

2006

Medi-Cal Payment Error Study

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



Fee-For Service and Dental
Programs



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EXECUTIVE SUMMARY

Consistent with its continuing efforts to detect, identify and prevent fraud and abuse in the Medi-Cal program, gauge the seriousness of the problem, and develop appropriate fraud control strategies, the California Department of Health Care Services (DHCS) has completed the third annual Medi-Cal Payment Error Study (MPES). Controlling fraud, waste, and abuse in publicly-funded health care programs requires continuous assessment to monitor emerging trends and to make informed decisions on the allocation of fraud control resources. Fraud, waste and abuse can have a significant impact on the Medi-Cal program which had an annual benefits budget of approximately \$33 billion in Fiscal Year 2005/06.

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

Due to the inherent difficulties in measuring payment errors associated with medical claims, very few states have attempted to scientifically determine a percentage of error in their health care program payments¹. California's MPES is the only study conducted by a state or federal entity that includes an estimate of potential fraud². The identification of risk is critical to guiding the development of fraud control strategies and the allocation of resources to those areas of the Medi-Cal program most vulnerable to fraud, waste and abuse, and more importantly, where Medi-Cal beneficiaries may be at risk of receiving inappropriate medical services, drugs and/or supplies. DHCS uses findings from the MPES to improve anti-fraud efforts and looks for ways to strengthen the MPES methodology.

The MPES 2006 indicates that 92.73 percent of total dollars paid in the Fee-For-Service (FFS) medical and dental programs were billed appropriately and paid accurately. In contrast, 7.27 percent of the total dollars paid had some indication that they contained a provider error, see Figure 1 on the following page. Claim errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as forged physician signatures or billing for services not provided. Consistent with the findings of the MPES 2005 and MPES 2004, the MPES 2006 again identified insufficient documentation by providers as one of the most significant factors contributing to the overall dollar error. This means that the documentation presented by the provider did not support the services claimed. It does not mean that the services were not provided or not medically necessary, and therefore, may not represent an overpayment.

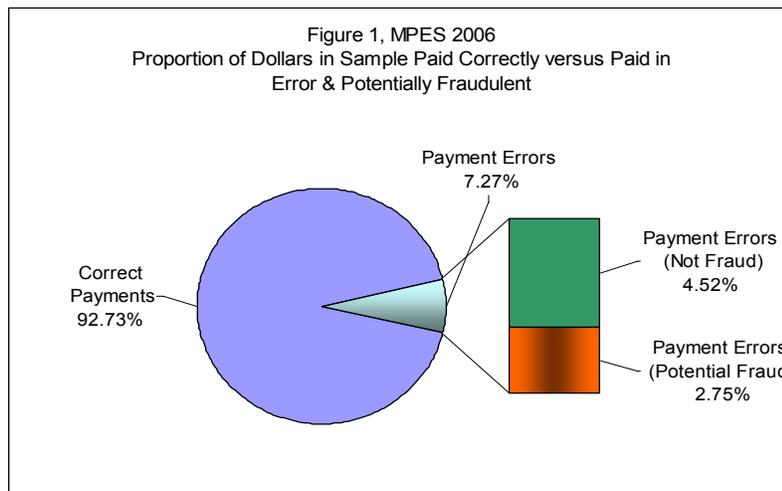
The 7.27 percent equates to \$1.2 billion of the total \$18 billion in annual payments made for FFS medical and dental services in calendar year 2006, and represents the percentage of payment error attributable to Medi-Cal program dollars "at risk" of being paid inappropriately due to findings related to such factors as a lack of medical necessity, abuse, or fraud.

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

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

The term “at risk” is used because this dollar figure is derived by applying the 7.27 percent rate to the program’s annual expenditure level. This figure cannot be considered as payments made in error unless all of the individual services that are questionable are identified through a complete medical record review or audit of all services submitted for payment and found to be medically unnecessary.

Of the total payments, 2.75 percent, or \$445 million, were for claims submitted by providers that disclosed characteristics of potential fraud. To determine exactly how much of the payment errors identified were indeed attributable to fraud requires a complete criminal investigation.



Due to the dynamic nature of health care-related fraud schemes and changes in provider behavior, the focus of anti-fraud efforts and the percentage of payment error are expected to vary from year-to-year. Figure 2 depicts the percentage contribution of the overall payment error by individual strata, or provider type.

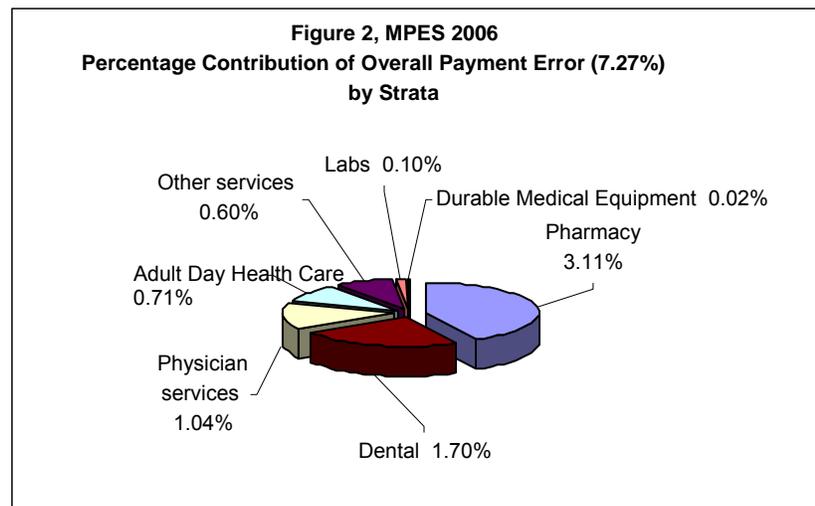
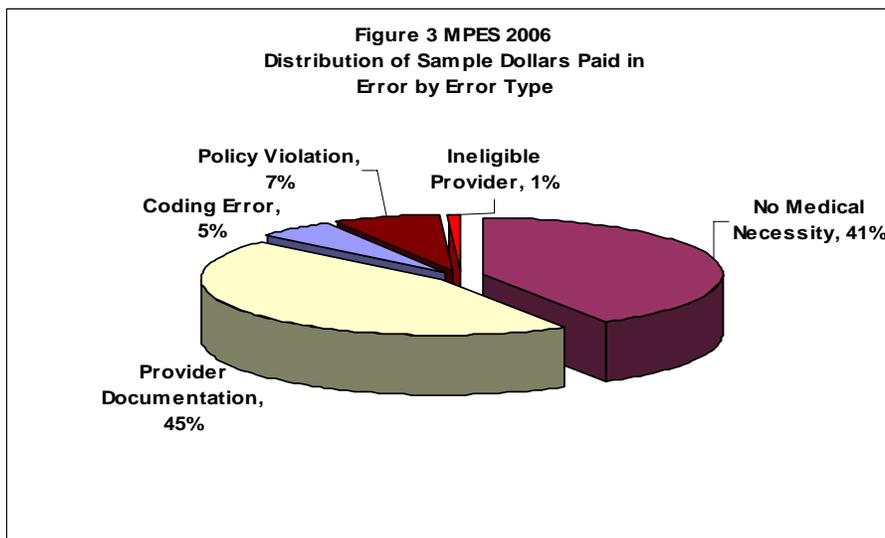


Figure 3 summarizes the percent of total dollars potentially paid in error by error type in the MPES 2006. MPES 2006 identified insufficient documentation by providers as the largest factor contributing to the overall dollar error.

The second largest factor in the overall dollar errors in MPES 2006 was the lack of medical necessity, which means Medi-Cal providers submitted claims for services that were not medically necessary.



The MPES 2006 found no errors in claims submitted by institutional providers. These providers generally have strong internal controls. Medi-Cal's most rigorous prior authorization processes are used to review the medical necessity for institutional services. All claims from institutional providers were determined to be for medically necessary services and to contain sufficient documentation to support the claim.

No processing errors were identified in MPES 2006. This indicates that the prepayment edits and audit methods employed by fiscal intermediaries, Electronic Data Systems (EDS) and Delta Dental, appear to be working effectively. In addition, no pricing errors³ were found.

The MPES 2006 did not include a review to determine if FFS beneficiaries were eligible for Medi-Cal at the time the beneficiary received services. A separate review to determine eligibility of Medi-Cal beneficiaries is being performed in accordance with the requirements of the federal Payment Error Rate Measurement (PERM) program. Under PERM, reviews of states will be conducted in three areas: (1) FFS, (2) managed care, and (3) program eligibility for both the Medi-Cal and State Children's Health Insurance Program (SCHIP). The Federal Government requires each state be responsible for measuring program eligibility for both Medi-Cal and SCHIP. A separate report on program eligibility is expected to be issued under separate cover by the federal Centers for Medicare and Medicaid Services in 2008.

³ Pricing errors represent payment for a service(s) that do not correspond with the established pricing schedule, contract, and reimbursable amount.

The MPES 2006 indicates that DHCS' current focus on non-institutional providers, specifically physicians, dentists and pharmacies, is targeting the area of highest risk for payment errors. In fact, some errors discovered in the MPES 2006 had already been identified by DHCS. Actions are currently being taken to stop these types of errors from continuing.

DHCS has initiated corrective actions for all providers identified in the MPES against which actions are warranted. In addition, DHCS will take additional actions to focus anti-fraud efforts on those areas identified by the MPES as most vulnerable to fraud and abuse. These additional actions include: evaluating and implementing each of the opportunities for improvement in the DHCS anti-fraud program identified by the independent top-to-bottom evaluation, following up on the errors identified during the on-site reviews of approximately 2,000 pharmacies, implementing legislation to reform the Adult Day Health Care (ADHC) program, expanding number of provider self-verifications, an increase of the number of investigational and routine field compliance audits, continuing joint actions with provider regulatory boards and provider associations to address provider claiming errors identified as potential fraud and abuse.

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

MEDI-CAL PAYMENT ERROR STUDY 2006

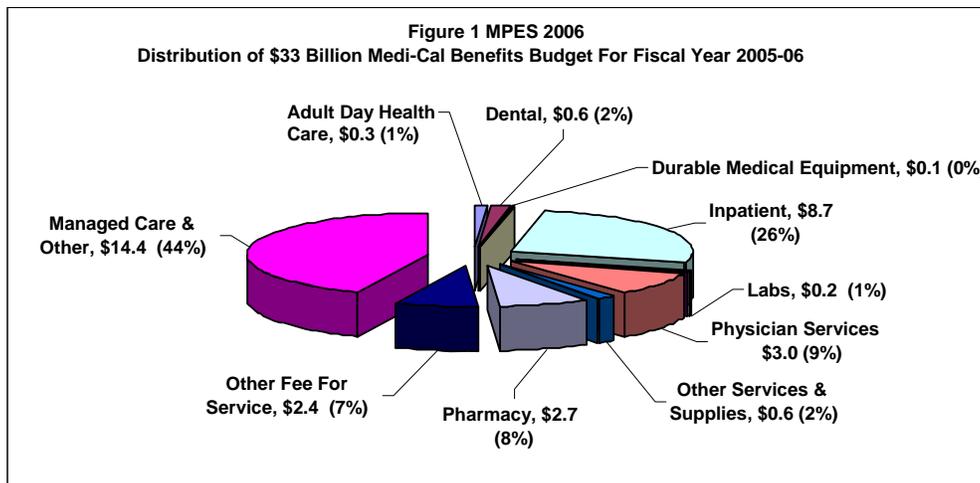
BACKGROUND

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

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

The Medi-Cal program serves over 6.6 million beneficiaries. Approximately 3.4 million beneficiaries (52 percent) are enrolled in the Medi-Cal Fee-For-Service (FFS) system. This means that providers are paid a fee for each service provided. An additional 3.2 million beneficiaries (48 percent) are enrolled in Medi-Cal Managed Care plans in designated Managed Care counties. Medi-Cal pays these Managed Care plans a capitated rate for services rendered to Medi-Cal beneficiaries.

The total Medi-Cal benefits budget for Fiscal Year 2005-06 was approximately \$33 billion.



The MPES 2006 reviewed claims paid through the FFS system in calendar year 2006. These claims total approximately \$18 billion and are a subset of the total \$33 billion. Figure 1 depicts the distribution of the \$33 billion benefits budget.

The primary focus and expansion of the Medi-Cal anti-fraud efforts over the past several years have been in the non-institutional FFS and Dental programs as these programs

are considered to be at greatest risk for payment errors as well as at highest risk for fraud, waste and abuse. In calendar year 2006 approximately 186 million claims were paid through the FFS system. DHCS focused the MPES in all three studies (MPES 2004, 2005, and 2006) on the non-institutional Medi-Cal FFS program, including FFS dental services.

The MPES 2006 is based on a sample of claims paid in the second quarter of calendar year 2006. The MPES 2006 reviewed the same types of medical and dental payments as did the MPES 2005. Claims paid to or by Medi-Cal Managed Care contractors, Medi-Cal claims paid for services administered by other state departments, and supplemental payments made to disproportionate share hospitals were not included in MPES 2004, 2005, or 2006.

MPES 2006 is the third annual Medi-Cal payment error study conducted by DHCS. As DHCS becomes more experienced performing these studies, the design and results of these studies will provide a benchmark against which to measure and compare future studies. Studies of this type typically take three to five years to establish a benchmark. The methodology for MPES 2007 will be refined and improved based upon what was learned from the last three studies in order to enhance the effectiveness of both the MPES 2007 as well as DHCS' fraud control activities.

The MPES 2006 sampling design, medical review processes, analysis of factors, discussion of findings, and follow-up recommendations are described in the following sections.

SAMPLING METHODOLOGY

The MPES 2006 sampling strategy used proportional stratified random sampling to generate estimates of payment and fraud error. These estimates were then extrapolated to estimate the potential dollar loss to the program due to provider claiming errors. This is a widely accepted standard statistical technique used to measure sample estimates⁴.

Other states and federal payment error studies also employ random sampling and extrapolation techniques to measure payment error for medical claims. These studies have reported payment errors ranging from 3 percent to 24 percent⁵. Based on the lessons learned from their prior experiences, those states that have undertaken subsequent studies have modified and refined their sampling and review methodologies to broaden the scope of the analysis and to improve the standardization of the claims review process as much as possible.

While MPES 2006 used the same statistical sampling design as the previous studies (section III), the review processes were further improved to minimize the non-sampling errors and improving the inter-rater reliability of the review process (details presented in section IV). A more comprehensive and standardized training program was used to prepare all staff in the review of claims and related supporting medical records and

⁴ See section III for sample plan details.

⁵ A detailed discussion of the studies conducted and methodologies utilized by other states and the U.S. DHHS is provided in section XII.

documentation in order to provide for a consistent and methodical evaluation of all claims.

DHCS' review processes are generally accepted standard review procedures that other states conducting similar studies have used⁶. A multidisciplinary team of medical professionals, auditors, analysts and researchers conducted the MPES. To ensure the integrity of the study, claims data were collected from an on-site review at the providers' offices. There were six components of the claims review process to confirm the following: (1) that the beneficiary received the service, (2) that the provider was eligible to render the service, (3) that the documentation was complete and included in the medical files as required by statute or regulation, (4) that the services were billed in accordance with applicable laws and regulations and policies, (5) that the claim was paid accurately, and (6) that the documentation supported the medical necessity of the service provided⁷. After the multidisciplinary team completed its review, findings were validated by the appropriate DHCS medical policy specialist.

Using the six review components and the characteristics⁸ of potentially fraudulent activities, DHCS identified claims that included characteristics of being potentially fraudulent. The California Department of Justice (DOJ) reviewed these claims further to validate DHCS' findings.

The MPES 2006 did not include a review to determine if FFS beneficiaries were eligible for Medi-Cal at the time the beneficiary received services. A separate review to determine eligibility of Medi-Cal beneficiaries is being performed in accordance with the requirements of the federal Payment Error Rate Measurement (PERM) program. Under PERM, reviews of states will be conducted in three areas: (1) FFS, (2) managed care, and (3) program eligibility for both the Medi-Cal and State Children's Health Insurance Program (SCHIP). The Federal Government requires each state be responsible for measuring program eligibility for both Medi-Cal and SCHIP. A separate report on program eligibility will be issued by the Federal Government in 2008.

KEY MPES FINDINGS

- Payments for claims that were billed appropriately, paid appropriately, for medically necessary services rendered by an eligible Medi-Cal provider represent 92.73 percent of total dollars paid through the Medi-Cal FFS system. Of the \$18 billion in payments made through the FFS system in calendar year 2006, 7.27 percent (\$1.2 billion) were identified as "at risk" of being paid inappropriately.
- The amount of payments for claims that were potentially fraudulent was projected to be \$445 million, or 2.75 percent of the total FFS payments. Determination of exactly how much of the payments are for claims that are indeed fraudulent require complete criminal investigations.

⁶ See Sections IV and XII for details regarding review processes.

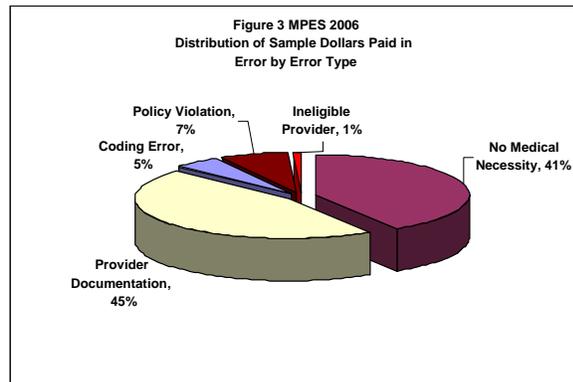
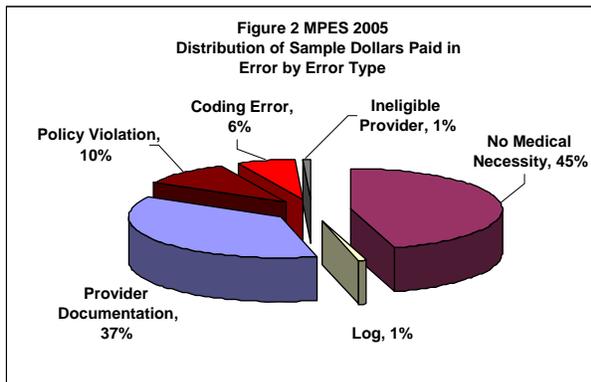
⁷ Other states and federal payment error studies do not state that their studies include an examination of the documentation supporting the medical necessity of the service provided.

⁸ Common indicators of fraud are provided in section VI

Types of Errors:

- Of the payments for claims with errors, 45 percent were for claims with insufficient documentation. This means that the documentation presented by the provider did not support the services claimed. This reflects an 8 percent increase in the sample dollars attributable to insufficient documentation when compared to MPES 2005 finding (45 percent less 37 percent).
- A total of 41 percent of all payments for claims with errors were for claims in which the provider's documentation did not support medical necessity for the services billed, meaning the services did not need to be provided. By comparison to MPES 2005, the sample dollars attributable to lack of medical necessity errors decreased by 4 percent (45 percent less 41 percent).
- This is the third consecutive MPES in which no claims processing errors were identified. This indicates that the prepayment edits and audit methods employed by fiscal intermediaries, Electronic Data Systems (EDS) and Delta Dental, appear to work effectively. This also means that claims submitted by providers contained the required information to be adjudicated and paid.

FINDINGS: PERCENTAGE OF PAYMENT ERROR



Errors by Provider Type:

- Institutional providers again had the highest payment accuracy rates as no inpatient claim errors have been identified in the first three MPES reports. No billing or payment errors were associated with claims reviewed from hospital or nursing facility services. Payments to Medi-Cal institutional provider types (e.g., hospitals, nursing facilities) involve the largest Medi-Cal expenditures per service and have more Medi-Cal programmatic oversight, such as prior authorization of services by Medi-Cal Utilization Review field offices, routine financial audits, licensing and certification reviews, and strong internal control systems.
- Pharmacies accounted for 43 percent of the MPES 2006 payment error (3.11 percent of the overall 7.27 percent) which is a decrease from the MPES 2005

findings⁹. Most pharmacy claim errors continue to be the result of absent or inadequate documentation, such as not having a valid prescription in the file or the provider did not obtain the required approved Treatment Authorization Request before dispensing a drug. The prescriber also accounted for pharmacy errors when it is determined that the prescription is not medically necessary.

- Dental services errors accounted for more than 23 percent of the overall percentage of payment error (1.70 percent of the 7.27 percent). This is a significant increase over the findings of MPES 2005¹⁰. Dental services were the second highest contributor to the MPES 2006 overall error rate. Dental errors were comprised of insufficient documentation of services, coding errors, medically unnecessary services, and policy violation errors.
- Physician services accounted for 14 percent of the overall percentage of payment error (1.04 percent of the 7.27 percent) which represents a decrease from the MPES 2005 findings¹¹. Physician claim errors involved miscoding, no documentation or insufficient documentation. Physicians also accounted for errors in other strata (Durable Medical Equipment (DME), Laboratory (Lab), and Pharmacy) as they are the prescriber. Lack of documentation of medical necessity by a physician led to errors in these ancillary services.
- ADHC errors accounted for 10 percent of the overall percentage of payment error (0.71 percent of the 7.27 percent) which represents a decrease from the MPES 2005 findings¹². ADHC errors were comprised of insufficient documentation of services and medical necessity, i.e., it was not medically necessary for the beneficiary to have received ADHC services. This represents a significant decrease from the MPES 2005 findings in which ADHCs had the highest percentage of claims completely in error. Actions such as unannounced DHCS site visits to ADHC providers, taken in response to the findings of the MPES 2005 have likely contributed to the reduced number of errors identified in MPES 2006. The errors found during unannounced site visits resulted in the imposition of sanctions. The number of ADHC providers, as well as the number of beneficiaries attending ADHCs from November 2005 to December 2006, declined significantly. It is likely that these declines are a direct result of the anti-fraud efforts undertaken by DHCS.
- Within the “Other Services and Supplies” stratum, Local Education Agency (LEA) claims comprised the largest number of errors for this stratum (twenty-three of the thirty-two claims). The LEA claim errors resulted from insufficient documentation to support that services were provided.

⁹ The MPES 2005 pharmacy errors accounted for almost half of the overall percentage of payment error (4.05 percent of the 8.40 percent).

¹⁰ The MPES 2005 dental services errors accounted for approximately 9 percent of the overall percentage of payment error (0.73 percent of the 8.40 percent).

¹¹ The MPES 2005 physician service errors accounted for 20 percent of the overall percentage of payment error (1.71 percent of the 8.40 percent).

¹² The MPES 2005 ADHC errors accounted for 15 percent of the overall percentage of payment error (1.30 percent of the 8.40 percent).

CONCLUSION

The MPES 2006 continues to demonstrate that the vast majority of Medi-Cal providers are billing correctly and being paid accurately. It also shows that DHCS' focus on noninstitutional providers, specifically physician services, pharmacies, dental services, and ADHCs, are targeting the areas of highest risk for payment errors and potential billing fraud.

The MPES 2006 did not reveal any claims processing errors. This finding indicates that the prepayment edits and audit methods employed by Electronic Data Systems (EDS) and Delta Dental, DHCS' fiscal intermediaries, appear to be working effectively. There were also no pricing errors found which indicates that EDS pays claims consistent with Medi-Cal policy.

The MPES studies are a valuable tool to assist DHCS in identifying those areas of the Medi-Cal program most at risk for fraud, waste and abuse. These systematic studies help guide the allocation of fraud control resources to ensure that DHCS focuses its fraud control efforts in the most effective and appropriate manner. As such, in response to the MPES 2006 findings, a number of actions have been taken or are in the process of being taken.

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

- In 2006, the Governor directed DHCS to arrange for an independent, top-to-bottom evaluation of the Department's anti-fraud program and identify any gaps in its efforts to protect the fiscal integrity of Medi-Cal. This evaluation was completed by Acumen, LLC in September 2007 and is included as Appendix A. Acumen's research of Medicaid integrity programs found that Medi-Cal has dedicated more resources to combating fraud, and as a result, has a more robust anti-fraud program than other states. Acumen identified a number of areas as opportunities for improvement. Acumen recommended that DHCS utilize more automation for provider application processes, consider screening treatment authorization requests for fraud and abuse, utilize beneficiary-centric models to flag more suspicious providers, seek efficiencies in the investigation process, expand existing audit tools, consider structural reforms, increase fraud prevention capabilities of the Denti-Cal program and expand the methodologies to measure the total cost effectiveness generated from anti-fraud efforts.
- DHCS conducted on-site reviews of approximately 2,000 pharmacies during 2006 to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse in response to one of the primary findings of MPES 2005. This project was termed the Pharmacy Outreach Project. The project did not uncover fraud and abuse schemes not previously identified. The types of errors identified were consistent with errors identified in all three Medi-Cal Payment Error Studies completed to date as well as with other audits and reviews of pharmacies that have been performed. This project resulted in a heightened awareness by California pharmacies of the importance

of Medi-Cal compliance requirements and identified areas for improvement. The report on the Pharmacy Outreach Project is included as Appendix B.

- DHCS is continuing to monitor the ADHCs placed on administrative controls as a result of the multidisciplinary interdepartmental task force audits performed in 2005 and 2006. Unannounced visits identified ADHC providers having submitted erroneous claims. Since being placed on Special Claims Review¹³, some ADHCs have demonstrated the ability to properly document the services provided to eligible beneficiaries and the medical necessity of these services.
- DHCS continues to examine 200 random claims on a weekly basis with a focus on physician and pharmacy provider claims. This was increased from 100 to 200 claims beginning in June 2006. The random claims sampling process is an additional layer of review beyond the automated edits and audits in the claims processing system. This sampling method allows all claims paid to have an opportunity to be selected for review. This random claims review process is a best practice that detects current Medi-Cal billing fraud and prevents future fraud via a deterrent effect.
- A total of 34 different sanctions have been placed on 21 billing and/or referring providers identified in the study as submitting claims with errors or characteristics of fraud. A total of 217 providers were identified with claim errors in the study. Follow up audits will be performed and sanctions applied on those providers identified as having submitted claims with errors or characteristics of fraud.

The following key actions will be taken to focus anti-fraud efforts on those areas most vulnerable to fraud and abuse:

- Expand the number of investigation and routine field compliance audits in the areas of dental services to identify provider claim errors, take appropriate corrective actions and apply appropriate sanctions. The majority of dental errors identified in the MPES 2006 related to insufficient chart documentation and claim coding errors. To mitigate these types of errors in the future, Denti-Cal will put additional focus on provider education via provider bulletins, seminars at dental conferences and conventions, and provide feedback and assistance to specific providers on documentation and/or billing issues. Denti-Cal also is currently undergoing a top-to-bottom review of its anti-fraud activities to assess the appropriateness and effectiveness of these efforts.
- Continue to perform investigation and routine field compliance audits in the areas of ADHCs, physicians and pharmacies to identify provider claim errors as identified in the MPES 2006 and prior studies and take appropriate corrective actions and apply appropriate sanctions.
- Continue to develop a joint plan of action with regulatory boards such as the Medical Board, Dental Board, Board of Pharmacy, and provider associations, such as the California Medical Association, to address the provider claiming

¹³ Special Claims Review is a post-service prepayment review process that requires providers to submit manually prepared claims and supporting documentation.

errors identified as potential fraud and abuse. Such plans will include extensive education of providers, utilizing training sessions and detailed Medi-Cal provider bulletins, on how to justify the medical necessity of the services or products provided as well as documentation requirements. DHCS will educate physicians, optometrists and dentists based on the plan of action resulting from this work.

In addition to the above key actions, DHCS will expand existing efforts and explore possible new actions as follows:

- The independent, top-to-bottom evaluation of the Department's anti-fraud program identified a number of areas as opportunities for improvement. DHCS will evaluate each of these areas for possible incorporation into its existing anti-fraud program.
- All providers whose claims were identified to be in error in MPES 2006 will be notified of their respective claim errors and allowed an opportunity to correct the problem(s).
- DHCS will review claiming patterns, develop cases, and place sanctions on those providers who submitted claims with errors or characteristics of fraud. Of the 217 unique providers identified with claim errors, 78 will be further reviewed for potential fraud.
- DHCS will continue working with the ADHC community to implement SB 1755 which revises eligibility requirements for ADHC services and requires the development of a new reimbursement methodology that will permit "unbundling" of the daily rate and establish rates in line with the cost of providing services.
- DHCS will continue to coordinate with the DOJ and expand the number of letters sent to Medi-Cal beneficiaries to verify that the beneficiaries actually received the services or products claimed by providers. This will assist in detecting those providers who submit claims for services and/or products not provided.
- The State Controller's Office (SCO) plans to conduct an in-depth study reviewing the utilization of the LEA services and make recommendations to address the issues identified by MPES 2006. The SCO will provide a report on their study to DHCS. The SCO report will be included in the MPES 2007.
- DHCS will expand the provider self-verification system to permit DHCS staff to focus their efforts on those providers who are submitting claims with characteristics of potential fraud. This expansion will allow providers who have not submitted claims in a fraudulent or abusive manner but who have submitted claims in error, to self-identify and self-correct system problems within their organizations and remit any inadvertent overpayments they may have received.
- DHCS will continue to provide feedback to providers regarding their billing practices when it is identified that their billing patterns change beyond the provider's normal billing history or the expected range of similar providers. These providers are identified as a result of ongoing audits and reviews.

- DHCS will use the MPES 2006 findings to assist in developing the methodology and focus of the MPES 2007.

MEDI-CAL PROGRAM OVERVIEW

In California, the California Department of Health Care Services (DHCS) administers the Medicaid (Medi-Cal) program. Medi-Cal serves over 6.6 million¹⁴ beneficiaries of which approximately 3.4 million (52 percent) are in the Fee-For-Service (FFS) system and 3.2 million are enrolled in Medi-Cal Managed Care plans. The total Medi-Cal benefits budget for FY 2005-06 was approximately \$33 billion, of which \$18 billion was allocated to 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 the State's control, such as disability actions determined by the Federal Social Security Administration (SSA). Once beneficiaries meet the eligibility requirements, they have access to a variety of Medi-Cal programs, including FFS, Managed Care, dental, and vision.

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

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

Over the past five years there has been significant focus placed on combating fraud, waste, and abuse in Medi-Cal. Through changes in laws, regulations and policies, as well as several successful anti-fraud initiatives which increased staffing, DHCS has been able to achieve significant savings to Medi-Cal and create new systems to prevent fraud from occurring. DHCS' current anti-fraud efforts focus on physicians, physician groups, pharmacies, and other provider types and services in the Medi-Cal FFS program. This focus is based on the assessment that these providers comprise the highest risk for potential fraud and abuse because: (1) they are generating directly or indirectly the largest expenditures and have fewer internal management controls; (2) they are not routinely audited by Medi-Cal, and (3) they have fewer services subject to prior authorization. The following are key elements of DHCS' current anti-fraud efforts.

¹⁴ Annual Statistical Report Calendar Year 2004, DHCS Medical Care Statistics Section

- Enrollment/Re-enrollment

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

- Moratoriums

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

- Administrative Sanctions

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

- Field Audit Reviews

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

- Procedure Code Limitation

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

- Random Claims Sample

A key element in an effective anti-fraud control strategy is the awareness by providers that every claim submitted for payment has some risk of review prior to payment. In April 2004, DHCS began randomly selecting 100 claims per week for review prior to payment. The random claim review is a real time look into services and trends in Medi-Cal billing. A&I, in cooperation with EDS, developed a systematic process for randomly selecting the claims. When a claim is selected, providers are required to submit documentation to support the claim prior to payment approval. Any claim that is not supported is denied. In addition to preventing improper claims from being paid, the review results are used to further enhance

the case detection and development process. To further increase the integrity and effectiveness of the random claims review process, A&I has directed EDS to monitor for re-submission of claims previously denied to ensure that providers do not attempt to re-submit the claims for payment.

- **Beneficiary Identification Card Re-Issuance**

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

- **Research and Development**

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

- **Medicare Data Match Agreement**

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

- **Criminal Fraud Referrals**

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

- **Beneficiary Investigations**

The Beneficiary Care Management Project was developed to identify beneficiaries abusing the Medi-Cal program by seeking more services than medically necessary. Beneficiaries found abusing the program are assigned to a primary care provider and/or pharmacy for a two-year period. The intent is to ensure beneficiaries receive medically needed services and continuity of care while decreasing physician/pharmacy shopping.

