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

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2011 Medi-Cal Payment Error Study

I am pleased to present the sixth Medi-Cal Payment Error Study (MPES) as part of the Department of Health Care Services' (DHCS) ongoing efforts to combat fraud, waste and abuse in the fee-for-service (FFS) Medi-Cal program.

DHCS places a high priority on protecting taxpayer dollars and assuring the fiscal integrity of its programs. DHCS uses the MPES to direct anti-fraud resources and activities to the Medi-Cal programs that face the greatest risk for payment errors and fraud.

The 2011 MPES found that an estimated 93.95 percent of payments to FFS Medi-Cal providers in 2011 were billed appropriately and paid accurately, while an estimated 6.05 percent of those payments had some indication of a provider payment error. The 6.05 percent payment error rate equates to approximately $1.25 billion of payments at risk of being erroneously paid for calendar year 2011. A portion of this payment error, 2.28 percent ($473 million), was for claims that disclosed characteristics of potential fraud.

Although both the overall payment error and potential fraud error rates are slightly higher than those found in MPES 2009 (5.45 percent and 1.16 percent, respectively), the MPES 2011 error rates are significantly lower than other previous MPES studies, especially when compared to the 2005 reported payment error rate of 8.40 percent and a potential fraud error rate of 5.04 percent. Overall, the MPES payment error rate and the potential fraud rate have been trending down.

DHCS' proactive monitoring program, aggressive provider education, and anti-fraud efforts, ensure that the vast majority of Medi-Cal expenditures are used appropriately to provide critical health care to California's most vulnerable populations. Examples of DHCS' continued efforts include the following:

- DHCS is in the process of instituting mandatory enrollment for ordering, referring and prescribing physicians to curb physician prescribing errors. This mandatory enrollment will facilitate DHCS' efforts to identify, investigate and take action against providers that contribute to potential over-utilization and medically-unnecessary services.

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- DHCS continues to collaborate with allied agencies to address drug diversion on many fronts. Most recently, DHCS assisted other state and federal law enforcement agencies in uncovering, prosecuting, and convicting several individuals in a $20 million drug harvesting scheme.

- Adult Day Health Care (ADHC) centers had been a high risk provider type since the inception of MPES with program costs increasing significantly in the last several years. Effective April 1, 2012, the ADHC program was replaced by the Community Based Adult Services (CBAS), a smaller, less expensive program with more stringent eligibility requirements. CBAS, now a Medi-Cal Managed Care benefit, offers services to eligible older adults and/or adults with disabilities to restore or maintain their optimal capacity for self-care and delay or prevent inappropriate or personally undesirable institutionalization.

- Effective July 1, 2013, the Diagnosis Related Group (DRG) payment methodology replaced the previous payment method of negotiated rates for contract hospitals and cost-based reimbursement for non-contract hospitals. Under the DRG, hospital payments will better align to the patient's severity of illness and care delivered.

- DHCS has deployed enhanced data analytics tools to more effectively identify vulnerabilities and "red flags" within the Medi-Cal program that warrant investigation.

For additional information, please contact Bruce Lim, Deputy Director, Audits and Investigations, at (916) 440-7552.

Sincerely,

Original signed by:

Toby Douglas
Director

Enclosure

2011

Medi-Cal Payment Error Study

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

Fee-For-Service Program

DHCS
California Department of
HealthCareServices

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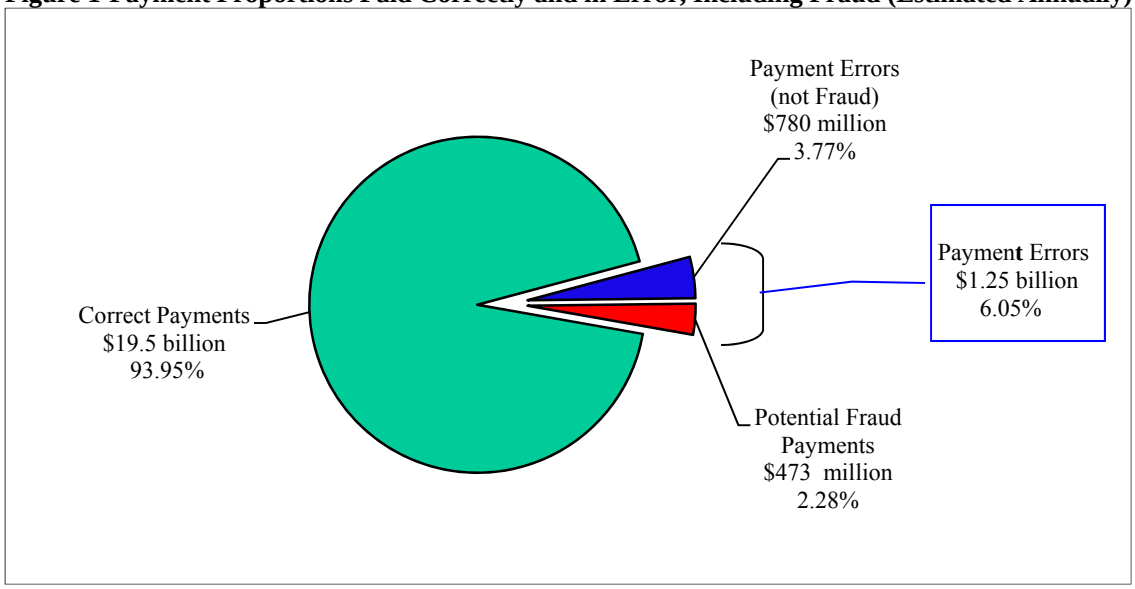
I. Executive Summary

The California Department of Health Care Services (DHCS) has completed its 2011 Medi-Cal Payment Error Study (MPES). The study, the fifth since 2005, identifies where the Fee-For-Service (FFS) Medi-Cal program is at greatest risk for payment errors. In addition, it allows DHCS to analyze the factors that influence the payment errors and determine what actions and strategies it needs to take in order to reduce the cost associated with those errors.

1) Overall Error

The MPES 2011 results continue to show that the overwhelming majority of payments, 93.95 percent of total payments made in FFS medical and dental programs, were billed and paid appropriately (Figure 1). In contrast, an estimated 6.05 percent of those payments had some indication that they contained a provider payment error (Figure 1). Payment errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as billing for services not provided or services that were not medically necessary.

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



Extrapolating from the MPES 2011 sample to the program as a whole, the 6.05 percent error rate equates to a projected $1.25 billion in total payments made in error for FFS medical and dental services in 2011. This extrapolated amount represents the percentage of payment error attributable to Medi-Cal program payments "at risk"[1] of being paid inappropriately, due to

[1] The term "at risk" is used because the $1.25 billion figure is derived by applying the 6.05 percent rate to the program's annual expenditure level. The $1.25 billion cannot be considered as actual payments made in error unless all of the individual services that are questionable are identified through a complete medical review or audit of all services submitted for payment and found to be in error.

findings related to simple provider mistakes or more significant findings indicative of intentional fraud or abuse.

The 6.05 percent payment error shows a slight increase over the 5.45 percentage rate of the 2009 study. Similarly, due to the slight increase in the overall payment error and the growth of the Medi-Cal FFS program, the projected $1.25 billion payments in error is higher than the $1.07 billion payment errors found in MPES 2009, but lower than the MPES 2005 amount of $1.4 billion.

Cumulatively, there are nearly $157 million fewer projected payments in error between MPES 2005 and MPES 2011 (Table 1).

Table 1 - Fewer Payments in Error Lead to Cummulative Projected Savings (2005- 2011)

MPES	Error Rate	FFS Projected Annual payments	Projected Annual Payments in Error	Difference in Projected Payment Errors From Prior MPES Study
MPES 2005	8.40%	$16,773,590,756	$1,409,704,505	
MPES 2006	7.27%	$16,177,256,316	$1,176,521,646	($233,182,859)
MPES 2007	6.56%	$15,968,390,500	$1,047,708,877	($128,812,769)
MPES 2009	5.45%	$19,636,308,388	$1,070,041,382	$22,332,505
MPES 2011	6.05%	$20,718,001,080	$1,252,789,452	$182,748,070
Projected Reduction in Payments in Error Since MPES 2005				**($156,915,053)**

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

2) Potential Fraud Error

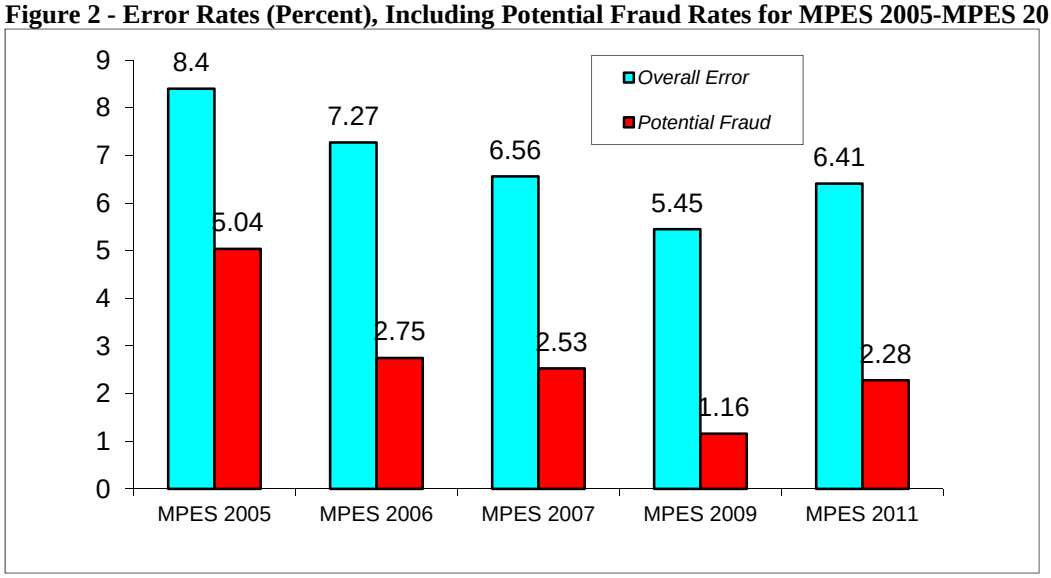
MPES 2011 findings reveal that 2.28 percent of the total payments in the Medi-Cal FFS medical and dental programs was for claims that disclosed characteristics of potential fraud. The 2.28 percent is equivalent to an annual amount of nearly $473 million in potential fraud.

Although the potential fraud rate increased significantly in MPES 2011, compared to MPES 2009 (2.28 percent vs. 1.16 percent), it is still relatively low when we look at the historical MPES fraud rate. For instance, the 2011 rate is the second lowest among all MPES studies (see Figure 2), behind the 2009 fraud rate of 1.16 percent. The average fraud rate for MPES 2005-MPES 2011 is 2.75 percent. This is higher than the MPES 2011 fraud rate. Overall, the fraud rate has been trending down.

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

mistakes, such as using the wrong code, rather than a malicious intent to deceive or defraud Medi-Cal.

Figure 2 - Error Rates (Percent), Including Potential Fraud Rates for MPES 2005-MPES 2011



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

3) Sampling

The MPES 2011 random sample includes 1,168 Medi-Cal claims paid during the second quarter of 2011 (April 1 through June 30) and is organized by major provider type (stratum). There are eight provider types in the sample: Adult Day Health Care (ADHC), Dental, Durable Medical Equipment (DME), Inpatient Services, Laboratory (referred to as Lab), Physician Services, Other Services, and Pharmacy. Dental claims, which were not part of the MPES 2009 sample, have been reinstated into the 2011 study.

Since MPES is designed to measure payment errors in the Medi-Cal program, the stratum that has the greatest impact on the error rate is the Inpatient Services, which accounted for the highest share (47.2 percent) of payments in the sample. That is because Inpatient claims have the highest cost per claim, $2,847, on average. Physician Services and Pharmacy were second and third with 22.2 percent and 19 percent, respectively. The remaining five strata (ADHC, DME, Dental, Lab, and Others Services) each accounted for five percent or less of the sample payments.

4) Error Breakdown by Stratum

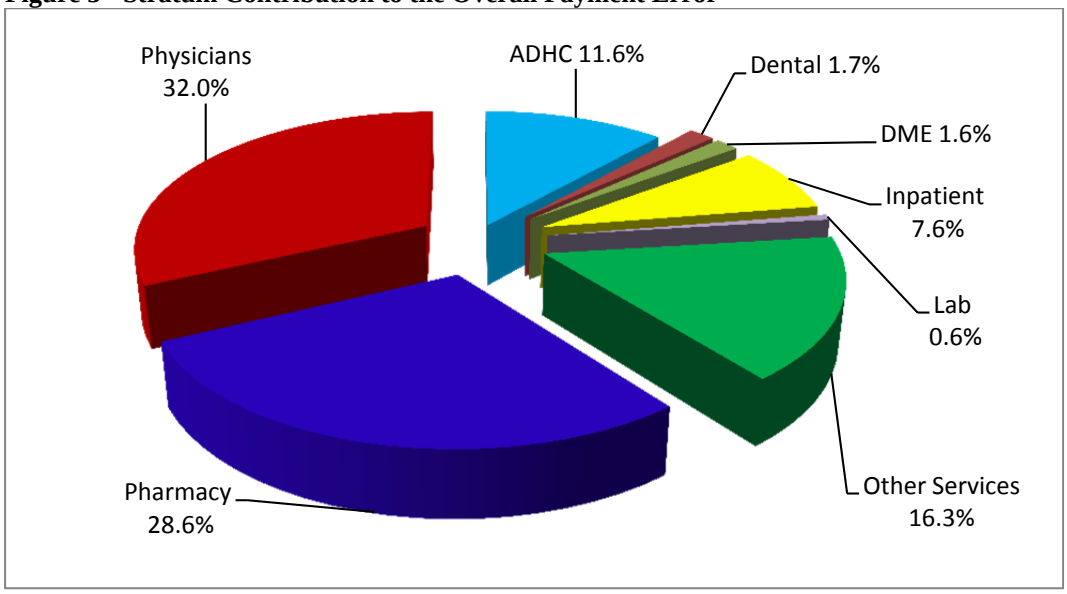
Due to the dynamic nature of health care-related fraud schemes and provider behavior, the contribution of each provider type to the overall payment error is expected to change from year to year. Figure 3, below, shows each provider type's share of the overall 6.05 percent payment error rate.

Physician Services contributed the most, 32 percent. Second in magnitude was Pharmacy, with 28.6 percent share of the overall payment error.

Two other strata, Other Services and Inpatient Services, saw their share of the overall payment error increase significantly, compared to MPES 2009. The Other Services stratum share, with 16.3 percent, increased nearly 6 times from 2009. It is the first time since the study began that this stratum's contribution reached double digits. Inpatient Services had no payment errors in the previous study; however, in MPES 2011, this provider type contributed 7.6 percent (nearly $95 million) to the overall payment error. These two strata are the main reason for the increase in the overall payment error in MPES 2011.

ADHC contributed 11.6 percent to the overall error rate. Although this is only about half the MPES 2009 share of 22.04 percent, ADHC's share remains high compared to its share of the payment volume in the universe (1.7 percent).

Figure 3 - Stratum Contribution to the Overall Payment Error



The remaining three, Dental, DME and Lab, had minimal contributions to the 6.05 percent error rate.

In terms of number of claim errors in the sample, the 123 errors out of the 1,168 sample claims represent a 10.5 percent claim error rate. This is lower than the 18.5 percent claim error rate of MPES 2009. In fact, for the 2005-2009 studies, the sample claim error rate averaged 18.5 percent. Therefore, in terms of claim errors, MPES 2011 has the lowest number of claims in

error. The main reason the MPES 2011 payment error rate is slightly higher this time around is because those errors, while fewer in numbers, are "high dollar" errors.

Pharmacy ranked first, with 34 claim errors, out of 123 total errors (27.6 percent). Physician Services came in second with 32 errors (26.2 percent). Other Services were third in number of errors in the sample, with 25 errors (20 percent) and ADHCs fourth with 20 errors (16.4 percent).

The four remaining strata, DME, Dental, Inpatient Services, and Lab contributed the fewest numbers of claims in error, 5, 4, and 2, and 1, respectively. However, the two Inpatient Services errors carried a significantly high and disproportionate monetary value.

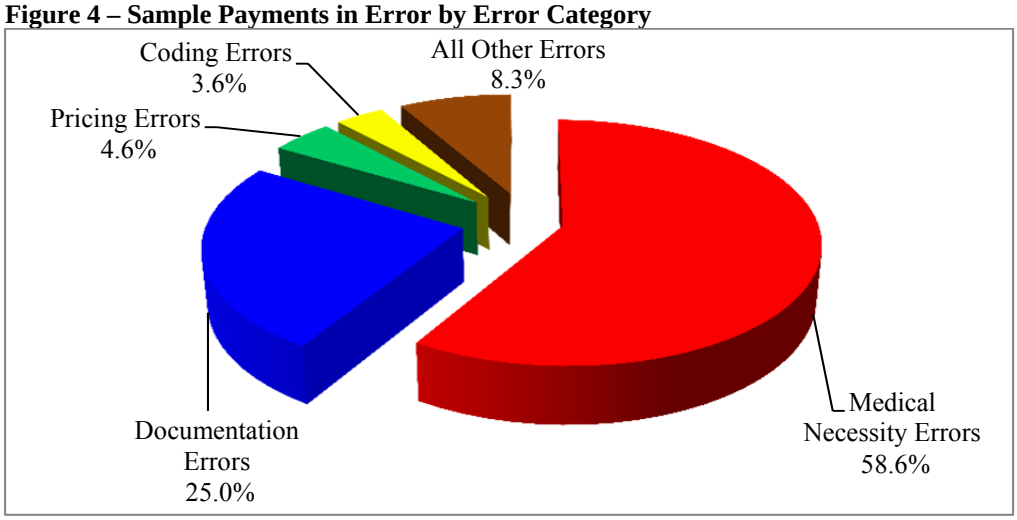
Physician Services errors were also involved in 11 Pharmacy errors, those committed by prescribers. These 11 prescriber errors in the pharmacy stratum were due to lack of medical necessity errors that dealt with non-needed prescriptions or referrals by physicians. Combining the 32 physician errors with the 11 prescriber errors in the Pharmacy stratum adds up to 43 total Physician Services errors in the sample. That represents more than a third (35.2 percent) of all the sample errors and makes Physician Services, still, the stratum most vulnerable in the Medi-Cal program.

Drug diversion continues to be a serious issue in the Medi-Cal program. Six pharmacy claims in error out of 34 (17.6 percent) were related to possible drug diversion schemes. This type of error is generally associated with narcotic or other pain medication that is used for non-medical or recreational reasons. Drug diversion products are also known to be acquired for street resale.

5) Error Breakdown by Type

Figure 4, below, displays the breakdown of sample payment errors by error type. The majority of all payment errors in the sample were for claims that lacked medical necessity. There were 37 claims in error of this type, accounting for 58.6 percent of all the payments in error in the sample. This error category is the most egregious because it means that the services should not have been provided, had no value, and were not simple mistakes for services that should not have been paid.

Figure 4 – Sample Payments in Error by Error Category



Documentation errors ranked second in sample payment errors with a 25% share of all payment errors. The share of each of the three remaining categories (pricing, coding, and all other errors) was in single digits.

