

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

Medi-Cal Payment Error Study

Fee-For-Service And Dental
Programs



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Director

2004

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EXECUTIVE SUMMARY

The Department of Health Services (DHS) completed two studies in calendar year 2004 that examined the accuracy of payments in Medi-Cal: California's first annual Medi-Cal Payment Error Study (MPES) of the Fee-For-Service (FFS) and Dental programs, and the Federal Payment Accuracy Measurement (PAM) study.

In Fiscal Year (FY) 2003/04, DHS obtained staffing from the State Legislature to conduct an annual Medi-Cal payment error study. The primary objectives of the MPES are to: (1) compute the amount of potential loss to Medi-Cal due to payment errors, including potential loss due to fraud or abuse; and (2) to identify where Medi-Cal is at greatest risk for payment errors, and thus establish how best to deploy Medi-Cal anti-fraud resources. This is the first study conducted by a state or federal entity that included an estimate of potential fraud.

DHS also responded to the solicitation by the Centers for Medicare and Medicaid Services (CMS) to participate in the national PAM pilot project. Participation provided DHS with the opportunity to compare Medi-Cal against other states' Medicaid programs using a single methodology to measure payment accuracy. The results of the PAM are provided in Appendix XI.

The Medi-Cal and Dental programs have an annual FFS benefits budget of approximately \$17.8 billion¹. On an annual basis, almost 50,000 providers bill the program and more than 224 million claims are adjudicated for health care services to 3.1 million FFS beneficiaries. MPES indicates that 96.43 percent of total dollars paid were billed appropriately and paid accurately.

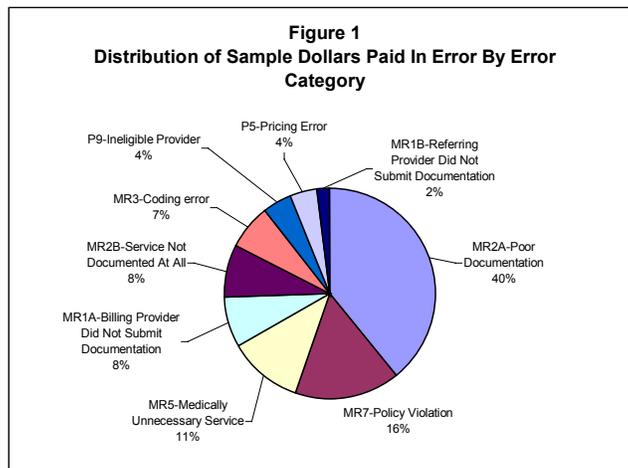
The U.S. General Accounting Office (GAO)² reported that estimates of losses resulting from fraud and abuse vary widely, but the most common is 10 percent of the nation's health care spending. Malcom Sparrow also quotes the GAO estimate in his book, License To Steal, How Fraud Bleeds America's Health Care System, but goes on to say that the actual amount of fraud, waste and abuse in America's health care system is unknown, because it had not been systematically measured. California's MPES results are 64.3 percent less than the 10 percent estimate used by the GAO. The MPES results are also favorable when compared to the annual error study conducted by the federal Medicare program. The recently issued "Improper Medicare Fee-For-Service Payment Report for 2004" reported payment errors of 9.3 percent, the MPES results are over 60 percent less than Medicare. The most recent analysis of another state Medicaid program in which a methodology was utilized similar to that used in the MPES, was a 1998 Illinois study. This study found payment errors of 4.72 percent; the MPES results were 24 percent less than Illinois. A comparison of the estimated loss due to potential fraud cannot be made because California is the first state to conduct a study that includes an estimate of potential fraud.

¹ All dollars are Total Funds and represent a combination of both state and federal funding.

² "Health Insurance: Vulnerable Payers Lose Billions to Fraud and Abuse" GAO/HRD-92-69, p.1.

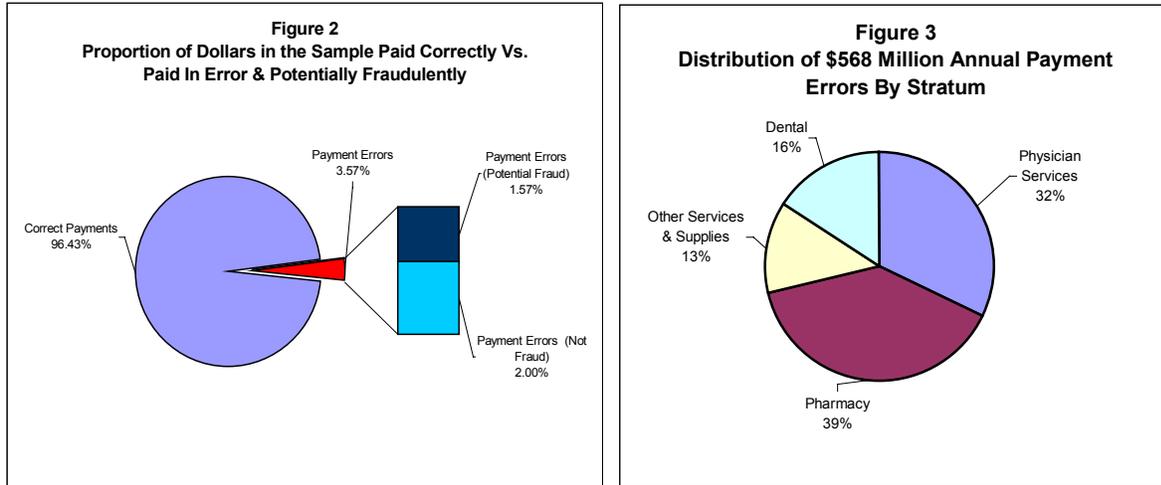
While DHS found that most providers were billing and being paid correctly, 3.57 percent of the total dollars paid indicated some type of billing or payment error. The claim errors ranged from simple mistakes, such as coding errors, to more significant findings that could indicate potential fraud, such as forged physician signatures and filling prescriptions in excess of the prescribed amount. Over half (58 percent) of the amount paid in error resulted from insufficient documentation or no documentation by the billing or referring provider (Figure 1). Some of the documentation errors were counted as potential fraud because a determination could not be made that the service was provided or medically necessary. However, insufficient documentation does not necessarily mean that the services were not provided or were not medically necessary, and therefore may not represent overpayments or potential fraud. For example, a pharmacy billed and was paid for a drug when there was a valid prescription and the medical record documented medical necessity. However, the pharmacy had no dispensing record. This example would have been classified as insufficient documentation, but it is likely the medication was in fact dispensed and paid appropriately.

Only 11 percent of the amount from the sample that was paid in error was related to medically unnecessary services and can therefore be considered actual overpayments. The remainder would require a more detailed review of the providers and even then a determination of an actual overpayment may not be possible. The study found no payment errors found in Acute Hospitals or Nursing Facilities (NF), however the sample size for this strata was not large enough to conclude that there are no errors in Acute and NF claims in Calendar Year 2003. There were also no errors found with the Electronic Data Systems' (EDS) or Delta Dental's claims processing edits and audits. Pharmacy and Physician Services (including Physician Groups) generated 71 percent of the projected annual payment errors.



The 3.57 percent equates to \$568 million of the \$15.9 billion in annual payments from Calendar Year 2003 that were “at risk” of being paid inappropriately. The total includes \$250 million in annual payments, or 1.57 percent that disclosed characteristics of potential fraud (Figure 2). The term “at risk” is used because the amount that is computed when applying the error percentage to the annual expenditures can not be considered potential savings unless all of the individual services that are questionable

are identified through a complete medical record review or audit of all services submitted for payment and found to be medically unnecessary. In addition, to determine exactly how much of the payment errors identified were indeed attributable to fraud requires a complete criminal investigation. Figure 3 displays the allocation of the projected payment errors by sample strata.



The MPES shows that DHS' current focus on non-institutional providers, specifically physicians (including physician groups) and pharmacies, is targeting the area of highest risk for payment errors and potential fraud. In fact, some errors discovered in the MPES already had been identified by DHS and corrections are currently being implemented. In addition, of the 611 providers in the claims sample, 41 (6.7 percent) were identified as potentially fraudulent by the MPES. Six of those providers were already under investigation by DHS and administrative actions have been taken against these providers.

The study did highlight areas that made the program at-risk for billing or payment errors, such as inadequate documentation by the providers and up coding (using an inappropriate code) to increase reimbursement. DHS has already begun work to address these at-risk areas and cases are being developed on the providers identified as potentially fraudulent.

The MPES has reinforced the need to remain aggressive in combating fraud, waste and abuse and to continue to develop innovative fraud prevention tools and technologies. The MPES has provided DHS with a basis for expanding the Medi-Cal Anti-fraud Strategic Plan for the future, and has set the baseline against which the effectiveness of future anti-fraud efforts can be measured.

MEDI-CAL PAYMENT ERROR STUDY (MPES)

BACKGROUND

Over the past several years, DHS has placed significant emphasis on combating fraud, waste and abuse in Medi-Cal. However, because a systematic program payment error study had not been completed, DHS has been unable to respond to legislative and public inquiries regarding the magnitude of the problem and to validate that its anti-fraud activities are focused in the areas of highest risk for fraud.

In Fiscal Year (FY) 2003/04, DHS obtained staffing from the State Legislature to conduct an annual Medi-Cal payment error study. The primary objectives of the MPES are to: (1) compute the amount of potential loss to Medi-Cal due to billing or payment errors, including potential loss due to fraud or abuse; and (2) to identify where Medi-Cal is at greatest risk for billing or payment errors, and thus establish how best to deploy Medi-Cal anti-fraud resources. The MPES is the first study conducted by a state or federal entity that included an estimate of potential fraud.

In addition to conducting the MPES, DHS also responded to the solicitation by the CMS to participate in the third year of the national Payment Accuracy Measurement (PAM) Pilot project. DHS had not participated in the first two years of the PAM pilot and participation in the third year provided DHS with the opportunity to compare Medi-Cal against other states' Medicaid programs using a single methodology to measure payment accuracy. There are key differences between the MPES and the PAM, which are outlined in a side-by-side comparison in Appendix II. Most notable is that the PAM model measures payment accuracy rates but not measure the nature and extent of fraud. The MPES goes beyond the PAM model and measures whether a billed service was actually medically necessary and whether a claim was potentially at risk for fraud. The PAM report is provided in Appendix XI.

The MPES and the PAM were conducted concurrently and the results will be used to expand and improve the Medi-Cal Anti-Fraud Strategic Plan for the future.

MPES OVERVIEW

Because the primary focus and expansion of the Medi-Cal anti-fraud efforts have been in the FFS and Dental programs, DHS focused the MPES to the Medi-Cal FFS program, including dental services. In dollars, this accounted for \$17.8 billion or 64 percent of the total Medi-Cal benefits budget estimate in FY 2002/03. The study did not include Medi-Cal Managed Care, claims paid or rendered by other state departments, such as the Department of Developmental Services or the Department of Mental Health, payments made through supplemental payments, such as disproportionate share hospitals (DSH), etc. The study also did not include a determination of beneficiary eligibility. MPES focused on the Medi-Cal FFS area, because this area of the program directly pays the largest number of individual providers and has the greatest risk for fraud. Focusing on the FFS area also helped keep the study to a manageable size.

The following table displays the portion of the Medi-Cal budget included in the MPES:

MEDI-CAL SERVICE CATEGORIES INCLUDED IN THE MPES

SERVICE CATEGORY	FY 2002/03 BUDGET ESTIMATE¹	CATEGORY/AMOUNT INCLUDED IN MPES
PROFESSIONAL	\$3,106,466,350	
PHYSICIANS	\$1,087,539,700	
OTHER MEDICAL	\$1,344,218,420	
COUNTY OUTPATIENT	\$174,329,610	
COMMUNITY OUTPATIENT	\$500,378,620	
PHARMACY²	\$2,948,855,800	
HOSPITAL INPATIENT	\$6,609,478,600	
COUNTY INPATIENT	\$2,883,241,820	
COMMUNITY INPATIENT	\$3,726,236,780	
LONG TERM CARE	\$3,229,576,350	
NURSING FACILITIES	\$2,898,323,030	
ICF-DD	\$331,253,320	
OTHER SERVICES	\$1,184,299,520	
MEDICAL TRANSPORTATION	\$130,564,260	
OTHER SERVICES	\$894,934,690	
HOME HEALTH	\$158,800,570	
TOTAL FEE FOR SERVICE (Physicians, Hospitals, NFS, etc.)	\$17,078,676,620	\$17,078,676,620
DENTAL	\$ 765,854,300	\$ 765,854,300
MANAGED CARE	\$5,087,471,500	
SHORT-DOYLE (MENTAL HEALTH)	\$1,369,763,000	
AUDITS/LAWSUITS	\$11,740,600	
EPSDT	\$30,613,500	
MEDICARE BUY-IN	\$1,187,004,700	
STATE HOSPITALS	\$336,503,000	
MISC. NON-FFS	\$2,020,329,000	
RECOVERIES	- \$184,404,000	
GRAND TOTAL MEDI-CAL	\$27,733,552,220	\$17,844,530,920

A proportional, stratified random sample of 800 claims was drawn. The sample size within each strata were determined using the proportion of the total number of claims

¹ Numbers as projected in the Medi-Cal May 2003 Local Assistance Estimate

² Net of rebates

represented by each strata in the sampling period, October 1, 2003 through December 31, 2003 inclusive. The sampling strata and calculated strata sizes are depicted in the table below.

SAMPLE SIZE BY STRATA

Strata	Sample Size
Inpatient (Acute Hospital, NF)	22
Physician Services	204
Pharmacy	426
Other Services & Supplies	116
Dental	32
Total	800

A multidisciplinary team of medical professionals, auditors, analysts and researchers conducted the MPES. Specific MPES objectives were developed to guide data collection for each provider type reviewed in the study. To ensure the integrity of the study, claim data was collected from an on-site review at the provider's offices. This sometimes required numerous contacts with the provider to obtain the documentation. There were five components of the claims review process to confirm the following: (1) that the beneficiary received the service, (2) that the provider was eligible to render the service, (3) that the documentation was complete and billed in accordance with laws and regulations, (4) that the claim was paid accurately, and (5) that the documentation supported medical necessity of the service provided. Reviews were repeated at multiple levels, including a review by Medi-Cal experts, to establish quality assurance. Using the five review components, DHS was able to identify claims that appeared suspicious or potentially fraudulent. The State Department of Justice (DOJ) reviewed those claims that appeared suspicious for potential fraud and abuse to validate DHS' findings.

MPES FINDINGS

- DHS found that 96.43 percent of the dollars in the study sample of 800 claims were billed and paid appropriately, were medically necessary and delivered by an eligible Medi-Cal provider.
- California's MPES results compare favorably to the GAO's fraud, waste, and abuse estimate of 10 percent of total national health care spending as well as to Medicare's annual error rate findings and results of other state Medicaid program payment error studies. Medicare's most recent payment error report found payment errors of 9.3 percent; the MPES results are more than 60 percent less. The Illinois Medicaid study from 1998 reported a payment error of 4.72 percent; the MPES results are 24 percent less. The results of Medi-Cal's PAM study also are favorable when compared to the PAM results of other States. See Appendix III.

- A comparison to other studies relating to the estimated loss due to potential fraud cannot be made because California is the first state to conduct a study that includes an estimate of potential fraud.
- Of the total dollars paid for the claims in the sample, 3.57 percent identified some type of billing or payment error and were thus at risk of being paid in error. The term “at risk” is used because these dollars cannot be considered as potential savings unless all the individual services that are questionable are confirmed as being paid in error through a complete medical record review or audit.
- The amount of dollars at risk due to potential fraud was projected to be \$250 million or 1.57 percent, which is a subset of the overall 3.57 percent of payments at risk for being in error. However, to determine exactly how much of the billing or payment errors identified were indeed attributable to fraud would require a complete criminal investigation.
- Medi-Cal institutional provider types (e.g., hospitals, NF) that involve the largest Medi-Cal expenditures per service and have more Medi-Cal programmatic oversight, such as authorization prior to services being rendered, routine financial audits and licensing and certification reviews, had the highest payment accuracy rates and therefore the lowest error rates. No billing or payment errors were identified in the MPES relative to hospital or NF services, however the sample size for this strata was not large enough to conclude that there are no errors in Acute or NF claims in Calendar Year 2003. The low risk of institutional providers was also confirmed in the PAM. Even with the PAM’s heavy sampling of institutional providers, the study identified relatively few errors.
- Non-institutional providers (physicians, pharmacies, dentists, etc.) are the largest group of providers, have more services provided at a lower cost per service and have less Medi-Cal programmatic oversight, such as fewer services requiring prior authorization and fewer audits. The claims from these providers disclosed the highest error rates. This finding is consistent with risk assessment in DHS’ Interim Anti-fraud Strategic Plan and current focus of the anti-fraud efforts. The PAM study confirmed that the highest risks were associated with non-institutional providers.
- Some errors in the MPES had already been identified by DHS and corrections were being implemented. In addition, of the 611 providers in the claims sample, 41 (6.7 percent) were identified as potentially fraudulent and six had already been identified by DHS independent of the MPES. Administrative actions have been taken against the six providers and cases are being developed on the other 35 providers.
- A total of 58 percent of all billing or payment errors identified resulted from insufficient or lack of documentation either at the billing provider or the referring provider. This does not necessarily mean that the services were not provided or were not medically necessary, and therefore may not represent overpayments. Thus, only 11 percent (\$70 million) of the amount paid in error were related to

medically unnecessary services and can be considered actual overpayments, the remainder would require a more detailed review of the providers and even then a determination of an actual overpayment may not be possible. This is consistent with the findings of the PAM.

- The beneficiary confirmation portion of the study was deemed unreliable. Because of the length of time between the service date and the date the beneficiary was contacted, the responses from the beneficiaries were not consistent when medical documentation was reviewed. The results were not included in the error calculations.

CONCLUSION

The MPES shows that the vast majority of Medi-Cal providers are billing and being paid appropriately. It also shows that DHS' current focus on non-institutional providers, specifically physicians (including groups) and pharmacies, is indeed targeting the area of highest risk for billing errors and potential fraud. The MPES did not find any claims processing errors, which indicates that the prepayment edits and audits used by both Electronic Data Systems (EDS) and Delta Dental appear to be working properly.

The study did identify areas that were at risk for billing or payment error, some of which had previously been identified independent of the MPES. The MPES also found other areas, such as billing code abuses (up-coding to increase reimbursement), as well as inadequate documentation being maintained by the providers to support the claims, that when addressed, will enhance the accuracy of Medi-Cal payments. DHS will use the MPES results to focus its anti-fraud efforts for FY 2004/05 and FY 2005/06 on the areas identified as the highest risk for potential loss. This will include but not be limited to the following action steps:

- Complete the development of cases on the providers identified as potentially fraudulent and take the appropriate action, such as an administrative sanction and/or referral to DOJ.
- Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted.
- Expand the number of investigational and routine compliance audits, (specifically in the area of physicians, physician groups and pharmacies) to provide a more in-depth look at billing code abuses that may not be identifiable through the prepayment edits and audits.
- Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclosure information.
- Develop a plan for educating providers on appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins.

- Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses.
- Evaluate the results of the study to identify where Medi-Cal laws, regulations and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors.
- Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software.
- Use the study findings to develop the methodology and focus of the 2005 MPES.

Much has been accomplished in combating fraud in Medi-Cal. However, the MPES has reinforced the need to remain aggressive in combating fraud, waste and abuse and the need to continue to develop innovative fraud prevention tools and technologies. The MPES has provided DHS with the basis for expanding the Medi-Cal Anti-fraud Strategic Plan for the future and has set the baseline against which anti-fraud efforts can be measured.

MEDI-CAL PROGRAM OVERVIEW

In California, DHS administers the Medicaid (Medi-Cal) program. The Medi-Cal program serves over 6.5 million¹ beneficiaries of which approximately 3.1 million (48 percent) are in the FFS system and the remainders are enrolled in Medi-Cal Managed Care plans. The total benefits budget is approximately \$27.7 billion, of which \$17.8 billion is in the FFS and dental programs, making it one of the largest programs in the nation.

Medi-Cal eligibility is determined at the county level based upon state requirements or by meeting other requirements outside of the states' control, such as disability actions determined by the Social Security Administration (SSA). Once beneficiaries meet the eligibility requirements, they have access to a variety of Medi-Cal programs, including FFS, dental and managed care.

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

Over the past five years there has been a significant focus placed on combating provider fraud in Medi-Cal. Through several anti-fraud initiatives, which increased staffing, as well as changes in laws, regulations and policies, DHS has been able to achieve a significant savings to Medi-Cal and has created new systems to prevent fraud from occurring. DHS' current efforts have focused on physicians, physician groups and pharmacies in the Medi-Cal FFS program. This focus was based on an assessment that these providers have the highest risk for fraud because: (1) they are generating directly or indirectly the largest expenditures and have fewer internal management controls; (2) their number prevents them from being routinely audited by Medi-Cal; and (3) they have fewer services subject to prior authorization. The following are the key elements of the DHS current anti-fraud efforts:

- Enrollments/Re-enrollment

To prevent fraudulent providers from enrolling and remaining enrolled in Medi-Cal, DHS tightened the enrollment process by developing new regulations, applications, provider agreements and internal security protocols to assure the integrity of the provider enrollment process. One of the key elements of the enrollment and re-

¹ Annual Statistical Report Calendar Year 2003, DHS Medical Care Statistics Section

enrollment efforts is a background check and an on-site review of providers by DHS' Audits and Investigations (A&I).

- Moratoriums

Because of the high risk for fraud, DHS has placed moratoriums on new enrollments of Durable Medical Equipment (DME), non-chain laboratories and non-chain, non-pharmacist owned pharmacies in Los Angeles and Adult Day Health Care (ADHC).