II

MPES 2006 COMPARISON WITH MPES 2005

Category	MPES 2005	MPES 2006
Results	<ul style="list-style-type: none"> • Billing or Payment Errors = 8.40% • Potential Fraud Billing or Payment Errors = 3.23% 	<ul style="list-style-type: none"> • Billing or Payment Errors = 7.27% • Potential Fraud Billing or Payment Errors = 2.75%
Funding	50% State Funds / 50% Federal Funds	50% State Funds / 50% Federal Funds
Project Designed By	California Department of Health Services, Audits & Investigations	Department of Health Care Services, Audits & Investigations
Sampling Plan Designed By	California Department of Health Services, Medical Care Statistics Section	Department of Health Care Services, Research Section and Medical Care Statistics Section
Objective	<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. 	<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
Universe	FFS claims paid between October 1 and December 31, 2004	FFS claims paid between April 1, and June 30, 2006
Method of Allocating Sampling Units to Strata	The proportion of <u>total claims</u> paid for the line items represented by each stratum in the sampling period October 1, 2004 through December 31, 2004, inclusive.	The proportion of <u>total claims</u> paid for the line items represented by each stratum in the sampling period April 1, 2006 through June 30, 2006, inclusive.
Sample Size	1,123 FFS (medical & dental) claims	1,147 FFS (medical and dental) claims

Category	MPES 2005	MPES 2006																																				
Sampling Unit	Entire Claim	Entire claim																																				
Confidence Level	95%	95%																																				
Level of Precision	+/-3%	+/-3%																																				
Sampling Methodology	Proportional stratified random sampling	Proportional stratified random sampling																																				
Study Design	<p>Fee-for-service and dental claims; added statistically valid number of claims with three additional strata (DME, Lab, and ADHC) reaching a total of strata in the sample.</p> <p>Increased the number of claims for dental and inpatient services to provide statistically valid number of claims. Beneficiary eligibility was reviewed for fee-for-service and managed care programs.</p>	<p>Fee-for-service and dental claims; increased overall sample size to 1,147 claims with same eight strata used in prior study; proportional allocation of sample size was used to determine sample size of each stratum, ensuring a minimum sample size of 50 claims per stratum.</p>																																				
Factors Impacting Error Rate	<p>Volume of claims</p> <p>Number of errors</p> <p>Dollar value of errors</p>	<p>Volume of claims</p> <p>Number of errors</p> <p>Dollar value of errors</p>																																				
Sample Composition	<p>FFS/Dental</p> <table> <tr> <td>Inpatient</td> <td>50</td> </tr> <tr> <td>Physician Services</td> <td>262</td> </tr> <tr> <td>Pharmacy</td> <td>561</td> </tr> <tr> <td>Other Services & Supplies</td> <td>50</td> </tr> <tr> <td>Dental</td> <td>50</td> </tr> <tr> <td>DME</td> <td>50</td> </tr> <tr> <td>ADHC</td> <td>50</td> </tr> <tr> <td>Laboratory</td> <td><u>50</u></td> </tr> <tr> <td>Total</td> <td>1,123</td> </tr> </table>	Inpatient	50	Physician Services	262	Pharmacy	561	Other Services & Supplies	50	Dental	50	DME	50	ADHC	50	Laboratory	<u>50</u>	Total	1,123	<p>FFS/Dental</p> <table> <tr> <td>Inpatient</td> <td>50</td> </tr> <tr> <td>Physician Services</td> <td>397</td> </tr> <tr> <td>Pharmacy</td> <td>401</td> </tr> <tr> <td>Other Services & Supplies</td> <td>82</td> </tr> <tr> <td>Dental</td> <td>51</td> </tr> <tr> <td>DME</td> <td>50</td> </tr> <tr> <td>ADHC</td> <td>50</td> </tr> <tr> <td>Laboratory</td> <td><u>66</u></td> </tr> <tr> <td>Total</td> <td>1,147</td> </tr> </table>	Inpatient	50	Physician Services	397	Pharmacy	401	Other Services & Supplies	82	Dental	51	DME	50	ADHC	50	Laboratory	<u>66</u>	Total	1,147
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Attempt to Estimate Error Rate Related to Potential Fraudulent Claims	Yes	Yes																																				

Category	MPES 2005	MPES 2006
Review Beneficiary Eligibility	Yes	No
Sample Size for Beneficiary Eligibility	FFS Cases (1,123 FFS sample claims) Managed Care Cases (1,000 MC sample claims)	N/A
Beneficiary Confirmation of Product	Yes - in select instances to verify receipt of pharmacy services	N/A
Validate medical necessity	Yes	Yes
Key Findings	<ul style="list-style-type: none"> • A total of 91.60 percent of the dollars in the study sample of 1,123 claims were billed and paid appropriately, were medically necessary and delivered by an eligible Medi-Cal provider to an eligible Medi-Cal beneficiary. • A total of 8.40 percent of the dollars in the sample had some indication of billing or payment error, which equates to \$1.4 billion in annual payments. Of the 8.40 percent, 0.97 percent was compliance errors. These resulted from providers failing to comply with one or more required claiming regulations, policies or procedures, but it was appropriate for the service to be provided. • Of the 8.40 percent, 7.43 percent represents the payment error rate attributable to Medi-Cal program dollars “at risk” of being paid inappropriately which are approximately \$1.25 billion. • Of the 8.40 percent, 3.23 percent had characteristics of potential fraud, which equates to \$542 million annually that are “at risk” for loss due to fraud. • Of the 113 unique providers submitting potentially fraudulent claims, 21 had already had been independently identified by CDHS and were in case development or on administrative sanctions when the study was conducted. • Errors ranged from simple mistakes such as coding 	<ul style="list-style-type: none"> • A total of 92.73 percent of the dollars in the study sample of 1,147 claims were billed and paid appropriately, were medically necessary and delivered by an eligible Medi-Cal provider to an eligible Medi-Cal beneficiary. • A total of 7.27 percent of the dollars in the sample had some indication of billing or payment error, which equates approximately to \$1.2 billion in annual payments. Compliance errors were not calculated as a separate entity. • All of the 7.27 percent represents the payment error rate attributable to Medi-Cal program dollars “at risk” of being paid inappropriately. • Of the 7.27 percent, 2.75 percent had characteristics of potential fraud. That amounts to \$445 million annually that are “at risk” for loss due to fraud. • There were 78 unique providers that submitted potentially fraudulent claims. These will be submitted for further review. • Errors ranged from simple mistakes, such as coding

Category	MPES 2005	MPES 2006
	<p>errors, to potential fraud such as forged physician signatures and filling prescriptions in excess of the prescribed amount.</p> <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 only state to conduct a study that includes an estimate of potential fraud. • No billing or payment errors were identified in the MPES relative to hospital or nursing facility services. • All errors were found in the non-institutional providers (Physicians, Pharmacies, DME, etc.) category. • Payments to pharmacies, physician services and ADHCs disclosed the highest error rates. • ADHCs had the highest percentage of claims completely in error and the greatest number of errors with no medical necessity. <ul style="list-style-type: none"> • The single largest error type of all payment errors, 45 percent, was that the documentation did not support medical necessity for the services billed. • The second largest error type for payment errors, 37 percent, resulted from insufficient documentation either by the billing provider or the referring provider. • Pharmacy errors contributed almost half of the overall MPES 2005 error rate (4.05 percent of the 8.40 percent). Most of the pharmacy errors were compliance errors. 	<p>errors, to potential fraud, such as providers committing policy violations and administering medically unnecessary services.</p> <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 only state to conduct a study that includes an estimate of potential fraud. • No billing or payment errors were identified in the MPES relative to hospital or nursing facility services. • All errors were found in the non-institutional providers (Physicians, Pharmacies, DME, etc.) category. • Payments to pharmacies, dental, and physician services disclosed the highest error rates. • Dental had the highest percentage of claims in error, 57 percent, or 29 out of 51 claims. To mitigate these types of errors in the future, Denti-Cal will put additional focus on provider education via provider bulletins, seminars at dental conferences and conventions, and feedback and assistance to specific providers on documentation and/or billing issues. Denti-Cal also is currently undergoing a 'top to bottom' review of its anti-fraud activities to assess the appropriateness and effectiveness of these efforts. • The single largest payment error type was lack of or insufficient provider documentation, with 43 percent sample dollars. • The second largest payment error type, with 41 percent sample dollars, was that the documentation the provider submitted did not support medical necessity for the services billed. • Pharmacies accounted for 43 percent of the MPES 2006 payment error (3.11 percent of the overall 7.27 percent) which is a decrease from the MPES 2005 findings.

Category	MPES 2005	MPES 2006
	<ul style="list-style-type: none"> • Physician services errors were the second highest contributing stratum. Physician errors involved miscoding, no documentation or insufficient documentation. • Two dental claims were found to be in error. These two claims revealed substandard and/or abusive patient care involving lack of anesthesia when warranted and billed but not delivered. • Also identified were two errors in physician and pharmacy services which identified substandard care. Both errors led to subsequent hospitalizations, and human suffering, and therefore, increased costs to the Medi-Cal program. • Review of 1,000 Managed Care beneficiaries found 56 eligibility errors, or 5.6 percent. Forty four of these errors were from Los Angeles County, with the majority due to incomplete redeterminations. • The eligibility errors for full scope FFS reviews was 5.4 percent although, the sample was not a random sample of beneficiaries. The errors associated with eligibility for managed care and FFS are not included in the 8.40 percentage of claims error calculation, however, these eligibility errors do result in a fiscal impact to the program. 	<ul style="list-style-type: none"> • Dental services errors accounted for more than 23 percent of the overall percentage of payment error (1.70 percent of the 7.27 percent). This is a significant increase over the findings of MPES 2005. • Physician services accounted for 14 percent of the overall percentage of payment error (1.04 percent of the 7.27 percent) which represents a decrease from the MPES 2005 findings. • Managed care beneficiaries were not included in the sample. • The MPES 2006 did not include a review to determine if FFS beneficiaries were eligible for Medi-Cal at the time the beneficiary received services. A separate review to determine eligibility of Medi-Cal beneficiaries is being performed in accordance with the requirements of the federal Payment Error Rate Measurement (PERM) program.
Potential Fraud Claims	124	80
High-Risk Provider Groups	<ul style="list-style-type: none"> • ADHCs • Physician Services • Pharmacies • Dental (patient abuse) 	<ul style="list-style-type: none"> • Pharmacies • Dental • Physician Services • LEAs
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. 	<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.

Category	MPES 2005	MPES 2006
	<ul style="list-style-type: none"> • Conduct on-site reviews of approximately 2,000 pharmacies to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse. • Expand use of new automated technology to better identify potential fraud schemes. This is a significant new development that will permit CDHS to identify patterns of potential fraud and abuse that CDHS has not previously been able to identify without on-site visits to providers. • Expand the number of investigational and routine field compliance audits in the areas of ADHCs, physicians and pharmacies to identify provider claim errors as identified in the MPES 2005 and take appropriate corrective actions and apply appropriate sanctions. • Work with the Legislature to enact reform of ADHC services as proposed by the California Department of Aging and CDHS. Reforms include revising the payment methodology and implementing more intensive monitoring of ADHCs. CDHS will perform additional unannounced visits to ADHC providers identified as having submitted erroneous claims and place administrative controls on these providers as appropriate. • Increase the number of claims examined randomly each week from 100 to 200 claims. This claims review process will focus on the physician and pharmacy provider claims. 	<ul style="list-style-type: none"> • DHCS conducted on-site reviews of approximately 2,000 pharmacies during 2006 to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse in response to one of the primary findings of MPES 2005. The report on the Pharmacy Outreach Project is included as Appendix B. • The State Controller’s Office (SCO) plans to conduct an in-depth study reviewing the utilization of the LEA services and make recommendations to address the issues identified by MPES 2006. The SCO will provide a report on their study to DHCS. The SCO report will be included in the MPES 2007. • Expand the number of investigational and routine field compliance audits in the areas of Dental and LEAs. • Continue efforts with regard to ADHCs, physicians and pharmacies, to identify provider claim errors as identified in the MPES 2005 and prior studies, take appropriate corrective actions and apply appropriate sanctions. • DHCS will continue working with the ADHC community to implement SB 1755 which revises eligibility requirements for ADHC services and requires the development of a new reimbursement methodology that will permit “unbundling” of the daily rate and establish rates in line with the cost of providing services. • DHCS continues to examine 200 random claims on a weekly basis with a focus on physician and pharmacy provider claims. This was increased from 100 to 200 claims beginning in June 2006. The

Category	MPES 2005	MPES 2006
	<ul style="list-style-type: none"> • CDHS is partnering with professional licensing boards and provider associations to educate the various providers as to the types of documentation issues identified in MPES 2005 in order to focus on those parts of the Medi-Cal program at greatest risk for fraud, waste and abuse. • To focus on resolution of the findings related to beneficiary eligibility issues: CDHS will continue its ongoing program for county Medi-Cal eligibility quality control reviews that includes a monthly random sample of approximately 225 cases to identify error trends by category and county, and targeted reviews of selected counties to examine specific problem areas. CDHS will work with the Legislature to enact changes to the statute to increase county compliance and accountability standards for completing timely determinations and redeterminations of eligibility. CDHS will work with the Legislature to obtain additional budget resources to increase and strengthen comprehensive monitoring of county compliance with eligibility determination performance standards. • Provide feedback to providers regarding their billing practices when billing patterns change beyond the 	<p>random claims sampling process is an additional layer of review beyond the automated edits and audits in the claims processing system.</p> <ul style="list-style-type: none"> • DHCS continue to develop a joint plan of action with regulatory boards, such as the Medical Board, Dental Board and Board of Pharmacy, and provider associations, such as the California Medical Association, to address the provider claiming errors identified as potential fraud and abuse. Such plans will include extensive education of providers, utilizing training sessions and detailed Medi-Cal provider bulletins, on how to provide justification for the medical necessity of the services or products provided as well as the maintenance of documentation requirements. DHCS will conduct education of physicians, optometrists and dentists based on the plan of action resulting from this work. • DHCS will continue to coordinate with the DOJ and expand the number of letters sent to Medi-Cal beneficiaries to verify that the beneficiaries actually received the services or products claimed by providers. This will assist in detecting those providers who submit claims for services and/or products not actually provided. • DHCS will continue to provide feedback to providers regarding their billing practices when it is identified

Category	MPES 2005	MPES 2006
	<p>providers' normal billing history or when billing patterns are beyond the expected range of other similar providers. As part of the ongoing feedback to providers, 1,114 letters describing their billing patterns and any areas of concern are being mailed to various providers.</p> <ul style="list-style-type: none"> • A self –verification system is underway and will be expanded to allow providers, who have not submitted claims in a fraudulent or abusive manner, to self-identify and self-correct system problems within their organizations and remit any inadvertent overpayment(s) they may have received. Providers can identify and correct internal system errors more efficiently than outside auditors. The self-verification process is a team approach between CDHS and providers to identify problems and initiate corrective actions more expeditiously. CDHS will verify the results of self-verifications as appropriate. The goal is to allow CDHS staff to perform more difficult audits as well as to perform an increased number of field audits. • Review claiming patterns, develop cases, and place sanctions on those providers identified as having claims with errors including those that are potentially fraudulent. To this end, the claiming patterns for 138 of the 203 providers with errors were reviewed. Of those reviewed, 68 have been assigned for field review. An additional 44 have been referred for audit. A total of 65 different controls have been placed on billing and/or referring providers related to the claims in error. • Use the MPES 2005 to assist in developing the methodology and focus of the MPES 2006. 	<p>that their billing patterns change beyond the provider's normal billing history or the expected range of other similar providers. These providers are identified as a result of ongoing audits and reviews.</p> <ul style="list-style-type: none"> • Expand the provider self-verification system to permit DHCS staff to focus their efforts on those providers who are submitting claims with characteristics of potential fraud. This change will allow providers who have not submitted claims in a fraudulent or abusive manner, but who have submitted claims in error, to self-identify and self-correct system problems within their organizations and remit any inadvertent overpayments they may have received. • Review claiming patterns, develop cases, and place sanctions on those providers who submitted claims with errors or characteristics of fraud. Of the 217 unique providers identified with claim errors, 78 of these unique providers will be further reviewed because of potential fraud. • Use the MPES 2006 findings to assist in developing the methodology and focus of the MPES 2007.

III

Sampling and Estimation Methodology

This section describes the sample selection process and the method by which the payment error is estimated. The sampling is performed at the claim level, i.e., a sampling unit includes all detail lines of the claim.

Universe of Claims Paid In Study

The sampling universe consists of Medi-Cal fee-for-service claims paid through the fiscal intermediary, Electronic Data Systems, as well as dental claims paid, during the period of April 1, 2006 through June 30, 2006 (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 those claims.

Table I
Medi-Cal Paid Claims in the Universe by Stratum

Stratum	Number of Claims in Universe	Medi-Cal Payments in Universe	Percent of Total Claims Volume	Percent of Payments Volume
ADHC	366,649	\$85,818,259	1.8%	2.1%
Dental	1,054,160	\$143,949,022	5.2%	3.6%
Durable Medical Equipment	155,332	\$31,704,970	0.8%	0.8%
Inpatient	786,049	\$2,163,550,993	3.9%	53.5%
Labs	1,305,328	\$45,950,912	6.4%	1.1%
Other Practitioners & Clinics	7,973,270	\$752,146,794	39.3%	18.6%
Other Services & Supplies	620,586	\$142,293,501	3.1%	3.5%
Pharmacy	8,010,661	\$678,899,628	39.5%	16.8%
Total	20,272,035	\$4,044,314,079	100.0%	100.0%

Sample Size

There are 1,147 claims in the sample. This sample size was extracted from a universe of 20,272,035 Medi-Cal paid claims. It was used to ensure a 95% confidence level with a +/-3% precision relative to the overall payment error rate. Proportional allocation of

the sample size was used to determine the sample size from each stratum ensuring a minimum sample size of 50 claims for each stratum. Simple random sampling without replacement was used in each stratum for overall the sample selection¹⁵.

Sample Stratification

The proportional stratified random sample is divided into eight strata. Each stratum is listed below. The list includes all vendor codes associated with each stratum (or provider type).

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

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

- Stratum 5: Labs, vendor code list:

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

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

5	Certified Nurse Midwife
7	Certified Pediatric Nurse Practitioner
8	Certified Family Nurse Practitioner
9	Respiratory Care Practitioner
10	Licensed Midwife

¹⁵ This sampling methodology used for MPES 2006 was reviewed and approved by Dr. Geetha Ramachandran, Professor of Statistics at California State University, Sacramento.

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

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

Each stratum size was determined using the proportion of the total number of claims represented by each stratum for claims paid for dates of April 1, 2006 through June 30, 2006. The sampling strata and their respective sizes and paid amounts are shown below (Table II).

**Table II
Claim Sample and Paid Amounts by Stratum**

Stratum	Size	Payments
ADHC	50	\$13,829
Dental	51	\$6,628

DME	50	\$6,583
Inpatient	50	\$86,664
Labs	66	\$2,357
Other Practitioners and Clinics	397	\$39,048
Other Services and Supplies	82	\$11,426
Pharmacy	401	\$33,741
Total	1,147	\$200,276

Estimation

- DHCS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits¹⁶. To calculate the payment error rate, the following steps were utilized. First, dollars for services included in the sample that were paid correctly were totaled by stratum and divided by the total payments for all services in the sample. This resulted in payment accuracy rates for each of the eight strata. Second, each of the accuracy rates for the eight strata were weighted by multiplying the payments made for services in the corresponding universe stratum and summed to arrive at an overall estimate of payments that were made correctly. Third, this estimate of the correct payments was divided by the total payment made for all services in the universe to arrive at the overall payment accuracy rate (Table III).

**Table III
Calculation of Payment Accuracy Rate by Stratum**

Stratum	Amounts Paid in Stratum	Amounts Paid Correctly	Payment Accuracy Rate	Payment Error Rate
ADHC	\$13,829	\$9,195	66.49%	33.51%
Dental	\$6,628	\$3,472	52.38%	47.62%
DME	\$6,583	\$6,442	97.84%	2.16%
Inpatient	\$86,664	\$86,664	100.00%	0.00%
Labs	\$2,357	\$2,145	90.99%	9.01%
Other Practitioners and Clinics	\$39,048	\$36,867	94.42%	5.58%
Other Services and Supplies	\$11,426	\$9,479	82.97%	17.03%
Pharmacy	\$33,741	\$27,491	81.48%	18.52%

¹⁶ William G. Cochran, Sampling Techniques (John Wiley & Sons, 1977), 164.

The projected annual payments made correctly was calculated by multiplying three quantities: 1) the payment accuracy rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) the number 4 (for the 4 quarters of the year). Finally, the error rate and projected annual dollars paid in error were computed as follows:

- **Payment error rate = 100 percent minus the overall payment accuracy rate**

Table IV
Overall Estimate of Payments Made Correctly

Stratum	Total Payments in Universe	Payment Accuracy Rate	Overall Estimated Payments Made Correctly	Overall Estimated Payments Made Incorrectly
ADHC	\$85,818,259	66.5%	\$57,060,013	\$28,758,246
Dental	\$143,949,022	52.4%	\$75,396,181	\$68,552,841
Durable Medical Equipment	\$31,704,970	97.8%	\$31,021,406	\$683,564
Inpatient	\$2,163,550,993	100.0%	\$2,163,550,993	\$0
Labs	\$45,950,912	91.0%	\$41,812,037	\$4,138,875
Other Practices and Clinics	\$752,146,794	94.4%	\$710,145,798	\$42,000,996
Other Services and Supplies	\$142,293,501	83.0%	\$118,054,091	\$24,239,410
Pharmacy	\$678,899,628	81.5%	\$553,143,150	\$125,756,478
Total	\$4,044,314,079	92.73%	\$3,750,183,667	\$294,130,412

- Projected annual payments made in error = payment error rate X 2nd quarter 2006 Medi-Cal FFS and Dental payments universe subject to sampling X 4 quarters.

Confidence Intervals

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

were divided by the total payments made for all services included in the universe to determine the upper- and lower-bound payment accuracy rates.

Formulas

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

Let

\hat{H} = estimated payment accuracy rate

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

X = known dollar value of total payments in the universe

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

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

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

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

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

where

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

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

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

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

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

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

8

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

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

$S_h^2 = A_h B_h$, where

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

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

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

IV

REVIEW PROTOCOLS

Purpose

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

Claims Processing Review Protocol

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

I. Medical Review Protocol

A. Documentation Retrieval for Claim Substantiation

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

B. Multiple Review Processes

First Level Review

- a. Initial review of claims assigned to each A&I Field Office (FO) is conducted by the respective field office staff, using standardized audit program guidelines specific to each provider type. The reviewer personally collects data, conducts the initial review, and completes the data entry form.
- b. Medical consultants perform a secondary level review of the findings.
- c. Supervisors conduct a final review.
- d. Each claim is reviewed for the following six components:
 1. Episode of treatment is accurately documented;
 2. Provider is eligible to render the service;

3. Documentation is complete;
4. Claim is billed in accordance with laws and regulations;
5. Payment of the claim is accurate;
6. Documentation supports medical necessity.

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

Second Level Review to Ensure Inter-rater Reliability

To determine the reliability of the first level review process and ensure consistency and accuracy of the findings, all cases with claims found in error plus a random sample of 10 percent of the non-error claims will be intermingled and reviewed by two different medical or nurse consultants.

This will be a blind¹⁷, but sequential review achieving three purposes: (a) that the dollar error identified truly reflects dollars at risk of being paid inappropriately, and (b) that the interviewer bias (the reviewer) has been minimized, and (c) the estimate of overall payment error is a true reflection of the universe being studied.

Specifically, multiple level reviews are conducted as follows:

- Errors deemed in the medically unnecessary category are first independently reviewed by at least three different medical consultants. If all three independent reviewers reach the same conclusion, the error status of the claim is held.
- If there is a difference of opinion among the independent reviewers, all initial reviewers discuss the claim and reach a consensus or majority vote decision is held. All physicians may be gathered in one room to complete this work; however, optometry and dental claims will require specialty reviews.
- The same process is repeated by clinical staff to review all claims identified as having errors not related to medical necessity. For MPES 2006, all MDs will participate in the second level medical review.

At all stages of the medical review, an electronic audit trail of each and every claim reviewed will be retained. With respect to each claim's error status at each stage in the review, the audit trail will specify decisions made, justification for that decision, who made the decision, and when. For the purpose of ensuring objectivity and consistency of the review processes, the audit trail will be available for subsequent analysis and evaluation of the review process. The audit trail will enhance inter-rater reliability and minimize non-sampling errors in the review process. This information will be made part of the MPES 2006 database.

¹⁷The reviewers will not be told which ones have errors and which ones do not. They will be told that "there are errors" to determine if inter-rater reliability is an issue.

Third Level Medical Review

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

II. Review Protocol for Potentially Fraudulent Claims

Level I Review: Presence or absence of medical documentation determined by field office staff.

Level II Review: Was the service medically necessary?

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

- Medical records are submitted, but documentation of the billed service does not exist and is out of context with the medical record.
- Context of claim and course of events laid out in the medical record does not make medical sense.
- No record that the beneficiary ever received the service. This is achieved by contacting the beneficiaries for claims without the required signature to verify receipt of the product or service.
- No record to confirm the beneficiary was present on the day of service billed.
- Direct denial by the listed referring provider that the service was ever ordered.
- Cooperation and attitude of providers and their office staff when contacted by A&I.
- Level of service billed is markedly outside the level documented.
- Policy violations that were illegal or outside accepted standards of ethical practice or contractual agreements.
- Medical record discrepancies coupled with a failure to run a legal business and fulfill licensing requirements.
- Medical record discrepancies coupled with the fact that the provider had a prior negative record of sanctions with DHCS.
- Medical record discrepancies for services with a historical record of abuse.
- Multiple types of errors on one claim.
- Billing for a more expensive service than what is documented as rendered.
- No actual place of business at the provider site listed.

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

Level V Review: DOJ staff review reports of all errors determined to have characteristics of potential for fraud by DHCS' A&I staff. After review, the assigned DOJ attorney shares all findings with A&I staff before a final determination is made. Findings

with which the senior attorney disagrees or has concerns are discussed with A&I staff. Before the final determination of “potential fraud” is assigned to the claim, a consensus is reached as to whether the claim is simply an error or indeed reaches the level of “potential fraud.”

III. Beneficiary Eligibility Selected Sample Methodology For Fee-For-Service

The MPES 2006 did not include a review to determine if Fee-For-Service (FFS) beneficiaries were eligible for Medi-Cal at the time the beneficiary received services. A separate review to determine eligibility of Medi-Cal beneficiaries is being performed in accordance with the requirements of the federal Payment Error Rate Measurement (PERM) program. Under PERM, reviews of states will be conducted in three areas: (1) FFS, (2) managed care, and (3) program eligibility for both the Medi-Cal and State Children’s Health Insurance Program (SCHIP). The Federal Government requires each state be responsible for measuring program eligibility for both Medi-Cal and SCHIP.

A separate report on program eligibility will be issued under separate cover by the federal Centers for Medicare and Medicaid Services in 2008.

V

SUMMARY OF PAYMENT ERRORS

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

There were 198 FFS medical provider errors and 29 dental provider errors for a total of 227 errors in the 1,147 claims sampled. These errors were also used to identify the program vulnerabilities to determine the areas of greatest risk for loss to the Medi-Cal program. A summary of the findings by type and strata is presented below. See section VII for explanation of each error and section VIII for explanation of the error reason codes.

Payment Errors

There were a total of 227 errors identified in the MPES 2006 for medical providers. Of the 227 errors 80 were identified as having a potential for fraud, waste, and/or abuse and were referred to the DOJ for review. Section VI is a summary of the potentially fraudulent claims.

Number of Payment Errors by Sample Strata

Error Type	Inpatient Hospital	Adult Day Health Care	Dental	Durable Medical Equipment	Laboratory	Physician Services	Pharmacy	Other Services	Total
Insufficient Documentation (MR2)		5	15		1	23	22	17	83
Coding Errors (MR3)(MR4)			6			26		3	35
Medically Unnecessary (MR5)		14	5	1	3	13	23	4	63
Policy Violation (MR7)(MR8) (PH10)			3	1		2	3	3	12
No Legal Prescription (PH2)							16		16
Prescription Missing Essential Information (PH3)							2		2
No Record of Drug/Supply Acquisition (PH6)							2	1	3
Refills too frequent (PH7)							6		6
Wrong Client Identified (WCI)								1	1
Ineligible provider (P9)				1		1		3	5
Ineligible recipient (P7)							1		1
TOTAL	0	19	29	3	4	65	75	32	227

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

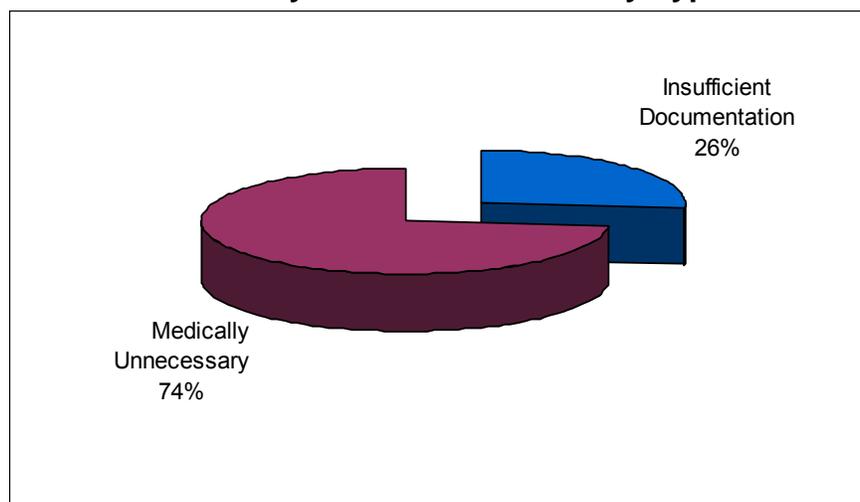
Inpatient Hospital and Nursing Facilities

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

Adult Day Health Care

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

Adult Day Health Care Errors by Type



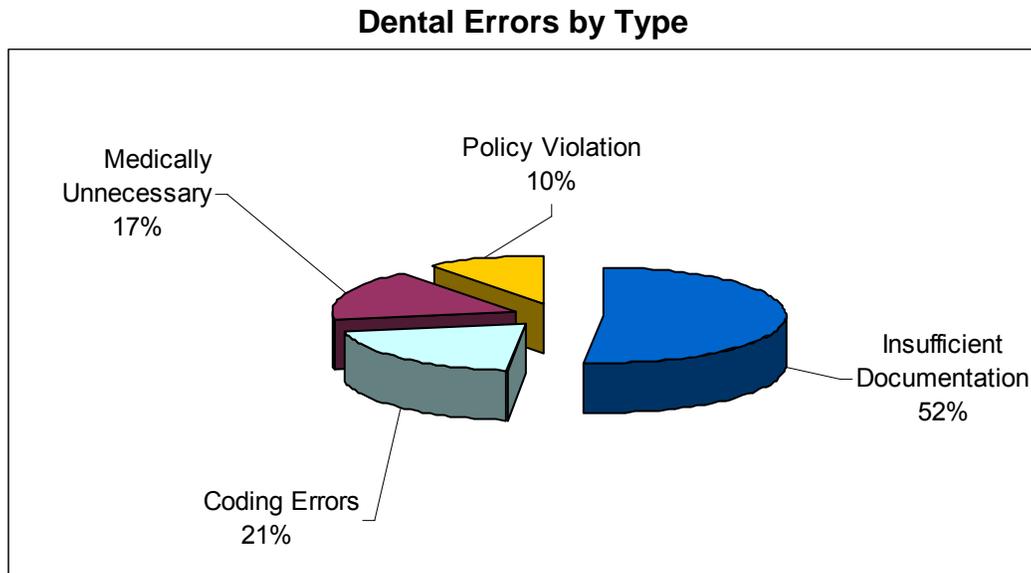
Examples:

- Insufficient/Poor Documentation for 8 of 22 days of ADHC services. There is no evidence the beneficiary attended. There is no documentation the patient was transported or received services on these 8 days. Also, the beneficiary did not sign in on the eight days in question. The documentation does support medical necessity for this beneficiary.
- Medically unnecessary: This beneficiary cares for herself, her spouse, who has vision problems, and her grandchildren. According to her PCP, her only physical limitation is she needs to avoid heavy lifting. She uses no aids for ambulation. The PCP states the beneficiary has no depression, yet the IPC

addresses depression as a problem. Since she is able to provide needed care to herself as well as her spouse and grandchildren and has no depression, ambulation limitations or significant physical limitations, there is no indication the beneficiary meets the medical necessity requirements for ADHC services.

Dental Provider Errors

Twenty-nine dental claims were noted as having errors. Dental errors were in the following types:



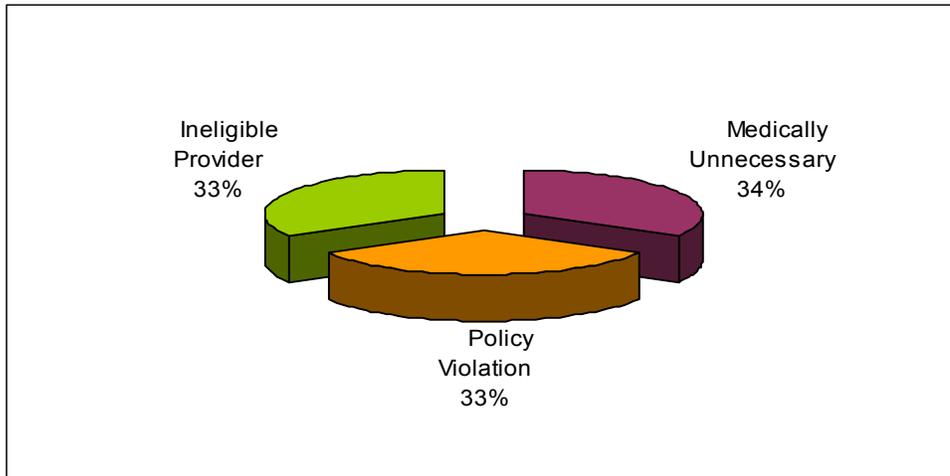
Examples:

- Insufficient documentation: There was no documentation of the use of local anesthesia for a subgingival curettage. Local anesthesia usage would be expected with this procedure and should have been documented.
- Coding errors: The dental provider billed for two X-rays. There were no X-rays or documentation the X-rays were taken. The provider also billed for Prophylaxis with Fluoride but only provided Prophylaxis.
- Medically unnecessary: This claim is for dental services for X-rays and fillings. There is no documentation of the necessity for the fillings or that local anesthetic was used for the procedures, which is the accepted standard. The treating dentist was not identified in the patient record. Therefore, dentist eligibility to provide services could not be determined.
- Other Medical Error: The treating provider was not identified in the record for this dental claim for X-rays and fillings. Since the treating provider could not be identified, their eligibility to provide services to Denti-Cal beneficiaries could not be verified.

Durable Medical Equipment

Three DME claims were noted as having errors. DME errors were in the following types:

Durable Medical Equipment Errors by Type



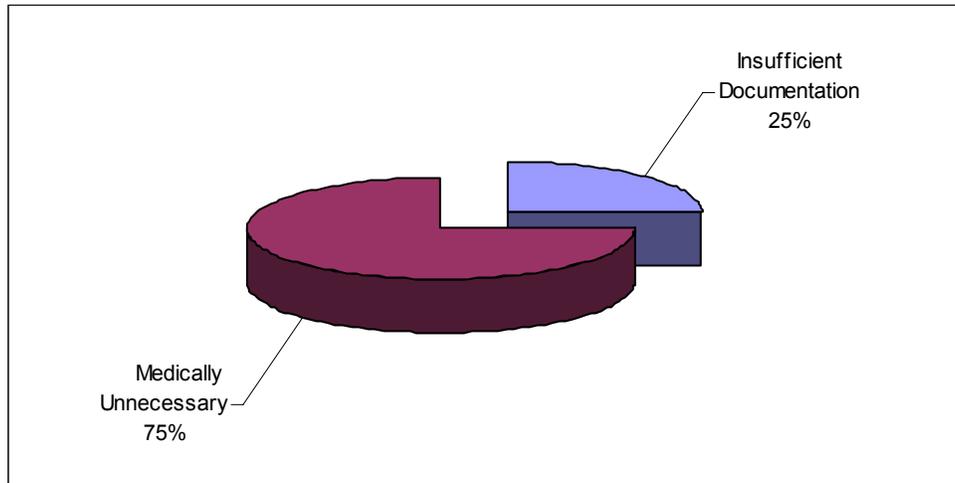
Examples:

- **Medically unnecessary:** This claim was for oxygen therapy five monthly rental charges for a premature infant with respiratory distress. The medical necessity at the time of the order was well documented. The referring provider discontinued the service on 12/16/05, after the third of the five monthly rentals on this claim. There was no medical necessity for the last two monthly rentals. The error is calculated as the difference between the amount paid for the five monthly rentals, HCPCS Code E0431, for 9/22/05, 10/22/05, 11/22/05, 12/22/05 and 1/22/06 and the amount that would have been paid for three monthly rentals on 9/22/05, 10/22/05, and 11/22/05.
- **Policy Violation:** This claim was for leads for a TENS unit used for electrical stimulation to relieve pain. A TAR is needed for any leads costing more than \$22.68. This claim was for \$45.36. The TAR that was available expired five months before the date of service on the claim. There was no prescription for the leads. The only prescription provided was for a replacement TENS unit. The wrong referring provider was listed on the claim. There was no signature verifying receipt of this item by the beneficiary or their representative. The error was calculated as the total amount paid for this claim.
- **Ineligible Provider:** This claim was for supplies used with a TENS unit to control pain. The DME provider was not licensed on the date of service. The license expired on May 1, 2006 and the renewal request was not submitted until three months later in August 2006.