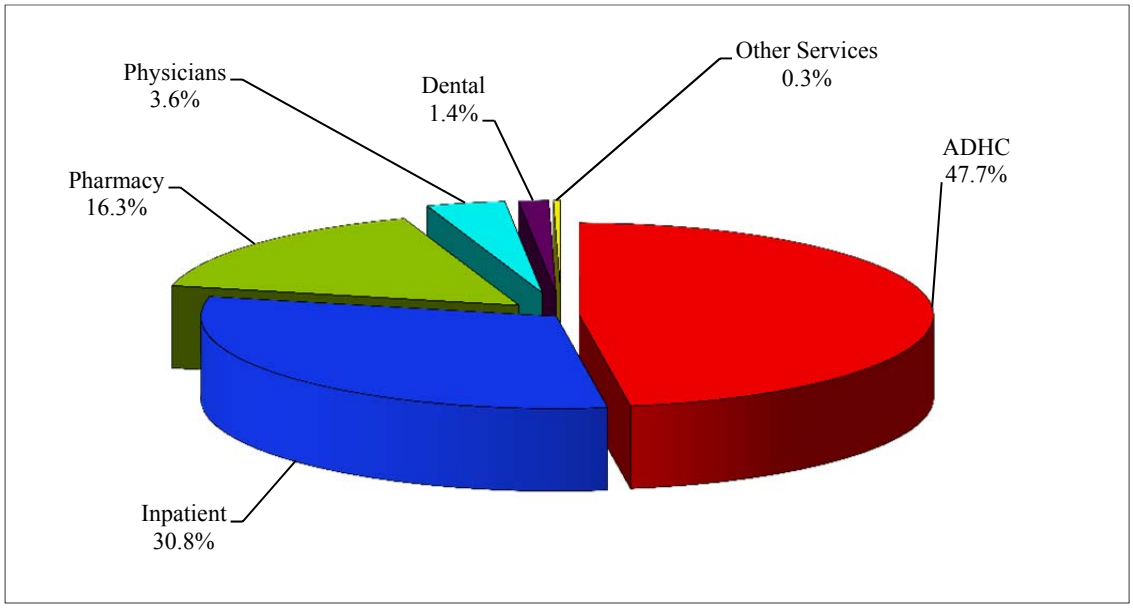
Medical necessity errors then still constitute the greatest risk of fraud, waste, and abuse for DHCS. A rough estimate of the potential magnitude of the risk posed by the 58.6 percent of medical necessity errors can be illustrated by multiplying that percent by the estimated annual payments in error ($1.25 billion). This totals to over $734 million potential loss to the Medi-Cal program. In terms of expenditures, the reduction or elimination of medical necessity errors in DHCS's funded health care programs would lead to potentially significant savings for the State.

Looking closely to the 37 medical necessity claim errors by provider type in the sample, we find that ADHCs had the highest number of errors, 15. Pharmacy came in second with 11 errors, Physician Services had five errors. However, the 11 medical necessity errors in Pharmacy were actually generated by physicians prescribing unnecessary drugs. Therefore, physicians, as a group, contributed to the highest number of medical necessity errors (16 or 43.2 percent) in the sample.

Other remaining strata had very few medical necessity errors.

In terms of payment errors, Figure 5, below, shows that ADHCs accounted for nearly half of all the medical necessity payment errors in the sample (47.6 percent). As was the case in MPES 2009, ADHCs' share of medical necessity errors in 2011 is very high. Therefore, this provider type continues to represent a very high risk to the Medi-Cal program.

Figure 5 – Breakdown of Sample Medical Necessity Errors by Stratum



6) Key Findings and Next Steps

MPES continues to assist DHCS in maintaining the Medi-Cal program integrity by identifying trends that in turn refine target areas for reducing fraud, waste, and abuse. For instance, the overall payment error has been reduced 40 percent since MPES 2005 and the potential fraud by nearly 42 percent since that same study. Still, additional efforts will continue to focus on the provider types most at risk.

- Physician Services contributed nearly a third (32 percent) of the overall payment error rate. This provider type has been the subject of an outreach program called Individual Provider Claims Analysis Report (IP-CAR) since 2010. IP-CAR supplied physician providers with comparative billing information and trends within the provider's individual peer group. The project goals were to encourage providers to become more conscientious about their billing, persuade them to bill accurate diagnosis codes, and educate physicians on how to conduct a self-audit. Preliminary results show that the 2010 IP-CAR helped reduce costs by $2 million among physicians during a six-month period.

  The second IP-CAR report, sent in October 2012, analyzed claims for office visits for children. Once again, providers with a very high percentage of the most expensive office visits received reports. Some providers that received reports contacted DHCS to explain that they were billing appropriately for very complex office visits in subspecialty practices. The next IPCAR will focus on the prescribing of controlled substances to adults. Letters will be sent to high prescribers so that they can compare their pattern of prescribing and diagnoses with that of their peers. The review will look for repetitive prescribing of combinations of addictive controlled substances. It will also report the average distance between beneficiaries and prescribers, and the frequency and percentage of a prescriber's beneficiaries receiving controlled substances from multiple prescribers. Because oversight of medical necessity for diagnostic studies and procedures, pharmaceutical items, medical supplies and equipment falls upon the referring and prescribing physicians, the mandatory enrollment process for ordering, referring and prescribing providers and planned implementation of related payment edits is expected to reduce payments for medically-unnecessary services and items, as well as enhance the ability to detect providers with patterns of ordering, referring or prescribing suggestive of waste and abuse.

- Pharmacy had the highest number of claims in error (34 errors or nearly 28 percent of all the errors in the sample). Pharmacy was also the highest contributor to fraudulent payments. More than half of all estimated fraudulent payments (51.2 percent) were in Pharmacy. That is significantly higher than the 24.4 percent of fraudulent pharmacy payments in MPES 2009.Efforts have been made and will continue to be made by DHCS to reduce the number of errors in this provider type. For instance, the Doc Shop Index (DSI) has been implemented to curb beneficiary-related drug diversion. The DSI concept and its related reports are based on the collaborative efforts by Audits and Investigations' (A&I) Medical Review and Investigations Branches (IB), aided by private contractors. These reports allow for an easy comparison of beneficiary drug claims activity and

clearly identify over-utilization by tabulating drug benefit usage patterns. The identified outlier beneficiaries are then subject to further scrutiny, including the standard investigation methods of A&I's IB investigators.

- The Other Services stratum saw its fraudulent payment error jump from zero in MPES 2009 to nearly eight percent in MPES 2011, hence contributing to the increase in the overall fraud rate in MPES 2011. Conversely, physician services fraudulent payments in MPES 2011 had a rate of 12.5 percent, or almost three times less than the rate in MPES 2009 (45.6 percent).

- ADHCs have been a high risk provider type since the inception of MPES. While they represented only 1.7 percent of payments in the MPES 2011 universe, their share in the overall payment error rate was disproportionately higher, nearly 12 percent. ADHC centers continued in 2011 to enroll large numbers of beneficiaries that did not meet the five admission criteria. In addition, the costs of this program have skyrocketed in the last several years. This has caused the Governor and the Legislature to close the ADHC program in 2012 and replace it with a smaller, less expensive new program, the Community Based Adult Services (CBAS). CBAS, now a Managed Care program, is meant to keep low-income elderly, disabled, and frail adults out of nursing homes and hospitals by offering medical care, physical therapy, counseling, and exercise at hundreds of centers throughout the state. This new program is expected to save the state about $90 million a year.

- Other Services has, in the previous study, made a very minimal contribution to the overall error rate; however, in MPES 2011, the share of this provider type jumped six-fold, to 16.3 percent. In terms of claim errors, the Local Education Agencies (LEA) led in that increase with 24 errors out of 25 total errors in the stratum. The following factors may have contributed to the higher payment error in LEA providers: a) many providers started using a newly-developed and confusing electronic record; b) the documentation of services that was collected from providers in late spring 2011 was incomplete, and the missing documents could not be obtained during the follow-up period because school offices were closed in some cases. In addition, A&I is partnering with Skilled Nursing Facilities (SNF) to enhance provider outreach and education and improve documentation and compliance. MRB/LEA liaison team members' attendance and contribution to LEA Ad Hoc Workgroup meetings and LEA provider training sessions are currently in progress and planned to be ongoing. The MRB online training presentation for LEAs updates is also currently in progress and will be made available to LEAs on the program website.

- Inpatient Services saw its share of the overall payment error rate go from zero in MPES 2009 to 7.6 percent in MPES 2011. This is due to two high-cost medical necessity errors. For future studies, the DRG payment methodology will replace the previous payment method of negotiated rates for contract hospitals and cost-based reimbursement for non-contract hospitals. Under the All Patient Refined Diagnosis Related Groups (APR-DRG) system, it is anticipated that coding will be better supported by documentation and reimbursements better aligned with the patient's severity of illness and care delivered.

Payment based on duplicate billings or services not provided would thus be eliminated. MRB will collaborate with Utilization Management Division and Financial Audits Branch by processing referrals, performing targeted reviews of inpatient hospital providers who are identified as high risk through UMD activities.

- There were five claim errors billed by Federally-Qualified Health Centers (FQHC) providers. Three of these errors were related to adults needing dental services while these services were not covered by Medi-Cal benefit in 2011. The other two errors were medical necessity and documentation errors, respectively. FQHCs provide services to underserved urban and rural populations and qualify for Medi-Cal reimbursement, usually under the Prospective Payment System (PPS). A&I will continue to provide stronger oversight of FQHCs, especially as they will be playing a bigger role as medical homes during the expansion of the Managed Care program.

II. Background

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

1) Medi-Cal Overview

Medi-Cal is California's version of the Federal Medicaid program. Operating in California since 1966; it is administered by DHCS under the California Health and Human Services Agency. Medi-Cal reimburses medically-necessary health care services provided to specified, low-income, medically-needy California residents. As such, it is California's largest publicly-funded health care program and its largest health care purchaser.

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

The most recent enrollment figures show there were 7.5 million Medi-Cal beneficiaries enrolled in January 2010, comprising 20% of the California resident population. There were 9.2 million beneficiaries enrolled in the Medi-Cal Program for at least one month during FY2010-11,[2] comprising 24.5 percent of the 2010 California resident population. On January 2011, there were approximately 3.3 million FFS beneficiaries and 4.2 million MMC beneficiaries.[3]

2) Medi-Cal Integrity

DHCS places high priority on combating fraud, waste, and abuse of Medi-Cal. To that end, it continuously monitors and assesses emerging trends in Medi-Cal fraud, waste, and abuse to make informed decisions on the allocation of fraud control resources and to secure the program's integrity. In FY 2011-12, DHCS recovered approximately $295 million from Medi-Cal providers due to fraud, waste, and abuse. That is an increase of $193 million (289%) in recoveries from FY 2009-10.

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[2] http://www.dhcs.ca.gov/dataandstats/statistics/Documents/2_1_Reporting_Year_FY2010-11.pdf.

3 State of California, Department of Health Care Services, Trend in Medi-Cal Program Enrollment by Managed Care Status – for Fiscal Year 2003-2011, 2003-07, 2011-01, Report Date: July 2012. http://www.dhcs.ca.gov/dataandstats/statistics/Documents/1_6_Annual_Historic_Trend.pdf.

3) MPES Overview

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

4) Provider Types

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

- Adult Day Healthcare Care (ADHC)
- Dental
- Durable Medical Equipment (DME)
- Pharmacy
- Inpatient
- Labs
- Physician Services
- Other Services

5) Main Payment Error Types

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

The six most significant categories of payment errors among the many types used and reported by MPES 2011 are:

- *Medical Necessity:* This occurs when a Medi-Cal beneficiary does receive a product or service, but the beneficiary does not have a medical need for it. Medi-Cal will only reimburse providers for products or services for which a beneficiary has a medical need.
- *Documentation:* This occurs when the presence or absence of documentation in the provider's records fails to adequately substantiate whether the service or product was medically-necessary or whether it was received by a Medi-Cal beneficiary.
- *Coding:* This occurs when a provider bills Medi-Cal using the wrong code for the diagnosis, product, or service that the beneficiary received. "Up-coding" refers to billing using a code for which the provider will receive a higher level of reimbursement than what is justified by the product or service the beneficiary actually received.
- *Policy Violation:* Violation of Medi-Cal policy.
- *Pricing Error:* Payment for the service does not correspond with the pricing schedule, contract, and reimbursable amount.

- *Other:* Payment errors that do not fall into the categories above, such as the recipient's signature missing or ineligibility of the provider or recipient.

6) MPES 2009 Findings

The previous study (MPES 2009) reported that 94.55 percent of all Medi-Cal FFS payments were correct, with a payment error rate of 5.45 percent. The 5.45 percent rate represented a steady decline in payment errors since MPES 2005. It further stated that DHCS was concerned mostly about payment errors for medically-unnecessary services.[4]

[4] MPES 2009, pp. 4, 6-9, et al.

III. MPES Design and Methodology

MPES 2011 reviews only Fee-For-Service (FFS) claims. The Medi-Cal Managed Care plans and programs are currently excluded from the study.

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

1) Process

MPES follows a multiple-stage process:

a) Draw a Sample of Claims: Using the same statistical sampling design as in previous MPES studies,[5] DHCS began by sampling 1,168 FFS claims paid in the second quarter of 2011. DHCS further refined the review processes to minimize the non-sampling errors and improve the reliability of the review process between the medical reviewers and the auditors.

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

c) Medical Staff Perform a Second Review to Confirm the First Review Findings: After the first-level reviews, DHCS medical staff performs a second-level review to validate the first review findings and identify claims that show characteristics of fraud, waste, or abuse.[6] Their findings are compiled into a database for analysis.

d) Department of Justice Review of Fraudulent Claims: DHCS sends each claim determined to be potentially fraudulent to the California Department of Justice (DOJ) Medicaid Fraud Control Unit for validation, according to their fraud protocols. DHCS then reevaluates its findings based upon DOJ's review.

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[5] The MPES 2011 sampling strategy uses a widely-accepted proportional stratified random sampling to generate estimates of payment and fraud error, then uses a ratio estimator to determine the potential dollar loss to the program, due to provider claiming errors.

[6] Common indicators of fraud are provided in Appendix I.

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

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

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

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

2) Data Universe and Sample

The sampling universe consists of Medi-Cal fee-for-service claims paid through the Fiscal Intermediary (FY), Allied Computer Services (ACS), during the period of April 1, 2011 through June 30, 2011 (Table III.1).

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

Stratum	Number of Claims in Universe	Medi-Cal Payments in Universe	Percent of Claims Volume	Percent of Payments Volume
ADHC	386,593	$91,863,971	1.46%	1.77%
Dental	969,915	$121,889,944	3.66%	2.35%
DME	330,194	$37,026,707	1.25%	0.71%
Inpatient	859,598	$2,446,871,902	3.25%	47.2%
Lab	1,796,027	$78,306,224	6.78%	1.51%
Physicians	10,414,070	$1,149,632,777	39.34%	22.20%
Other Services	2,241,600	$269,565,934	8.47%	5.20%
Pharmacy	9,474,516	$984,342,811	35.79%	19.00%
Total	26,472,513	$5,179,500,270	100.00%	100.00%

The 1,168 claims sampled for MPES 2011 represent the eight major provider types and distributed as follows:

- 421 Physician Services
- 383 Pharmacy claims
- 91 Other Services claims
- 73 Lab claims
- 50 ADHC claims
- 50 Dental claims
- 50 DME claims
- 50 Inpatient Services claims.

Each claim includes all detail lines (claim lines). Claims with zero payment amounts and adjustments were excluded from the universe; however, all adjustments to a sampled claim that

occurred within 60 calendar days of the original adjudication date were included. Dental claims are again included in the sampling universe.

The sample size was extracted from a universe of 26,472,513 Medi-Cal paid claims. It was used to ensure a 95% confidence level with a ± 3% precision relative to the overall payment error rate. Proportional allocation of the sample size was used to determine the sample size from each stratum ensuring a minimum sample size of 50 claims for each. Simple random sampling without replacement was used in each stratum for the overall the sample selection.[7]

3) Sample Stratification

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

- Stratum 1: Adult Day Health Care (ADHC), vendor code = 01
- Stratum 2: Dental, plan code equal to 0 and claim type equal to 5 and vendor code equal to 27.
- Stratum 3: Durable Medical Equipment (DME), [provider type equal to 002 and category of service not equal to 017 or 039] or [category of service equal to 059]
- Stratum 4: Inpatient, claim type = 2 (Inpatient), and vendor code list:

Vendor Code Description*

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

Stratum 5: Lab, with vendor code 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 (Physician Services), vendor code list:

5	Certified Nurse Midwife
7	Certified Pediatric Nurse Practitioner
8	Certified Family Nurse Practitioner
9	Respiratory Care Practitioner
10	Licensed Midwife
12	Optometric Group Practice
13	Nurse Anesthetists

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

20	Physicians
21	Ophthalmologist
22	Physicians Group
28	Optometrists
30	Chiropractors
31	Psychologists
32	Podiatrists
33	Certified Acupuncturists
34	Physical Therapists
35	Occupational Therapists
36	Speech Therapists
37	Audiologists
38	Prosthetists
39	Orthotists
49	Birthing Center
52	County Hospital – Outpatient
58	County Hospital - Hemodialysis
62	Community Hospital – Outpatient
68	Community Hospital – Renal Dialysis
72	Surgi-center
75	Organized Outpatient Clinics
77	Rural Health Clinics / FQHCs
78	Community Hemodialysis Center
91	Outpatient Heroin Detox

*Not all the vendor codes listed are represented in the MPES 2011 sample

- Stratum 7: Other Services and Supplies, all other claims that do not meet the criteria for the other strata.
- Stratum 8: Pharmacy, vendor code = 26

Each stratum size was determined using the proportion of the total number of claims represented by each stratum for claims paid for dates of April 1, 2011 through June 30, 2011. The sampling strata and their respective claim sizes and paid amounts are shown below (Table III.2).

4) Error Types

Each claim in error was given an error code. Appendix 3 lists all possible error codes and their descriptions that could be assigned to a claim in error. Sixteen different errors were found in the MPES 2011 sample. MRB grouped these 16 error codes into the six most prevalent categories (or types), as follows:

Error Category	Error Code	Error Description
Medical Necessity	MR5	Medically-unnecessary service
Documentation	MR1	No documents were submitted with the claim
	MR2A	Poor/insufficient documentation
	MR2B	Documentation of the procedure claimed was not provided
Policy	MR8	Other medical error
	PH10	Other pharmacy policy error
Coding	MR3	Coding error
	MR4	Unbundling error
Pricing	P5	Pricing error
Other	PH2	No legal prescription for date of service
	PH3	Prescription missing essential information
	PH5	Wrong information on label
	P2	Non-covered service
	PH7B	Prescription Splitting
	P9B	Rendering provider not eligible to bill for services/supplies
	P10	Other

5) Estimation

DHCS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits.[8] To calculate the payment error rate, the following steps were utilized:

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

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

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

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

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

Stratum	Sample Size	Amounts Paid in Sample	Amounts Paid Correctly After Review	Payment Accuracy Rate	Payment Error Rate
ADHC	50	$13,500	$8,161	60.45%	39.55%
Dental	50	$6,568	$6,282	95.64%	4.36%
DME	50	$6,407	$5,563	86.82%	13.18%
Inpatient	50	$279,296	$276,589	99.03%	0.97%
Lab	73	$3,433	$3,344	97.41%	2.59%
Physicians	421	$52,561	$47,979	91.28%	8.72%
Other Services	91	$5,381	$4,360	81.02%	18.98%
Pharmacy	383	$38,599	$35,087	90.90%	9.10%
Total	**1,168**	**$405,746**	**$387,365**	**93.95%**	**6.05%**

The projected annual payments made correctly were calculated by multiplying three quantities: 1) the payment accuracy rate, 2) the 2nd quarter 2011 Medi-Cal FFS payments universe subject to sampling, and 3) the number 4 (for the 4 quarters of the year). Finally, the error rate and projected annual dollars paid in error were computed as follows:

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

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

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

Stratum	Payment Accuracy Rate	Total Payments in Universe	Overall Estimated Payments Made Correctly	Overall Estimated Payments Made Incorrectly	Projected Annual Payments in Error
ADHC	60.45%	$91,863,971	$55,533,587	$36,330,384	$145,321,537
Dental	95.64%	$121,889,944	$116,580,489	$5,309,455	$21,237,819
DME	86.82%	$37,026,707	$32,148,151	$4,878,555	$19,514,221
Inpatient	99.03%	$2,446,871,902	$2,423,154,205	$23,717,697	$94,870,787
Lab	97.41%	$78,306,224	$76,280,540	$2,025,684	$8,102,736
Physicians	91.28%	$1,149,632,777	$1,049,403,098	$100,229,679	$400,918,716
Other Services	81.02%	$269,565,934	$218,412,504	$51,153,430	$204,613,722
Pharmacy	90.90%	$984,342,811	$894,790,332	$89,552,479	$358,209,915
Total	**93.95%**	**$5,179,500,270**	**$4,866,302,907**	**$313,197,363**	**$1,252,789,452**

6) Confidence Intervals and Formulas

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

all services included in the universe to determine the upper- and lower-bound payment accuracy rates.