- Administrative Sanctions

Administrative sanctions include withhold of payments, temporary suspension from Medi-Cal, Special Claims Review, and prior authorization for services, etc. The sanctions are placed on a provider as a result of field reviews and preliminary investigations.

- Field Audit Reviews

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

- Procedure Code Limitation (PCL)

Medi-Cal and non-Medi-Cal providers that are suspected of abusing certain procedure codes are denied reimbursement when billing with those codes.

- Random Claims Sample

Every week 100 FFS claims are randomly selected for review prior to payment.

- Beneficiary Identification Card (BIC) Re-issuance

The BIC replacement project consists of two components: (1) replacing BICs for Los Angeles County beneficiaries whose cards were possibly subject to identity theft, and (2), replacing all BICs, statewide, with new cards that contain a pseudo Social Security Number (SSN). Providers use the new pseudo numbers and correct issue dates to have their claims adjudicated.

- Research and Development

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

- Medicare Data Match Agreement

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

- Criminal Fraud Referrals

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

APPENDIX II

COMPARISON OF PAYMENT ACCURACY MEASUREMENT AND MEDI-CAL PAYMENT ERROR STUDY

	MEDI-CAL PAYMENT ERROR STUDY (MPES)	PAYMENT ACCURACY MEASUREMENT (PAM)
Results	<ul style="list-style-type: none"> • Billing or Payment Errors – 3.57% • Potential Fraud Billing or Payment Errors - 1.57% 	<ul style="list-style-type: none"> • Billing or Payment Errors – 1.6%
Funding	50% State Funds/50% Federal Funds	100% Federal Funds (Federal Grant)
Project Designed By	Department of Health Services Audits & Investigations	Centers for Medicare and Medicaid (CMS). Project Guidelines were outlined in the federal grant.
Sampling Plan Designed by	Medical Care Statistics Section	CMS
Objective	<p>The objectives of the project are:</p> <ol style="list-style-type: none"> 1. Measure the amount of errors in the Medi-Cal FFS claims payment system 2. Identify the amount of potential fraud or abuse in Medi-Cal. 3. Identify the vulnerabilities of the Medi-Cal program. 	<p>To develop state level estimates of Medicaid payment errors. The state level measurements will be aggregated into a national accuracy rate for Medicaid.</p> <p>The project focus is on the accuracy of the payment, including overpayments as well as underpayments.</p>
Universe	FFS claims paid between October 1, 2003 and December 31, 2003	<p>Claims paid between October 1, 2003 and December 31, 2003</p> <p>FFS claims and managed care capitated payments to managed care contractors</p>
Method of allocating sampling units to strata	The proportion of <u>total claims</u> paid for the line items represented by each strata in the sampling period October 1, 2003 through December 31, 2003 inclusive.	The proportion of the <u>total dollars</u> paid for the line items represented by each strata in the recent four quarters prior to sampling period.
Sample Size	800 FFS (medical & dental) claims	<ol style="list-style-type: none"> 1. 864 FFS (medical & dental) claims Subset-60 beneficiaries for eligibility review 2. 864 managed care capitated payments for managed care beneficiaries to managed care contractors. Subset-60 beneficiaries for eligibility review.
Sampling Unit	Entire claim	Claim line
Confidence Level	95%	95%
Level of Precision	+/-3%	+/-3%
Sampling Methodology	Proportional stratified random sampling	Proportional stratified random sampling

	MPES	PAM																																
Strata & Sampling Unit Differences	<p>FFS/DENTAL</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>1. Inpatient</td><td style="text-align: right;">22</td></tr> <tr><td>2. Physician Services</td><td style="text-align: right;">204</td></tr> <tr><td>3. Pharmacy</td><td style="text-align: right;">426</td></tr> <tr><td>4. Other Services & Supplies</td><td style="text-align: right;">116</td></tr> <tr><td>5. Dental</td><td style="text-align: right;"><u>32</u></td></tr> <tr><td>Total</td><td style="text-align: right;"><u>800</u></td></tr> </table> <p>BENEFICIARY CONFIRMATION 481</p>	1. Inpatient	22	2. Physician Services	204	3. Pharmacy	426	4. Other Services & Supplies	116	5. Dental	<u>32</u>	Total	<u>800</u>	<p>FFS/DENTAL</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>1. Inpatient Hospital</td><td style="text-align: right;">187</td></tr> <tr><td>2. Nursing Facilities</td><td style="text-align: right;">175</td></tr> <tr><td>3. Physician Services</td><td style="text-align: right;">143</td></tr> <tr><td>4. Prescription Drugs</td><td style="text-align: right;">247</td></tr> <tr><td>5. Home & Community Based Services</td><td style="text-align: right;">16</td></tr> <tr><td>6. Other Services & Supplies</td><td style="text-align: right;">53</td></tr> <tr><td>7. Dental</td><td style="text-align: right;"><u>43*</u></td></tr> <tr><td>Total</td><td style="text-align: right;"><u>864</u></td></tr> </table> <p>MANAGED CARE 864</p> <p>BENEFICIARY ELIGIBILITY</p> <table style="width: 100%; border-collapse: collapse;"> <tr><td>1. FFS/Dental</td><td style="text-align: right;">60</td></tr> <tr><td>2. Managed Care</td><td style="text-align: right;">60</td></tr> </table> <p>*For purposes of PAM grant reporting, dental has been combined into other services & supplies.</p>	1. Inpatient Hospital	187	2. Nursing Facilities	175	3. Physician Services	143	4. Prescription Drugs	247	5. Home & Community Based Services	16	6. Other Services & Supplies	53	7. Dental	<u>43*</u>	Total	<u>864</u>	1. FFS/Dental	60	2. Managed Care	60
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Attempt to estimate error rate related to potential fraudulent claims	Yes	No																																
Review beneficiary eligibility	No	Yes																																
Beneficiary confirmation of product	Yes	No																																
Validate medical necessity	Yes	No																																
Key Findings	<ul style="list-style-type: none"> • A total of 96.43 percent of the dollars in the study sample of 800 claims was billed and paid appropriately, were medically necessary and delivered by an eligible Medi-Cal provider. • A total of 3.57 percent of the dollars in the sample had some indication of billing or payment error, which equates to \$568 million in annual payments that are “at risk” of being paid inappropriately. • Of the 3.57 percent, 1.57 percent disclosed characteristics of potential fraud, which equates to \$253 million annually are “at risk” to potential loss due to fraud. • The MPES results compare favorably to (1) the GAO’s fraud, waste and abuse estimate of 10 percent, (2) Medicare Program’s 2004 report estimate of 9.3 percent and the study conducted by Illinois in 1998 that reported 4.72 percent. 	<ul style="list-style-type: none"> • Using the PAM methodology, the Medi-Cal accuracy rate was 98.4 percent or 1.6 percent of the payments had some indication of billing or payment error. • The results compare favorably with 2002/03 PAM studies from 11 participating states, the average error rate was 4.3 percent. • The primary error was insufficient or no documentation. • The majority of the errors were from claims submitted by non-institutional providers. • The PAM did identify four beneficiaries in Managed Care that were not Medi-Cal eligible. 																																

	MPES	PAM
Key Findings (cont.)	<ul style="list-style-type: none"> • A comparison to other studies relating to the estimated loss due to potential fraud cannot be made because California is the first state to conduct a study that includes an estimate of potential fraud. • Errors ranged from simple mistakes such as coding errors, to potential fraud such as forged physician signatures and filling prescriptions in excess of the prescribed amount. • All errors were found in the non-institutional providers (Physicians, Pharmacies, DME, etc.) category, of which 71 percent were in the Pharmacy and Physician service category. • Over half of the errors related to no documentation or insufficient documentation either at the billing provider or at the referring provider. • Some errors identified in the MPES had already been identified by DHS independent of the study and corrections were being implemented. • Six of the 41 providers identified as submitting claims suspicious of fraud has already been identified by DHS and administrative sanction had been taken. • Findings from the beneficiary confirmations were deemed unreliable and not used in computing the results of the MPES. 	
Potential Fraud Claims	45	N/A
High risk provider groups	<ul style="list-style-type: none"> • Physician Services • Pharmacies 	<ul style="list-style-type: none"> • Physician Services
Recommendations	<ul style="list-style-type: none"> • Complete the development of cases on the providers identified as potentially fraudulent and take the appropriate action, such as an administrative sanction and/or referral to DOJ. • Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted. • Expand the number of investigational and routine compliance audits, (specifically in the area of physicians, physician groups and pharmacies); to provide a more in-depth look at billing code abuses that may not be identifiable through the pre- 	<ul style="list-style-type: none"> • Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted. • Expand the number of investigational and routine compliance audits to provide a more in depth look at billing code abuses and split coding that may not be identifiable through the pre-payment edits and audits. • Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclose information. • Develop a plan for educating providers on

	<p>payment edits and audits.</p> <ul style="list-style-type: none"> • Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclosure information. • Develop a plan for educating providers on appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins. • Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses. • Evaluate the results of the study to identify where Medi-Cal laws, regulations and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors. • Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software. • Use the study findings to develop the methodology and focus of the 2005 MPES. 	<p>appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins.</p> <ul style="list-style-type: none"> • Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses. • Evaluate the results of the study to identify where Medi-Cal laws, regulations and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors. • Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software. • Work with the counties to ensure that eligibility re-determinations are appropriate and completed in a timely manner and that computer systems are operating properly. • Add rates to the file so Medi-Cal field office staff can choose the most appropriate reimbursement based on level of care needed.
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HOW CALIFORNIA COMPARES TO OTHER STATES AND MEDICARE

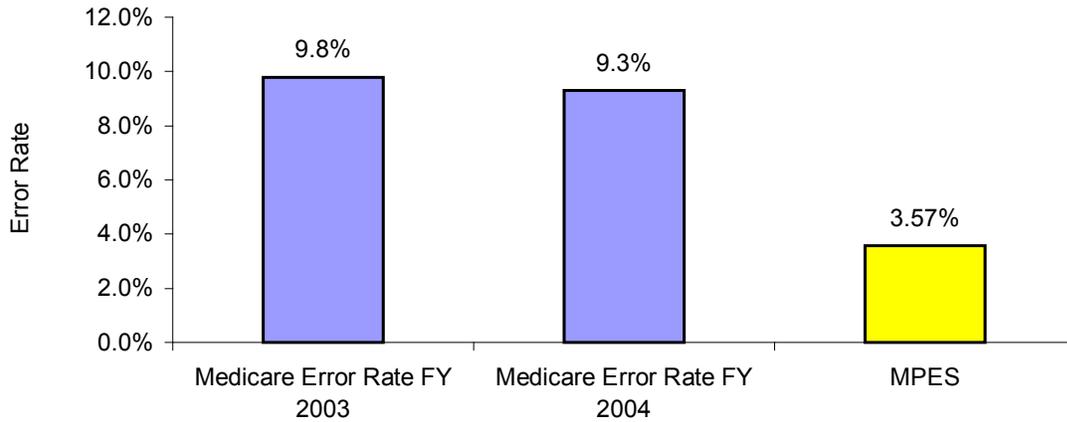
The U.S. General Accounting Office (GAO) reported that estimates of losses resulting from fraud and abuse vary widely, but the most common is 10 percent of the nation's health care spending. Malcom Sparrow also quotes the GAO estimate in his book, License To Steal, How Fraud Bleeds America's Health Care System, but goes on to say that the actual amount of fraud, waste and abuse in America's health care system is unknown, because it had not been systematically measured. Over the past several years more and more government programs have started performing systematic measurement studies. California's MPES showed that 3.57 percent of the dollars were at risk of being paid inappropriately, which is 64.3 percent less than the 10 percent estimate used by the GAO.

Comparing California's study results with other states and federal efforts to measure payment accuracy or error rates is difficult because of inconsistent study design. For example, the California MPES was the first study that included a determination of potential loss due to fraud. Many studies evaluated only the accuracy of claims processing and payment, while others evaluated every aspect of the claim, including whether the medical service was necessary. One of the other key differences between the MPES and other studies was in the approach to collection of provider documentation. California collected data by going to the provider's location for all providers in the sample and these visits were unannounced to non-institutional providers. This included visits not only to the dispensing provider but also to the prescribing provider to ensure there was documentation to support the medical necessity claim. California believes on-site data collection provides greater integrity of the data and also results a lower percentage of the total errors caused by non-response to data requests. This process also maximized the completeness and accuracy of the MPES sample. In addition to study design, other critical components of the studies are difficult to compare. For example, the experience and training of the review staff can greatly impact error identification and interpretation. However, there is one common finding in all the studies. By far the most common error in all the studies was provider documentation, either no documentation or insufficient documentation.

While the study designs may not be identical the following will provide some indication of how California compares to Medicare and other states.

Medicare has been evaluating its error rate since 1996. Medicare's Fee-For Service Error Reports for Fiscal Year 2003 and 2004 disclosed error rates of 9.8 percent and 9.3 percent respectively. The Medi-Cal payment error rate of 3.57 percent is over 60 percent less than Medicare error rates for each of the last two years (Figure I).

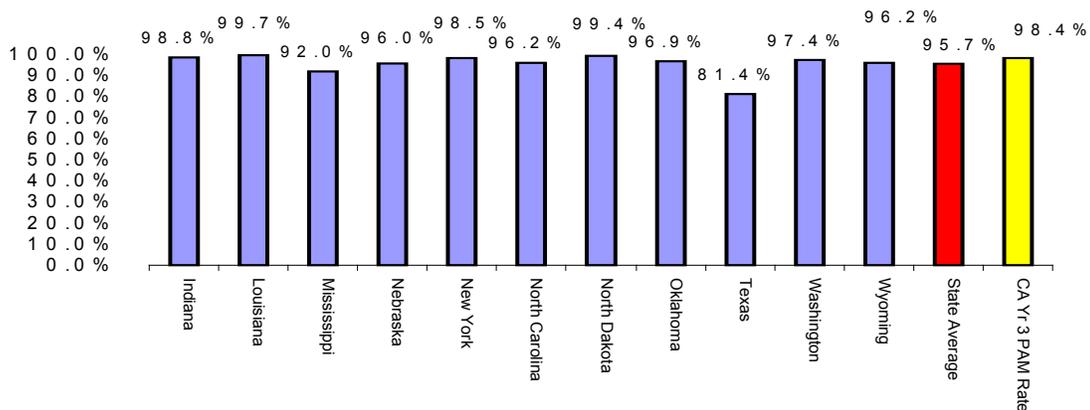
Figure 1
Comparison of MPES To National Medicare Error Rate Study



The State of Illinois conducted a Payment Accuracy Review of their Medical Assistance Program in 1998. The Illinois study was designed to measure payment accuracy and did not attempt to measure potential fraud. However, their methodology was otherwise similar to the one used for the MPES. The Illinois study identified a payment accuracy rate of 95.28 percent for an error rate of 4.72 percent, which was 24 percent greater than Medi-Cal.

The PAM studies required participants to utilize similar methodologies, making comparisons among states somewhat easier than comparisons between independently designed studies, such as the one used by Medicare. Also PAM study protocols do not change significantly from one year to the next, so a comparison between Year 2 PAM states' results and Year 3 results for California can be made. The 11 states participating in the Year 2 PAM studies disclosed an average payment accuracy rate of 95.7 percent. California's Year 3 PAM accuracy rate of 98.4 percent compares favorably to the average payment accuracy rate, and is higher than 7 of the 11 participating Year 2 PAM states (Figure II).

Figure II
P A M Year 2 F F S Accuracy Rate Results Accuracy Rate



SAMPLING AND ESTIMATION METHODOLOGY

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

SAMPLING PLAN

Sampling Unit

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

Universe of Claims Paid In Study

The sampling universe consisted of Medi-Cal FFS claims paid through the fiscal intermediary, Electronic Data Systems, as well as dental claims paid through Delta Dental during the months of October 1, 2003 through December 31, 2003 inclusive (Table I). Claims with zero payment amounts and adjustments were excluded from the universe. However, all adjustments to a sampled claim that occurred within 60 calendar days of the original adjudication date were included. Dental claims do not report the adjudication date. Therefore, the check date was used as a substitute for the adjudication date for dental claims.

Table I – Claims Paid In Universe By Strata

Strata	Claims	Dollars Paid	Percentage of Total Paid
Inpatient	783,253	\$1,614,877,124	2.71%
Physician Services	7,365,371	\$662,724,087	25.46%
Pharmacy	15,416,063	\$1,249,308,104	53.28%
Other Services & Supplies	4,210,841	\$352,281,834	14.55%
Dental	1,157,189	\$165,107,141	4.00%
Total	28,932,717	\$4,044,298,292	100.00%

Sample Size

The sample size selected was 800. The sample size was estimated to ensure a 95 percent confidence level with a +/-3 percent precision.

Sample Stratification

A proportional stratified random sample was drawn. The sample observations were divided into five strata:

Strata 1 – Inpatient

Strata 2 – Physician Services

Strata 3 – Pharmacy

Strata 4 – Other Services & Supplies

Strata 5 - Dental

The sample size within each strata were determined using the proportion of the total number of claims represented by each strata for claims paid between the dates of October 1, 2003 through December 31, 2003 inclusive (Table I). The sampling strata and calculated strata sizes are depicted in Table II.

Table II – Sample Size By Strata

Strata	Sample Size	Dollars Paid
Inpatient	22	\$46,447
Physician Services	204	\$19,525
Pharmacy	426	\$38,561
Other Services & Supplies	116	\$11,162
Dental	32	\$3,472
Total	800	\$119,167

ESTIMATION

Payment Error Rate

DHS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits¹. To calculate the payment error rate, the following steps were utilized. First, dollars for services included in the sample that were paid correctly were totaled by strata and divided by the total payments for all services in the sample. This resulted in payment accuracy rates for each of the five strata. Second, each of the accuracy rates for the five strata were weighted by multiplying the payments made for services in the corresponding universe stratum and summed to arrive at an overall estimate of payments that were made correctly. Third, this estimate of the correct payments was divided by the total payment made for all services in the universe to arrive at the overall payment accuracy rate. The estimated annual payments made correctly was calculated by multiplying two quantities: 1) the payment accuracy rate, and 2) calendar year 2003 Medi-Cal FFS and dental payments. Finally, the error rate and estimated annual dollars paid in error were calculated as follows:

- 100 percent - Overall Accuracy Payment Rate = Overall Payment Error Rate

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

- Payment Error Rate X Calendar Year 2003 Medi-Cal FFS and Dental payments (see Table 1)

Table III- Calculation of Payment Accuracy and Error Rate By Strata

Strata	Dollars Paid in Sample Strata	Dollars Found to be Paid Correctly After Review	Payment Accuracy Rate by Strata	Payment Error Rate
Inpatient	\$46,447	\$46,447	100%	0.00%
Physician Services	\$19,525	\$18,176	93.09%	6.91%
Pharmacy	\$38,561	\$36,764	95.34%	4.66%
Other Services & Supplies	\$11,162	\$10,553	94.54%	5.46%
Dental	\$3,472	\$3,024	87.10%	12.90%

Table IV – Overall Estimate of Payments Made Correctly and Incorrectly

Strata	Total Dollars Paid for Services in Strata Universe (4th Qtr 2003 FFS Medi-Cal/ Dental and Paid Claims)	Payment Accuracy Rate by Strata	Overall Estimate of Payments Made Correctly by Strata in 4th Qtr 2003	Overall Estimate of Payments Made Incorrectly by Strata in 4th Qtr 2003
Inpatient	\$1,614,877,124	100%	\$1,614,877,124	\$0
Physician Services	\$662,724,088	93.09%	\$616,939,986	\$45,784,102
Pharmacy	\$1,249,308,105	95.34%	\$1,191,106,607	\$58,201,498
Other Services & Supplies	\$352,281,835	94.54%	\$333,034,759	\$19,247,076
Dental	\$165,107,141	87.10%	\$143,802,994	\$21,304,147
Total	\$4,044,298,293	N/A	\$3,899,761,470	\$144,536,823

Confidence Intervals

Confidence limits were calculated for the payment accuracy rate and error 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 or incorrect 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 and error rates.

Formulas

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

Let

\hat{H} = estimated payment accuracy rate

\hat{Y} = estimate of dollar value of accurate payments

X = known dollar value of total payments in the universe

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

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

x_h = sample estimate of the dollar value of the total payments for stratum h

The formula for the payment accuracy rate estimate is as follows:

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

where

$$\hat{Y} = \sum_{h=1}^3 (y_h / x_h) X_h$$

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

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

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

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

$$\text{lower limit} = \sum_{h=1}^3 (y_h / x_h) X_h - 1.96S$$

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

$$S = \sqrt{S^2} = \sqrt{\sum_{h=1}^3 S_h^2}$$

$S_h^2 = A_h B_h$, where

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

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

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

REVIEW PROTOCOLS

Processing Review Protocol

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

Medical Review Protocol

Documentation Retrieval for Claim Substantiation

To ensure integrity of the documentation, a multidisciplinary team of staff collected the data from the providers in person. Prescribing or referring providers were visited or contacted by phone to obtain the documents supporting the ordered service. In some cases, many requests were necessary to make the documents for the claim review complete. These efforts occurred at multiple levels of the medical review process.

First Level Medical Review

The initial reviews of claims were done at multiple field offices. This consisted of a first review by the staff member who collected the data and then a second review by supervisors and licensed medical staff (e.g. physicians, dentists, and registered nurses).

All claims were reviewed for the following components: (1) that the episode of treatment was accurately documented, (2) the provider was eligible to render the service, (3) the documentation was complete, (4) the claims were billed in accordance with laws and regulations, (5) the payment of the claim was accurate, and (6) for inpatient and direct physician service claims, documents to substantiate medical necessity were also evaluated.

Second Level Medical Review

To ensure consistency and accuracy of the first level review findings, a Peer Review Committee (Committee) of Medical Consultants and a Dental Consultant subjected all claims with dollar errors to another review. The Committee gave a consensus opinion on all aspects of the six components listed above and consulted with other specialists, such as pharmacists and optometrists, when needed. In addition, Medical program specialists were also consulted to ensure accuracy. For example, pricing errors were confirmed with EDS or Delta Dental, and provider eligibility errors were confirmed with DHS Provider Enrollment Branch (PEB).

