.	\$438.00	\$0.00	\$438.00
0694	Pharmacy	MR8 - (Other Medical Error)	This claim is for five, one-liter containers of 5% Dextrose/.5% Normal Saline IV solution for a resident in a skilled nursing facility. According to the medical record at the skilled nursing facility, the physician ordered intravenous solution of 0.45% Normal Saline. He did not order intravenous solution with dextrose. The resident was a diabetic with a high blood sugar so a dextrose solution would be contraindicated. The SNF administered two liters of the dextrose solution. This contributed to the beneficiary's deteriorating condition and subsequent transfer to the emergency department and admission to the acute care hospital. The SNF returned three of the five liters to the pharmacy, who did not credit the cost to Medi-Cal. In addition, the Pharmacist billed using the wrong referring provider's number. The error is calculated as the total amount paid for this claim. The SNF medical error was reported by A&I to the appropriate Licensing and	\$98.50	\$0.00	\$98.50

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			Certification field office for further investigation.			
0697	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Verapamil, a medication for blood pressure and heart problems. The pharmacist's documentation consisted of a telephone prescription which was not documented in the "prescribing" physician's records. The physician denied calling in this prescription and in fact stated that he specifically denied a request for refill of this prescription since he had no record of prescribing it, and had not seen the patient for two years. The signature log does not identify the names of the drugs, the printed name of the person signing for them, or the date. The error is calculated as the total amount paid for this claim.	\$9.46	\$0.00	\$9.46
0699	Pharmacy	PH2 – (No Rx for date of service)	This claim is for Glucostix reagent strips, for home testing of diabetes control. Although this is a medically necessary product, the medical record does not detail any home glucose testing, nor document an order for this product. The pharmacist does not have a legal prescription on file. The error is calculated as the total amount paid for this claim.	\$104.35	\$0.00	\$104.35
0712	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Ensure, a nutritional supplement. The medical record does not document the medical necessity for this prescription. There is no documented weight loss at the time the prescription was written and no documentation of difficulty with adequate nutritional intake. There are other documentation problems in the record regarding the patient's identity and age. There is no signature to document receipt of the medication by the residential facility. The error is calculated as the total amount paid for this claim.	\$127.69	\$0.00	\$127.69
0728	Pharmacy	PH3 (Rx missing essential information)	This claim is for Guaifenesin cough syrup with codeine. The pharmacy had only a telephone prescription which stated the prescription was called in by the MD, but the identity of the person who took the prescription is not documented. There is no documentation in the medical record that the physician prescribed this medication. Also, the person who signed for the prescription was not the patient, and the relationship to the patient is not documented. The error is calculated as the total amount paid for this claim.	\$8.00	\$0.00	\$8.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0739	Pharmacy	PH4 - (Wrong NDC code billed)	This claim is for Tylenol with codeine tablets for a patient with chronic back pain seen in the emergency room. The medication is medically necessary. The pharmacy does not have an invoice with an NDC code that matches that billed. The actual NDC is not a Medi-Cal benefit, and therefore was not payable. The error is calculated as the total amount paid for this claim.	\$9.56	\$0.00	\$9.56
0748	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Triamcinolone (corticosteroid) cream used to treat inflammation or itching of the skin. There are no diagnoses or symptoms in the medical record to support the medical need for this medication. The prescription is missing essential information necessary for a legal prescription, a violation of B&P Code 4076(a) (2). The pharmacist entered the wrong referring provider ID number on the claim. The error is calculated as the total amount paid for this claim.	\$10.35	\$0.00	\$10.35
0753	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Prevacid, a medication used to reduce secretion of acid in the stomach. It is most commonly used for periods of 4-8 weeks to treat ulcers and the reflux of acid from the stomach into the esophagus. Extended use is reserved for specific conditions, and necessitates evaluation for potential complications of acid reflux. The medical records in this case do not document a diagnosis of any gastrointestinal disorder or otherwise indicate medical necessity for this medication, even though the patient has been taking it for at least 18 months. The error is calculated as the total amount paid for this claim.	\$128.35	\$0.00	\$128.35
0754	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for Marinol, a medication given to treat anorexia-associated weight loss in patients with HIV. This drug has a Code One Restriction and if used for any reason other than treating AIDS related weight loss, a TAR is required. The medical record did not contain documentation to support this drug's use for AIDS related weight loss. The pharmacy did not obtain a TAR as the Code One Restriction requires. The error is calculated as the total amount paid for this claim.	\$531.27	\$0.00	\$531.27

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0765	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for pediatric electrolyte solution for a -month-old baby with history of cough, nasal congestion and fever for days. The baby's temperature was normal. Much of the medical record is illegible. History of present illness, pertinent physical findings, and assessment are all illegible. There is no indication of dehydration or failure of the baby to take regular diet or fluids. The pharmacy records do not include a signature to document receipt of this product. The error is calculated as the total amount paid for this claim.	\$18.00	\$0.00	\$18.00
0786	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for Clonazepam, a medication used to treat nervousness or anxiety. Poor documentation in medical record, last notation was 1/16/2001 regarding this medication. Medication label was from original dispensing and this claim is for the second refill. The invoice was not available. The error is calculated as the total amount paid for this claim.	\$24.36	\$0.00	\$24.36
0787	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Advair, a medication used to manage asthma. Medical necessity is documented in the medical record. The referring provider number entered on the claim is incorrect. The provider actually providing the service is licensed in good standing in California and enrolled in good standing with Medi-Cal. The prescription was originally written five months before the date of service with two refills. The refills were exhausted three months before the date of service. Both the pharmacy and the prescribing provider staff stated they do not keep records to show the medication was renewed or further refills were authorized. The error is calculated as the total amount paid for this claim.	\$147.36	\$0.00	\$147.36
0792	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Hydrochlorothiazide, a blood pressure medication. Medical necessity was documented in the medical record. The pharmacist refilled the prescription after its expiration date without contacting the prescribing physician for authorization. The error is calculated as the total amount paid for this claim.	\$16.42	\$0.00	\$16.42
0793	Pharmacy	MR5 - (Documentation Does not Support	This claim is for Promethazine, a medication used to treat nausea. The patient was pregnant with twins. There was no record of a visit or telephone contact with this patient on the	\$13.55	\$0.00	\$13.55

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
		Medical Necessity)	date this prescription was called in. There is concern for substandard care, since the gestational age was 29 weeks, and the patient was not told to come in to the clinic for examination to look for serious causes of her new onset of nausea that might threaten the pregnancy. The patient was seen in the emergency room a few days later, where elevated liver enzymes and urinary tract infection were found. The patient was hospitalized a week after this prescription for nausea, vomiting, fever, and dehydration. The error is calculated as the total amount paid for this claim.			
0805	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Naphazolone 0.1% eye drops. This is an over-the-counter medication used for irritated eyes. The physician's notes are illegible. There is no documentation to support medical necessity. There is no documentation of complaints or an exam of the eye. The prescription is illegible and does not state quantity or instructions for use which is required by Business and Professions Code 4040(a). The pharmacist did not contact the physician to obtain the missing information. The error is calculated as the total amount paid for this claim.	\$10.65	\$0.00	\$10.65
0807	Pharmacy	PH10 - (Other Pharmacy Policy Violation)	This claim is for Iron elixir, a medication for anemia for a two-year-old-child. The signature for receipt of the medication is not the same surname as the beneficiary and the relationship to the beneficiary is not identified as required by W&I Code 14043.341(a). The pharmacy billed using an incorrect provider number. They used the Physician Assistant's (PA) license number. The prescription instruction/receipt label each list different supervising physicians for the PA on the same date. Medical necessity is documented in the medical record. The physician assistant and both supervising physicians have current California licenses. The PA wrote the prescription for a 6 month supply of the medication. The pharmacy would need a TAR to fill the prescription for more than a 100 day supply. The pharmacy changed the prescription to a 100 day supply to avoid getting a TAR and there is no indication the pharmacy obtained the prescribing provider's permission to	\$10.28	\$0.00	\$10.28

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			change the prescription. Furthermore, on subsequent refills, the pharmacy will be able to collect additional dispensing fees. The error is calculated as the total amount paid for this claim.			
0811	Pharmacy	PH2 – (No Rx for date of service)	This claim is for Isosorbide dinitrate, a medication used to treat angina. Since the patient has a history of a previous heart attack, the medication was probably medically necessary. The pharmacist does not have a signed prescription, the physician's records do not document that the medication was prescribed, and the pharmacist's records do not document that the beneficiary picked up the medication. The error is calculated as the total amount paid for this claim.	\$51.36	\$0.00	\$51.36
0821	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for a refill of Simvastatin, a cholesterol-lowering drug. The latest documentation of a prescription for this drug was two years and four months earlier, and neither the pharmacy nor the physician's records document any refill authorization. In addition, the pharmacy failed to obtain the signature of the person who received the drug, in violation of W&I Code 14043.341. The patient's history of Coronary Artery Disease seems to indicate that the drug was necessary, but there is no indication that the patient's lipids had been checked. The patient resides in an assisted living center, and the person who gives the medications to the patients in this facility stated that she regularly gives this medication to the patient. The error is calculated as the total amount paid for this claim.	\$130.42	\$0.00	\$130.42
0831	Pharmacy	PH7 – (Refills too frequent)	This claim is for Spiroloctone a diuretic used to treat congestive heart failure. There is a signature log for receipt of the medication. However, the facility staff that received the medication did not date or time the log for when the medication was received. There is documentation in the medical record the medication was administered to the patient. There is no record of the prescription in the pharmacy. The pharmacy is dispensing the medication by-weekly. The patient is in a skilled nursing facility so the medication should be dispensed to the facility on a monthly basis. By-weekly dispensing doubles the handling fees the	\$8.15	\$4.20	\$3.95

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			pharmacy can claim. The error is calculated as the cost of an additional dispensing fee.			
0841	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Diovan HCT, a medication used to treat high blood pressure. The pharmacy had no record of an original prescription. This is a violation of Business and Professions Code 4081(a) which explains the requirement to keep records related to sale of dangerous drugs for at least three years from the date the record was made. There is evidence of medical necessity, receipt, and administration of the medication at the skilled nursing facility where the patient resides. The pharmacy dispensed the medication by-weekly twice. The patient is in a skilled nursing facility so the medication should be dispensed to the facility on a monthly basis. By-weekly dispensing doubles the handling fees the pharmacy can claim. The error is calculated as the total dispensing fee for the second bi-weekly dispensing on December 7, 2004.	\$29.92	\$21.92	\$8.00
0847	Pharmacy	PH10 - (Other Pharmacy Policy Violation)	This claim is for Tylenol with Codeine tablets, a medication for pain. Medi-Cal policy restricts the medication to a maximum dispensing quantity of 45 tablets or capsules and a maximum of 3 dispensings in a 75-day period without a Treatment Authorization Request (TAR). The prescription was written for 100 tablets. The pharmacist dispensed 45 tablets on two different occasions. The pharmacist changed the prescribed number of tablets to 45 without the prescribing provider's authorization. By filling the prescription more frequently with fewer tablets, the pharmacy collected additional dispensing fees. Medical necessity is evident in the medical record. Therefore, the error is calculated at the rate of the dispensing fee for one additional fill of the prescription.	\$16.87	\$9.62	\$7.25
0852	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Famotidine (Pepsid) a medication for GERD or ulcer disease. The prescribing physician's records reveal multiple visits with no legible complaint, no history, and no diagnosis. Multiple medications are prescribed with no documented necessity. The error is calculated as the total amount paid for this claim.	\$16.25	\$0.00	\$16.25