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

Let

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

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

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

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

where

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

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

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

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

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

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

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

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

$S_h^2 = A_h B_h$, *where*

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

where and $R_h = y_h / x_h$

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

IV. Findings

Overall, the MPES 2011 results estimate that, of the $19.6 billion in all Medi-Cal FFS payments made in 2011, a very large majority, $19.5 billion (or 93.95 percent), were appropriately and correctly billed and paid. In contrast, about $1.25 billion (6.05 percent) were erroneous payments to Medi-Cal providers.

1) Summary Statistics

The following three tables summarize the main MPES 2011 findings, including the overall payment error rate, the potential fraud rate, the error rates for each stratum (provider type), the payments amounts in error, projected annual payments in error, and calendar year 2011 total Medi-Cal payments. In addition, the first two tables show the computed margins of error and confidence intervals per stratum. A detailed explanation of how these amounts were computed and the statistical methodology used in MPES is described in Section III of this report.

Table IV.1 - Payment Error Rates in the Sample and Projected Annual Payments Made in Error by Stratum (Using Claims Paid in Second Quarter of 2011)

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

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual error rate for the population of claims is 6.05%, plus or minus 2.72%, or that the true error rate lies within the range of 3.33% and 8.77%.

The projected annual payments in error are computed by multiplying the following quantities: the payment error rate, the 2nd quarter 2011 Medi-Cal FFS payments universe included in the sampling, and the number 4 (four quarters in a year).

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

and payment error projections for each stratum are independent from one another. Therefore, the sum of the seven individual strata payment errors is not equal to the overall payment error.

Table IV.2 - Potential Fraud Rates in the Sample and Projected Annual Fraudulent Payments by Stratum (Using Claims Paid in Second Quarter of 2011)

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

The confidence interval for the payment error rate is calculated at 95%. There is a 95% probability that the actual potential fraud rate for the population of claims is 2.28 %, plus or minus 1.74%, or that the true error rate lies within the range of 0.54 and 4.02%.

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the 2nd quarter 2011 Medi-Cal FFS payments universe included in the sampling, and the number 4 (four quarters in a year).

Table IV.3 – Calendar Year 2011 Medi-Cal FFS Payments by Quarter

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

2) Claims Processing Errors

This is the sixth consecutive MPES in which no claims processing errors were made by the fiscal intermediary, Allied Computer Services (ACS). This indicates that the prepayment edits, audit methods and pricing tables prescribed by DHCS continue to be accurately applied.

3) Payment Errors

The MPES 2011 findings identified $313 million erroneous payments of Medi-Cal FFS payments made during the 2nd quarter of 2011 (universe). This amount extrapolates to $1.25 billion, annually, in payment errors. Of the $1.25 billion annualized payments in error, nearly $473 million (or 2.28 percent) were for potentially fraudulent claims.

The projected $1.25 billion in erroneous payments are higher than the projected $1.07 billion payments in error found in MPES 2009. Cumulatively, there were nearly $157 million fewer projected payment errors from MPES 2005 to MPES 2011 (Table IV.4 below). Both the overall payment error rate and the potential fraud rate continue to decline, when compared to MPES 2005, demonstrating the success of DHCS efforts to reduce and minimize payment errors, fraud, waste, and abuse in Medi-Cal.

Table IV.4- Fewer Payments in Error – MPES 2005 Through MPES 2011

MPES	Error Rate	Payments In Universe	Projected Annual Payments in Error	Difference in Projected Payments Errors From Prior MPES Study
MPES 2005	8.40%	$4,193,397,689	$1,409,704,505	
MPES 2006	7.27%	$4,044,314,079	$1,176,521,646	-$233,182,859
MPES 2007	6.56%	$3,992,097,625	$1,047,708,877	-$128,812,769
MPES 2009	5.45%	$4,909,077,097	$1,070,041,382	$22,332,505
MPES 2011	6.05%	$5,179,500,270	$1,252,789,452	$182,748,070
Projected Reduction in Payments in Error Since MPES 2005				**($156,915,053)**

a) Payment Errors by Type[9]

Among the error types in the sample, medical necessity errors accounted for the majority (58.6 percent) of all the payment errors in MPES 2011 (Table IV.5). This finding is similar to that of MPES 2009: medical necessity is the most common, most serious error type. This means that, for MPES 2011, more than half of all the payment errors in the sample submitted by Medi-Cal providers were claims for services that were not medically- necessary.

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

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

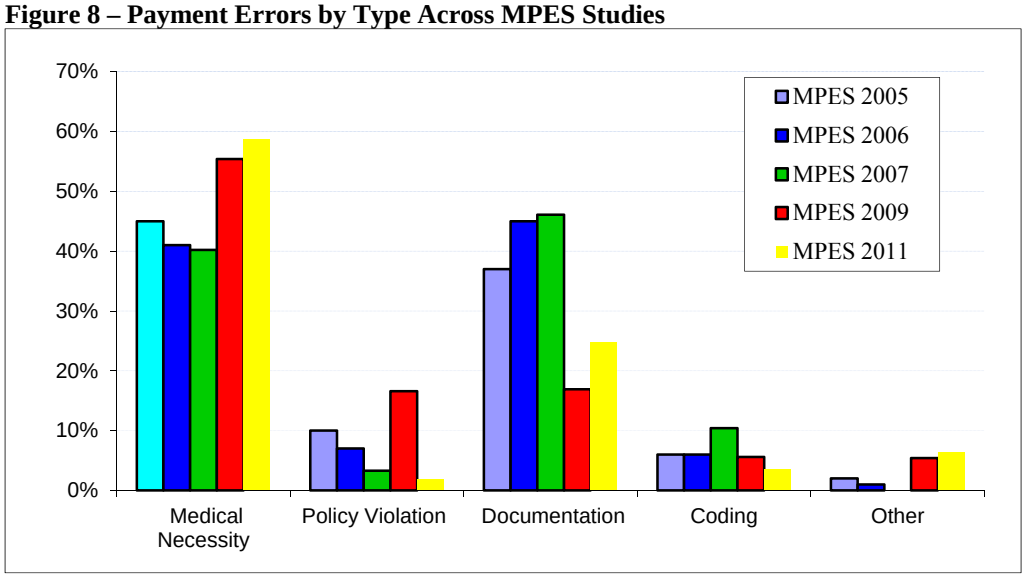
Payment Error Type	Amount	Percent
Medical necessity errors	$8,811	58.6%
Documentation errors	$3,728	24.9%
Pricing errors	$689	4.6%
Coding errors	$541	3.6%
All other errors	$1,243	8.3%
Total Sample Payments in Error	$15,012	100.0%

As far as the breakdown of medical necessity claim errors, by provider type, in the sample, we found that 40.5 percent of all errors due to medical necessity errors were attributed to ADHC providers. Medical necessity errors pertaining to Pharmacy providers came in second with 29.7 percent. Physician Services ranked third, contributing nearly four percent of all medical necessity errors in the MPES 2011 sample.

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

Figure 8, below, shows the trend of payment error by type, from MPES 2005 through MPES 2011. The chart shows that medical necessity increased again from the high MPES 2009 level.

Figure 8 – Payment Errors by Type Across MPES Studies



To ensure the sample included claims from all types of providers, DHCS first organized the universe of claims by provider type and *then* randomly sampled claims in proportion to the number of providers existing in each provider type category with no fewer than 50 claims drawn from each category. This is called "stratifying the sample" and ensures that the sample represents all major provider types.[10]

b) Payment Errors by Stratum (Provider Type)

Payment errors, as defined in Section II, are identified as potential dollar value loss due to payment or billing errors, including potential loss due to fraud, waste and/or abuse. Claim errors in the MPES 2011 study ranged from simple mistakes, such as insufficient documentation, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided. Table IV.6 below shows the breakdown of the 123 errors by stratum and by error type.

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

Error Code and Description	ADHC	Dental	DME	Inpatient	Lab	Other Services	Pharmacy	Physicians	Total
MR1- No documents submitted	2	2	1				1		6
MR2A - Poor/insufficient documentation	3		1		1	13	10	5	32
MR2B - No documentation		1				4		2	7
MR3 - Coding error								12	12
MR4 - Coding error (unbundling)								1	1
MR5 -Medical necessity	15	1	1	2		2	11	5	37
MR8 – Other (policy violation)						2			2
P10 - Other error						1			1
P2 - Other (non-covered service)						2		3	5
P5 - Pricing error			2			1		1	4
P9B - Other (rendering provider not eligible to bill)								3	3
PH10 – Other (policy violation)							2		2
PH2 - Other (no legal prescription for date of service)							2		2
PH3 - Other (prescription missing essential information)							2		2
PH5 - Other (wrong information on label)							1		1
PH7B - Other (wrong information on label)							5		5
Total by Stratum	***20***	***4***	***5***	***2***	***1***	***25***	***34***	***32***	***123***

There were 118 unique providers represented in the 123 claims in error in the MPES 2011 sample. Of those 118 unique providers, five had two errors. Please see Appendix 3

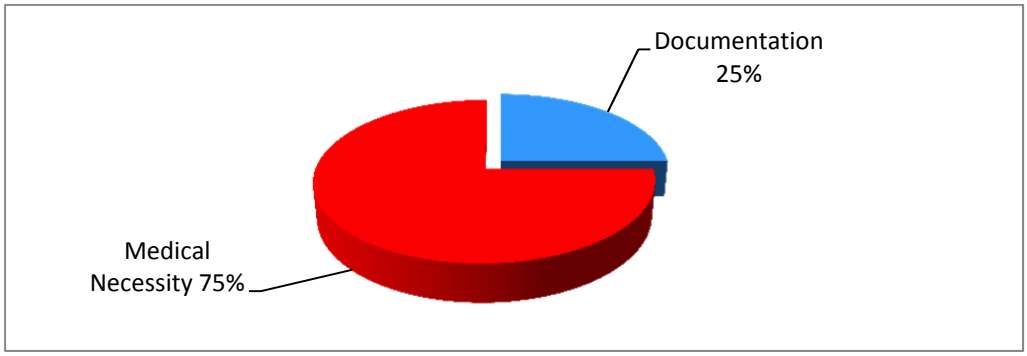
[10] The claim universe was first stratified by provider type prior to random sampling so that it does not produce unreliable results and inferences. In addition, this report does not attempt to project or infer anything about the Medi-Cal universe from the individual error types.

for a complete description of the error codes and Appendix 4 for a detailed explanation of each error.
Payment errors include those claims with insufficient or no documentation, claims with coding errors (e.g., up-coding), claims where the documentation did not support medical necessity of the service, missing signature of the recipient, Claims billed at a higher amount than needed, and claims paid that were in conflict with Medi-Cal rules and regulations.

Error types are assigned depending upon the error and the most potentially costly errors. The most serious errors are: a lack of medical necessity, a legal requirement not met by the provider; insufficient or no documentation; coding errors; ineligible providers and policy violation errors. Examples of the types of error within each stratum follow.

Adult Day Health Care

Twenty ADHC claims were found to have payment errors, 15 (75 percent) were medical necessity errors and five (25 percent) documentation errors (see chart below).



Error Examples

Poor/Insufficient Documentation - The claim is for one day of ADHC services. The beneficiary is a young adult with multiple admissions for psychiatric conditions. The date of service on the claim is a make-up Saturday for a scheduled day of attendance missed earlier in the week. The documentation does not show provision of individualized core services from the plan of care on the make-up day. The error is calculated as the total amount paid for this claim.

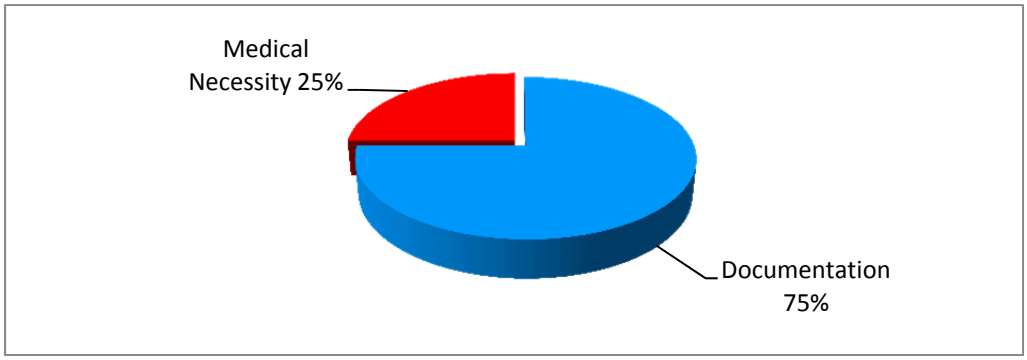
No Documentation Submitted - The claim is for 3 days of ADHC services for an elderly female beneficiary. The ADHC did not comply with the request for documentation to support the claim. The error is calculated as the total amount paid for this claim.

Medical Necessity – The claim is for 2 days of ADHC services for a beneficiary with bipolar disorder. The beneficiary lives with her mother and receives in home support services. The ADHC care plan is stereotypical and includes services such as monitoring for falls and symptoms of heart disease when the Primary Care Physician's evaluation and patient history do not indicate an increased risk for either of these problems.

The nursing care flow sheets do not document skilled nursing care, assessment or interventions. The documentation does not indicate a need for services beyond those provided outside the ADHC nor does there appear to be a high potential for deterioration resulting in institutionalization, hospitalization or utilization of emergency services without the ADHC. The beneficiary does not meet all 5 criteria for ADHC. The error is calculated as the total amount paid for this claim.

Dental Services

Four Dental Services claims were found in errors. Three (75 percent) were documentation errors and 1 (25 percent) a medical necessity error (see chart below).



Error Examples:

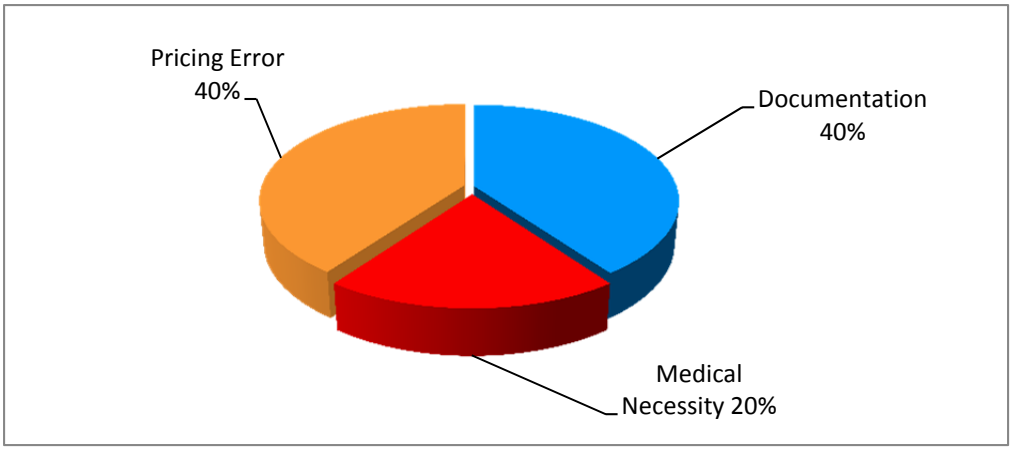
No Documentation Submitted - The claim is for fluoride dental prophylaxis provided for a child at a school. The dental hygienist was appropriately licensed and treatment authorization request approved for the service. No documentation of the service was received to support the claim. The provider's phone number was disconnected and the pay to address found to be a Copy Pack and Ship business. The error is calculated as the total amount paid for this claim.

No Documentation - The claim is for an oral examination for an elderly male beneficiary, an inpatient in an Extended Care Facility. The daily log at the facility indicates a dental visit for the beneficiary on the date of the claim. No clinical record of the type and extent of service or record of findings at examination was provided. The error is calculated as the total amount paid for this claim.

Medical Necessity - The claim was for a tooth extraction for a 7-year-old child. The radiographic image of the tooth was normal and no reason for extraction was listed in the record of service. The error is calculated as the total amount paid for this claim.

Durable Medical Equipment

Five DME claims had payment errors in the MPES 2011 sample. One error (20 percent) was due to lack of medical necessity, two errors (40 percent) for lack of documentation, and two errors (40 percent) were pricing errors (see chart below).



Error Examples:

No Documentation - The claim is for a walker and a heating pad for a female beneficiary. The equipment was supplied by the pharmacy and receipt acknowledged by the beneficiary. An error is assigned because the referring physician refused to provide records to substantiate the medical necessity of the equipment. The error is calculated as the total amount paid for this claim.

Poor/Insufficient Documentation - The claim is for a tub stool for a male Medicare/Medi-Cal beneficiary. The tub stool is not a Medicare benefit. The beneficiary requested a tub stool and one was ordered. Two months prior to the order the record showed the beneficiary complained of left knee pain but the record described the examination as unremarkable. The documentation submitted to support the claim does not adequately describe the need for this equipment. The error is calculated as the total amount paid for this claim.

Medical Necessity - The claim is for a prescription for an Albuterol inhaler, a medication used to prevent or treat bronchospasm due to asthma, for a toddler. The medication was dispensed as prescribed. The prescriber's progress note for the visit describes a healthy child and is listed as a routine visit. The physical examination reveals clear lungs without wheezing. The record indicates intent to prescribe albuterol for use as needed. The prescriber's medical record provides no medical reason for the medication. An error is calculated because no medical necessity for the drug was documented. The error is calculated as the total amount paid for the claim.

Pricing Error - The claim is for wheelchair components and accessories for a male beneficiary. The equipment was medically necessary and appropriately ordered and provided to the beneficiary. The assistive device dealer overbilled Medi-Cal for two of five components of the ordered equipment. The Medi-Cal Upper Limit Policy permits billing a markup of no more than 100% of the suppliers' cost. The dealer markup exceeded the 100% limit for both a custom built wheelchair cushion and back cushion. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.

Inpatient Services

There were two Inpatient Services claims in error and both were medical necessity errors.

Error Example:

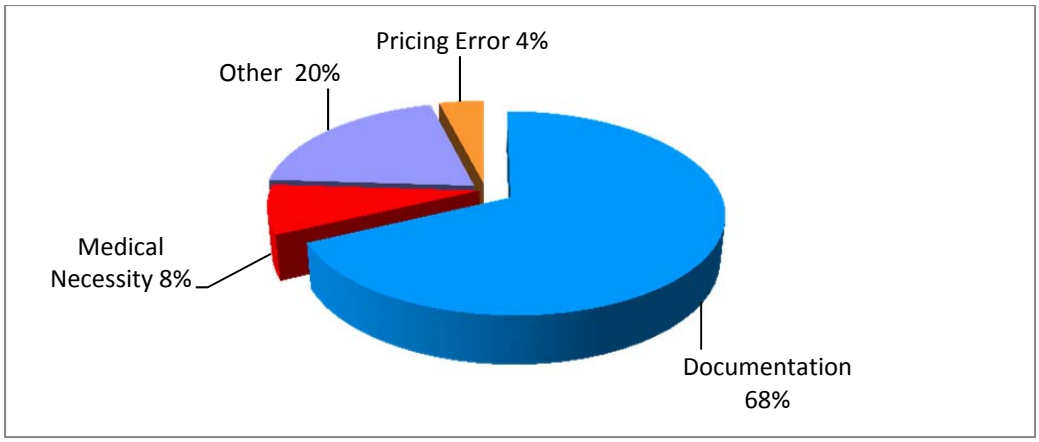
Medical Necessity Error - The claim is for hospital services for a beneficiary admitted for a scheduled repeat cesarean section at a noncontract hospital in an open area. Reimbursements were made at 0.24 rate. According to the hospital charge list, the first hour of recovery on labor and delivery was charged 7 times resulting in an overpayment of $1152 for the 6 duplicate charges. A large abdominal binder was charged and reimbursed $45.60 prior to admission with no physician order or documentation that it was needed or provided. A small binder was ordered, provided and charged after admission. A duplicate charge for a knit baby hat was reimbursed at $288. $72 was reimbursed for a second overnight pulse oximetry which was not ordered or documented as necessary. $65.35 was charged for a set of labs which were ordered but without documentation of medical reason and for which evidence based medicine does not support medical necessity on a routine basis. The error is calculated as the difference between the total hospital reimbursement and the reimbursement minus the listed duplicate, unordered and unnecessary items.