Third Level Medical Review

The third level review consisted of two parts: (1) all claims identified as potentially fraudulent were reviewed and confirmed by DOJ, and (2) the Chief Medical Consultant for the Medi-Cal program reviewed all errors to ensure that all errors were consistent with existing Medi-Cal policy.

Quality Assurance of Non-Errors Protocol

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

Medical Review Protocol for Assessing Potentially Fraudulent Claims

Level I Review

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

Level II Review

Service medically necessary or not.

Level III Review

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

- 1) Medical records were submitted but documentation of the billed service does not exist and is out of context with the medical record
- 2) Context of claim and course of events laid out in the medical record did not make medical sense
- 3) No record that the beneficiary ever received the service
- 4) No record to confirm the beneficiary was present on the day of service billed
- 5) Direct denial that the service was ever ordered by the listed referring provider
- 6) Cooperation and attitude of providers and their office staff when contacted by the DHS
- 7) Level of service billed was markedly outside of the level documented
- 8) Policy violations that were illegal or outside accepted standards of ethical practice or contractual agreements
- 9) Medical record discrepancies coupled with a failure to run a legal business and fulfill licensing requirements
- 10) Medical record discrepancies coupled with the fact that provider had a prior negative record of sanctions with DHS
- 11) Medical record discrepancies for services with a historical record of abuse
- 12) Multiple types of errors on one claim

- 13) Billing for a more expensive service than what was documented as rendered
- 14) No actual place of business at the provider site listed

Level IV Review

Review of provider's billing patterns, presence of stereotyped errors or other suspicious activity not necessarily apparent on the claim under review for the MPES

Level V Review

DOJ review to confirm agreement with designation as "at risk for potential fraud."

Beneficiary Confirmation Methodology

Beneficiary Confirmation Sample Selection

A subset of beneficiaries was selected from the claims reviewed for contact by phone regarding the services that were claimed for and paid. After removing the sensitive cases such as HIV/AIDs, reproductive health among others and duplicate claims from the original 800 claims, there were 481 beneficiaries left in the confirmation subset. Of this subset, 98 beneficiaries or their legal representatives were successfully contacted by eligibility specialists. The selected beneficiaries were contacted by phone and interviewed regarding services received using a predetermined set of questions. The eligibility of the beneficiaries to participate in the Medi-Cal program was not determined as it was not a part of the scope of this study.

Beneficiary Survey Methodology

The Spanish-speaking beneficiaries were assigned to Spanish speaking staff. Staff attempted to contact the beneficiaries by phone. If there was no response to the first attempt, one follow-up phone call was attempted. When reached, staff executed the script and completed the survey instrument provided by the study's design team.

SUMMARY OF ERRORS

There were 73 FFS medical provider errors and seven dental provider errors for a total of 80 errors in the 800 claims sampled. The total dollars associated with these errors were used to compute the payment error rate of 3.57 percent. These errors were also used to identify the program vulnerabilities and determine the areas of greatest risk for loss to the Medi-Cal program. A summary of the findings by type and strata is presented below. Also provided is a summary of the results of the beneficiary confirmations, but the results of the confirmations were questionable and not included as errors in the MPES. See Appendix IX for explanation of the error reason codes and Appendix VIII for explanation of each error.

Medical Provider Errors

There were a total of 73 errors identified in the MPES for medical providers. Errors were placed into 2 categories: processing errors (9) and medical review errors (64).

Number of Medical Errors by Medical Provider Type

Error Type	Inpatient Hospital and Nursing Facilities	Physician Services	Pharmacy	Other Services and Supplies	Total FFS
Processing Errors					
Pricing Errors		4	2		6
Ineligible Provider		2		1	3
Medical Review Errors					
No Documents		1	7	1	9
Insufficient Documentation		11	8	7	26
Coding Errors		7	2		9
Medically Unnecessary		1	7	2	10
Policy Violation			10		10
Totals	0	26	36	11	73

Summary statistics table and notable findings, by review type:

Processing Errors

Processing errors had two causes identified: pricing errors and ineligible provider. The first cause was found in the Family Planning, Access, Care and Treatment (FPACT) program where certain family planning drugs and supplies were not billed at cost as required but up to the maximum on file. The second cause was due to ineligibility of the provider who rendered the services. This type of error was found in one claim for Comprehensive Perinatal Services Program (CPSP), one for FPACT services, and for one DME provider who did not have the proper license to dispense the product. There were no errors found attributable to either EDS' or Delta Dental's claims adjudication processes.

Medical Review Errors

Medical errors were comprised of claims with no documentation, claims with insufficient documentation, coding errors (up-coding), claims where the documentation did not support the necessity of the service, and claims paid which were in conflict with policy.

Examples:

- No documentation: A claim was made for collecting and handling a blood specimen. However, the medical record reveals no blood was drawn.
- Insufficient documentation: A claim was made for a drug screen where the laboratory could not produce the order for the test.
- Medically unnecessary services: A claim was made for incontinent supplies. However, the progress notes of the treating physician did not mention any incontinence problem and the form requesting "In Home Support Services" during the same month as the bill for the incontinent supplies, indicated the patient was continent.
- Up coding: A claim for high complexity office visit for a new patient was billed. However, this claim was for a returning patient with a minor problem.
- Payment in conflict with policy: A pharmacy claim was billed for a drug to treat diabetes. However, the drug that was prescribed was used to treat constipation. Such usage for this drug is against federal guidelines and requires a TAR for Medi-Cal reimbursement. No TAR was obtained.

Summary statistics table and notable findings, by strata:

Inpatient

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

Physician Services

These included payments made to physician services, FPACT, CPSP providers, among others. The majority of these errors were due to poor documentation and up-coding.

Examples:

- A claim for a rural health clinic visit for prenatal services had very minimal documentation provided except for the billing sheet. There was no documentation for the educational session that was billed.
- A claim was made for a highly complex visit when presenting problem and treatment was for an uncomplicated urinary tract infection.

Pharmacy

Errors in pharmacy claims were due to both the pharmacies making errors and to errors found in the prescriber's documentation.

Pharmacy errors:

- Not producing the prescriptions or invoices for drugs.
- Not following prescription instruction and dispensing different amount of medication or a different strength of the drug.
- Double billing where a clinic and pharmacy billed for the same service.

Prescriber errors:

- Prescribing drugs unnecessary to meet the patient's need. In one instance, Silvadene cream, which is used for severe burns, was prescribed for simple sunburn.
- No medical record documentation to support the need for the medication. The medical records did not mention any problem in this area or that the medication had been ordered. For example, a physician said he prescribed Miconazole cream; a drug used to treat vaginal yeast infections, for a diabetic patient, but forgot to chart it.

Other Services & Supplies

Included in this category were Labs, DMEs, medical supplies, Adult Day Health Care (ADHC) facilities, Local Education Assistance (LEAs) programs among others. Again, the major finding was lack of documentation.

Examples:

- A claim for health and mental evaluation/education provided in a school. The school provided only a daily log for the date of service, with the column named

“psyche social” marked for this beneficiary. The school representative stated that the daily log was the progress notes.

- A claim for ADHC where there was no documentation to support that the beneficiary was at the center on the date the services were claimed.
- A claim for Lab services where there was no documentation for a physician’s order and the physician denied ordering the tests.
- A claim for incontinent supplies where the physician did not sign the prescription and the physician confirms that he did not authorize the products.

Dental Provider Errors

Seven dental claims were noted as having errors. Out of seven errors identified, four were also identified as poor standard of care and abusive. Referrals have been made to the Dental Board on the abusive providers.

Dental errors were in the following types:

Dental Errors by Type

Insufficient Documentation	2
Coding Errors	1
Medically Unnecessary Services	4
Total	7

Examples:

- Insufficient documentation: claims on which a provider billed for more dental x-rays than documented.
- Coding errors: a claim for a prophylaxis fluoride treatment on which the provider documented only prophylaxis and not the application of fluoride.
- Medically necessary services: a claim for a complete set of x-rays when there was no need to do so. Provider had taken a similar set of x-rays the year before. With the patient’s history of minimal dental problems, there was need for the services.
- Substandard dental care:
 - Exposing a patient to unnecessary dental x-rays.
 - Provider fails to identify the cause of a patient’s pain.
 - Provider places a filling without the benefit of a diagnostic x-ray.
 - Provider extracted four teeth that could have been treated more conservatively and prevented the loss to the patient. Provider also attempted to split billing codes for the extractions to increase revenue.

Beneficiary Confirmation Findings

The initial claim sample size was 800. After eliminating the sensitive cases and multiple claims, there were 481 beneficiaries to interview with the questionnaire. Beneficiaries affirmatively responded 91 times when asked if the surveyor was speaking to the Medi-

Cal beneficiary. There were also six parents of children beneficiaries who responded, and one conservator, for a total of 98 responses.

Of those 98 respondents, 12 responded negatively. They indicated that they did not receive the services, that the provider did not provide the billed item, or both. Review of the medical records showed these negative responses might not have been reliable. Some beneficiaries or their parents had signed for services they did not remember receiving. One beneficiary was actually seen at the clinic by a nurse practitioner but the claim had a physician's name for the provider and the beneficiary did not recognize the physician's name. There was no indication the service was claimed more than once.

All of the negative responses have a viable explanation why the beneficiary may have been unaware of the service or provider. The results of the questionnaire did not indicate any wrong doing on the part of the claiming providers.

Because the results of the beneficiary confirmations were deemed not to be reliable, they were not included as errors.

POTENTIAL FRAUD CLAIMS

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

The MPES review protocols called for the medical review team to examine each claim for potential fraud or abuse (Appendix V). There were 611 providers represented in the original 800 claims sample. A total of 45 claims submitted by 41 providers were found to be suspicious of potential fraud. DOJ reviewed all claims so designated and concurred with DHS’ assessment. Of the 41 providers identified as submitting potentially fraudulent claims, six had independently been identified by DHS and were already in case development or on administrative sanction when the study was conducted. The other 35 providers are undergoing further review to determine if further action is needed.

The following table summarizes the types of errors found:

Breakdown of Suspicious Claims by Type of Service and Error Code

Provider Type	Number of Suspicious Claims	Billing Provider did not Submit Documents (MR1A)	Referring Provider did not submit documents (MR1B)	Poor Documentation Submitted (MR2A)	Service not documented at all (MR2B)	Coding Error (MR3)	Medically Unnecessary (MR5)	Policy Violation (MR7)	Pricing Error (P5)	Ineligible Provider (P9)
Dental	1						1			
Pharmacy	19	4	1	1	2	2	4	5		
Other Providers and Clinics										
Podiatrist	1				1					
Dialysis Services (M.D.)	1				1					
Office Visits (Individual providers, group providers, and hospital outpatient clinics)	9	1			3	5				
FPACT services	2								1	1
CPSP services	3				1		1			1

Provider Type	Number of Suspicious Claims	Billing Provider did not Submit Documents (MR1A)	Referring Provider did not submit documents (MR1B)	Poor Documentation Submitted (MR2A)	Service not documented at all (MR2B)	Coding Error (MR3)	Medically Unnecessary (MR5)	Policy Violation (MR7)	Pricing Error (P5)	Ineligible Provider (P9)
Other Services and Supplies										
ADHC	3				1		2			
DME	2			1						1
Laboratory	1				1					
School Services (LEA)	3	1		2						
TOTALS	45	6	1	4	10	7	8	5	1	3

Documentation Errors

Documentation errors dominated among suspicious claims. For 21 claims there was simply no documentation or insufficient documentation to support the visit or procedure claimed. Some of these omissions may represent sloppy record keeping. Others may hint at serious fraudulent activity that warrants a comprehensive, detailed investigation of claiming patterns and medical records at the provider's site. Sloppy record keeping makes the system vulnerable to fraud, waste and abuse because auditors may be unable to judge whether the service claimed was actually performed. An example of a documentation error identified by MPES is a CPSP provider who billed for education and counseling services, but had no record that this service was done.

Medical Coding Errors

There were seven suspicious claims with medical coding errors. While it is common for documentation to be somewhat scanty, perhaps not quite justifying the level claimed, a few claims had discrepancies that were blatant enough to cross the threshold into the suspicious category. One physician, for example, billed the code 99213 (established patient, level 3, office visit). To bill this code, a provider must document an expanded problem-focused history and/or examination, and medical decision making of low complexity. In this case, the patient was seen for routine exam. No problems were identified and the decision was to return in six months. A 99212-code visit would have been the appropriate code for a problem-focused history and/or exam, and straightforward decision-making.

Medically Unnecessary Services

Eight claims were found to be suspicious due to lack of medical necessity. Medical necessity is inherently difficult to judge, so only the most clear-cut discrepancies were designated as suspicious claims. For example, one physician clearly wrote that the

patient was continent of bladder and bowel (i.e. NOT incontinent.) Even so, the physician signed a prescription for incontinent supplies. Another provider billed for a pregnancy test, even though the patient had been on continuous birth control (Depo-Provera), did not have symptoms of pregnancy, and was not yet due for her menstrual period. In this case a pregnancy test was judged to be completely unnecessary.

Medically unnecessary services were also found in ADHC claims. For example, a patient who lived independently received ADHC, a service, which is reserved for patients who would otherwise be at risk for long-term nursing care. In another case, the ADHC forged a physician's signature on a TAR in order to get approval for ADHC services, which the physician had stated were not necessary.

Policy Violation

Five suspicious pharmacy claims fell into this category. For example, one pharmacist filled a prescription with three times the number of tablets prescribed. Another pharmacist substituted a different medication from the one prescribed. These changes were medically inappropriate and they resulted in excess reimbursement to the pharmacist.

Ineligible Provider

Three claims were assigned the Ineligible Provider error code. An example of this category is a DME provider who was billing from a site that did not have the appropriate Home Medical Device Retailer (HMDR) license. Further review revealed that this provider was on SCR for abusive billing of incontinence supplies at another location. The other two claims involved rendering providers who were not enrolled in Medi-Cal.

Pricing Error

One claim had a pricing error. This was a FPACT provider who mispriced an item that should be billed at invoice cost, but instead billed Medi-Cal the maximum level.

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

Error Type	Potential Fraud Identified	No Potential Fraud Identified
No Documentation Submitted (MR 1)	On site visit, the provider's place of business was abandoned and all telephone numbers associated with the provider were either disconnected or inaccurate.	Medical necessity could not be validated because the prescribing physician had retired.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
Poor Documentation (MR2)	The claim was for a nail trimming procedure for 6 or more nails. The record does not document any nail debridement, or any patient complaints or physical findings suggesting the need for nail trimming.	The claim was for 17 laboratory tests billed by a hospital. The only medical records available from the hospital were the laboratory results themselves and radiograph results. However, in looking at other claims data on the same beneficiary, it appears the tests were performed pre-operatively for a liver transplant. There was ample documentation of the need for a transplant. These surgeries are commonly cancelled at the last minute for many reasons. Thus, there was nothing particularly suspicious about the claim and it appeared the hospital had likely mis-filed the records.
Coding Error (MR3)	A level four-office visit for a new patient (reimbursement higher than an established patient). However the patient is well established. In addition, the detailed level billed was not supported by the documentation. The multiple levels of errors add to the suspicion on this claim.	The claim is for individual family planning counseling. However, the patient was seen for the follow-up for an abnormal mammogram. An office visit code and not a family planning code would be more appropriate. There is a very small difference in reimbursement rates (\$0.97). The error appears to be unintentional miscoding.

Error Type	Potential Fraud Identified	No Potential Fraud Identified
Medically Unnecessary Service (MR5)	A pharmacy claim for a calcium supplement for a male patient. There was no supporting diagnosis or mention of the need for the supplement in the medical record. Furthermore, all the progress notes by this cardiologist provider were very scant and the medical necessity of many of the medical procedures performed on the patient highly doubtful.	A pharmacy claim for antibiotic eardrops. The doctor's progress note reveals the patient was seen for ear pain but there is no documentation of a history or exam regarding the ear. However, there was an undated telephone order for the drug. There was no clear documentation of medical necessity but sufficient contextual evidence that it likely was prescribed. Furthermore, there was a lack of any other suspicious indicators.
Policy Violation (MR 7)	A pharmacy claim for 10 tablets of Vicodin (a schedule II controlled substance, narcotic pain reliever.) The practitioner did not have a permit to prescribe controlled substances. The pharmacist is responsible to verify that the prescriber is a licensed person with a DEA (Drug Enforcement Administration) permit. Filling this prescription was illegal, and there is a potential for fraud since the pharmacist received payment for a drug illegally prescribed.	A pharmacy claim for a diabetes medication. The medication has the side effect of causing diarrhea. The medication was used to treat constipation, which is not a Federal Drug Administration-approved use of this medication. This was against Medical Cal policy unless a TAR was obtained. No TAR was submitted for the claim. Likely the pharmacy would assume the medication was for diabetes and would not know that the provider had prescribed the medication for this uncommon purpose. Thus, there was a policy violation but no apparent intent of fraud.

APPENDIX VIII

DETAIL OF REASONS FOR ERRORS

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
45	2 - Physician Services	MR-2B (Poor documentation)	<i>This claim was for code 90925 (end stage renal disease-related physician services, per day, patient 20 years old and over). The claim was for six days of physician hemodialysis services at \$16.62 per day, for a total of \$99.72. The physician's notes fail to document any physician services for four of the dates of service in question. Thus, the error claim was calculated as the cost of the four days at \$16.62 per day, or \$66.48 overpaid.</i>	\$ 99.72	\$ 33.24	\$ 66.48
55	2 - Physician Services	MR-3 (Coding error)	<i>This claim was for an office visit, level-4 four (99214), which requires at least two of the following three elements: a detailed history, detailed exam, and medical decision-making of moderate complexity. The medical documentation revealed a visit for a straightforward urinary tract infection. This visit included only one of the three components (detailed exam), and therefore did not qualify to bill code 99214. A lower level code, such as 99213, would have been appropriate. Therefore, the overpayment was calculated as the difference between the payment for code 99214 (\$40.00) and the amount, which would have been paid for code 99213 (\$24.00). \$40 - \$24 = \$16.00 overpaid.</i>	\$ 40.00	\$ 24.00	\$ 16.00
57	2 - Physician Services	MR-2B (Service not documented at all)	<i>This claim was for 15 minutes of individual health education (code Z6410). However, there was no documentation of education services to the patient. The visit was essentially a routine prenatal care office visit. The provider had exhausted their limit of office codes allowed by the Comprehensive Perinatal Services Program and thus billed a health education code instead. The error was the total amount paid.</i>	\$ 8.41	\$ -	\$ 8.41
59	2 - Physician Services	P-5 (Pricing error)	<i>This claim was for 12 condoms (X1500). The clinic billed \$16.00 for 12 condoms, even though they are required to bill for condoms AT COST. The wholesale invoice reveals that they paid \$.57 each, plus tax for these</i>	\$ 44.62	\$ 38.90	\$ 5.72

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>condoms, so they should have billed \$7.37. Since the claim was late, there was a 25% reduction in the amount paid. This resulted in payment of \$11.25. A 25% reduction in the correct amount would have resulted in a payment of $\\$7.37 \times 75\% = \\5.53. Therefore, the error was calculated as $\\$11.25 - \\$5.53 = \\$5.72$ overpaid.</i>			
61	2 - Physician Services	MR-2A (Poor documentation)	<i>This claim had two codes that were billed. The first was code 99212, an office visit, and the second was code X1500, which was for the distribution of condoms. The 99212 claim did not have any errors and was billed appropriately. However, the provider was unable to produce documentation substantiating the acquisition cost for the condoms. Therefore, the error was calculated as the amount paid for the condoms, or \$15.00 overpaid.</i>	\$ 37.41	\$ 22.41	\$ 15.00
63	2 - Physician Services	MR-2A (Poor documentation)	<i>This claim was for code Z6412, six hours of group perinatal health education. Three hours were claimed on 9/10/03 and three more hours were claimed on 9/17/03. There was a sign-in sheet and a description of class content for the first date, but not for the second. Therefore, the error was calculated as 1/2 the total amount of the claim, representing the three hours of health education which were not sufficiently documented ($\\$98.28 / 2 = \\49.14 overpaid).</i>	\$ 98.28	\$ 49.14	\$ 49.14
66	2 - Physician Services	MR-2A (Poor documentation)	<i>The claim was for a blood transfusion for a dialysis patient in the emergency room (ER), billed by a hospital. The ER records are missing with the exception of a laboratory result of a "type and cross," which is done in preparation for a transfusion. There was no documentation of an order to give the transfusion or documentation that the patient received the transfusion (no nursing record, medication record, physician progress note, or record of a post-transfusion blood count). After multiple attempts to obtain records covering the date of service, the hospital admits the records are lost. Thus, the error was the total amount paid.</i>	\$ 232.37	\$ -	\$ 232.37