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0854	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Spectazole, an antibiotic cream. The medical record documents severe stasis dermatitis for which this cream was prescribed, but the records were scanty and incomplete. The pharmacist repeatedly filled a prescription from 1/12/04 which did not include refills, and also filled twice the amount that was originally prescribed. There was no legal prescription for the date of service 11/18/04, and no evidence in the physician's records that a refill was authorized. The error is calculated as the total amount paid for this claim.	\$71.38	\$0.00	\$71.38
0857	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Plan B, the "day after" pill to prevent pregnancy. Although the standard of contraceptive care allows this pill to be prescribed in advance of need, there was no prescription for this date of service. The error is calculated as the total amount paid for this claim.	\$30.08	\$0.00	\$30.08
0858	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Hydrochlorothiazide, a medication to treat high blood pressure. Medical necessity was documented in the medical record. The physician prescribed the medication in June and October of 2004. However, there is no documentation that the physician ordered/re-ordered the medication for the date of service on 12/3/2004. This was verified with the physician's office staff. Since there is no order for the medication the error is calculated as the total amount paid for this claim.	\$8.98	\$0.00	\$8.98
0860	Pharmacy	PH10 - (Other Pharmacy Policy Violation)	This claim is for Trileptal, a medication used to treat Epilepsy. Medical necessity was documented in the medical record. The prescription was written for 600 mg twice a day on 2/1/04. The pharmacy filled the prescription with two 300 mg tablets twice a day. The monthly pharmacy orders from the board and care listed epilepsy as one of the diagnoses, but there is no physician's record to verify this diagnosis. The most recent physician's assessment does not list epilepsy as a diagnosis, but does list Trileptal as one of the medications planned. The assessment and all the physician's orders are unsigned. The person who signed for receipt of the medications at the facility is not identified. The error is calculated as the total amount paid for this claim.	\$233.17	\$0.00	\$233.17

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
0868	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Levaquin, an antibiotic. The pharmacist recorded this prescription as a telephone order. The physician listed as the prescriber denied seeing this patient since 1996, and denied prescribing this medication. The signature for receipt of this medication does not appear to be that of the beneficiary, and no relationship to the patient is specified. The error is calculated as the total amount paid for this claim.	\$99.28	\$0.00	\$99.28
0877	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for Clonazepam, a medication for anxiety. The medical records are scanty, poorly legible, and have no physician's name on them. There is no diagnosis of anxiety. There is a diagnosis of schizophrenia, The psychiatrist apparently prescribed the medication, but it is unclear that the prescription was appropriate and necessary. In addition, this medication is restricted to 90 days dispensing after the date of the first prescription, except with approval of a Treatment Authorization Request (TAR). This claim is for services after the 90 day time frame and no TAR was obtained. The error is calculated as the total amount paid for this claim.	\$14.62	\$0.00	\$14.62
0884	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Clozaril, a medication for psychosis which was needed for this patient. However, the pharmacist did not have a legal prescription for this date of service, and the wrong referring provider is identified on the claim. The date of the claim is later than the date of receipt of the medication. The error is calculated as the total amount paid for this claim.	\$88.21	\$0.00	\$88.21
0885	Pharmacy	PH10 - (Other Pharmacy Policy Violation)	This claim is for Paxil 40 mg. A medication used to treat depression. Medical necessity was documented in the medical record. The beneficiary has been prescribed 60 mg of Paxil once a day. This is given as one 40 mg. tablet and one 20 mg. tablet. The pharmacy did not have a prescription label to verify dispensing 40 mg of Paxil. They had only labels for dispensing Paxil 20 mg. for the date of service. The pharmacy also did not have a requisition from the facility for Paxil 40 mg. This in violation of B&P code 4081(a). The referring provider number listed on the claim is the incorrect number. The prescribing physician is licensed	\$90.36	\$0.00	\$90.36

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			in good standing in California. The error is calculated as the total amount paid for this claim.			
0902	Pharmacy	PH7 – Refills too frequent)	This claim is for Lipitor a medication to treat high cholesterol. The physician wrote the prescription for 90 pills but the pharmacist dispensed 30 tables each month instead. There is no documentation the pharmacy received permission from the physician to make a change to his prescription. By filling the prescription for 30 pills every month instead of giving the beneficiary the full 3 month supply prescribed, the pharmacy can bill for two additional dispensing fees. The error is calculated as the amount of one dispensing fee.	\$71.59	\$64.34	\$7.25
0905	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for Ciprofloxacin, an antibiotic that is restricted in the Medi-Cal formulary to lower respiratory tract and bone infections. Medical necessity was documented in the medical record. This male patient was seen for burning with urination and was diagnosed with a kidney infection. No urinary or sexual history was done. No urine culture or tests for sexually transmitted infections were done. No medical work-up for causes of urinary tract infection was done. No prostate exam was done. The error is calculated as the total amount paid for this claim.	\$56.84	\$0.00	\$56.84
0926	Pharmacy	PH7 – (Refills to frequent)	This claim is for incontinence supplies (240 At Ease disposable inserts). This number (240) was also dispensed for each of the previous 3 months. The prescription was for "up to" 3 changes per day (93 per month). Therefore 240 should have lasted almost 3 months. The error is calculated as the total amount paid for this claim.	\$69.53	\$0.00	\$69.53
0930	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a liquid Iron supplement for a two-year-old. There was no evidence in the medical record of iron deficiency. The hemoglobin and hematocrit were in the normal range. There was no documentation that the patient's diet, especially with respect to iron content or fortification, was discussed. Therefore medical necessity is	\$12.19	\$0.00	\$12.19

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			not established. The error is calculated as the total amount paid for this claim.			
0933	Pharmacy	PH3 (Rx missing essential information)	This claim is for Plavix, a medication used to prevent heart attack and stroke for a patient with a diagnosis of coronary artery disease. The pharmacist who took the telephone prescription is not identified, and the refill is not authorized in the patient's medical record. The referring provider's number was entered incorrectly on the claim. The physician's medical record is extremely poor. There is a list of medications with no instructions for use, but the physician's notes are scanty and entirely illegible. The error is calculated as the total amount paid for this claim.	\$120.54	\$0.00	\$120.54
0954	Pharmacy	PH7 - (Refills too frequent)	This claim is for Quinine, a medication for leg cramps. The pharmacist filled the prescription too frequently, so that 90 pills were dispensed in a 28-day period. The third refill took place just before the first prescription would have run out. Therefore the patient would not have needed a refill on this date of service. Also, the pharmacy did not have a prescription on file for this medication, but obtained it from the prescribing physician after the audit. The error is calculated as the total amount paid for this claim.	\$29.74	\$0.00	\$29.74
0979	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Ketoconazole cream (an antifungal cream). There is no documentation in the medical record of any indication for an antifungal cream. The telephone order filled out by the pharmacist does not have a physician's name on it. This is a violation of Business and Professions Code 4040(a) (1) (D). There is no signature to document that the patient received the medication. This is a violation of Welfare and Institutions Code 14043.341. The error is calculated as the total amount paid for this claim.	\$42.18	\$0.00	\$42.18
0980	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for an over-the-counter antacid, Mylanta. Medical necessity was documented in the medical record. The prescribing physician and the pharmacist are the same person. The drugstore keeps the doctor's prescription pads on hand. According to California Business and Professions	\$21.22	\$0.00	\$21.22

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			Code, section 41111, the pharmacy board shall not issue or renew a license to conduct a pharmacy to a person authorized to prescribe or write prescriptions, or to any person who shares a financial interest with a prescriber. The error is calculated as the total amount paid for this claim.			
0998	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Nexium, a medication used for peptic ulcer disease or GERD. The patient was given a diagnosis that would make this medication medically appropriate. The pharmacist dispensed the medication according to a legal prescription. However, the prescribing physician's documentation is very poor. The physician had noted a diagnosis of GERD 3 months earlier, but no history to support the diagnosis. There was no documentation of any discussion with the patient as to current symptoms or need for this medication on or near the date of this prescription. The error is calculated as the total amount paid for this claim.	\$128.47	\$0.00	\$128.47
1000	Pharmacy	PH2 – (No Rx for date of service)	This claim is for glucose test strips for a diabetic patient. The pharmacist refilled this prescription 4 months after the prescription had expired. The physician's record does not mention a refill of these strips, and there is no indication in the medical record that the patient is using these strips. The error is calculated as the total amount paid for this claim.	\$81.50	\$0.00	\$81.50
1004	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Flomax a medication for prostate problems. There was no rationale for this prescription in the medical record. This is the only member of this drug family that is not indicated for the treatment of high blood pressure as well as prostate problems. This patient is a female so she does not have prostate problems. Therefore, this medication was not medically necessary. There was no explanation by the physician prescribing the drug why he intended the patient have it. The pharmacist did not contact the physician for an explanation why this medication was prescribed. The error is calculated as the total amount paid for this claim.	\$58.86	\$0.00	\$58.86

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
1008	Pharmacy	PH10 – (Other pharmacy policy violation)	This claim is for Fluconazole tablets, a medication which is a Medi-Cal benefit only for patients with cancer or HIV, unless pre-approved by a TAR. The pharmacist did not supply a diagnosis on the claim, and did not obtain a TAR. Medical necessity was documented in the medical record. The medical record reveals that the patient had vaginal candidiasis due to antibiotic treatment for a urinary tract infection, but no other diagnoses. The treatment was begun without any tests to verify infection. The error is calculated as the total amount paid for this claim.	\$18.88	\$0.00	\$18.88
1010	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Amitriptyline with Chlordiazepoxide (Limbitrol). The clinical information available in the medical record is not sufficient to document medical necessity. There is no indication of depression or other symptoms, i.e. insomnia or neuropathic pain, which would justify prescribing this medication. The prescription number on the claim and in the signature log is different from the number on file for this prescription. The error is calculated as the total amount paid for this claim.	\$118.53	\$0.00	\$118.53
1019	Pharmacy	PH2 - (No Rx for date of Service)	This claim is for Hyzaar, a medication for hypertension. The medical record documents blood pressure in good control on this medication, and 11 refills requested. The pharmacist could not find the original prescription, or the signature log. A&I staff was unable to verify receipt of the prescription with the beneficiary. The error is calculated as the total amount paid for this claim.	\$66.15	\$0.00	\$66.15
1032	Pharmacy	PH3 - (Rx missing essential information)	This claim is for Temazepam, a medication to help sleep. The prescription did not contain the name of the prescribing physician. After several attempts, the DHS staff was unable to obtain medical records to determine which of the seven physicians in this medical group ordered the medication. No documentation could be found to establish the necessity of this medication in a patient with 15 other prescriptions for multiple medical problems. The physician group staff said records were in the warehouse and none of the documents scanned into the computer contained documentation of the	\$11.35	\$0.00	\$11.35