Lab

There was one error in this stratum, *a poor/insufficient documentation error: The claim is for a comprehensive chemistry panel for an adult male beneficiary with Diabetes. The beneficiary had a prior Chemistry panel ordered by his regular physician two months prior. The beneficiary was out of town and saw an alternate MD who ordered the chemistry panel claimed for. The laboratory conducted, interpreted and reported the test results appropriately and no error is assigned to this laboratory. An error is assigned to the referring provider because of the repetition of the testing within a short period. There is no documentation to indicate that the second MD contacted the beneficiary's regular MD prior to ordering the lab tests. Several of the test results for the claimed service were abnormal. The error is assigned as the total cost of the laboratory test.*

Other Services and Supplies

Included in this category were transportation, medical supplies, and Local Education Agency (LEA) programs, among others. The major error type in this stratum was poor/insufficient and no documentation, accounting for 68 percent of total errors in this stratum. Two medical necessity errors equaled eight percent. There were five “Other” errors, making up 20 percent. Additionally, there was one pricing error (4 percent of the total errors). A detailed breakdown of errors is shown on the chart below.



Error Examples:

Poor/Insufficient Documentation - The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation provided in support of the claim does not indicate the nature and extent of the services provided. The progress notes are incomplete and unsigned, and the therapy schedule differs from the original recommendation for therapy. The error is calculated as the total amount paid for this claim.

No Documentation - The claim is for three days of medical transportation via wheel chair van for a male beneficiary with end stage renal disease. The transportation occurred three times weekly for hemodialysis. The service was medically appropriate; however, there was no transportation trip log for one of the three dates of service. The error is calculated as the amount reimbursed for 1 trip.

Medical Necessity - The claim is for speech and language therapy for a male student beneficiary at a LEA. The documentation submitted does not demonstrate medical necessity for the services; rather, it suggests that a focus on English as a second language in the home is presenting barriers to progress, rather than an identified clinical issue requiring therapy. Furthermore, the required physician review and approval of the plan of care was not demonstrated. The error is calculated as the total amount paid for this claim.

Policy Violation - The claim is for nursing aide services for a male student beneficiary at a LEA. The documentation submitted indicates that the services were provided by a classroom teacher. Nursing aide services for LEA students are mandated by Medi-Cal to be provided by trained health care aides, supervised by a licensed health professional, thus this claim should not have been reimbursed. The error is calculated as the total amount paid for this claim.

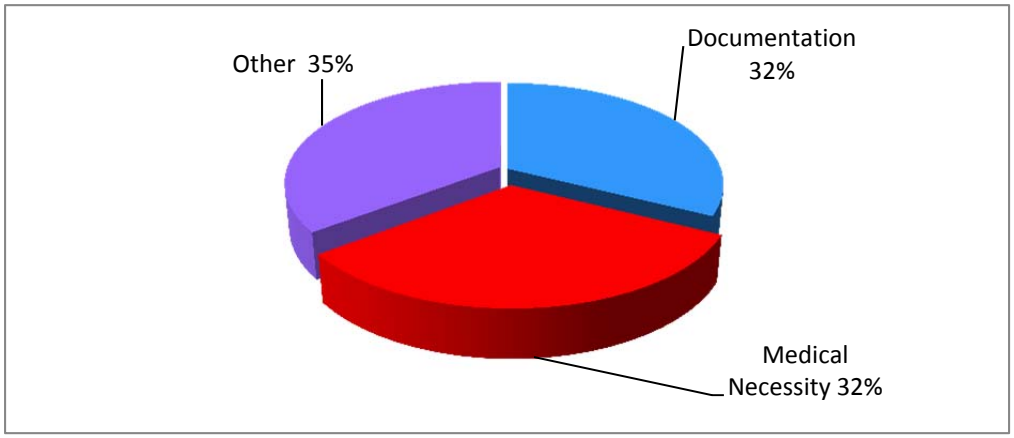
Other - The claim is for transportation from home to a LEA for a male student beneficiary. The child did not attend school on the day billed for. The agency has submitted documentation to Medi-Cal to reverse the claim and admits the error.

Non-Covered Service - The claim is for nursing aide services for a student beneficiary at a LEA. The child complained of a stomach ache. Her temperature was taken and her parents were called to take her home from school. The claim is invalid because this is not a Medi-Cal covered service. The service would be provided to any child at the school in a similar situation and thus does not qualify for Medi-Cal reimbursement. There is no documentation as to who provided the services or if there was supervision by an appropriately licensed health professional. The error is calculated as the total amount paid for this claim.

Pricing Error - The claim is for speech and language therapy for a male student beneficiary at a LEA. The documentation submitted in support of the claim, the Individualized Education Plan (IEP) recommends therapy services once per month. The claim is for weekly services. The error is calculated as the total amount paid for this claim.

Pharmacy

Claim errors in pharmacy were due to both the pharmacies making errors and errors found in the prescriber's documentation. Medical necessity errors are the fault of the prescribing provider, not of the pharmacy. Thirty-five percent of the 34 errors were attributed to other errors (including policy violations, no legal prescription for date of service, prescription missing essential information and wrong information on the label). Medical necessity errors (these are committed by prescribing physicians) and documentation errors accounted for 32 percent each of the total pharmacy errors. A breakdown of these errors in the sample is shown in the chart below.



Error Examples:

No Documentation - The claim is for a prescription for gabapentin, a medication for the treatment of seizures or neuropathic pain, for an adult female beneficiary. The pharmacy dispensed the medication appropriately from a valid prescription. The prescribing provider refused to release medical records for the beneficiary to substantiate the medical necessity of the prescription; therefore, the claim cannot be verified. The error is calculated as the total amount paid for this claim.

Poor/Insufficient Documentation - The claim is for a prescription for Nexium, a medication for the treatment of gastro esophageal reflux disease (GERD), or heartburn, for an adult male beneficiary. Although the diagnosis of GERD is referenced in the problem summary, there is no documentation to substantiate ongoing evaluation of the problem or continued medical necessity of the medication; the only progress note available for review is from three months prior to the date of service and does not mention GERD. The error is calculated as the total amount paid for this claim.

Medical Necessity - The claim is a prescription for Seroquel, an atypical anti-psychotic medication, for a young adult female beneficiary. The records submitted by the prescribing provider do not substantiate the medical necessity for the medication. There are no records which document an evaluation of this patient by the prescribing physician since 2005. The error is calculated as the total amount paid for this claim.

Policy Violation - The claim is for a prescription for Loestrin 24 FE, a type of birth control pill, for an adult female beneficiary. The prescription written by the nurse practitioner read 'LoLoEstin 1 po Qd' for three cycles. Loestrin 24 FE contains .02 mg of ethinyl estradiol in comparison to .01 mg in Lo Loestrin. They are not the same. There is no evidence that the pharmacy validated the prescription prior to dispensing an alternative drug. The error is calculated as the total amount paid for this claim.

No Legal Prescription for Date of Service - The claim is for a prescription for solifenacin, a medication for the treatment of overactive bladder, for an elderly male beneficiary. The pharmacy was unable to provide appropriate documentation for a refill for the medication. The prescribing provider had previously ordered the medication, but had no record of authorizing a refill for the date on which the medication refill was dispensed. The error is calculated as the total amount paid for this claim.

Prescription Missing Essential Information - The claim is for a prescription for incontinence supplies (disposable liner/shield/pads) for an adult female beneficiary experiencing urinary incontinence. The prescription does not document the number of incontinence supplies prescribed and is, therefore, missing essential information. The error is calculated as the total amount paid for this claim.

Wrong Information on Label - The claim is for a prescription for a female beneficiary. The prescription label has an incorrect prescriber name and while the prescription was written for 20 tablets, 28 tablets were dispensed. The original claim submitted had a different prescriber name but that claim was reversed and not paid.

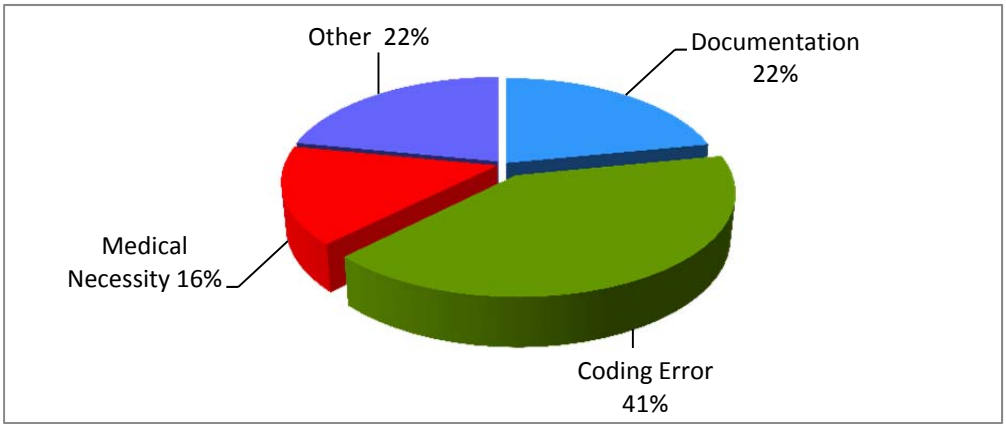
Wrong Information on Label - The claim is for a prescription for Vicodin, a controlled substance utilized for pain control, for an adult male beneficiary. The prescription was a refill of the original prescription for 40 tablets. The pharmacy dispensed 30 tablets initially, and another 10 tablets three days later. This resulted in an additional dispensing fee, and there is no evidence that the pharmacy discussed the change in the prescription with the prescribing provider. The same dispensing practice occurred with the original prescription. A treatment authorization request would have been necessary

had the prescribed amount been dispensed. The error is calculated as the amount paid for the dispensing fee for this claim.

Physician Services

Physician Services recorded 32 payment errors in the study sample. This provider type includes physicians, clinics, emergency room visits and other licensed providers.

Just under half, 41 percent, of all physician errors were coding errors, 16 percent were for medical necessity and 22 percent were documentation errors. Pricing errors accounted for less than 1 percent and the remaining 19 percent were for other miscellaneous error types (see chart below).



Examples of Physician Services Errors:

Poor/Insufficient Documentation - The claim is for developmental testing; limited with interpretation and report for a child at a county clinic. The child was receiving covered health screening at the clinic. There was no documentation of a service beyond the screening included in the health assessment. A developmental screening tool is incomplete and does not include scoring, interpretation or report for the service. The error is calculated as the total amount paid for this claim.

No Documentation - The claim is for ophthalmic biometry on the same date of service as documented cataract surgery. The operative report does not mention biometric measures. The medical record contains a report dated 3 months prior to the date of service of the claim on which the provider was observed adding a date 1 year later than the date of service at the onsite visit. No documentation of the service for the claimed date was provided. The error is calculated as the total amount paid for this claim.

Coding Error - The claim is for an inpatient level 5 oncology consult for a beneficiary with esophogeal cancer. Requirement for all inpatient consultation codes include a physical examination of the patient and communication by written report to an appropriate source of the request for the consultation. Documentation for this claim is brief and includes no physical examination or written report. The most appropriate code

for the service would be level 1 subsequent hospital care 99231. The error is calculated as the difference between the two codes.

Coding Error (unbundling) - The claim is for a level 3 office visit, colposcopy with biopsies, colposcopy supplies and a pregnancy test. In order to bill an office visit on the same date of service as a procedure, a separately identifiable problem must be present and addressed. There is no documentation of a visit or reason for a visit distinct from the colposcopy procedure. The error is calculated as the amount paid for the office visit.

Medical Necessity - The claim is for a second trimester obstetric ultrasound. The physician's order sheet listed unspecified abnormality and the report listed size/dates as the reasons for the study. The beneficiary had a normal ultrasound 4 weeks prior to this ultrasound and the clinical record showed no size discrepancies or other abnormalities. The error is calculated as the total amount paid for this claim.

Non-Covered Service - The claim is for dental services for an adult male beneficiary. The services provided included the injection of an anesthetic and bone filing to smooth a tooth. The service is not a Med-Cal benefit as beneficiary does not meet criteria for exemption to optional benefits exclusion. The error is calculated as the total amount paid for this claim.

Pricing Error - The claim is for an office visit and dispensing 4 packs of oral contraceptive pills. The visit was appropriately documented and claimed. The beneficiary signed for receipt of three monthly packs. The error is calculated as the cost of 1 monthly pack of contraceptive pills.

Rendering Provider Not Eligible to Bill - The claim is for a fetal stress test provided for a pregnant beneficiary. The rendering provider was incorrectly listed on the claim and while the service was medically appropriate, the rendering provider was not eligible to bill Medi-Cal for his services. The error is calculated as the total amount paid for this claim.

c) Potential Fraud Errors

One of the most significant MPES goals is to identify potentially fraudulent claims. Nearly 40 percent (49 of 122 or 39.8 percent) of the claims in error were identified as having characteristics of potential fraud or abuse, such as claiming for services that were not medically necessary. While this finding appears significant, it needs to be interpreted with caution as a single claim does not prove fraud. Without a full criminal investigation of the actual practice of the provider there is no certainty that actual fraud has occurred.

This 40 percent amount in fraudulent claims is much higher than the nearly 19 percent of fraudulent claims in MPES 2009, but is lower than the 40.4 percent of fraudulent claims in MPES 2005. Fraudulent claims average 34.5 percent for MPES 2005-MPES 2011.

The number of claims identified as having characteristics for potential fraud occurred in ADHC, pharmacy, physician services, other services, lab and dental claims. Medical necessity errors were dominant among potentially fraudulent claims in the 2007, 2009 and 2011 studies. The table below displays the breakdown of potential fraud errors.

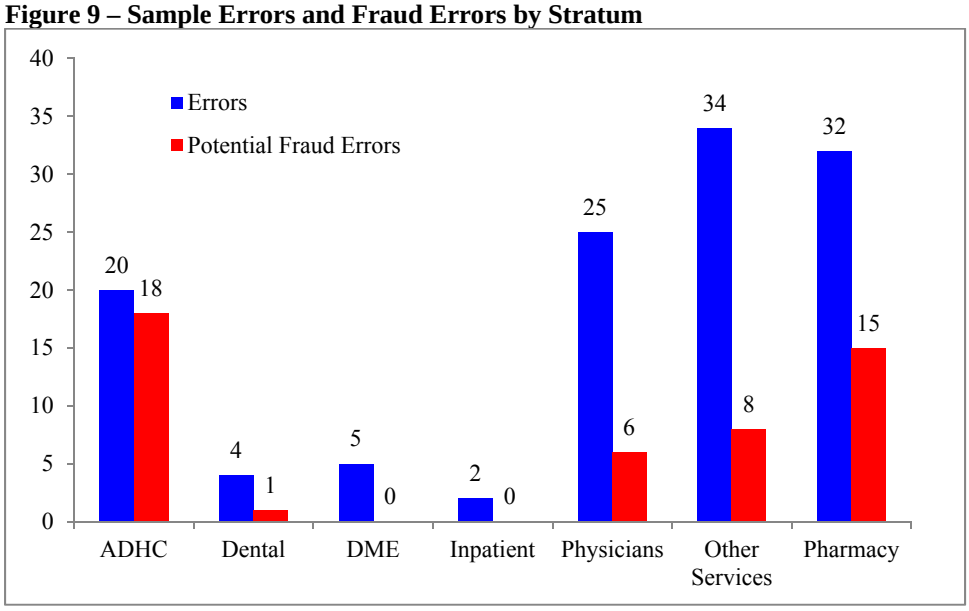
Table IV.7 Potential Fraudulent Errors by Stratum and Error Type

Error Type	ADHC	Dental	Lab	Other Services	Pharmacy	Physicians	Total
Coding Error						1	1
No documentation				1			1
No documents submitted	2	1			1		4
Poor/Insufficient Documentation	2		1	3	4	2	11
Medical Necessity	14				5	2	21
No legal Prescription for date of service					1		1
Other - Non-covered service				2			2
Other - Rendering provider not eligible to bill for services/supplies						1	1
Policy Violation				2			2
Prescription split					4		4
Total by Stratum	**18**	**1**	**1**	**8**	**15**	**6**	**49**

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

MPES 2011 consists of 958 unique providers represented in the sample of 1,168 claims. A total of 48 claims, submitted by 46 unique providers, were found to be potentially fraudulent. All of these claims were forwarded to the California Department of Justice (DOJ). DOJ reviewed all claims so designated and concurred with DHCS' assessment of potentially fraudulent activity. All 46 providers of these claims are currently undergoing further review by field audit staff to determine the appropriate actions needed. Sixteen of the providers identified as submitting potentially fraudulent claims had been independently identified by DHCS prior to the MPES 2011 and were already undergoing case development and/or placed on administrative sanction when the study was conducted. A comparison of total claims in error and potentially fraudulent claims in error is shown on the chart below.