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
71	2 - Physician Services	MR-5 (Not medically necessary)	<p>There were two claim lines which had errors in this claim:</p> <p>#1 The provider billed for a pregnancy test (code 81025) for a patient who had not missed a period, and who had been on injectable birth control (Depo-Provera) for five months continuously. (The injections had been well documented by the same clinic). The date of service of the claim was two months into the three months of coverage provided by the prior shot. The test was not medically necessary and the error was calculated as the total amount claimed \$5.43.</p> <p>#2 The provider billed code Z9753 (Family Planning Education and Counseling 16-30 minutes). The amount of time for this visit was not documented. The topics documented on this visit warranted less than 15 minutes. Therefore, code Z9752 (Family planning E&C 11 -15 minutes) was felt to be more appropriate, and the coding error was calculated as the difference between the reimbursement rates for the different times (\$31.71 - \$19.07) = \$12.64 overpaid.</p> <p>The overall error was \$5.43 + \$12.64 = \$18.17 overpaid. The overall error code assigned was MR5 (not medically necessary).</p>	\$ 114.16	\$ 95.99	\$ 18.17
80	2 - Physician Services	MR-3 (Coding error)	<p>This claim was for code Z9752 (individual family planning counseling, lasting 11-15 minutes, provided by a clinician and/or counselor). No family planning counseling was documented and the duration of the visit was not documented. The medical record revealed that the patient had an abnormal mammogram, ordered by another physician, which this provider discussed with her. The error was calculated as the difference between code Z9752 (\$19.07), and the appropriate office visit code, 99212, established patient- level two (\$18.10) = \$0.97 overpaid.</p>	\$ 19.07	\$ 18.10	\$ 0.97
92	2 - Physician Services	MR-2B	<p>This claim was for 4 codes:</p> <p>#1 X1500 (Condoms). Condoms were noted in the plan for this date of service, but no quantity dispensed was documented. At the wholesale price of \$.0475 per</p>	\$ 46.14	\$ 26.82	\$ 19.32

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<p>condom, 315 condoms would have been dispensed to equal the cost of \$15.00 which was billed. Medi-Cal regulations require that condoms be billed AT COST. Since there was no documentation that any condoms were dispensed, the error was calculated as the amount paid for the condoms, \$15.00 overpaid.</p> <p>#2 99213 (Office visit level three). The record documented a problem-focused history and exam, and straightforward decision-making, consistent with a level two, not a level three-office visit. The reason for the visit was to recheck an intrauterine contraceptive device (IUD) placement. The doctor noted the IUD was in place and strings visible. The plan was to return in six months and use condoms. The coding error was calculated as the difference between the amount paid for code 99213 (\$24.00), and the amount that would have been paid for the correct code, 99212 (\$22.48) = \$1.52 overpaid.</p> <p>#3 81000 (Urinalysis, non-automated, with microscopy). The medical record reveals no reason for this test, and no test results. Therefore, the documentation error was calculated as the total amount of the claim, \$2.80.</p> <p>#4 81025 - (Pregnancy test) - a pregnancy test was needed because the patient's last menstrual period was 5 months earlier. However, the physician did not note the size of the uterus, and did not address the lack of menstruation during the visit. This represents poor quality of care. Since quality of care, per se, is not under review in this study, this is a "non-dollar" error.</p> <p>The overall error code assigned was MR2B (service not documented at all). The overall error was calculated as \$15.00 + \$1.52 + \$2.80 = \$19.32 overpaid.</p>			
107	2 - Physician Services	P-5 (Pricing error)	<p>There were two claim lines with errors on this claim.</p> <p>#1: The provider billed code Z9753 (Family planning education and counseling, 16 - 30 minutes) even though the rendering provider checked code Z9752 (8 to 15 minutes) on the claim. The medical record does not document education and counseling, but does document a clinical exam, which would have been appropriately</p>	\$ 51.13	\$ 36.33	\$ 14.80

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<p><i>billed as code 99213. The error for this line was calculated as the difference between code Z9753 (\$29.13) and code 99213 (\$24.00) = \$5.13 overpaid. #2 The provider billed and was paid \$15.00 for code X1500 (condoms), quantity 24. Family Planning, Access, Care, and Treatment Program policy allows payment for condoms AT COST only. The wholesale invoice obtained onsite revealed that the unit price was \$0.222 per condom. Therefore, the provider should have billed 24 X 0.222, or \$5.33. The pricing error was calculated as (\$15.00 - \$5.33) = \$9.67 overpaid. The overall error code assigned was P5 (pricing error). The overall error was calculated as \$9.67 + \$5.13 = \$14.80 overpaid.</i></p>			
112	2 - Physician Services	MR-3 (Coding error)	<p><i>This claim was for a level-four office visit for a new patient. Review of the medical record reveals that the patient was seen in the clinic three weeks earlier, and therefore was not a new patient. In addition, the visit did not reach the complexity required for a level-four visit. This level requires a detailed history, detailed exam, and medical decision-making of moderate complexity. The patient was a newborn with cough and nasal congestion, without fever, and eating well. An extended problem-focused examination was done, and there was decision-making of low complexity, consistent with a level-three office visit. Therefore, the error was calculated as the difference between the amount paid for code 99204 (\$75.17), and the amount that would have been paid for code 99213 (\$26.18) = \$48.99 overpaid.</i></p>	\$ 75.17	\$ 26.18	\$ 48.99
124	2 - Physician Services	MR-3 (Coding error)	<p><i>This claim was for an office visit for a 4-day-old baby for a bilirubin recheck. The provider billed code 99203 (level three-office visit) for a new patient. Billing this code requires a detailed history, a detailed examination, and medical decision-making of low complexity. Usually the presenting problem(s) are of moderate severity. Physicians typically spend 30 minutes face-to-face with the patient and/or family. The medical record reveals that this visit was no more than a level one (which</i></p>	\$ 72.08	\$ 28.85	\$ 43.23

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<p>typically requires 10 minutes of face-to-face physician time, problem-focused history and exam, and straightforward decision-making). In addition, the wrong rendering provider was listed on the claim. Also, the baby's mother was seen three weeks later and noted to be living in a boarding house with limited support. The patient was seen by three different providers in three weeks and was not referred to a counselor or social worker. These deficiencies raise concerns about quality of medical care. The error was calculated as the difference between the amount paid for code 99203 (\$72.08) and the amount that would have been paid for a level one visit code for a new patient, 99201 (\$28.85), or $\\$72.08 - \\$28.85 = \\$43.23$ overpaid.</p>			
125	2 - Physician Services	P-9 (Ineligible provider)	<p>This claim included 5 claim lines: Z1034: Follow-up visit for pregnancy care Z6202: Nutrition Counseling, 15 minutes Z6302 Psychosocial Counseling, 15 minutes Z6404: Health Education Counseling, 15 minutes Z7500: Treatment Room Multiple errors were found including that none of the counseling was documented. The Z1034 visit was with a Nurse Midwife who was not enrolled with Medi-Cal, and the appropriate modifier to indicate that a non-physician provider rendered the service was not used on the claim. Appropriate errors include MR3 (coding error), P9 (ineligible rendering provider), and MR2-B (service not documented at all). The overall error code assigned was P9 (ineligible provider) and the overall error was the total amount paid).</p>	\$ 122.00	\$ -	\$ 122.00
128	2 - Physician Services	MR-1A (No records available from billing provider)	<p>This claim was for an office visit at a rural health clinic. The provider was unable to provide the documentation to validate the services provided, despite multiple requests. The error is the total amount paid.</p>	\$ 86.61	\$ -	\$ 86.61
132	2 - Physician Services	MR-2B (Service not	<p>There were 5 lines for this claim. An error was found for claim line 5: code X7700 (Administration, Intravenous</p>	\$ 92.27	\$ 74.22	\$ 18.05

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
		<i>documented at all)</i>	<i>(IV) Solution). Review of medical records revealed no physician's order and no indication that an IV catheter was placed. The error calculated as the amount paid for the IV solution, \$18.05 overpaid.</i>			
148	2 - Physician Services	MR-2B <i>(Service not documented at all)</i>	<i>This claim had 4 lines. Only one line had an error: code Z5220 (collecting and handling of a blood specimen). However, the record reveals that no blood was drawn. The error was the cost of the Z5220 code, or \$3.63 overpaid.</i>	\$ 80.49	\$ 76.86	\$ 3.63
152	2 - Physician Services	MR-2B <i>(Service not documented at all)</i>	<i>The claim was for 11719 (Nail trimming, non-dystrophic nails, 6 or more nails), billed by a podiatrist. The record for this date of service does not document any nail debridement, or any patient complaints or physical findings suggesting the need for nail debridement. The error was the total amount paid.</i>	\$ 13.00	\$ -	\$ 13.00
156	2 - Physician Services	P-5 <i>(Pricing error)</i>	<i>This claim was for a brief office visit (99211), and code X7706 (contraceptive pills). The error was for the code X7706 portion of the claim. Medi-Cal Policy requires that contraceptive supplies be billed AT COST. The invoice showed the cost was \$2.05 per unit. Two units were dispensed, so the amount paid should have been \$4.10. The error was calculated as the difference between the amount paid for the contraceptives (\$24.00) and the amount that should have been paid (\$4.10) = \$19.90 overpaid.</i>	\$ 38.86	\$ 18.96	\$ 19.90
157	2 - Physician Services	P-5 <i>(Pricing error)</i>	<i>The claim was for a family planning visit: code 99213 (office visit), code 81002 ZS (urinalysis), code X7706 (birth control pills), code Z7610 (sulfa antibiotic medication), and code X7722 (emergency contraceptive medication). Medical necessity was verified. Two of the claims (X7706 and X7722) should be billed AT COST and require that the providers put the unit cost paid in box 19 of the claim form. Nothing was noted in box 19 of the claim form. From the invoices provided and the amount billed, the provider billed at higher than cost for both codes, but was paid the "price on file": \$12.00 per unit x 13 units = \$156.00 for X7706, and \$20.86 per unit</i>	\$ 211.83	\$ 63.47	\$ 148.36

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>x 1 unit = \$20.86. There was no audit in place to have EDS check the "at cost" price. The provider's invoice shows that for code X7706, the amount that should have been paid was \$2.05 per unit x 13 units = \$26.65, and for X7722 \$1.85 per unit x 1 unit = \$1.85. The error was calculated as the overpayment of the two claims discussed above [(\$156- \$26.65)+ (20.86 - \$1.85)]= \$129.35+ \$19.01= \$148.36 overpaid.</i>			
159	2 - Physician Services	MR-3 (Coding error)	<i>This claim had 3 lines: 99213 (office visit), code X1500 (other contraceptive supplies), and code Z7500 (room charge). The error was noted with the office visit code 99213. There was insufficient documentation to support the code billed. The correct code was 99212. The error was calculated as the difference between the 99213 code (\$29.71) and the correct 99212 code (\$22.41) = \$7.30 overpaid.</i>	\$ 66.37	\$ 59.07	\$ 7.30
179	2 - Physician Services	MR-3 (Coding error)	<i>This claim was for an office visit, code 99214, in which a physician saw a patient for infertility evaluation. Based on the level of decision-making complexity and the work involved in performing the history and exam that were reflected in the documentation, a lower level code was more appropriate. The error was calculated as the difference between the rate for the billed code and the correct code (\$18.75 - \$9.05) = \$9.70 overpaid.</i>	\$ 18.75	\$ 9.05	\$ 9.70
191	2 - Physician Services	P-9 (Ineligible provider)	<i>This claim was for 2 services: code 81025 (pregnancy test), and code Z9753 (family planning education and counseling 16-30 minutes). The patient's record documents a physical exam with no history. There was no reason stated for the visit. No pelvic exam was done. No counseling was documented. The nurse practitioner who signed the visit was not a Medi-Cal provider. Errors include MR 2B (service not documented), and P9 (ineligible provider). The overall error code assigned was P9 (ineligible provider) and the overall error was the total amount paid.</i>	\$ 36.13	\$ -	\$ 36.13
207	2 - Physician Services	MR-2A (Poor documentation)	<i>The claim was for a group perinatal health education. Minimal documentation for the date of service in question was found. All that was available was a billing</i>	\$ 116.34	\$ -	\$ 116.34

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>sheet for that day for the clinic, but very little else. In addition, the Comprehensive Perinatal Services Program (CPSP), which funds these services, has requirements for documentation that were not met by the provider. The error was the total amount paid.</i>			
211	2 - Physician Services	MR-2A (Poor documentation)	<i>The claim was for 17 laboratory tests billed by a hospital. From the available records, it appears that the tests were performed pre-operatively for a liver transplant. However, the only medical records were the lab and radiograph results. Requests for further records were made without success. Thus, medical necessity could not be verified and the error was the total amount paid.</i>	\$ 222.82	\$ -	\$ 222.82
221	2 - Physician Services	MR-3 (Coding error)	<i>This claim was for a physician office visit. The services were not commensurate with the level billed. Based on the level of decision-making complexity and the work involved in performing the history and exam that were reflected in the documentation, a lower level code was more appropriate. The error was calculated as the difference between the rate for the billed code and the correct code: \$26.18- \$19.75 = \$6.43 overpaid.</i>	\$ 26.18	\$ 19.75	\$ 6.43
246	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This was a pharmacy claim for Triamcinolone cream (a steroid cream for inflammatory rashes). The pharmacy provided a telephone prescription, unsigned by the prescribing physician. The physician's records do not include an order for this medication, or any reason for its use. The error was the total amount paid.</i>	\$ 17.90	\$ -	\$ 17.90
249	3 - Pharmacy	MR-2A (Poor documentation)	<i>This claim was for Miconazole cream (a medicine used for vaginal yeast infections). The prescription that the pharmacist had on file was a telephone order for a refill from two months earlier. There was no physician's signature on the prescription, and the prescribing physician's records do not mention any symptoms or physical findings suggestive of a yeast infection. There was nothing in the prescriber's notes which indicated that he prescribed it or why. The error was the total amount paid.</i>	\$ 13.88	\$ -	\$ 13.88
278	3 - Pharmacy	MR-2A (Poor)	<i>The claim was for sixty pills of Allegra (a non-sedating anti-histamine). Medical necessity was verified. The</i>	\$ 79.71	\$ -	\$ 79.71

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
		documentation)	<i>records supplied had a dispensing label and patient signature log with the wrong date of service. The records for the correct date of service were requested from the pharmacy without success. Thus, it was impossible to confirm the medication was actually dispensed on the date of service claimed. The error was the total amount paid.</i>			
280	3 - Pharmacy	MR-7 (Policy error)	<i>The claim was for 100 pills of Tylenol. The refill for the date of service in question occurs after the expiration date of the prescription. The pharmacy admits it does not have documentation of a signed/verbal refill request. Thus, the refill was invalid and illegal. The error was the total amount paid.</i>	\$ 8.99	\$ -	\$ 8.99
286	3 - Pharmacy	MR-1B (No records available from the referring provider)	<i>The claim was for Tylenol with codeine. The pharmacy had complete documentation. Medical necessity could not be substantiated because the prescribing physician had retired. The error was the total amount paid.</i>	\$ 8.05	\$ -	\$ 8.05
292	3 - Pharmacy	MR-1A (No records available from the billing provider)	<i>This claim was for a prescription of Dilantin, a medication used to treat people who have seizures and pain syndromes. The only documentation submitted was a prescription for Dilantin that clearly was not the prescription in question (wrong prescription number and wrong date of service). The pharmacy was unable to provide further documents related to the claim despite multiple requests. The error was the total amount paid.</i>	\$ 27.79	\$ -	\$ 27.79
293	3 - Pharmacy	MR-2B (Service not documented at all)	<i>The claim was for 60 tablets of Glyburide, (a medication used to treat diabetes) 5 mg each. The pharmacy did not have a prescription for the Glyburide. The referring physician's medical record indicates that the patient was being treated for diabetes, but not with this medication. In fact, the physician provided a written statement that he had no record of prescribing this medication. He also provided documentation of three visits with this patient, which revealed that he prescribed other medications for diabetes, but not Glyburide. The error was the total amount paid.</i>	\$ 44.63	\$ -	\$ 44.63

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
298	3 - Pharmacy	MR-1B (Service not documented at all)	<i>This was a pharmacy claim for 31 tablets of Nifedipine XL 90 mg (a medication used to treat high blood pressure). The pharmacy documentation was complete. However, no documentation was submitted by the prescribing doctor's office after many attempts. Medical necessity could not be verified. The error was the total amount paid.</i>	\$ 75.02	\$ -	\$ 75.02
331	3 - Pharmacy	MR-7 (Policy error)	<i>This was a pharmacy claim for Glyset (a medication used to treat diabetes). The medication was prescribed to treat constipation, which is not a Federal Drug Administration-approved use of this medication. This was against Medi-Cal policy unless a TAR was obtained. No TAR was submitted for the claim. The error was the total amount paid.</i>	\$ 44.52	\$ -	\$ 44.52
336	3 - Pharmacy	MR-3 (Coding error)	<i>This was a pharmacy claim for 100 tablets of 500 mg Tylenol (acetaminophen, a pain reliever and anti-pyretic). The pharmacy labeled the bottle as Tylenol 500 mg. However, the NDC number on the label specifies a different manufacturer and the wrong strength. The pharmacist billed a completely different NDC number than apparently what was dispensed. There was no invoice for the NDC number billed. Since it was impossible to determine which medicine was actually dispensed, it was not possible to calculate the difference between the amount paid the amount which should have been paid. Therefore, the error was the total amount paid.</i>	\$ 8.58	\$ -	\$ 8.58
346	3 - Pharmacy	MR-1A (No documentation available from the billing provider)	<i>This was a pharmacy claim. The place of business was abandoned and all telephone numbers associated with the provider were either disconnected or inaccurate. Although the beneficiary's physician could be contacted to obtain clinical verification of services needed, the providing pharmacy could not be contacted to get basic transaction data to substantiate that the medication was actually dispensed. The error was the total amount paid.</i>	\$ 7.13	\$ -	\$ 7.13
347	3 - Pharmacy	MR-1A (No documentation)	<i>This was a pharmacy claim. The place of business was abandoned and all telephone numbers associated with the provider were either disconnected or inaccurate.</i>	\$ 47.39	\$ -	\$ 47.39

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
		<i>available from the billing provider)</i>	<i>Although the beneficiary's physician could be contacted to obtain clinical verification of services needed, the providing pharmacy could not be contacted to get basic transaction data to substantiate the claim. Therefore, the error was the total amount paid.</i>			
366	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This was a pharmacy claim for antibiotic eardrops. There was an undated telephone order, which was illegible. The doctor's progress notes indicate a complaint of ear pain for one day, written by the medical assistant. There are no notes at all from the physician regarding history or physical examination of the ear. There was no documentation of medical necessity for the antibiotic. The error was the total amount paid.</i>	\$ 77.97	\$ -	\$ 77.97
372	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This claim was for a prescription of Silvadene cream, an antibiotic medication used on the skin, especially for burns. Medical necessity could not be verified in the patient record. The error was the total amount paid.</i>	\$ 13.23	\$ -	\$ 13.23
387	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This claim was for a prescription of Trazadone, a medication to treat depression, sleep, and pain syndromes. The pharmacy documentation was sufficient. However, the physician's clinical notes do not support the need for the medication. Although Trazadone was listed in the treatment plan of the physician's notes, the scope of the beneficiary's visits and the chronic conditions list did not cover any related condition where Trazadone would be used. The error was the total amount paid.</i>	\$ 7.65	\$ -	\$ 7.65
388	3 - Pharmacy	MR-7 (Policy violation)	<i>The claim is for Nordette-28 (an oral contraceptive pill) three months supply, billed by a Federally Qualified Health Center (FQHC). Medical necessity was verified. This FQHC bills pharmacy claims under a centralized pharmacy provider number. If a FQHC chooses to bill for pharmacy separately, the pharmacy reimbursement costs need to be excluded from the overall flat rate. This FQHC had not declared separate billing for pharmacy costs and thus, was in essence, being double paid for pharmacy costs. The error was the total amount paid.</i>	\$ 104.12	\$ -	\$ 104.12

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
396	3 - Pharmacy	MR-1A (No documentation available from the billing provider)	<i>This was a pharmacy claim for Glucophage (a medication to treat diabetes and metabolic syndrome). The pharmacy did not cooperate with the request for documentation, after multiple attempts and threat of suspension. The error was the total amount paid.</i>	\$ 93.06	\$ -	\$ 93.06
398	3 - Pharmacy	P-5 (Pricing error)	<i>The claim was a Pharmacy claim for 120 milliliters of Phenergan DM (cough syrup). The pharmacy documentation was in order. Medical necessity was verified. The price on file by EDS had been entered incorrectly into the EDS computer. Thus, the cost per milliliter was incorrectly paid at \$0.443 per milliliter instead of the correct price of \$0.264 per milliliter. (This error was subsequently caught and corrected by an EDS pharmacist before this study, but was never corrected for this provider). The overall price is calculated as [(price per pill x number of pills = 120)+ dispensing fee of \$4.05] - 0.50. The error was calculated as the difference between the amount paid (\$8.87) and the amount that should have been paid (6.72) = \$2.15 overpaid.</i>	\$ 8.87	\$ 6.72	\$ 2.15
409	3 - Pharmacy	MR-2A (Poor documentation)	<i>This claim was for an antidepressant/anxiolytic medication called Effexor 75 mg. The pharmacy documentation for the claim was sufficient and the physician's chart documents the use of Effexor in the medication history. The physician did not document in the progress notes why the patient needs the medication, whether the medication was effective, or whether the patient was being monitored for depression or anxiety. The beneficiary has an extensive medication list, and so documentation of necessity would have been particularly important. The error was the total amount paid.</i>	\$ 92.07	\$ -	\$ 92.07
411	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This was a claim for urinary incontinence hygiene supplies. On a form requesting "In Home Support Services", written during the same month of the first order of incontinence supplies, the physician clearly stated that the patient had both bowel and bladder continence. This contradicts the request for incontinence</i>	\$ 14.35	\$ -	\$ 14.35