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			referring provider seeing the patient or ordering the medication. This is in violation of CCR Title 22 51476(a). A progress note written by another physician in this group indicated that he would refill her medications. The error is calculated as the total amount paid for this claim.			
1042	Pharmacy	PH2 (No Rx for date of service)	This claim is for Prilosec, a medication used to treat peptic ulcer disease. Medical necessity was documented in the medical record. This patient is in a nursing home, but there are no orders, history, physical exam, or progress notes signed by a physician. The pharmacy does not have a legal prescription on file. In addition, the pharmacist regularly supplies 30 pills every 28 days on all prescriptions. This results in dispensing more pills than necessary. This particular prescription was filled with 33 capsules, with no documentation of the reason for this increased number. There was no signed delivery receipt for this prescription. The error is calculated as the total amount paid for this claim.	\$122.90	\$0.00	\$122.90
1045	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Eurax 10% lotion. The prescribing physician's record for the same date of service documents a new patient with a chief complaint of "refill meds"; Congestive Heart Failure. Eurax lotion was prescribed, but the reason for the Eurax was not documented. The error is calculated as the total amount paid for this claim.	\$17.42	\$0.00	\$17.42
1049	Pharmacy	PH6 - (No record of drug acquisition)	This claim is for Flagyl, an antibiotic. Medical necessity was documented in the medical record. The pharmacist stated that he destroyed 2004 drug acquisition invoices. This is in violation of Business and Professions code 4081 (a). The error is calculated as the total amount paid for this claim.	\$8.52	\$0.00	\$8.52
1054	Pharmacy	PH7 - (Refills too frequent)	This claim is for Paxil a medication for treatment of depression. The claim has the wrong rendering provider listed. Refill of the prescription was dispensed too soon. The pharmacy was unable to provide a signature log verifying the beneficiary received the medication in violation of W&I Code 1403.341. The error is calculated as the total amount paid for this claim.	\$93.73	\$86.48	\$7.25

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
1057	Pharmacy	PH3 – (Rx missing essential information)	This claim is for Doxycycline, prescribed for acute exacerbation of COPD. The prescription in the pharmacy does not have the complete prescriber information, and the pharmacist put the wrong provider's name on the label, as well as on the claim. There was no signature log for receipt of this medication. This violates W&I Code 14043.341. A&I was unable to reach the beneficiary to confirm receipt of this medication. The error is calculated as the total amount paid for this claim.	\$9.34	\$0.00	\$9.34
1060	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Vicodin, a medication for pain. The documentation by the prescribing provider did not support medical necessity prior to the date on the claim. There was no signature log for receipt of this medication. This violates W&I Code 14043.341. A&I staff was unable to verify receipt of the medication with the beneficiary. The pharmacy listed an incorrect rendering provider on the claim. The error is calculated as the total amount paid for this claim.	\$16.54	\$0.00	\$16.54
1063	Pharmacy	PH3 - (Rx missing essential information)	This claim is for Dicyclomine, which was prescribed for Irritable Bowel Syndrome. Medical necessity was documented in the medical record. The prescription was missing essential information as required by B&P code 4040(a1)(B) which states that the directions for use is required information for a prescription. Specifically the prescription was not dated. There was no signature verifying receipt of this medication. The error is calculated as the total amount paid for this claim.	\$14.36	\$0.00	\$14.36
1065	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Acular eye drops, a non-steroidal anti-inflammatory agent used for eye itching and after cataract surgery. The medical record from the referring provider is not legible. There is no indication of an eye examination or rationale for use of this medication. There was no signature log for receipt of this medication. This is in violation of W&I Code 14043.341(a). A&I staff was unable to verify receipt of the medication with the beneficiary. The error is calculated as the total amount paid for this claim.	\$118.21	\$0.00	\$118.21

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
1067	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for a Quinine, a medication used to treat leg cramps. The prescribing physician's records do not mention leg cramps at all. In addition, The pharmacy was unable to provide a signature log verifying the beneficiary received the medication. The error is calculated as the total amount paid for this claim.	\$13.09	\$0.00	\$13.09
1078	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Nasonex nasal spray, a prescription used for allergic rhinitis. The medical record was insufficient to document medical necessity, and the pharmacy did not document beneficiary receipt of prescription. A&I was unable to contact the beneficiary. The error is calculated as the total amount paid for this claim.	\$28.20	\$0.00	\$28.20
1082	Pharmacy	PH3 – (Rx missing essential information)	This claim is for Singular, a medication for asthma, filled on 11/4/04. The medical record documents multiple visits from 1-9-04 for cellulites, diabetes, and peripheral vascular disease, but not asthma. There is a notation on the physician's problem list that the patient has COPD. The prescribing physician's medication list indicates prescriptions for Singular but not until 2005. According to the pharmacy record, a new prescription was called in on 7/1/04 by a different physician with no refills. On 7/2/04 the pharmacy's computer data screen indicated six (6) refills were requested via fax, however, there was no documentation to support this. The physician listed as the referring provider had no documentation of a prescription on 7/1/04 or a refill order on 7/2/04. There was no signature log to verify receipt of the medication by the beneficiary. The error is calculated as the total amount paid for this claim.	\$33.28	\$0.00	\$33.28
1084	Pharmacy	PH2 – (No Rx for date of service)	This claim is for Low-Olestra, a birth control medication, for three cycles with four refills. Medical justification is documented in the medical record. However, a signed receipt or delivery log could not be produced by the pharmacy. The pharmacy also could not provide a copy of the dispensing label. The prescription copy from the health center was dated 11/13/03 the same date as the office visit that stated the medication as the plan for birth control. The prescription copy from the pharmacy was dated 12/13/03. The prescriptions were identical except for the different date	\$69.89	\$0.00	\$69.89

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
			of issue. It appears the date on the prescription at the pharmacy may have been altered. The prescription was initially dispensed 12/29/03. If 11/13/03 is the issue date and the refill date is 12/5/04, per the claim history this is greater than one year. Receipt of the medication was unable to be confirmed with the recipient. The error is calculated as the total amount paid for this claim.			
1094	Pharmacy	PH1 - (No Signature Log or log missing required information)	This claim is for Glucose test strips for Diabetes. The medical record documents that the patient had been testing her sugars at home. Test strips were noted as prescribed this date. However, there is no beneficiary signature for receipt of these strips at the pharmacy. This is a violation of W&I Code 14043.341(a). A&I reached the beneficiary who denied having Diabetes, being seen in this clinic or receiving these test strips. Also, the prescriber did not write directions for use on the prescription, and the pharmacy placed "Use as Directed" on the label. This is a violation of B&P code 4040(a)(1)(B). The error is calculated as the total amount paid for this claim.	\$77.45	\$0.00	\$77.45
1098	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Klonopin, a medication for anxiety. This medication has a code I restriction, and therefore requires a TAR for use beyond 90 days. No TAR was obtained. Also, the pharmacy was unable to provide a signature log to verify receipt of the medication. A&I was unable to verify that the patient received the medication. The prescribing physician did not document the reason for this medication in the records supplied. The error is calculated as the total amount paid for this claim.	\$30.67	\$0.00	\$30.67
1104	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Zantac 300 mg which is a medication for gastroesophageal reflux disease (GERD) or peptic ulcer disease. There is no pharmacy error. The medication was prescribed for dyspepsia, not peptic ulcer disease, and the appropriate dose was therefore half the dose prescribed. The doctor's progress note indicates the intention to prescribe 300 mg once a day, but his prescription says twice a day. The error is calculated as the difference between the amount paid for 60 tablets, and the amount that would have been paid for 30 tablets.	\$26.33	\$16.79	\$9.54

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
1110	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for incontinence supplies. These supplies require documentation in the physician's record of the specific causal diagnosis of the patient's incontinence, and the anticipated rate of use of each item prescribed. (Provider Manual incont sup 2). The physician's records do not contain any documentation of medical necessity for the prescribed items. The pharmacist also does not have documentation of meeting Code I restriction for incontinence supplies, and does not specify frequency of use. The error is calculated as the total amount paid for this claim.	\$6.95	\$0.00	\$6.95
1112	Pharmacy	MR5 - (Documentation Does not Support Medical Necessity)	This claim is for Detrol LA, a medication used to treat overactive bladder. The phone prescription and other records on hand at the pharmacy did not include correct provider contact information. This prescription does not have any refills authorized. However, the pharmacy has refilled the prescription at least six times. The pharmacy states the refill number is put into the computer and the computer counts down the refills left. There is no printed documentation to support this. The provider contact information on file at the pharmacy was incorrect. A&I staff were unable to locate the referring provider listed on the claim. The referring provider is unknown to the staff at the board and care where the beneficiary resides. The provider listed on the board and care documents as the primary provider for this beneficiary denies ever ordering the medication for the patient. The referring provider on this claim is also unknown to the beneficiary's primary provider. There are no medical records to review so medical necessity cannot be determined. The pharmacy did not have a signature log verifying receipt of the medication. The board and care documents do show they have the medication. The referring provider had been referred to Provider Enrollment Branch for further review. The error is calculated as the total amount paid for this claim.	\$90.95	\$0.00	\$90.95
1117	Pharmacy	P9-B – (Rendering provider not eligible to provide)	This claim is for Wellbutrin, a medication for depression. Medical necessity is well-documented in the medical record. However, the referring provider has been suspended by Medi-Cal. Therefore, he/she is ineligible to prescribe for	\$112.73	\$0.00	\$112.73

DETAIL OF REASONS FOR ERRORS

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount In Error
		this service)	Medi-Cal beneficiaries. This provider is being paid by a mental health plan, which is a policy violation. The wrong provider was identified by the pharmacy on the claim. There was no signature to verify that the beneficiary received this medication. The error is calculated as the total amount paid for this claim.			