Figure 9 – Sample Errors and Fraud Errors by Stratum



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

Error Type	Potential Fraud Identified	No Potential Fraud Identified
No documents submitted MR1	**Dental Claim** The claim is for fluoride dental prophylaxis provided for a child at a school. The dental hygienist was appropriately licensed and treatment authorization request approved for the service. No documentation of the service was received to support the claim. The provider's phone number was disconnected and the pay to address found to be a Copy Pack and Ship business. The error is calculated as the total amount paid for this claim.	**Dental Claim** The claim is for a dental office visit with X-Rays and a fluoride treatment for a juvenile male beneficiary. The dentist did not respond to a request for records, his telephone number is disconnected and his dental office closed. The provider is voluntarily inactivated from the Denti-Cal program and a sign on the door of his closed dental office indicates that he has retired. The error is calculated as the total amount paid for this claim.
Poor/Insufficient Documentation MR2A	The claim is for a comprehensive chemistry panel for an adult male beneficiary with Diabetes. The beneficiary had a prior Chemistry panel ordered by his regular physician two months prior. The beneficiary was out of town and saw an alternate MD who ordered the chemistry panel claimed for. The laboratory conducted, interpreted and reported the test results appropriately and no error is assigned to this laboratory. An error is assigned to the referring provider because of the repetition of the testing within a short period. There is no documentation to indicate that the second MD contacted the beneficiary's regular MD prior to ordering the lab tests. Several of the test results for the claimed	The claim is for a tub stool for a male Medicare/Medi-Cal beneficiary. The tub stool is not a Medicare benefit. The beneficiary requested a tub stool and one was ordered. Two months prior to the order the record showed the beneficiary complained of left knee pain but the record described the examination as unremarkable. The documentation submitted to support the claim does not adequately describe the need for this equipment. The error is calculated as the total amount paid for this claim.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	service were abnormal. The error is assigned as the total cost of the laboratory test.	
No documentation MR2B	**Physicians Claim** The claim is for ophthalmic biometry on the same date of service as documented cataract surgery. The operative report does not mention biometric measures. The medical record contains a report dated 3 months prior to the date of service of the claim on which the provider was observed adding a date 1 year later than the date of service at the onsite visit. No documentation of the service for the claimed date was provided. The error is calculated as the total amount paid for this claim.	**Other Services Claim** The claim is for three days of medical transportation via wheel chair van for a male beneficiary with end stage renal disease. The transportation occurred three times weekly for hemodialysis. The service was medically appropriate; however, there was no transportation trip log for one of the three dates of service. The error is calculated as the amount reimbursed for 1 trip.
Coding error MR3	**Physicians Claim** This claim is for a level 3 emergency department visit for a 14 year old with a chief complaint of sore throat. A level 3 visit requires an expanded problem focused history, expanded problem focused examination and medical decision making of moderate complexity. The documentation contains a brief history, an examination that contains multiple elements but lacks findings of an examination of the symptomatic area, the throat, and straightforward decision making which supports a level 1 visit. The error is calculated as the difference between the two codes.	**Physicians Claim** The claim is for an inpatient level 5 oncology consult for a beneficiary with esophogeal cancer. Requirement for all inpatient consultation codes include a physical examination of the patient and communication by written report to an appropriate source of the request for the consultation. Documentation for this claim is brief and includes no physical examination or written report. The most appropriate code for the service would be level 1 subsequent hospital care 99231. The error is calculated as the difference between the two codes.
Medical necessity MR5	**ADHC Claim** The claim is for 2 days of ADHC services for a beneficiary with bipolar disorder. The beneficiary lives with her mother and receives in home support services. The ADHC care plan is stereotypical and includes services such as monitoring for falls and symptoms of heart disease when the Primary Care Physician's evaluation and patient history do not indicate an increased risk for either of these problems. The nursing care flow sheets do not document skilled nursing care, assessment or interventions. The documentation does not indicate a need for services beyond those provided outside the ADHC nor does there appear to be a high potential for deterioration resulting in institutionalization, hospitalization or utilization of emergency services without the ADHC. The beneficiary does not meet all 5 criteria for ADHC. The error is calculated as the total amount paid for this claim.	**ADHC Claim** The claim is for 3 days of ADHC services for an elderly female beneficiary. The physician referral for ADHC services cites hypertension and dyslipidemia as qualifying conditions. The beneficiary exhibits stable blood pressure readings on the nursing flow sheets. The documentation does not indicate the presence of conditions or performance of nursing assessments or interventions for conditions with a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
Other policy violation MR8	**Other Services** Claim The claim is for nursing aide services for a male student beneficiary at a Local Education Agency (LEA). The documentation submitted indicates that the services were provided by a classroom teacher. Nursing aide services for LEA students are mandated by Medi-Cal to be provided by trained health care aides, supervised by a licensed health professional, thus this claim should not have been reimbursed. The error is calculated as the total amount paid for this claim.	**Other Services Claim** There is no example of this type because no such error was found in the MPES 2011 sample that was not potentially fraudulent.
Other non-covered service P2	**Other Services Claim** The claim is for nursing aide services for a student beneficiary at a Local Educational Agency. The child complained of a stomach ache. Her temperature was taken and her parents were called to take her home from school. The claim is invalid because this is not a Medi-Cal covered service. The service would be provided to any child at the school in a similar situation and thus does not qualify for Medi-Cal reimbursement. There is no documentation as to who provided the services or if there was supervision by an appropriately licensed health professional. The error is calculated as the total amount paid for this claim.	**Physicians Claim** The claim is for dental services for an adult female beneficiary at a Federally Qualified Health Center. The documentation submitted to support the claim does not provide evidence that the beneficiary's dental problems involve trauma, pain, or infection, nor is the beneficiary described as being pregnant. The criteria for exemption from the elimination of dental services for adults from Medi-Cal optional services are not met and the beneficiary is not eligible for the service. The error is calculated as the total amount paid for this claim.
Pricing error P5	**DME Claim** The prescribed item, a tub stool was appropriately ordered and supplied for female beneficiary with quadriplegia. The Pharmacy overbilled for the equipment. The cost to the Pharmacy was $19.25, with the 100% markup in cost permitted by Medi-Cal policy, the provider could bill for $38.50. The provider billed for $75 and was reimbursed $59.01. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.	**DME Claim** The claim is for Wheelchair components and accessories for a male beneficiary. The equipment was medically necessary and appropriately ordered and provided to the beneficiary. The Assistive Device dealer over billed Medi-Cal for two of five components of the ordered equipment. Medi-Cal Upper Limit Policy permits billing a markup of no more than 100% of the suppliers' cost. The dealer markup exceeded the 100% limit for both a custom-built wheelchair cushion and back cushion. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.
Other rendering provider not eligible to bill for claimed services/supplies P9B	**Physicians Claim** The claim is for an office visit for an adult female beneficiary. The claim lists an MD as the rendering and billing provider. The services were actually provided by a Non-medical Practitioner (NMP), who is an appropriately licensed Physicians Assistant	**Physicians Claim** The claim was for an office visit for an adult female beneficiary. The visit was medically necessary and conducted appropriately. The service was provided by a Nurse Practitioner who, while licensed to practice in the State of California, is not

Error Type	Potential Fraud Identified	No Potential Fraud Identified
	(PA); however, the PA is not enrolled in the Medi-Cal program and her services may not be billed to Medi-Cal. The error is calculated as the total amount billed for this claim.	enrolled as a Medi-Cal provider and her services could not be billed to the Medi-Cal program. The modifier required for the services of a non-physician medical practitioner was not utilized on the claim. The error is calculated as the total amount paid for this claim.
Other –no legal prescription for date of service PH2	**Pharmacy Claim** The claim is for a prescription for Solifenacin, a medication for the treatment of overactive bladder, for an elderly male beneficiary. The pharmacy was unable to provide appropriate documentation for a refill for the medication. The prescribing provider had previously ordered the medication, but had no record of authorizing a refill for the date on which the medication refill was dispensed. The error is calculated as the total amount paid for this claim.	**Pharmacy Claim** The claim is for a prescription for docusate sodium, a stool softener, for an adult female beneficiary. The original prescription was three years old and there was no documentation that a current refill was authorized. The beneficiary had not seen the prescribing physician for two years and requests for refill authorization had been declined by the physician because of poor beneficiary compliance and a lack of a recent evaluation by the physician. The error is calculated as the total amount paid for this claim.
Other - prescription split PH7B	**Pharmacy Claim** The claim is for a prescription for Vicodin, a controlled substance utilized for pain control, for an adult male beneficiary. The prescription was a refill of the original prescription for 40 tablets. The pharmacy dispensed 30 tablets initially, and another 10 tablets three days later. This resulted in an additional dispensing fee, and there is no evidence that the pharmacy discussed the change in the prescription with the prescribing provider. The same dispensing practice occurred with the original prescription. A treatment authorization request would have been necessary had the prescribed amount been dispensed. The error is calculated as the amount paid for the dispensing fee for this claim.	**Pharmacy Claim** The claim is for a prescription for Risperdone, an atypical anti-psychotic medication, for an adult female beneficiary. The prescription was written for 30 tablets. The pharmacy dispensed the appropriate number of pills over several months; however, they dispensed the medication 13 pills at a time, resulting in excessive dispensing fees charged to the Medi-Cal program. The error is calculated amount paid for the dispensing fee for this claim.

4) MPES Study Comparison of Significant Items (MPES 2005 – MPES 2011)

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

Study Objective	The study objectives remained the same for 2005-2009 1. Measure the payment amount of errors in Medi-Cal FFS system; 2. Identify the amount of potential fraud or abuse in Medi-Cal; 3. Identify the vulnerabilities of the Medi-Cal program.
Study Universe	The universe has changed from the second quarter in MPES 2005-2007 to the last quarter of MPES 2009.
Sampling Design	Methodology is unchanged: proportioned stratified random sampling which is dollar-weighed. This means a hospital claim in error has more of an impact than a DME claim because of the dollars associated with the stratum. All other design items, i.e.; sample size, units, confidence level, precision level, and stratum composition had no significant changes.
Error Rate & Fraud Error	The payment error rate and its subset, fraud rate, are decreasing overall: Error Rate — Fraud Error Rate 2005 – 8.40% — 2005 – 3.23% 2006 – 7.27% — 2006 – 2.75% 2007 – 6.56% — 2007 – 2.53% 2009 – 5.45% — 2009 – 1.16% 2011 – 6.05% — 2011 - 2.28%
Trends	The MPES studies have been successful in identifying vulnerabilities in the Medi-Cal program and in redeploying resources to reduce their impact. **MPES 2005** identified ADHC providers as being a significant risk to the program with the highest percentage of claims in error and the greatest number of medical necessity errors, 31 and 28, respectively).DHCS initiated large exercises involving ADHC field reviews resulting in numerous sanctions and utilization controls being placed on providers. MPES 2006 and 2007 demonstrated a decrease in the number of errors in ADHC. **MPES 2006** showed dental claims with the highest percentage of errors – 57 percent or 29/51 claims. The increased focuses were directed to the area of dental provider education and increased dental provider reviews, as well as in a "top to bottom" review of anti-fraud activities to assess the appropriateness of anti-fraud errors. MPES 2007 showed a decline in the number of dental errors (29 vs. 14 or a reduction of 15). **MPES 2007** identified the following areas of risk: • This is the first study to find inpatient errors (two in Long Term Care facilities). • Physician Services, which contributed the most errors (71), have an even higher rate when those errors are combined with those in other strata caused by physicians (primarily due to lack of medical necessity and non-needed prescriptions or referrals by physicians – an additional 43 errors). When combining Physician Services errors with other strata errors caused by prescribing providers, they account for 55 percent of all errors. • Fifty percent of all Local Education Agencies claims had errors. • Half of Ground Medical Transportation Claims Other Services) had errors. • One hundred percent Incontinence Supplies errors also were associated with fraud characteristics.

	MPES 2009 identified the following areas of risk • MPES 2009 identified claims lacking medical necessity as the payment error type with greatest vulnerability. This occurs with greatest frequency among ADHC providers. • Physician Services that include prescribing errors identified in pharmacy claims are the provider type posing the greatest payment error vulnerability. • Pharmacies pose the second-greatest threat with 45 percent of the sample payment errors. • ADHCs pose the third highest threat. Though they represent only about 2.0 percent of the payment volume in the universe, they share 22 percent of the overall 5.45 payment error in MPES 2009. • Potential fraud has decreased 64 percent since MPES 2005. **MPES 2011** identified the following areas of risk: MPES 2011 estimated 6.05 percent of all FFS payments had indication of provider payment error. 2.28% of all FFS payments had indications of potential fraud. Payment errors ranked by provider type: o Physician services: 32 percent; o Pharmacy payment: 28.6 percent; o Other Services: 16 percent. This was a nearly six-fold increase from MPES 2009; o ADHC: 11.6 percent; o Inpatient: 7.6 percent. Though this provider type had no payment errors in MPES 2009, it contributed nearly $95 million to the overall payment error this time around; o DME: 1.6 percent; o Lab: 0.6 percent. Consistent with previous years, 58.7 percent of all the payments in error in the sample were for claims that lacked medical necessity, ADHCs accounted for nearly half (47.6 percent) of all the medical necessity payment errors in the sample.
Trend in Payment Errors	Prevalent error types have changed from less-serious documentation errors to more costly and serious medical necessity errors of medical necessity.
Fraud Trends	• ADHC stratum had more characteristics of fraud in MPES 2005 and 2009 than in MPES 2007. • In MPES 2007 physician services, including prescribing physicians, replaced ADHCs as the greatest risk for fraud. • MPES 2007 also identified a possible new area with characteristics of fraud – Incontinence Supplies. • MPES 2009 showed that ADHCs billing for medically-unnecessary services were the providers showing the greatest vulnerability. • MPES 2011 revealed that Physician Services contributed nearly a third (32 percent) of the overall payment error rate. In addition, Other Services' share of the overall payment error jumped six-fold, to 16.3 percent. The Local Education Agencies (LEA) led in that increase.
Conclusion	MPES studies have successfully measured the impact of payment errors to the Medi-Cal program, identified vulnerabilities, and evaluated the effectiveness of the DHCS actions to mitigate these vulnerabilities.

V. Significant Actions Taken After MPES Studies

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

All cases identified as potentially fraudulent in MPES studies are forwarded to the Department of Justice (DOJ) for a preliminary review. All cases that DOJ determines to be potentially fraudulent are reviewed one more time by MRB to determine if a field audit is warranted.

An audit of the provider's entire practice begins with an onsite and in-depth review of all aspects of the practice. These audits are specific to each provider type. Sanctions and/or utilization controls based on Medi-Cal regulations are placed on providers depending on the audit findings. Referrals to other state agencies and/or licensing boards are based on the findings of the in-depth audits. Multiple actions may be taken on a single provider. Various agencies and licensing boards may work together for a complete and thorough investigation.

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

- MPES 2005 identified 124 potentially fraudulent claims out of the 1,123 sampled claims. Audits of those 124 claims resulted in 147 actions and 58 referrals. MRB audits identified issues common to several ADHC providers. Training seminars were developed and presented to all ADHC providers. MRB staff were made available, via telephone, to answer provider questions. Based on further investigations 5 providers closed their doors.

- Eighty of the 1,147 claims in the MPES 2006 sample were identified as potentially fraudulent, resulting in 106 actions and 40 referrals. Based on referrals to DOJ, six providers were suspended from Medi-Cal. Documentation errors were dominant among the potentially fraudulent claims. This may indicate unorganized or incomplete record-keeping or some serious fraudulent activity. Detailed investigations were conducted on the provider's claiming patterns, as well as their business practices.

- Eighty of the 1,148 claims in the MPES 2007 sample were identified as potentially fraudulent. The field audits of these 80 providers resulted in 125 actions taken and 24 referrals to other agencies and/or licensing boards made. Claims noted as medically-unnecessary dominated the potentially fraudulent claims in 2007 MPES, with 63% of them being pharmacy claims.

- The 2009 MPES sample had 40 potentially fraudulent claims, out of the 1,148 claims in that sample. DOJ reviewed these 40 cases and concluded that all of them contained signs of being potentially fraudulent. Focused onsite field audits were conducted on 55 unique providers. If the claims are for any type of prescription, the provider who wrote the

prescription is also reviewed. The field audits conducted resulted in 86 actions and 5 referrals. Audits are continuing on a few of those cases.

- The 2011 MPES sample identified 58 claims with the potential for fraud out of the 1,168 claims included in the study. Although the field audits of these 58 providers are in the process of being audited, 60 actions have already been taken.

Table V.1, below, shows the number and type of all actions taken as a result of MPES findings from 2005- 2011.

Table V.1- MPES 2005 through 2011 Sanctions and Referrals

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

VI. Payment Error Rate Measurement

The Office of Management and Budget (OMB) has identified Medicaid and the Children's Health Insurance Program (CHIP) as programs at risk for significant improper payments. As a result, Centers for Medicare and Medicaid Services (CMS) developed the Payment Error Rate Measurement (PERM) program to comply with the Improper Payments Information Act (IPIA) and related guidance issued by OMB.

The PERM program measures improper payments in Medicaid and CHIP and determines error rates for each program. The error rates are based on reviews of the fee-for-service (FFS), Managed Care, and eligibility components of Medicaid and CHIP in the fiscal year (FY) under review. It is important to note the error rate is not a "fraud rate" but simply a measurement of payments made that did not meet statutory, regulatory or administrative requirements. FY 2008 was the first year in which CMS reported error rates for each component of the PERM program.

CMS divided all fifty states into three cycles with 17 states in each cycle. The states in each cycle perform the PERM review every three years. California is a cycle two state and completed its first PERM review in 2007 and the second PERM review in 2010. California is conducting its third PERM review in 2013. The PERM review consists of Medi-Cal eligibility determinations, Medi-Cal paid claims medical record and Data Processing reviews for both paid claims and Managed Care capitation payments to ensure the claim or payment was paid correctly.

The medical records review requires Medi-Cal providers who are selected at random to submit copies of patient medical records to PERM reviewers. The medical records are reviewed to ensure that medical services were provided as needed and that the state correctly paid for the services billed. States are required to remit all identified overpayments to CMS as well as submit a corrective action plan indicating how future overpayments will be prevented.

CMS calculated California's error rate for the FY 2010 PERM study at 1.6 percent. This error rate was the second lowest of the 17 states reviewed in this cycle. The national average was calculated at 6.7 percent. The results are an improvement over the 2007 PERM study in which California's error rate was calculated at 6.11 percent.

California was able to reduce the 2007 6.11 percent error rate to 1.6 percent by improving provider education strategies, strengthening payment processes, and by collaborating with all State agencies administering Medi-Cal programs. The successful outcome of California's PERM review is an indicator that the overwhelming majority of providers and health plans are being paid accurately and that counties are correctly determining the eligibility of those receiving benefits in the Medi-Cal program.

VII. Conclusions and Recommendations

MPES is reaching its goal of identifying and reducing fraud, waste, and abuse in the Medi-Cal program. As indicated, MPES continues to assist DHCS in maintaining the program's integrity by identifying trends that in turn refine target areas for reducing fraud, waste, and abuse. For instance, the overall payment error has been reduced 40 percent since MPES 2005 and the potential fraud by nearly 42 percent since that same study.

In terms of payments made in error, of the approximately $21 billion budgeted for Medi-Cal fee-for-service payments, an estimated $1.25 billion were paid in error. The overall trend in payment errors is continuing to decline. For instance, cumulatively, there are nearly $157 million fewer projected payments in error between MPES 2005 and MPES 2011.

Of the $1.25 billing in erroneous payments, 2.28 percent showed some characteristic of potential fraud. That is equivalent to $473 million, annually, in potential fraud. DHCS uses the term "potential" fraud because confirming the actual presence of fraud requires a more detailed criminal investigation.

Although the potential fraud rate increased significantly in MPES 2011, over the 2009 rate, it is still the second lowest fraud rate, historically, behind the MPES 2009 rate of 1.16 percent. Overall, the fraud rate is still trending down. In terms of fraudulent payments by stratum, pharmacy was the largest contributor to the potential fraud rate. In addition, the "Other Services" stratum contributed to the increase of the fraud rate. This stratum saw its share of the fraud rate go from zero in MPES 2009 to nearly eight percent in MPES 2011.

Physician Services contributed the most, 32 percent, to the overall payment error, followed by Pharmacy with 28.6 percent. Two other provider types, Other Services and Inpatient Services, saw their contribution increase significantly, compared to MPES 2009. The former, with a 16.7 percent contribution, increased nearly six times from the previous study. This is due to a large jump in the number of errors in Local Education Agencies (LEA) claims. Inpatient Services, which had no payment error in 2009, contributed 7.6 percent to the overall payment error.

In terms of number of claim errors in the sample, pharmacy ranked first, with 34 errors, out of 123 total errors. Physician services came in second with 32 errors (26 percent). Other Services was third in number of errors in the sample, with 25 errors (20 percent) and ADHCs fourth with 20 errors (16 percent).

The lack of medical necessity in billed claims by Medi-Cal providers continues to be the most serious payment error type uncovered by MPES. It has constituted the greatest vulnerability among all error types. As in MPES 2009, a majority of sample errors (58.6 percent) were medical necessity errors. Roughly, $734 million may be lost to Medi-Cal due to the continuing threat posed by provider claims billed without medical necessity.

ADHCs accounted for nearly half (47.6 percent) of all those medical necessity errors in the sample. Their share continues to be very high for a relatively small program (in volume of

payments). It is mainly for this reason the ADHC program, which was an optional benefit in Medi-Cal, has been eliminated by the legislature and Governor and replaced with the Community Based Adult Services, a Managed Care program.