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>supplies. Progress notes from the physician regarding the beneficiary also do not mention the patient having this problem. The error was the total amount paid.</i>			
421	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for 60 tablets of Altace 10 mg (a medication for heart failure or blood pressure). The pharmacist failed to produce a valid prescription for this medication. The prescribing physician's progress note for the same date confirms a plan for Altace 10 mg once per day. However, the pharmacist labeled the bottle (apparently) incorrectly, to be taken twice per day. The pharmacist did not have a written prescription or record of a verbal order on file, which could account for the difference between what the physician's record stated and what was dispensed. The error was the total amount paid.</i>	\$ 100.14	\$ -	\$ 100.14
449	3 - Pharmacy	P-5 (Pricing error)	<i>This claim was for a prescription of Zocor (a medication for high cholesterol). The pharmacy was paid \$375.44 for this medication. However shortly before the date of service, there was a reimbursement rate change, which meant the pharmacy should have been reimbursed \$391.29. The provider did not receive a retroactive readjustment. The error was calculated as the difference between what they should have been paid (\$391.29) and what they were paid (\$374.94) = -\$16.35 underpaid.</i>	\$ 374.94	\$ 391.29	\$ -16.35
469	3 - Pharmacy	MR-2A (Poor documentation)	<i>This claim was for Zoloft (a medication for depression and anxiety). There was a valid prescription, and the medical records documented necessity. However, the pharmacy had no record of dispensing the medication. The error was the total amount paid.</i>	\$ 77.16	\$ -	\$ 77.16
504	3 - Pharmacy	MR-5 (Not medically necessary)	<i>The claim was for 100 tablets of Os-Cal, a calcium supplement. The pharmacy documentation was in order. There was no evidence of medical necessity. The progress notes are very scant in general, making the necessity of the general medical care by this specialist unclear. The error is the total amount paid.</i>	\$ 8.67	\$ -	\$ 8.67
515	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for Coumadin tablets (an anticoagulant). The pharmacy documentation was in order. Due to the prescribing provider's internal policy</i>	\$ 60.66	\$ -	\$ 60.66

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>regarding the authorization of refills, unlicensed personnel refill medications directly without approval from the doctor (refills are authorized as long as the patient has been seen within the year). The office manager states she, "always refills coumadin, because all people on coumadin need it long term". However, many people take coumadin for short-term purposes. Furthermore, coumadin is a dangerous drug for which the refills should be monitored. The error was the total amount paid.</i>			
534	3 - Pharmacy	MR-2A (Poor documentation)	<i>This was a pharmacy claim for Zerit, a medication for HIV. The pharmacist could not find a prescription for the medication that was billed, and there was no evidence to show that the medication was actually dispensed. The prescribing physician's clinical documents support the use of the medication by the beneficiary, however, there was no evidence that a prescription was obtained or filled by the pharmacy. The error was the total amount paid.</i>	\$ 319.76	\$ -	\$ 319.76
543	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for Aricept 10 mg tablets, a medication used to treat Alzheimer's Disease (AD). Medi-Cal regulations require pre-approval (TAR) if the medication is to be used for any diagnosis other than Alzheimer's Disease (including non-Alzheimer's dementias). The medical record reveals that the patient was diagnosed with dementia of non-Alzheimer's type. A TAR was not obtained. Therefore, Aricept was not a benefit payable by Medi-Cal. The error was calculated as the total amount paid.</i>	\$ 137.55	\$ -	\$ 137.55
545	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for 31 tablets of Celebrex (an anti-inflammatory pain medication). The prescription was for only 30 tablets. The error was calculated as the amount paid for one tablet, \$2.78 overpaid.</i>	\$ 86.70	\$ 83.92	\$ 2.78
561	3 - Pharmacy	MR-3 (Coding error)	<i>This was a pharmacy claim for Ferrous Sulfate (iron) tablets used for treating iron deficiency anemia. The prescriber ordered 325mg tablets (at \$0.0113/tablet), and these were dispensed with the appropriate NDC number. However, the pharmacy billed for 324mg tablets</i>	\$ 5.63	\$ 4.23	\$ 1.40

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>(at \$0.0347/tablet) from a different company, which was more expensive. The pharmacist did not have an invoice to show the purchase of the medicine billed. The error was calculated as the difference between the amount paid for the tablets billed, and the amount that would have been paid if billed appropriately, \$1.40 overpaid.</i>			
574	3 - Pharmacy	MR-2B (Service not documented at all)	<i>This was a pharmacy claim for 90 amitriptyline 25mg tablets. The pharmacy paperwork was all in order. The prescribing doctor's paperwork was lacking. There was evidence from the prescribing doctor's medicine log that the medicine was prescribed, but there was no date and despite exhaustive efforts to obtain further records, no progress notes were available. A search of claims data for this patient revealed no diagnosis to verify the necessity for this medication. The error was the total amount paid.</i>	\$ 9.43	\$ -	\$ 9.43
579	3 - Pharmacy	MR-5 (Not medically necessary)	<i>This was a pharmacy claim for lubricating jelly. The partner of the prescribing physician billed several services on this date of service. There was no indication of a patient complaint or physical finding which would result in medical necessity for a lubricating jelly. The error was the total amount paid.</i>	\$ 2.26	\$ -	\$ 2.26
593	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for 10 tablets of Vicodin (a schedule II narcotic pain reliever). The practitioner who wrote the prescription did not have a permit to write for this controlled substance. The error was the total amount paid.</i>	\$ 4.70	\$ -	\$ 4.70
606	3 - Pharmacy	MR-2A (Poor documentation)	<i>This was a pharmacy claim for Lorazepam (a medication for anxiety). The pharmacy has a faxed prescription and an approved TAR signed by the pharmacist. However, the referring physician's last progress note was dated two years prior to the date of service in question and therefore does not support medical necessity for this medication. Because this is a potentially addictive medication, continued documentation of necessity is particularly important. The error was the total amount paid.</i>	\$ 20.70	\$ -	\$ 20.70

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
609	3 - Pharmacy	MR-1A (No documents available from billing provider)	<i>This was a pharmacy claim. The place of business was abandoned and all telephone numbers associated with the provider were either disconnected or inaccurate. Although the beneficiary's physicians could be contacted to obtain clinical verification of services needed, the providing pharmacy could not be contacted to get basic transaction data to substantiate the claim. The error was the total amount paid.</i>	\$ 57.47	\$ -	\$ 57.47
619	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for Norvasc 10-mg tablets (an anti-hypertensive agent). The physician ordered 30 tablets with three refills. The pharmacy dispensed 100 tablets. This was illegal. The error was calculated as the difference between the amount billed (\$199.25), and the amount that would have been paid for 30 tablets (\$62.26), or \$136.99 overpaid.</i>	\$ 199.25	\$ 62.26	\$ 136.99
622	3 - Pharmacy	MR-7 (Policy violation)	<i>This was a pharmacy claim for a medication called Vioxx (for pain and/or inflammation). The pharmacy staff was unable to retrieve the original prescription for the medication when requested to do so. Instead, they submitted a copy of an old prescription for a different but related medication for the beneficiary and stated that the beneficiary's physician changed this to Vioxx. However, when our staff contacted the physician's office manager, she denied that the physician ever endorsed the change. In fact, the manager stated that the pharmacy called in June 2004 (when our audit of the agency for this project took place), 6 months after the date of service, to say that the patient wanted to switch to Vioxx. It was not legal for a pharmacist to change a physician's prescription. The error was the total amount paid.</i>	\$ 84.92	\$ -	\$ 84.92
654	4 - Other Services & Supplies	MR-5 (Not medically necessary)	<i>This was a claim for a day of ADHC (Adult Day Health Care) services. According to the patient's Individual Care Plan at the ADHC, he has difficulty with activities of daily living due to left-side weakness, degenerative arthritis, and progressive diabetic neuropathy. However, the physician's notes indicate that his musculoskeletal system was normal, and the occupational therapy reassessment identified the patient as independent with</i>	\$ 69.58	\$ -	\$ 69.58

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>activities of daily living. Therefore, this service was not necessary to prevent institutionalization, a necessary requirement according to Medi-Cal regulations. The error was the total amount paid.</i>			
659	4 - Other Services & Supplies	MR-2A (Poor documentation)	<i>This claim was for a drug screen test performed by a laboratory. The providing laboratory was able to produce some documentation such as the test results. However, after several requests, staff from the lab was unable to provide a copy of the requisition to substantiate the ordering of this test. The error was the total amount paid.</i>	\$ 17.92	\$ -	\$ 17.92
685	4 - Other Services & Supplies	MR-2A (Poor documentation)	<i>This claim was for code X4900 (Health and Mental evaluation/education) provided in a school. The school provided only a daily log for the date of service, with the column named "psych social" check-marked for this beneficiary. The school representative stated that this "daily log was the progress note." Regulations require that the nature and extent of the service be documented, and this was not done. The error was the total amount paid.</i>	\$ 10.40	\$ -	\$ 10.40
695	4 - Other Services & Supplies	MR-5 (Not medically necessary)	<i>This claim was for one day of Adult Day Health Care (ADHC) services. The primary physician for this patient states that she was asked on numerous occasions to sign a referral for ADHC services, but she refused, since she did not feel that the services were necessary. The signature on the Treatment Authorization Request was not hers, but appears to be a forgery of her signature. The error was of the amount paid.</i>	\$ 69.58	\$ -	\$ 69.58
696	4 - Other Services & Supplies	MR-2A (Poor documentation)	<i>This claim was for urinary incontinence hygiene supplies billed by a Durable Medical Equipment (DME) provider. The copy of the prescription/order that the pharmacy submitted during the review had a signature for the physician that was not confirmed as genuine by the physician's office. In two separate calls to the physician's office manager, it was confirmed that the physician did not authorize the order for the services claimed by the pharmacy. The DME provider was unable to produce a legitimate prescription or physician's order for the</i>	\$ 145.30	\$ -	\$ 145.30

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>services provided. The error was the total amount paid.</i>			
720	4 - Other Services & Supplies	MR-2A (Poor documentation)	<i>The claim was for a session of individual speech therapy at a school. Medical necessity was verified. The documentation was nearly complete but lacks a progress note describing the nature and extent of the therapy session that day (as required by Medi-Cal regulations). The error was the total amount paid.</i>	\$ 12.91	\$ -	\$ 12.91
730	4 - Other Services & Supplies	MR-2B (Service not documented at all)	<i>The claim was for one day of ADHC (Adult Day Health Care) services. There was no documentation to support that the beneficiary was at the center on the date of service claimed. In fact, none of the attendance sheets had any entries for that day. The error was the total amount paid.</i>	\$ 69.58	\$ -	\$ 69.58
732	4 - Other Services & Supplies	P-9 (Ineligible provider)	<i>The claim was for code E098-Y2, a wheelchair airplane buckle. The service was provided at location, which does not have a Medi-Cal provider number or a Home Medical Device Retailer (HMDR) license as required by the State of California to sell durable medical equipment. Therefore, the provider was ineligible to bill for this service. The error was the total amount paid.</i>	\$ 30.84	\$ -	\$ 30.84
738	4 - Other Services & Supplies	MR-2B (Service not documented at all)	<i>The claim was for two laboratory tests. The lab submitted no documentation to support the claim. The referring provider listed on the claim denies having ordered the labs. The error was the total amount paid.</i>	\$ 77.60	\$ -	\$ 77.60
760	4 - Other Services & Supplies	MR-1A (No documents available from billing provider)	<i>This claim was for speech therapy services billed by a school. The provider failed to provide documents substantiating that the services were rendered, despite multiple requests. The error was the total amount paid.</i>	\$ 12.91	\$ -	\$ 12.91
764	4 - Other Services & Supplies	MR-2A (Poor documentation)	<i>This claim was for physical and mental health evaluation/education services and speech audiology services. All that was submitted for the dates in question was an attendance sheet for speech therapy. There was no documentation for the health and mental evaluation. Several unsuccessful attempts were made to obtain the pertinent documents stating the nature and extent of services provided, as required by Medi-Cal regulations. The error was the total amount paid.</i>	\$ 93.24	\$ -	\$ 93.24

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
770	5 - Dental	MR-5 (Not medically necessary)	The provider took a complete set of x-rays when there was no indication to do so. The provider had taken a similar set of x-rays the year before and with the patient's history of minimal dental problems there was no indication for exposing the patient to the radiation. The error was calculated as the amount paid for the x-rays, \$30.00 overpaid.	\$ 40.00	\$ 10.00	\$ 30.00
773	5 - Dental	MR-2A (Poor documentation)	The provider billed for two additional x-rays than what was documented and present in the record. Provider over-billed for services. The error was calculated as the cost of the two unnecessary x-rays, \$6.00 overpaid.	\$ 62.00	\$ 56.00	\$ 6.00
779	5 - Dental	MR-5 (Not medically necessary)	The provider attempted to bill for service provided two months earlier. The provider repeated the service due to pain. Other treatment (such as extraction of the baby teeth) would have been more appropriate. This is inconsistent with standards, as provider did not record attempts to identify the cause of patient's pain. Other treatments may have been more appropriate for the patient's pain. The error was calculated as the amount of the inappropriate service, \$25.00 overpaid.	\$ 55.00	\$ 30.00	\$ 25.00
786	5 - Dental	MR-5 (Not medically necessary)	The provider placed an amalgam filling into a primary tooth without the benefit of diagnostic x-rays of the affected area. This was inconsistent with standards. The error was calculated as the amount of the amalgam filling, \$35.00 overpaid.	\$ 98.00	\$ 63.00	\$ 35.00
789	5 - Dental	MR-3 (Coding error)	The provider billed for a prophylaxis fluoride treatment, but only documented prophylaxis without fluoride application. Thus, the wrong code was billed. The error was calculated as the difference between the two codes, \$151.00 overpaid.	\$ 197.00	\$ 46.00	\$ 151.00
793	5 - Dental	MR-5 (Not medically necessary)	There was a data entry error on one tooth code; three of the four teeth extracted could have been restored. In addition, the provider appeared to have split out billings of extractions to increase revenue. The provider's treatment was too aggressive. The provider could have fixed the problems with three of the four teeth. By extracting these teeth, the provider created a problem for the patient's future dental care (crowding of teeth). The	\$ 83.00	\$ -	\$ 83.00

ID number	Strata	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in error
			<i>error was the total amount paid.</i>			
796	5 - Dental	MR-2A (Poor documentation)	<i>The provider did not sufficiently document the procedure code billed, and failed to note the use, type, and amount of local anesthetic for the procedure. The documentation submitted did not fully describe the extent and nature of the service. The error was the total amount paid.</i>	\$ 118.00	\$ -	\$ 118.00

**MEDI-CAL PAYMENT ERROR STUDY
FINAL REVIEW ERRORS CODES**

Administrative Error Codes

- NE - No Errors
- DE - Data Entry
- WPI - Wrong Provider Identified
- WCI - Wrong Client Identified
- O - Other (List or Describe)

Processing Validation Error Codes

- P1 - Duplicate item (claim) – an exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.
- P2 - Non-covered service – policies indicate that the service is not payable by Medi-Cal
- P3 - MCO covered service – the beneficiary is enrolled in a Managed Care organization (HMO) that should have covered the service and it was inappropriate to bill Medi-Cal.
- P4 - Third party liability – inappropriately billed to Medicaid.
- P5 - Pricing error – payment for the service does not correspond with the pricing schedule, contract, reimbursable amount
- P6 - Logical edit – a system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid.
- P7 - Ineligible recipient—the recipient was not eligible for the services or supplies.
- P8 - Data entry errors – there were clerical errors in the data entry of the claim.
- P9 - Ineligible provider—this code includes the following situations:
- ✓ The billing provider was not eligible to bill for the services or supplies, or has already been paid for the service by another provider.
 - ✓ The rendering provider was not eligible to bill for the services or supplies.
 - ✓ The referring provider was suspended from Medi-Cal, and therefore could not cause Medi-Cal expenditures to be made.
- Note: When the error is due to a change of location, new provider, or new group, Provider Enrollment Branch (PEB) is contacted to see if there had been a delay in entering an approved change.
- P10 - Other – if this category is selected a written explanation is provided.

Medical Review Error Codes

- **MR1 – No documents submitted**

The billing provider did not respond to the request for documentation.
The referring (ordering or prescribing) provider did not respond to the request for documentation.
- **MR2 – Documentation problem error**
 - 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. But the documentation was insufficient 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.
 - B. Service not documented at all: 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 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 is medically unnecessary based upon the documentation of the patient's condition in the medical record. Or in the case of pharmacy, DME, laboratory tests, etc., the information in the referring provider's record did not document medical necessity. For up coding, use MR-3.
- **MR6 – Administrative error**

Medical review indicates an administrative error, such as an incorrect decision on a previous medical review or other administrative errors as designated by the state. This error may or may not result in a payment error.
- **MR7 – Policy violation**

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

 - One example was a prescription for a Federal Drug Administration unapproved indication for a medication which would require a Treatment Authorization Request for treatment.
- **MR8 – Other Medical error**

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

Indication of Fraud or Abuse:

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

Verification of Errors:

- All errors were reviewed and discussed by a medical team at DHS A&I.
- For all claims, which were errors due to missing documentation, multiple attempts were made to obtain records, including from alternate sources. In some cases, as many as 20 attempts were made, including advisement of possible suspension from Medi-Cal.
- EDS specialists verified all claims with coding and pricing errors.
- All ADHC TAR issues were discussed with the appropriate specialty Medi-Cal Field office.
- All Nursing Facilities errors were discussed with the appropriate specialty Medi-Cal Field Office.
- All general TAR issues were discussed and/or case reviewed by the DHS TAR office.
- The Dental Consultant for the DHS’ Denti-Cal Program did final review of all dental claims.
- All Pharmacy errors were discussed with pharmacists in the Medi-Cal Policy Division.
- Any errors regarding licensing (CLIA or State license) for lab tests were verified by calling Lab Field Services and/or CLIA (Region 9 CMS).
- For all claims where the error was found to be MR2-A, insufficient response to document request, the provider was contacted repeatedly and pressured to provide the requested documentation.
- All claims that were identified as potentially fraudulent were reviewed by DOJ.
- The Chief Medical Consultant for the Medi-Cal Program performed the final review for the dollar errors.

STUDY RESULTS AND STATISTICAL SUMMARIES

This Appendix presents the results of the MPES in tabular and graphical form. It includes:

Table 1 Dollar Error Rates and Estimated Annual Payments Made in Error by Strata

Table 2 Potential Fraud Rate by Strata and Estimated Annual Potential Fraudulent Payments by Strata

Table 3 Dollar Value of Errors by Category

Table 4 Calendar Year 2003 Medi-Cal Fee-For-Service and Dental Payments by Quarter

Figure 1 Proportion of Claims Paid Correctly vs. Claims Paid in Error & Potentially Fraudulent

Figure 2 Distribution of Sample Dollars Paid in Error by Error Category

Figure 3 Distribution of Sample Claim Errors by Error Category

MPES – TABLE 1
Dollar Error Rates and Estimated Annual Payments Made in Error by Strata

	Payment Error Rate & Confidence Interval			Dental/FFS Medi-Cal Payments Calendar Year 2003 (See Table 4)	Estimated Annual Payments Made In Error
Strata 1 – Inpatient	0.00%	±	00.0%	\$6,463,563,523	An annual payment error estimate was not calculated due to small sample size
Strata 2 – Physician Services	6.91%	±	4.60%	\$2,654,459,113	\$183,423,125
Strata 3 – Pharmacy	4.66%	±	2.77%	\$4,748,668,799	\$221,287,966
Strata 4 – Other Serv. & Supp.	5.46%	±	5.59%	\$1,344,754,615	\$73,423,602
Strata 5 – Dental*	12.90%	±	9.44%	<u>\$700,108,359</u>	<u>\$90,313,978</u>
Overall Payment Error Rate	3.57%	±	1.30%	<u>\$15,911,554,409</u>	<u>**\$568,042,492</u>

The confidence interval for the payment error rate is calculated at 95% confidence. There is a 95% probability that the actual rate for the population is 3.57% ± 1.30%, or that the true error rate lies within the range 2.27% and 4.87%. The estimated annual payment errors are calculated by multiplying two quantities: 1) the payment error rate, 2) the calendar year 2003 Medi-Cal FFS and dental payments (see Table 4).

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

** An independent simple random sample was drawn in each strata. A separate ratio estimate of the total of each strata was calculated and weighted by total dollars paid within each strata. The error rate and payment error projections for each strata are independent from one another. Therefore, the summations of the 5 strata payment errors do not total the overall payment errors.

MPES - TABLE 2
Potential Fraud Rate By Strata and Estimated Annual Potential Fraudulent Payments By Strata

(See Table 4) Medical Services	Rate & Confidence Interval Calendar Year 2003			Dental/FFS Medi-Cal Payments Potentially Fraudulent	Estimated Annual Payments Made For
Strata 1 – Inpatient	0.00%	±	00.0%	\$6,463,563,523	An annual payment error estimate was not calculated due to small sample size
Strata 2 – Physician Services	2.72%	±	2.07%	\$2,654,459,113	\$72,201,288
Strata 3 – Pharmacy	2.08%	±	1.49%	\$4,748,668,799	\$98,772,311
Strata 4 – Other Serv. & Supp.	5.19%	±	5.39%	\$1,344,754,615	\$69,792,765
Strata 5 – Dental*	0.72%	±	1.11%	<u>\$700,108,359</u>	<u>\$5,040,780</u>
Overall Payment Error Rate	1.57%	±	0.75%	<u>\$15,911,554,409</u>	<u>**\$249,811,404</u>

The confidence interval for the payment error rate is calculated at 95% confidence. There is a 95% probability that the actual rate for the population is 1.57% ± 0.75%, or that the true error rate lies within the range 0.82% and 2.32%. The projected annual payment errors are calculated by multiplying two quantities: 1) the payment error rate, 2) calendar year 2003 Medi-Cal FFS and dental payments (see Table 4).

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

** An independent simple random sample was drawn in each strata. A separate ratio estimate of the total of each strata was calculated and weighted by total dollars paid within each strata. The error rate and payment error projections for each strata are independent from one another. Therefore, the summations of the 5 strata payment errors do not total the overall payment errors.