Laboratory

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

Laboratory Errors by Type



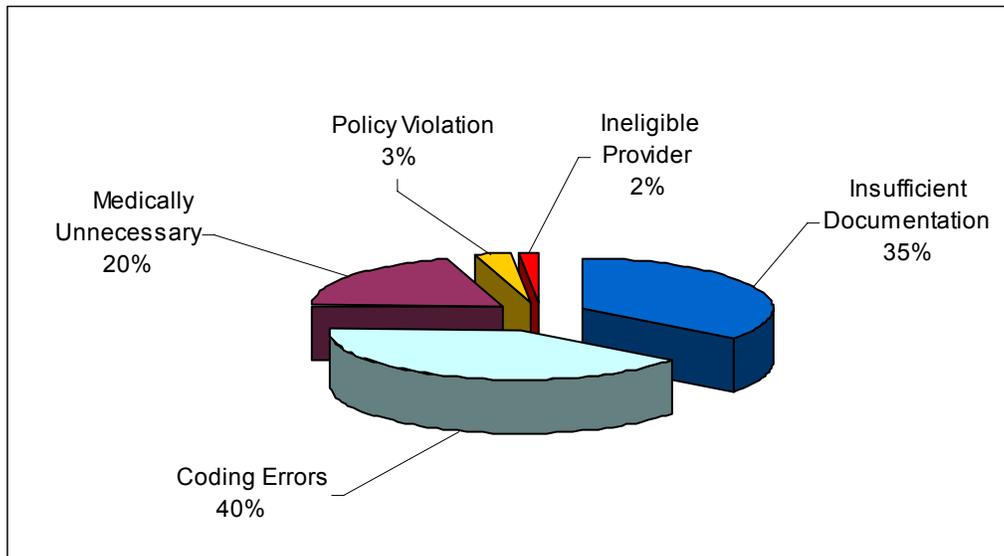
Examples:

- **Insufficient Documentation:** This claim was for laboratory services. No errors were identified with the laboratory processing and reporting of the laboratory test. There was no documentation in the referring provider's record that an exam was done or the specimen was collected on the date of service. There is no signature from the beneficiary verifying the source of the specimen as required by Welfare and Institutions Code Section 14043.341.
- **Medically Unnecessary:** This claim was for a urine pregnancy test. The patient was on her menses at the time of the pregnancy test and had no signs or symptoms of pregnancy. The clinic protocol was to do pregnancy test at each visit. There was no medical necessity for this test.

Physician Services

Sixty-five physician services claims were noted as having errors. Physician services provider type includes physicians, clinics, and other licensed providers. Insufficient/poor documentation and coding errors continued to be high, as identified in the MPES 2005, accounting for 77 percent of errors by this provider type identified in that study. In the MPES 2006, 75 percent of the errors were found in these error types. Physician services errors were in the following types:

Physician Services Errors by Type



Examples:

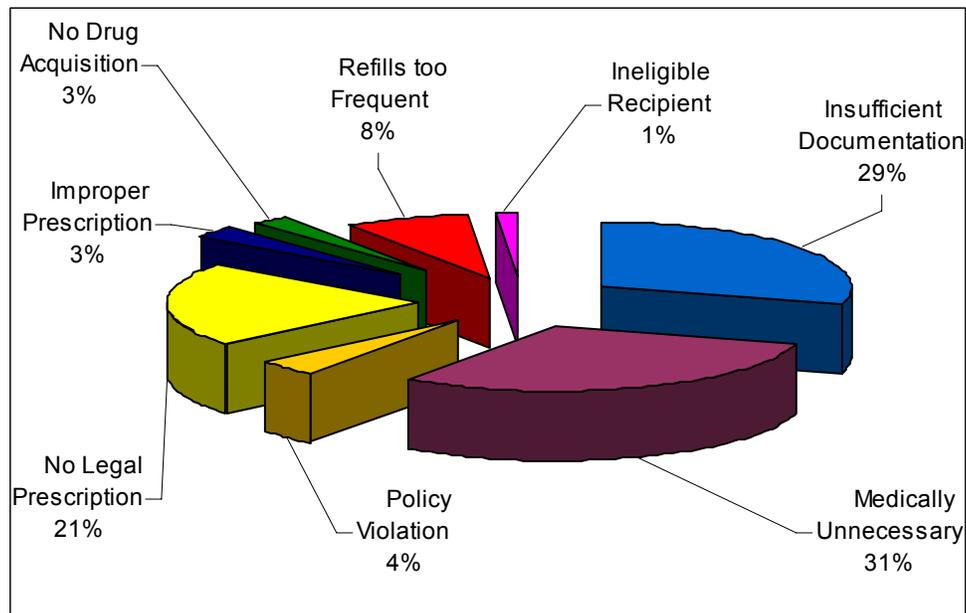
- **Insufficient Documentation:** This claim was for nine participants in a paneled team conference for a child enrolled through California Children's Services (CCS). There was insufficient documentation to support the required assessment by the registered nurse or the evaluation, that should have been done by the social worker, was accomplished. The social worker identified through the medical record documentation was not paneled by CCS as required to provide this service. The social worker identified was not licensed as a clinical social worker which is required to bill for this service.
- **Coding Errors:** This claim was for a level-four office visit for an established patient two and one half weeks after delivery. The physician billed globally for the delivery. The global fee includes post partum care for six weeks. This visit should not have been billed separately.
- **Medically Unnecessary:** This claim was for an Obstetrical Ultrasound for a single fetus pregnancy less than 14 weeks. The radiologist performed the ultrasound on referral. The referring provider requested an Obstetrical ultrasound for fetal size. There is no indication in the referral there is a concern about the fetal size. An incorrect diagnosis was used on the claim - excess fetal growth. There is no documentation indicating this ultrasound was medically necessary.
- **Policy Violation:** This claim included three different laboratory tests done in the hospital-based clinic. There were two tests for urinalysis, CPT 81002, done on different dates when an antepartum follow up visit was on the same day. These tests are included in the rate for the antepartum follow up visit and should not be claimed or paid separately. There is no beneficiary signature verifying source of the biological specimens. The error was calculated as the difference between the amount paid for the claim and the amount that was paid for the two CPT 81002 tests.

- Ineligible Provider: This claim was for a patient visit to a Rural Health Clinic (RHC). The note by the physician assistant was insufficient to support an actual visit with the patient. The social worker seeing the patient was a registered associate social worker however, the services should be delivered by a licensed clinical social worker. The registered associate social worker was not authorized to provide services billed to the Medi-Cal program. It appeared the brief note by the physician assistant was done to circumvent the requirement that services be provided by a licensed clinical social worker. This practice appeared to have occurred on multiple visits. The error was calculated as the total amount paid for this claim.

Pharmacy

Errors in pharmacy claims were due to both the pharmacies making errors and errors found in the prescriber's documentation. Thirty-one percent of the pharmacy errors were attributed to the referring physician as these were deemed 'Medically Unnecessary.' Pharmacy errors occurred in the following areas:

Pharmacy Errors by Type



Examples:

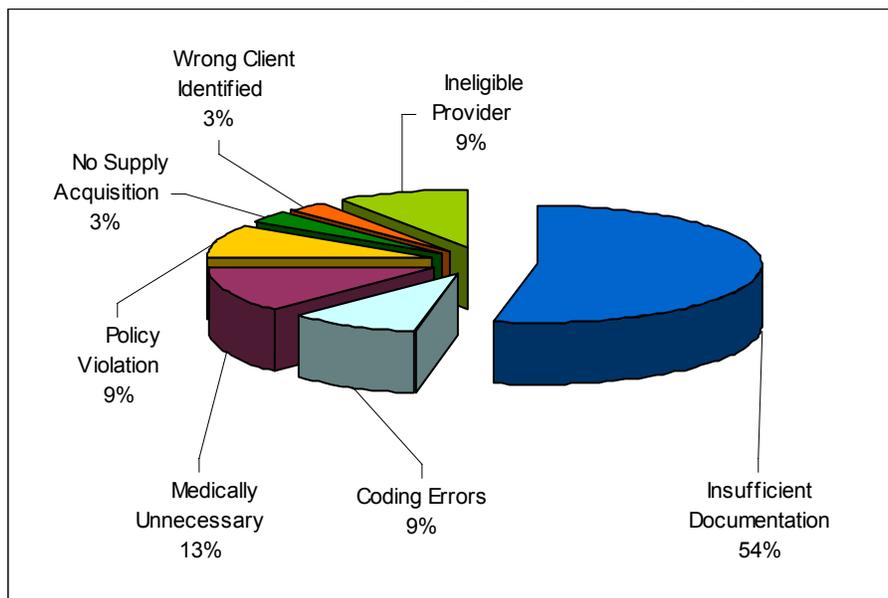
- Insufficient Documentation: This claim was for Effexor, a medication used to treat depression and anxiety. There were no errors in the service or documentation provided by the pharmacy. The prescribing provider's documentation was illegible. There was minimal documentation to support the need for continued use of this medication; one word was written under assessment "depression." There was no indication how the beneficiary's depression was being managed by this medication. The progress note written by the prescriber totaled four words.

- Medically unnecessary: This claim was for Fosamax, a medication used to treat osteoporosis. There was no documentation in the medical record that the patient has osteoporosis; no history or tests to support the diagnosis of osteoporosis or Paget's disease. The NDC number on the claim did not match the NDC number on the invoice provided by the pharmacy.
- Policy Violation: This claim was for Fluconazole, a medication used to treat candidiasis or cryptococcal meningitis. Medi-Cal restricts the use of this medication to patients with cancer and Human Immune Deficiency (HIV) infection. There was no indication this patient had either cancer or HIV. The medication was prescribed for an uncomplicated vaginal yeast infection. The NDC on the invoice was not the same as the NDC number used on the claim. The beneficiary did not sign, verifying receipt of the medication.
- No Legal Prescription: This claim was for Loratadine, a medication used to manage allergies. The prescription was a telephone refill according to the pharmacist. There was no documentation correlating this date of service with the refill documentation provided by the pharmacist. The prescribing provider maintains a refill log and this refill was not included in that log. The prescribing provider's documentation did not support this refill nor did the pharmacy documentation.
- Prescription Missing Essential Information: This claim was for Furosemide, a medication used to treat edema and high blood pressure. The prescription for this medication on file at the pharmacy was incomplete. The current authorization at the pharmacy did not have the strength of the medication or the quantity to be dispensed. The referring provider's medical records were also missing this information.
- No Record of Drug Acquisition: This claim was for the Ortho Evra Patch used as a means of birth control. The invoice provided by the pharmacy was for over a year before the date of service on the claim. There was no indication the pharmacy had more current medication in stock. An invalid number was used to identify the referring provider. The actual referring provider was licensed-in good standing.
- Refills Too Frequent: This claim was for lancets used to check blood sugar levels for someone with diabetes. The patient resided in a skilled nursing facility. The prescription for 50 lancets was to be filled every month and had been filled at least three times before the date of service on the claim. The patient blood sugar per order and nursing documentation at the SNF was checked once a week. Therefore 50 lancets should have lasted almost a year however, the prescription was filled every month. The order was for blood sugar testing once a week. The directions on the label from the pharmacy were for blood sugar checks before meals.
- Ineligible Recipient: This claim was for Metformin, a medication used to treat type II Diabetes. Medical necessity was documented in the medical record however, the beneficiary is eligible for emergency and obstetrical services only. This medication does not fall into either of those categories. Therefore, the beneficiary was not eligible for the medication.

Other Services and Supplies

Included in this category were transportation, medical supplies, Local Education Assistance (LEA) programs, hospice, Multipurpose Senior Services Program, home health agencies, genetic diseases, Aids Waiver Services, rehabilitation clinics and care coordinators. Again, the major finding was a lack of documentation. Thirty-two of the claims in this provider type were noted as having errors. Eight were LEA claims, two, transportation claims, and one, a medical supply claim. Other services and supplies errors were in the following areas:

Other Services and Supplies Errors by Type



Examples:

- **Insufficient Documentation:** This claim was for speech and audiology services through a LEA. The student was enrolled in an Individualized Education Program (IEP). There was no prescription or referral from a physician for this service as required by California Code of Regulations, Title 22, section 51309(a). The documentation did not include a plan of care, how the beneficiary will benefit from the therapy, who rendered the service, or where it was rendered.
- **Coding Error:** This claim was for medical transportation by ambulance with mileage and an electrocardiogram (ECG) while in route. There was documentation to support the medical necessity for the transport. The actual mileage from the ambulance company was poorly documented. The odometer readings are provided but without the source document for this information that was requested during the audit. The mileage was confirmed by map. The ECG cost is included in the ambulance rate and should not have been billed separately.
- **Medically Unnecessary:** This claim was for multiple incontinence supplies. There was no documentation in the medical record that the beneficiary had urinary incontinence.

- **Policy Violation:** This claim was for transportation services for a child in a LEA and the accompanying mileage. The claim was for two trips. The IEP stated the child needs home to school transport. The family delivered the child to the school in the morning. There was no recommendation the child be transported from school to home at the end of the school day. Therefore, no transportation and associated mileage should have been claimed.
- **No Record of Supply Acquisition:** This claim was for medical supplies for a quadriplegic's use at home. The medical necessity was apparent from the medical record however, there was no record the provider had acquired the supplies to dispense to the patient. There was no legal prescription for the date of service. The most current prescription was for five months earlier. The beneficiary did not sign verifying receipt of the supplies. The wrong referring provider was identified on the claim.
- **Wrong Client Identified:** This was a claim for two occupational therapy services. The first service was adequately documented and medically necessary. The second service was not documented. Discussion with the provider staff revealed the second service was provided to a different patient and should not have been billed to this patient.
- **Ineligible Provider:** This claim was for health and mental evaluation/education through a LEA. The student had an IEP. According to the IEP, there were no general health concerns and nothing in the IEP calls for general health assessments. This assessment was done by a public health nurse. There was no documentation of any medical need for the student to have this assessment. The school nurse stated all students in special education get this assessment but only those with Medi-Cal are charged.

VI

POTENTIAL FRAUD CLAIMS

One of the goals of the MPES 2006 was to identify claims that were potentially fraudulent. Thirty-five percent of the claims found to have errors were also identified to have characteristics for potential fraud or abuse, such as claiming for services not delivered. While this is significant, it needs to be interpreted with caution. Obviously, a single claim does not prove fraud. Without a full criminal investigation of the actual practice of the provider, there is no certainty that fraud has occurred. The MPES 2006 merely identified the claim as being potentially fraudulent.

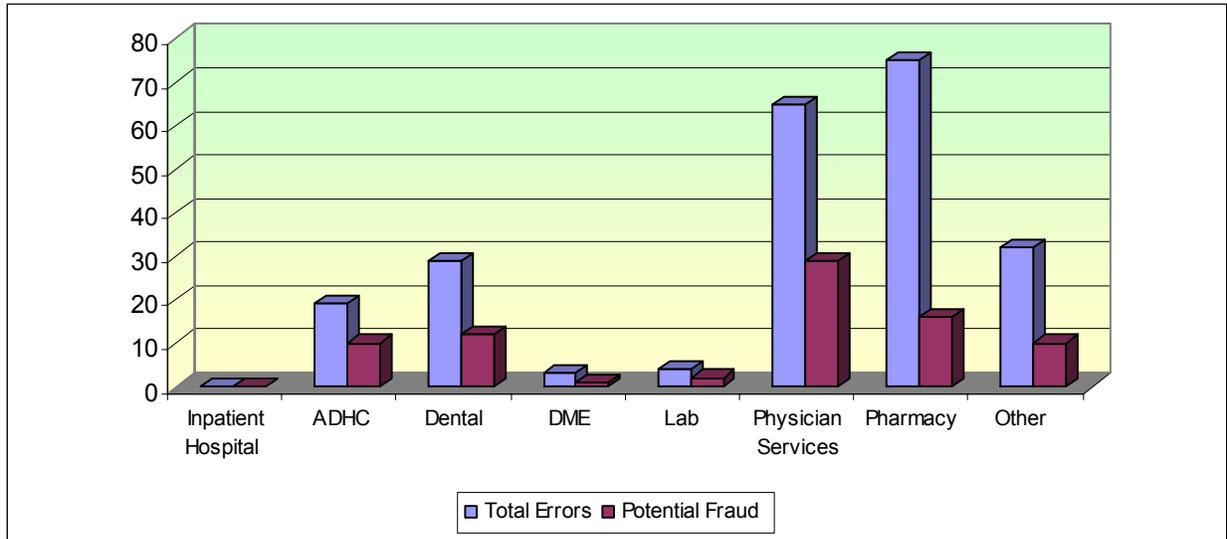
The MPES 2006 review protocols called for the medical review team to examine each claim for potential fraud, waste, and/or abuse (section IV). There were 999 unique providers represented in the sample of 1,147 claims. A total of 80 claims, submitted by 78 unique providers, were found to be potentially fraudulent. The Department of Justice (DOJ) reviewed all claims so designated and concurred with DHCS' assessment of potentially fraudulent activity in the 80 claims. The 78 unique providers of these 80 claims are undergoing further review by field audit staff to determine the appropriate actions needed. Of the 78 providers identified as submitting potentially fraudulent claims, 21 had been independently identified by DHCS prior to the MPES 2006 and were already undergoing case development and/or placed on administrative sanction when the study was conducted.

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

Breakdown of Potentially Fraudulent Claims by Sample Strata and Error Code

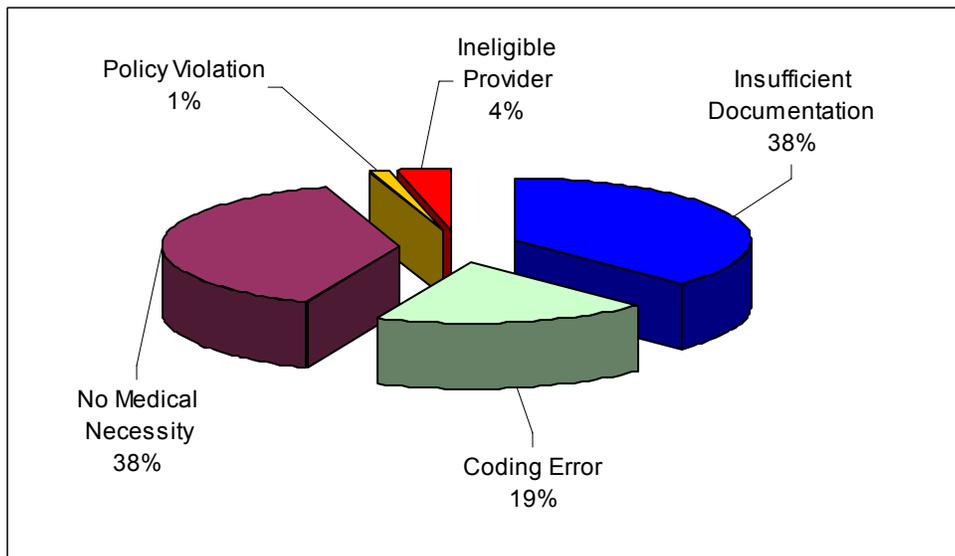
Provider Type	Number of Potentially Fraudulent Claims	Insufficient Documentation	Coding Error	No Medical Necessity	Policy Violation	Ineligible Provider	% Errors by Provider Type
Inpatient Hospital	0	0	0	0	0	0	0.00%
Adult Day Health Care	10	2	0	8	0	0	12.50%
Dental	12	4	5	3	0	0	15.00%
Durable Medical Equipment	1	0	0	1	0	0	1.25%
Laboratory	2	1	0	1	0	0	2.50%
Physician/ Clinic Services	29	9	9	9	1	1	36.25%
Pharmacy	16	10	0	6	0	0	20.00%
Other Services and Supplies	10	4	1	3	0	2	12.50%
Potential Fraud by Primary Errors	80	30	15	31	1	3	
Percent of Errors	100.00%	37.50%	18.75%	38.75%	1.25%	3.75%	

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



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

Summary of Potentially Fraudulent Errors



Documentation Errors

Documentation errors were dominant among potentially fraudulent claims. For thirty (37.50 percent) claims there was insufficient documentation to support the visit or service claimed. Some of these omissions may represent unorganized or incomplete

record keeping by providers. Others may be more indicative of serious fraudulent activity that warrants a comprehensive, detailed investigation of the providers' claiming patterns.

Unorganized and incomplete record keeping by providers makes the system vulnerable to fraud, waste and abuse, because auditors may be unable to judge whether the service claimed was actually performed.

For example, there was no documentation of a 30 minute nursing assessment for a child with pulmonary disease as claimed. There were only documents from the rendering provider.

Medical Coding Errors

Of the claims with characteristics for potential fraud, there were fifteen (18.75 percent) claims with medical coding errors. Although it is not uncommon for documentation to be inadequate or insufficient to justify the level claimed, a few claims had discrepancies that were serious enough to cross the threshold into the potentially fraudulent category.

For example, an emergency department claimed the use of an emergency room for a patient that was triaged with a non-emergent condition and then left the emergency department before being seen by the physician. This claim should have been billed as a hospital examination room which is reimbursed at a lower rate than use of an emergency room.

Medically Unnecessary Services

Thirty-one (38.75 percent) claims were found to be at risk due to lack of medical necessity. Medical necessity is inherently difficult to judge, as such, only the claims with the most obvious lack of medical need were considered potentially fraudulent.

For example, there was no documentation in the prescribing physician's record of a diagnosis or condition for a 12 year-old patient treated with Paxil. Paxil is used to treat depression or anxiety. The Food and Drug Administration had not approved Paxil for use in pediatric patients as of the date of service. Furthermore, the prescription was written and filled seven months before the date of service with no refills so there was no valid prescription for this service.

Policy Violation

One (1.25 percent) claim fell into the policy violation category. Federally Qualified Health Centers (FQHC) are required to follow Medi-Cal/Denti-Cal policy and provide services in the same manner as the Medi-Cal/Denti-Cal program. FQHCs bill by encounter and details of the service provided were not included with the claim submitted for payment. The dentist at the FQHC performed a procedure called gross scaling. This

is not a service covered by the Denti-Cal program. Therefore, the program should not have been billed for these services.

Ineligible Provider

The MPES 2006 identified three (3.75 percent) claims that were potentially fraudulent involving an ineligible provider.

As an example, a Local Education Agency (LEA) claimed a health and mental evaluation/education for a student. The school nurse verified all students in special education received this evaluation by a public health nurse but only those students with Medi-Cal were charged for the evaluation. According to the student's Individual Education Plan (IEP), there were no general health concerns so there was no documentation of any medical need for this evaluation.

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

Error Type	Potential Fraud Identified	No Potential Fraud Identified
<p>Insufficient Documentation (MR 2-A, MR2-B)</p>	<p>Dental Services The dentist claimed for extracting two teeth for a six year old child. The documentation in the record stated one tooth exfoliated on its own so there was no extraction necessary. There is no evidence any local anesthesia was given to this child as would be expected with a tooth extraction. The treating dentist is not identified in the record. Since there is no identification of the treating dentist, eligibility to provide this service can not be determined.</p>	<p>Dental Services This claim was for dental services of periodontal scaling and root planting. This is a procedure that would normally require local anesthesia. There was no documentation of anesthesia use. The lack of anesthesia could be considered substandard care.</p>
<p>Coding Error (MR3, MR4, PH4)</p>	<p>Non-emergency Medical Transportation This claim was for medical transportation by ambulance with mileage and an electrocardiogram (ECG) while in route. There was documentation to support the medical necessity for the transport however, the actual mileage from the ambulance company was poorly documented. The odometer</p>	<p>Physician Services This claim was for a level four office visit for an established patient. The claimed level visit required a detailed history and examination and medical decision making of moderate complexity. The provider only excised a mole. This does not meet the requirement for more than a level two office visit. An</p>

	readings are provided but without the source document for this information that was requested during the audit. The mileage was confirmed by map. An ECG is included in the ambulance rate and should not have been billed separately.	incorrect diagnosis code was used on the claim. This claim should have been for CPT Code 99212 instead of CPT Code 99214.
Policy Violation (MR 7, PH10)	Dental Services This claim was for dental services at a Federally Qualified Health Center (FQHC). FQHCs are required to follow Medi-Cal/Denti-Cal policy and provide services in the same manner as the Medi-Cal/Denti-Cal program. FQHCs bill by encounter and details of the service provided was not included with the claim submitted for payment. The dentist at the FQHC performed a procedure called gross scaling. This is not a service covered by the Denti-Cal program. Therefore, the program should not have been billed for these services.	Other Services and Supplies This claim was for occupational therapy through a LEA. There was documentation in the IEP that the services were appropriate however, there was no prescription from a physician, podiatrist or dentist as required for this service.
Ineligible Provider (P9)	Other Services and Supplies This claim was for speech pathology services for a child through a LEA. The speech pathologist signing the assessment for the date of service did not have a license; their license expired in 1982. The same person was identified as the therapist on the speech therapy log. The log demonstrated a service was provided but there was no documentation of the nature or extent of services or the child's response to services. No physician's order or minimum standards of medical need were available for this service.	Other Services and Supplies This claim was for school health aid services through a LEA. School health aid services are payable only when performed by a trained health care aid. These services were performed by a teacher and there is no documentation the teacher is qualified as a trained health care aid. The services were for diapering and diapering is not a covered service.

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0003	Dental	MR2A - Poor/insufficient documentation	This claim was for dental services billed as emergency services. A lesser service was provided with no definitive treatment documented. This error was calculated as the difference between the total amount paid for the claim and the amount paid for the emergency visit.	\$65.00	\$20.00	\$45.00
0007	Dental	MR2B - No documentation	This claim was for dental X-rays and emergency treatment. There was no documentation the X-ray was taken. The error was calculated as the difference between the total amount paid for the claim and the amount paid for the X-ray.	\$55.00	\$45.00	\$10.00
0008	Dental	MR2B - No documentation	This claim was for emergency dental services and X-rays. There were no X-rays in the patient record for the date of service. The progress note had a signature but the person signing was not identified. Therefore the treating dentist was not identified in the patient record as required by Title 22 Section 51476(a) (7). This error was calculated as the amount paid for the X-rays.	\$10.00	\$0.00	\$10.00
0009	Dental	MR5 - Medically unnecessary service	This claim was for several dental services; X-rays, two fillings, two uncomplicated tooth removals as well as regular periodic oral examination and fluoride prophylaxis for an eleven year old child. There was no documentation in the record to support the need for the two uncomplicated extractions of primary teeth. The record indicates two bite-wing X-rays were taken, yet the provider billed for four. The record states a Prophylaxis was performed but the provider billed for Prophylaxis with Fluoride. This procedure was documented as being done by a registered dental assistant (RDA). It can only be done by a dentist or registered dental hygienist. The RDA cannot legally perform this service. This error was calculated as the total amount paid for this claim.	\$323.00	\$0.00	\$323.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0011	Dental	MR5 Medically unnecessary service	This claim was for dental services for an eleven year-old child. The dentist claimed for 18 fillings in one visit. There was no documented or X-ray evidence of the necessity for many of these fillings. This was considered substandard care since 18 fillings is considered excessive for one visit. There was no documentation anesthesia was given for these procedures. The provider also billed for a periodontal emergency visit yet the record states this was a non-emergency visit. This error was calculated as the total amount paid for this claim.	\$1,015.00	\$0.00	\$1,015.00
0012	Dental	MR2A Poor/insufficient documentation	This claim was for an initial dental examination. The initial examination was inadequately documented. Key components such as conditions of hard and soft tissues, existing restorations, periodontal condition and other pathology were not noted. The error was calculated as the total amount of the claim.	\$25.00	\$0.00	\$25.00
0014	Dental	MR2A Poor/insufficient documentation	This claim was for dental services. The documentation of the extraction of tooth number 28 was not adequately documented. The treating provider could not be identified in the patient record. The error was calculated at the amount paid for procedure code 202 surgical removal of tooth.	\$190.00	\$105.00	\$85.00
0016	Dental	MR3 Coding error	This claim was for periodic dental exam and X-rays. The record shows two bite-wing X-rays were taken. The provider billed for four bite-wing X-rays. This error was calculated at the difference between four bite-wing X-rays and two bite-wing X-rays.	\$91.00	\$83.00	\$8.00
0017	Dental	MR8 Other medical error	This claim was for dental services. The treating provider could not be identified in the record. Therefore, eligibility to provide the services could not be determined. The error was calculated as the total amount paid for the claim.	\$58.00	\$0.00	\$58.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0019	Dental	MR3 Coding error	This claim was for dental services. The provider billed for two X-rays. There were no X-rays or documentation the X-rays were taken. The provider also billed for Prophylaxis with Fluoride but only provided Prophylaxis. The error was calculated as the total amount paid for the X-rays and the difference between Prophylaxis with Fluoride and Prophylaxis.	\$73.00	\$55.00	\$18.00
0021	Dental	MR2B No documentation	This claim was for dental services. There was no documentation in the record the Prophylaxis was provided. The dentist that rendered the services was not the dentist listed as the rendering provider on the claim. The error was calculated at the amount paid for the Prophylaxis.	\$84.00	\$44.00	\$40.00
0022	Dental	MR2A Poor/insufficient documentation	This claim was for multiple dental services including several X-rays, Prophylaxis with Fluoride and five fillings. The record states a Prophylaxis was performed. However, the claim was billed as a Prophylaxis and Fluoride. There was no documentation of the type and amount of anesthesia given. The error was calculated as the total amount for this claim.	\$256.00	\$0.00	\$256.00
0027	Dental	MR2A Poor/insufficient documentation	This was a dental claim for subgingival curettage. There was no documentation of the use of local anesthesia. Local anesthesia usage would be expected with this procedure and should have been documented. The error was calculated as the total amount of the claim.	\$118.00	\$0.00	\$118.00
0029	Dental	MR2A Poor/insufficient documentation	This claim was for dental services of periodontal scaling and root planing. This was a procedure that would normally require local anesthesia. There was no documentation of anesthesia use. The lack of anesthesia could be considered substandard care. This error was calculated as the total amount paid for	\$118.00	\$0.00	\$118.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			this claim.			
0030	Dental	MR5 Medically unnecessary service	This claim was for dental services for routine exam, X-rays, prophylaxis and a tooth extraction. The X-rays did not indicate any pathology with the extracted tooth. There was no documentation in the record explaining the reason for the extraction. This error was calculated as the difference between the total amount of the claim and the amount paid for the extraction.	\$124.00	\$79.00	\$45.00
0031	Dental	MR3 Coding error	This claim was for dental services. The provider was not identified in the record. Since the provider was not identified, their qualifications to provide the claimed service could not be verified. The provider billed for two occlusal X-rays but the record contained two periapical X-rays which are reimbursed at a lower rate. Since the eligibility of the provider could not be verified, the error for this claim was calculated at the total amount of the claim.	\$103.00	\$0.00	\$103.00
0032	Dental	MR2A Poor/insufficient documentation	This claim was for two tooth extractions for a six year-old child. The documentation in the record stated one tooth exfoliated on its own so there was no extraction necessary. There is no evidence any local anesthesia was given to this child as would be expected with a tooth extraction. The treating dentist was not identified in the record. Since there was no identification of the treating dentist, their eligibility to provide this service could not be determined. Therefore, this error was calculated at the total amount paid for the claim.	\$83.00	\$0.00	\$83.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0033	Dental	MR5 Medically unnecessary service	This claim was for dental services for X-rays, an initial exam and a tooth extraction. The documentation for the initial examination was incomplete. The presence of tooth decay, existing restorations and any other pathology were not mentioned. There was no documentation of the need for the tooth extraction. This error was calculated as the difference between the total cost of the claim and the cost of the exam and the extraction.	\$93.10	\$26.60	\$66.50
0034	Dental	MR2B No documentation	This claim was for periodic oral exam, prophylaxis with fluoride and two bite-wing X-rays. There were no X-rays in the record dated for the date of service for this claim. The error was calculated at the difference between the total claim and the cost for the two bite-wing X-rays.	\$65.00	\$55.00	\$10.00
0035	Dental	MR5 Medically unnecessary service	This claim was for dental services for denture repair. There was no documentation in the record that supports the need for this service. The error was calculated as the total amount of the claim.	\$140.00	\$0.00	\$140.00
0037	Dental	MR2A Poor/insufficient documentation	This claim was for dental services. The provider billed and was paid for two bite-wing and two periapical X-rays. The record indicates only one bite-wing and one periapical X-rays were done. The treating provider was not identified in the record. Since there was no identification of the treating provider, eligibility to provide this service could not be determined. The error was calculated as the total amount of the claim.	\$66.00	\$0.00	\$66.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0038	Dental	MR2A Poor/insufficient documentation	This claim was for dental services for X-rays and fillings. There was no documentation of the necessity for the fillings. There was no documentation local anesthetic was used for the procedures which is the accepted standard. The treating dentist was not identified in the patient record. Therefore, their eligibility to provide services could not be determined. The error was calculated as the total amount paid for this claim.	\$162.00	\$0.00	\$162.00
0040	Dental	MR2A Poor/insufficient documentation	This claim was for dental services for sub gingival curettage and two root canals. There was no documentation for the use of local anesthesia for these procedures which is the standard of practice. The rendering provider could not be identified in the record so their eligibility to provide the service could not be determined. This error was calculated at the total amount paid for the claim.	\$118.00	\$0.00	\$118.00
0041	Dental	MR2A Poor/insufficient documentation	This claim was for dental examination, prophylaxis with fluoride, and two bite-wing X-rays among other services. The provider billed for two bite-wing X-rays but only one was performed. The provider did not sign the record so could not be identified. Therefore, eligibility to provide the billed services could not be determined. This error was calculated as the total amount paid for this claim.	\$71.00	\$0.00	\$71.00
0042	Dental	MR8 Other medical error	This claim was for dental services for a tooth extraction. There were no X-rays taken to determine the presence of the tooth or a need for extraction. The error was calculated as the total amount paid for this claim.	\$45.00	\$0.00	\$45.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0043	Dental	MR3 Coding error	This claim was for several dental services. The provider billed for two bite-wing X-rays yet the record indicate only one bite-wing X-ray was done. This error was calculated as the difference between the amount paid for two bite-wing X-rays and the amount that would have been paid for one bite-wing X-ray.	\$77.00	\$73.00	\$4.00
0044	Dental	MR8 Other medical error	This claim was for dental X-rays and fillings. The treating provider is not identified in the record. Since the treating provider cannot be identified, eligibility to provide services to Denti-Cal beneficiaries cannot be verified. Therefore, this error was calculated at the total amount paid for the claim.	\$51.00	\$0.00	\$51.00
0050	Dental	MR3 Coding error	This claim was for several dental services. The provider billed for an intra-oral photograph but the photo was not in the record. This error was calculated as the difference between the total cost of the claim and the cost of the intra-oral photograph.	\$296.00	\$289.00	\$7.00
0051	Dental	MR3 Coding error	This claim was for several dental services. The record states a Prophylaxis was performed. However, the provider billed for Prophylaxis with Fluoride. The provider identified in the patient record as providing the services is not licensed in California. The error was calculated as the total amount paid for this claim.	\$56.00	\$0.00	\$56.00