DHCS will continue to target its efforts on the provider types determined to be most at risk. For instance, regarding Physician Services, and to curb physician prescribing errors, Medi-Cal is in the process of instituting mandatory enrollment for ordering, referring and prescribing physicians. This enrollment will facilitate A&I efforts to identify, investigate and take action against providers that contribute to potential overutilization and medically-unnecessary services. This is expected to reduce reimbursement for medically-unnecessary services. In addition, DHCS has implemented the Individual Provider Claims Analysis Report (IP-CAR). Its purpose is to develop a more collaborative partnership among the physician community. IP-CAR 2010 supplied primary care providers with information about their billing patterns to compare with that of similar providers. Those who billed a higher percentage of the most expensive office visits were selected to receive reports. IPCAR appears to have changed provider behavior and saved the state a substantial amount of money. In addition, DHCS implemented field audits, utilization controls, sanctions, suspensions, and audits for recovery for a few of the providers identified by this first project. The calculated cost savings was more than 2 million dollars for the second half of 2011 alone. IP-CAR 2012 was sent in June, and focused on pediatric drug prescriptions. Calculations of the number of prescriptions and billings per beneficiary overall, as well as for specific categories, determined who received reports. Providers whose prescriptions were substantially higher than the norm received reports describing their prescribing pattern. Some physicians reported that their NPI numbers had been used erroneously by pharmacists. They were advised to notify the pharmacists to correct the errors. Some providers reported that it was appropriate for their prescribing to rise above the norm, due to sub-specialty practices. Others called to discuss their reports and volunteered to be more careful about their prescribing in the future. The second IP-CAR report, sent in October 2012, analyzed claims for office visits for children. The next IPCAR will focus on the prescribing of controlled substances to adults. Letters will be sent to high prescribers so that they can compare their pattern of prescribing and diagnoses with that of their peers. The review will look for repetitive prescribing of combinations of addictive controlled substances.

Regarding Pharmacy and prescription drugs, DHCS recently started using the Doc Shop Index (DSI) statewide in a number of projects aimed at curbing beneficiary-related drug diversion. The DSI concept and its related reports are based on the collaborative efforts by A&I's Medical Review and Investigations Branches, aided by private contractors. These reports allow for an easy comparison of beneficiary drug claims activity and clearly identify hyper-utilization by tabulating drug benefit usage patterns. These identified outlier beneficiaries are then subject to further scrutiny, including the standard investigation methods of A&I's IB investigators. DSI has shown a high degree of success in identifying outlier beneficiaries and eliminating the vast majority of beneficiaries from this review process. For instance, IB's 2012 Two-County DSI Project took a group of, on average, 400,000 beneficiaries per month, and through a designed report series, yielded sixty-six DSI outlier beneficiaries. Of the sixty-six cases opened, fifty-one (71%) resulted in administrative or criminal actions. Additional case results have proven that the DSI is an important benchmark indicator of unexpected and often suspicious behavior. More recent results of DSI-prompted investigations are showing that arrests and convictions can and

are being initiated with this tool. Ongoing DSI Projects are focusing on accurate determinations of cost-avoidance figures related to DSI- prompted investigations.

Since the majority of pharmacy errors in the sample (75 percent) were medical necessity and documentation errors, DHCS is also planning on requiring enrollment of prescribing providers and prescribing provider identification in all claims submitted, starting in 2014. This will allow the Department to identify and take action against providers with patterns of excessive prescribing. This will aid our efforts significantly, as pharmacy claims have not previously been required to include reliable prescriber identification for reimbursement.

The success of the DSI concept and associated reports illustrate that a small set of data elements ordered within a well-thought out, highly-defined, and focused algorithm, can yield an amazingly useful report that can reap enormous benefits for a variety of users, including staff in non-research/non-data-centric specialties. The greatest practical benefit of the DSI reports is that they allow law-enforcement professionals to spend their time investigating and utilizing their expertise and training in addressing the suspicious behavior of a small subset of beneficiaries. The ease of use of the DSI reports, as well as the usefulness of the beneficiary DSI number, show that effective collaboration between diverse groups of professionals is possible and is necessary to achieve the common goals of detecting and reducing fraud and abuse in Medi-Cal.

Other Services and Inpatient Services saw their share of the overall payment error increase significantly, compared to MPES 2009. The Other Services stratum share, with 16.3 percent, increased nearly 6 times from 2009. Payment errors in these two provider types are the main reason the overall error rate increased from 5.45 percent in MPES 2009 to 6.05 percent in MPES 2011. To address this, A&I is partnering with Small Nursing Facilities (SNF) to enhance provider outreach and education and improve documentation and compliance. MRB/LEA liaison team members' attendance and contribution to LEA Ad Hoc Workgroup meetings and LEA provider training sessions are currently in progress and planned to be ongoing. The MRB online training presentation for LEAs updates is also currently in progress and will be made available to LEAs on the program website.

Regarding Inpatient claims, two of which revealed large payment errors in MPES 2011, effective July 1, 2013, the DRG payment methodology will replace the two previous payment methods of negotiated rates for contract hospitals and cost-based reimbursement for non-contract hospitals. Under the All Patient Refined Diagnosis Related Groups (APR-DRG) system, it is anticipated that coding will be better supported by documentation and reimbursements better aligned with the patient's severity of illness and care delivered. Payment based on duplicate billings or services not provided would thus be eliminated. MRB will collaborate with Utilization Management Division and Financial Audits Branch by processing referrals, performing targeted reviews of inpatient hospital providers who are identified as high risk through UMD activities.

Appendix 1 - Review Protocols

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

A. Claims Processing Review Protocol

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

a) Medical Review Protocol

Documentation Retrieval for Claim Substantiation

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

b) Multiple Review Processes

First-Level Review

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

Failure to comply with any one of the six components may constitute an error. A claim in error is any claim submitted and/or paid in error because the provider did not comply with a

statute, regulation or instruction in the Medi-Cal manual, or the provider failed to document that services were medically necessary.

Second-Level Review to Ensure Inter-rater Reliability

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

This will be a blind[11] but sequential review achieving three purposes: (a) that the dollar error identified truly reflects dollars *at risk* of being paid inappropriately, (b) that the interviewer bias (the reviewer) has been minimized, and (c) the estimate of overall payment error is a true reflection of the universe being studied.

Specifically, multiple-level reviews are conducted as follows:

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

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

Third-Level Medical Review

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

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

B. Review Protocol for Potentially Fraudulent Claims

a) Level I Review

Presence or absence of medical documentation by FOs

b) Level II Review

Was the service medically necessary?

c) Level III Review

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

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

d) Level IV Review

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

e) Level V Review

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

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

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

Appendix 2 – Previous Studies Statistics

MPES 2009 Summary Statistics

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The projected annual fraudulent payments are computed by multiplying the following quantities: the potential fraud rate, the second quarter of 2006 Medi-Cal FFS and dental payments universe included in the sampling, and the number 4 (four quarters in a year).
*An independent simple random sample was drawn for each stratum. A separate ratio estimate of each stratum was calculated and weighed by total payments within each stratum. The potential fraud rate and fraudulent payment projections for each stratum are independent from one another. Therefore, adding the eight strata fraud errors does not total to the overall potential fraud error.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Appendix 3 - Error Codes

A. Administrative Error Codes

NE - No Error

WPI - Wrong Provider Identified on the Claim

WPI-A - Wrong Rendering Provider Identified on the Claim

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

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

WPI-B - Wrong Referring Provider

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

WPI-C - Non-physician Medical Provider Not Identified

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

WCI - Wrong Client Identified

O - Other (List or Describe)

B. Processing Validation Error Codes

P1 - Duplicate Item (claim)

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

P2 - Non-Covered Service

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

P3 - MCO Covered Service

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

P4 - Third Party Liability

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

P5 - Pricing Error

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

P6 - Logical Edit

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

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

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

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

P9 - Ineligible Provider

This code includes the following situations:

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

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

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

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

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

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

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

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

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

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

P10 – Other

If this category is selected, a written explanation is provided

C. Medical Review Error Codes

MR1 – No Documents Submitted

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

MR2 – Documentation Problem Error

MR2-A - Poor Documentation

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

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

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

MR2 –B - No Documentation

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

MR3 – Coding Error

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

MR4 – Unbundling Error

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

MR5 – Medically Unnecessary Service

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

MR6 – No Record of Product Acquisition

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

MR7 – Policy Violation

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

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

MR8 – Other Medical Error

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

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

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

MR9 – Recipient Signature Missing

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

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

D. Pharmacy Error Codes

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

PH1 - No Signature Log

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

PH2 - No Legal Rx for Date of Service

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

PH3 - Rx Missing Essential Information

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

PH5 - Wrong Information on Label

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

PH7 - Refills Too Frequent

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

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

PH10 - Other Pharmacy Policy Violation

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

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

E. Compliance Error Codes

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

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

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

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

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

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

F. Indication of Fraud or Abuse

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

Appendix 4 - Description of All Claims in Error

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0001	Dental	MR1	No documentation submitted	The claim is for fluoride dental prophylaxis provided for a child at a school. The dental hygienist was appropriately licensed and treatment authorization request approved for the service. No documentation of the service was received to support the claim. The provider's phone number was disconnected and the pay to address found to be a Copy Pack and Ship business. The error is calculated as the total amount paid for this claim.	$34.65	$0.00	$34.65
0005	Dental	MR5	Medical necessity	The claim was for a tooth extraction for a7 year old child. The radiographic image of the tooth was normal and no reason for extraction was listed in the record of service. The error is calculated as the total amount paid for this claim.	$119.79	$0.00	$119.79
0019	Dental	MR2B	No documents	The claim is for an oral examination for an elderly male beneficiary, an inpatient in an Extended Care Facility. The daily log at the facility indicates a dental visit for the beneficiary on the date of the claim. No clinical record of the type and extent of service or record of findings at examination was provided. The error is calculated as the total amount paid for this claim.	$44.55	$0.00	$44.55
0041	Dental	MR1	No documentation submitted	The claim is for a dental office visit with X-Rays and a fluoride treatment for a juvenile male beneficiary. The dentist did not respond to a request for records, his telephone number is disconnected and his dental office closed. The provider is voluntarily inactivated from the Denti-Cal program and a sign on the door of his closed dental office indicates that he has retired. The error is calculated as the total amount paid for this claim.	$87.12	$0.00	$87.12
0057	ADHC	MR5	Medical necessity	The claim is for 2 days of Adult Day Health Care (ADHC) services for an elderly female beneficiary with multiple health problems. The documentation indicates the patient ambulates independently and takes her medication independently. The nursing flow sheets do not indicate evidence of instability or deterioration of the medical conditions and show no record of personalized services. The documentation does not show the beneficiary has a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0060	ADHC	MR5	Medical necessity	The claim is for 3 days of ADHC services for an elderly female beneficiary. The physician referral for ADHC services cites hypertension and dyslipidemia as qualifying conditions. The beneficiary exhibits stable blood pressure readings on the nursing flow sheets. The documentation does not indicate the presence of conditions or performance of nursing assessments or interventions for conditions with a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0061	ADHC	MR5	Medical necessity	The claim is for 4 days of ADHC services for an elderly male beneficiary with mild cognitive disorder and hypertension. The beneficiary has 50 hours of IHSS and no unmet need for assistance with activities of daily living. The documentation does not indicate a condition with high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$305.08	$0.00	$305.08
0065	ADHC	MR5	Medical necessity	The claim is for 2 days of Adult Day Health Care (ADHC) services for an elderly female beneficiary with type II diabetes and hypertension controlled with oral medication. The beneficiary ambulates independently, takes her own medication and is receiving no individual therapy at the facility. The documentation does not show the beneficiary has a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services and does not support the need for ADHC attendance. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0066	ADHC	MR2A	Poor or insufficient documentation	The claim is for one day of ADHC services. The beneficiary is a young adult with multiple admissions for psychiatric conditions. The date of service on the claim is a make-up Saturday for a scheduled day of attendance missed earlier in the week. The documentation does not show provision of individualized core services from the plan of care on the make-up day. The error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0070	ADHC	MR2A	Poor or insufficient documentation	The claim is for 5 days of ADHC services for an elderly female beneficiary with coronary artery disease and hypertension who had been recently hospitalized. The documentation of ADHC services is inconsistent. For example, cognitive impairment and depression/anxiety are listed as problems in the plan of care but not included in the referring provider's records. On the date of service, no individualized therapies or skilled nursing services are documented. The documentation does not substantiate the provision of ADHC services appropriate to the beneficiary's conditions. The error is calculated as the total amount paid for this claim.	$381.35	$0.00	$381.35
0071	ADHC	MR5	Medical necessity	The claim is for 4 days of ADHC services for an elderly beneficiary with stable hypertension, coronary artery disease and depression. The beneficiary lives at home with his wife and receives 73 hours a month of In Home Supportive Services. The documentation shows no skilled nursing interventions and does not substantiate the need for services beyond those provided outside the ADHC or a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$305.08	$0.00	$305.08

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0073	ADHC	MR5	Medical necessity	The claim is for 2 days of ADHC services for a beneficiary with bipolar disorder. The beneficiary lives with her mother and receives in home support services. The ADHC care plan is stereotypical and includes services such as monitoring for falls and symptoms of heart disease when the Primary Care Physician's evaluation and patient history do not indicate an increased risk for either of these problems. The nursing care flow sheets do not document skilled nursing care, assessment or interventions. The documentation does not indicate a need for services beyond those provided outside the ADHC nor does there appear to be a high potential for deterioration resulting in institutionalization, hospitalization or utilization of emergency services without the ADHC. The beneficiary does not meet all 5 criteria for ADHC. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0075	ADHC	MR2A	Poor or insufficient documentation	The claim is for 3 days of ADHC services for an elderly female with multiple chronic medical conditions. Documentation of the conditions in the individual plan of care is inconsistent with the interventions described by the ADHC and the primary care provider's documentation. The ADHC documentation documents infrequent nursing services and interventions. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0077	ADHC	MR5	Medical necessity	The claim is 1 day of ADHC services for an elderly male beneficiary. The documentation supplied does not substantiate the need for skilled nursing services at an ADHC. The beneficiary performs activities of daily living independently. He lives with a family member and his needs for assistance are met with 160 hours of In Home Supportive Services (IHSS) each month. There is no evidence that skilled nursing services were provided at the ADHC facility as the documentation reflects monitoring of the beneficiary without interventions and his vital signs are recorded as being within acceptable limits. The error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0080	ADHC	MR1	No documentation submitted	The claim is for 3 days of ADHC services for an elderly female beneficiary. The ADHC did not comply with the request for documentation to support the claim. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81
0084	ADHC	MR5	Medical necessity	The claim is for 3 days of ADHC services for an elderly male beneficiary. Physician records in April and June of 2011 do not support medical instability as claimed on the Individualized Care Plan submitted by the ADHC. The beneficiary walks with a cane and is described as tolerating exercise well. The documentation submitted in support of the claim does not substantiate that the beneficiary requires professional nursing services and that the beneficiary's mental or physical condition has a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$228.81	$0.00	$228.81

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0085	ADHC	MR5	Medical necessity	The claim is for2 days of ADHC services for a frail elderly beneficiary with multiple stable medical conditions. The beneficiary receives 140 hours of IHSS and the documentation does not support the need for services that are not provided outside the ADHC or that beneficiary has a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0086	ADHC	MR1	No documentation submitted	REMOVE due to the fact that this claim, ultimately, is not in error. The center was closed when auditors got to the location. It was agreed early on that, if and ADHC center was closed (as a result, perhaps, of the change to the CBASS program), then a non-error would be used if the documentation supporting the ADHC claim could not be located.	$228.81	$0.00	$228.81
0087	ADHC	MR5	Medical necessity	The claim is for 2 days of ADHC services for an adult female beneficiary with multiple chronic medical problems including diabetes, hypertension, osteoarthritis and obesity. Review of ADHC flow sheets indicates the medical conditions are chronic and stable. Her family assists her with medication administration at home. She has IHSS services. The documentation does not indicate a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0088	ADHC	MR5	Medical necessity	The claim is for 2 days of ADHC services for a recent immigrant. She entered ADHC with diagnoses of Hypertension (HTN) and anxiety which appear to be well controlled with medication. It appears that this patient was referred to the ADHC for cultural socialization to alleviate isolation. The beneficiary does not have a high potential for deterioration of her medical conditions that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$152.54	$0.00	$152.54
0091	ADHC	MR5	Medical necessity	The claim is for 1 day of ADHC services for an elderly beneficiary with multiple stable chronic medical conditions. The beneficiary lives alone, is independent in activities of daily living and receives assistance from a daughter with housework. Vital signs and medical conditions are documented as stable and no skilled nursing interventions are recorded. There is no evidence that the beneficiary has a high potential for deterioration of her medical conditions that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for this claim.	$76.27	$0.00	$76.27
0093	ADHC	MR5	Medical necessity	The claim is for 12 days of ADHC services for an elderly female beneficiary. The beneficiary has mild hypertension and mild dementia. The beneficiary lives at home with her husband and daughter and no documentation was provided which shows that her needs were not met at home. The Individual Assessment by the ADHC staff indicates that she self-medicates and ambulates with only the assistance of a cane required. Medical necessity for attendance is not established. The error is calculated as the total amount paid for this claim.	$915.24	$0.00	$915.24

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0098	ADHC	MR5	Medical necessity	The claim is for 2 days of ADHC services for an elderly female beneficiary with hypertension and diabetes. The beneficiary is identified as knowledgeable and compliant with oral medications and she lives alone successfully with regular oversight from family members. The nursing flow sheets for the billing period of the claim indicate relative medical stability. Although the flow sheets show some elevated blood sugars, the plan does not call for intervention or notification of the primary care provider. The documentation does not establish that the beneficiary has a high potential for deterioration of her medical conditions that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. The error is calculated as the total amount paid for the claim.	$152.54	$0.00	$152.54
0100	ADHC	MR5	Medical necessity	The claim is for 13 days of ADHC services for a male beneficiary with multiple chronic medical conditions. The nursing documentation from the ADHC shows stable vital signs and no professional nursing services other than some quarterly assessments. The beneficiary is independent in activities of daily living and does not have unmet needs for assistance. There does not appear to be a high potential for deterioration that would lead to emergency department visits, hospitalization or other institutionalization in the absence of ADHC services. Criteria for medical necessity for ADHC are not met. The error is calculated as the total amount paid for the claim.	$991.51	$0.00	$991.51
0103	DME	MR5	Medical necessity	The claim is for a prescription for an Albuterol inhaler, a medication used to prevent or treat bronchospasm due to asthma, for a toddler. The medication was dispensed as prescribed. The prescriber's progress note for the visit describes a healthy child and is listed as a routine visit. The physical examination reveals clear lungs without wheezing. The record indicates intent to prescribe albuterol for use as needed. The prescriber's medical record provides no medical reason for the medication. An error is calculated because no medical necessity for the drug was documented. The error is calculated as the total amount paid for the claim.	$13.80	$0.00	$13.80
0110	DME	P5	Pricing error	The claim is for Wheelchair components and accessories for a male beneficiary. The equipment was medically necessary and appropriately ordered and provided to the beneficiary. The Assistive Device dealer over billed Medi-Cal for two of five components of the ordered equipment. Medi-Cal Upper Limit Policy permits billing a markup of no more than 100% of the suppliers' cost. The dealer markup exceeded the 100% limit for both a custom built wheelchair cushion and back cushion. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.	$3,053.54	$2,411.68	$641.86
0122	DME	MR2A	Poor or insufficient documentation	The claim is for a tub stool for a male Medicare/Medi-Cal beneficiary. The tub stool is not a Medicare benefit. The beneficiary requested a tub stool and one was ordered. Two months prior to the order the record showed the beneficiary complained of left knee pain but the record described the examination as unremarkable. The documentation submitted to support the claim does not adequately describe the need for this equipment. The error is calculated as the total amount paid for this claim.	$53.46	$0.00	$53.46