FINAL REVIEW ERROR CODES

Claim Errors:

A claim was determined to be in error when the claim should not have been paid due to the provider's failure to document medical necessity or follow established regulation or policy. The following error codes were assigned to the identified errors:

Administrative Error Codes:

- **NE - No Error**
- **DE - Data Entry Error**
- **WPI - Wrong Provider Identified on Claim**

A. Wrong Rendering Provider Identified on Claim

If the actual rendering provider is a Medi-Cal provider, has a license in good standing, and has a notice from CDHS' Provider Enrollment Branch (PEB) documenting that his/her application for this location has been received, or there is a written locum tenens agreement, this is considered a non-dollar error.

Note: If a provider did not have a license in good standing, or is otherwise ineligible to bill Medi-Cal then this is an ineligible provider. See below for error code P9 - Ineligible Provider. An ineligible provider may be a Medi-Cal provider who has not submitted an application for the specific location or does not have a written locum tenens agreement. An ineligible provider may also be provider that is not a Medi-Cal provider.

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 non-dollar error.

C. Non-Physician Medical Provider (NMP) 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. If the provider has not submitted an application to PEB for the NMP, or if the NMP is not appropriately supervised, code P9 is applicable and used as the error code. However, if the NMP has a license in good standing, is appropriately supervised, and the services are medically appropriate, this is a non-dollar error.

Note: Because of the confusion between attending and referring providers, a dollar error was not designated or assigned for WPI for long-term care (LTC) facilities.

- **WCI - Wrong Client Identified**
- **Other (List or Describe)**

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. The beneficiary is enrolled in a Managed Care organization (MCO).

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.

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 - The recipient was not eligible for the services or supplies.
 Example 1: Beneficiary's eligibility is limited and is not eligible for the service billed such as eligible for emergency and obstetrical services but received other services unrelated to authorized services.

Example 2: The beneficiary was just not eligible for services at all.

Example 3: The beneficiary's assets were too great for eligibility.

P8 - Data Entry Errors - There were clerical errors in the data entry of the claim.

P9 - Ineligible Provider - This code includes the following situations:

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 DME provider changed ownership without notifying PEB.

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 PEB.

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 appropriate 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.

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, new provider, or new group, 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.

Medical Review Error Codes:

MR1 – No Documents Submitted

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

B. The referring (ordering or prescribing) provider did not respond to the request for documentation. The claim is unsupported due lack of cooperation from the referring provider.

MR2 – Documentation Problem Error - Poor Documentation

A. 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.

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 was 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, ADHC, DME, LEA’s, etc., the information in the referring provider’s record did not document medical necessity.

MR6 – Administrative Error

Medical review indicates an administrative error, such as an incorrect decision on a previous medical review or other administrative errors as designated by the State. This error may or may not result in a payment error.

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

Example 2: An obstetrician bills for a routine pregnancy ultrasound, which is not covered by Medi-Cal. However, the diagnosis of “threatened abortion” is used in order for the claim to be paid.

Example 3: A pharmacist changes a prescription without documenting the prescribing physician’s authorization to do so.

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 sign for receipt of the service. If no signature was obtained, it is considered a dollar (payment) error.

Pharmacy Error Codes:

In the MPES 2004 all pharmacy claims were reviewed and assigned errors using Medical Review Error Codes. To better reflect the errors found in pharmacy claims, the following codes were developed specifically for pharmacy in MPES 2005.

When a pharmacy claim was reversed, but billed again on the same date of service, the error was calculated based on the claim which was paid on that date, even though a different claim control number was assigned. In this way, the latest positive adjustment for the claim was selected for MPES 2005 review.

PH1 - No Signature Log

Statute is in place requiring a beneficiary sign for the receipt of medication or other item. If no signature was obtained, it is considered a dollar (payment) error with a potential for fraud or abuse.

PH2 - No Legal Prescription (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 Rx use.

PH4 - Wrong National Drug Code (NDC) Billed

The NDC code claimed did not match the NDC code on the wholesale invoice.

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

This code was used when the pharmacy did not have a wholesale invoice to document purchase of the drug dispensed.

PH7 - Refills Too Frequent

This code was used when a pattern of refills was found which resulted in excessive numbers of pills being dispensed over the period of a year. For example, a pharmacist delivers 30 pills every 28 days to a patient of a nursing facility.

PH10 - Other Pharmacy Policy Violation

Indication of Fraud or Abuse:

Each claim, which was designated as an error, was also evaluated for the potential for fraud or abuse. If the claim was suspicious, a separate category was designated as “yes” for the potential for fraud or abuse. Each claim so designated was reviewed by the Department of Justice.

Verification of Errors:

All errors were reviewed and discussed by a medical team at CDHS Audits & Investigations (A&I), including the lead Medical Consultant II, Medical Consultant I, and a Nurse Consultant II.

All errors had a final review by CDHS’ A&I Medical Review Branch Chief, and referrals for field audit were made for all providers where there was the potential for fraud or abuse.

EDS specialists performed calculations of coding and pricing errors.

The Nurse Consultant III of CDHS’ Medi-Cal Benefits Branch reviewed all ADHC errors.

The Dental Consultant I of CDHS’ Dental Services reviewed all dental claims.

Pharmacy errors were reviewed by A&I’s Pharmacy Consultant I and discussed with pharmacy consultants in the Medi-Cal Policy Division.

The optometry consultant from the Medi-Cal Policy Division reviewed all optometrist claims.

The Chief or a Medical Consultant of the Medi-Cal Policy Division performed the final review of all medical claims.

All claims that were identified as potentially fraudulent were reviewed by DOJ.

STUDY RESULTS AND STATISTICAL SUMMARIES

This Appendix presents the results of the Error Rate Study in tabular and graphical form. It includes:

- Table 1A Dollar Error Rates and Projected Annual Payments Made in Error By Stratum (2004) including those claims determined by Audits and Investigations to be “not at risk” for dollar error.
- Table 1B Dollar Error Rates and Projected Annual Payments Made in Error By Stratum (2004) excluding those claims determined by Audits and Investigations to be “not at risk” for dollar error.
- Table 1C Previous Year’s Dollar Error Rates and Projected Annual Payments Made in Error By Stratum (2003)
- Table 2A Post Study Review Potential Fraud Rate and Projected Annual Potential Fraudulent Payments By Stratum (2004)
- Table 2A.1 Potential Fraud Rate By Stratum and Projected Annual Potential Fraudulent Payments By Stratum (2004)
- Table 2B Previous Year’s Potential Fraud Rate By Stratum and Projected Annual Potential Fraudulent Payments By Stratum (2003)
- Table 3A Calendar Year 2004 Medi-Cal Fee-For-Service and Dental Payments By Quarter
- Table 3B Calendar Year 2003 Medi-Cal Fee-For-Service and Dental Payments By Quarter

ERROR RATE STUDY – TABLE 1A
Dollar Error Rates and Projected Annual Payments Made in Error by Stratum
Including those claims determined to be “Not at Risk” for Dollar Error

	<u>Fourth Quarter 2004</u> <u>Dental/Medi-Cal FFS Payments</u>					
	Payment Error Rate & Confidence Interval			Universe Dollars	Payment Errors	Projected Annual Payment Errors
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 - Durable Medical Equipment	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 Practitioners & Clinics	9.65%	±	5.22%	\$744,417,656	\$71,836,304	\$287,345,215
Stratum 7 - Other Services & Supplies	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%	<u>\$4,193,397,689</u>	<u>*\$352,245,406</u>	<u>*\$1,408,981,624</u>

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 payment errors are calculated by multiplying three quantities: 1) the erroneous payment rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the 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 dollars paid 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 errors.

ERROR RATE STUDY – TABLE 1B
Dollar Error Rates and Projected Annual Payments Made in Error by Stratum
Excluding those claims determined to be “Not at Risk” for Dollar Error

				<u>Fourth Quarter 2004</u> <u>Dental/Medi-Cal FFS Payments</u>		
	Payment Error Rate & Confidence Interval			Universe Dollars	Payment Errors	Projected Annual Payment Errors
Stratum 1 - ADHC	60.55%	±	13.21%	\$87,655,628	\$53,075,483	\$212,301,931
Stratum 2 - Dental	16.33%	±	16.21%	\$154,041,783	\$25,155,023	\$100,620,093
Stratum 3 - Durable Medical Equipment	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 Practitioners & Clinics	9.65%	±	5.22%	\$744,417,656	\$71,836,304	\$287,345,215
Stratum 7 - Other Services & Supplies	9.73%	±	3.12%	\$166,695,184	\$16,219,441	\$64,877,766
Stratum 8 - Pharmacy	10.47%	±	4.42%	\$1,308,403,593	\$136,989,856	\$547,959,425
Overall Payment Error Rate	7.43%	±	1.80%	<u>\$4,193,397,689</u>	<u>*\$311,569,448</u>	<u>*\$1,246,277,793</u>

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 7.43% ± 1.80%, or that the true error rate lies within the range 5.63% and 9.23%. The projected annual payment errors are calculated by multiplying three quantities: 1) the erroneous payment rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the 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 dollars paid 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 errors.

ERROR RATE STUDY – TABLE 1C
Previous Year (2003) Dollar Error Rates and Projected Annual Payments Made in Error by Stratum

	Payment Error Rate & Confidence Interval			<u>Fourth Quarter 2003</u> <u>Dental/Medi-Cal FFS Payments</u>		
				Universe Dollars	Payment Errors	Projected Annual Payment Errors
Stratum 1 – Inpatient	0.00%	±	00.0%	\$1,614,877,124	No Payment errors were identified, but due to small sample size no inference was made regarding the population.	An annual payment error projection was not calculated due to small sample size
Stratum 2 – Other Prac. & Clinics	6.91%	±	4.60%	\$662,724,088	\$45,794,234	\$183,423,125
Stratum 3 – Pharmacy	4.66%	±	2.77%	\$1,249,308,105	\$58,217,758	\$221,287,966
Stratum 4 – Other Serv. & Supp.	5.46%	±	5.59%	\$352,281,835	\$19,234,588	\$73,423,602
Stratum 5 – Dental*	12.90%	±	9.44%	\$165,107,141	\$21,298,821	\$90,313,978
Overall Payment Error Rate	3.57%	±	1.30%	<u>\$4,044,298,293</u>	<u>**\$144,381,449</u>	<u>**\$568,042,492</u>

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 3.57% ± 1.30%, or that the true error rate lies within the range 2.27% and 4.87%. The projected annual payment errors are calculated by multiplying two quantities: 1) the payment error rate, 2) calendar year 2003 Medi-Cal FFS and dental payments (see Table 3B).

* Given the small sample size in the Dental stratum, the estimation of the rate and the projection of payment errors may not be reliable.

** 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 dollars paid within each stratum. The error rate and payment error projections for each stratum are independent from one another. Therefore, the summations of the 5 strata payment errors do not total the overall payment errors.