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0057	ADHC	MR5 Medically unnecessary service	This claim was for four days of regular Adult Day Health Care (ADHC) services. The primary care provider's (PCP) request for services does not support the need for ADHC services. The documentation in the PCP records was inconsistent with the assertions made in the Individual Plan of Care (IPC). There is no documentation in the PCP records that support the ADHC's assertion of Alzheimer's disease or depression. The documentation from the ADHC is stereotypical; nursing medication sheets have only slash marks for the medications. There are no initials to identify who gave each medication. Some medications are noted to have been given five times a week when the beneficiary only attends four times a week. According to the attendance log, the beneficiary was not in attendance on the fifth day. This error was calculated as the total amount paid for the claim.	\$294.24	\$0.00	\$294.24
0058	ADHC	MR2A Poor/insufficient documentation	This claim was for two days of regular ADHC. The beneficiary meets the eligibility criteria for ADHC services. The IPC states no skilled physical therapy needed. However, there was a flow sheet documenting the patient received skilled physical therapy. The quarterly assessment states the beneficiary continues to have uncontrolled blood pressure. Hypertension was not addressed on the IPC as a problem needing monitoring. The blood pressures noted were within normal limits. It was impossible to determine the beneficiary's actual needs and if they were being addressed from the conflicting documentation provided. This error was calculated as the total amount paid for this claim.	\$147.12	\$0.00	\$147.12

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0063	ADHC	MR5 Medically unnecessary service	This claim was for two days of regular ADHC attendance. There was no mention of cognitive impairment, Alzheimer's disease or the use of Aricept for Alzheimer's disease in the records from the PCP. The medication was not listed on any of the medication lists in the ADHC or the PCP records. Aricept is mentioned in the IPC only. The ADHC staff stated the beneficiary forgets to take her medication for hypertension and diabetes. However, her blood pressure and blood sugars were stable. The documentation in this record did not support medical necessity for ADHC services. This error was calculated as the total amount of the claim.	\$147.12	\$0.00	\$147.12
0064	ADHC	MR5 Medically unnecessary service	This claim was for one day of ADHC services. There was no indication the beneficiary met the medical necessity requirements for ADHC services. She cares for self, her spouse who has vision problems and her grandchildren. According to her PCP, her only physical limitation is she needs to avoid heavy lifting. She uses no aids for ambulation. The PCP states the beneficiary has no depression, yet the IPC addresses depression as a problem. Since she was able to provide needed care to herself as well as her spouse and grandchildren and has no depression, ambulation limitations or significant physical limitations, there was no indication the beneficiary meets the requirements for ADHC services. The error was calculated at the total amount of the claim.	\$73.56	\$0.00	\$73.56

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0065	ADHC	MR5 Medically unnecessary service	<p>This claim was for one day of ADHC services. This beneficiary lives with his spouse and family and was independent in activities of daily living including shopping and preparing meals with his spouse. According to the physician's treatment plan and history the beneficiary has no physical limitations, is mobile without aids, and takes no medication. The record contains contradictory information. The IPC talked about elevated blood pressure but there was no history of hypertension, the blood pressures taken at the center were stable within normal limits and the beneficiary was not on any antihypertensive medications. The social worker talked of isolation since the beneficiary is home alone most of the time yet he lives with his spouse and family, has a car, a current driver's license and still drives. The documentation on the nursing flow sheets showed stable medical conditions needing no intervention. The documentation available did not support medical necessity for ADHC services for this beneficiary. The error was calculated as the total amount paid for this claim.</p>	\$73.56	\$0.00	\$73.56
0066	ADHC	MR5 Medically unnecessary service	<p>This claim was for two days of Adult Day Health Care services. The documentation of services provided was inconsistent and erratic. The beneficiary was assessed as being independent in most activities of daily living. The beneficiary was referred to as a male and a female in different notes. The beneficiary is a male. The participant, as described by the center, was not at risk for institutionalization. There was no indication there was any contact with the primary care provider. The documentation for occupational therapy services was unclear as to what, if any, services were provided</p>	\$147.12	\$0.00	\$147.12

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			for one date of service claimed. According to the documentation, the participant's primary need is social not medical. Therefore, the error was calculated as the total amount paid for this claim.			
0069	ADHC	MR5 Medically unnecessary service	This claim was for four days of ADHC services. There was no indication the services were medically necessary or that the beneficiary met the criteria for admission. The primary physician notes a list of diagnoses without obvious impact on activities of daily living (ADL). The IPC did not address ADLs at all. The nursing IPC stated capillary refill would be evaluated but there was no indication in the nursing documentation this was done. Flow sheets for physical and occupational therapies showed frequent absences and refusals with no assessment as to why. This questions eligibility if the lack of planned therapy did not lead to deterioration of conditions and increased risk of institutionalization. The error was calculated at the total amount paid of this claim.	\$294.24	\$0.00	\$294.24
0074	ADHC	MR5 Medically unnecessary service	This claim was for one day of ADHC services for a 44-year old woman with a diagnosis of psychosis. The beneficiary lives in a board and care facility. Her PCP describes the beneficiary as independent in all aspects of care on the assessment form for the board and care. The physical for the ADHC showed all systems were normal. Regular visits to the beneficiary at the board and care by the PCP showed a stable patient. Medical necessity for ADHC services as described in the IPC submitted with the Treatment Authorization Request (TAR) was not substantiated with the PCP or ADHC documentation. The ADHC's ADL personal care flow sheets showed the beneficiary as independent for several months including the date of service. The	\$73.56	\$0.00	\$73.56

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			<p>nursing flow sheets described the beneficiary's pain as at a level of 1-2/10 which indicated minimal pain with no intervention for the pain. The Physical Therapy flow sheets consistently showed the beneficiary either absent or refusing service so there was no positive impact on the minimal pain. However, there was no increase in the pain with the lack of therapy. There also was no assessment as to why the beneficiary refused services or change in interventions to better meet the beneficiary's needs. Except for the pain measurement, the nursing flow sheets are annotated with "/" only. There was no indication what services were provided or the beneficiary's response to the services. The Social Work flow sheets have a legend but the symbols used to document the service were not on the legend so there was no way to determine the services provided or the beneficiary's response to it. As such, the documentation was insufficient. The error was calculated as the total amount paid for this claim.</p>			
0078	ADHC	MR2B No documentation	<p>This claim was for 22 days of ADHC services. On eight of these days, there was no evidence the beneficiary attended. There was no documentation the patient was transported or received services on these eight days. Also, the beneficiary did not sign in on the eight days in question. The documentation does support medical necessity for this beneficiary. The error was calculated as the difference between the amount that was paid for 22 days of ADHC service and the amount that would have been paid for 14 days of ADHC service.</p>	\$1,618.32	\$1,029.84	\$588.48

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0079	ADHC	MR2A Poor/insufficient documentation	<p>This claim was for one day of ADHC services. Medical necessity was well documented in the record. However, there was incomplete documentation of services provided as described on the IPC. Most of the care flow sheets were annotated with "/" only so there was no indication what services were provided or the beneficiary's response to the services. The OT and PT skilled services are annotated with "0" and "declined." There was no reason for declining or a plan for interventions as a result of that assessment. The beneficiary was diagnosed with dementia and confusion. The documentation stated the beneficiary was being instructed in a no added salt diet, safety awareness, and energy conservation among other things. The effectiveness of education/ instruction was questionable since the beneficiary has dementia and confusion. The OT and PT maintenance program have this confused beneficiary with dementia doing a total of 13 different activities each visit. The beneficiary is taking nature walks with the activities staff daily as well. That may be more activity than can be tolerated for an elderly person with dementia and confusion. The inconsistent, incomplete documentation was insufficient to adequately support that the needed services were provided. The error was calculated as the total amount paid for this claim.</p>	\$73.56	\$0.00	\$73.56

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0082	ADHC	MR2A Poor/insufficient documentation	This claim was for one day of ADHC services. The documentation showed the beneficiary did not receive the nursing and personal care services described in the IPC as being needed each day at the center. The services not provided were personal care assistance with ADLs, monitoring for falls and injury and a regular diet. The documentation on the nursing flow sheet was illegible and there was no legend to describe the symbols. The beneficiary has a diagnosis of mental retardation but there was no assessment to support that diagnosis. There was no documentation of periodic communication with the beneficiary's primary care provider. The error was calculated as the total amount paid for this claim.	\$73.56	\$0.00	\$73.56
0086	ADHC	MR5 Medically unnecessary service	This claim was for one day of ADHC services. Although the beneficiary has conditions that may make her eligible for ADHC services, her inconsistent attendance reflected little need for or therapeutic effect from services. The periodic reassessments reflect goals not being met due to irregular attendance. The documentation on the nursing flow sheets was insufficient to determine what services were provided. One page of the flow sheet showed none of the services were provided, including diet. The error was calculated as the total amount paid for this claim.	\$73.56	\$0.00	\$73.56
0087	ADHC	MR2B No documentation	This claim was for three days of ADHC services. The beneficiary met the four criteria for eligibility for admission to the center however, there was no documentation the beneficiary attended the center on one of the three days claimed. The error was calculated as the difference between the amount paid for three days of attendance and the amount that would have been paid for two days of attendance.	\$220.68	\$147.12	\$73.56

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0088	ADHC	MR5 Medically unnecessary service	This claim was for one day of ADHC services. The beneficiary was approved for services for five days a week but attended only once a week during the month which included the date of service. There was no documentation the professional staff queried the beneficiary about the reason for her infrequent attendance. There was no decline in her condition as a result of this infrequent attendance. This indicated the beneficiary was not at risk for decline and institutionalization, one of the four required criteria the beneficiary must meet to be eligible for ADHC services. This error was calculated at the total amount paid for this claim.	\$73.56	\$0.00	\$73.56
0093	ADHC	MR5 Medically unnecessary service	This claim was for four days of ADHC services. The documentation did not support medical necessity for this service. The beneficiary has no conditions that require treatment or rehabilitation. All diagnoses were stable with no impairments that hamper activities of daily living. The beneficiary lives with family who provide her with needed transportation. She is able to provide her own personal care, has no mobility problems and takes her own medications. The PCP assessment requested physical, occupational and speech therapy assessments, activities and social services. No nursing services were required. This error was calculated at the total amount paid for this claim.	\$294.24	\$0.00	\$294.24
0095	ADHC	MR5 Medically unnecessary service	This claim was for eleven days of ADHC services. There was no indication the beneficiary meets all the criteria for admission. The beneficiary lives "independently" with family. The PCP did not indicate any problems related to the beneficiary's diagnosis of Osteoarthritis. There was no indication this condition handicapped his activities of daily living. There was no	\$809.16	\$0.00	\$809.16

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DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			documented medical necessity for this service. This error was calculated as the total amount paid for this claim.			
0097	ADHC	MR5 Medically unnecessary service	This claim was for six days of ADHC services. The patient is described as having Chronic Obstructive Pulmonary Disease (COPD), Asthma and Hypertension. All three of these are well controlled with medication and did not appear to limit this beneficiary's ability to function. The requesting physician's physical examination was normal and chest x-rays showed no indication of COPD. The beneficiary's main issues seem to be she is lonely and worried about decline in health. The beneficiary complained of severe shoulder pain, first addressed in IPC in October 2004. No assessment of this pain was done and there was no referral for further evaluation by her personal physician. This error was calculated as the total amount paid for this claim.	\$441.36	\$0.00	\$441.36
0100	ADHC	MR5 Medically unnecessary service	This claim was for ten days of ADHC. Her primary medical problem is Hypertension, which is controlled with medication. The main reason the beneficiary attended the ADHC is social isolation. She is alone at home during the day as other family members are out of the home during the day. There was no indication this beneficiary is medically eligible for ADHC services. The error was calculated as the total amount paid for this claim.	\$735.60	\$0.00	\$735.60

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0101	ADHC	MR5 Medically unnecessary service	This claim was for two days of ADHC services. The patient was attending the center for emotional support. There was insufficient medical justification for services. The only medical diagnosis/condition was hypertension and related lower extremity edema which are stable. The error was calculated as the total amount paid for this claim.	\$147.12	\$0.00	\$147.12
0125	Durable Medical Equipment	MR7 Policy violation	This claim was for leads for a TENS unit used for electrical stimulation to relieve pain. A Treatment Authorization Request (TAR) is needed for any leads costing more than \$22.68. This claim was for \$45.36. The TAR available expired five months before the date of service on the claim. There was no prescription for the leads. The only prescription provided was for a replacement TENS unit. The wrong referring provider was listed on the claim. There was no signature verifying receipt of this item by the beneficiary or their representative. The error was calculated as the total amount paid for this claim.	\$45.36	\$0.00	\$45.36
0138	Durable Medical Equipment	MR5 Medically unnecessary service	This claim was for oxygen therapy for five monthly rental charges for a premature infant with respiratory distress. The medical necessity at the time of the order is well documented. The referring provider discontinued the service on 12/16/05, after the third of the five monthly rentals on this claim. There was no medical necessity for the last two monthly rentals. The error was calculated as the difference between the amount paid for the five monthly rentals, HCPCS Code E0431, for 9/22/05, 10/22/05, 11/22/05, 12/22/05 and 1/22/06 and the amount that would have been paid for three monthly rentals on 9/22/05, 10/22/05, and 11/22/05.	\$137.66	\$86.44	\$51.22

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0145	Durable Medical Equipment	P9B Rendering provider not eligible to bill for services/ supplies	This claim was for supplies used with a TENS unit to control pain. The Durable Medical Equipment (DME) provider was not licensed on the date of service. The license expired on May 1, 2006 and the renewal request was not submitted until three months later in August 2006. Since this provider was not licensed to provide services on the date of service claimed, the error was calculated as the total amount paid for this claim.	\$45.36	\$0.00	\$45.36
0204	Labs	MR5 Medically unnecessary service	This claim was for several diagnostic laboratory tests for a 15 year-old child including thyroid tests and hepatitis screenings. There were no errors on the part of the laboratory. There was minimal documentation of symptoms or diagnoses to support the need for these tests by the referring provider. The record did not describe what was wrong with this child to warrant such tests. All the documentation addressed, by check marks only, are acute issues such as cough, sore throat, shortness of breath. None of these on their own would trigger the need for the ordered tests. There was no elaboration of these checked symptoms. The specimens were collected by the referring provider staff. There was no signature verifying source of the specimen as required by Welfare and Institutions Code section 14043.341. The error was calculated as the total amount paid for this claim.	\$113.54	\$0.00	\$113.54
0227	Labs	MR5 Medically unnecessary service	This claim was for several laboratory tests done for a patient enrolled in the Family Planning, Access, Care and Treatment (PACT) program. There are no errors by the laboratory. There was no medical justification for the tests for Chlamydia and Gonorrhea. The beneficiary had these tests done two months prior. There was no history or exam to justify repeating these	\$92.46	\$14.86	\$77.60

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			tests in two months. Furthermore, the beneficiary did not meet the criteria set by Family PACT to do these tests annually. There was no signature from the beneficiary verifying the source of these specimens as required by Welfare and Institutions Code section 14043.431. This error was calculated at the difference between the total paid for this claim and the cost of CPT 87491 and CPT 87591.			
0229	Labs	MR5 Medically unnecessary service	This claim was for a urine pregnancy test. The patient was on her menses at the time of the pregnancy test and had no signs or symptoms of pregnancy. The clinic protocol is to do a pregnancy test at each visit. There was no medical necessity for this test. The error was calculated as the total amount paid for this claim.	\$4.34	\$0.00	\$4.34
0265	Labs	MR2A Poor/insufficient documentation	This claim was for laboratory services. No errors were identified with the laboratory processing and reporting of the laboratory test. There was no documentation in the referring provider's record that an exam was done or the specimen was collected on the date of service. There was no signature from the beneficiary verifying the source of the specimen as required by Welfare and Institutions Code Section 14043.341. This error was calculated as the total amount of the claim.	\$16.80	\$0.00	\$16.80

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0270	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient. To be a level three office visit, two of the following three components must exist: an expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. The documentation provided a problem-focused history, but no exam and straightforward decision making. This is consistent with a level two office visit. The provider did not sign the progress note and there was no patient identification on the progress note. The error was calculated as the difference between the cost of a CPT Code 99213 and a CPT Code 99212 office visit.	\$24.00	\$18.10	\$5.90
0285	Other Practices and Clinics	MR2B No documentation	This claim was for chiropractic spinal manipulations one-two regions. The CPT Code 98940 requires a pre-manipulation patient assessment. The notes provided were for visits a year before the date of service on the claim. There was no documentation for services provided on the date of service under review. The error was calculated as the total amount paid for this claim.	\$16.72	\$0.00	\$16.72
0286	Other Practices and Clinics	MR3 Coding error	This claim was for a new level five office visit for a patient with cardiovascular disease. For this level office visit, there must be a comprehensive history, comprehensive examination and medical decision making of high complexity. The documentation supported a level three new patient office visit with a detailed history, detailed examination and medical decision making of low complexity. This error was calculated as the difference between the amount that was paid for the CPT code 99205 and the amount that would have been paid for the CPT code 99203.	\$107.30	\$81.80	\$25.50

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0295	Other Practices and Clinics	MR3 Coding error	This claim was for a level four office visit for an established patient. This level visit requires a detailed history and examination, and medical decision making of moderate complexity. The provider excised a mole. This did not meet the requirement for more than a level two office visit. An incorrect diagnosis code was used on the claim. The error was calculated as the difference between the amount that was paid for a CPT code 99214 and the amount that would have been paid for a CPT code 99212.	\$35.62	\$17.19	\$18.43
0305	Other Practices and Clinics	MR3 Coding error	This claim was for an emergency department visit billed at a level three CPT Code 99283. To bill at this level requires these three components: an expanded problem focused history; expanded problem focused examination and medical decision making of moderate complexity. Usually, the presenting problem is of moderate severity. The services provided met a level two visit CPT Code 99282 visit. To bill at this level the following three components are required: expanded problem focused history, expanded problem focused examination and medical decision making of low complexity. Usually, the presenting problems are of low to moderate severity. The error was calculated as the difference between the amount paid for the CPT code 99283 and the amount that would have been paid for CPT Code 99282.	\$44.60	\$24.38	\$20.22
0306	Other Practices and Clinics	MR3 Coding error	This claim was for use of the emergency room code Z7502. The patient came to the emergency department with a non-emergent condition, was triaged by the nurse and then left without being seen by the physician. Since this patient had a non-emergent condition and left without being seen, the provider should have billed for use of a hospital exam	\$49.60	\$33.99	\$15.61

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			room code Z7500. The error was calculated as the difference between the amount paid for Z7502 and the amount that would have been paid for Z7500.			
0309	Other Practices and Clinics	MR3 Coding error	This claim was for two days of level three inpatient visits to a patient in the Intensive Care Unit after a motor vehicle accident. The documentation did not reflect the services required met a level three visit. A level three visit requires at least two of the three following components: detailed interval history; detailed examination and medical decision making of high complexity. The documentation for both days of service reflects problem-focused interval history; expanded problem-focused examination and decision-making of moderate complexity which is consistent with a level two visit. The error for this claim was calculated as the difference between the amount that was paid for two visits at CPT code 99233 and the amount that would have been paid for two visits at CPT Code 99232.	\$87.02	\$71.82	\$15.20
0314	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient. For a level three office visit, there must be two of the following three components: expanded problem-focused history; expanded problem focused-examination and medical decision-making of low complexity. The documentation for this claim had a problem focused-history; problem-focused examination and straightforward medical decision-making. This supports a level two office visit. The error was calculated as the difference in the amount that was paid for CPT Code 99213 and the amount that would have been paid for CPT Code 99212.	\$24.00	\$18.10	\$5.90

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0319	Other Practices and Clinics	MR2B No documentation	This was a claim for 30 minutes of nursing assessment for a child with pulmonary disease. There was no documentation in the record of a nursing assessment. The only documents provided were from the rendering physician. The rendering physician listed on the claim was not the physician actually rendering the service. Since there was no documentation of a nursing assessment, the error was calculated as the total amount paid for this claim.	\$24.10	\$0.00	\$24.10
0326	Other Practices and Clinics	MR2B No documentation	This claim was for a level three office visit for an established patient and the handling of blood specimen. There was no progress note for the date of service at all. The closest documentation date of service was for a Depo-Provera injection three days earlier with an office visit that was billed as such. There was no documentation any blood specimen was collected or handled on the date of service or the earlier date. The error was calculated as the total amount paid for this claim.	\$33.34	\$0.00	\$33.34
0339	Other Practices and Clinics	MR7 Policy violation	This claim included three different laboratory tests done in the hospital based clinic. There were two tests for urinalysis, CPT 81002, done on different dates when an antepartum follow up visit was on the same day. These tests are included in the rate for an antepartum follow up visit and should not be claimed or paid separately. There was no beneficiary signature verifying source of the biological specimens. The error was calculated as the difference between the amount paid for the claim and the amount that was paid for the two CPT 81002 tests.	\$81.98	\$74.84	\$7.14
0340	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient. To be considered a level three office visit, it must consist of two of the following	\$19.89	\$15.00	\$4.89

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			<p>components: An expanded problem-focused history; an expanded problem-focused examination; and medical decision-making of low complexity. The documentation for this visit consisted of a problem-focused history; problem-focused examination and straightforward decision-making which is consistent with a level two office visit. The error was calculated as the difference between the amount paid for a level three office visit, CPT Code 99213 and the amount that would have been paid for a level two office visit, CPT Code 99212.</p>			
0341	Other Practices and Clinics	MR5 Medically unnecessary service	<p>This claim was for a visit to a Federally Qualified Health Center (FQHC). All services were provided by a medical assistant so should not have been billed. Services provided by medical assistants are not covered services. The nurse practitioner countersigned the medical assistant notes but there was no indication the nurse practitioner provided any services. This error was calculated as the total amount paid for the claim.</p>	\$118.09	\$0.00	\$118.09
0344	Other Practices and Clinics	MR7 Policy violation	<p>This claim was for dental services at a FQHC. FQHCs are required to follow Medi-Cal/Denti-Cal policy and provide services in the same manner as the Medi-Cal/Denti-Cal program. FQHCs bill by encounter and details of the service provided was not included with the claim submitted for payment. The dentist at the FQHC performed a procedure called gross scaling. This is not a service covered by the Denti-Cal program. Therefore, the program should not have been billed for these services. This error was calculated as the total amount paid for this claim.</p>	\$120.60	\$0.00	\$120.60

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0345	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim wais for dental services through Indian Health Services Tribal Health Program for tooth extractions. The procedure was inadequately documented in the patient record. This error was calculated as the total cost of the claim.	\$223.00	\$0.00	\$223.00
0358	Other Practices and Clinics	MR3 Coding error	This claim was for a level four office visit for an established patient. To claim for this service there must be two of the three following components present: a detailed history; a detailed examination; and medical decision-making of moderate complexity. The documentation provided included an exam which had vital signs and a description of general appearance of the patient. The medical decision-making was straightforward. The documentation supported a level two office visit which must have two of the following three components; a problem-focused history; problem-focused examination and straightforward medical decision-making. The error wais calculated as the difference between the amount paid for the level four office visit, CPT Code 99214 and the amount that would have been paid for a level two office visit, CPT Code 99212.	\$41.84	\$22.44	\$19.40
0370	Other Practices and Clinics	MR2B No documentation	This claim was for condoms for birth control. There is no record for the date of service. The clinic staff stated the record for the date of service was lost. There was no documentation to support medical need or provider order for the contraceptive. The error was calculated as the total amount paid for this claim.	\$15.00	\$0.00	\$15.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0373	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for an X-ray of the pelvis and the administration of the initial 1000cc of intravenous solution. The diagnosis code listed on the claim was not accurate. There was no documentation there are any abnormalities with the patient's genitourinary organs. The medical record indicated an X-ray of the uterus and fallopian tubes, a hysterosalpingogram, was ordered secondary to infertility. The intravenous solution was a part of the procedure. This is not a Med-Cal covered service. This procedure was also not indicated without a work-up to rule out ovulatory or sperm problems as reason for infertility. The incorrect diagnosis code on the claim masked the actual reason for the X-ray and intravenous therapy. Had the correct diagnosis been used, the X-ray and intravenous fluid would not have been covered. The error was calculated as the total amount paid for this claim.	\$38.80	\$0.00	\$38.80
0377	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for nine participants in a paneled team conference for a child enrolled through California Children's Services (CCS). There was insufficient documentation to support the required assessment by the registered nurse or the evaluation by the social worker was accomplished. The social worker identified through the medical record documentation was not paneled by CCS, as required, to provide this service. The social worker identified was not licensed as a clinical social worker, which is required to bill for this service. The error was calculated as the difference between the total amount that was paid and the claim minus the amount paid for the registered nurse assessment, Z4301, and the social worker evaluation, Z4307.	\$395.45	\$361.85	\$33.60

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0385	Other Practices and Clinics	MR2B No documentation	This claim was for a level two office visit for an established patient, condoms for birth control, a urinalysis, urine pregnancy test and a test for anemia. There was documentation the patient did not provide a urine sample for the urinalysis and urine pregnancy test. The test for anemia is not included as a Family PACT benefit for the diagnosis code oral contraception used on the claim. The patient was seen by a physician assistant but a modifier was not used on the claim. The physician assistant's progress notes were not countersigned by the physician. The error was calculated as the difference between the amount paid for the total claim and the amount that was paid for the three laboratory tests, CPT codes 81025, 81000, and 85018.	\$39.84	\$30.60	\$9.24
0403	Other Practices and Clinics	MR3 Coding error	This claim was for a level five inpatient consultation. This level consultation requires a comprehensive history and examination and medical decision making of high complexity. This consultation documented a detailed examination and medical decision making of low complexity which is consistent with a level three consultation. However, the history was on an expanded problem-focused history which is consistent with a level two consult. Since all three components must be present for each level of consultation, this should have been billed as a level two initial inpatient consultation. This error was calculated as the difference between the amount that was paid for the CPT code 99255 and the amount that would have been paid for a CPT Code 99252.	\$81.94	\$30.84	\$51.10

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0404	Other Practices and Clinics	MR3 Coding error	This claim was for a level five office visit. For a visit to meet the requirements of CPT Code 99215, there must be a comprehensive history and exam and medical decision making of high complexity. The documentation supported a detailed history and exam and straight forward medical decision-making which is consistent with CPT Code 99214. The date of service on the claim was not the date the service was provided. There was no documentation of services on the date of service on the claim. The error was calculated as the difference between the amount paid for CPT Code 99215 and the amount that would have been paid for CPT Code 99214.	\$57.20	\$37.50	\$19.70
0406	Other Practices and Clinics	MR4 Unbundling error	This claim was for a level four office visit for an established patient two and one half weeks after delivery. The physician billed globally for the delivery. The global fee includes post partum care for six weeks. This visit should not have been billed separately. The error was calculated as the total amount paid for this claim.	\$37.50	\$0.00	\$37.50
0411	Other Practices and Clinics	MR3 Coding error	This claim was for use of the emergency room. There is no indication in the record the patient was seen for an emergent condition. The claim should have been for use of examination room. The error was calculated as the difference between what was paid for Z7502 and the amount that would have been paid for Z7500.	\$34.10	\$23.44	\$10.66
0418	Other Practices and Clinics	MR3 Coding error	This claim was for a level five office visit for an existing patient. For a level five visit, there must be a least two of the following three components: a comprehensive history; comprehensive examination and medical decision making of high complexity. There was an expanded problem-focused history and examination with low complexity medical decision-making. The	\$57.20	\$24.00	\$33.20

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			wrong rendering provider was identified on the claim. The error for this claim was calculated as the difference between the amount that was paid for CPT Code 99215 and the amount that would have been paid for CPT Code 99213.			
0420	Other Practices and Clinics	MR3 Coding error	This claim was for an hour of critical care through the Emergency Department and an Electrocardiogram (EKG). To bill this code, the provider must provide critical care, evaluation and management of a critically ill or critically injured patient. The patient's condition was documented as urgent or emergent but not critical. The services should have been billed at the emergency level of high severity. There was documentation of the required components to bill at the high severity level with a comprehensive history and examination and medical decision making of high complexity. The EKG should not have been billed since it is included in the evaluation and management services by the emergency physician. This error was calculated at the total amount paid for the EKG as well as the difference between the amount paid for CPT Code 99291 and CPT Code 99285.	\$166.63	\$134.20	\$32.43
0421	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient. For a level three office visit, there must be at least two of the following three components. An expanded problem-focused history; an expanded problem-focused examination and medical decision-making of low complexity. The visit consisted of a problem-focused history; a problem-focused exam and straight forward medical decision-making. This constitutes a level two office visit for an established patient. The error was calculated as the difference between the amount paid for this claim and	\$26.18	\$19.75	\$6.43

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			the amount that would have been paid for a CPT code 99212.			
0430	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for a level three office visit for an established patient. For a level three office visit, there must be at least two of the following three components. An expanded problem-focused history; an expanded problem-focused examination and medical decision-making of low complexity. The visit consisted of a problem-focused history; a problem-focused exam and straight forward medical decision-making. This constitutes a level two office visit for an established patient. There was no documentation to support the medical need for the laboratory tests ordered and performed. The error was calculated as the total amount paid for the laboratory tests and the difference that was paid for CPT 99213 and the amount that would have been paid for CPT 99212.	\$56.59	\$50.69	\$5.90

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0431	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for a level four office visit for an established patient and for a noninvasive test for bilateral upper and lower extremity vascular elasticity. There was no documentation supporting a condition that would require such as test. Furthermore, the device used to do this test does not do bilateral tests as was billed. The office visit documentation did not support a level four office visit. For a level four office visit, there needs to be two of the following three components: a detailed history; detailed examination and medical decision making of moderate complexity. The documentation for the visit had a problem-focused history, and straight forward medical decision-making. Therefore it only meets the requirements for a level two office visit. The error for this claim was calculated as the total amount paid for CPT 93923 the noninvasive vascular elasticity test, and the difference in the amount paid for the CPT 99214 level four office visit and what would have been paid for a CPT 99212 level two office visit.	\$121.36	\$18.10	\$103.26
0435	Other Practices and Clinics	MR2B No documentation	This claim was for the managed care differential for a rural health clinic. There is no documentation of services for the date of service on the claim. The error was calculated as the total amount paid for this claim.	\$68.67	\$0.00	\$68.67
0458	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for a level three office visit for an established patient, urine pregnancy test, and an injection of Depo-Provera for birth control. There was no indication of need for the urine pregnancy test since it was less than three months from the previous Depo-Provera injection. The rendering provider was a Family Nurse Practitioner. No modifier identifying a non-medical practitioner rendered the service was used on the claim. The error was calculated as the difference	\$94.05	\$89.71	\$4.34

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			between the total amount paid for the claim and the amount that was paid for the urine pregnancy test.			
0460	Other Practices and Clinics	MR2A Poor/insufficient documentation	This is a managed care differential claim for an office visit at a rural health clinic. The patient presented with a complaint of cough and fever for two days. The lungs were clear on examination. The documentation in the medical record was minimal and there was no patient history or examination that supports the diagnosis of bronchitis. There was also a diagnosis of gastritis with no history or examination to support it. This error was calculated the total amount paid for this claim.	\$45.88	\$0.00	\$45.88
0462	Other Practices and Clinics	MR3 Coding error	This claim was for a CPT code 99244 level office consultation. This level office consultation requires all three of the following components: a comprehensive history; comprehensive examination and medical decision making of moderate complexity. The documentation for this visit had a problem-focused history and exam and decision-making is straight forward. This claim supports a CPT code 99241 level consultation. The error for this claim was calculated as the difference between the amount paid for CPT code 99244 and the amount that would have been paid for CPT code 99241.	\$81.40	\$30.60	\$50.80
0463	Other Practices and Clinics	MR2B No documentation	This claim was for three views of X-rays of the knee through the emergency department. The X-rays were medically appropriate. The X-rays were for only two views of the knee while the claim is for three views. The error was calculated as the difference between the amount paid for three views and the amount that would have been paid for two views.	\$21.80	\$14.53	\$7.27

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0466	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient. For a level three office visit there must be two of the following three components: an expanded problem-focused history; expanded problem- focused examination; and medical decision-making of low complexity. The patient presented with an uncomplicated upper respiratory infection. The documentation supported a problem-focused history and examination and straightforward medical decision-making which is required for a level two office visit. The error was calculated as the difference between the amount paid for a CPT Code 99213 and the amount that would have been paid for a CPT Code 99212.	\$26.18	\$19.75	\$6.43
0475	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for three laboratory tests done in the provider's office and fifteen minutes of Family Pact family planning counseling. The patient was seen for an office visit for back pain. The diagnosis code for oral contraception was used on the claim. There was no documentation to support this code. The patient was evaluated for back pain only. There was no documentation any counseling was provided. No signature verifying the source of the biological specimens collected was obtained. The patient is enrolled for Family Pact services only and is not eligible for these services. The error was calculated as the total amount paid for this claim.	\$26.73	\$0.00	\$26.73

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0477	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for an obstetrical ultrasound for a single fetus pregnancy less than 14 weeks. The radiologist performed the ultrasound on referral. The referring provider requested an obstetrical ultrasound for fetal size. There was no indication in the referral there is a concern about the fetal size. An incorrect diagnosis was used on the claim - excess fetal growth. There was no documentation indicating this ultrasound was medically necessary. The error was calculated at the total amount paid for the claim.	\$78.42	\$0.00	\$78.42
0482	Other Practices and Clinics	MR3 Coding error	This claim was for a level four office visit for an established patient. CPT Code 99214. This level office visit requires at least two of the following components: a detailed history; a detailed examination; and medical decision-making of moderate complexity. The visit consisted of a problem-focused history and straightforward medical decision-making which are appropriate for a level two office visit. The error is calculated as the difference between the amount paid for CPT 99214 a level four office visit and the amount that would have been paid for a level two office visit CPT 99212.	\$56.93	\$35.77	\$21.16
0483	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for a level three office visit for an established patient. The record was partially illegible. The patient's chief complaint was cough. No vital signs were taken. The examination of the lungs was checked as clear. An antibiotic was circled as ordered. There was no indication from the documentation the antibiotic was needed. The plan for this patient was not legible. This error was calculated as the total amount paid for this claim.	\$12.00	\$0.00	\$12.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0487	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for a FQHC visit for psychotherapy billed for a beneficiary enrolled in a managed care plan. The FQHC is expected to meet the Medi-Cal requirements in providing and documenting services. There was no plan of care for this patient. The time in and out was not documented nor was the total time for the service documented. There was no description of the problem discussed or therapy given. These are all required documentation. This error was calculated as the total amount paid for this claim.	\$138.00	\$0.00	\$138.00
0488	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for an encounter at a rural health center. The patient was seen for follow up. The record did not say why she needed follow up, and there were no complaints listed by the patient. This error was calculated as the total amount paid for this claim.	\$163.30	\$0.00	\$163.30
0498	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for an antepartum follow-up office visit and fifteen minutes of perinatal education. There was no documentation of the time spent providing the perinatal education. The patient reported smoking methamphetamine two days before office visit. There was no indication of counseling, referral or any other intervention to address the patient's drug use. This error was calculated as the difference between the total amount paid for the claim and the amount paid for the patient education Z6410.	\$68.89	\$60.48	\$8.41
0500	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for three hospital care visits. The documentation for the first date of service was minimal and poorly legible. There was no documentation for the second and third dates of service on the claim. The patient's name or other identifying information was not on the progress note. This error was calculated as the difference between the total amount paid for this claim and the amount that would have been paid for one	\$82.50	\$27.50	\$55.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			hospital visit at CPT Code 99231.			
0505	Other Practices and Clinics	MR2B No documentation	This claim was for five different laboratory tests. These tests were related to preparing a blood transfusion for an extremely critical infant. The transfusion was started and the infant transferred to a medical center before all the tests were accomplished so two of the five tests were not done. The antibody screen and direct coombs test were not accomplished according to the medical records. The error was calculated as difference between the total amount paid for this claim and the amount that was paid for CPT Code 86850 and CPT Code 86880.	\$4.50	\$2.40	\$2.10
0506	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for the professional component for a urine culture. There was no urinalysis done to determine the need for a urine culture. There was no mention in the progress notes for the date of service of any signs or symptoms of urinary tract infection. There was no indication from the patient's history that she has a problem with urinary tract infections. The patient's complaint was abdominal pain for three months. The medical necessity for the test was not established in the medical record. The beneficiary's signature verifying the source of the biological specimen was not obtained. This error was calculated as the total amount paid for this claim.	\$1.22	\$0.00	\$1.22
0508	Other Practices and Clinics	MR3 Coding error	This claim was for a level five office visit for an established patient. For a level five visit two of the three following components must be present: a comprehensive history; a comprehensive examination and medical decision making of high complexity. The documentation for this date of service supports a level three office visit with an expanded problem-focused	\$69.75	\$29.27	\$40.48