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0128	DME	P5	Pricing error	The prescribed item, a tub stool was appropriately ordered and supplied for female beneficiary with quadriplegia. The Pharmacy overbilled for the equipment. The cost to the Pharmacy was $19.25, with the 100% markup in cost permitted by Medi-Cal policy, the provider could bill for $38.50. The provider billed for $75 and was reimbursed $59.01. The error is calculated as difference between the amount paid for the claim and the amount with maximum allowable markup.	$59.01	$38.50	$20.51
0146	DME	MR1	No documentation submitted	The claim is for a walker and a heating pad for a female beneficiary. The equipment was supplied by the pharmacy and receipt acknowledged by the beneficiary. An error is assigned because the referring physician refused to provide records to substantiate the medical necessity of the equipment. The error is calculated as the total amount paid for this claim.	$114.53	$0.00	$114.53
0165	Inpatient	MR5	Medical necessity	The claim is for hospital services for a beneficiary admitted for a scheduled repeat cesarean section at a noncontract hospital in an open area. Reimbursements were made at 0.24 rate. According to the hospital charge list, the first hour of recovery on labor and delivery was charged 7 times resulting in an overpayment of $1152 for the 6 duplicate charges. A large abdominal binder was charged and reimbursed $45.60 prior to admission with no physician order or documentation that it was needed or provided. A small binder was ordered, provided and charged after admission. A duplicate charge for a knit baby hat was reimbursed at $288. $72 was reimbursed for a second overnight pulse oximetry which was not ordered or documented as necessary. $65.35 was charged for a set of labs which were ordered but without documentation of medical reason and for which evidence based medicine does not support medical necessity on a routine basis. The error is calculated as the difference between the total hospital reimbursement and the reimbursement minus the listed duplicate, unordered and unnecessary items.	$10,779.35	$9,156.40	$1,622.95
0170	Inpatient	MR5	Medical necessity	The claim is for inpatient services for an elderly male beneficiary with Chronic Obstructive Pulmonary Disease exacerbation and Hypertension. The initial hospitalization was appropriate but documentation does not substantiate the need for a full six days of inpatient care. The physician progress notes indicate blood pressure levels readily managed in an outpatient setting and do not document significant respiratory problems for the last several days of hospitalization. The available documentation supports a hospital stay of four days rather than five days. The error is calculated as the difference between the amount paid and the amount less the reimbursement for the hospital room, supplies and therapies on the final day of the stay.	$6,593.60	$5,509.31	$1,084.29

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0210	Lab	MR2A	Poor or insufficient documentation	The claim is for a comprehensive chemistry panel for an adult male beneficiary with Diabetes. The beneficiary had a prior Chemistry panel ordered by his regular physician two months previously. The beneficiary was out of town and saw an alternate MD who ordered the chemistry panel claimed for. The laboratory conducted, interpreted and reported the test results appropriately and no error is assigned to the laboratory which claimed for the service. An error is assigned to the referring provider because of the repetition of the testing within a short period. There is no documentation to indicate that the second MD contacted the beneficiary's regular MD prior to ordering the lab tests. Several of the test results for the claimed service were abnormal. The error is assigned as the total cost of the laboratory test of $33.81.	$33.81	$0.00	$33.81
0276	Physicians	MR3	Coding Error	The claim is for a level 5 emergency department visit for a female beneficiary complaining of a headache for one week. A level 5 visit requires a comprehensive history, comprehensive examination and medical decision making of high complexity. The documentation submitted details a comprehensive medical history, a detailed examination and decision making of moderate complexity, which meets the requirements of a level 4 visit. The error is assigned as the difference between reimbursements for the two codes.	$107.00	$67.67	$39.33
0283	Physicians	MR5	Medical necessity	The claim is for 1 day of ADHC services in an FQHC for a male beneficiary with multiple medical conditions including insulin dependent diabetes, hypertension, angina, gastritis and asthma. The ADHC Care Plan states that the beneficiary receives good support and glucose monitoring and insulin injections at home, thus not requiring these services at the ADHC. The plan of care is inconsistent with documentation of services and listed medical conditions and the professional nursing services documented. There is no documentation which indicates that the beneficiary has need of core services that are not met outside the ADHC and that would require hospitalization or increased emergency room visits if he did not attend the ADHC three times a week. The error is calculated as the total amount paid for this claim.	$170.54	$0.00	$170.54
0301	Physicians	MR2A	Poor or insufficient documentation	The claim is for a complete pelvic ultrasound for an asymptomatic postmenopausal beneficiary who is seen to have a cervical polyp on examination at an office visit. The procedure claimed requires a complete evaluation of the pelvic anatomy including description and measurements of the uterus and adnexa, measurement of the endometrium and bladder and description of any pathology as well as a permanently recorded images and a final written report. Use of ultrasound without thorough evaluation of the anatomic structures or region, image documentation and final written report is not separately reportable according to procedural terminology guidelines. The documentation did not include a complete evaluation, image documentation, measurements or a separate report and so was not separately billable from the office visit. The error is calculated as the total amount paid for this claim.	$66.97	$0.00	$66.97

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0308	Physicians	MR3	Coding Error	The claim is for level 3 inpatient hospital care per day by the admitting physician at the first hospital inpatient encounter. The beneficiary is admitted from the emergency department where she presented with complaints of pelvic pain and low back and flank pain. The level 3 care requires a comprehensive examination, a comprehensive history and medical decision making of high complexity. The history is detailed. The examination is not comprehensive and lacks examination of the back, pelvis or flank. The documentation of supports a level 1 visit CPT code 99221. The error is calculated as the difference between the two codes.	$132.17	$33.96	$98.21
0316	Physicians	MR3	Coding Error	This claim is for a level 3 emergency department visit for a 14 year old with a chief complaint of sore throat. A level 3 visit requires an expanded problem focused history, expanded problem focused examination and medical decision making of moderate complexity. The documentation contains a brief history, an examination that contains multiple elements but lacks findings of an examination of the symptomatic area, the throat, and straightforward decision making which supports a level 1 visit. The error is calculated as the difference between the two codes.	$44.15	$15.03	$29.12
0327	Physicians	MR5	Medical necessity	The claim is for a second trimester obstetric ultrasound. The physician's order sheet listed unspecified abnormality and the report listed size/dates as the reasons for the study. The beneficiary had a normal ultrasound 4 weeks prior to this ultrasound and clinical record showed no size discrepancies or other abnormalities. The error is calculated as the total amount paid for this claim.	$81.17	$0.00	$81.17
0355	Physicians	MR5	Medical necessity	The claim is for urine and blood cultures for an adult male beneficiary who was seen in the emergency department with nasal congestion, a productive cough and low grade fever. No symptoms of urinary difficulty or discomfort were documented. The physician's notes indicate a diagnosis of bronchitis. No medical reason for urine and blood cultures is documented. The studies were performed and reported by the laboratory. The error is on the part of the ordering physician. The error is calculated as the total amount paid for this claim.	$3.76	$0.00	$3.76
0386	Physicians	P9B	Rendering provider not eligible to bill for services	The claim is for a fetal stress test provided for a pregnant beneficiary. The rendering provider was incorrectly listed on the claim and while the service was medically appropriate, the rendering provider was not eligible to bill Medi-Cal for his services. The error is calculated as the total amount paid for this claim.	$9.03	$0.00	$9.03
0388	Physicians	P2	Non-covered service	The claim is for dental services for an adult female beneficiary at a Federally Qualified Health Center. The documentation submitted to support the claim does not provide evidence that the beneficiary's dental problems involve trauma, pain, or infection, nor is the beneficiary described as being pregnant. The criteria for exemption from the elimination of dental services for adults from Medi-Cal optional services are not met and the beneficiary is not eligible for the service. The error is calculated as the total amount paid for this claim.	$139.53	$0.00	$139.53

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0389	Physicians	MR3	Coding error	The claim is for an office visit for an established patient for family planning services. The visit was billed as a level 4 visit which requires 2 of the 3 components: a detailed history, a detailed physical examination and decision making of moderate complexity. The documentation provided shows a problem focused history with review of prior history, an examination of the upper body and medical decision making of low complexity. FPACT may bill a visit based on time if more than 50% of the visit is spent in counseling, but no counseling or education are documented. The documentation barely meets the criteria for a level 3 visit. The error is calculated as the difference between the two codes.	$90.73	$56.72	$34.01
0393	Physicians	MR2A	Poor or insufficient documentation	The claim is for an office visit to a Federally Qualified Health Center for a male child beneficiary. The child received a tetanus diphtheria vaccination on the date of the claim, a service that is not billable as a physician encounter. The provider submitted a progress note dated 11 months prior to the date of the claimed service referring to a pathology report from an excisional biopsy of a skin lesion 20 months prior to the date of the claim. The note is largely illegible. There is no documented examination of the biopsy site or other notations that indicate a billable face to face encounter occurred on the date of service claimed. The error is calculated as the total amount paid for the claim.	$157.85	$0.00	$157.85
0422	Physicians	MR2A	Poor or insufficient documentation	The claim is for a level 3 office visit for an established patient and a urine pregnancy test. The presenting problems are headache on oral contraceptive pills, amenorrhea and a rash. The beneficiary had been seen 2 weeks earlier and had a negative pregnancy test. Urinalysis on both visits contained gross blood. The documentation does not contain an order for the urinalysis or a reason that it is being repeated at a short interval. The error is calculated as the amount paid for the urine pregnancy test.	$61.06	$56.72	$4.34
0446	Physicians	MR3	Coding error	The claim is for a level 3 office visit for an established patient. A level 3 visit requires 2 of the following 3 components: an expanded problem focused history and physical, medical decision making of low complexity and a presenting complaint of low to moderate severity. The documentation supports an expanded problem focused history, a brief physical exam unrelated to reason for the visit and not explained and straightforward decision making which is a level 2 visit. FPACT may bill a visit based on time if more than 50% of the visit is spent in counseling, but the amount of time spent in education and topics covered are not documented. The error is calculated as the difference between the 2 codes.	$45.82	$42.78	$3.04
0448	Physicians	MR3	Coding error	This claim is for a level 4 office visit for family planning for an established patient as well as a birth control shot, pregnancy test and condoms. A level 4 visit requires 2 of the 3 following components: a detailed history, a detailed examination and medical decision making of moderate complexity. The documentation reflects an expanded problem focused history, a brief examination of systems unrelated to the reason for the visit and below complexity decision making. No education or counseling is documented. The visit qualifies for a level 3 visit. The error is calculated as the difference between the 2 codes.	$109.34	$46.00	$63.34

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0458	Physicians	MR3	Coding error	The claim is for a level 4 office visit for an established patient seeing a neurologist for follow up of seizure medication. A level 4 visit requires 2 of the 3 following components: a detailed history, a detailed examination and medical decision making of moderate complexity. An expanded problem focused history including brief comparison with previous visit, a vague non-focused exam and decision making of low complexity are documented. The visit qualifies for a level 3 visit. The error is calculated as the difference between the two codes.	$37.12	$23.76	$13.36
0469	Physicians	MR2B	No documents	The claim is for ophthalmic biometry on the same date of service as documented cataract surgery. The operative report does not mention biometric measures. The medical record contains a report dated 3 months prior to the date of service of the claim on which the provider was observed adding a date 1 year later than the date of service at the onsite visit. No documentation of the service for the claimed date was provided. The error is calculated as the total amount paid for this claim.	$21.71	$0.00	$21.71
0476	Physicians	MR2A	Poor or insufficient documentation	The claim is for developmental testing; limited with interpretation and report for a child at a county clinic. The child was receiving covered health screening at the clinic. There was no documentation of a service beyond the screening included in the health assessment. A developmental screening tool is incomplete and does not include scoring, interpretation or report for the service. The error is calculated as the total amount paid for this claim.	$91.68	$0.00	$91.68
0477	Physicians	P9B	Rendering provider not eligible to bill for services	The claim was for an office visit for an adult female beneficiary. The visit was medically necessary and conducted appropriately. The service was provided by a Nurse Practitioner who, while licensed to practice in the State of California, is not enrolled as a Medi-Cal provider and her services could not be billed to the Medi-Cal program. The modifier required for the services of a non- physician medical practitioner was not utilized on the claim. The error is calculated as the total amount paid for this claim.	$49.45	$0.00	$49.45
0525	Physicians	MR3	Coding error	The claim is for one initial and 2 subsequent level 3 hospital care encounters for a 2 month old male infant admitted with high fever. A level 3 initial care requires a comprehensive examination, a comprehensive history and decision making of high complexity. The documentation of pertinent history is detailed and largely illegible, the examination comprehensive and decision making moderate which qualifies for a level 2 initial care. Level 3 subsequent care requires 2 of the 3 components detailed interval history, detailed examination and medical decision making of high complexity. Documentation for the first subsequent day shows problem focused interval history, illegible exam and no documented decision making or new physician orders, which qualifies as a level 1 visit. Documentation of the second subsequent day shows a problem focused interval history, illegible exam and low complexity decision making for discharge and follow up, which qualifies as a level 1 visit. The error is calculated as the difference between the codes.	$185.46	$126.93	$58.53

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0526	Physicians	MR3	Coding error	The claim is for an inpatient level 5 oncology consult for a beneficiary with esophogeal cancer. Requirement for all inpatient consultation codes include a physical examination of the patient and communication by written report to an appropriate source of the request for the consultation. Documentation for this claim is brief and includes no physical examination or written report. The most appropriate code for the service would be level 1 subsequent hospital care 99231. The error is calculated as the difference between the two codes.	$85.39	$27.23	$58.16
0531	Physicians	MR4	Coding error - Unbundling	The claim is for a level 3 office visit, colposcopy with biopsies, colposcopy supplies and a pregnancy test. In order to bill an office visit on the same date of service as a procedure, a separately identifiable problem must be present and addressed. There is no documentation of a visit or reason for a visit distinct from the colposcopy procedure. The error is calculated as the amount paid for the office visit.	$196.30	$150.48	$45.82
0539	Physicians	P5	Pricing error	The claim is for an office visit and dispensing 4 packs of oral contraceptive pills. The visit was appropriately documented and claimed. The beneficiary signed for receipt of three monthly packs. The error is calculated as the cost of 1 monthly pack of contraceptive pills.	$82.84	$70.84	$12.00
0583	Physicians	MR2B	No documents	The claim is for miscellaneous drugs and medical supplies used during an Emergency Department (ED) visit for a middle aged female beneficiary, complaining of shortness of breath, subsequently diagnosed with acute bronchitis. An error is assigned because the documentation submitted by the ED to support the claim, fails to list any drugs or miscellaneous supplies. The error is calculated as the total amount paid for this claim.	$56.16	$0.00	$56.16
0601	Physicians	MR5	Medical necessity	The claim is for a urinalysis for an adult female beneficiary. The documentation submitted in support of the claim does not include a lab requisition for the test. No patient signature verifying the source of the specimen was obtained and there is no reason for the test being performed included in the office visit documentation. The visit note does not support the medical necessity for the test and there is no indication of urinary problems or kidney disease documented. The chief complaint listed for the visit is that the patient is following up for lab results. The error is calculated as the total amount paid for this claim.	$2.46	$0.00	$2.46
0620	Physicians	P2	Non-covered service	The claim is for a tooth restoration for an adult beneficiary. An error is assigned because the service was inappropriately reimbursed as adult dental services ceased to be a Medi-Cal optional benefit in 2009. The documentation submitted to validate this claim does not support a waiver for this procedure. The error is calculated as the total amount paid for this claim.	$224.19	$0.00	$224.19

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0640	Physicians	MR5	Medical necessity	The claim is for testing for gonorrhea and chlamydia testing for a 47 year old adult seen for pain in the stomach area. The pelvic exam is normal. No other complaints, history of risk factors for sexually transmitted disease or patient request for testing are documented. Has unprotected intercourse or has a history of STD. Routine testing is not indicated in this beneficiary's age group. The documentation does not substantiate the medical necessity of STD testing. The error is calculated as the total amount paid for this claim.	$56.04	$0.00	$56.04
0658	Physicians	P2	Non-covered service	The claim is for dental services for an adult male beneficiary. The services provided included the injection of an anesthetic and bone filing to smooth a tooth. The service is not a Med-Cal benefit as beneficiary does not meet criteria for exemption to optional benefits exclusion. The error is calculated as the total amount paid for this claim.	$145.38	$0.00	$145.38
0667	Physicians	MR2A	Poor or insufficient documentation	The claim is for six days of inpatient hospital care, subsequent, level 2 and level 3 services, for an adult female beneficiary with metastatic cancer. The rendering provider is a consulting neurologist who billed for the six days of inpatient hospital visits. For two of the six days, there was no documentation of any services by the provider; for two additional days, the only documentation consisted of a signed order; and for the final two days, there were two progress notes signed by the provider but which were virtually illegible. The error is calculated as the total amount paid for these claims.	$264.12	$0.00	$264.12
0670	Physicians	MR3	Coding error	The claim is for a level 4 emergency department visit for an adult female beneficiary complaining of a migraine headache. The medical record indicates recurrent visits for the same problem by this beneficiary who was given narcotic pain medication and released an hour later. No other diagnoses were discussed; no studies or labs were done. A level-4 visit medical decision making of moderate complexity. The documentation substantiates low complexity medical decision making which qualifies as a level 2 visit. The error is calculated as the difference between the 2 codes.	$67.67	$24.74	$42.93
0686	Physicians	MR3	Coding error	The claim is for a follow up level 4 office visit with a neurologist for titration of seizure medications. A level-4 visit requires 2 of the 3 components: a detailed history a physical examination and medical decision making of moderate complexity. The documentation indicates a problem focused history, physical exam "the same" and straightforward medical decision making with no change in plan which meets the criteria for a level-2 visit. The error is calculated as the difference between the two codes.	$56.58	$27.33	$29.25
0693	Physicians	P9B	Rendering provider not eligible to bill for services	The claim is for an office visit for an adult female beneficiary. The claim lists an MD as the rendering and billing provider. The services were actually provided by a Non-Medical Practitioner (NMP), who is an appropriately licensed Physicians Assistant (PA) however, the PA is not enrolled in the Medi-Cal program and her services may not be billed to Medi-Cal. The error is calculated as the total amount billed for this claim.	$23.76	$0.00	$23.76

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0694	Physicians	MR3	Coding Error	The claim is for a level 4 office visit for an established patient. The level 4 visit requires 2 of the following 3 components: a detailed history, a detailed physical examination and decision making of moderate complexity. The documentation submitted to support the claim has no detailed history, only a chief complaint. A physical exam was documented and decision making of low complexity was required. The visit meets criteria for a level 3 visit. The error is calculated as the difference between the 2 codes.	$40.50	$14.58	$25.92
0700	Other Services	P10	Other	The claim is for transportation from home to a Local Educational Agency (LEA) for a male student beneficiary. The child did not attend school on the day billed for. The agency has submitted documentation to Medi-Cal to reverse the claim and admits the error.	$6.40	$0.00	$6.40
0704	Other Services	MR2B	No documents	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The student log for the date of service shows that no services were provided on that date. 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. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0707	Other Services	MR2A	Poor or insufficient documentation	The claim is for group speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation submitted to support the claim does not include a referral from a physician, or a Minimum Standard of Medical Necessity. Although medical necessity for the services appears to exist and periodic progress reports were submitted, there was no progress note from the date of service which described the nature and extent of services provided. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0708	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language services for a student beneficiary at a Local Educational Agency (LEA). The services were appropriate for the child; however, the only progress note in support of the services on the date of the claim, was an email from the speech and language therapist, sent in response to the audit and post-dated to the date of service. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0709	Other Services	MR2B	No documents	The claim is for three days of medical transportation via wheel chair van for a male beneficiary with end stage renal disease. The transportation occurred three times weekly for hemodialysis. The service was medically appropriate; however, there was no transportation trip log for one of the three date of service. The error is calculated as the amount reimbursed for 1 trip.	$226.14	$150.81	$75.33
0711	Other Services	MR8	Policy Violation - other medical error	The claim is for nursing aide services for a male student beneficiary at a Local Education Agency (LEA). The documentation submitted indicates that the services were provided by a classroom teacher. Nursing aide services for LEA students are mandated by Medi-Cal to be provided by trained health care aides, supervised by a licensed health professional, thus this claim should not have been reimbursed. The error is calculated as the total amount paid for this claim.	$18.24	$0.00	$18.24