ERROR RATE STUDY - TABLE 2A
Post Study Review Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum

Interval	Fraud Payment Rate & Confidence			<u>Fourth Quarter 2004</u> <u>Dental /Medi-Cal FFS Payments</u>		
				Universe Payments	Potential Fraud Potential	Projected Annual Fraud Payments
Stratum 1- ADHC	58.04%	±	13.41%	\$87,655,628	\$50,875,326	\$203,501,306
Stratum 2 – Dental	5.04%	±	6.16%	\$154,041,783	\$7,763,706	\$31,054,823
Stratum 3 – Durable Medical Equipment	5.22%	±	9.11%	\$29,558,596	\$1,542,959	\$6,171,835
Stratum 4 – Inpatient	0.00%	±	N/A	\$1,656,440,246	N/A	N/A
Stratum 5 – Labs	1.24%	±	1.62%	\$46,185,003	\$572,694	\$2,290,776
Stratum 6 – Other Practitioners & Clinics.	4.72	±	3.11	\$744,417,656	\$35,136,513	\$140,546,053
Stratum 7 – Other Services & Supplies	3.96%	±	1.64%	\$166,695,184	\$6,601,129	\$26,404,517
Stratum 8 - Pharmacy	2.52%	±	228%	\$1,308,403,593	\$32,971,771	\$131,887,082
Overall Payment Error Rate₁	3.23%	±	0.98%	<u>\$4,193,397,689</u>	<u>\$135,446,745</u>	<u>\$541,786,981</u>

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 3.23% ± 0.98%, or that the true fraud rate lies within the range 2.25% and 4.21% the projected annual payment errors are calculated by multiplying three quantities: 1) the fraud rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the 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 dollars paid 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 errors.

(1) See Appendix XVI

ERROR RATE STUDY - TABLE 2A.1
Potential Fraud Rate By Stratum and Projected Annual Potential Fraudulent Payments By Stratum

Interval	Fourth Quarter 2004 Dental /Medi-Cal FFS Payments			Universe Payments	Potential Fraud Potential	Projected Annual Fraud Payments
	Fraud Payment Rate & Confidence					
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 – Durable Medical Equipment	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 Practitioners & Clinics.	7.88%	±	4.65%	\$744,417,656	\$58,660,111	\$234,640,445
Stratum 7 – Other Services & Supplies	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 Rate₁	5.04%	±	1.37%	<u>\$4,193,397,689</u>	<u>*\$211,347,244</u>	<u>*\$845,388,974</u>

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 5.04% ± 1.37%, or that the true fraud rate lies within the range 3.67% and 6.41%. The projected annual payment errors are calculated by multiplying three quantities: 1) the fraud rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the 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 dollars paid 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 errors.

(1) See Appendix XVI

ERROR RATE STUDY - TABLE 2B

Previous Year (2003) Potential Fraud Rate By Stratum and Projected Annual Potential Fraudulent Payments By Stratum

Interval	Fourth Quarter 2003 Dental /Medi-Cal FFS Payments			Universe Payments	Potential Fraud Potential	Projected Annual Fraud Payments
	Fraud Payment Rate & Confidence Dollars					
Stratum 1 – Inpatient	0.00%	±	00.0%	\$1,614,877,124	No Payment errors were identified, but due to small sample size no inference was made regarding the population.	An annual projection was not calculated due to small sample size
Stratum 2 – Other Prac. & Clinics	2.72%	±	2.07%	\$662,724,088	\$18,021,803	\$72,201,288
Stratum 3 – Pharmacy	2.08%	±	1.49%	\$1,249,308,105	\$25,991,634	\$98,772,311
Stratum 4 – Other Serv. & Supp.	5.19%	±	5.39%	\$352,281,835	\$18,274,087	\$69,792,765
Stratum 5 – Dental*	0.72%	±	1.11%	\$165,107,141	\$1,188,848	\$5,040,780
Overall Payment Error Rate	1.57%	±	0.75%	<u>\$4,044,298,293</u>	<u>**\$63,495,483</u>	<u>**\$249,811,404</u>

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 1.57% ± 0.75%, or that the true error rate lies within the range 0.82% and 2.32%. The projected annual payment errors are calculated by multiplying two quantities: 1) the payment fraud rate, 2) calendar year 2003 Medi-Cal FFS and dental payments (see Table 3B).

* Given the small sample size in the Dental stratum, the estimation of the rate and the projection of payment errors may not be reliable.

** 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 dollars paid within each stratum. The error rate and payment error projections for each stratum are independent from one another. Therefore, the summations of the 5 strata payment errors do not total the overall payment errors.

ERROR RATE STUDY – TABLE 3A
Calendar Year 2004 Medi-Cal Fee-For-Service and Dental Payments By Quarter

Category	Total Paid By Quarter				Total
	First	Second	Third	Fourth	
Dental	\$ 139,970,080	\$ 158,159,800	\$ 171,738,938	\$ 154,041,783	\$ 623,910,600
Subtotal Dental	\$ 139,970,080	\$ 158,159,800	\$ 171,738,938	\$ 154,041,783	\$ 623,910,600
ADHC	\$ 81,305,437	\$ 96,840,971	\$ 82,461,099	\$ 87,655,628	\$ 348,263,135
Durable Medical Equipment	\$ 35,930,340	\$ 31,945,892	\$ 26,320,807	\$ 29,558,596	\$ 123,755,634
Inpatient	\$ 1,650,383,949	\$ 1,806,947,126	\$ 1,600,957,381	\$ 1,656,440,246	\$ 6,714,728,702
Labs	\$ 47,403,960	\$ 52,073,647	\$ 42,350,385	\$ 46,185,003	\$ 188,012,995
Other Practices & Clinics	\$ 695,981,480	\$ 803,708,120	\$ 671,245,874	\$ 744,417,656	\$ 2,915,353,130
Other Services & Supplies	\$ 177,213,705	\$ 202,190,058	\$ 163,171,146	\$ 166,695,184	\$ 709,270,094
Pharmacy	\$ 1,204,578,109	\$ 1,344,953,431	\$ 1,151,686,177	\$ 1,308,403,593	\$ 5,009,621,309
Subtotal Medi-Cal FFS	\$ 3,892,796,979	\$ 4,338,659,245	\$ 3,738,192,869	\$ 4,039,355,906	\$ 16,009,004,999
TOTAL Med-Cal FFS and Dental	\$ 4,032,767,058	\$ 4,496,819,045	\$ 3,909,931,807	\$ 4,193,397,689	\$ 16,632,915,600

ERROR RATE STUDY – TABLE 3A
Calendar Year 2004 Medi-Cal Fee-For-Service and Dental Payments By Quarter

	Total Claims By Quarter					
Category	First	Second	Third	Fourth	Total	
Dental	1,187,023	1,347,200	1,499,678	1,419,656	5,453,557	
Subtotal Dental	1,187,023	1,347,200	1,499,678	1,419,656	5,453,557	
ADHC	351,463	430,929	379,444	406,294	1,568,130	
Durable Medical Equipment	296,495	325,281	276,832	306,887	1,205,495	
Inpatient	965,282	941,972	1,409,683	882,451	4,199,388	
Labs	1,397,305	1,663,565	1,292,223	1,377,397	5,730,490	
Other Practices & Clinics	8,966,880	9,381,358	7,789,121	8,562,229	34,699,588	
Other Services & Supplies	1,569,776	2,169,503	1,363,890	1,380,569	6,483,738	
Pharmacy	16,460,198	17,723,336	15,388,616	18,105,709	67,677,859	
Subtotal Medi-Cal FFS	30,007,399	32,635,944	27,899,809	31,021,536	121,564,688	
TOTAL Med-Cal FFS and Dental	31,194,422	33,983,144	29,399,487	32,441,192	127,018,245	

ERROR RATE STUDY – TABLE 3B
Calendar Year 2003 Medi-Cal Fee-For-Service and Dental Payments By Quarter

		Total Paid By Quarter				
	Category	First	Second	Third	Fourth	Total
Dental		\$ 172,388,457	\$ 182,431,667	\$ 180,181,094	\$ 165,107,141	\$ 700,108,359
	Subtotal Dental	\$ 172,388,457	\$ 182,431,667	\$ 180,181,094	\$ 165,107,141	\$ 700,108,359
Medi-Cal FFS						
	Inpatient	\$ 1,552,331,597	\$ 1,660,689,689	\$ 1,635,665,113	\$ 1,614,877,124	\$ 6,463,563,523
	Other Prac. & Clinics	\$ 650,960,034	\$ 682,464,249	\$ 658,310,742	\$ 662,724,088	\$ 2,654,459,113
	Other Serv. & Supp.	\$ 333,444,405	\$ 332,961,712	\$ 326,066,664	\$ 352,281,835	\$ 1,344,754,615
	Pharmacy	\$ 1,125,560,462	\$ 1,175,235,537	\$ 1,198,564,695	\$ 1,249,308,105	\$ 4,748,668,799
	Subtotal Medi-Cal FFS	\$ 3,662,296,498	\$ 3,851,351,186	\$ 3,818,607,215	\$ 3,879,191,151	\$ 15,211,446,050
Total Dental & Medi-Cal FFS		\$ 3,834,684,954	\$ 4,033,782,853	\$ 3,998,788,309	\$ 4,044,298,293	\$ 15,911,554,409

ERROR RATE STUDY – TABLE 3B
Calendar Year 2003 Medi-Cal Fee-For-Service and Dental Payments By Quarter

Category	Total Claims By Quarter				
	First	Second	Third	Fourth	Total
Dental	1,049,546	1,127,160	1,146,696	1,157,189	\$ 4,480,591
Subtotal Dental	1,049,546	1,127,160	1,146,696	1,157,189	4,480,591
Medi-Cal FFS					
Inpatient	773,720	789,903	781,410	783,253	\$ 3,128,286
Other Prac. & Clinics	7,574,516	7,684,151	7,321,488	7,365,371	\$ 29,945,526
Other Serv. & Supp.	3,753,336	3,861,337	3,470,791	4,210,841	\$ 15,296,305
Pharmacy	14,530,588	14,698,997	14,594,218	15,416,063	\$ 59,239,866
Subtotal Medi-Cal FFS	26,632,160	27,034,388	26,167,907	27,775,528	107,609,983
Total Dental & Medi-Cal FFS	27,681,706	28,161,548	27,314,603	28,932,717	112,090,574

Significant Findings and Actions Taken On Errors Found in MPES 2005

Substandard Medical Care

- While researching the medical necessity of pharmacy claims, two instances of substandard medical care were revealed both of which led to hospitalization and additional costs to the Medi-Cal program:
 1. One case was in a skilled nursing facility and was reported to CDHS Licensing and Certification (L&C) as a complaint by A&I. An investigation was performed by L&C and a citation was issued to the nursing facility for providing an inappropriate prescription to a nursing facility patient.
 2. The second instance involved the prescription of a medication for nausea. The medication was prescribed for a woman who was 29 weeks pregnant with twins without the proper medical examination having been performed prior to prescribing the medication.