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			history and examination and medical decision-making of moderate complexity. The error was calculated as the difference between the amount paid for CPT Code 99215 and the amount that would have been paid for CPT Code 99213.			
0517	Other Practices and Clinics	MR2B No documentation	This claim was for a level one office visit for an established patient and the dispensing of condoms. A level one office visit is for the evaluation and management of a patient that may or may not require the presence of the physician. The only documentation provided was the claim to Family PACT for the condoms. There was no documentation to support the patient was in the clinic on or near the date of service. The only documentation was for seven months earlier. The error was calculated as the total amount paid for the claim.	\$26.86	\$0.00	\$26.86
0524	Other Practices and Clinics	MR2B No documentation	This claim was for a level one office visit for an established patient and the dispensing of condoms. A level one office visit consists of evaluation and management of a patient that may or may not require the presence of a physician. There was no documentation of any evaluation of this patient. There was no beneficiary signature verifying receipt of the product. The error was calculated as the total amount paid for this claim.	\$26.86	\$0.00	\$26.86
0537	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for a chest X-ray following the placement of a central line. The chest X-ray was ordered twice by the referring provider for the same evaluation of line placement. The second order was actually done first so this X-ray should not have been billed. Therefore, the error was calculated as the total amount paid for this claim	\$6.92	\$0.00	\$6.92

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0555	Other Practices and Clinics	P9B Rendering provider not eligible to bill for services/supplies	This claim was for a patient visit to a rural health clinic. A note by the physician assistant was insufficient to support an actual visit with the patient. The social worker seeing the patient was a registered associate social worker. The services should be billed as licensed clinical social worker services. A registered associate social worker is not authorized to provide services billed to the Medi-Cal program. It appeared the brief note by the physician assistant was done to circumvent the requirement that services be provided by a licensed clinical social worker. This practice occurred on multiple visits. The error is calculated as the total amount paid for this claim.	\$102.96	\$0.00	\$102.96
0561	Other Practices and Clinics	MR3 Coding error	This claim was for use of the emergency room and two urinalysis tests. The use of the emergency room was appropriate. The two urinalysis tests, CPT 81002 and 81003 were billed but the report showed that CPT81001 was the test done. This error was calculated as the difference paid for the two urinalysis tests, CPT81002 and CPT81003, and the amount that would have been paid for the urinalysis, CPT 81001.	\$38.53	\$38.51	\$0.02
0562	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for the professional component of an X-ray of the neck and an X-ray of the chest. This patient had respiratory problems that made the chest X-ray medically appropriate. There was no examination of abnormal findings of the neck or any other indication to demonstrate medical necessity for the neck X-ray. This error was calculated as the amount paid for the X-ray exam of the neck.	\$13.84	\$6.92	\$6.92
0566	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for eight laboratory tests done through a hospital outpatient clinic. No physical examination was done of this new patient. There was no abnormal examination, patient complaints or history to suggest	\$108.58	\$71.80	\$36.78

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			hepatitis and no abnormal liver studies. Therefore, there was no medical necessity for the Hepatitis B Core Antibody and Hepatitis C Antibody laboratory tests. The error was calculated as the difference between the amount paid for this claim and the amount that was paid for the Hepatitis B Core Antibody and Hepatitis C Antibody tests.			
0604	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for a urinalysis, urine pregnancy test and level four office visit for an established patient. The patient was complaining of vaginal itching. There was no indication for the pregnancy test since it had only been two weeks since the patient's last menstrual period and she was discussing the need for referral for infertility with the provider. The provider's signature was illegible. The beneficiary did not sign verifying the source of the specimens. The error was calculated as the difference between the total amount paid for the claim and the amount paid for the urine pregnancy test.	\$53.03	\$48.69	\$4.34
0608	Other Practices and Clinics	MR3 Coding error	This claim was for CPT Code 99070, special supplies. This code is to be used when billing for supplies used above and beyond those usually used in an office visit or for other services supplied. The code was used to bill for Toradol injection. This medication is not on the list of injectable drugs so it should have been billed with the HCPCS code J3490 by report. By report means an explanation of the service being billed. The error was calculated as the total amount paid for this claim.	\$6.00	\$0.00	\$6.00

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0619	Other Practices and Clinics	MR2B No documentation	This claim was for group perinatal education each fifteen minutes. There was no documentation of education provided on the date of service. There was no indication if this was group or individual education and the beneficiary did not sign she received the education as required. The error was calculated as the total amount paid for this claim.	\$4.03	\$0.00	\$4.03
0620	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for urine culture and colony count. There was an order and documentation the provider intended the patient to have this test however, there was no documentation of the rationale for ordering this test. The beneficiary did not sign verifying the source of the specimen. The error was calculated as the total amount paid for this claim.	\$10.90	\$0.00	\$10.90
0621	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for chest X-ray ordered through the emergency department. The seventeen year old patient had a history of asthma and presented at the emergency department with wheezing and chest pain. Chest examination was clear with no wheezing or other abnormal lung sounds. There was no indication for a chest X-ray. The X-ray was reported twice with two different indications for the X-ray -chest pain and positive Tuberculosis test. There was no indication in the record the patient had a positive Tuberculosis test. The chest X-ray was done after hours and read by a different radiology group. There is a contract between this billing provider and the other radiology group that gives an incentive if a certain number of X-rays are referred which could be the reason for the two readings of the one X-ray. The error was calculated as the total amount paid for this claim.	\$8.57	\$0.00	\$8.57

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0622	Other Practices and Clinics	MR3 Coding error	This claim was for level three office visit for an established patient. To be a level three office visit, two of the following three components must be present: an expanded problem-focused history; expanded problem focused-examination; and medical decision-making of low complexity. The documentation provided had a focused history and straightforward medical decision-making. This is consistent with a level two office visit. The error was calculated as the difference between the amount that was paid for a level three office visit, CPT Code 99213 and the amount that would have been paid for a level two office visit, CPT Code 99212.	\$22.80	\$17.20	\$5.60
0624	Other Practices and Clinics	MR2A Poor/insufficient documentation	This claim was for a TB test. There was mention of exposure on the lab request form or documentation in the medical record of an exposure to Tuberculosis. The error was calculated as the total amount paid for this claim.	\$8.08	\$0.00	\$8.08
0628	Other Practices and Clinics	MR3 Coding error	This claim was for a level three office visit for an established patient, a pregnancy test and oral contraceptive medication. There was no medical necessity for the pregnancy test since the patient is on oral contraception and it has been only eight days since her last menstrual period. To bill for a level three office visit, there must be two of the three following components: an expanded problem-focused history, an expanded problem-focused examination and medical decision-making of low complexity. There is no physical examination documented and the medical decision making was straight forward. This documentation supported a level two office visit. The error was calculated at the total amount paid for the pregnancy test, CPT Code 81025 and the difference between what was paid for CPT Code 99213 for the	\$70.05	\$62.34	\$7.71

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			level three office visit and the amount that would have been paid for a level two office visit, CPT Code 99212.			
0631	Other Practices and Clinics	MR5 Medically unnecessary service	This claim was for the technical component of a chest X-ray. There were no errors identified with the radiological services. The referring provider ordered the chest X-ray to rule out Valley Fever. A chest X-ray is not a test done to diagnose Valley Fever. Valley Fever is diagnosed with blood and sputum tests. The medical record was poorly legible. There was no medical necessity documented for this test. This error was calculated as the total amount paid for this claim.	\$25.98	\$0.00	\$25.98
0656	Other Practices and Clinics	MR3 Coding error	This claim was for six antepartum follow-up office visits. The third visit was not an antepartum follow-up visit but only a brief office visit. There was no exam, history or plan. The error was calculated as the difference between the amount paid for six antepartum office visits and the amount that would have been paid for five antepartum office visits.	\$353.82	\$293.34	\$60.48
0662	Other Practices and Clinics	MR3 Coding error	This claim was for a level four office visit for an established patient. For a level four office visit, two of the three following components must be present: a detailed history; a detailed examination; medical decision-making of moderate complexity. The documentation for this visit reflects a problem-focused history, no examination and straightforward decision-making, which are the components for a level two office visit. This error was calculated as the difference between the amount paid for this claim, CPT code 99214 and the amount that would have been paid for a level two office visit, CPT code 99212.	\$37.50	\$18.10	\$19.40

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0663	Other Practices and Clinics	MR2B No documentation	This claim was for two acupuncture with electrical stimulation visits. There was no description of the procedure on either note. The progress note for the first date of service does mention manual acupuncture. Neither note mentions electrical stimulation. The provider did not sign either note. The error was calculated as the total amount paid for this claim.	\$11.00	\$0.00	\$11.00
0667	Other Services and Supplies	MR2B No documentation	This claim was for AIDS Waiver services for case management and administrative costs as well as attendant care for one month. There was no documentation of nursing or psychological assessment or re-assessments or any case coordination activities, which is expected for a month of case management services. There was no documentation of any services so no administrative costs should have been accrued. The attendant plan listed four hours of service twice a week. The provider billed for eight hours of service on one day. There was no documentation any services were provided. Since there was no documentation of any services for the patient, the error was calculated as the total amount paid for this claim.	\$550.65	\$0.00	\$550.65
0669	Other Services and Supplies	PH6 No record of drug acquisition	This claim was for medical supplies for a quadriplegic's use at home. Medical necessity was apparent from the medical record. There was no record the provider had acquired the supplies to dispense to the patient. There was no legal prescription for the date of service. The most current prescription was for five months earlier. The beneficiary did not sign, verifying receipt of the supplies. The wrong referring provider was identified on the claim. This error was calculated as the total amount paid for this claim.	\$53.70	\$0.00	\$53.70

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0670	Other Services and Supplies	MR2B No documentation	This claim was for two days of targeted case management through the Local Education Agency (LEA). There was documentation the second date of service was provided but there was no documentation for the first date of service. The error was calculated as the difference between the amount paid for the claim and the amount that would have been paid for one day of targeted case management.	\$18.57	\$12.38	\$6.19
0672	Other Services and Supplies	MR5 Medically unnecessary service	This claim was for multiple incontinence supplies. There was no documentation in the medical record that the beneficiary has urinary incontinence. The error was calculated as the total amount paid for this claim.	\$183.67	\$0.00	\$183.67
0674	Other Services and Supplies	MR2B No documentation	This claim was for six speech services and six health and mental evaluation/education through a LEA. The school district was unable to locate any records other than the records obtained through the billing vendor. There is a log for dates of speech services but there was no documentation of the nature or extent of the service provided. There was no documentation of the health and mental evaluation/education services. The error was calculated as the total amount paid for this claim.	\$140.58	\$0.00	\$140.58

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0677	Other Services and Supplies	MR3 Coding error	This claim was for one month of case coordination on site through the Multipurpose Senior Services Program (MSSP). There was a telephone visit with the caregiver but no contact with the beneficiary and no case coordination activity, such as assessment, care planning, or coordinating a package of long term care services for the patient. There was one phone call on the last day of the month. The correct code should have been Z8583 for one hour of telephone contact for social support. The error was calculated as the difference between the amount paid for Z8550, MSSP case management and the amount that would have been paid for Z8583, social reassurance telephone contact.	\$284.00	\$83.75	\$200.25
0679	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for health and mental evaluation/education through a LEA. The child was not enrolled in the Individual Education Program (IEP). According to the school staff interviewed, the counseling was done by the school psychologist whose credentials the school could not verify. The record did not provide information on counseling topics and the student's psychological functioning. No observations of the student were documented. This error was calculated as the total amount paid for this claim.	\$9.57	\$0.00	\$9.57
0680	Other Services and Supplies	WCI Wrong client identified	This was a claim for two occupational therapy services. The first service was adequately documented and medically necessary. The second service was not documented. Discussion with the provider staff revealed the second service was provided to a different patient and should not have been billed to this patient. The error was calculated as the difference between the total amount paid for this claim and the	\$42.38	\$21.19	\$21.19

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			amount paid for code X4110.			
0681	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for audiologist services through a LEA. The student is enrolled in the IEP and the service was medically appropriate. There was no physician referral for the service as required. The student was in attendance at school on the date of service and a lesson plan is noted however, there was no individually identifiable information regarding services for the student on the date of service. It is unclear who, if anyone, did speech therapy on the date of service. The error was calculated as the total amount paid for this claim.	\$11.88	\$0.00	\$11.88
0687	Other Services and Supplies	MR2B No documentation	This claim was for ambulance mileage for transport to and from a dialysis center. There was no documentation of dialysis services for this date of service. According to the dialysis center, this patient has not received dialysis since February 28, 2006 and has returned to Mexico. The claim date of service is April 18, 2006. The service billed was not provided. This error was calculated as the total amount paid for this claim.	\$2.60	\$0.00	\$2.60
0691	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for speech and audiology services through a LEA. The student is enrolled in an IEP. There was no prescription or referral from a physician for this service as required by California Code of Regulations Title 22 section 51309(a). The documentation does not include a plan of care, how the beneficiary is benefiting from the therapy, who rendered the service or where it was rendered. The error was calculated as the total amount paid for this claim.	\$11.88	\$0.00	\$11.88

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0692	Other Services and Supplies	P9B Rendering provider not eligible to bill for services/supplies	This claim was for health and mental evaluation/education through a LEA. The student has an IEP. According to the IEP, there were no general health concerns and nothing in the IEP calls for general health assessments. This assessment was done by a public health nurse. There was no documentation of any medical need for this assessment. The school nurse stated all students in special education get this assessment but only those with Medi-Cal are charged. The error was calculated as the total amount paid for this claim.	\$9.57	\$0.00	\$9.57
0702	Other Services and Supplies	MR2B No documentation	This claim was for targeted case management for a student through a LEA. There was no documentation to support the claim. The school staff stated another student with the same name had been provided service through the LEA and had graduated a year before. Thus the wrong student was billed for this service. The student billed for this service has no special education problems and does not receive LEA services. The error was calculated as the total amount paid for this claim.	\$230.40	\$0.00	\$230.40
0703	Other Services and Supplies	MR4 Unbundling error	This claim was for medical transportation by ambulance with mileage and an electrocardiogram (ECG) while in route. There was documentation to support the medical necessity for the transport. The actual mileage from the ambulance company was poorly documented. The odometer readings are provided but without the source document for this information that was requested during the audit. The mileage was confirmed by map. An ECG is included in the ambulance rate and should not have been billed separately. The error was calculated as the difference between the total amount paid and the amount that	\$818.55	\$803.28	\$15.27

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			was paid for the ECG.			
0705	Other Services and Supplies	MR7 Policy violation	This claim was for transportation services for a child through the LEA. To bill this code, the child must need liter or wheelchair transportation. The IEP states the child needs transportation in a child safety seat, not wheelchair transportation. This child does not qualify for the level of transportation billed. There was no transportation log or other documentation to support the transportation was actually performed. This error was calculated at the total amount paid for this claim.	\$27.64	\$0.00	\$27.64
0706	Other Services and Supplies	MR8 Other medical error	This claim was for transportation services for a child in a LEA and the accompanying mileage. The claim was for two trips. The IEP stated the child needs home to school transport. The family delivers the child to the school in the morning. There was no recommendation the child be transported from school to home at the end of the school day. Therefore, no transportation and associated mileage should have been claimed. The error was calculated as the total amount paid for this claim	\$23.74	\$0.00	\$23.74
0707	Other Services and Supplies	MR2B No documentation	This claim is for transportation services through a LEA. To be a billable service at least one of the services on the IEP must be provided on the date of service. The documentation provided does not describe the service provided so it cannot be identified as a service covered by the IEP. There is no transportation log or other documentation to support the transportation was actually performed. The error is calculated as the total amount paid for this claim.	\$15.86	\$0.00	\$15.86
0708	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for transportation services through a LEA. To be a billable service, at least one of the services on the IEP must be provided on the date of service. The documentation provided does not	\$22.44	\$0.00	\$22.44

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			describe the service provided so it cannot be identified as a service covered by the IEP. There was no transportation log or other documentation to support the transportation was actually performed. The error was calculated as the total amount paid for this claim.			
0710	Other Services and Supplies	MR2B No documentation	This claim was for speech/audiology services through a LEA. The IEP and physician criteria support the service. The services were scheduled for twice a week. There was no documentation of student attendance or service being provided on the date of service of the claim. This error was calculated as the total amount paid for the claim.	\$11.88	\$0.00	\$11.88
0711	Other Services and Supplies	MR5 Medically unnecessary service	This claim was for incontinent supplies through a DME supplier. There was no documentation in the medical record that the referring provider examined the patient or that the patient had a diagnosis of incontinence. The referring provider's staff stated the DME provider faxed the request to the referring provider who signed it without ever seeing the patient. There was no signature of receipt for the date of delivery. The products were "left on doorstep" according to the DME provider documentation. There was no documentation the patient received the product for the date of service. The error was calculated as the total amount paid for this claim.	\$95.56	\$0.00	\$95.56
0718	Other Services and Supplies	MR2B No documentation	This was a claim for speech/audiology services by a LEA. There was an IEP in place for this child that includes the need for speech therapy existed; a physician's authorization for service. There was documentation the student was present at school on the date of service but no documentation of the nature or extent of speech therapy services or the name of the provider documented for the date of service. The	\$11.88	\$0.00	\$11.88

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			error was calculated as the total amount paid for this claim.			
0720	Other Services and Supplies	P9B Rendering provider not eligible to bill for services/supplies	This claim was for school health aid services through a LEA. School health aid services are payable only when performed by a trained health care aid. These services were performed by a teacher and there was no documentation the teacher is qualified as a trained health care aid. The services were for diapering and diapering is not a covered service. The error was calculated as the total amount paid for this claim.	\$3.03	\$0.00	\$3.03
0722	Other Services and Supplies	MR2B No documentation	This claim was for two days of targeted case management services through a LEA. Targeted case management services assist eligible children to access needed medical, social, educational, and other services. These services are billed in fifteen minute increments. The need for these services was documented in the IEP however, the documentation provided was for speech therapy only. There was no documentation targeted case management services were provided on the dates of service claimed. The error is calculated as the total amount paid for this claim.	\$12.38	\$0.00	\$12.38

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0723	Other Services and Supplies	MR5 Medically unnecessary service	This claim was for transportation services for a child to attend school. The child must need either liter or wheelchair transportation and receive at least one of the specified services identified in the IEP to be paid. The IEP stated a need for transportation but does not specify why; there was no indication the child needed liter or wheelchair transportation as the billing code requires. There was documentation the child can hop on one foot and attends and participates in regular as well as adaptive physical education classes. There was documentation the child was in attendance at school the date of service but no indication any services identified in the IEP were provided. The error was calculated as the total amount paid for the claim.	\$18.54	\$0.00	\$18.54
0726	Other Services and Supplies	MR5 Medically unnecessary service	This claim was for physical therapy case conference-thirty minutes through CCS. There was documentation one month prior that the child was not eligible for services through CCS. The diagnosis code for hemiplegia was not correct and documentation in the record that the child does not have hemiplegia. The case was closed one day before this service was provided. The child did not meet medical necessity requirements for the services on this date of service. The error was calculated as the total amount paid for this claim.	\$21.19	\$0.00	\$21.19

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0729	Other Services and Supplies	MR2B No documentation	This claim was for low cost LEA provider services for three consecutive days through a LEA. These services can only be billed by LEAs that have been designated as low cost LEA providers. It is unclear whether this provider had that designation. There was documentation for the first of the three days of service. The nature and extent of service provided on that date is unclear. There was no documentation of services for the other two days of service claimed. The error was calculated as the total amount paid for this claim.	\$74.28	\$0.00	\$74.28
0733	Other Services and Supplies	MR3 Coding error	This claim was for school health aid services through a LEA. The services were appropriate and provided two times a day as ordered by the physician. The claim was for three services. There was no documentation of more than two services being ordered or provided. The error was calculated as the difference between the cost of three services and the cost of two services.	\$9.09	\$6.06	\$3.03
0736	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for five dates of service for occupational therapy through a LEA. There was an attendance log stating the child received occupational therapy for 30 minutes on the five dates of service on the claim. There was no documentation of the nature or extent of the service or the child's response to the service. Occupational therapy requires a physician prescription. There was no prescription for this service. The error was calculated as the total amount paid for this service.	\$91.65	\$0.00	\$91.65

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0737	Other Services and Supplies	MR2B No documentation	This claim was for two services of speech pathology through a LEA. There is an IEP for speech pathology and the student has received the services for nine years. The school was unable to find any documents to support the services were provided on the date of service. There were no physician orders or Minimum Standard of Medical Necessity which is required for speech therapy. The error was calculated as the total amount paid for this claim.	\$23.76	\$0.00	\$23.76
0738	Other Services and Supplies	MR7 Policy violation	This claim was for occupational therapy through a LEA. There was no prescription from a physician, podiatrist or dentist as required for this service. The error was calculated as the total amount paid for this claim.	\$18.33	\$0.00	\$18.33
0742	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for speech pathology services for a child through a LEA. The log demonstrated a service was provided but there was no documentation of the nature or extent of services or the child's response to services. No physician order or minimum standards of medical need were available for this service. The error was calculated as the total amount paid for this service.	\$11.88	\$0.00	\$11.88
0744	Other Services and Supplies	MR2A Poor/insufficient documentation	This claim was for speech/audiology services for a student through a LEA. Although the IEP provider did not include the date of service, there was indication the speech therapy was ongoing and goals were being evaluated. There was no prescription/order from a physician for the service as required. The error was calculated as the total amount paid for this claim.	\$11.88	\$0.00	\$11.88

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0749	Pharmacy	PH7B Prescription split	This claim was for Wellbutrin, a medication used to treat depression. There is medical necessity for the medication. The prescription was written for 60 tablets. The pharmacy filled the prescription with 30 tablets with no documentation they had authorization from the prescriber to change the prescription. This resulted in more frequent prescription fills and additional dispensing fees. The error was calculated as the difference between the total amount paid for this claim and the amount that was paid as the dispensing fee.	\$127.87	\$120.62	\$7.25
0752	Pharmacy	PH7B Prescription split	This claim was for Ducosate sodium, a medication used to treat constipation. The prescription was to take one tablet twice a day with a quantity of 180 tablets, which is a three month supply. The pharmacy filled the prescription with sixty tablets or a one month supply. There was no documentation at the pharmacy that the prescribing provider authorized the change. This claim was for the second fill of the split prescription. The error was calculated at the amount paid for the dispensing fee for this claim.	\$7.85	\$2.48	\$5.37
0764	Pharmacy	MR5 Medically unnecessary service	This claim is for Keflex, an antibiotic for an eight year-old child. There was a urinalysis that indicates the child may have had a urinary tract infection. There were no progress notes for the date of service on the urinalysis or the prescription to support medical necessity or an evaluation related to any infection the antibiotic may have been prescribed for. The pharmacy was unable to provide an invoice to support having the medication in stock to fill the prescription. The error was calculated at the total amount paid for this claim.	\$33.39	\$0.00	\$33.39
0767	Pharmacy	MR5 Medically	This claim was for oral electrolyte solution. There are no errors identified with the pharmacy service. The	\$10.99	\$0.00	\$10.99

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
		unnecessary service	medical record states the patient has good oral intake, no vomiting or diarrhea, no fever and no evidence of dehydration. There is no medical necessity for the prescription. The error was calculated as the total amount paid for this claim.			
0773	Pharmacy	PH6 No record of drug acquisition	This claim was for Clotrimazole cream, a medication used to treat vaginal candidiasis. According to the pharmacist at the now CVS pharmacy, all purchase invoices for over the counter medications were destroyed when CVS bought this pharmacy. This error was calculated as the total amount paid for this claim.	\$14.99	\$0.00	\$14.99
0789	Pharmacy	PH2 No legal Rx for date of service	This claim was for Benazepril, a medication to treat high blood pressure. The telephone prescription was dated three months before the date of service. There were no refills on the prescription. There was no documentation provided by the pharmacy that this refill was authorized. The person signing to verify receipt of the drug was not the patient and their relationship was not listed. The telephone prescription was not legible. The error was calculated as the total amount paid for this claim.	\$21.97	\$0.00	\$21.97
0802	Pharmacy	PH2 No legal Rx for date of service	This claim was for Loratadine, a medication used to manage allergies. The prescription was a telephone refill according to the pharmacist. There was no documentation correlating this date of service with the refill documentation provided by the pharmacist. The prescribing provider maintains a refill log and this refill was not included in that log. The prescribing provider's documentation did not support this refill nor did the pharmacy documentation. The error was calculated as the total amount paid for this claim.	\$13.25	\$0.00	\$13.25
0809	Pharmacy	PH10 Other pharmacy	This claim was for Fluconazole, a medication used to treat candidiasis or cryptococcal meningitis. Medi-Cal	\$18.81	\$0.00	\$18.81

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
		policy error	restricts the use of this medication to patients with cancer and Human Immune Deficiency (HIV) infection. There was no indication this patient had either cancer or HIV. The medication was prescribed for an uncomplicated vaginal yeast infection. The National Drug Code (NDC) on the invoice was not the same as the NDC number used on the claim. The beneficiary did not sign verifying receipt of the medication. The error was calculated as the total amount paid for this claim.			
0813	Pharmacy	MR5 Medically unnecessary service	This claim was for Diphenhydramine, a medication for allergies and sleep. There was no documentation in the medical record to support the beneficiary has either of these problems, thus medical necessity is not established. No invoice was provided by the pharmacy for the medication. The error was calculated as the total amount paid for this claim.	\$5.83	\$0.00	\$5.83
0814	Pharmacy	MR2B No documentation	This claim was for Erythromycin 2% solution used to treat infection. The pharmacy services were correct and properly documented. The prescriber's medical records did not contain any documentation for the date of service evaluating the reason for prescribing the medication. There was also no documentation of the provider's intent to prescribe the medication. This error was calculated as the total amount paid for this claim.	\$11.37	\$0.00	\$11.37
0822	Pharmacy	MR5 Medically unnecessary service	This claim was for Wellbutrin, a medication used to treat depression. The patient is on many medications for symptoms of delusions with hallucinations. There is no mention of problems with mood. The NDC on the invoice provided by the pharmacy did not match the NDC on the claim. The person signing for the medication was not the patient and their relationship to the patient was not noted. The error was calculated as	\$127.87	\$0.00	\$127.87

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			the total amount paid for this claim.			
0829	Pharmacy	PH7A Refills too frequent (less than 75%)	This claim was for lancets used to check blood sugar levels for someone with diabetes. This patient resides in a skilled nursing facility (SNF). The prescription for 50 lancets is filled every month and had been filled at least three times before the date of service on this claim. The patient blood sugar per order and nursing documentation at the SNF is checked once a week. Therefore 50 lancets should have lasted almost a year. The prescription is filled every month. The order was for blood sugar testing once a week. The directions on the label from the pharmacy were for blood sugar checks before meals. This error was calculated as the total amount paid for this claim.	\$18.93	\$0.00	\$18.93
0838	Pharmacy	MR5 Medically unnecessary service	This claim was for Lorazepam, a medication given for anxiety. There is no indication in the records the patient has anxiety. She was diagnosed with Alzheimer's. The prescriber's office was closed so the records are limited. There is no current prescription with the prescriber's signature. The pharmacy was using unsigned orders from an assisted living facility. The receipt for delivery was not signed. The invoice provided had a different NDC number. The error was calculated as the total amount paid for this claim.	\$15.23	\$0.00	\$15.23
0839	Pharmacy	MR2B No documentation	This claim was for Bzotropine Mesylate, a medication used to manage Parkinson's disease. The pharmacy was unable to provide any documents to support the claim. The provider stated they were in the process of merging with another pharmacy and relocating and were unable to locate any of their records. The error was calculated as the total amount paid for this claim.	\$17.01	\$0.00	\$17.01

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0845	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Zithromax, an antibiotic used to treat bacterial infection. There are no errors identified with the pharmacy documentation. There was little documentation by the referring provider why the antibiotic was prescribed. There is documentation on the problem list of abnormal lung sounds and nasal drainage. The only medical evaluation for these problems was a note about the patient having nasal polyps; this was not a reason to give an antibiotic. The need for this medication was not sufficiently documented. The error was calculated as the total amount paid for this claim.	\$38.41	\$0.00	\$38.41
0851	Pharmacy	MR2B No documentation	This claim was for Metronidazole, a medication to treat bacterial infections. There was a medical necessity for the medication. The pharmacy has closed so there is no documentation to support the service was provided. The error was calculated as the total amount paid for this claim.	\$7.93	\$0.00	\$7.93
0854	Pharmacy	MR5 Medically unnecessary service	This claim was for Zanax, a medication used to treat anxiety. The prescribing provider provided only a letter stating the patient's condition. No progress notes or other evidence of evaluation or examination were provided. There was no mechanism to evaluate medical necessity without the medical record. The pharmacy did not obtain the beneficiary's signature verifying receipt of the medication. Since progress notes were not provided after numerous attempts to obtain them, the error was calculated as the total amount paid for this claim.	\$28.49	\$0.00	\$28.49

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0858	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Mobic, a medication used to treat arthritis. There was mention of degenerative joint disease in the record but no evaluation of its severity. This is a code one restricted drug for use with arthritis only. There was no indication the pharmacy verified this diagnosis before filling this prescription. The error was calculated as the total amount paid for this claim.	\$94.92	\$0.00	\$94.92
0861	Pharmacy	MR5 Medically unnecessary service	This claim was for Topamax, for food craving behaviors. This is an infrequent use of the medication. The prescribing provider did not respond to repeated attempts to obtain the medical records to support this diagnosis and prescription; there was no means to verify medical necessity. The prescription did not state the number of tablets to be dispensed and there were no refills written on prescription. The error was calculated as the total amount paid for this claim.	\$284.97	\$0.00	\$284.97
0862	Pharmacy	MR5 Medically unnecessary service	This claim was for Paxil, a medication used to treat depression and anxiety. This claim is for a 12 year-old patient. There is no documentation in the medical record to support any diagnosis or condition that would be treated with Paxil. The Federal Drug Administration has not approved the use of Paxil in pediatric patients. The NDC on the invoice supplied by the pharmacy did not match the NDC code on the claim. There was no valid prescription for the date of service. The only prescription supplied was an incomplete telephone prescription that appears to order the medication daily. The prescription was written in October 2005 with no refills. This claim was for a refill in May of 2006. The pharmacy instructions to the patient on the label were to take the medication two days a week. According to the label instructions, the 30 tablets would be a fifteen week supply. The pharmacy has been consistently	\$73.07	\$0.00	\$73.07

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			filling the prescription every 30 days with no refills authorized. The error was calculated as the total amount paid for this claim.			
0863	Pharmacy	MR5 Medically unnecessary service	This claim was for Colace, a stool softener. There was no signature verifying the medication was received by or for the beneficiary. There was mention of the medication in the prescribing provider's medical record but there was no indication of medical need. This error was calculated as the total amount paid for the claim.	\$12.70	\$0.00	\$12.70
0864	Pharmacy	MR2B No Documentation	This claim was for Abilify, a medication used to treat Schizophrenia. The referring provider could not be contacted to obtain medical records. Therefore, medical necessity could not be determined. There were no errors in the records provided by the pharmacy. The error was calculated as the total amount paid for this claim.	\$326.29	\$0.00	\$326.29
0868	Pharmacy	MR5 Medically unnecessary service	This claim was for Wellbutrin, a medication used to treat depression. The progress notes obtained from the referring provider do not identify the patient they are for. All of the progress notes say the same things except one that speaks of the patient as "she" instead of "he." Medi-Cal records identify the patient as a male. The progress notes are dated monthly. There was no mention of the medications the patient is on or any individualized mental assessment of the patient. The person that signed for receipt of the medication was not the patient and their relationship to the patient was not identified. This error was calculated as the total amount paid for this claim.	\$127.87	\$0.00	\$127.87
0869	Pharmacy	MR5 Medically unnecessary service	This claim was for Pseudoephedrine HCL, a decongestant. There were no errors in the service and documentation provided by the pharmacy. There were no medical record progress notes available to indicate	\$10.82	\$0.00	\$10.82

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			the reason for the medication. The only documents available from the prescribing provider were a copy of the prescription. This error was calculated as the total amount paid for this claim.			
0870	Pharmacy	PH2 No legal Rx for date of service	This claim was for blood sugar test strips. The pharmacy was unable to provide documentation to support authorization for the refill for this date of service. The error was calculated at the total amount paid for this claim.	\$98.38	\$0.00	\$98.38
0887	Pharmacy	MR5 Medically unnecessary service	This claim was for Lorazepam, a medication used to treat anxiety, insomnia or stress. There is no documentation in the medical record the patient has any of the symptoms or problems this medication would be used to treat. The prescription was written for 60 tablets. The pharmacy dispensed 30. There is a Code 1 restriction for 30 tablets per dispensing and only three dispensings in seventy five days. This claim was for the third dispensing. There is no documentation the pharmacy had authorization from the prescriber to change the prescription. The error was calculated at the total amount paid for this claim.	\$24.40	\$0.00	\$24.40
0891	Pharmacy	PH2 No legal Rx for date of service	This claim was for Toprol XL, a medication used to treat hypertension. The pharmacy had no documentation the prescription for this date of service was ever dispensed. There was no beneficiary signature of receipt for the medication. The most recent prescription was dated five months before the date of service with thirty days supply and no refills. There was documentation on the patient profile this prescription was filled twice without authorization for additional fills from the prescriber. The error was calculated as the total amount paid for this claim.	\$43.48	\$0.00	\$43.48

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0892	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Prevacid, a medication used to treat gastric and duodenal ulcers and gastric esophageal reflux disease (GERD.) There are no errors in the service and documentation provided by the pharmacy. There was documented history of GERD and gastrointestinal bleeding; these support medical necessity. There was no indication in the medical record the provider intended the patient have this medication. He had historically been on other medications for his GERD. There was no indication why the medication was changed. This error was calculated as the total amount paid for this claim.	\$404.20	\$0.00	\$404.20
0896	Pharmacy	PH2 No legal Rx for date of service	This claim was for Clonazepam, a medication to treat Schizophrenia. The medication was delivered to a facility on the date of service. However, the provider progress note written a week earlier stated the patient was recently released from the hospital. The faxed prescription written on the date of service was signed by someone other than the provider name entered on this prescription. That provider signed a declaration stating the signature on the prescription was not his. The NDC number on the invoice is not the same as the NDC number on the claim. The error was calculated at the total amount paid for this claim.	\$25.11	\$0.00	\$25.11
0903	Pharmacy	MR2B No documentation	This claim was for Celebrex, a nonsteroidal anti-inflammatory drug (NSAID). There are no errors with the service and documentation provided by the pharmacy. The prescribing provider did not document anything in the medical record on or before the date of service for this claim related to a need for a NSAID. This error was calculated as the total amount paid for this claim.	\$93.96	\$0.00	\$93.96