MPES - TABLE 3
Dollar Value of Errors By Category

Error Category	Dollars Paid In Error	% of Total Total Paid In Error	No. Of Claims With An Error
MR2A- Poor Documentation	\$1,642.72	39.1%	18
MR7- Policy Violation	\$685.37	16.3%	10
MR5- Medically Unnecessary Service	\$472.36	11.3%	14
MR1A- Billing Provider Did Not Submit Documentation	\$332.36	7.9%	7
MR2B- Service Not Documented At All	\$330.13	7.9%	10
MR3- Coding error	\$293.6	7.0%	10
P9- Ineligible Provider	\$188.97	4.5%	3
P5- Pricing Error	\$174.58	4.1%	6
MR1B- Referring Provider Did Not Submit Documentation	\$83.07	1.9%	2
Total	<u>\$4,203.16</u>	<u>100.00%</u>	<u>80</u>

MPES – TABLE 4
Calendar Year 2003 Medi-Cal Fee-For-Service and Dental Payments By Quarter

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

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

Figure 1
Proportion of Sample Dollars Paid Correctly Vs. Dollars Paid In Error & Potentially Fraudulently

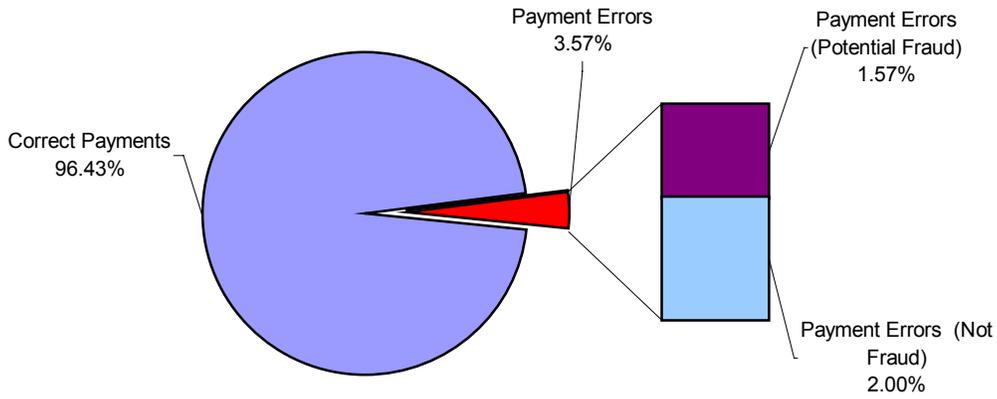


Figure 2 - Distribution of Sample Dollars Paid In Error By Error Category

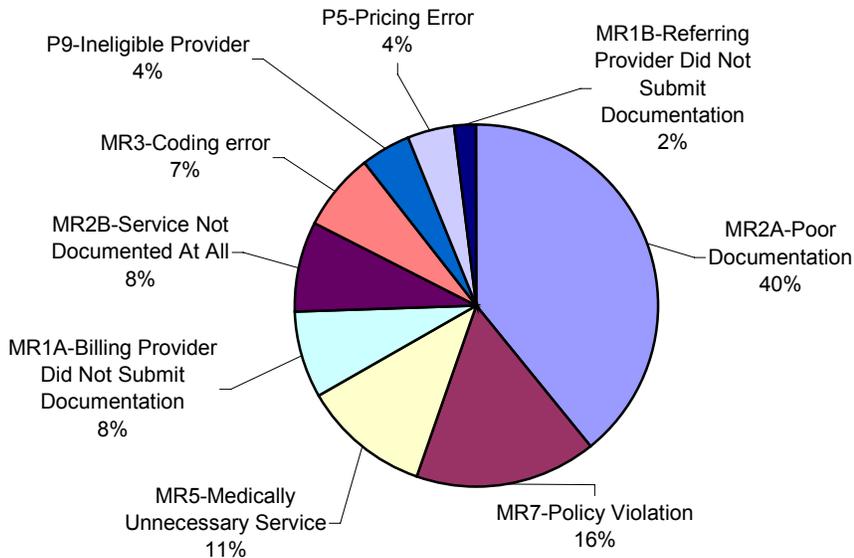
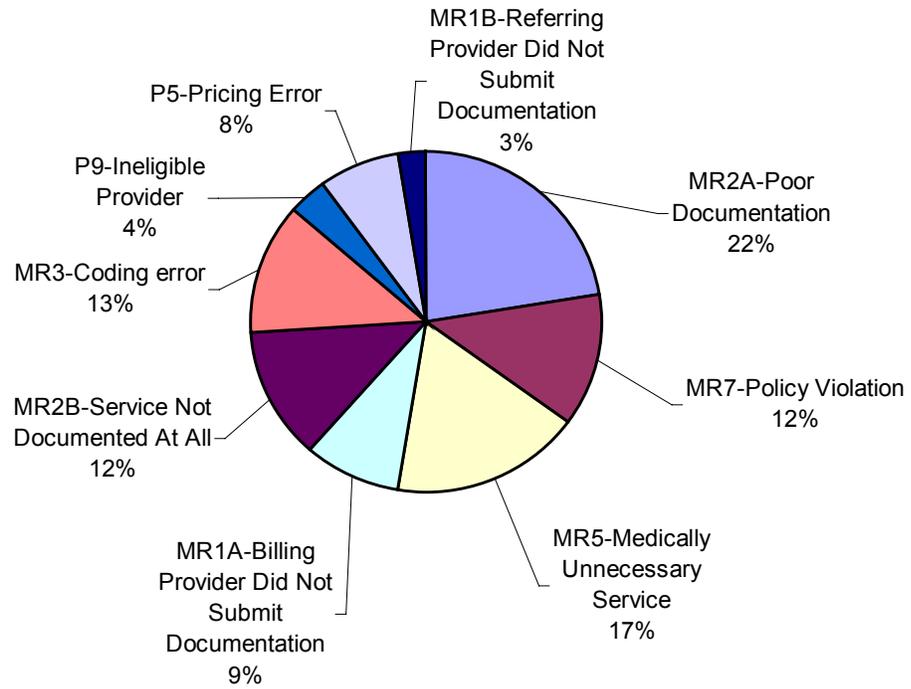


Figure 3 - Distribution of Sample Claim Errors By Error Category Total Number of Claims With An Error = 80



**PAYMENT ACCURACY
MEASUREMENT
(PAM)
STUDY**

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

**PAYMENT ACCURACY
MEASUREMENT
(PAM)
STUDY**

FY 2004 Pilot



**Arnold Schwarzenegger
Governor
State of California**

Kimberly Belshé
Secretary
California Health & Human Services Agency

Sandra Shewry
Director
Department of Health Services

PAYMENT ACCURACY MEASUREMENT

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* Attachments are available upon request to:
California Department of Health Services
Medical Review Branch, MS 2303
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

Payment Accuracy Measurement Summary

Background

In Fiscal Year (FY) 2003/04, DHS responded to the solicitation by the Centers for Medicare and Medicaid Services (CMS) to participate in the third year of the federally funded national Payment Accuracy Measurement (PAM) Pilot project. Participation in the PAM provided DHS with the opportunity to evaluate its Medi-Cal program against other states using a single methodology to measure payment accuracy.

In the third year of the PAM pilot, which consisted of three primary components: (1) Medicaid Fee-For-Service (FFS), (2) Medicaid Managed Care (MC), and (3) State Children's Health Insurance Program (SCHIP), states were not required to participate in all components, DHS chose to participate in only the FFS and MC components, because the SCHIP program is not administered by DHS. Also included in the PAM was a test of Medi-Cal eligibility for a sub-sample of beneficiaries in both FFS and Managed Care.

The following table provides a summary of the components of the Medi-Cal program that were included in the PAM study:

Medi-Cal Service Categories Included in the PAM Study

SERVICE CATEGORY	FY 2002/03 BUDGET ESTIMATE¹	CATEGORY/AMOUNT INCLUDED IN PAM STUDY
FEE FOR SERVICE (Physicians, Hospitals, NF, etc.)	\$17,078,676,620	\$17,078,676,620
DENTAL	\$ 765,854,300	\$ 765,854,300
MANAGED CARE	\$5,087,471,500	\$5,087,471,500
SHORT-DOYLE (MENTAL HEALTH)	\$1,369,763,000	
AUDITS/LAWSUITS	\$11,740,600	
EPSDT	\$30,613,500	
BUY-IN	\$1,187,004,700	
STATE HOSPITALS	\$336,503,000	
MISC. NON-FFFS	\$2,020,329,000	
RECOVERIES	- \$184,404,000	
GRAND TOTAL MED-CAL	\$27,733,552,220	\$22,932,002,420

PAM Findings

- DHS found that 98.4 percent of the dollars were billed and paid correctly.

¹ Numbers as projected in the Medi-Cal May 2003 Local Assistance Estimate

- Of the total dollars paid for claims, 1.6 percent were “at risk” of being paid in error. The term “at risk” is used because these dollars cannot be considered as potential savings unless all the individual services that are questionable are confirmed to be paid in error through a complete medical record review or audit.
- Medi-Cal institutional provider types (e.g., hospitals, Nursing Facilities (NF) facilities) that have more Medi-Cal programmatic oversight, requiring authorization prior to services being rendered, routine financial audits and licensing and certification reviews, had the highest payment accuracy rates and therefore, the lowest error rates.
- Non-institutional provider types (physicians, pharmacies, dentists, etc.), the largest category of providers, have less Medi-Cal programmatic oversight, fewer services requiring prior authorization, and disclosed the highest error rates. This finding is consistent with risk assessment in DHS’ Interim Anti-fraud Strategic Plan and current focus of the anti-fraud efforts.
- The prominent of all errors identified resulted from insufficient or lack of documentation. This does not necessarily mean that the services were not provided or were not medically necessary, and therefore may not represent overpayments.
- Four beneficiaries out of 46 reviewed in Medi-Cal Managed Care (MC) were identified as being ineligible for the program. Three were financial related and one was due to a computer system problem at the county. There were no eligibility errors found with the 54 beneficiaries reviewed in the FFS program.
- Some errors had already been identified independent of the PAM. Corrections are currently being implemented and administrative actions have been taken against these providers.

Conclusion

The PAM shows that the vast majority of Medi-Cal providers are billing and being paid appropriately. It also shows that DHS’ current focus on non-institutional providers, specifically physicians and pharmacies, is indeed targeting the area of highest risk for billing errors and potential fraud. The PAM did not find any claims processing errors, which indicates that the prepayment edits and audits used by Electronic Data Systems (EDS) and Delta Dental appear to be working properly.

The study did identify areas of the FFS Medi-Cal program that were at-risk for billing and payment errors. Some of these errors had previously been identified independent of the PAM and corrections are currently being implemented. Billing and payment errors such as billing code abuses (up-coding or splitting codes to increase reimbursement), as well as documentation inadequacies, were also found and when addressed, will enhance the accuracy of Medi-Cal payments.

To address the billing and payment errors identified DHS will:

- Review the claiming patterns of all providers that had claims identified as having dollar-impact errors and determine if additional case development and investigation is warranted.
- Expand the number of investigational and routine compliance audits, (specifically in the area of physicians, physician groups and pharmacies) to provide a more in-depth look at billing code abuses that may not be identifiable through the pre-payment edits and audits.
- Include physician groups in the re-enrollment plan for FY 2004/05 and FY 2005/06 to ensure DHS has updated and accurate provider disclosure information.
- Develop a plan for educating providers on appropriate documentation and providing feedback to providers regarding their billing practices. This will include but not be limited to working with provider associations to conduct training sessions, and providing information in Medi-Cal provider bulletins.
- Work with fiscal intermediaries (EDS and Delta Dental) to identify additional claims payment edits and audits, as well as additional analytical techniques to identify procedure code abuses.
- Evaluate the results of the study to identify where Medi-Cal laws, regulations and policies can be enhanced to prevent and detect billing or payment errors. DHS will also work collaboratively with the Legislature, DOJ and the provider associations to obtain their input and support for programmatic changes to prevent billing or payment errors.
- Explore the wide variety of technology-based solutions being proposed by the industry, such as counterfeit proof prescription pads and fraud detection software.
- Work with county governments to ensure that eligibility re-determinations are appropriate and completed in a timely manner and that computer systems are operating properly.

I. Overview of the Project

A. Study components

1. Medicaid (Medi-Cal) Fee-For-Service

The Medi-Cal FFS component included reviews of both services and beneficiary eligibility, and also included the Denti-Cal FFS claims paid through a capitation contract with Delta Dental.

2. Medicaid (Medi-Cal) Managed Care

The Medi-Cal Managed Care component included a review of capitated payments made to MC plans and a review of beneficiary eligibility to participate in the Medi-Cal program. This component did not include a review of services by MC plan providers.

3. SCHIP Fee- For-Service

Not applicable/Not included in study

4. SCHIP Managed Care

Not applicable/Not included in study

B. Medicaid Fee-For-Service

1. Overview

In California, Medi-Cal eligibility is determined at the county level based upon state or federal requirements.

Approximately 3.1 million (46 percent) of the 6.5 million eligible Medi-Cal beneficiaries are in the FFS system.

Medical payments for the FFS system are made through the fiscal intermediary, Electronic Data Systems (EDS), and dental services are paid via a capitated contract with Delta Dental, which pays dental claims on a FFS basis. These entities process and adjudicate claims against state-established claim adjudication edits and audits, and payment guidelines. Payments to providers are subject to pre- and post-payment reviews, special claims reviews, annual cost report audits and rate setting audits. California also employs an extensive prior authorization system in the FFS program to grant service approval before a claim can be submitted for services, such as hospital care and/or many outpatient services. DHS has an extensive anti-fraud program to prevent and detect fraud, waste and abuse in the Medi-Cal program.

2. Data sources and sampling methods

a. Sampling unit

In most cases, the sampling unit was one claim line, which represents one specific service that was billed to the Medi-Cal program. The exception to this one claim line/one service-sampling unit was hospital inpatient claims. In these cases, one paid claim line may represent a summation of many

different services because DHS' method of reimbursement for the majority of hospitals is through contracts with an all-inclusive rate per day.

b. Sampling universe

The sampling universe consisted of FFS medical claims paid through EDS and FFS dental claims paid through California's capitated dental plan, Delta Dental. These sample claims were paid during the months of October 2003 through December 2003 as prescribed by the PAM methodology. Claims not processed through EDS, such as non-federally subsidized claims (state-only aid codes), Medicare/Medi-Cal dual eligibility claims, and claims with zero payment amounts, were excluded from the sampling universe.

c. Sample size

The FFS sample size selected was 864, which was obtained by utilizing the sampling size tool at the PAM Pilot website. This sample size ensured that the resulting estimate could be made within +/- 3 percent of the true accuracy rate with 95 percent confidence.

d. Sample stratification

A proportional, stratified random sample was drawn in March 2004 to allow for a 60-day period for payment adjustments to occur. The sample sizes within each stratum (category of service) were determined using the proportion of the total dollars paid for the line items represented by each stratum in the most recent four quarters prior to the sampling period.

Two changes were made to the strata recommended in the PAM Pilot project description. Because Primary Care Case Management (PCCM) no longer exists in California as defined by federal guidelines, this stratum was eliminated from the study and a dental stratum was added. For calculation of the payment accuracy measure, the dental stratum was combined with the Physician Services category. The overall sample size, as well as sample sizes within strata (Table I), were developed using the sampling size tool provided on the CMS PAM Pilot website, see Appendix I for Sampling Plan.

**Table I: Stratum Sizes
By Number of Items and Dollar Value**

Stratum	Sample Size (claim lines)	Percent of Sample	Sample Size by Expenditures	Percent of Expenditures
Inpatient Hospital	187	21.7%	\$1,097,461	80.9%
Nursing Facilities	175	20.3%	220,111	16.2%
Physician Services	186	21.5%	13,759	1.0%
Prescription Drugs	247	28.5%	20,352	1.5%
Home & Community Based Services	16	1.9%	3,321	0.2%
Other Services & Supplies	53	6.1%	1,502	0.1%
Total	864	100.0%	\$1,356,506	100.0%

3. Any differences between the study methodology used and the Year 3 core model

DHS followed the Year 3-core model without deviation.

4. Processing review protocol

Validation of claims processing focused on correct submission of claims to EDS or Delta Dental and accurate claim adjudication resulting in payment. The claim processing system was reviewed by comparing the provider’s billing information and medical records to the adjudicated claims. DHS prescribed audits and edits within the EDS and Delta Dental adjudication process were reviewed in conjunction with the medical review of the sample claims.

5. Medical review protocol

a. Documentation retrieval for claim substantiation

Specific audit objectives were developed to guide data collection for each provider type reviewed in the study (Attachment G). While not required by the PAM protocols, to ensure integrity of the documentation, multidisciplinary staff collected the claim data from the providers in person. In some cases, many requests were necessary to ensure the documents for the claim review were complete.

b. First level medical review

The initial reviews of claims were done at multiple field offices. This consisted of a first review by the staff member who collected the data and then a second review by supervisors and licensed medical staff (e.g. physicians, dentists, and registered nurses).

The claims were reviewed for all of the following components: (1) that the episode of treatment was accurately documented, (2) that the provider was eligible to render the service, (3) that the documentation was complete, (4) that the claims were billed in accordance with laws and regulations, (5) that the amount of payment for the claim was accurate, and (6) for inpatient and direct physician service claims, documents substantiating that the service was medically necessity were also evaluated.

c. Second level medical review

To ensure consistency and accuracy of the first level review findings, a Peer Review Committee (Committee) of medical consultants and a dental consultant subjected all claims with dollar errors to another review. The Committee gave a consensus opinion on all aspects of the six components listed above and consulted with other specialists, such as pharmacists and optometrists, when needed. In addition, Medi-Cal program specialists were also consulted to ensure accuracy. For example, pricing errors were confirmed with EDS, and provider eligibility errors were confirmed with DHS Provider Enrollment Branch (PEB).

d. Third level medical review

Finally, the Chief Medical Consultant for the Medi-Cal program reviewed all errors to ensure that they were identified correctly consistent with existing Medi-Cal policy.

e. Quality assurance of non-errors protocol

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

6. Eligibility review protocol (e.g., whether Option 1 or Option 2 was used, how sub-sample was pulled, exclusions used, if cases were dropped, reasons for drops, and how cases were replaced)

a. Which option used

Option 1, which is a full Medicaid Eligibility Quality Control (MEQC) review of beneficiary eligibility at the time of service, was selected for the study.

b. How sub-sample was pulled

Although the study required an eligibility sub-sample of 50 to be selected,

an eligibility sub-sample of 60 beneficiaries' eligibility cases was randomly selected from within the sample of 864 payments. The larger sub-sample was selected to allow for case replacement during the course of the study.

c. Exclusions used

The sub-sample excluded cases where Medi-Cal eligibility is automatic, due to eligibility for other programs. This would include Supplemental Security Income (SSI), adoption assistance/foster care, refugee programs that are 100 percent federally funded, and California's Public Assistance program, CalWORKS (CW).

d. Reasons for dropped cases

1. Cases in which the beneficiaries were receiving cash assistance from CW or SSI were dropped because they are subject to CW or SSA quality control.
2. Cases that are funded 100 percent by Federal Government funds are not reviewed by MEQC and were dropped from the study.
3. Cases that appear twice in the same six-month base period were dropped from the study.
4. All cases receiving minor consent services exclusively were dropped from the study.
5. All cases receiving Edwards Aid Code 38 (cases transitioning from cash-grant-linked Medi-Cal to Medi-Cal assistance only coverage) for the review month were dropped from the study.

e. How cases were replaced

As stated previously, the state statisticians provided 60 eligibility sub-samples, 10 greater than what was required to allow for cases that would be dropped. This process made it more likely we would reach the desired goal of 50 cases for FFS program. After dropping cases, there were 54 beneficiary cases remaining for the eligibility review.

f. PAM beneficiary case review process

Steps for the beneficiary case reviews included:

1. Review of Medi-Cal Eligibility Data System (MEDS) and Income and Eligibility Verification System (IEVS) information on the beneficiaries prior to reviewing the case records in various county offices.
2. Review of county case records to assess whether eligibility was determined correctly and if the share of cost, if any, was computed correctly.
3. Home visits were completed on the cases when it was deemed appropriate (i.e., cases with income or family composition issues, potentially outdated information, or other possible discrepancies).
4. Third party verifications were obtained, when appropriate, to clarify inconsistencies or to confirm reported information.

C. Medicaid (Medi-Cal) Managed Care

1. Overview

MC is available in 24 of California's 58 counties and provides services to 52 percent or 3.54 million of all Medi-Cal beneficiaries. Distribution of eligibles by major aid category is approximately 47 percent Public Assistance and 45.1 percent Medically Needy and Indigent. The distribution of eligibles by aid category varies between counties depending upon the type of MC plan contracted in any given country.

To obtain Medi-Cal benefits under a MC plan in California, county eligibility workers establish whether an applicant is eligible for Medi-Cal. Based upon the eligibility criteria, the beneficiaries are placed in an aid code that establishes which services and MC plan choices are available. A state contractor is responsible for providing plan choices to the beneficiaries and for entering their plan of choice into the MEDS database. DHS extracts the beneficiary data from the MEDS for summarization by county, aid code and plan for payment computation. DHS Medi-Cal Managed Care Division inputs the beneficiary summary data into an Excel spreadsheet for payment computation. A payment request is then made to DHS Accounting, and the plan is pre-paid for the liability of the beneficiary's month of care.

2. Data sources and sampling methods

a. Sampling unit

The sampling unit, as prescribed by the CMS PAM Pilot, was the capitation payment to a MC plan contractor. Review of capitation services delivered and under or over utilization of services was not part of this study's scope.

b. Sampling universe

The sampling universe consisted of Medi-Cal eligibility records with a Health Care Plan Status of "1," designating a MC plan assignment, which after summarization in the Monthly Capitation Report resulted in a payment during the months October 2003 through December 2003 inclusive. Plans categorized as "Special Projects," "FFS/MC" hybrid plans, and the California version of "PCCM" were excluded. Only capitation payments for beneficiaries with aid codes including Federal Financial Participation (FFP) were included in the universe. Beneficiaries with state-only aid codes, Medicare/Medi-Cal dual eligibles, and retroactive enrollments and disenrollments were excluded from the universe.

c. Sample size

The sample size selected was 864. This sample size ensured that the resulting estimate could be made within +/- 3 percent of the true accuracy rate with 95 percent confidence. A simple random sample was drawn with no stratification of the sample. The overall sample size was developed using the sampling size tool provided on the CMS PAM Pilot website.