Medical Necessity of ADHC Services

- The MPES 2005 found that ADHCs enroll a high percentage of clients/patients who do not require ADHC services. These medically unnecessary and high cost (due to the reimbursement methodology) services leave the Medi-Cal program vulnerable to loss of program dollars.

To address this vulnerability, a joint multidisciplinary interdepartmental task force conducted simultaneous onsite reviews of 15 ADHCs in November 2005. The task force, which included representatives from CDHS' A&I and L&C, California Department of Aging, State Controllers Office and Centers for Medicare and Medicaid Services (CMS). These centers have had Medi-Cal payments withheld, been placed on special claims review and referred to other programs for additional actions as appropriate. Remaining ADHCs identified by MPES 2005, but not reviewed in November 2005 will receive further evaluation and review as appropriate in calendar year 2006.

Approximately twenty-four physicians were identified as contributing to the ADHC issue and have been placed on procedure code limitation, which prevents them from making further referrals of beneficiaries to ADHCs.

A&I referred additional ADHCs, as appropriate, to DHS' L&C, other professional licensing boards, and to CMS for substandard, abusive care and suspicious billing to the Medicare program.

Proof of Receipt Signatures Requirement

- One of the requirements resulting from changes to Welfare and Institutions Code section 14043.341, in January 2004, required pharmacies to obtain signatures from persons receiving prescriptions as proof of receipt of products. The MPES identified that several pharmacies were not complying with this requirement. For the pharmacy claims in the MPES 2005 sample without signatures, attempts were made to contact the beneficiaries in order to verify receipt of the products. Of the beneficiaries contacted all but one verified receipt of the prescribed products. Since the beneficiaries verified receipt of the products and medical necessity was verified with the prescribing provider, this non-compliance with the new statute was not considered an error for the purpose of the MPES.

Summary of Actions Taken

Actions Taken	Number
Total errors found in MPES 2005	203
Number of unique providers with errors that will be sent Civil Money Penalty letters explaining errors	191
Number of providers assigned for Field Audit Review	68
Providers placed on Special Claims Review requiring manual review of claims	40
Ongoing investigations taking place	12
Providers whose Medi-Cal payments are being withheld	11
Providers Temporarily Suspended from the Medi-Cal Program	4
Providers placed on Procedure Code Limitation	10
Provider cases submitted to State Controllers Office for evaluation of Audits for Recovery	37
Provider cases referred for potential criminal investigation	5
Beneficiaries referred to the Beneficiary Care Management Project for evaluation for assignment of a single provider to coordinate necessary services	14
Providers instructed to conduct self verification	1
Providers referred for compliance audits	7
Provider enrollment preparing to reenroll optometrists	2,900
Providers referred to respective licensing boards for further investigation	7
After investigation, no further actions warranted	4

Actions Taken on Errors and Recommendations Resulting From MPES 2004

The MPES 2004 identified 80 errors that resulted in various recommendations and actions being taken by CDHS and other agencies.

The table below summarizes the MPES 2004 recommendations and the status of actions taken.

MPES 2004 Recommendations	Status of Actions
<ul style="list-style-type: none"> ▪ Complete the development of cases on the providers identified as potentially fraudulent and take the appropriate action, such as an administrative sanction and/or referral to DOJ. 	<ul style="list-style-type: none"> ▪ These providers have been further reviewed through CDHS field audits or SCO audits. Actions have been taken as appropriate, including Civil Money Penalties, audits for recovery, placement of withhold and special claims review and referral for criminal investigation.
<ul style="list-style-type: none"> ▪ Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted. 	<ul style="list-style-type: none"> ▪ Claiming patterns for all providers with errors were reviewed. Cases were developed and actions taken as appropriate including Civil Money Penalties, audits for recovery, placement of withhold and special claims review.
<ul style="list-style-type: none"> ▪ Expand the number of investigations and routine compliance audits, (specifically in the area of physicians, physician groups and pharmacies) to provide a more in-depth look at billing code abuses that may not be identifiable through the pre-payment edits and audits. 	<ul style="list-style-type: none"> ▪ Twelve pharmacy compliance audits were performed with one resulting in a Temporary Suspension/Withhold and an arrest. ▪ As a result of the findings compliance audits will also be performed on DME providers.
<ul style="list-style-type: none"> ▪ Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclosure information. 	<ul style="list-style-type: none"> ▪ CDHS began re-enrolling physician groups in the spring of 2005. ▪ 182 groups are currently undergoing the re-enrollment process.

MPES 2004 Recommendations	Status of Actions
	<ul style="list-style-type: none"> ▪ Applications will continue to be processed as received and existing physician groups will continue to be re-enrolled.
<ul style="list-style-type: none"> ▪ Develop a plan for educating providers on appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins. 	<ul style="list-style-type: none"> ▪ CDHS participated in the <i>Medi-Cal Now</i>, Sept. 7-9, 2005, by providing presentations on documentation issues to those providers in attendance. ▪ CDHS has been updating the fraud and abuse training module for statewide training to providers. ▪ A standardized script is being developed for any CDHS personnel to include in the various presentations made to public groups. This is in process. ▪ Participating and providing information and training to professional organizations at their regular meetings and conferences.
<ul style="list-style-type: none"> ▪ Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses. 	<ul style="list-style-type: none"> ▪ The additional claim edit necessary as identified in MPES 2004, is the referring provider edit. CDHS is continuing to work with EDS for this edit solution. ▪ Identifying payment system edits is an ongoing process.
<ul style="list-style-type: none"> ▪ Evaluate the results of the study to identify where Medi-Cal laws, regulation and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ, and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors. 	<ul style="list-style-type: none"> ▪ Regulations have been promulgated concerning rendering providers. Once enrolled as a rendering provider, providers do not have to re-enroll with every group they provide services for. ▪ Workgroups are being developed to review and recommend enhancements to regulations and policies in preventing and identifying billing errors.

MPES 2004 Recommendations	Status of Actions
<ul style="list-style-type: none"> ▪ Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software. 	<ul style="list-style-type: none"> ▪ EDS has contracted with Fair Isaac Corporation for enhanced data mining tools that CDHS is currently evaluating for use.
<ul style="list-style-type: none"> ▪ Use the study findings to develop the methodology and focus of the 2005 MPES. 	<ul style="list-style-type: none"> ▪ Based upon lessons learned from conducting the first MPES in 2004, CDHS refined the design of MPES 2005 to focus more precisely on the areas of suspected program vulnerabilities.

Summary of Actions Taken

Actions Taken	Number
Total errors found in MPES 2004	80
Number of unique providers with errors that were sent Civil Money Penalty letters explaining their respective errors	73
Number of providers assigned to the State Controllers Office for evaluation and Audit for Recovery (AFR)	14
Number of AFR's conducted	3
Number of providers sent for Field Audit Review	22
Providers placed on Special Claims Review requiring manual review of claims	4
Providers placed on withhold pending further investigation	1
Provider cases referred for potential criminal investigation	1
Investigation still on ongoing	1
After investigation, no further actions warranted	2

REVIEW OF PAYMENT ERROR STUDIES

This Appendix provides an exemplary review of previous Medicare and Medicaid studies that measured payment errors in the Medicare and Medicaid programs. The scope of this Appendix describes the methodologies utilized, error rates, rationales for higher error rates (if provided), review processes, and study limitations in other payment error studies. The studies presented in chronological order demonstrate the evolutionary refinement in the error rate study domain. The review of these prior payment error studies directly influenced the development and refinement of MPES 2005.

The studies cited indicate that the most predominant payment error was for no documentation or insufficient documentation to substantiate medical necessity, though it also appeared highly probable that the beneficiary received the service. Additionally, the studies reviewed indicate the methodologies were designed to measure payment error rates, but not fraud. The rationale behind the methodological limitation is based on the fact that fraud measurement was uncharted territory and assumed provider intent, which falls outside the scope of payment error studies.

Medicare Error Rate Study (1996 - 2003)

Medicare was the first government agency to measure payment error. The objective was to develop an error rate baseline to evaluate program integrity. From 1996 through 2002, the Office of the Inspector General (OIG) estimated the Medicare payment error. The OIG sampling unit consisted of distinct beneficiaries and associated services. The payment error data was generated with a difference generator. The initial OIG study identified an error rate of 13.8 percent, reflecting an estimated \$23.3 billion in payment errors.

The OIG error rate studies exposed limitations in the study's design. For example, samples were too small, and therefore, unreliable to estimate findings. Additionally, the OIG was unable to determine and generate findings related to payment error or abuse by geographic region, provide type, procedure, or any other specific strata.

In 2003, the Centers for Medicare and Medicaid Services (CMS) assumed responsibility for the error rate study previously conducted by the OIG. The CMS methodology changed the sampling unit from distinct beneficiaries to distinct claims. The sample for this study was random. The sample size for the 2003 error rate study increased to 120,000 claims; a significant increase from the 6,000 claims reviewed in 1996. The OIG's difference generator approach was abandoned by CMS for use of a ratio estimator method. As CMS internal controls and enforcement efforts increased yearly, the associated Medicare payment error decreased. For example, between 1996 and 2003, the payment error declined from 13.8 percent to 5.8 percent. The decreases in payment error rates can be attributed to revised methodologies utilized by CMS since assuming management of the error rate study.

Illinois Error Rate Study (1998)

Illinois conducted its first Medicaid error rate study in 1998. The objective was to establish a benchmark for other program integrity organizations engaged in payment error rate studies. The sampling unit was “service level” detail. “Service level” means for example, only one of five lines on a claim may have been reviewed. The random sample consisted of 600 services paid during the month of January 1998. Proportional stratified sampling was utilized to address three strata of interest. The three strata were (1) physician and pharmacy services, (2) inpatient hospital and hospice services, and (3) all other services. A ratio estimator was utilized to estimate overall error rate and confidence intervals.

The accuracy of the service was determined via a four-part review process, which included a client interview, medical record review, contextual claims review, and final analysis-expert review. Illinois estimated a 4.72 percent error rate in the review of claim payments. Illinois noted limitations within the four-part review. For example, in many cases beneficiaries (especially those with developmental disabilities) could not verify whether they indeed received a service.

Kansas Error Rate Study (1999)

The Kansas Medicaid payment error rate study was also based on a one-month review of paid claims data. The sampling unit was service level with a sample size of 600 claims paid during March 1999. The service levels were divided into four strata: (1) pharmacy; (2) inpatient; (3) home and community based services; and, (4) all other service levels.