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0917	Pharmacy	PH3 Rx missing essential information	This claim was for Furosemide, a medication used to treat edema and high blood pressure. The prescription for this medication on file at the pharmacy was incomplete. The current authorization at the pharmacy did not have the strength of the medication or the quantity to be dispensed. The referring provider's medical records were also missing this information. The error was calculated as the total amount paid for this claim.	\$9.05	\$0.00	\$9.05
0918	Pharmacy	PH2 No legal Rx for date of service	This claim was for Oyst-Cal, a calcium supplement used to prevent or treat osteoporosis. The prescription available in the pharmacy has no refill authorization for this date of service. The wrong referring provider was listed on the claim. The referring provider's progress note on this date of service lists medications but Oyst-Cal is not one of the medications listed. The error was calculated as the total amount paid for this claim.	\$9.01	\$0.00	\$9.01
0919	Pharmacy	PH2 No legal Rx for date of service	This claim was for Lipitor, a medication used to treat high cholesterol. The prescription the pharmacy provided was for Mevacor, a different medication used to treat high cholesterol. The documentation from the referring provider addresses giving the patient Mevacor. There was no indication either in the pharmacy or referring provider documentation, the referring provider authorized the change in medication. There was no signature of receipt for this medication. This error was calculated as the total amount paid for this claim.	\$79.20	\$0.00	\$79.20
0924	Pharmacy	PH2 No legal Rx for date of service	This claim was for a thirty day supply of Trileptal, a medication used to manage seizures. The prescription available was dated over a month before the claim with no refill. There was a note on the trailer label for the date of service on the claim. There was a faxed	\$453.69	\$0.00	\$453.69

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			<p>refill authorization dated three days after the date the prescription was filled. The signature verifying receipt was not the signature of the patient and the relationship to the patient was not noted. The drug being signed for was not identified on the signature form either. This error was calculated as the total amount paid for the claim.</p>			
0925	Pharmacy	P7 Ineligible recipient	<p>This claim was for Metformin, a medication used to treat type II Diabetes. Medical necessity was documented in the medical record however; the beneficiary is eligible for emergency and obstetrical services only. This medication does not fall into either of those categories. Therefore, the beneficiary was not eligible for the medication. The error was calculated as the total amount paid for this claim.</p>	\$37.01	\$0.00	\$37.01
0926	Pharmacy	MR5 Medically unnecessary service	<p>This claim was for Miconazole Nitrate cream, a medication used to treat vaginal yeast infections. The prescription was missing essential information; i.e., type of vaginal cream such as seven day, three day or single dose. The progress note in the medical record did not explain the rationale for the medication. There was no examination or symptoms noted. The nurse practitioner that wrote the prescription did not have a license to furnish prescriptions. The license to furnish prescriptions expired six years before this prescription was written. The referring provider on the prescription was the supervising physician rather than the nurse practitioner writing the prescription. The error was calculated as the total amount paid for this claim.</p>	\$16.75	\$0.00	\$16.75

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0932	Pharmacy	MR5 Medically unnecessary service	This claim was for diabetic test strips. These test strips were ordered for a gestational diabetic to test her blood sugar during pregnancy. For a gestational diabetic there is no need to continue checking blood sugars after delivery. This prescription was filled two weeks after delivery. There is no medical need for this service. The pharmacy had no signature verifying the beneficiary or her representative received the product. The error was calculated as the total amount paid for this claim.	\$146.47	\$0.00	\$146.47
0934	Pharmacy	MR2B No documentation	This claim was for Seroquel, a medication used to treat psychosis. The most current prescription was written for a thirty one day supply eight months before the date of service and had no refills authorized. The dispensing label for this date of service was marked as a new prescription but there was no documentation to support a new prescription. The prescription was signed for at the board and care where the beneficiary resides but the medications were not itemized. The prescribing physician was not available to provide records when they were requested and referred DHS staff to his physician assistant. When DHS staff contacted the physician assistant, he stated he "needs some time to put the patient chart together." The error was calculated as the total amount paid for this claim.	\$239.86	\$0.00	\$239.86
0935	Pharmacy	MR2B No documentation	This was a claim for Risperidone, a medication used to treat psychosis. Several attempts to locate the referring provider were unsuccessful. Therefore, there were no medical records to review to determine medical necessity. The pharmacy had no record the current refill was authorized by the referring provider. The NDC number on the claim did not match the NDC on the invoice provided. The error was calculated as	\$366.64	\$0.00	\$366.64

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			the total amount paid for this claim.			
0936	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Amoxicillin, an antibiotic. The pharmacy services and documentation was without error. The prescribing provider's medical record was mostly illegible. The words asthmatic bronchitis can be identified on the day of service which is a medical indication for the antibiotic. The examination and plan to support this diagnosis were not legible. This error was calculated as the total amount paid for this claim.	\$11.16	\$0.00	\$11.16
0948	Pharmacy	MR2B No documentation	This claim was for Folic Acid, a vitamin supplement used to treat megaloblastic or macrocytic anemia. There is no prescription, physician or facility order available for this medication. The invoice provided was dated a month after the date of service on the claim. The patient was residing in a skilled nursing facility and has died since the date of service. The skilled nursing facility was unable to provide records for the beneficiary. Therefore, medical necessity could not be determined. The error was for the total amount paid for this claim.	\$9.96	\$0.00	\$9.96
0949	Pharmacy	MR5 Medically unnecessary service	This claim was for Clindamycin Phosphate, a medication designed to treat bacterial vaginal infections. The pharmacy services and documentation was without error. Cultures done for this date of service show yeast infections. This medication is not appropriate for yeast infections. The error was calculated as the total amount paid for this claim.	\$51.17	\$0.00	\$51.17

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0959	Pharmacy	PH2 No legal Rx for date of service	This claim was for 3 cc syringes with 25 gauge needles. The prescription was for insulin syringes. The patient is a diabetic. An insulin syringe is specially marked to draw insulin according to the number of units prescribed. A 3cc syringe would be difficult, if not impossible, to use to draw the correct amount of insulin. There was no indication the prescriber authorized this change in the prescription. The error was calculated as the total amount paid for this claim	\$16.79	\$0.00	\$16.79
0966	Pharmacy	PH3 Rx missing essential information	This claim was for lancets used to obtain specimens for blood sugar testing. The beneficiary did not sign for this item; he did sign for other items on the same day. The wrong rendering provider was listed on the claim. The prescription did not have a quantity of product listed. There was no indication the pharmacy obtained authorization from the prescriber for the amount provided the patient. This error was calculated as the total amount paid for this claim.	\$22.15	\$0.00	\$22.15
0977	Pharmacy	PH10 Other pharmacy policy error	This claim was for Novolog Penfill Insulin Cartridge and the needles used for administration of this prefilled cartridge of insulin. The referring provider wrote a prescription for Novofine 31(6ml) disposable needles. The dispensing label was for the same Novofine 31 needle which supports the pharmacy filled the prescription as ordered. According to the Medi-Cal formulary, the Novofine 31 needle is not a covered drug or device. The pharmacy billed Medi-Cal for Novofine 30 which is covered by Medi-Cal. The error was calculated as the difference between the total amount paid for this claim and the amount that was paid for the Novofine 30 needles.	\$177.13	\$136.31	\$40.82

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
0980	Pharmacy	PH10 Other pharmacy policy error	This claim was for Risperdal, a medication used to treat schizophrenia. The pharmacy was closed, the phone had been disconnected, and no forwarding information was available for the pharmacy. The pharmacy appeared to have gone out of business. There were no records available to review. California Department of Health Services Provider Enrollment Branch (PEB) had not been notified by the provider of his decision to close or move. Since no documents were available for review and the pharmacy had not informed PEB of their change in status as required, the error was calculated as the total amount paid for this claim.	\$857.69	\$0.00	\$857.69
0993	Pharmacy	PH2 No legal Rx for date of service	This claim was for Aspirin 81 mg to help prevent heart attack. There was a prescription written with one refill. The fill of the prescription for the date of service on this claim was the second fill. There was no documentation the prescribing provider authorized the additional refills for this medication. There was no signature verifying receipt of the medication. The NDC on the invoice does not match the NDC on the claim. The pharmacy technician stated the pharmacy had switched to a new computer system and the invoices in question was in the old system and not retrievable. The error was calculated as the total amount paid for the claim.	\$8.49	\$0.00	\$8.49
0998	Pharmacy	PH2 No legal Rx for date of service	This claim was for Mytussin AC Syrup, an expectorant with codeine. The pharmacy was unable to provide a prescription or dispensing labels for this medication. A patient profile was the only record available for the medication for this patient. The person signing for the medication was not the patient and their relationship was not established. The error was calculated as the total amount paid for this claim.	\$12.24	\$0.00	\$12.24

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1000	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Nitroglycerin tablets for angina. The prescription was for 30 tablets and the pharmacy filled the prescription with 25 tablets and there was no documentation a change was authorized by the prescribing physician as required by Medi-Cal regulation. There was no documentation in the prescribing provider's record for the rationale or intent to prescribe the medication. The error was calculated as the total amount paid for the claim.	\$10.69	\$0.00	\$10.69
1002	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Dicyclomine, a medication used to treat functional gastrointestinal disorders such as irritable bowel syndrome. There is no documentation as to any intestinal problems with this patient. All documentation was about gastric upset, for which this medication is not indicated. The medication receipt was signed by someone other than the patient and the signer was not identified as required by Welfare and Institutions Code Section 14043.341. The error was calculated as the total amount paid for this claim.	\$13.36	\$0.00	\$13.36
1004	Pharmacy	PH6 No record of drug acquisition	This claim was for the Ortho Evra Patch used as a means of birth control. The invoice provided by the pharmacy was for over a year before the date of service on the claim. There was no indication the pharmacy had more current medication in stock. An invalid number was used to identify the referring provider. The referring provider is licensed in good standing. Since the provider was unable to demonstrate he had current stock available to fill the prescription on the date of service, the error was calculated as the total amount paid for this claim.	\$51.98	\$0.00	\$51.98

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1007	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Ibuprophen, an anti-inflammatory and pain medication. There were no errors by the pharmacy. There was minimal documentation in the medical record to support the need for this medication. There was only a problem of myalgia and back pain with no further work up. The error was calculated as the total amount paid for this claim.	\$8.97	\$0.00	\$8.97
1009	Pharmacy	PH2 No legal Rx for date of service	This claim was for Calcium Carbonate, a medication used to prevent or treat osteoporosis. There was no authorization for a refill for this date of service. The prescription was written five months before the date of service with no refills authorized. There was no signature verifying receipt of medication. The error was calculated as the total amount paid for this claim.	\$8.56	\$0.00	\$8.56
1021	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Folic Acid. There was no clear indication in the medical record why the medication was prescribed. The record makes brief mention of more than one potential reason for the Folic Acid but does not elaborate sufficiently to provide a definitive reason. There was no signature of receipt for the medication. The dispensing label obtained was not for the date of service. This error was calculated as the total amount paid for this claim.	\$9.96	\$0.00	\$9.96
1024	Pharmacy	PH7B Prescription split	This claim was for Ferrous Sulfate, an iron supplement. The prescription was written for 150 day supply. The pharmacy filled the prescription with a 30 day supply. There was no indication the pharmacy obtained authorization to change the prescription from the prescriber. The NDC number used on the claim was not the same as the NDC number on the invoice provided by the pharmacy. The error was calculated as the total amount paid for this claim.	\$15.61	\$0.00	\$15.61

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1028	Pharmacy	MR5 Medically unnecessary service	This claim was for Zithromax, an antibiotic used to treat bacterial infections. This patient presented to the referring provider with a sore throat and productive cough. There is no indication of a bacterial infection such as a throat culture. The patient had no temperature. The physical exam stated throat "red." There was no description of sputum from productive cough nor examination of lungs as would be expected with a suspected respiratory infection. The wrong referring provider was listed on the claim. The error was calculated as the total amount paid for this claim.	\$52.86	\$0.00	\$52.86
1029	Pharmacy	MR5 Medically unnecessary service	This claim was for Promethazine, a medication used to treat nausea and vomiting. There is a note from two years earlier when the patient was admitted to the hospital with abdominal pain and all tests were negative. There was no indication any further evaluation had been done to determine a continued need for this medication. The pharmacy did not have an invoice to support the purchase of this medication. The pharmacy was purchased recently and invoices were not included when the purchase occurred. The error was calculated as the total amount paid for this claim.	\$28.27	\$0.00	\$28.27

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1036	Pharmacy	MR5 Medically unnecessary service	This claim was for Lopid, a medication used to treat high cholesterol. The pharmacy had two telephone prescriptions with three refills obtained one month apart. With the combination of the two prescriptions there were enough refills to cover this date of service. There was no explanation why they obtained a second telephone prescription when the current prescription still had refills on it. The referring provider listed on the prescription denied seeing the patient or prescribing the medication. Since no medical record was available, medical necessity could not be verified. The error was calculated as the total amount paid for this claim	\$30.05	\$0.00	\$30.05
1046	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Docusate Sodium, a stool softener. There were no errors with the pharmacy services or documentation. The prescribing provider's record listed chronic constipation and abdominal pain by history and referred the patient to a gastroenterologist. There was no final diagnosis or treatment plan for constipation in the record as would be expected. The documentation was minimally sufficient to support medical necessity. This error was calculated as the total amount of the claim.	\$8.80	\$0.00	\$8.80
1059	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Effexor, a medication used to treat depression and anxiety. There were no errors in the service or documentation provided by the pharmacy. The prescribing provider's documentation was illegible. There was minimal documentation to support the need for continued use of this medication. There was one word written under assessment: "depression." There was no indication how the beneficiary's depression is being managed by this medication. The progress note written by the prescriber totaled four words. This error	\$328.15	\$0.00	\$328.15

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ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
			was calculated as the total amount paid for this claim.			
1071	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Nexium, a medication used to treat gastritis. There were no errors found in the services or documentation provided by the pharmacy. The prescribing provider's documentation for January 10, 2006 states the patient's gastritis was resolved after a six week treatment of Nexium. The documentation for May 18, 2006 shows the medication was restarted but there was no indication why. The error was calculated as the total amount paid for this claim.	\$191.05	\$0.00	\$191.05
1082	Pharmacy	MR5 Medically unnecessary service	This claim was for Ibuprophen, a medication for pain. There was no indication in the medical record of any need for this medication. There is no evaluation for pain in the medical record on or about the time of the prescription. The error was calculated as the total amount paid for this claim.	\$10.79	\$0.00	\$10.79
1094	Pharmacy	MR5 Medically unnecessary service	This claim was for Acetaminophen liquid for a child. There were no errors in service or documentation by the pharmacy. The prescribing provider's record stated the medication is for fever and pain. There was no documentation in the record that the patient had a fever or any condition that may cause fever, such as a respiratory or urinary infection. There was also no documentation the child had any pain or any condition that may have caused pain. There was no medical necessity documented for the prescription. The error was calculated as the total amount paid for this claim.	\$8.89	\$0.00	\$8.89

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1100	Pharmacy	MR2B No documentation	This claim was for Claritin, a medication to manage allergies. There was no documentation in the medical record the patient has a problem with allergies. The documentation provided discussed migraine headaches. The error was calculated as the total amount paid for this claim.	\$13.19	\$0.00	\$13.19
1109	Pharmacy	PH2 No legal Rx for date of service	This claim was for Neurotin, a medication used to treat neurological pain or seizures. The only prescription available was written a year before the date of service with no refills. According to the patient refill history, this was the last refill of a prescription written six months earlier. The pharmacy had no other documentation of this prescription. The beneficiary did not sign for receipt of the medication and the NDC on the claim did not match the NDC on the invoice. The error was calculated as the total amount paid for this claim.	\$106.68	\$0.00	\$106.68
1110	Pharmacy	PH2 No legal Rx for date of service	This claim was for Sodium Fluoride, a medication used to prevent tooth decay for a two year old child. The prescription was written for 0.25 mg drops, the pharmacy dispensed 0.5mg drops with no indication a change was authorized by the referring provider. There was no documentation in the medical record assessing the child for the medication or of intent to prescribe the medication. The beneficiary or their representative did not sign for receipt of the medication. The error was calculated as the total amount paid for this claim.	\$11.49	\$0.00	\$11.49

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1116	Pharmacy	PH2 No legal Rx for date of service	This claim was for Prevacid, a medication used to treat duodenal ulcer as well as other gastrointestinal irritability, gastroesophageal reflux disease. The prescription the pharmacy had was for one fill only one month before the date of service. There was no indication the pharmacy obtained authorization from the referring provider for this refill of the prescription. There was no signature of receipt obtained. The error was calculated as the total amount paid for this claim.	\$178.45	\$0.00	\$178.45
1119	Pharmacy	PH7B Prescription split	This claim was for Risperdal, a medication used to treat schizophrenia. The prescription was written for 180 tablets but filled with 120 tablets with no documentation the prescriber authorized the change. This resulted in an increased number of fills with additional dispensing fees paid. There was no signature verifying receipt of the medication. The error was calculated at the difference between the total amount paid for this claim and the amount paid for the dispensing fee.	\$702.84	\$695.59	\$7.25

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1122	Pharmacy	MR5 Medically unnecessary service	This claim was for Prednisolone 6.7mg/5milieters, a corticosteroid used to resolve inflammation. This 10 month old child was seen in an emergency department for symptoms of an ear infection. Physical examination revealed mild to moderate ear infection and no indication of need for a corticosteroid to resolve inflammation. There was also no history of a serious health problem that would indicate use of a corticosteroid. Medical necessity could not be established. The prescription was written for 5mg per 5 milliliters (1 teaspoon) of medication with directions to give one teaspoon twice a day. According to the pharmacy records, the patient was given a solution of 6.7mg/5milieters with directions to give one teaspoon twice a day. In one day, the child would get over 3mg more medication than was ordered. There was no indication the pharmacy obtained authorization to change the dosage from the prescribing provider. The error was calculated as the total amount paid for this claim.	\$16.03	\$0.00	\$16.03

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1133	Pharmacy	PH2 No legal Rx for date of service	This was a claim for Celebrex, a nonsteroidal anti-inflammatory drug used to manage arthritis and pain. Medi-Cal has a restriction on the use of this drug for patients with a diagnosis of arthritis without a TAR. There was no indication in pharmacy records that verified a diagnosis with the referring provider. There was no TAR for this prescription. There was also no prescription with the same prescription number as on the claim. There was general indication the patient may have rheumatoid arthritis in the medical record however, there is no testing to determine this fact. There was no definite diagnosis of arthritis in the medical record to support the use of Celebrex without a TAR. The error was calculated as the total amount paid for this claim.	\$180.67	\$0.00	\$180.67
1134	Pharmacy	PH7B Prescription split	This was a claim for Vicodin, a medication used for moderate to severe pain. There was limited documentation in the medical record of the need for this medication. The only diagnosis in the record was diabetic neuropathy. The need for this medication was not mentioned and there was no evaluation of pain for this patient. The prescription was written for 100 tablets but the pharmacy dispensed 30 tablets. There is a restriction on this medication of thirty tablets per fill and no more than three fills in 75 days without a TAR. A review of the patient profile reveals the pharmacy was billing Medi-Cal for the 30 tablets within the restriction and the patient was being charged for the other 70 tablets. The error was calculated as the total amount paid for this claim.	\$9.75	\$0.00	\$9.75

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1139	Pharmacy	MR5 Medically unnecessary service	This claim was for a prescription for Tylenol and Codeine, a medication given for pain. There was no valid prescription in the pharmacy for this medication for this date. The documentation in the medical record reflected frequent complaints of pain but no evaluation of the pain and the medical necessity for this strong a medication. The error was calculated as the total amount paid for this claim	\$16.87	\$0.00	\$16.87
1142	Pharmacy	MR5 Medically unnecessary service	This claim was for Fosamax, a medication used to treat osteoporosis. There was no documentation in the medical record that the patient has osteoporosis and no history or tests to support a diagnosis of osteoporosis or Paget's disease. The NDC number on the claim did not match the NDC number on the invoice provided by the pharmacy. The error was calculated as the total amount paid for the claim.	\$82.19	\$0.00	\$82.19
1145	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Zofran, a medication used to treat nausea. There was a diagnosis of gastroparesis written three years ago when the medication was first started. There was no indication of continued problems or an evaluation of the effectiveness of the medication. The prescription was for ninety tablets and the pharmacy filled the prescription with ten tablets. There was no indication the referring provider authorized the change in the prescription. Medi-Cal has a restriction on the use of this medication; the medication is restricted to twelve tablets per fill. By changing the prescription to ten tablets, the pharmacy avoids needing to obtain a TAR for this medication. The NDC on the claim did not match the NDC on the invoice. The error was calculated as the total amount paid for this claim.	\$356.21	\$0.00	\$356.21

VII

DETAIL OF REASONS FOR ERROR

ID Number	Strata	Error Code	Reason for Error	Amount Paid	Correct Amount	Amount in Error
1146	Pharmacy	MR2A Poor/insufficient documentation	This claim was for Vytorin, a medication used to treat high cholesterol. There were no errors in the services or documentation provided by the pharmacy. The medical record had no cholesterol level results for three years. The patient was on a different medication to control his cholesterol and then after a short period with no medication for high cholesterol, the patient was started on Vytorin in June 2005. There was no lipid panel obtained to evaluate the patient's cholesterol levels and the need for continued medication at the time the medication was started nor have there been any since. The error was calculated at the total amount paid for this claim.	\$87.85	\$0.00	\$87.85

VIII

FINAL REVIEW ERROR CODES

Administrative Error Codes

- **NE - No Error**
- **WPI - Wrong Provider Identified on the Claim**

A. Wrong Rendering Provider Identified on the Claim

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

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

B. Wrong Referring Provider

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

C. Non-physician Medical Provider Not Identified

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

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

Processing Validation Error Codes

- **P1 - Duplicate Item (claim)**
An exact duplicate of the claim was paid – same patient, same provider, same date of service, same procedure code, and same modifier.
- **P2 - Non-Covered Service**
Policies indicate that the service is not payable by Medi-Cal.
- **P3 - MCO Covered Service**

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

- **P4 - Third Party Liability**

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

- **P5 - Pricing Error**

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

- **P6 - Logical Edit**

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

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

The recipient was not eligible for the services or supplies

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

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

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

- **P9 - Ineligible Provider**

This code includes the following situations:

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

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

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

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

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

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

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

Example 3: The rendering provider is a NMP who is not licensed, not appropriately trained to provide the service, or who is not appropriately supervised.

Example 4: The referring/prescribing provider was suspended from Medi-Cal, is not licensed, or is otherwise ineligible to prescribe the service.

- C. The billing or rendering provider is a Medi-Cal provider, but not at this location. When the error is due to a change of location, or new provider, PEB is contacted to see if there had been a delay in entering an approved change.

- **P10 – Other**

If this category is selected, a written explanation is provided

Medical Review Error Codes

- **MR1 – No Documents Submitted**

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

- **MR2 – Documentation Problem Error**

- A. Poor Documentation**

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

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

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

- B. No Documentation**

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

- **MR3 – Coding Error**

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

- **MR4 – Unbundling Error**

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

- **MR5 – Medically Unnecessary Service**

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

- **MR7 – Policy Violation**

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

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

- **MR8 – Other Medical Error**

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

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

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

- **MR9 – Recipient Signature Missing**

A statute is in place requiring that the beneficiary, or their representative, sign for receipt of the service. If no signature was obtained, it is considered a dollar-impact error. This code is used for DME and Laboratory signatures.

Pharmacy Error Codes

In the MPES 2004 all the pharmacy claims were reviewed and assigned errors using the Medical Review Error Codes. To better reflect the errors found in pharmacy claims, the following codes were developed for subsequent Medi-Cal payment error studies.

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

- **PH1 - No Signature Log**
Statute is in place requiring a beneficiary or their representative sign for the receipt of medication or other item.
- **PH2 - No Legal Rx for Date of Service**
This code was used when no legal prescription (e.g., expired Rx, no Rx) could be found in the pharmacist's file.
- **PH3 - Rx Missing Essential Information**
The prescription lacked information required for a legal prescription, such as the patient's full name, the quantity to be dispensed, or instructions for use.
- **PH4 - Wrong National Drug Code (NDC) Billed**
The NDC code claimed did not match the NDC code on the wholesale invoice.
- **PH5 - Wrong Information on Label**
This code was used when the label did not match the prescription. For example, the physician's name on the prescription label did not match the prescription.
- **PH6 - No Record of Drug Acquisition**
This code was used when the pharmacy did not have a wholesale invoice to document purchase of the drug dispensed.
- **PH7 - Refills Too Frequent**
PH7-A – Refilled earlier than 75 percent of product/drug should have been used.
PH7 B – Prescription split into several smaller prescriptions increasing dispensing fee.
- **PH10 - Other Pharmacy Policy Violation**

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

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

Compliance Error Codes

- CE1 – Medi-Cal policy or rule not followed but service medically appropriate and a benefit to the Medi-Cal program.
- These claims are usually assigned other error codes and then determined to be compliance errors.

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

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

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

Indication of Fraud or Abuse

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

IX

STUDY RESULTS AND STATISTICAL SUMMARIES

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

- Table 1A MPES 2006 Payment Error Rates and Projected Annual Payments Made in Error by Stratum (Using Claims Paid in Second Quarter of Calendar Year 2006)
- Table 1B MPES 2005 Payment Error Rates and Projected Annual Payments Made in Error by Stratum (Using Claims Paid in Fourth Quarter of Calendar Year 2004)
- Table 2A MPES 2006 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum (Using Claims Paid in Second Quarter of Calendar Year 2006)
- Table 2B MPES 2005 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum (Using Claims Paid in Fourth Quarter of Calendar Year 2004)
- Table 3A Calendar Year 2006 Medi-Cal Fee-For-Service and Dental Payments by Quarter
- Table 3B Calendar Year 2004 Medi-Cal Fee-For-Service and Dental Payments by Quarter

Table 1A
MPES 2006 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2006)

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

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

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

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

Table 1B
MPES 2005 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 2004)

Payment Error	Fourth Quarter 2004						
	Rate & Confidence			Universe		Payment	Projected Annual
			Interval	Dollars	Errors	Payment Errors	
Stratum 1 - ADHC	62.23%	±	13.06 %	\$87,655,628	\$54,548,097	\$218,192,389	
Stratum 2 - Dental	19.95%	±	16.72%	\$154,041,783	\$30,731,336	\$122,925,343	
Stratum 3 - Durable Medical Equipment	7.51%	±	11.85%	\$29,558,596	\$2,219,851	\$8,879,402	
Stratum 4 - Inpatient	0.00%	±	N/A	\$1,656,440,246	N/A	N/A	
Stratum 5 - Labs	13.80%	±	6.71%	\$46,185,003	\$6,373,530	\$25,494,122	
Stratum 6 - Other Practitioners & Clinics	9.65%	±	5.22%	\$744,417,656	\$71,836,304	\$287,345,215	
Stratum 7 - Other Services & Supplies	10.13%	±	3.16%	\$166,695,184	\$16,886,222	\$67,544,889	
Stratum 8 - Pharmacy	12.98%	±	4.64%	\$1,308,403,593	\$169,830,786	\$679,323,145	
Overall Payment Error Rate	8.40%	±	1.85%	<u>\$4,193,397,689</u>	<u>*\$352,245,406</u>	<u>*\$1,408,981,624</u>	

The confidence interval for the payment error rate is calculated at 95% confidence. There is a 95% probability that the actual rate for the population is 8.40% ± 1.85%, or that the true error rate lies within the range 6.55% and 10.25%. The projected annual payment errors are calculated by multiplying three quantities: 1) the erroneous payment rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the year).

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

Table 2A
MPES 2006 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2006)

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

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

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

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

Table 2B
MPES 2005 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Fourth Quarter of Calendar Year 2004)

Fraud Payment	<u>Fourth Quarter 2004</u>					
	<u>Dental /Medi-Cal FFS Payments</u>					
	Rate & Confidence			Universe	Potential	Projected Annual
		Interval	Payments	Fraud	Fraud Payments	
Stratum 1- ADHC	58.04%	± 13.41%	\$87,655,628	\$50,875,326	\$203,501,306	
Stratum 2 – Dental	6.50%	± 6.46%	\$154,041,783	\$10,012,716	\$40,050,864	
Stratum 3 – Durable Medical Equipment	5.22%	± 9.11%	\$29,558,596	\$1,542,959	\$6,171,835	
Stratum 4 – Inpatient	0.00%	± N/A	\$1,656,440,246	\$0	\$0	
Stratum 5 – Labs	10.28%	± 5.16%	\$46,185,003	\$4,747,818	\$18,991,273	
Stratum 6 – Other Practices & Clinics.	7.88%	± 4.65%	\$744,417,656	\$58,660,111	\$234,640,445	
Stratum 7 – Other Services & Supplies	9.73%	± 3.12%	\$166,695,184	\$16,219,441	\$64,877,766	
Stratum 8 - Pharmacy	5.31%	± 3.28%	\$1,308,403,593	\$69,476,231	\$277,904,923	
Overall Payment Error Rate	5.04%	± 1.37%	<u>\$4,193,397,689</u>	<u>*\$211,347,244</u>	<u>*\$845,388,974</u>	

The confidence interval for the payment error rate is calculated at 95% confidence. There is a 95% probability that the actual rate for the population is 5.04% ± 1.37%, or that the true fraud rate lies within the range 3.67% and 6.41%. The projected annual payment errors are calculated by multiplying three quantities: 1) the fraud rate, 2) the 4th quarter 2004 Medi-Cal FFS and dental payments universe subject to sampling, and 3) 4 (for 4 quarters in the year).

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

**Table 3A
Calendar Year 2006 Medi-Cal Fee-for-service and Dental Payments by Quarter**

Stratum	Total Paid By Quarter				Total
	First	Second	Third	Fourth	
Dental	\$ 147,641,273	\$ 147,820,141	\$ 147,805,592	\$ 149,742,617	\$ 593,009,622
ADHC	\$ 104,211,340	\$ 85,803,586	\$ 97,900,452	\$ 94,001,060	\$ 381,916,438
Durable Medical Equipment	\$ 28,141,104	\$ 26,968,565	\$ 29,656,147	\$ 29,308,103	\$ 114,073,920
Inpatient	\$ 1,853,000,303	\$ 1,998,572,102	\$ 2,089,924,309	\$ 1,903,410,322	\$ 7,844,907,035
Labs	\$ 50,438,577	\$ 46,754,614	\$ 56,207,717	\$ 50,871,708	\$ 204,272,616
Other Practices & Clinics	\$ 771,196,694	\$ 792,102,836	\$ 887,287,370	\$ 852,313,145	\$ 3,302,900,045
Other Services & Supplies	\$ 181,712,566	\$ 178,462,115	\$ 201,558,467	\$ 184,288,689	\$ 746,021,837
Pharmacy	\$ 857,027,295	\$ 616,770,479	\$ 701,631,689	\$ 672,394,319	\$ 2,847,823,782
FFS Subtotal	\$ 3,845,727,879	\$ 3,745,434,297	\$ 4,064,166,152	\$ 3,786,587,345	\$ 15,441,915,674
Total Dental & FFS	\$ 3,993,369,152	\$ 3,893,254,438	\$ 4,211,971,744	\$ 3,936,329,962	\$ 16,034,925,296

**Table 3B
Calendar Year 2004 Medi-Cal Fee-For-Service and Dental Payments by Quarter**

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

X

SIGNIFICANT FINDINGS / ACTIONS TAKEN ON ERRORS FOUND IN MPES 2006

Dental Claims

The dental stratum had 57 percent of its sampled claims in error, which was the highest percentage of claims in error for any stratum in the MPES 2006. This is a considerable increase as last year 24 percent of the dental claims were found to be in error. Behind pharmacy, the dental provider type was the second largest contributor to the MPES 2006 overall error rate, accounting for 1.70 percent of the 7.27 percent of the overall percentage of payment error. This is a significant increase from the MPES 2005 in which dental services errors accounted for 0.73 percent of the 8.40 overall percentage of payment error. Most of the dental errors, 52 percent, involved insufficient documentation of services. The remaining dental errors were as follows: coding errors, 21 percent; medically unnecessary errors, 17 percent; and policy violation errors, 10 percent. Also, dental had 15 percent of all potential fraud cases in the MPES 2006 compared to 6 percent for the MPES 2005.

Most dental errors identified in the MPES 2006 related to insufficient chart documentation as well as billing coding errors. To mitigate these types of errors in the future, Denti-Cal will put additional focus on provider education via provider bulletins, seminars at dental conferences and conventions, and feedback and assistance to specific providers on documentation and/or billing issues. Denti-Cal also is currently undergoing a 'top to bottom' review of its anti-fraud activities to assess the appropriateness and effectiveness of these efforts.

Local Education Agency (LEA) Claims

Local Education Agency (LEA) claims accounted for 23 out of the 32 claims in error in the "Other Services and Supplies" stratum. Out of the 44 LEA claims in the sample, 52 percent were found to be in error. Of those LEA errors, 65 percent were insufficient documentation errors. For the MPES 2005, LEA claims also comprised the largest number of errors for this stratum. The LEA claim errors resulted from insufficient documentation to support that services were provided. The Other Services and Supplies stratum had 13 percent of all potential fraud cases in the MPES 2006 compared to 8 percent for the MPES 2005. Claims from the LEA provider type accounted for most (40 percent) of the potential fraud cases in this stratum.

ADHC Improvements

Possibly in part due to actions by DHCS related to the MPES 2005 study, the error rate for the ADHC provider type has shown some improvement in the MPES 2006.

ADHC errors dropped from 62 percent reported by the MPES 2005 to 38 percent reported by the MPES 2006. Medical necessity errors accounted for 74 percent of the MPES 2006 errors by ADHCs, compared to 90 percent for the MPES 2005. Unannounced site visits to ADHC providers taken by DHCS in response to the findings of the MPES 2005 have likely contributed to the reduction in errors by ADHCs this year. ADHCs had 13 percent of all potential fraud cases in the MPES 2006, down from 23 percent for the MPES 2005.

Summary of Actions Taken based on the MPES 2006

Actions Taken	Number
Total errors found in MPES 2006	227
Total number of unique providers	217
Number of unique providers with errors that will be sent Civil Money Penalty letters explaining errors	67
Number of providers assigned for possible Field Audit Review	59
Special letter to provider or prescriber	13
Referred to Denti-Cal	29
Referred to Multipurpose Senior Services Program	1
Referred to California Children Services	3
Refer to AIDS Program	1
Provider cases submitted to State Controllers Office for evaluation of Audits for Recovery	23
To be reviewed by A&I staff for further action	25
Providers instructed to conduct self audit	3
Providers referred for compliance audits	0
AFR	2
Providers referred to respective licensing boards for further investigation	0
After investigation, no further actions warranted	1

XI

SIGNIFICANT FINDINGS / ACTIONS TAKEN ON ERRORS FOUND IN MPES 2005

Substandard Medical Care

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

Medical Necessity of ADHC Services

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

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

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

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

Proof of Receipt Signatures Requirement

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

Summary of Actions Taken

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

XII

REVIEW OF PAYMENT ERROR STUDIES

This section provides an exemplary review of previous Medicare and Medicaid studies that measured payment errors in the Medicare and Medicaid programs. The scope of this section describes the methodologies utilized, error rates, rationales for higher error rates (if provided), review processes, and study limitations in other payment error studies. The studies, presented in chronological order, demonstrate the evolutionary refinement in the error rate study domain. The review of these prior payment error studies directly influenced the development and refinement of MPES 2005 and MPES 2006.