3. Any differences between the study methodology used and the Year 3 core model

DHS followed the MC Year 3 core model without exception.

4. Processing review protocol

To conduct tests for payment accuracy, data for the 864 beneficiaries were processed through the DHS data processing systems in order to verify that a through-the-system test would duplicate the operational results for the sample. The test compared beneficiary identification data that would have been used by the contractor to the operational outcomes of the MC plan's payment amount.

The test replicated the samples known outcome, except the results varied for 21 beneficiaries. Upon further inquiry, these 21 beneficiaries all had eligibility or eligibility aid code changes between the original eligibility determination and the data processing test that accounted for the changed result. This test measured only the input data to the output data without consideration for the findings from the eligibility review.

Staff then established whether proper computations were made for each of the aid code payment rates and that correct payment was made to each of the contracting plans. An error would result from any payment that did not correspond with the contractual pricing schedule. No errors were found during this review.

Staff tested to determine if any MC plan-covered beneficiary claims were in the FFS claims database to determine duplication of payments made for any services. A contractually covered service error would result if the beneficiary was enrolled in a MC plan that should have covered the service and it was inappropriately billed as a Medi-Cal FFS claim. No duplications were found.

Many Medi-Cal MC plan contractors have services that are not contractually covered (carved out services). A master list of all the plan's carved out services is provided to EDS for claim edit purposes. A total of 124 carved out claims from the MC sample population were adjudicated as payable during the review scope period. Each of these claims was compared to the carved out services listing for claims processing. Each claim appeared to be properly adjudicated. All 124 claims were also in the FFS population and subject to being in the FFS sample for claims review.

5. Eligibility review protocol

a. Which option used

Option 1, which is a full MEQC review of beneficiary eligibility at the time of service, was selected for the study.

b. How sub-sample was pulled

Although the study required an eligibility sub-sample of 50 to be selected, an eligibility sub-sample of 60 beneficiaries of eligibility cases was randomly selected from within the sample of 864 payments. The larger sub-sample was selected to allow for cases that would be replaced during the course of the study.

c. Exclusions used

The sub-sample excluded cases where Medi-Cal eligibility is automatic, due to eligibility for other programs. This would include SSI, adoption assistance/foster care, refugee programs that are 100 percent federally funded and CW.

d. Reasons for dropped cases:

1. Cases in which the beneficiaries were receiving cash assistance from CW or SSI were dropped because they are subject to CW Quality Control or SSA oversight.
2. Cases with 100 percent Federal Government funding were not reviewed by MEQC and were dropped from the study.
3. Cases that appeared twice in the same six-month base period.
4. All cases receiving minor consent services exclusively.
5. All cases receiving Edwards Aid Code 38 (cases transitioning from cash grant linked Medi-Cal assistance only coverage) for the review month were dropped from the study.

e. How cases were replaced

State statisticians provided eligibility sub-samples of 60, 10 greater than what was required to allow for cases that would be dropped, to contact or resolve the case. This process made it more likely the desired goal of 50 cases would be reached for each MC program. In the MC eligibility sample, 46 cases were reviewed.

f. PAM beneficiary case review process

The MC eligibility review followed the same guidelines as the FFS review.

D. SCHIP Fee-For-Service

1. Overview

Not applicable / Not included in study

2. Data sources and sampling methods

Not applicable / Not included in study

3. Any differences between the study methodology used and the Year 3 core model

Not applicable / Not included in study

- 4. Processing review protocol**
Not applicable / Not included in study
 - 5. Medical review protocol**
Not applicable / Not included in study
 - 6. Eligibility review protocol**
Not applicable / Not included in study
- E. SCHIP Managed Care**
- 1. Overview**
Not applicable / Not included in study
 - 2. Data sources and sampling methods**
Not applicable / Not included in study
 - 3. Any differences between the study methodology used and the Year 3 core model**
Not applicable / Not included in study
 - 4. Processing review protocol**
Not applicable / Not included in study
 - 5. Eligibility review protocol**
Not applicable / Not included in study

II. Findings, Medicaid

The following information is a summary of the types of findings and is extracted only from errors resulting in an incorrect payment. For a complete list of error details, please refer to Attachment B.

A. Summary statistics table and notable findings, by component

1. Fee-For-Service errors

The most common error among all provider types in FFS was insufficient documentation to support the service billed. The FFS review also revealed billing code abuses, such as billing for codes that would provide a higher rate of reimbursement, and that ADHC providers were billing and being paid for more days than were authorized. The ADHC billing problem had independently been identified and corrected in the billing system so this payment error should no longer occur. Also identified in the FFS review was one NF claim that was billed at the Skilled Nursing Facility (SNF) rate. Review of the provider records determined that the appropriate level of care should have been Intermediate Care Facility (ICF), which is paid at a lower rate. The Medi-Cal field office that approved the SNF level of service did not have a choice for the lower level of care because the ICF rates were not on the SNF payment file.

Overall, in the FFS program billing errors occurred more often in among non-institutional provider types, such as Physicians, Other Services and Supplies, than among institutional provider types, such as Inpatient Hospitals and NF facilities. Not only are there a large number of non-institutional providers but they have a high claim volume and are subject to less program utilization control, which results in a higher risk for errors. Institutional providers have more oversight, such as prior authorization, routine audits and licensing and certification activities, which results in a lower risk for payment errors.

Summary Statistics

Total cases reviewed	864
Dollar value of cases reviewed	\$1,356,507.23
Number of overpayment errors	29
Dollar value of overpayment errors	\$4,259.53
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	29
Absolute dollar value of errors	\$4,259.53
Overall accuracy rate	99.69%

2. Managed Care errors

No errors were found in the capitation payments made to the MC plans. All four of the MC errors related to beneficiary eligibility. The initial eligibility sample of 60 beneficiaries was reduced to 46 cases because of the transitioning from public assistance grants (CW) to Medi-Cal only. The means of service delivery had no effect on the eligibility case findings. The errors are

related solely to the beneficiaries not being eligible to participate in the Medi-Cal program at the time of service.

In one case, a beneficiary's financial resources exceeded the need level during the service month and the individual was not aware of his continued Medi-Cal coverage. A second case involved the continued inclusion in the family budget unit of a parent that no longer resided in the home. The third case was due to the expiration of transitional Medi-Cal benefits. The last case was for a beneficiary's eligibility that had expired on the county records, but the county system did not properly interface with the state's eligibility system to remove the beneficiary's eligibility status.

Summary Statistics

Total cases reviewed	864
Dollar value of cases reviewed	\$85,541.58
Number of overpayment errors	4
Dollar value of overpayment errors	\$308.15
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	4
Absolute dollar value of errors	\$308.15
Overall accuracy rate	99.64%

B. Summary statistics table and notable findings, by error type

1. Processing review errors

Both errors, from two separate claims reviewed, are related to the same ineligible provider. A laboratory that added a location failed to comply with both the federal Clinical Laboratory Improvement Act (CLIA) and state licensing regulations. DHS Laboratory Field Services has been notified and is working to bring this provider into compliance.

Summary Statistics

Total cases reviewed	864
Dollar value of cases reviewed	\$1,356,507.23
Number of overpayment errors	2
Dollar value of overpayment errors	\$12.66
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	2
Absolute dollar value of errors	\$12.66
Overall accuracy rate	100.00%

2. Medical review errors

There were 27 medical review errors. Eighteen of these 27 errors were related to insufficient or no documentation to support the claim. Examples include the following: a provider billed for a 15-minute team conference, but after two requests, could not provide any documentation to support this claim. In another instance, the provider billed for 2.5 hours of perinatal group

education for a six-week pregnant patient. No education was documented in this patient's medical record for the date of service claimed.

Summary Statistics

Total cases reviewed	864
Dollar value of cases reviewed	\$1,356,507.23
Number of overpayment errors	27
Dollar value of overpayment errors	\$4,246.87
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	27
Absolute dollar value of errors	\$4,246.87
Overall accuracy rate	99.69%

3. Eligibility review errors

Eligibility errors in the FFS sample did not cause claim overpayments. None of the errors were related to ineligible recipients. Share of cost (SOC) issues found would not impact the claims reviewed in the sample. One SOC error involved the county failing to act on the 2003 Social Security Cost of Living Allowance increase. The amount paid for the claim in the sample would not have changed because of the difference in SOC. In total, there were four SOC errors related to FFS claims with no correlation to the amount paid for the sample claims.

Summary FFS Statistics

Total cases reviewed	60
Less cases dropped	6
Cases reviewed	54
Dollar value of cases reviewed	\$195,026.70
Number of overpayment errors	0
Dollar value of overpayment errors	\$0
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	0
Absolute dollar value of errors	\$0
Overall accuracy rate	100.00%

C. Summary statistics table and notable findings, by strata (provider type)

1. Hospital/inpatient errors

There were two inpatient errors. One is related to insufficient documentation to support the claim. After multiple requests, the hospital failed to provide physician progress notes, physician orders and nursing notes. There was no documentation to support the second two days of a beneficiary's hospital visit. The beneficiary was stable with lab results within normal limits and no medical issues in the medical record during the second two days. The other error is related to a policy violation – billing for an outpatient service four days prior to admission but lumping these outpatient services into a later inpatient stay.

Summary Statistics

Total cases reviewed	187
Dollar value of cases reviewed	\$1,097,461.28
Number of overpayment errors	2
Dollar value of overpayment errors	\$3,090.80
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	2
Absolute dollar value of errors	\$3,090.80
Overall accuracy rate	99.72%

2. Nursing Facilities (NF) errors

The one error in this category relates to a beneficiary not meeting the criteria for the level of care billed and paid. This claim is for a weeklong stay in a SNF. However, the medical record documents impairments that are not severe enough to require this level of care.

Summary Statistics

Total cases reviewed	175
Dollar value of cases reviewed	\$220,111.39
Number of overpayment errors	1
Dollar value of overpayment errors	\$272.86
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	1
Absolute dollar value of errors	\$272.86
Overall accuracy rate	99.88%

3. Physician Services (includes physicians, dentists, clinics, pathology, osteopaths, radiology, family planning clinics)

There are 16 errors in the category “other individual practitioners and clinics.” Thirteen of these errors involved insufficient or no documentation to support the claim. For example, a provider billed for 15 minutes of perinatal education, but there was no documentation in the medical record to support this claim. One of the dental providers billed for additional X-rays that were not documented in the charts.

Summary Statistics

Total cases reviewed	186
Dollar value of cases reviewed	\$13,759.46
Number of overpayment errors	16
Dollar value of overpayment errors	\$413.51
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	16
Absolute dollar value of errors	\$413.51
Overall accuracy rate	96.995%

4. Prescription drugs

There are four pharmacy claim errors. Three of these errors are related to insufficient documentation to support the claim. For example, a pharmacy was unable to produce a valid prescription for a medication that was dispensed. One error related to a policy violation. The pharmacy dispensed twice as much medication as the prescription called for. The provider had obtained prior authorization for 60 tabs per month, but when the prescription changed to 30 tabs per month, the provider continued to dispense the quantity approved by Medi-Cal instead of the quantity actually prescribed.

Summary Statistics

Total cases reviewed	247
Dollar value of cases reviewed	\$20,351.71
Number of overpayment errors	4
Dollar value of overpayment errors	\$302.83
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	4
Absolute dollar value of errors	\$302.83
Overall accuracy rate	98.51%

5. Home and community-based services (including home health agencies, services, and home/community-base waiver services)

The study did not find any errors associated with Home and Community Based Services.

Summary Statistics

Total cases reviewed	16
Dollar value of cases reviewed	\$3,321.01
Number of overpayment errors	0
Dollar value of overpayment errors	\$0
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	0
Absolute dollar value of errors	\$0
Overall accuracy rate	100.0%

6. Other services and supplies (includes laboratory, optometry, and Adult Day Health Centers)

Two claims are related to insufficient or no documentation to support the claim and two are related to the same ineligible provider that did not have current CLIA and state licenses. Two ADHC providers submitted a TAR for three days of service per week. Two days per week were approved. However, the provider billed for and was paid for three days a week. This vulnerability in the claims system is currently being addressed through Medi-Cal policy and EDS and thus, this type of ADHC error payment should be prevented in the future.

Summary Statistics

Total cases reviewed	53
Dollar value of cases reviewed	\$1,502.37
Number of overpayment errors	6
Dollar value of overpayment errors	\$179.53
Number of underpayment errors	0
Dollar value of underpayment errors	\$0
Total number of errors	6
Absolute dollar value of errors	\$179.53
Overall accuracy rate	88.05%

7. PCCM

Not applicable / Not included in study.²

² For complete description of service related error with dollar impact, see Attachment B.

III. Findings, SCHIP

A. Summary statistics and notable findings, by component

Not applicable / Not included in study

1. Fee-For-Service

Not applicable / Not included in study

2. Managed Care or premium payments

Not applicable / Not included in study

B. Summary statistics and notable findings, by review type

Not applicable / Not included in study

1. Processing review

Not applicable / Not included in study

2. Medical review

Not applicable / Not included in study

3. Eligibility review

Not applicable / Not included in study

IV. Summary and Conclusions

A. Description of any significant issues or problems encountered during the course of the project, and how they were resolved

There were three primary issues encountered in conducting the study: (1) maintaining consistency in the document collection and review processes; (2) obtaining complete documentation from the providers; and (3) the error codes available were too broad to differentiate the errors.

Because there were multiple teams involved in the first level medical review, maintaining consistency in the review decisions was difficult. For example, some reviewers assigned an error when documentation was missing, while others went to great lengths to contact providers to obtain documentation. To ensure consistency, a second level medical review team was tasked with addressing inconsistencies. To ensure that all claims data was collected, subsequent rounds of data collection efforts ensued. This required several contacts with the provider, including notification that the provider could be subject to an administrative sanction if the documentation was not provided.

It was also determined that the error codes available in the PAM were too broad, and consequently did not adequately identify the types of errors. The team developed error codes that more closely represented the errors they were seeing (refer to Attachment I for details). Again multiple re-reviews of claims were needed to ensure consistency.

B. Lessons learned that may be helpful to other states and to CMS

DHS learned some practical lessons about improving procedures and processes in its first PAM study.

One significant problem encountered was consistency in data collection. To facilitate data collection, a check sheet should be used to ensure all documentation needed has been collected. In addition, staff at all levels should receive training to ensure efficiency, consistency and completeness of data collection and review. A manual with detailed protocols to guide staff through every step of the document collection and review process should be developed. These protocols could then be updated and improved upon each year of the study.

DHS used multiple field offices for data collection; this made the project difficult to manage. Use of a centralized team would have been more effective and resulted in fewer inconsistencies.

The PAM study allows for a mail-in approach for documentation collection. Looking at the results from past PAM studies, states experienced a much lower rate of receipt than California, which used an on-site data collection approach. Only two providers (0.23 percent of total claims) failed to submit any documentation. However, this rate was only achieved through on-site visits and intense follow-up with the providers.

To assist with the claim data collection process, when first approaching a provider to gain cooperation, the letter used to introduce the project should have explicit directions regarding the provider's role and the expectations. Any steps that the State or Federal Government is prepared to take in the unlikely event of the provider's failure to cooperate should be clearly stipulated at the outset.

A greater level of review needs to occur when the documents are collected on-site to ensure that a complete package of documents is obtained. To increase the likelihood of consistent medical reviews and findings, the remaining review process and assignment of error codes should be centralized.

A hierarchy of errors should be developed to streamline continuing review decisions. Certain errors at the top of the hierarchy would make further review unnecessary. For example, it would not be necessary to review medical records in detail if the rendering provider is not eligible to bill Medi-Cal. Further, assigning the final categorical code for the errors should be deferred at the last stage of review.

Because of the complexity of the Medi-Cal program, it was critical that appropriate experts be consulted to verify the accuracy of the errors. The fiscal intermediary should review all pricing issues and specialists of the pertinent Medi-Cal program sections should also review all claims errors to confirm the accuracy of the findings with regulations and policies.

C. Recommendations for Implementation for Future Studies

It is recommended that the sample methodology for allocating sampling units to each strata of the sample be changed from "dollar driven" to "volume driven." This would be more effective at identifying the extent of program vulnerabilities. Since the PAM Pilot sample methodology was driven by dollars, more high cost services like hospitalization and long-term care stays were selected. While institutional providers have high reimbursements from the program, they have greater internal controls in addition to greater program controls, such as prior authorization, audits and licensing and certification activities. Thus, the error rate was low (.1 percent-.3 percent). Whereas non-institutional provider types, such as physicians, who are large in number and have higher volume of claims at a lower cost than institutional claims, were selected less frequently with this prescribed process. But non-institutional providers have fewer internal controls, and because of the number of providers, there is less program oversight. Even in this limited PAM Pilot sample of non-institutional providers, the review identified an error rate of 3 percent, which is three times that of the institutional providers.

Because of the dollar driven methodology, DHS could not rely on the PAM Pilot study entirely to identify program vulnerabilities. The sample methodology in California's Medi-Cal Payment Error Study (MPES), which was conducted concurrently with the PAM, was a "volume driven" selection allocation. As a

result in the MPES, there were a higher number of non-institutional provider types such as, physicians, pharmacies and laboratories selected in the sample.

A significant portion of the errors found in the PAM was due to poor documentation. Most of the services were likely medically necessary and provided to the beneficiary. Because these types of errors are computed as a dollar error, it could be misleading and the Federal Government, state Legislators and program managers may equate errors with potential cost savings. Consideration should be given to separately noting those errors associated with poor documentation and those that are clearly overpayment errors.

V. Final Report Attachments

A. Summary of Payment Accuracy Statistics -- Medicaid Program

State: California

	Payment Accuracy Rate	Estimate using Bootstrap Method ³			Projected Total \$ Value of Errors
		Standard Error	95% Confidence Interval	Point Estimate of Rate	
TOTAL	98.4	0.67	97.2 – 99.6	98.4	\$ 75,416,551
Total, FFS	98.1	0.76	96.6 – 99.6	98.1	\$ 72,444,822
Hospital	99.7	0.23	99.2 – 100.0	99.7	\$ 2,389,736
NF	99.9	0.12	99.7 – 100.0	99.9	\$ 762,777
Physician Services	97.0	1.10	94.6 – 99.0	96.8	\$ 23,536,195
Rx	98.5	1.35	95.8 – 100.0	98.4	\$ 17,375,097
HCBS	100.0	*	*	100.0	\$ -
Other	88.1	*	*	87.9	\$ 28,800,485
PCCM, if app.	n/a	n/a	n/a	n/a	n/a
Total, MC	99.6	0.20	99.3 – 100.0	99.6	\$ 3,602,596

	Number of Items in Sample	\$ Value of Items in Sample	Number of Items in Universe	\$ Value of Items in Universe	Proportion of Items in Sample	Proportion of Dollars in Sample	Proportion of Items in Universe	Proportion of Dollars in Universe
TOTAL	1,728	1,442,049	46,506,825	4,713,534,445	1.0000	1.0000	0.00003716	0.00030594
Total, FFS	864	1,356,507	37,315,554	3,812,885,370	0.5000	0.9407	0.00001858	0.00028779
Hospital	187	1,097,461	141,223	796,578,639	0.1082	0.7610	0.00000402	0.00023283
NF	175	220,111	578,507	762,777,337	0.1013	0.1544	0.00000376	0.00004722
Physician Ser	186	13,759	15,390,790	784,539,829	0.1076	0.0095	0.00000400	0.00000292
Rx	247	20,352	14,449,313	1,158,339,808	0.1429	0.0141	0.00000531	0.00000432
HCBS	16	3,321	339,863	68,628,874	0.0093	0.0023	0.00000034	0.00000070
Other	53	1,502	6,415,858	242,020,884	0.0307	0.0010	0.00000114	0.00000032
PCCM, if app	n/a	n/a	n/a	n/a	n/a	n/a	n/a	n/a
Total, MC	864	85,542	9,191,271	900,649,075	0.5000	0.0593	0.00001858	0.00001815

³ Estimates were made by generating 1,000 samples with replacement (bootstrapping). The point estimate is the mean of the 1,000 samples; the standard deviation comprises the simulated standard error.

* Stratum size is too small to report the standard error and confidence interval.