Kansas validated each claim via patient confirmation, evaluation of state payment process, and a clinical evaluation of the medical record. Each reviewer captured findings with a pre-designed coding method. An estimated payment error rate of 24 percent was calculated with a margin of error of 9 percent. A significant portion of dollars paid inaccurately was associated to documentation errors, which represented 78 percent of all dollars paid in error.

Texas Error Rate Study (2001)

Unlike Medicare (2003) and Illinois (1998), Texas took a different approach to measure payment error within the Medicaid program. The sampling unit for this study was the beneficiary. The sample consisted of 100 beneficiaries within pre-determined service categories and within the service date range of September 1, 2001 through November 20, 2001. The service categories included: (1) ancillary/outpatient; (2) home health; (3) inpatient; (4) mental health; and, (5) dental services. The study reviewed 800 beneficiaries with 2,122 associated services rendered. The study identified a 7.24 percent error rate with lack of documentation and insufficient documentation as the most common types of errors.

Summary

The design of payment error rate studies is evolving. In some cases, innovations and refinements in methodologies have produced greater payment error rates in studies

conducted in the succeeding year(s). Most of the payment error studies reviewed so far have employed different random sampling and extrapolation techniques to measure payment error and have reported error rates ranging from 4.72 percent (Illinois) to 24 percent (Kansas). Based on the lessons learned from their prior experiences, the states that have undertaken subsequent studies have modified and refined their methodologies to broaden the scope of the analysis in a variety of ways. Some have even reported a much higher payment error rate than their preceding study. California's experience appears to be consistent with other entities gauging the level of fraud, waste, and abuse in their publicly funded health care programs.

Beneficiary Eligibility Review Summary

The MPES 2005 included a review of eligibility of beneficiaries who received Medi-Cal services in Fee-For-Service (FFS) as well as under Medi-Cal Managed Care (MMC). CDHS' Medi-Cal Eligibility Branch conducted the beneficiary eligibility case review process. County social services offices perform eligibility determinations for all Medi-Cal applicants and recipients using the same rules. Counties are held to the same standards, regardless of whether the beneficiary is in FFS or Managed Care.

The eligibility review was comprised of a random sample of 1,000 beneficiaries enrolled in Managed Care from the fourth quarter of 2004 and 1,028 FFS beneficiaries.

The State FFS beneficiary case review process was comprised of the following:

- Review of Medi-Cal Eligibility Data System (MEDS), the Income Eligibility Verification System information, and alienage information from the Homeland Security Immigration and Naturalization Services database on the beneficiaries prior to reviewing the case records in various county offices.
- Review of county case records, automated eligibility, and data imaging systems to assess whether eligibility was determined correctly, or not, and if the share of cost (SOC), if any, was computed correctly.
- Third party verifications were obtained, when appropriate, to clarify inconsistencies or to confirm reported information.
- Additional beneficiary contacts were handled by telephone contact and letters when feasible.
- Home visits were completed on the cases when it was deemed appropriate (i.e., cases with income or family composition issues, potentially outdated information, or other possible discrepancies).

Detailed Summary of Managed Care Eligibility Reviews:

As part of the MPES 2005, the Program Review Section (PRS) reviewed the eligibility of beneficiaries who received Medi-Cal services in selected months of service under MMC.

There were two categories of cases included in the beneficiary case reviews, Medi-Cal Only or Medi-Cal Linkage.

- **Medi-Cal Only Case Reviews: 606 Cases**

The Medi-Cal Only case reviews include detailed review of all identifiable data sources including those at the county level and contact with the beneficiary. As a result, it was anticipated that the majority of error and case discrepancy findings will occur in those cases as documented by the findings below (Chart I).

- **Medi-Cal Linkage Case Reviews: 394 Cases**

The Medi-Cal Linkage case reviews include those beneficiaries in Public Assistance (PA) Aid Codes whose eligibility for Medi-Cal is contingent on their eligibility for the PA program from which they receive a cash grant. These individuals are in the Adoption Assistance, California Work Opportunity and Responsibility to Kids, Foster Care, and Supplemental Security Income/State Supplementary Payment aid codes. Reviews for these individuals were limited to verification that the beneficiary qualified as PA for the review month (Chart II).

Chart I: The Cases Included in the Medi-Cal Only Review Category Had the Following Results:

State MPES Case Reviews in Sample	606	
Dropped State MPES Case Reviews	0	
Completed State MPES Case Reviews	606	100%
Case Reviews with Errors	56	9.2%
Case Reviews with No Eligibility Errors	550	90.8%

Chart II: The Cases Included in the Medi-Cal Linkage Review Category Had the Following Results:

State MPES Case Reviews in Sample	394	
Dropped State MPES Case Reviews	0	
Completed State MPES Case Reviews	394	100%
Case Reviews with Eligibility Errors	1	.2%
Case Reviews with No Eligibility Errors	393	99.8%

Chart III: Combining the Review Categories Had the Following Results:

State MPES Case Reviews in Sample	1,000	
Dropped State MPES Case Reviews	0	
Completed State MPES Case Reviews	1,000	100.0%
Case Reviews with Errors	56	5.6%
Case Reviews with No Eligibility Errors	944	94.4%

Table 1 categorizes the eligibility errors by county for the Medi-Cal Only Managed Care eligibility reviews that may have led to health plans receiving capitation payments for ineligible beneficiaries.

Table 1 MMC Medi-Cal Only Eligibility Errors

COUNTY NAME	MMC Medi-Cal Only Eligibility Errors				
	Annual Redetermination (1)	Ineligible for Any Medi-Cal Program (2)	Share of Cost (3)	Eligible With Ineligible Services (4)	Totals
FRESNO				1	1
LOS ANGELES	27	12	2	3	44
ORANGE		1	1		2
RIVERSIDE		1		1	2
SACRAMENTO		1	1		2
SAN BERNARDINO		2			2
SAN JOAQUIN			1		1
SAN MATEO		1			1
TULARE			1		1
Totals	27	18	6	5	56

- (1) CDHS staff was unable to locate evidence of completed Redetermination forms in the county file. CDHS staff attempts to make contact with the beneficiaries were unsuccessful. This indicates that county eligibility staff did not complete the Redetermination process on a timely basis
- (2) The Medi-Cal beneficiaries were ineligible for any Medi-Cal program based on an evaluation by CDHS staff. The following reasons were identified:
 - 7 cases – The beneficiaries were determined not to be eligible for any Medi-Cal program based on information in the case record or information received by CDHS staff.
 - 6 cases – County discontinued Medi-Cal in County System but beneficiaries continued to be eligible in state MEDS.
 - 2 cases – Beneficiaries had excess resources and were not eligible for Asset Waiver Programs or any other Medi-Cal program.
 - 2 cases – Beneficiaries failed to complete the mandatory income report forms and were not exempt from the requirement to do so. Beneficiaries were ineligible for any Medi-Cal program as a result.
 - 1 case – Beneficiary had moved out of California and did not meet residency requirements to receive Medi-Cal from California.
- (3) The county determined that the beneficiaries had no SOC. DHS reviewers determined there should be a SOC. Although the beneficiaries were otherwise eligible for Medi-Cal, the SOC that was determined by the county was incorrect based on information that was

obtained from the beneficiaries. The beneficiaries are not eligible for Managed Care if there is a SOC, except County Organized Health System counties.

- (4) The beneficiaries were aliens without lawful permanent resident alien status. The beneficiaries should have been issued restricted scope of services instead of full scope services.

Error Documentation/Fraud Referrals

Of the 1,000 completed Managed Care beneficiary case reviews, CDHS referred five cases to Audits and Investigations (A&I) as follows:

<u>County</u>	<u>Number of Referrals</u>
Los Angeles	Three
Riverside	Two
Sacramento	One

Detailed Summary of Fee-For-Service Eligibility Reviews:

As part of the MPES 2005, the Program Review Section (PRS) reviewed the eligibility of beneficiaries who received Medi-Cal services in selected months of service. There were two categories of cases included in the `beneficiary case reviews, Medi-Cal Only or Medi-Cal Linkage.

- **Medi-Cal Only Reviews: 329 Cases**

The Medi-Cal Only reviews include detailed review of all identifiable data sources including those at the county level and contact with the beneficiary (Chart IV).

- **Medi-Cal Linkage Reviews: 699 Cases**

The Medi-Cal Linkage reviews include those beneficiaries in Public Assistance (PA) Aid Codes whose eligibility for Medi-Cal is contingent on their eligibility for the PA program from which they receive a cash grant. These individuals are in the Adoption Assistance, California Work Opportunity and Responsibility to Kids, Foster Care, and Supplemental Security Income/State Supplementary Payment aid codes. Reviews for these individuals were limited to verification that the beneficiary qualified as PA for the review month (Chart V).

Chart IV: The Cases Included in the Medi-Cal Only Review Category Had the Following Results:

State MPES Case Reviews in Sample	329	
Dropped State MPES Case Reviews	2	
Completed State MPES Case Reviews	327	100 percent
Case Reviews with Eligibility Errors	18	5.5 percent
Case Reviews with No Eligibility Errors	309	94.5 percent

Chart V: The Cases Included in the Medi-Cal Linkage Review Category Had the Following Results:

State MPES Case Reviews in Sample	699	
Dropped State MPES Case Reviews	0	0 percent
Completed State MPES Case Reviews	699	100 percent
Case Reviews with Eligibility Errors	0	0 percent
Case Reviews with No Eligibility Errors	699	100 percent

Chart VI: Combining Review Categories Had the Following Results:

State MPES Case Reviews in Sample	1,026	
Dropped State MPES Case Reviews	2	
Completed State MPES Case Reviews	1,024	100 percent
Case Reviews with Eligibility Errors	18	1.8 percent
Case Reviews with No Eligibility Errors	1,006	98.2 percent

Table 2 shows the type of eligibility errors by county for the Medi-Cal Only FFS eligibility reviews and an explanation of the types of errors.

Table 2 FFS Medi-Cal Only Errors

COUNTY NAME	FFS Medi-Cal Only Errors			
	Ineligible for Any Medi-Cal Program (1)	Eligible with Ineligible Services (2)	Share of Cost (3)	Totals
ALAMEDA			1	1
EL DORADO	1			1
IMPERIAL	1			1
LOS ANGELES	1		7	8
RIVERSIDE			2	2
SAN DIEGO	1	1		2
SAN JOAQUIN		1		1
STANISLAUS			2	2
Totals	4	2	12	18

- (1) The Medi-Cal beneficiaries were ineligible for any Medi-Cal program based on an evaluation by CDHS staff. The following reasons were identified:
- 2 cases – The beneficiaries were determined not to be eligible for any Medi-Cal program based on information in the case record or information received by CDHS staff.
 - 2 cases – Beneficiaries had excess resources and were not eligible for Asset Waiver Programs or any other Medi-Cal program.