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

Florida Payment Accuracy Measurement Study (2005)

Navigant Consulting conducted Florida's 2005 payment accuracy study. The study included an examination of Medicaid and State Children's Health Insurance Program (SCHIP) fee-for-service and managed care claim cases. The sample consisted of 866 Medicaid claims and 741 SCHIP claims with dates of payment October 1, 2003 through December 31, 2003. The sample size was designed to achieve a 95 percent confidence, plus or minus three percentage points.

The Medicaid strata reviewed included: Inpatient Hospital, Long Term Care, Individual Practitioners/Clinics, Prescription Drugs, Home and Community Based Services, Other Services and Supplies, and Medicare cross-over cases. SCHIP strata included: Healthy Kids, MediKids, Children's Medical Services Network, and B-Net cases. Accuracy of payment was determined by review of claims processing, medical record reviews and recipient eligibility verification for claimed benefits. SCHIP accuracy rate was projected at 97 percent and Medicaid accuracy rate was projected at 90 percent.

Medicare Error Rate Study (1996 - 2003)

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

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

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

Illinois Error Rate Study (1998)

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

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

Kansas Error Rate Study (1999)

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

Kansas validated each claim via patient confirmation, evaluation of state payment process, and a clinical evaluation of the medical record. Each reviewer captured findings with a pre-designed coding method. An estimated payment error rate of 24 percent was calculated with a margin of error of 9 percent. A significant portion of

dollars paid inaccurately was associated to documentation errors, which represented 78 percent of all dollars paid in error.

Texas Error Rate Study (2001)

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

Summary

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

XIII

BENEFICIARY ELIGIBILITY REVIEW SUMMARY

The MPES 2006 did not include a review to determine if the Fee-For-Service (FFS) beneficiaries were eligible for Medi-Cal at the time the beneficiary received services. A separate review to determine eligibility of Medi-Cal beneficiaries is being performed in accordance with the requirements of the federal Payment Error Rate Measurement (PERM) program. Under PERM, reviews of states will be conducted in three areas: (1) FFS, (2) managed care, and (3) program eligibility for both the Medi-Cal and State Children's Health Insurance Program (SCHIP). The Federal Government requires each state be responsible for measuring program eligibility for both Medi-Cal and SCHIP.

A separate report on program eligibility will be issued under separate cover by the federal Centers for Medicare and Medicaid Services in 2008.

XIV

GLOSSARY OF ACRONYMS

A&I	Audits and Investigations
ADHC	Adult Day Health Care
ADL	Activities of Daily Living
B&P Code	Business and Professions Code
BIC	Beneficiary Identification Card
CCR	California Code of Regulations
CDHS	California Department of Health Services
CFR	Code of Federal Regulations
CMS	Centers for Medicare and Medicaid Services
CPT	Current Procedural Terminology
DHHS	U. S. Department of Health and Human Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DOJ	Department of Justice
EDS	Electronic Data Systems
FFS	Fee-For-Service
FPACT	Family Planning, Access, Care and Treatment
FQHC	Federally Qualified Health Centers
GERD	Gastro esophageal Reflux Disease
HALT	Health Authority Law Enforcement Team
IEP	Individual Education Plan
IPC	Individual Plan of Care
Lab	Laboratory
LEA	Local Education Agency
MCE	Managed Care Enrollment
MEQC	Medi-Cal Eligibility Quality Control
MMC	Medi-Cal Managed Care
MMEF	Monthly Medi-Cal Eligibility File
MPES	Medical Payment Error Study
OIG	Office of Inspector General
PA	Public Assistance
PEB	Provider Enrollment Branch
PIA	Prison Industry Authority
PRS	Program Review Section of CDHS Medi-Cal Eligibility Branch
RHC	Rural Health Clinic
SCR	Special Claims Review
SNF	Skilled Nursing Facility
SSA	Social Security Administration
SSI	Social Security Income
TAR	Treatment Authorization Request
VSAM	State Medi-Cal eligibility database
W&I Code	Welfare and Institutions Code

XV

DESCRIPTION OF STRATA

There were eight different strata in the MPES 2006. The following list describes the different types of providers that are covered by each stratum. These provider types are covered by the strata even if a claim from a particular provider type was not selected for this year's study. The provider types listed below are the most common providers encountered. Any provider with a Medi-Cal provider number who submits claims to Medi-Cal could be selected for a payment error study.

Dental –

Outpatient dental services

Adult Day Health Care (ADHC) –

Adult Day Health Care centers

Inpatient –

Inpatient acute care hospital

Long term care facilities such as skilled nursing facilities

Durable Medical Equipment (DME) –

Durable medical equipment for outpatient as well as long-term care patients from assistive device and sick room supply dealers and from pharmacies/pharmacists

Laboratory (Lab) –

Outpatient clinical laboratory services testing biological specimens

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

Other Services and Supplies –

Local Education Agency (LEA)

Hospice

Multipurpose Senior Services Program

Ground Medical Transportation

Home Health Agencies

Genetic Disease

Aids Waiver Services

Assistive Device & Sick Room Supply Dealers

Rehabilitation Clinics

Care Coordinator (CCA)

Physician Services –

Individual physicians

Physician groups

Hospital outpatient clinics

Federally Qualified Health Centers

Rural Health Clinics

Individually licensed ambulatory surgery services

Community Clinics

Optometrists

Audiologists

Podiatrists

Psychologists

Physical, speech, occupational therapists

Health Access Program

Other providers rendering outpatient services to Medi-Cal beneficiaries

Pharmacy –

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

APPENDIX A –

Report on the Independent Evaluation of the Departments Anti-Fraud Program

The MPES studies are a valuable tool to assist DHCS in identifying those areas of the Medi-Cal program most at risk for fraud, waste and abuse. These systematic studies help guide the allocation of fraud control resources to ensure that DHCS focuses its fraud control efforts in the most effective and appropriate manner. As such, in response to the MPES 2005 findings, the DHCS arranged for an independent, top-to-bottom evaluation of the Department's anti-fraud program to identify any gaps in its efforts to protect the fiscal integrity of Medi-Cal. This assessment was intended to ensure that DHCS is taking every appropriate action to prevent Medi-Cal fraud and payment error.

In December 2006, Acumen, LLC was chosen as the independent contractor responsible for conducting the top-to-bottom evaluation of Medi-Cal's anti-fraud activities. Implemented from January to June 2007, the evaluation involved dozens of interviews with DHCS officials, an analysis of documents pertaining to Medi-Cal's anti-fraud program, and a review of other states' anti-fraud activities and integrity programs.

Acumen's research of Medicaid integrity programs found that Medi-Cal has dedicated more resources to combating fraud, and as a result, has a more robust anti-fraud program than other states. Tight claims processing, thorough onsite audits, and sanctioning power are a few of Medi-Cal's comparative strengths.

A number of areas have been identified by Acumen as opportunities for improvement. Acumen recommends that DHCS utilize more automation for provider application processes, consider screening treatment authorization requests for fraud and abuse, utilize beneficiary-centric models to flag more suspicious providers, seek efficiencies in the investigation process, expand existing audit tools, consider structural reforms, increase fraud prevention capabilities of the Denti-Cal program and expand the methodologies to measure the total cost effectiveness generated from anti-fraud efforts.

The complete report prepared by Acumen, LLC is attached immediately following this page.

DHCS is currently evaluating each of the opportunities for improvement identified by Acumen for implementation and integration into its' existing anti-fraud efforts.

**Evaluation of the
California Department of Health Care Services
Medi-Cal/Denti-Cal Anti-Fraud Activities**

Acumen, LLC

September 2007

Executive Summary

Because of the cost, size, and complexity of U.S. healthcare delivery, healthcare fraud has been a source of concern for federal and state policymakers for more than a decade. As early as 1992, the General Accounting Office (GAO) estimated potential fraud loss at ten percent of the total healthcare budget.¹ Although grounded in relatively little empirical evidence, this ten percent figure helped spark the first national anti-fraud effort. During his first term, former President Bill Clinton declared healthcare fraud to be the number two priority for the Department of Justice after violent crime, leading to laws and initiatives intended to curb the “one hundred billion dollar problem.”²

The 1992 GAO report was one of the numerous governmental and media reports to cite the California Medi-Cal program among those vulnerable to fraud and abuse, culminating in a *60 Minutes* exposé in 2000. In light of these reports, as well as concerns over rapidly growing Medi-Cal expenditures, California substantially expanded its commitment to address waste and abuse in healthcare. Former Governor Gray Davis established the Medi-Cal Fraud Taskforce, conducted in cooperation with the State Department of Justice, the State Controller, the Federal Bureau of Investigations, and the United States Attorney. With a starting budget of approximately \$23 million, the California Department of Health Services (CDHS) implemented sweeping changes to its anti-fraud organization, designating Audits and Investigations (A&I) as the central coordinating point for all anti-fraud activities.³

As the anti-fraud budget has increased considerably over the years, in 2006, Governor Arnold Schwarzenegger directed CDHS, now known as the Department of Health Care Services (DHCS), to coordinate an independent evaluation of the Department’s anti-fraud initiatives. In December of the same year, Acumen, LLC was chosen as the contractor responsible for conducting the top-to-bottom evaluation of Medi-Cal’s activities to combat fee-for-service provider fraud. To offer an independent analysis of anti-fraud efforts after almost a decade of heightened resources, the evaluation, culminating in this report, seeks to address the following four questions:

1. How have Medi-Cal anti-fraud efforts expanded over time?
2. How do anti-fraud activities in Medi-Cal compare to other states?
3. How can we know if anti-fraud activities are cost effective?
4. What strategies can Medi-Cal implement to strengthen its anti-fraud program?

In response to the first question, the report describes anti-fraud’s recent expansion by dividing activities into three categories: ongoing fraud controls in claims processing, enhancements made to traditional anti-fraud measures, and innovations to detect and stop emerging fraud trends. Among other findings, this review identified two activities that fill gaps noted in previous studies:

¹ GAO Testimony: “Health Insurance – More Resources Needed to Combat Fraud and Abuse” (GAO/T-HRD-92-49), July 28, 1992.

² Malcolm Sparrow, *License to Steal*. Boulder: Westview Press, 1996. Pg. 2.

³ California Department of Health Services, “Description of Medi-Cal Provider Fraud and Abuse Prevention Activities.” Attachment C. February 2004.

- *Implementation of Random Claims Review:* Designed to meet one of the criteria identified for a “model anti-fraud program,” Random Claims Reviews aim to deter fraud by making providers aware that all claims can be subject to greater scrutiny. Begun in 2004, Medical Review Branch (MRB) field offices now review a random sample of 200 claims per week.
- *Publication of annual Medi-Cal Payment Error Studies (MPES):* The third annual Medi-Cal Payment Error Study (MPES) is scheduled for publication shortly. While the most recent MPES was not available for this evaluation, these studies serve as an important tool in estimating the overall level of fraud and in identifying emerging trends in fraud.

To place these Medi-Cal activities in context, we compared anti-fraud activities to those in other large states, including Florida, Ohio, Illinois, and Texas. This comparison shows:

- *The MPES and the Random Claims Review move California beyond other states in the comprehensiveness of its anti-fraud activities.* California also includes a broader range of controls in its provider enrollment and pursues more avenues for data-mining.
- *Relative to the size of their Medicaid programs, Texas and Illinois conduct more on-site audits.* All the comparison states conducted more limited scope or “desk” audits.
- *Only Florida imposed relatively more sanctions than California.* However, the comparison states recovered a larger amount of overpayments as a share of their overall Medicaid budgets. We do not have information on how recoveries compared to detected overpayments by state.

It is difficult to judge the effectiveness of the California anti-fraud programs compared to other states, or over time, in the absence of an established methodology in the Department to determine the cost effectiveness of its activities. Earlier studies have expressed the same concern. Many of the pieces needed to determine cost effectiveness are in place in DHCS, but the most rigorous financial calculations are conducted for the budget forecast and, as such, are not explicitly tailored to determining cost effectiveness. While a simplistic calculation of returns validates the overall cost effectiveness of anti-fraud activities, the calculation is subject to both significant over- and underestimation issues. More importantly, a cost effectiveness framework is needed to guide the additional investments in fraud, determining the specific activities with the highest expected returns on investment.

Through the final section in the report, we identify some additional opportunities for improvement in the anti-fraud program, including:

- *Detect more providers through stronger technical and human resources:* Through increasing internal capacity to data mine and using additional technologies such as beneficiary-centric models, Medi-Cal could improve fraud detection.
- *Improve tracking systems for greater accountability:* To develop cost effectiveness measures for anti-fraud activities and enhance performance, Medi-Cal should improve relevant tracking systems.
- *Enhance MPES methodology, but conduct less frequently:* Although MPES serves as a powerful fraud detection tool, by implementing it less frequently, Medi-Cal can dedicate more time responding to its findings.

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Introduction

Because of the cost, size, and complexity of U.S. healthcare delivery, healthcare fraud has been a source of concern for federal and state policymakers for more than a decade. As early as 1992, the General Accounting Office (GAO) estimated potential fraud loss at ten percent of the total healthcare budget.⁴ Although grounded in relatively little empirical evidence, this ten percent figure helped spark the first national anti-fraud effort. During his first term, former President Bill Clinton declared healthcare fraud to be the number two priority for the Department of Justice after violent crime, leading to laws and initiatives intended to curb the “one hundred billion dollar problem.”⁵ The GAO eventually conceded that “because of the hidden nature of fraudulent and abusive practices...the exact magnitude of the problem cannot be determined.”⁶

The 1992 GAO report was one of a number of governmental and media reports to cite the California Medi-Cal program among those programs vulnerable to fraud and abuse, culminating in a *60 Minutes* exposé in 2000. In light of these reports, as well as concerns over rapidly growing Medi-Cal expenditures, California substantially expanded its commitment to address waste and abuse in healthcare. Former Governor Gray Davis established the Medi-Cal Fraud Taskforce, conducted in cooperation with the State Department of Justice, the State Controller, the Federal Bureau of Investigations, and the United States Attorney. With a starting budget of approximately \$23 million, the California Department of Health Services (CDHS) implemented sweeping changes to its anti-fraud organization, designating Audits and Investigations (A&I) as the central coordinating point for all fraud activities.⁷ Since then, investment in anti-fraud has grown. Between 2000 and 2005, the anti-fraud budget increased from \$22 to \$30 million, distributed among more than two dozen CDHS agencies. Within the same time period, approximately 250 anti-fraud positions were added.

In addition to increasing resources, the California Legislature passed a series of bills to strengthen the state’s ability to address provider fraud in the Medi-Cal program, as shown in Table 1. AB1107, passed in June 1999, clarifies the definition of “fraud” into a workable form for CDHS, the Department of Justice, and the State Controller’s Office.⁸ In doing so, AB1107 offered a foundation on which future pieces of anti-fraud legislation have been based. A year later, AB1098 was passed, increasing criminal penalties for provider fraud and strengthening the requirements for enrolling providers. Passed in 2002, SB1699 gave Medi-Cal authority to suspend providers who are under investigation for fraud and abuse in any CDHS program. SB857 (2004) then placed further controls on the provider enrollment process, establishing a one-year provisional period after which providers would be reassessed before gaining full-

⁴ GAO Testimony: “Health Insurance – More Resources Needed to Combat Fraud and Abuse” (GAO/T-HRD-92-49), July 28, 1992.

⁵ Malcolm Sparrow, *License to Steal*. Boulder: Westview Press, 1996. Pg. 2.

⁶ GAO Testimony: “Health Insurance – Remedies Need to Reduce Losses From Fraud and Abuse” (GAO/T-HRD-93-8), March 8, 1993.

⁷ California Department of Health Services, “Description of Medi-Cal Provider Fraud and Abuse Prevention Activities,” Attachment C. February 2004.

⁸ AB1107 defines “fraud” as “an intentional deception or misrepresentation made by a person with the knowledge that the deception could result in some unauthorized benefit to himself or herself or some other person. It includes any act that constitutes fraud under applicable federal or state law.” This bill also defines “provider” as “any individual, partnership, group, association, corporation, institution, or entity...that has been enrolled in the Medi-Cal program.”

enrollment status. SB857 also gave more sanctioning power to CDHS, while facilitating the recovery of overpayments.

Table 1: Recent Legislation Related to Anti-Fraud

Legislation	Effects on Anti-Fraud
AB1107 (1999)	Tightens legal definitions of “fraud” to improve ability to sanction providers. Allows the Provider Enrollment Division to place moratoriums on the enrollment of specific provider types.
AB1098 (2000)	Increases criminal penalties for provider fraud. Strengthens the requirements for enrolling providers.
SB1699 (2002)	Gives Medi-Cal authority to suspend providers who are under investigation for fraud and abuse in any DHCS program.
SB857 (2004)	Places further controls on the provider enrollment process, establishing a one-year provisional period before full-enrollment status. Facilitates the recovery of overpayments.

Given the expansion in funding as well as new legislative tools to fight fraud, anti-fraud work has been the subject of continued scrutiny. For example, a 2003 report from the State Auditor cited the absence of an overall estimate of the extent of fraud and clear designation of authority for fraud control as two components missing from the Department’s anti-fraud plans.⁹ By 2004, a “report card” on the state’s fee-for-service anti-fraud efforts from the Legislative Analyst’s Office (LAO) described California as having four out of seven features of a “model” anti-fraud program: the adoption of a problem-solving approach; a focus on early detection, including detection of new types of fraud; prepayment fraud controls; and a system that makes all claims potentially subject to audit. The remaining three features were under implementation, including an ongoing commitment to systematic measurement, an allocation of anti-fraud resources to the most serious areas as determined by this measurement, and finally, clear designation of responsibility for fraud control within CDHS in coordination with the California Department of Justice.¹⁰ As recommended by the State Auditor and LAO, the overall estimate of the extent of fraud has been examined in three payment error studies conducted for 2004-2006 by the Department, now known as the California Department of Health Care Services (DHCS).

As the payment error studies address the question of the extent of fraud, Governor Schwarzenegger directed DHCS to also coordinate an independent evaluation of the Department’s anti-fraud initiatives. According to the *2005 Medi-Cal Payment Error Study*, “this assessment is intended to ensure that DHCS is taking every appropriate action to prevent Medi-Cal fraud and payment error.”¹¹ This report represents the core findings from this evaluation. In particular, it seeks to address four key questions:

⁹ California State Auditor, “Department of Health Services: It Needs to Better Plan and Coordinate Its Medi-Cal Antifraud Activities,” (Bureau of State Audits 2003-112), December 2003.

¹⁰ Legislative Analyst’s Office, “Analysis of the 2004 Budget Bill: Improving the State’s Medi-Cal Antifraud Program,” February 18, 2004.

¹¹ California Department of Health Services, “2005 Medi-Cal Payment Error Study,” 2005. Pg. 1.

1. How have Medi-Cal anti-fraud efforts expanded over time?
2. How do anti-fraud activities in Medi-Cal compare to other states?
3. How can we know if anti-fraud activities are cost effective?
4. What strategies can Medi-Cal implement to strengthen its anti-fraud program?

In answering these four questions, we focus solely on fee-for-service provider fraud. The findings draw on information gathered through interviews with dozens of DHCS staff, review of anti-fraud and Medi-Cal/Denti-Cal payments documents, and review of the anti-fraud activities employed in other states. We contacted staff in Ohio, Florida, Texas, New York, Illinois, and at Medicare to investigate their work and conduct a comparative analysis.

Our findings are summarized in four sections that relate to the questions above. In answering the first question, we describe the key features to anti-fraud activities, including ongoing fraud controls in Medi-Cal processes as well as recent innovations. The second section compares Medi-Cal's anti-fraud activities to those of other states, highlighting strengths and weaknesses. Section Three provides a framework for DHCS to measure the cost effectiveness of its anti-fraud work through the discussion of costs, recoveries, and savings associated with anti-fraud efforts. The report ends with strategies that Medi-Cal can employ to generate a higher return on its anti-fraud investments.

1. How Have Medi-Cal's Anti-Fraud Efforts Expanded Over Time?

The additional resources invested in anti-fraud have resulted in a broad-based program that maintains ongoing controls within claims processing, while promoting innovative strategies. To demonstrate anti-fraud's expansion over time, we divide activities into three broad categories:

- Ongoing fraud controls in claims processing
- Enhancements to traditional anti-fraud activities
- Innovations to detect and stop emerging fraud trends

Within each of these sub-sections, we present the key features of the Department of Health Care Services' (DHCS) anti-fraud apparatus and describe their roles in reducing waste and abuse in public healthcare.

A. Ongoing Fraud Controls in Claims Processing

Although not traditionally viewed as anti-fraud activities, controls within the regular flow of service authorization and claims payment play an essential role in the anti-fraud apparatus because they stop improper payments before they happen. Through these controls, Audits and Investigations (A&I) avoids wasting valuable time and resources with simple payment errors and can detect more sophisticated fraud schemes.

Treatment Authorization Requests (TARs) prevent the over-utilization of certain services by requiring that providers prove a procedure's medical necessity. This pre-payment activity targets many expensive inpatient treatments; the majority of procedures do not require TARs. TAR field offices also can interface with the anti-fraud units in DHCS. While they do not have the legal authority to perform audits to verify information in the TAR, field offices can refer suspicious patterns in submitted TARs to the Investigations Branch of A&I.

Edits and audits are one of the most significant parts of the pre-checkwrite anti-fraud process because they prevent most common billing errors. Medi-Cal's fiscal intermediary, Electronic Data System (EDS), uses a claims processing system known as CA-MMIS. A series of automated edits and audits controls fraud by denying the payment of claims with certain billing inconsistencies. Edits and audits are adapted as policies and provider billing behavior change. Denti-Cal also subjects each claim to a series of automated edits and audits, which along with the TAR act as a first line of defense against simple fraud schemes.¹²

B. Enhancements to Traditional Anti-Fraud Activities

In addition to incorporating a stronger anti-fraud component in provider enrollment, Medi-Cal has implemented mechanisms to ensure services are received by legitimate beneficiaries. The auditing process has also been improved to detect and investigate more providers. These enhancements to the anti-fraud structure have resulted in the more effective prevention, detection, investigation, and penalization of fraud.

¹² Denti-Cal is administered separately from the core Medi-Cal program, through the Medi-Cal Dental Services Branch (MDSB) and fiscal intermediary, Delta Dental.

1. *Ensuring that Both Providers and Beneficiaries are Legitimate*

A strict enrollment process stops fraud before services are even billed by preventing certain providers from joining the Medi-Cal program. Medi-Cal's provider enrollment activities are administered by the DHCS Provider Enrollment Division (PED), formally known as the Provider Enrollment Branch, which operates under established guidelines to require proof of applicants' capabilities to render services, conduct thorough background checks, and deny non-compliant applicants. Checks can involve web-based tools that review the applicant's history more thoroughly and unannounced onsite audits that allow Medi-Cal to better assess the provider's practice and billing behavior. A parallel system within Denti-Cal processes approximately 12,000 yearly provider enrollment applications.

Due to recent legislation, PED has the authority to place moratoriums on the enrollment of certain provider types. Moratoriums temporarily prohibit a provider type from applying for enrollment in the Medi-Cal program, thereby giving Medi-Cal the space to investigate fraud schemes, increase standards, and change application procedures for that specific provider type. Legislation has also allowed PED to require the reenrollment of provider types more likely to engage in fraudulent behavior using the newer and more rigorous enrollment process. Currently, PED is reenrolling provider types in waves as to not overwhelm the system. Since 2004, approved applicants within Medi-Cal and Denti-Cal must be placed under provisional provider status for 12 or 18 months. During this time, providers are under greater scrutiny, and if they do not comply with regulations, they are more easily removed from the program.

PED has worked to balance a rigorous enrollment process with the need to quickly process applications. The challenge of implementing an efficient and timely review process was highlighted in 2004, when the California Performance Review published "Medi-Cal Fraud Detection Misses the Mark," questioning the effectiveness of additional requirements and criticizing the sizable backlog of provider applications.¹³ At one point, PED had a backlog of 15,000 applications to process. In response to this and provider association complaints that the prolonged enrollment process jeopardized beneficiaries' access to care, PED streamlined the review process and cut several unnecessary steps. Applicants may now apply for preferred enrollment status, which cuts processing time in half. Rendering physicians also do not have to reapply for separate provider numbers when joining new locations, reducing the number of applications and allowing analysts to track particular providers more carefully. Finally, to ensure that enough providers are rendering services in particular clinical or geographic areas, PED has allowed exemptions to moratoriums.¹⁴

Despite progress, there still remain trouble spots that PED seeks to remedy. According to the *2007 State Auditor Report*, preferred provider status is not effective due to the low number of applicants who take advantage of its benefits. The PED tracking system was also criticized for not allowing analysts to accurately monitor referred cases and reasons for denial. Furthermore, the report states that mistakes are made within the review process, and too many applications are not processed within a timely manner. Since the publication of the report, PED has remedied some of these issues. For example, the Legislature now mandates that applications are processed

¹³ California Performance Review, "Medi-Cal Fraud Detection Misses the Mark," accessed at: <http://cpr.ca.gov/report/cprprt/issrec/hhs/hhs31.htm#2b>, 2004.

¹⁴ At the time this report was published, the provider types placed on moratoriums were: Adult Day Health Centers, Clinical Laboratories, Durable Medical Equipment (DME), and Non-Chain Non-Pharmacist Owned Los Angeles County Pharmacy Providers.

within 180 or 90 days, depending on the provider status. We found that less than one percent of applications exceed this time limit. Furthermore, PED has since implemented an extra layer of review to reduce error.

Just as providers must prove their capability to render legitimate services, recipients of these services should also be valid Medi-Cal beneficiaries. To address this issue, Medi-Cal is continuously improving upon processes to prevent providers from billing for procedures on non-eligible or non-existent patients. In the past, fraudulent providers stole Social Security Numbers and billed Medi-Cal for services never rendered. To address this form of beneficiary identification theft, Medi-Cal removed Social Security Numbers from the Beneficiary Identification Cards and re-issued over six million cards statewide with a new 14-digit identification number.

Medi-Cal has also uncovered numerous providers who have attempted to use fake beneficiary numbers to bill Medi-Cal. By submitting hundreds of automated requests, providers hope to guess valid beneficiary numbers. In response, Medi-Cal began generating monthly reports detailing the number of eligibility requests submitted and the number of requests that receive an eligible response or an ineligible response. These reports help Medi-Cal flag suspicious providers. Furthermore, an extra layer of user identification will be added to the Medi-Cal website to ensure that there is human interaction when eligibility requests are submitted.

2. Thorough Provider Investigations and Penalization Result in Savings

Both Medi-Cal and Denti-Cal operate sophisticated processes to flag suspicious providers, conduct thorough investigations, and penalize fraud. These post-payment investigations often lead to savings for the state as a result of reduced billing or recoveries of overpayments. In 1999, the Medical Review Branch (MRB), within A&I, began implementing the Field Audit Review, which has become Medi-Cal's most significant audit activity, consuming more time and staff resources than any other audit. In 2006 alone, MRB dedicated 46,692 staff hours to approximately 400 of these audits. The Field Audit Review combines three distinct disciplines – statistics, medicine, and auditing – to identify suspicious providers and subject them to on-site, unannounced reviews. Through claims data-mining efforts, MRB, with EDS' support, identifies providers with abnormal billing profiles. After cases are developed, field office auditing and medical staff visit the provider's site unannounced and perform an audit on a predetermined subset of beneficiary medical records. Auditors often simultaneously educate the provider on billing errors, such as an overused procedure code. Field audits are effective because providers do not have the time to prepare for the visit, possibly tampering with medical documentation and invoices.

When auditors find evidence of suspicious activity, MRB usually places one or more administrative sanctions on the provider. These administrative sanctions have been effective in generating savings because as a result, providers curb fraudulent behavior. Savings are measured annually to evaluate the impact of different sanction types and adjust future Medi-Cal budgets accordingly. In addition to sanctions, MRB may recommend an Audit for Recovery, which determines the amount of money the provider owes the state. Through the review of a statistically representative sample of claims, MRB can identify errors and extrapolate the total amount overpaid to the provider. Third Party Liability within DHCS is then responsible for collecting these overpayments from the provider either through withholding future payments or seizing assets.

When MRB finds it necessary to pursue criminal charges against a provider, the Investigations Branch, also within A&I, is typically called upon to serve as the central point of coordination between the Department of Justice, the Bureau of Medi-Cal Fraud, the Federal Bureau of Investigation, and A&I. While the Branch, made up primarily of peace officers, investigates approximately 500 providers each year, beneficiary fraud, which falls outside the scope of this report, is its primary focus. In terms of provider fraud, the Branch targets issues not easily identified by suspicious billing patterns, such as quality of care. Many of its referrals come from the fraud 1-800 number and other outside sources. The Investigations Branch thus adds a different and valuable perspective to Medi-Cal anti-fraud efforts.

To detect fraudulent providers, Denti-Cal primarily relies on the Surveillance and Utilization Review Subsystem (SURS), administered by its fiscal intermediary, Delta Dental. The SURS System monitors the billing activity of Denti-Cal's providers with a variety of reports and tools. Delta Dental is generally involved in the detection of provider suspects and implementation of some provider sanctions, while Medi-Cal Dental Services Branch (MDSB) primarily handles follow-up investigations with providers. After a suspicious provider is flagged and reviewed, follow-up activities usually encompass one of the following:

- The audit queue, where providers are placed in line for a field audit by Delta Dental
- A board referral, where the Dental Board is informed of the provider's activities to determine if a provider should have his/her license revoked
- The Prior Authorization utilization control, where Delta Dental must authorize each procedure before a provider submits a claim
- The Special Claims Review utilization control, which requires providers to submit supporting documentation with claims
- A clarification letter sent with the purpose of educating the provider or clarifying billing policy
- Referral to the state where either the Investigations Branch and/or the Department of Justice pursue the case

C. Innovations that Detect and Stop Emerging Fraud Trends

As the more obvious fraudulent providers were removed from the program in the early 2000s, Medi-Cal is consistently developing new programs to detect and tackle emerging fraud schemes.

1. Random Claims Reviews and Self-Audits Expand MRB's Repertoire of Audits

One of the biggest changes in the Medi-Cal anti-fraud activities has been the institution of Random Claims Review. Designed to meet one of the criteria identified for a "model anti-fraud program," Random Claims Reviews aim to deter fraud by making providers aware that all claims can be subject to greater scrutiny. In 2004, MRB field offices began reviewing a random sample of 100 weekly claims, which have since increased to 200 claims per week. When a claim is selected, payment is held while the auditor requests more information from the provider. If the suspicious claim is suspected to be an indicator of a more systemic problem, like-providers may also be examined, possibly triggering a policy change.

Although a smaller program, self-audits have been introduced as a low cost investigative tool that has led to millions of dollars in recoveries. Starting in late 2005, MRB began requiring

that certain providers conduct self-audits to correct inappropriate billing behavior and make reimbursements to Medi-Cal. A recent example pertains to prescription drugs. When the drug reimbursement rate at nursing homes increased in relation to pharmacies, the number of nursing home prescriptions shot up. Therefore, MRB requested self-audits of 56 providers. Providers who recognized their errors sent Medi-Cal over \$700,000 in a four-month period. Self-audits and voluntary reimbursement for payment require few resources compared to an onsite audit, which typically costs between \$10,000 and \$20,000. Furthermore, self-audits help Medi-Cal maintain a positive relationship with the medical community. Because they are less disruptive to providers than onsite visits from MRB auditors, self audits are less likely to hamper provider practices and compel them to leave the program.

2. The Medi-Cal Payment Error Study (MPES) and Special Projects Reduce New Fraud Schemes

Although developed to measure the extent of payment error in the Medi-Cal system, the yearly Medi-Cal Payment Error Study (MPES) plays an important role in detecting emerging fraud schemes. Reports estimating payment levels of erroneous claims have been published in 2004 and 2005 and will soon be published in 2006. By reviewing the medical documentation behind a stratified random sample of claims, MPES auditors are able to identify different types of claim errors and variation among provider types and locations. Ultimately, MPES gives A&I the ability to recognize problems as they arise and shift priorities to curb new trends in fraud.

To tackle emerging fraud schemes or investigate specific fraud issues more thoroughly, A&I has initiated a number of special projects. While MPES provides breadth through a survey of all provider types, special projects provide depth once a specific provider type has been identified as having widespread issues of fraud. Three special projects have stood out in particular: the Pharmacy Outreach Program, the Adult Day Health Center (ADHC) project, and the Hospice Care project.

The Pharmacy Outreach Program stemmed from the 2004 and 2005 MPES, which demonstrated high rates of payment errors in pharmacies. A&I partnered with the pharmacy community and the Board of Pharmacy to visit 2,000 pharmacies, review their medical documentation, and provide education to improve billing practices. Although the program included a strong review element, A&I did not take punitive action against non-compliant providers. This project was met positively by the pharmacy provider community, largely because of MRB's approach of providing education without the threat of sanction. Results of this special project should be published shortly.

ADHCs became a major focus of Medi-Cal anti-fraud efforts when the 2005 MPES revealed that 62% of ADHC claims had a payment error. In particular, ADHCs tended to overstate patients' level of illness, charge higher rates, and have insufficient medical documentation. In 2005 and 2006, A&I audited many ADHC providers, which also lead to the identification of low quality of care. As a result, the majority of ADHCs audited received administrative sanctions and utilization controls. Strategies have emerged from this project to improve overall ADHC Medi-Cal billing compliance, including the development and implementation of a two-day training for ADHC staff. Furthermore, SB1755 was recently passed to decrease opportunities for fraud and abuse by modifying the eligibility criteria for ADHCs and by requiring DHCS to establish a cost-based reimbursement system by August 2010.

The Hospice Care project began in 2005 when MRB detected a rapid increase in payments made to hospice providers. Hospices present a significant fraud threat because of the growing number of providers and the difficulty of placing a timeline on illness and death. In many cases, providers code for hospice care when in actuality they are providing normal home healthcare services. The MRB San Diego field office led the initiative to curb over-utilization by analyzing a non-profit San Diego hospital with a reputation for quality care and reasonable lengths of hospice services. This analysis created benchmarks for service provision and the certification and re-certification of patients. The San Diego office was able to train other MRB offices on proper audit procedures and hospice standards. Since then, field offices have conducted reviews on hospice providers with excessive lengths of stay and placed many providers on sanctions. As a result, Medi-Cal payments to hospice providers have decreased significantly in recent years.

D. Summary of Activities and Their Roles in Anti-Fraud

Each of the mechanisms described above plays a crucial role in anti-fraud, either through prevention, detection, investigation, or penalization. Through the following table, we present each activity’s primary role in the anti-fraud apparatus and the agencies that collaborate with these efforts. The need for better coordination among these actors was highlighted in the 2003 State Auditor’s report. However, over the years, partnerships have gradually been strengthened, leading to a more comprehensive program.