**B. Summary of Errors -- Medicaid Program
State: California**

Overpayments

FFS Processing Errors	# of Errors	\$ Value of Errors	FFS Medical Review Errors	# of Errors	\$ Value of Errors	Managed Care Errors	# of Errors	\$ Value of Errors
Duplicate item			No documents provided	2	27.87	Ineligible beneficiary	4	308.15
Non-covered service			Insufficient documentation	16	2868.49	Incorrect payment amt		
MCO covered service			Coding error	5	429.51	FFS payment in error		
Third party liability			Unbundling			Other		
Pricing error			Medically unnecessary	2	139.16			
Logical edit			Administrative error					
Ineligible recipient			Policy violation	2	781.84			
Data entry errors			Other					
Other (ineligible provider)	2	12.66						
Total	2	12.66	Total	27	4246.87	Total	4	308.15

Underpayments

FFS Processing Errors	# of Errors	\$ Value of Errors	FFS Medical Review Errors	# of Errors	\$ Value of Errors	Managed Care Errors	# of Errors	\$ Value of Errors
Duplicate item			No documents provided			Ineligible beneficiary		
Non-covered service			Insufficient documentation			Incorrect payment amt		
MCO covered service			Coding error			FFS payment in error		
Third party liability			Unbundling			Other		
Pricing error			Medically unnecessary					
Logical edit			Administrative error					
Ineligible recipient			Policy violation					
Data entry errors			Other					
Other								
Total			Total			Total		

If there is more than one error within the processing or medical review components, allocate the errors to reflect the dollars reduced or denied for the claim, in the order in which the errors are discovered

C. Detail of Reasons for Errors

Medical Claims

Detail: Overpayments

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
4	6 – Other Services	MR5	<i>This claim is for 1 day of Adult Day Health Care (ADHC). The provider submitted a Treatment Authorization Request for three days a week for this patient. The Medi-Cal TAR office denied this request, but approved two days a week. Provider billed and was paid for three days a week anyway. The error is for the total amount of the claim, one day of ADHC.</i>	\$69.58	\$0	\$69.58
7	6 – Other Services	MR5	<i>This claim is for 1 day of Adult Day Health Care (ADHC). The provider submitted a Treatment Authorization Request for three days a week for this patient. The Medi-Cal TAR office denied this request, but approved two days a week. Provider billed and was paid for three days a week anyway. The error is for the total amount of the claim, one day of ADHC.</i>	\$69.58	\$0	\$69.58
27	3 – Physician Services	MR3 & WPI (Wrong provider identified)	<i>The optometrist who billed for the service did not render the service. Both the rendering and billing providers are O.D.'s, are valid Medi-Cal providers, and they work in the same office. In addition, the wrong code was billed. The exam performed lacks a retinal exam, which is required to allow billing for the 92014 code (comprehensive ophthalmology examination). The rendering doctor explained that the retinal exam is usually performed when the patient comes to pick-up their glasses. In this case, however, the patient never received the retinal exam. The doctor admits there is a coding error. Since the wrong physician billed for the service, and the examination was incomplete, the error is calculated as the total amount paid.</i>	\$47.45	\$0	\$47.45
42	3 – Physician Services	MR1	<i>The provider billed for a team conference, 1/4 hour, but could not provide documentation after 2 requests. Therefore the error is calculated as the total amount paid.</i>	\$16.80	\$0	\$16.80
170	3 – Physician Services	MR3	<i>The provider billed for intra-arterial administration of chemotherapy, when in fact the medication was given intravenously. The correct code is 96408. The error was calculated as the difference between the amount paid (\$58.91) and the amount that would have been paid for the correct code 96406 (\$25.09).</i>	\$58.91	\$25.09	\$33.82
198	6 – Other Services	P9 (ineligible)	<i>Laboratories are required by law to be licensed by the federal laboratory licensing agency regulated under the "Clinical</i>	\$7.60	\$0	\$7.60

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
		<i>provider)</i>	<i>Laboratory Improvement Act" (CLIA license), and in California, by DHS ("state license"). This provider moved many months prior to the audit and did not notify either agency of its new location as required by law (within 30 days). The site-specificity of laboratory licensing was verified by CMS and DHS Lab Field Services. (In fact, the laboratory only recently became compliant with CLIA in July 2004 and is still non-compliant with DHS). Thus, because the laboratory was essentially unlicensed to perform any laboratory tests, the error was calculated as the total amount of the claim</i>			
199	6 – Other Services	P9 <i>(ineligible provider)</i>	<i>Laboratories are required by law to be licensed by the federal laboratory licensing agency regulated under the "Clinical Laboratory Improvement Act" (CLIA license), and in California, by DHS ("state license"). This provider moved many months prior to the audit and did not notify either agency of its new location as required by law (within 30 days). The site-specificity of laboratory licensing was verified by CMS and DHS Lab Field Services. (In fact, the laboratory only recently became compliant with CLIA in July 2004 and is still non-compliant with DHS). Thus, because the laboratory was essentially unlicensed to perform any laboratory tests, the error was calculated as the total amount of the claim</i>	\$5.06	\$0	\$5.06
323	4 – Rx	MR2	<i>The pharmacy was unable to provide a valid prescription for the medication dispensed. Therefore, the error is the total amount of the claim.</i>	\$265.35	\$0	\$265.35
350	1 – Hospital Inpatient	MR2	<i>The hospital submitted only three documents to support this claim: 1) History and Physical, 2) Discharge Summary, and 3) list of medications. Multiple attempts were made to obtain further medical records, but no physician progress notes, or nurses' notes, or orders were provided. The patient had chest pain and was admitted to the intensive care unit to rule out myocardial infarction (MI). The EKG, cardiac enzymes, and telemetry were normal. The hospital billed and was paid for two days of stay in the intensive care unit (ICU) on a separate claim line. This claim (#350) is for another two days of hospitalization outside of the ICU. There is no evidence in the documentation provided that there was medical necessity for hospitalization beyond the first two days in the ICU. Therefore the error was calculated as the total amount for the second two days.</i>	\$2334.00	\$0	\$2334.00

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
379	2 – Nursing Facilities	MR3	<i>This claim is for one week in a long-term skilled nursing facility (SNF). Medical records document impairments that are not severe enough to require this level of care. An Intermediate level of care (ICF) would be sufficient for a patient with mild dementia (short-term memory problems), fewer than seven medications, stable chronic medical problems, using a wheelchair, and requiring minimal assistance with bathing, feeding, and dressing. Provider used accommodation code 01 but should have used 21. The error was calculated as the difference between the cost for SNF and ICF.</i>	\$837.20	\$564.34	\$272.86
403	3 – Physician Services	MR2 & MR3	<i>The claim is for 76805-ZS (ultrasound of pregnant uterus, greater than or equal to 14 weeks, complete, with professional interpretation.) Three errors were found: 1) the pregnancy was less than 14 weeks, 2) the exam was "limited" not "complete" according to definitions in the CPT manual, since the exam was of the fetus only and did not include exam of maternal organs, and 3) there was no professional interpretation. Therefore the correct code would have been 76815-TC (ultrasound of the pregnant uterus, limited, technical component only.) The error was calculated as the difference between the reimbursement rates of these two codes.</i>	\$94.32	\$37.77	\$56.55
470	3 – Physician Services	MR2	<i>The provider billed for 2 and 1/2 hours of perinatal group education for this 6-week pregnant patient. The records fail to document that any education was given to this patient on the date of service claimed. Therefore the error is calculated as the total amount paid.</i>	\$28.10	\$0	\$28.10
490	3 – Physician Services	MR2	<i>An IV antibiotic, Sodium Ceftriaxone, was ordered by the emergency room physician (billed by the hospital), but not actually given to the patient. The patient was transferred to another hospital before the antibiotic ordered had been given. The medical record documents that the hospital alerted the accepting facility that the antibiotic would need to be given after transfer of the patient was completed. Therefore, the payment for the antibiotic is an error calculated as the total amount paid.</i>	\$40.50	\$0	\$40.50
520	3 – Physician Services	MR2	<i>The provider billed for checking the oxygen level of the patient, but the medical record did not contain results of the oxygen level. The charting of the results of this test is the only way to document that it was done. The error was calculated as the total amount billed.</i>	\$7.09	\$0	\$7.09

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
521	3 – Physician Services	MR2	<i>There was no documentation in the patient's medical record to verify that education and counseling (E&C) services were rendered apart from the regular obstetrical visit. The error was calculated as the total amount billed.</i>	\$8.41	\$0	\$8.41
562	6 – Other Services	MR2	<i>The claim was submitted by the optometry laboratory (PIA). The glasses were manufactured by the laboratory based on a prescription that was not signed by the optometrist. Therefore it was not a legal prescription and the error is calculated as the total amount of the claim.</i>	\$16.64	\$0	\$16.64
578	3 – Physician Services	MR2	<i>The provider billed 99201, a level 1, new patient office visit which requires, a problem focused history, a problem focused examination and straightforward decision making. For this code, physicians typically spend 10 minutes face to face with the patient. The clinic is billing this code for a patient coming in for a pregnancy test, but who does not see a provider. The correct code for this would be solely to bill for the pregnancy test itself (no office visit). The clinic admits there is no progress note for the visit in question (only a note that the pregnancy test is positive and that a follow-up appointment was booked). The error is calculated as the total amount paid</i>	\$22.90	\$0	\$22.90
581	3 – Physician Services	MR3 & WPI (wrong provider identified)	<i>The patient was billed as a new patient, but in fact, is an established patient. The service was upcoded. The service does not qualify for code 99204 (New patient, Comprehensive visit.) The correct code is 99213 (Established Patient, Low Complexity). In addition, the doctor who billed for the service did not see the patient. The service was provided by another physician at a different location who had been working together with the billing physician without an application to form a group. Since the doctor who billed for the service did not perform the service, the error is calculated as the total amount of the claim.</i>	\$68.90	\$0	\$68.90
635	4 – Rx	MR7	<i>This is a pharmacy claim for Labetalol tablets. The pharmacist obtained authorization (TAR) from Medi-Cal for sixty 200-mg tablets of this medicine, to be taken as one tablet twice a day (a one-month supply). Subsequently, the prescription was changed to "1/2 Tablet twice a day, #30 Tablets". Since the provider already had authorization to dispense 60 tabs, he did dispense all 60 tabs, which was then a two-month supply. Since it is illegal for a pharmacist to dispense more medication than that prescribed, the error was calculated as the total amount of the claim.</i>	\$25.04	\$0	\$25.04

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
642	3 – Physician Services	MR3	<i>The provider billed code 87070 for a urine bacterial identification. This code is reserved for any source EXCEPT urine, blood, or stool. The correct code to use for a urine specimen is 87088. The error is calculated as the difference between the amount paid for 87070, and the amount that would have been paid for the correct code.</i>	\$12.56	\$6.08	\$6.48
644	4 – Rx	MR2	<i>The pharmacy did not have a prescription for this claim. The pharmacist stated they had inadvertently billed for a 10-day supply of Nortryptiline, which was never filled. The error is calculated as the total amount of the claim.</i>	\$6.36	\$0	\$6.36
654	3 – Physician Services	MR2	<i>The provider was paid for two health education codes for this pregnant patient on this date. One is for Z6410 perinatal education, which is documented as 15 minutes of time in the patient's medical record. The other code billed on this date is the claim in question. It is for Z6406, 15 minutes follow-up health education. There was no documentation to verify that this service was done. A total of only 15 minutes of health education was documented. The error was calculated as the total of the claimed amount for Z6406.</i>	\$8.41	\$0	\$8.41
715	1 – Hospital Inpatient	MR7	<i>This claim is for nine codes, lumped into one hospital claim. The provider improperly billed for observation services (code 710), which occurred 4 days prior to delivery. When the patient comes in for observation and this stay does not result in a delivery, the hospital must bill separately for these services according to outpatient services guidelines (Provider Manual cont ip 13). It is improper to lump such outpatient services into the inpatient delivery bill. Therefore the error was calculated as the portion of the claim which was for outpatient observation.</i>	\$3,196.00	\$2,439.20	\$756.80
716	3 – Physician Services	MR2	<i>The provider billed for a psychosocial assessment for this pregnant patient. However, there is no documentation in the patient's record to substantiate that the patient received this service. The error was calculated as the total amount of the claim.</i>	\$12.10	\$0	\$12.10
767	4 – Rx	MR2	<i>The pharmacy dispensed this medication after the prescription had expired. The pharmacist subsequently provided us with a refill authorization, signed by the doctor in 2004, approving the refill. However, at the time the prescription was filled, there was no valid prescription. Therefore the error was calculated as the total amount of the claim.</i>	\$6.08	\$0	\$6.08
825	6 – Other Services	MR1	<i>The laboratory billed for this blood panel, but did not provide a diagnosis for the medical necessity of the test. Multiple</i>	\$11.07	\$0	\$11.07

ID Number	Stratum	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			<i>additional requests for documents were made to the prescribing physician, but no documentation was provided. Therefore, we calculated the error as the total amount of the claim.</i>			
MC-22	Managed Care	MC1	<i>Ineligible recipient, capitation paid in error.</i>	\$87.44	\$0	\$87.44
MC-58	Managed Care	MC1	<i>Ineligible recipient, capitation paid in error.</i>	\$115.21	\$0	\$115.21
MC-126	Managed Care	MC1	<i>Ineligible recipient, capitation paid in error.</i>	\$95.09	\$0	\$95.09
MC-271	Managed Care	MC1	<i>Ineligible recipient, capitation paid in error.</i>	\$10.41	\$0	\$10.41

Dental Claims

Detail: Overpayments

ID Number	Stratum	Error Code	Reason for Error	Amount paid	Correct Amount	Amount in Error
103	3 – Physician Services	MR2	<i>The provider billed for bite-wing x-rays, but did not properly describe in the patient record the type and number of x-rays taken. The record could not properly verify the date, type and number of x-rays. Therefore, it calls into question whether or not these are the x-rays taken on that date for that patient. The error was calculated as the total amount of the claim.</i>	\$10.00	\$0	\$10.00
154	3 – Physician Services	MR2	<i>The provider billed for an x-ray, however, did not properly describe in the patient record the type and number of x-rays taken (six in total). The record could not properly verify the date, type and number of x-rays. Therefore, it calls into question whether or not these are the x-rays taken on that date for that patient. The error was calculated as the total amount paid</i>	\$3.00	\$0	\$3.00
169	3 – Physician Services	MR2	<i>The provider submitted a claim for an amalgam filling; however, the record indicates a composite filling was placed. The claim was auto-adjudicated. Had it been manually reviewed, it would have been denied. The billed procedure does not match the record and the clinical record does not make sense. The error was calculated as the total amount of the claim.</i>	\$43.00	\$0	\$43.00

D. Timeline (actual and proposed)

Attachments are available upon request to:
California Department of Health Services
Medical Review Branch, MS 2303
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

E. Letters to providers requesting documentation

Attachments are available upon request to:
California Department of Health Services
Medical Review Branch, MS 2303
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

F. Beneficiary surveys or interview protocols

Attachments are available upon request to:
California Department of Health Services
Medical Review Branch, MS 2303
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

G. Written guidelines (e.g. review manuals) used for review or audit of services

Attachments are available upon request to:
California Department of Health Services
Medical Review Branch, MS 2303
1500 Capitol Avenue
P.O. Box 997413
Sacramento, CA 95899-7413

1. Hospital/inpatient
2. Nursing Facilities
3. Physician Services
4. Prescription drugs
5. Home and community based services
6. Other Services and supplies

H. Copies of RFPs for PAM contractors

Not applicable. No contractors used.

I. Procedures for Final Review of Errors

Error Codes

Processing Validation Error Codes

- NE – No Errors
- DE – Data Entry
- WPI – Wrong Provider Identified
- WCI – Wrong Client Identified
- O – Other (List or Describe)

Processing Validation Error Codes

- P1 - Duplicate item (claim) – an exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.
- P2 - Non-covered service – policies indicate that the service is not payable by Medi-Cal
- P3 - MCO covered service – the beneficiary is enrolled in a Managed Care organization (HMO) that should have covered the service and it was inappropriate to bill Medi-Cal.
- P4 - Third party liability – inappropriately billed to Medicaid.
- P5 - Pricing error – payment for the service does not correspond with the pricing schedule, contract, reimbursable amount.
- P6 - Logical edit – a system edit was not in place based on policy or a system edit was in place but was not working correctly and the claim line was paid.
- P7 - Ineligible recipient—the recipient was not eligible for the services or supplies.
- P8 - Data entry errors – there were clerical errors in the data entry of the claim.
- P9 - Ineligible provider—the provider was not eligible to bill for the services or supplies.
- P10 - Other – if this category is selected a written explanation is required in the comment section beside the category.

Medical Review Error Codes

- MR1 – No documentation submitted – the line is unsupported due to no response to the documentation request.
- MR2 – Insufficient documentation submitted – the line is unsupported due to insufficient response to documentation request. Information was submitted by the provider, but it either was for the wrong date of service or did not support the procedure code billed.
- MR3 – Coding error – the procedure was performed but billed using an incorrect procedure code.
- MR4 – Unbundling – billing components of procedure codes when only one procedure code is appropriate.
- MR5 – Medically unnecessary service – medical review indicates that the service is medically unnecessary based upon the documentation of the patient's condition in the medical record.
- MR6 – Administrative error – medical review indicates an administrative error, such as an incorrect decision on a previous medical review or other administrative errors as designated by the state. This error may or may not result in a payment error.
- MR7 – Policy violation – a policy is in place regarding the service or procedure performed and medical review indicates that the service or procedure is not in agreement with the documented policy. An inappropriate diagnosis for a service or procedure, as documented in the policy, would also fall into this error code. (Example: a pharmacy circumvents the policy that a 20-mg dosage of a medicine requires a TAR, by giving two 10-mg tabs tabs instead.)
- MR8 – Referring Physician Error – unable to verify physician order/prescription with referrer or referrer's documentation.
- MR9 – Ineligible Referrer Error – Referring provider was suspended/ineligible.
- MR10 – Inconsistent with Professional Standards – Service or procedure is inconsistent with Professional Standards or Plan of Care.
- MR11 – Provider's Policy Error – an error in billing due to provider's internal policy.
- MR12 – No record of Beneficiary – an error assigned to a claim where provider has no record of beneficiary or no record of providing the service to the beneficiary.

- MR13 – Beneficiary Confirmation error – an error assigned to a claim when the beneficiary is unable to confirm receipt of services/products from the provider.
- MR14 – Provider Master File error – an error assigned to a claim when provider number record has incorrect address for provider, incorrect service address, or incorrect rendering provider.
- MR15 – Other - if this category is selected a written explanation is required in the comment section beside the category.

Assumptions/Defaults

Upcoding:

All Errors attributed to the provider submitting claims for a higher level of service than that documented were assigned MR3 – Coding error (i.e., we did not call it a medical necessity error.)

MR2 errors:

The MR2 error code was divided into two issues:

MR2-A – Insufficient response to documentation request (example: a hospital submitted copies of the discharge summary, but not progress notes.)

MR2-B – Information was submitted by the provider, but did not support the service billed. (Example: A provider billed for a prenatal visit, plus nutritional counseling. The documentation submitted supports the prenatal visit but not the counseling.)

Pharmacy Claims:

Pharmacy claims were not reviewed for medical necessity. Only pharmacy procedures were audited. We also did not audit for a signature/receipt log since the law did not require this documentation during the period reviewed. When prescriptions were missing, the claim was denied entirely.

Laboratory Claims:

The accuracy of the diagnoses used by the laboratory for claimed services was not verified if the diagnosis appeared to justify the service. However, if the diagnosis did not seem to support the service (for example, if the diagnosis was a fracture of the humerus, and the service was glycohemoglobin), an attempt was made to obtain the physician's progress notes for appropriate diagnosis.

Errors regarding provider location:

If the provider's actual physical location did not agree with the location listed on the Provider Master File (PMF), we used the error code P9 - Ineligible Provider. However, we also checked with Provider Enrollment Branch (PEB) to see if there had been a delay in entering an approved change of address or new location, which caused the error. If so, we used error code MR 14 – Provider Master File error.

WPI Errors:

WPI means “wrong provider Identified” (such as in a group practice, a nurse practitioner rendered the service, but the supervising physician was listed on the claim as the rendering provider). We expanded this definition to cover a situation not otherwise described in the error codes which is that the wrong provider billed for the service (i.e.: there is no group practice listed with Provider Enrollment, both providers have a valid Medi-Cal number, but the wrong provider billed for the service).

Ineligible Provider Errors (P9):

This code was used under the following circumstances:

The actual rendering provider did not have a Medi-Cal provider number for the location of the service. The rendering provider has already been paid for the service under a contract (such as a radiologist who was paid to read CT scans for a hospital, then billed the service individually as well).

Verification of errors:

- All errors were reviewed and discussed by a medical team at DHS A&I.
- For all claims, which were errors due to missing documentation, multiple attempts were made to obtain records, including from alternate sources. In some cases, as many as 20 attempts were made, including advisement of possible suspension from the Medi-Cal Program.
- EDS specialists verified all claims with coding and pricing errors.
- All ADHC TAR issues were discussed with the appropriate specialty Medi-Cal Field office.
- All Nursing Facilities errors were discussed with the appropriate specialty Medi-Cal Field Office.
- All general TAR issues were discussed and/or case reviewed by the DHS TAR office.
- The Dental Consultant for the Department’s Denti-Cal Program did final review of all Dental claims.
- All Pharmacy errors were discussed with pharmacists in the Medi-Cal Policy Division.
- Any errors regarding licensing (CLIA or State license) for lab tests were verified by calling Lab Field Services and/or CLIA (Region 9 CMS).

- For all claims where the error was found to be MR2-A, insufficient response to document request, the provider was contacted repeatedly and pressured to provide the requested documentation.
- The Chief Medical Consultant for the Medi-Cal Program performed the final review for the dollar errors.

GLOSSARY

A&I	Audits and Investigations
Claim Line	Sampling unit
CDR	Claim Details Report
Coding Error	Incorrect Procedure Code
DME	Durable Medical Equipment
EDS	Electronic Data Systems
MPES	Medi-Cal Payment Error Study
FFP	Federal Financial Participation
FFS	Fee for Service
GAGAS	Generally Accepted Government Auditing Standards
GAAS	Generally Accepted Auditing Standard
HMO	Health Maintenance Organization
ICD 9 CM Coding	International Classification of Disease, 9 th Revision, Clinical Modification
Line Item	Sampling Unit or Claim Line
Improper Payments Information Act	Directs each executive agency, in accordance with the Office of Management and Budget to review all of its programs and activities annually, identify those that may be susceptible to significant improper payments, estimate the annual amount of improper payments, and submit those estimates to Congress before March 31 of the following applicable year.
MCO	Managed Care Organization
MRB	Medical Review Branch
NDC	National Drug Codes
OMB	Office of Management and Budget

PAM	Payment Accuracy Measurement
PCCM	Primary Care Case Management
RAI	Resident Assessment Instrument
SCHIP	State Children's Health Insurance Program
SSI	Supplementary Security Income
Sample	A sample is a collection of units from a population.
Sample Size	The number of elements in a sample from a population.
Stratified Sample	The population is divided into two or more strata and each subpopulation is sampled (usually randomly).
Unbundling Errors	Two or more billing components were used when only one procedure code was appropriate
Universe	Set of claims from which the sample is drawn

Appendix I

Sampling Plan

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