- (2) The beneficiaries should have been issued eligibility for restricted scope of services instead of full scope services.
 - 1 case - alien without lawful permanent resident alien status.
 - 1 case – LTC beneficiary transferred resources without adequate consideration and was ineligible for LTC scope of benefits.
- (3) Although the beneficiary was otherwise eligible for Medi-Cal, the SOC that was determined by the county was incorrect based on information that was obtained from the beneficiary.

Error Documentation/Fraud Referrals

Of the 327 completed FFS beneficiary case reviews, PRS referred three cases to A&I as follows:

<u>County</u>	<u>Number of Referrals</u>
Alameda	One
Imperial	One
San Diego	One

Why Inferences Regarding FFS Medi-Cal Eligibility Propriety Cannot Be Made From the MPES 2005 Results

The MPES 2005 was designed to validate FFS Medi-Cal provider payments. The evaluation process entailed evaluating each claim in the sample and determining whether the payment should have been made. As part of this process, the beneficiaries associated with each sample claim were screened for Medi-Cal eligibility. That is, reviewers evaluated whether the FFS beneficiary was eligible for the Medi-Cal program for the date-of-service reflected on the sample claim. As an example, assume a sample claim disclosed a physician visit during October 2004 generating a \$26 payment. Further assume that the FFS beneficiary receiving the service was determined not eligible for the Medi-Cal program. In this case, the \$26 payment would be deemed a payment error. The reason the claim was found to be paid in error related to eligibility.

Because the audit objective is determining the total Medi-Cal program payments made in error, the sampling unit selected was the claim. As such, attempting to infer beyond the sampling objective is not advisable. For example, the “eligibility errors” should not be utilized to infer anything beyond the “reason” for a payment error. If an attempt is made to make inferences about the propriety of Medi-Cal eligibility utilizing the claim as the sampling unit, the results would be subject to selection bias. Such a bias could potentially result in misleading conclusions. Utilizing the claim as the sampling unit for such an endeavor would result in selecting FFS beneficiaries that are users generating the highest medical utilization. Therefore, beneficiaries with chronic illnesses and those associated with specific aid codes (e.g., Aid code 60 SSI/SSP) would have a higher probability of being selected. To the extent that these beneficiaries exhibit different eligibility errors than the overall Medi-Cal population, the results will certainly be biased. As an example, it may be found that beneficiaries with chronic health conditions or disabilities are less likely to experience an eligibility error. It is likely that such

beneficiaries would have a high incentive to comply with all eligibility requirements, as their continued medical care is reliant upon it.

Table 3 provides a hypothetical example of the issue described above. Assume that a claim is selected from a pool of five beneficiaries, each generating different utilization rates (as measured by claims volume). The total claims volume for all 5 beneficiaries equaled 300. If 1 claim was drawn at random from the 300 claims, beneficiary “C” would have a 66.67 percent chance of being selected. If this beneficiary exhibited different eligibility characteristics (e.g., linked to Medi-Cal through SSI/SSP etc. or suffers from a chronic condition) than the norm, it would not provide a representative sample. As such, utilizing this beneficiary to make inferences about the entire population would be misleading.

Table 3 Claims Volume Example

Beneficiary	Claims Volume	Probability of Being Selected
A	40	40/300
B	50	50/300
C	200	200/300
D	5	5/300
E	5	5/300
Total	300	

To make inferences regarding eligibility propriety, the sampling unit should be the beneficiary or member months etc. In addition, sample stratification should be considered. As stated previously, the sample design utilized by the 2005 MPES cannot be utilized to make inferences regarding Medi-Cal eligibility propriety.

MPES Eligibility Conclusions:

- In December 2005, CDHS program review staff conducted a follow-up on-site review in Los Angeles County and found that the County had instituted corrective action and was completing redeterminations timely. CDHS reviewed 100 new case files and all were in compliance with redetermination requirements for timeliness. In addition, CDHS staff has monthly discussions with this County to discuss this issue and other eligibility issues. As of March 2006, MEDS records indicate that Los Angeles County has taken corrective actions on 14 of the 27 overdue annual redeterminations. In addition, CDHS staff regularly communicates with individual counties as well as with the County Welfare Directors Association to discuss eligibility policies, issues, and corrective action necessary to improve program compliance.
- The program review staff works closely with counties to develop appropriate corrective actions to address the errors identified in individual case files as well as the underlying policy or procedure. In addition, approximately 80 targeted

focused reviews and special studies are performed annually to concentrate on specific problem areas as identified in the monthly quality control reviews. Problems identified in the focused reviews are discussed with the county and a follow-up visit is scheduled to assess improvement. This process will focus on resolution of the types of errors found in this study.

- As a result of the eligibility findings, CDHS continues to follow up with the counties which had eligibility errors, including Los Angeles County which had the majority of errors, to ensure that appropriate corrective actions are taken.
- CDHS has an ongoing program for county Medi-Cal eligibility quality control reviews that includes a monthly random sample of approximately 225 cases to identify error trends by category and county, and targeted reviews of selected counties to examine specific problem areas. Follow-up with counties is done to develop corrective action plans. This process will focus on resolution of the types of errors found in this study.
- Working within the current level of resources, CDHS conducts limited monitoring of county compliance with statutory performance standards enacted in 2004 that require a 90 percent compliance rate for completing timely eligibility determinations and annual redeterminations. These standards also require prompt disenrollment of beneficiaries who become ineligible for Medi-Cal. Failure to meet the standards puts counties at risk for a fiscal penalty.
- Consideration should be given by CDHS and the Legislature to raising the performance standards above 90 percent because county errors in the eligibility determination process result in the potential for significant fiscal impact to the Medi-Cal program.

In Fiscal Year 2004-05, CDHS proposed a comprehensive approach for monitoring county compliance with performance standards, state staff resources and contractors; however only four positions were approved by the Legislature for this activity. In light of the number of errors identified and their significant fiscal impact, consideration should be given to strengthening this function through additional staff and contractor resources. These resources should include a third-party contingency contract, where the contractor receives a payment for each individual found ineligible for Medi-Cal and subsequently disenrolled from Medi-Cal.

GLOSSARY OF ACRONYMS

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
CCR	California Code of Regulations
CDHS	California Department of Health Services
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DHHS	U. S. Department of Health and Human Services
DHS	Department of Health Services
DME	Durable Medical Equipment
DOJ	Department of Justice
EDS	Electronic Data Systems
FFS	Fee-For-Service
FPACT	Family Planning, Access, Care and Treatment
FQHC	Federally Qualified Health Centers
GERD	Gastro esophageal Reflux Disease
HALT	Health Authority Law Enforcement Team
IEP	Individual Education Plan
IPC	Individual Plan of Care
Lab	Laboratory
LEA	Local Education Agency
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
OIG	Office of Inspector General
PA	Public Assistance
PEB	Provider Enrollment Branch
PIA	Prison Industry Authority
PRS	Program Review Section of CDHS Medi-Cal Eligibility Branch
RHC	Rural Health Clinic
SCR	Special Claims Review
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Social Security Income

TAR
VSAM
W&I Code

Treatment Authorization Request
State Medi-Cal eligibility database
Welfare and Institutions Code

DESCRIPTION OF STRATA

There were eight different strata in the MPES 2005. The following list describes the different types of providers that are covered within each stratum. The provider types listed below are the most common providers encountered. Any provider with a Medi-Cal provider number who submits claims to the Medi-Cal program could have claims selected in a payment error study such as MPES 2005.

1. Dental –

Outpatient dental services

2. Adult Day Health Care (ADHC) –

Adult Day Health Care centers

3. Inpatient –

Inpatient acute care hospital

Long term care facilities such as skilled nursing facilities

4. Durable Medical Equipment (DME) –

Durable medical equipment for outpatient as well as long-term care patients

5. Laboratory (Lab) –

Outpatient clinical laboratory services testing biological specimens

Prison Industry Authority – optical laboratory that makes eyeglass lenses for Medi-Cal beneficiaries

6. Other Services and Supplies –

Local Education Agency (LEA)

Visiting nurse associations

Nurse practitioners

Home Health Agencies

Hospice

Transportation services

Medical supplies

Genetic Disease Branch

Institute on Aging

7. Physician Services –

Individual physicians

Physician groups

Hospital outpatient clinics

Federally Qualified Health Centers

Rural Health Clinics

Individually licensed ambulatory

surgery services

Optometrists

Audiologists

Podiatrists

Psychologists

Physical, speech, occupational therapists

Other providers rendering outpatient

services to Medi-Cal beneficiaries

8. Pharmacy –

Retail pharmacies individually owned, chain pharmacies, and “closed door” pharmacies, not open to the public, but provide pharmaceutical products and medical supplies to institutions such as skilled nursing facilities

Post Study Review

Claim errors with characteristics of potential fraud

An examination of the billing practices of those providers who submitted claims identified by the MPES 2005 as containing characteristics of potential fraud was performed to validate the study's preliminary findings. The billing patterns of each of these providers were reviewed subsequent to completion of the MPES 2005 study and prior to issuance of the MPES 2005 report. Additional claims from each provider, beyond those that were part of the sample, were reviewed to determine if the errors were unique single occurrences or indicative of patterns consistent with fraud.

This additional analysis, i.e., review of additional provider claims, was not part of the MPES 2005 review protocols or sampling and estimation methodology. One of the MPES' main objectives is to estimate the potential dollar loss due to the payment of claims that are potentially fraudulent; the additional analysis provides the most accurate estimate of the potential Medi-Cal funds that are at risk due to fraud.

MPES 2005 identified 124 claims, submitted by 113 unique providers, which disclosed characteristics of potential fraud. After detailed review of these providers' claiming patterns, it was determined that 38 of these providers (42 claims) did not have patterns consistent with fraud and do not require additional review or action. The 42 claims were found to be unique single occurrence errors and not fraudulent. The remaining 75 providers (82 claims) were determined to warrant additional investigation and/or immediate action. While concern has been raised and will be further investigated, the 75 providers cannot be assumed to be fraudulent without performing a complete investigation.

This post study review of claims did not change the overall 8.40 percentage of payments to claims with errors. However, it did reduce the percentage of payment errors for potentially fraudulent claims from 5.04 percent to 3.23 percent.

These 82 claims, submitted by 75 unique providers, with characteristics of potential for fraud are in various stages of review and examination, including referral to the Department of Justice for criminal investigation and application of sanctions by CDHS. Of the reviews that have been completed, more than 80 different sanctions have been placed on providers. Some providers received more than one sanction such as procedure code limitations, special claims review, withhold, etc.

The findings and follow-up actions on these providers will be presented in the MPES 2006 report.