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0712	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation provided in support of the claim does not indicate the nature and extent of the services provided. The progress notes are incomplete and unsigned, and the therapy schedule differs from the original recommendation for therapy. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0713	Other Services	MR2A	Poor or insufficient documentation	The claim is for targeted case management services for an adolescent male student beneficiary at a Local Educational Agency (LEA). The documentation submitted for the case management services on the date of the claim consists only of cursory check marks which do not describe the nature and extent of services. There are two emails, dated the two days subsequent to the claim, which appear to document case management services in greater detail, but the email does not clearly refer to the date of service of the claim. The error is calculated as the total amount paid for this claim.	$10.11	$0.00	$10.11
0714	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation submitted supports medical necessity for the services; however, the records do not document the extent of the services provided or the child's response to the services. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0717	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language services for a male student beneficiary at a Local Educational Agency (LEA). There is no record that a physician reviewed or approved the plan of care. The documentation submitted does not demonstrate medical necessity for the services; rather, it suggests that a focus on English as a second language in the home is presenting barriers to progress, rather than an identified medical issue requiring therapy. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0724	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). Although there is evidence that the student attended a therapy session on the date of service, the documentation submitted does not describe the nature and extent of the services rendered, or their impact on the student. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0728	Other Services	MR2B	No documents	The claim is for targeted case management services for a male student beneficiary at a Local Educational Agency (LEA). The medical necessity for the services was substantiated in the documentation submitted in support of the claim; however, there was no record of the provision of services on the date of the claim. The error is calculated as the total amount paid for this claim.	$17.74	$0.00	$17.74
0732	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). While there is evidence of attendance at group therapy sessions, there are no progress notes to indicate the type and extent of service or the efficacy of the therapy. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0734	Other Services	MR2B	No documents	The claim is for registered nurse (RN) services for a female student beneficiary at a Local Educational Agency (LEA). The documentation submitted to support the claim fails to indicate what, if any, services were provided by an RN on the date of service. The error is calculated as the total amount paid for this claim.	$10.86	$0.00	$10.86
0740	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). Although there are brief computer template notes for the dates of service on the claim, the notes are not signed, and though electronic, there is no evidence of electronic signatures. It cannot be verified that the service was performed by a qualified provider. The error is calculated as the total amount paid for this claim.	$28.40	$0.00	$28.40
0742	Other Services	MR8	Policy Violation - other medical error	The claim is for group behavioral health interventions for a female student beneficiary at a Local Educational Agency (LEA). The student did not attend school on the date of service for the claim. However, a progress note dated for the date of service is submitted in support of the claim. The documentation submitted to support medical necessity of the services is unsigned and does not indicate the duration and frequency of treatment required. The error is calculated as the total amount paid for this claim.	$27.48	$0.00	$27.48
0745	Other Services	MR5	Medical necessity	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation submitted does not demonstrate medical necessity for the services; rather, it suggests that a focus on English as a second language in the home is presenting barriers to progress, rather than an identified clinical issue requiring therapy. Furthermore, the required physician review and approval of the plan of care was not demonstrated. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0754	Other Services	MR2A	Poor or insufficient documentation	The claim is for 16 units of nursing aide services for a student beneficiary at a Local Educational Agency (LEA). The documentation submitted in support of this claim has no progress notes to describe the services rendered on the date of the claim. Furthermore, the student's Individualized Education Plan (IEP) does not authorize nursing aide services for this autistic child with social and safety needs. The error is calculated as the total amount paid for this claim.	$72.96	$0.00	$72.96
0756	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation submitted to support the claim does not describe the content of the therapy provided, or the student's response to the therapy. The speech pathologist who provided the services states that she destroys her records at the end of each school year, which is a violation of both standard of care and Medi-Cal regulations. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0758	Other Services	MR5	Medical necessity	The claim is for speech and language therapy for a male student beneficiary at a Local Education Agency (LEA). Medical necessity for the services could not be established as no Individualized Evaluation Plan (IEP) for the child's need for services or goals of therapy was available for the time period when this claim was submitted. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0765	Other Services	P5	Pricing error	The claim is for speech and language therapy for a male student beneficiary at a Local Educational Agency (LEA). The documentation submitted is in support of the claim; the Individualized Education Plan (IEP) recommends therapy services once per month. The claim is for weekly services. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0767	Other Services	MR2A	Poor or insufficient documentation	The claim is for nursing aide services for a disabled student at a Local Educational Agency (LEA). The documentation submitted to support the claim does not identify the nurse's aide providing services; therefore, her qualifications cannot be verified. There are no physician orders for the services provided and no description of the nature of the services. The documentation does not verify the student's diagnosis as qualifying the student for the services, and does not indicate that the student received the timed services. The error is calculated as the total amount paid for this claim.	$18.24	$0.00	$18.24
0775	Other Services	P2	Non-covered service	The claim is for Group Speech, Language and Voice Treatment (CPT code 92508) for a student beneficiary at a Local Educational Agency (LEA). The reviewed documentation indicates that the child improved sufficiently to be discontinued from the treatment program 5 days before the date of service claimed. A letter from the LEA, dated after the MPES audit documents were collected, acknowledges that this claim was in error and a copy of a request to have the claim reversed was provided. However, the claim was not reversed and, there is an additional claim for 92508 a week after this claim. The error is calculated as the total amount paid for this claim.	$14.20	$0.00	$14.20
0776	Other Services	MR2A	Poor or insufficient documentation	The claim is for speech and language therapy for a student beneficiary at a Local Educational Agency (LEA). The documentation submitted to support the claim fails to identify a clinical reason for the therapy. All documents submitted are unsigned, therefore therapist licensing and/or certification cannot be verified. Finally, all progress notes are written every six days, except for the progress note for the date of service, whose date is hand written, and which follows the previous progress note by one day, in contrast to the usual pattern. The error is calculated as the total amount paid for this claim.	$69.72	$0.00	$69.72
0783	Other Services	P2	Non-covered service	The claim is for nursing aide services for a student beneficiary at a Local Educational Agency. The child complained of a stomach ache. Her temperature was taken and her parents were called to take her home from school. The claim is invalid because this is not a Medi-Cal covered service. The service would be provided to any child at the school in a similar situation and thus does not qualify for Medi-Cal reimbursement. There is no documentation as to who provided the services or if there was supervision by an appropriately licensed health professional. The error is calculated as the total amount paid for this claim.	$13.68	$0.00	$13.68
0788	Pharmacy	MR5	Medical necessity	The claim is for a prescription for Calcitriol, a medication to improve calcium levels in the body, for an adult female beneficiary. The medical record lists osteopenia as the diagnosis for which this drug is the treatment. Prevention of osteoporosis is not an established indication for this drug. The medical record does not show low blood levels of calcium or a rationale for using this medication. The error is calculated as the total amount paid for this claim.	$37.37	$0.00	$37.37

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0805	Pharmacy	PH3	Prescription - missing essential info	The claim is for a codeine/promethazine cough suppressant medication for an elderly female beneficiary. The medication was dispensed without a valid prescription. An authorization to refill a prior prescription was signed by a non-clinical office manager and not countersigned by a physician. There is no documentation in the beneficiary's medical record that a refill was authorized. The error is calculated as the total amount paid for this claim.	$14.09	$0.00	$14.09
0806	Pharmacy	PH10	Policy Violation - other pharmacy policy error	The claim is for a prescription for Pedialyte for a 19 month old male beneficiary. The prescription was for six, 200 ml bottles, or a total of 1200 ml. The pharmacy dispensed 6000 ml in error, resulting in 4800 ml more being dispensed than was ordered. The error is the difference between the amount paid and the amount that would be paid for the prescribed amount.	$37.85	$13.37	$24.48
0808	Pharmacy	PH7B	Prescription - prescription split	The claim is for a prescription for low dose aspirin as a cardiac disease preventive measure for an adult female beneficiary. The prescription was for 100 tablets with 4 refills. The pharmacy dispensed the medication in 30 tablet increments, thus increasing the dispensing fees and resulting in increased cost to the Medi-Cal program. The prescribing provider states he wrote the prescription but does not have documentation of it. The error is calculated amount paid for the dispensing fee.	$8.61	$1.36	$7.25
0827	Pharmacy	PH7B	Prescription - prescription split	The claim is for a prescription for Risperdone, an atypical anti-psychotic medication, for an adult female beneficiary. The prescription was written for 30 tablets. The pharmacy dispensed the appropriate number of pills over several months; however, they dispensed the medication 13 pills at a time, resulting in excessive dispensing fees charged to the Medi-Cal program. The error is calculated amount paid for the dispensing fee for this claim.	$59.25	$52.00	$7.25
0840	Pharmacy	PH10	Policy Violation - other pharmacy policy error	The claim is for a prescription for Loestrin 24 FE, a type of birth control pill, for an adult female beneficiary. The prescription written by the nurse practitioner read 'LoLoEstin 1 po Qd' for three cycles. Loestrin 24 FE contains .02 mg of ethinyl estradiol in comparison to .01 mg in Lo Loestrin. They are not the same. There is no evidence that the pharmacy validated the prescription prior to dispensing an alternative drug. The error is calculated as the total amount paid for this claim.	$209.72	$0.00	$209.72
0893	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for fluoride drops prescribed for a female toddler beneficiary. Documentation does not include evaluation of exposure to other sources of fluoride or risk factors for dental caries before prescribing supplementation for the child. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0904	Pharmacy	PH2	No legal prescription for date of service	The claim is for a prescription for docusate sodium, a stool softener, for an adult female beneficiary. The original prescription was three years old and there was no documentation that a current refill was authorized. The beneficiary had not seen the prescribing physician for two years and requests for refill authorization had been declined by the physician because of poor beneficiary compliance and a lack of a recent evaluation by the physician. The error is calculated as the total amount paid for this claim.	$9.39	$0.00	$9.39
0907	Pharmacy	MR5	Medical necessity	The claim is for a prescription for hydrocodone, a controlled substance utilized for pain control, for an adult female beneficiary. The documentation submitted by the prescribing provider does not substantiate medical necessity for the medication. On the date of service of the claim, no physical examination was performed, and the beneficiary was noted to have no pain. The error is calculated as the total amount paid for the claim.	$16.59	$0.00	$16.59
0913	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Cogentin, a medication for the treatment of essential tremors or those that result from other medications, for an adult male beneficiary. The medical records available do not support the medical necessity for the prescription. Although the beneficiary has been taking the medication for over a year, there were no medical records on or around the date of service on the claim to substantiate the need for the medication. The error is calculated as the total amount paid for the claim.	$14.88	$0.00	$14.88
0914	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Nexium, a medication for the treatment of gastro esophageal reflux disease (GERD), or heartburn, for an adult male beneficiary. Although the diagnosis of GERD is referenced in the problem summary, there is no documentation to substantiate ongoing evaluation of the problem or continued medical necessity of the medication; the only progress note available for review is from three months prior to the date of service and does not mention GERD. The error is calculated as the total amount paid for this claim.	$522.04	$0.00	$522.04
0922	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Depakote for an adult female beneficiary. Depakote is labeled for use as in epilepsy, bipolar disorder and migraine prophylaxis. The beneficiary's primary complaint is documented as pelvic pain. The documents submitted by the prescribing provider do not indicate the medical necessity for this medication. The error is calculated as the total amount paid for this claim.	$122.56	$0.00	$122.56
0941	Pharmacy	MR5	Medical necessity	The claim is a prescription for calcium tablets in a pregnant adult female beneficiary. The prescribing provider's records do not substantiate medical necessity for additional calcium. There was no evaluation of dietary calcium intake in addition to the 200 mg of calcium in her daily prenatal vitamin. The error is calculated as the total amount paid for this claim.	$10.21	$0.00	$10.21

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
0956	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for bismuth subsalicylate, a medication for the treatment of diarrhea, heartburn or upset stomach, in an adult female beneficiary. Although the prescription lists the indication for the medication as 'prn diarrhea', the medical records do not substantiate the medical necessity for the medication; there is no mention of diarrhea or heartburn in the records available for review. The error is calculated as the total amount paid for this claim.	$15.70	$0.00	$15.70
0960	Pharmacy	MR5	Medical necessity	The claim is for a prescription for Loratadine, a medication for the treatment of allergy symptoms, for an adult male beneficiary. The prescribing provider's medical records do not substantiate medical necessity for the medication, nor do they document any intent to prescribe the medication. The error is calculated as the total amount paid for this claim.	$19.25	$0.00	$19.25
0963	Pharmacy	PH2	Prescription - No legal prescription for date of service	The claim is for a prescription for Solifenacin, a medication for the treatment of overactive bladder, for an elderly male beneficiary. The pharmacy was unable to provide appropriate documentation for a refill for the medication. The prescribing provider had previously ordered the medication, but had no record of authorizing a refill for the date on which the medication refill was dispensed. The error is calculated as the total amount paid for this claim.	$154.64	$0.00	$154.64
0964	Pharmacy	MR5	Medical necessity	The claim is a prescription for Seroquel, an atypical anti-psychotic medication, for a young adult female beneficiary. The records submitted by the prescribing provider do not substantiate the medical necessity for the medication. There are no records which document an evaluation of this patient by the prescribing physician since 2005. The error is calculated as the total amount paid for this claim.	$1,192.91	$0.00	$1,192.91
0985	Pharmacy	MR5	Medical necessity	The claim is for a prescription for Claritin, a medication for the treatment of allergy symptoms, for an elderly female beneficiary. The documentation submitted by the prescribing provider does not substantiate medical necessity for the medication. The drug was originally prescribed for the beneficiary in 2008 for allergic rhinitis. The medical record has no update regarding allergy symptoms or the continued necessity for the medication. The error is calculated as the total amount paid for this claim.	$8.44	$0.00	$8.44
1005	Pharmacy	MR5	Medical necessity	The claim is for an antibiotic prescribed for a male infant beneficiary with a diagnosis of Otitis Media (an ear infection). The medical record does not substantiate the basis for the diagnosis or the need for antibiotics. The error is calculated as the total amount paid for this claim.	$7.06	$0.00	$7.06
1012	Pharmacy	PH7B	Prescription - prescription split	The claim is a prescription for atenolol, a medication for the treatment of high blood pressure, for an elderly female beneficiary. The prescription was for 90 tablets with three refills. The pharmacy dispensed 30 tablets each time, resulting in excessive dispensing fees charged to the Medi-Cal program. The error is calculated as the amount for dispensing fees for this claim.	$9.32	$2.07	$7.25
1022	Pharmacy	MR5	Medical necessity	The claim is for Nasonex nasal spray for an adult board and care resident, male beneficiary. The documentation provided to support the claim lacks medical justification for the prescription. The error is calculated as the total amount paid for this claim.	$111.09	$0.00	$111.09

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
1034	Pharmacy	MR5	Medical necessity	The claim is for a prescription for Claritin, a medication for the treatment of allergy symptoms, for an adult male beneficiary. The pharmacy has a record of a phone prescription for the medication. No medical records were available to verify that the prescribing provider saw the beneficiary during the month prior to the medication being dispensed, and the provider has no record or recollection of seeing the patient. Therefore, medical necessity for the prescription cannot be verified. The error is calculated as the total amount paid for this claim.	$13.25	$0.00	$13.25
1042	Pharmacy	PH5	Prescription - wrong info on label	The claim is for a prescription for a female beneficiary. The prescription label has an incorrect prescriber name and while the prescription was written for 20 tablets, 28 tablets were dispensed. The original claim submitted had a different prescriber name but that claim was reversed and not paid.	$22.17	$0.00	$22.17
1045	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for promethazine, a medication for the treatment of nausea and vomiting. The prescription was signed by a physician whose physician's assistant was the provider who most consistently evaluated the beneficiary. There is no documentation of an office visit close to the date of service to substantiate the medical necessity of the medication. The error is calculated as the total amount paid for this claim.	$16.19	$0.00	$16.19
1071	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Prilosec, a medication for the treatment of gastro esophageal reflux disease (GERD) or heartburn, for an elderly female beneficiary. The prescribing provider's medical records do not indicate any reason for the prescription or document a clinical issue necessitating the beneficiary's need for Prilosec. The error is calculated as the total amount paid for this claim.	$26.23	$0.00	$26.23
1078	Pharmacy	PH3	Prescription - missing essential info	The claim is for a prescription for incontinence supplies (disposable liner/shield/pads) for an adult female beneficiary experiencing urinary incontinence. The prescription does not document the number of incontinence supplies prescribed and is, therefore, missing essential information. The error is calculated as the total amount paid for this claim.	$88.44	$0.00	$88.44
1081	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Nexium, a medication for the treatment of gastro esophageal reflux disease (GERD), or heartburn, for an adult male beneficiary. The prescription was filled appropriately and labeled correctly. The prescribing provider's records do not substantiate the medical necessity for the medication as the records submitted in support of the claim were illegible. The error is calculated as the total amount paid for this claim.	$178.85	$0.00	$178.85

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
1085	Pharmacy	PH7B	Prescription - prescription split	The claim is for a refill of a prescription for Synthroid, a medication to supplement thyroid hormone production, for an adult female beneficiary. The medication was appropriately prescribed. The prescription was for 90 tablets but the pharmacy dispensed only 30 tablets at a time, which resulted in excessive dispensing fees charged to the Medi-Cal program. The error is calculated as the amount of the dispensing fee paid for this claim.	$15.98	$8.73	$7.25
1091	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Nicoderm patches for an adult female beneficiary as part of a smoking cessation treatment plan. Although the prescribing provider's progress notes document that the beneficiary had started smoking again, and wanted to stop, the notes do not document the intent to prescribe the Nicoderm patch, or the particular strength of the patch. The prescription was authorized by a medical assistant at the physician's office, and faxed to the pharmacy. This activity is beyond the scope of practice for a medical assistant. The error is calculated as the total amount paid for this claim.	$43.57	$0.00	$43.57
1102	Pharmacy	MR2A	Poor or insufficient documentation	The claim is for a prescription for Vicodin, a controlled substance utilized for pain control, for an adult female beneficiary. The prescribing provider's medical records, lacking follow up of the beneficiary's symptoms and determination of the efficacy of the prescribed medication, do not adequately substantiate the medical necessity for continued refills in this beneficiary with low back pain. The error is calculated as the total amount paid for this claim.	$82.92	$0.00	$82.92
1121	Pharmacy	MR5	Medical necessity	The claim is for a prescription for ferrous sulfate (iron) tablets for an elderly female beneficiary. The pharmacy labeled and dispensed the medication appropriately. The documentation submitted by the prescribing provider does not substantiate the medical necessity of the medication. The only progress note submitted is from one year prior to the date of service and notes 'anemia' without further description. There are no laboratory studies to indicate that the beneficiary had an iron deficiency. The error is calculated as the total amount paid for this claim.	$6.99	$0.00	$6.99
1147	Pharmacy	MR1	No documentation submitted	The claim is for a prescription for gabapentin, a medication for the treatment of seizures or neuropathic pain, for an adult female beneficiary. The pharmacy dispensed the medication appropriately from a valid prescription. The prescribing provider refused to release medical records for the beneficiary to substantiate the medical necessity of the prescription; therefore, the claim cannot be verified. The error is calculated as the total amount paid for this claim.	$124.11	$0.00	$124.11
1149	Pharmacy	PH7B	Prescription - prescription split	The claim is for a prescription for Vicodin, a controlled substance utilized for pain control, for an adult male beneficiary. The prescription was a refill of the original prescription for 40 tablets. The pharmacy dispensed 30 tablets initially, and another 10 tablets three days later. This resulted in an additional dispensing fee, and there is no evidence that the pharmacy discussed the change in the prescription with the prescribing provider. The same dispensing practice occurred with the original prescription. A treatment authorization request would have been necessary had the prescribed amount been dispensed. The error is calculated as the amount paid for the dispensing fee for this claim.	$19.86	$0.00	$19.86

ID	Stratum	Primary Error	Error Description	Final Comments	Paid Amount	Correct Amount	Payment Error
1162	Pharmacy	MR5	Medical necessity	The claim is for a prescription for lorazepam, an anti-anxiety medication, for an adult male beneficiary. The prescription was filled appropriately by the pharmacy. The documentation submitted by the prescribing provider fails to describe any medical diagnosis which would substantiate the need for the medication. The error is calculated as the total amount paid for the claim.	$9.72	$0.00	$9.72

Appendix 5 - Glossary

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

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