Table 2: Summary of Activities and Their Role in Anti-Fraud

Organization(s)	Anti-Fraud Activities	Prevention	Detection	Investigation	Corrections	Recoveries
PED, A&I	Provider Enrollment	●				
TAR Offices	Treatment Authorization Requests	●				
EDS, Payments Division	Edits and Audits	●				
A&I Field Offices	Random Claims Review	●				
Payments Division	Beneficiary Identification Theft	●	●			
EDS w/A&I Research	Data-Mining		●			
A&I, A&I Research	Medi-Cal Payment Error Study		●			
A&I Field Offices	Field Audit Reviews		●	●	●	
A&I	Self-Audits			●		●
A&I, Third Party Liability	Audits for Recovery			●	●	●
A&I, A&I Research	Special Projects			●	●	●

2. How Do Anti-Fraud Activities in Medi-Cal Compare to Other States?

Perhaps the best way to understand the scope of California's anti-fraud efforts is by comparison to other states. We conducted document review as well as a mixed mode (telephone/paper) survey with anti-fraud staff in four comparison states: Florida, Texas, Ohio and Illinois.¹⁵ In this section, we review the breadth of anti-fraud activities and the number of audits and sanctions relative to the size of the states' Medicaid budgets. Although in absolute terms, California exceeds other states in most categories, when accounting for Medi-Cal's larger budget, findings are adjusted.

A. *Breadth of Anti-Fraud Activities*

Table 3 presents an overview of the breadth of anti-fraud activities reported in our comparison states and in California.

Provider Enrollment: Medi-Cal tends to have more thorough background checks in provider enrollment than the Medicaid programs in the comparison states. Although all states have similar requirements for provider applicants, strategies to verify information vary. Whereas provider enrollment agencies tend to check medical licenses online, they generally do not systematically call provider phone numbers or reenroll vulnerable provider groups. One strategy not implemented in California, however, is a criminal background check. Texas conducted over 10,000 criminal history checks in 2006, and Illinois reviews the criminal history of all nonemergency transportation applicants (who tend to be more susceptible to fraud). Although some states conduct onsite reviews or "surveys" for suspicious providers, we found that these reviews are not as common as in Medi-Cal. Florida was an exception. With a Medicaid budget about half the size of that of California, Florida conducted over 900 site visits to provider applicants in 2006. In the same year, Medi-Cal conducted approximately 500.¹⁶ PED is ahead of the game in terms of the automation of application forms. PED is initiating an effort to move its application process online, whereas all other states continue to request paper submissions. As soon as PED gets this system up and running, analysts will make fewer errors inputting information into its tracking system and avoid time wasted on incomplete applications.

Beneficiary Identification Theft in Provider Fraud: California has implemented important programs to reduce beneficiary identification theft. However, there are even tighter eligibility request regulations in Medicare, where providers must submit at least 80 claims for every 100 eligibility requests. This standard exceeds that of Medi-Cal, which does not yet have a strategy to block the use of automated computer programs to submit thousands of transactions in search of valid beneficiary numbers. Both Ohio and Florida use a different fraud control, through which billed procedures are verified with beneficiaries.¹⁷ Every month, Ohio sends letters to 6,000 randomly selected recipients with descriptions of the procedures billed for them. If a beneficiary did not receive the services, a further investigation is conducted. As very few beneficiaries respond to these letters, this strategy does not generate many referrals. Florida implements a similar program on a larger scale, sending letters to approximating 800,000 beneficiaries each quarter. Beneficiary verification might complement Medi-Cal's current activities by triggering referrals and making beneficiaries more aware of anti-fraud efforts.

¹⁵ New York State declined to participate because it is in the midst of its own evaluation of anti-fraud efforts. Staff from New York will share the results with California on publication in October.

¹⁶ Illinois conducts site visits for all DME and nonemergency transportation applicants.

¹⁷ Medi-Cal does this on a smaller scale with its Beneficiary Feedback Letters.

Claims Processing: All of the comparison states require prior authorization for some services – certain prescription drugs, hospital stays, and nonemergency transportation. States also have similar edits and audits policies, updating claims processing systems as needed. Although anti-fraud actors acknowledge the importance of edits and audits in stopping the most common billing errors, they recognize their limitations in combating fraud. Some states expressed frustration in systems that let common errors through, requiring anti-fraud resources to be channeled toward collecting these overpayments. This occurrence was viewed as rare in Medi-Cal, as its edits and audits system is relatively comprehensive.

Table 3: Overview of Anti-Fraud Efforts in California versus Other States

Anti-Fraud Activity	California	Florida	Texas	Ohio	Illinois
1. Automated Provider Enrollment Application	In Process				
2. Background Checks on All Provider Applications					
a. Call provider	●	●			
b. Review licenses online	●	●	●	●	●
c. Review of past applications	●	●			●
3. More Thorough Checks on Suspicious Providers					
a. Web search of name	●	●			●
b. Review of billing history	●	●			●
c. Onsite audit	●	●	●		●
d. Criminal background checks			●		●
4. Mechanisms to Reduce Beneficiary ID Theft	●	●		●	
5. Treatment Authorization Request					
a. Hospital stays	●	●	●	●	
b. Other procedures	●		●	●	●
6. Evolving Edits and Audits	●	●	●	●	●
7. Data-mining					
a. Abnormal provider billing	●	●	●	●	●
b. Beneficiary-centric models					
c. Claim risk scores	●		●		
d. Ad hoc reports	●	●	●	●	●
8. Random Claims Reviews	●				
9. Education within Anti-Fraud	●		●		●

We found that states use similar mechanisms to disseminate information about changes in code, legislation, and billing procedures to prevent error. All states have 1-800 numbers, through which automated information is provided and service agents can be contacted.¹⁸ Furthermore, provider bulletins and up-to-date websites serve as important portals of information for Medicaid programs.

Data-Mining: For all of these states, data-mining involves comparing provider peer groups to assess abnormal billing behavior, such as a sharp increase in billing or overuse of a certain procedure code. Once these providers have been flagged, analysts then conduct ad hoc reports to give depth to standard reports. Texas and California are the only evaluated states that have slightly more sophisticated methods by using techniques that assign risk scores to individual claims. In 2005, this additional tool was implemented in Medi-Cal with Fair Isaac technology, provided through a subcontract with EDS. Although Fair Isaac and other vendors offer the beneficiary-centric models – which account for provider services inconsistent with the expected patterns of given beneficiaries – none of the states incorporate these techniques.¹⁹

Random Claims Review: Medi-Cal has a unique program through which a random selection of pre-payment claims is reviewed weekly to deter fraud and identify new schemes. Although other states audit some randomly selected providers whose billing behavior does not indicate fraud, this practice is often not prioritized due to focus on higher risk targets.

Provider Education: In California, A&I has shifted some of its activities toward provider education, based on the observation that many billing errors stem from providers' lack of knowledge on proper procedure, not fraud. Although providers have access to information on websites and can order hard copies of billing manuals, attend face-to-face trainings, and request onsite support, providers continue to miscode procedures, misinterpret medical necessity, and inadequately retain medical documentation. Therefore, provider education and outreach could be effective activities for anti-fraud field staff. However, we found that other states seldom combine outreach and education with fraud oversight. Because many anti-fraud efforts are conducted by a state's Office of Inspector General, or similar oversight agency, we found little evidence of educational activities directly implemented by anti-fraud actors. One exception was Texas, where the Texas Office of Inspector General expressed concern over its new responsibility to conduct provider educational activities: "Concerns about the inherent conflicts that exist between (Medicaid Integrity Program) MIP's duties of exercising oversight and providing technical assistance have been raised in consultations with interested parties."²⁰ To address this issue, Texas Medicaid plans to assign staff from different geographic areas to conduct reviews. Under the same logic, Ohio moved oversight, audit, and recovery activities away from provider education to ensure greater enforcement power. Illinois plays a small role in provider education. When a vulnerable billing area has been detected, clarification letters are sent to all providers to remind them of proper policy. Although outreach and educational activities hold significant potential, Medi-Cal may want to review whether such activities should be managed by other entities within DHCS (perhaps after piloting with A&I), particularly since A&I could be perceived as sending mixed messages if it undertakes both educational and punitive endeavors.

¹⁸ Whereas the Texas phone system provides information on provider enrollment, the Medi-Cal system does not.

¹⁹ Beneficiary-centric models and claim risk scores are currently being incorporated in the new Predictive Modeling System within Illinois Medicaid.

²⁰ Texas Office of Inspector General, Semi Annual Report, accessed at: <https://oig.hhsc.state.tx.us/Reports/reports.aspx>, September 2006.

B. Use and Impact of Audits and Sanctions

All of the states we interviewed conducted a range of audits, imposed sanctions, and sought payment recovery. The first column of Table 4 shows how frequently these activities are done in California. The remaining columns show whether such activities are more common relative to the size of the Medicaid budget in other states, that is, whether the number of audits or the value of payments is greater than in California (>CA) or less than in California (<CA). We adjust for Medi-Cal's size by multiplying a state's indicator (e.g. number of audits) by the ratio of Medi-Cal's budget to the respective state's budget. The final four rows focus on analyses of the overall magnitude of errors and the savings generated and ultimate cost effectiveness of anti-fraud activities.

Table 4: Magnitude of Anti-Fraud Audits and Sanctions in California versus Other States

	California	Florida	Texas	Ohio	Illinois
Budget (billions)	\$34	\$16	\$19	\$13	\$15
1. Number of Onsite Audits	900	< CA	> CA	< CA	> CA
2. Number of Limited Scope Review (Desk Audits)	*	> CA	> CA	> CA	> CA
3. Number of Self-Audits	120	< CA	< CA	< CA	< CA
4. Number of Sanctions	1,200	> CA	= CA	< CA	< CA
5. Amount Recovered (millions)	\$30**	> CA	> CA	= CA	> CA
6. Annual Payment Error Study	●				
7. Error Rate	3.6% (2004) 8.4% (2005) 7.3% (2006)				3.3% (2005)
8. Special Projects That Target Vulnerable Areas	Pharmacy ADHC Hospice	Pharmacy Residential Health Care Facilities	Outpatient Rehabilitation Facilities		Nonemergency Transportation DME
9. Calculates Savings	●	●	●		●
10. Calculates Cost Effectiveness		●			●

> CA = Greater than Medi-Cal; < CA = Less than Medi-Cal

* Although we were not able to obtain exact numbers, interviewees indicated that limited scope reviews are not a formalized process within Medi-Cal.

** This figure represents the actual recoveries made by Third Party Liability and is therefore, an underestimation. Before Third Party Liability receives a recovery case, EDS withholds payments from the provider. The amount of EDS "offsets," which was not obtainable for this evaluation, should be included for a more accurate number.

Full Scope, Limited Scope, and Random Claims Reviews: Self-audits are new to California; however, Medi-Cal implements relatively more of them than other states.²¹ Although the onsite audit is rare in some Medicaid programs due to lack of resources, larger states tend to use this anti-fraud measure as frequently, or relatively more often, than Medi-Cal. Limited scope reviews are significantly more common outside of California, which indicates that Medi-Cal

²¹ The Pennsylvania Medicaid program also has an ample self-audit process. For more information on Pennsylvania's self-audit protocol, see: <http://www.dpw.state.pa.us/business/fraudabuse/003670226.htm>.

could benefit from formalizing and expanding this program. The majority of MRB investigations involve a full-scope review, usually a Field Audit Review. These onsite reviews offer a number of benefits: they are unannounced and thorough, allowing auditors to observe an accurate slice of the provider's practice. However, limited scope reviews are less expensive and time-consuming, as they require providers to mail or fax the documentation to field offices or headquarters.

Provider and beneficiary feedback letters, which warn providers and beneficiaries that inappropriate billing behavior has been flagged and that they are now under greater scrutiny, are also more common in other Medicaid programs. DHCS has conducted evaluations of four feedback letter initiatives; only one was estimated to generate statistically significant savings. To improve feedback letter impact, MRB may consider requiring providers to sign acknowledgement forms, thereby offering proof that providers are aware of correct billing procedures and facilitating harsher penalties in the future.

Sanctions: There was wide variation in the reported frequency of sanctions across states. Although its overall sanction rate is on par with Medi-Cal, Texas notably uses more Civil Money Penalties than California. Staff members within A&I have expressed frustration with the underutilization of this sanction, which demands the recovery of three times the amount of overpayments. Legislation allows A&I to impose this sanction on providers after a third offense. However, according to different staff members within A&I, Civil Money Penalties have not been applied effectively for various reasons. Some staff state that not enough time has elapsed for many providers to commit the same offense three times. Others state that there is confusion regarding the definition of third offense. For example, it is unclear if providers must up-code the same procedure three times to receive the penalty, or if up-coding in general warrants the sanction. A&I should clarify these issues and use the penalty more effectively because it provides a strong financial deterrent to fraud.

Recoveries: Despite the fact that Medi-Cal is significantly larger than the other programs in terms of beneficiaries and budget, DHCS tends to collect a similar amount of fraud-related overpayments in absolute terms than do the other states we surveyed.²² As a result, recoveries are lower in California relative to the Medicaid budget. As noted in Table 4, the Medi-Cal recovery figure is an underestimation because it does not include provider payments withheld by EDS. However, it is not likely that this additional amount would be significant enough for Medi-Cal to collect more fraud-related overpayments than other states relative to its budget. We do not have detailed information on the rate of actual recoveries compared to recoveries sought across the comparison states.

Error Rate Studies and Special Projects: Although many states are participating in the national program, Payment Error Rate Measurement (PERM), Medi-Cal is unique in systematically measuring the extent of fraud in the program. Illinois, however, did implement a project similar to MPES in 2005. Through the Random Claims Sampling project, analysts in Illinois reviewed the medical necessity behind 420 claims. High risk services were excluded from the study to expose new schemes that were not as well understood. Although annual payment error studies are not common, all states including California design and implement projects that target particularly vulnerable areas, such as home healthcare services, prescription drugs, and nonemergency transport.

²² Medi-Cal collects a significant amount of overpayments made to institutional providers. Because these payments are related to rate changes, and not fraud, we did not include them in our analysis.

Financial Impact: Many states measure the financial impact of anti-fraud efforts by tracking recoveries and reviewing provider billing before and after the implementation of utilization controls and administrative sanctions. This latter concept is often referred to as cost avoidance, as sanctions stop payments that the provider would have collected had previous billing continued. Because methodologies and terms are quite different, it is impossible to compare findings and hence, financial impact of anti-fraud efforts. Florida and Illinois are the only states reviewed that officially measures return on investment by incorporating cost into its savings calculations. MRB conducts this type of analysis, but numbers are not official. Illinois also conducts cost effectiveness analyses for particular anti-fraud activities related to beneficiary fraud.

C. Dental Services

Dental services were not included in our Medicaid comparative analysis. However, by evaluating Denti-Cal along with Medi-Cal, we found that Denti-Cal tends to have less sanctioning power. After being flagged by Delta Dental and investigated by A&I, fraudulent providers are removed from the program under the authority of A&I and/or the Department of Justice. However, when non-compliant billing is less severe, Denti-Cal places the provider on utilization controls. After nine months, the provider is reviewed and the controls are either extended or lifted. If provider billing does not provide enough evidence of corrected behavior (e.g. the provider stops billing the vulnerable procedure altogether), the utilization control continues. As a result, some providers can be on utilization controls for years. Consistent with Medi-Cal, Denti-Cal should consider promoting a regulation that allows it to remove providers who are being consistently sanctioned without improvement. Currently, Denti-Cal can only suspend a provider if they stop billing or cannot be found (i.e. address change). By giving MDSB more authority to directly remove providers, Denti-Cal could more efficiently weed out the most costly providers who require extensive monitoring.

3. How Can We Know if Anti-Fraud Activities Are Cost Effective?

Both the 2003 State Auditor’s report and the 2004 LAO analysis noted that Medi-Cal does not track the cost effectiveness of its activities. This is still true today. While the payment error rate study helps identify key issues for anti-fraud focus, it alone is not sufficient to determine the best allocation of resources. Many of the elements necessary for a cost effectiveness analysis are in place, but Medi-Cal does not systematically conduct this type of evaluation for its anti-fraud activities. For example, DHCS does estimate the savings that result from sanctions, but these calculations are used for forecasting overall Medi-Cal expenditures, and to a lesser extent, to determine incentive payments for contractors. The methods used for budget forecasting and contractor payments are not only tailored to these specific purposes, but also somewhat different for each setting.

Thus, the ability to identify which anti-fraud activities pay for themselves – achieving savings in excess of their costs – remains a central policy challenge for the Medi-Cal program. In this section, we review a basic framework for cost effectiveness analysis, as well as gaps in the existing information needed to construct a measure of cost effectiveness.

A. *Understanding the Components of a Cost Effectiveness Measure*

Conceptually, an anti-fraud program can be thought of as an investment. An agency spends money now to implement activities that detect and correct fraudulent billing. Depending on the success of these efforts, the state earns benefits from this investment now and into the future in the form of lower and more accurate billings. The value of the return on the investment determines the cost effectiveness of the program. At the most basic level, a return on an activity is computed as follows:

$$\begin{aligned} \text{Cost} &= \text{annual cost of providing the designated activity;} \\ (1) \quad \text{Savings} &= \text{total savings received in current and future years attributable to activity;} \\ \text{Return} &= \text{Savings} / \text{Cost}. \end{aligned}$$

Whereas measuring Costs can be quite straightforward, there are substantial challenges in measuring the Savings attained through anti-fraud investments. There are three principal sources of reduced Medi-Cal expenditures, or Savings, that can be attributed to anti-fraud activities:

Corrected-Practice Savings (CPS) = savings from correcting non-compliant billing with sanctions or utilization controls;

Direct Recoveries (DR) = reimbursements to DHCS received from overpaid providers; and

Deterrence Savings (DS) = savings achieved by deterring providers from engaging in fraud.

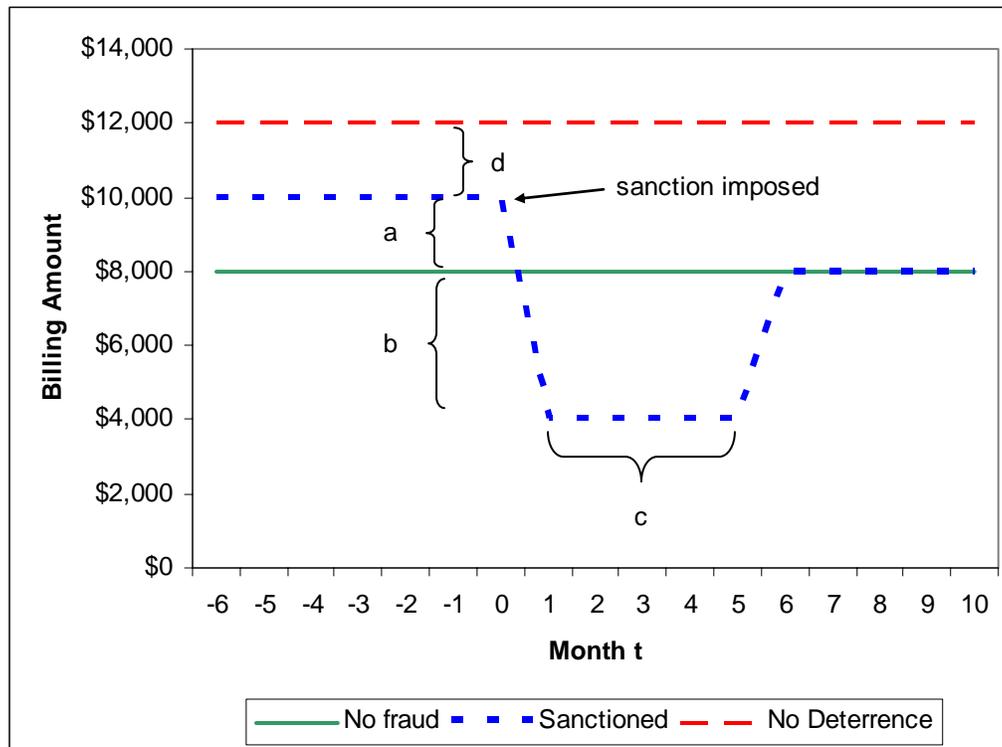
Total savings is the sum of these three sources:

$$(2) \quad \text{Savings} = \text{CPS} + \text{DR} + \text{DS}.$$

The three types of savings listed above can be demonstrated by three example providers, whose billing behavior is depicted by the three lines in Figure 1. One is a non-fraudulent provider who bills properly (labeled “no fraud”). The second provider (labeled “sanctioned”) bills fraudulently until being sanctioned in month 0; is sanctioned from month 0 to month 5; and then bills properly after month 5. The third is a non-deterred provider (labeled “no deterrence”),

who operates in an environment with no deterrence and fraudulently bills with little risk of being discovered and punished.

Figure 1: Billing Profiles of Three Prototypical Providers



Imagine that all three providers start with the same level of real medical services. The non-fraudulent provider bills these services at \$8,000 per month. A counterpart provider starts by improperly billing \$10,000 per month for the \$8,000 in services, which results in a utilization control. If some of the services affected by this sanction were valid, the decline in billing may be greater than the level of fraud. In other words, to abide by the restrictions dictated by the sanction, this provider decreases claims submissions to \$4,000 per month; this decline corresponds to the amount $\$a + \b in the figure. After 6 months – measured by c in the figure – the sanction is removed and the provider is then presumed to bill properly. Under this scenario, the sanctioned provider raises billing to levels equaling those of the non-fraudulent provider; this increase equals the amount $\$b$ in the figure.

To demonstrate the deterrence effect of anti-fraud activities, the figure shows the fraudulent provider practicing in an environment with little likelihood of punishment for inappropriate billing. With less risk of a sanction, this provider commits more fraud than in a setting where the state penalizes improper behavior. To reflect this response, the figure shows this non-deterred provider billing at \$12,000 per month, which is $\$d$ more than the same provider would bill when improper behavior carries threat of sanction penalties.

The three categories of savings earned from anti-fraud activities can be simply described using the information in Figure 1. For each month that a sanction has an impact, that month's Corrected Practice Savings (CPS) corresponds to $\$a$ in the figure. The potential for Direct Recoveries (DR) is the overcharge amount, $\$a$, for the pre-sanction months where the fraudulent billing occurred. Finally, $\$d$ in the figure measures Deterrence Savings (DS), since this quantity

captures how much less billing occurs each month when fraudulent providers are deterred from inappropriate billing due to fear of discovery through the state’s monitoring activities.

B. Estimating Return on Investment Using DHCS Data

DHCS does not attempt to measure DS. However, it does conduct some calculations of the DR, CPS, and Costs. Although the Department’s information is not sufficient to develop a reliable measure of return, we can use the existing information to indicate how such a measure would be developed. In this section, we review what we know of savings from DHCS estimates and then turn to costs. Finally, we present what this information suggests about returns.

1. Direct Recoveries

DR refers to the amount a provider repays Medi-Cal after billing for services never rendered or provided at a lower value. The method to calculate DR simply requires tallying up all recoveries made during a current fiscal year. However, we must isolate payments that can be directly linked to activities implemented by DHCS. This allows us to present a more accurate picture of the fiscal impact of Medi-Cal’s anti-fraud work. In Table 5, we provide a breakdown of recoveries from provider fraud cases by source.²³ We have divided these recoveries into two categories: those directly related to DHCS activities and those referred from outside sources. For example, the jump in total recoveries in FY 2005/2006 is a result of overpayments recovered through federal anti-fraud activities. As we will see below, FY 2004/2005 is the period for which we have the most complete information to conduct a return on investment calculation. In FY 2004/2005, there were \$11.4 million in DR attributable to DHCS activities; this number is highlighted in Table 5.

Table 5: Total Money Recovered by Source

Source	FY 03/04	FY 04/05	FY 05/06
<i>Directly Related to DHCS Activities</i>			
Criminal Restitution (50/50)	\$2,106,390	\$1,540,674	\$18,787,433
MRB Administrative	\$598,822	\$193,213	\$126,535
Audit MRB	\$3,617,027	\$6,998,127	\$6,161,175
Audit MRB Pharmacy	\$112,391	\$0	\$0
Investigations Branch	\$704,698	\$572,641	\$405,205
Other Coverage	\$235,685	\$1,719,453	\$1,173,267
Audit Adult Day Health Care	\$334,941	\$377,552	\$525,158
Dental Restitution	\$0	\$0	0
Sub-Total	\$7,709,954	\$11,401,660	\$27,178,773
<i>Not Related to DHCS Activities</i>			
	\$16,497,854	\$9,710,356	\$59,408,223
Total	\$24,207,808	\$21,112,016	\$86,586,996

²³ Recoveries related to beneficiary fraud have been removed from the table, however, due to Third Party Liability’s current tracking system, we have not been able to separate managed care recoveries.

Third Party Liability recovers a small portion of money owed from all non-institutional Medi-Cal provider overpayments.²⁴ In FY 2005/2006, whereas A&I demanded over \$70 million in fraud-related cases,²⁵ Third Party Liability recovered \$11 million.²⁶ Although funds recovered through EDS payment withholds are not included in the Third Party Liability figure, this information provides insight on general recovery rates. Full fraud-related recoveries are rare for several reasons. First, providers are able to reduce the amounts owed through appeals and negotiations. Second, the longer cases are open, the more likely it is that the providers either disappear or transfer their assets away from their businesses.

Unlike in Medi-Cal, Third Party Liability is not the entity responsible for recouping Denti-Cal overpayments. Between July and March of FY 2006/2007, Third Party Liability had only recovered \$11,000 for improperly paid dental services. Delta Dental, on the other hand, recovered \$2,939,354 in FY 2006/2007. According to Denti-Cal, annual recoveries tend to fall around this \$3 million figure.

2. Corrected Practice Savings

To calculate CPS for fiscal forecasting, DHCS reviews a sanctioned provider's claims data and compares billing behavior before and after the sanction. The monthly average difference between these two periods is annualized to estimate total yearly savings. The most recent estimates of CPS are for FY 2003/2004 and FY 2004/2005, due to lags inherent in waiting a sufficient period after sanctions are applied. In tracking savings, DHCS distinguishes by the types of sanctions applied to providers. As shown in Table 6, the estimated total savings from sanctions in FY 2004/2005 was \$131 million.

**Table 6: Annualized Cost Savings for Sanctions
Performed in FY 03/04 and FY 04/05**

Sanctions	FY 03/04	FY 04/05	FY 05/06
<i>Full</i>			
Denied Reenrollments	\$9,863,736	\$8,798,000	
Withholds	\$26,390,920	\$11,648,000	Not Yet
Temporary Suspensions	\$18,847,471	++	Calculated
Deactivations	**	\$13,432,000	
<i>Partial</i>			
Audits for Recovery	\$46,410,025	\$12,226,000	Not Yet
Special Claims Review and Provider Prior Authorization ^{††}	\$74,494,235	\$53,057,000	Calculated
Provider Feedback Letters	**	\$14,631,000	
Beneficiary Confirmation Letters		\$16,971,000	

²⁴ It is important to note that the vast majority of Third Party Liability recoveries come from non-fraudulent institutional providers. These payments can be three to four times the amount of fraud-related recoveries.

²⁵ This figure is not indicative of A&I's yearly demand amount as auditors identified less than \$50 million in each of the two previous fiscal years.

²⁶ Both A&I's demand figure and Third Party Liability's recovery figure are results of audits implemented by MRB and the State Controller's Office (SCO).

Sanctions	FY 03/04	FY 04/05	FY 05/06
Procedure Code Limitations		**	\$420,000
Total	\$176,006,387	\$131,183,000	

When measuring the fiscal impact of its anti-fraud work, Denti-Cal assumes that savings impact a provider's behavior for three years. Denti-Cal estimates that in FY 2005/2006, \$29 million were saved due to all sanctions implemented within the three years prior to the analysis. Of these \$29 million, \$5 million were saved due to sanctions implemented in FY 2005/2006. We were unable to obtain estimates for earlier periods, so we cannot report the savings for sanction activities in Denti-Cal for FY 2004/2005.

3. *Costs of Anti-Fraud Programs*

Thus far, we have focused on measuring the savings of a return on investment calculation. To complete the calculation of return, we must compare these savings to the cost of activities. DHCS uses a cost tracking tool to capture information on the costs of anti-fraud activities in the Medi-Cal program. Nearly thirty divisions or offices within the DHCS devote at least part of their time to anti-fraud activities, as measured by this cost tracking. EDS and Delta Dental, as fiscal intermediaries, also have contractual roles to address fraud.

If we focus on fee-for-service provider fraud, the cost estimate based on DHCS numbers is around \$34.1 million for FY 2004/2005, with the breakdown by organization shown in Table 7. This estimate remains imprecise for a number of reasons. First, as the table notes, these numbers still include some costs associated with beneficiary fraud. Since these costs do not appear to be separately tracked, we cannot allocate costs between the two groups. There are also groups whose work is important to deterring fraud, but who do not track anti-fraud costs, such as TAR offices.

Table 7: Costs Tracked to Anti-Fraud Activities among Groups Working with Fee-For-Service Providers FY 04/05

Unit	FY 04/05
A&I MRB*	\$12,927,648
Provider Enrollment Division+	\$7,253,270
EDS Provider Review Unit & Cost Containment	\$3,823,014
Delta Dental Anti-Fraud Activities*	\$4,480,522
Medi-Cal Fraud Prevention*	\$2,158,852
Departmental Costs, State-Wide Costs*	\$558,660
Medical Dental Services Branch	\$449,002
Rate Development Branch	\$309,197
Third Party Liability*	\$346,591
Benefits Branch	\$280,188
Performance and Change Management*	\$327,920
Policy and Program Development Branch*	\$116,899
Office of Medi-Cal Payment*	\$86,407
A&I Division Office	\$30,179
Total	\$33,148,349

Unit	FY 04/05
+ Includes all provider enrollment activities	
* Includes costs associated with beneficiary fraud	

4. An Initial Return Estimation

To the degree that the measures of DR, CPS and costs are credible, the actual calculation of total returns on investment is simple, as shown in the box below. The numbers are drawn from the components highlighted in Tables 5-7. Although this calculation shows a clear return on overall investment, there are a number of reasons to question the specific estimate shown in the calculation. In the following sections, we address the key issues behind either the over- or underestimation of the return calculation to aid DHCS in creating a more accurate calculation.

Simplistic Measure of Return FY04/05 excluding Denti-Cal:	
Direct Recoveries from Anti-Provider Fraud	\$11,401,660
+Corrected Practice Savings	<u>\$131,183,000</u>
=	<u>\$142,584,660</u>
Divided by Total Costs for Anti-Fraud	\$28,667,827
=	\$4.97 return per \$1 spent
Reasons This May Be An <i>Overestimate</i> :	
<ul style="list-style-type: none"> • Corrected Practice Savings were not appropriately isolated from total drop in billing • Included costs are lower than A&I costs calculated in internal documents 	
Reasons This May be An <i>Underestimate</i> :	
<ul style="list-style-type: none"> • Does not count savings over long enough time horizon • Does not account for effect of deterrence 	

C. Reasons for an Overestimation: Isolating CPS from Total Drop in Billing

One of the main challenges in measuring CPS is isolating reduced fraudulent billing from the total drop in savings. Recalling Figure 1, the distinction between reduced fraudulent billing (*a*) and total drop in savings (*a + b*) is important because as a sanctioned provider changes service and billing behavior, some patients will seek services from other providers. Thus, using the full drop in monthly billing of $\$a + \b would exaggerate the savings achieved through sanctions.

This concept can be clearly seen when DHCS applies a full sanction, such as Deactivation, Temporary Suspension, and Withhold.²⁷ These penalties constrain a provider from participating in Medi-Cal altogether for a certain period of time or permanently. DHCS accounts for a sanctioned provider's non-fraudulent behavior when it calculates savings generated from one of these sanctions. Through claims data, analysts compare a sanctioned provider's billing behavior before and after a sanction. After monthly averages are calculated for each of the time periods, the monthly difference is annualized to estimate total yearly savings. To account for the provider's non-fraudulent billing, analysts multiply the annualized savings by the "beneficiary factor," which equals the total dollar amount of claims found to be fraudulent divided by the total dollar amount of all claims audited. For all providers, the beneficiary factor is approximately 43%, which was obtained from State Controller Office (SCO) audit results.

Despite this adjustment, CPS measures are likely to be overestimated because current methodologies do not properly isolate CPS from the total drop in billing. First, DHCS agencies assume that no beneficiary factor need be applied when considering partial sanctions, also referred to as utilization controls. Typically, however, sanctions impose restrictions on billing that go well beyond the reason for applying the sanction. For example, a physician caught up-coding can receive a sanction not permitting this provider to bill the higher price code at all. Yet, some of the physician's pre-sanction patients undoubtedly merited receiving the higher-priced treatment. When unable to receive such treatments from the sanctioned provider, the patient will go to other Medi-Cal doctors to obtain the services. Furthermore, the beneficiary factor is likely set too high because the vast majority of the SCO audits used by DHCS to calculate the beneficiary factor began in 1998, 1999, and 2000, when fraud was more rampant. After more than a half-decade of heightened anti-fraud efforts, it is likely that the percent of sanctioned providers' fraudulent claims have lowered.

There are several alternate approaches to measuring CPS that more appropriately account for the beneficiary factor. As DHCS acknowledges that the beneficiary factor needs adjustment, analysts have already begun reevaluating data utilized for its calculation and strategies for improvement. By using more recent audits within both A&I and SCO, and ensuring that the claims sampling method is consistent for all audits, DHCS can more accurately determine the percent of a sanctioned provider's fraudulent claims. Two additional alternatives are both more labor intensive. As one alternative, the audited claims of each sanctioned provider could be used to determine the percent of that provider's fraudulent claims and the amount of overpayments made. With this information, analysts could "re-bill" claims appropriately and determine the amount saved upon sanctioning the provider. This strategy would not require reviewing pre- and post-sanction billing because the sanction is assumed to correct the provider's fraudulent behavior. As a second alternative, DHCS could create and implement a tracking/reporting system that would make it possible to analyze the migration and/or attrition patterns of the beneficiaries of sanctioned providers. Using claims data, these beneficiaries would be tracked on a pre- and post-sanction basis. A&I has already tested this type of analysis on ADHCs; efforts could be expanded to include other provider types. If DHCS finds that the beneficiary factor tends to vary among provider types, different rates could be applied accordingly. In any case, all types of effective sanctions are likely to have some impact on providers' willingness to bill even some valid services. Therefore, even partial sanctions should incorporate some beneficiary

²⁷ When a Withhold is applied, a provider can continue to provide Medi-Cal services, but all payments will be held. Although the sanctioned provider's Medi-Cal status is not revoked, this sanction is considered full because providers tend to stop providing and billing for services altogether.

factor, although the magnitude of this factor may vary widely by both provider type and severity of sanction.

D. Reasons for an Underestimation: Time Horizon and Deterrence Effect

Other important factors to take into account when estimating CPS for return purposes is the length of time a sanction will have an impact on provider billing behavior and how the sanction's impact will change over time. Because DHCS calculates CPS for budget forecasting purposes, analysts segregate the savings earned in one year. As these annualized savings are applied to the budget base, any additional savings resulting from sanctions will be incorporated into future budgets. However, once they have been added to the base for forecasting purposes, these savings are not separately tracked. For a return calculation, however, it is essential to develop a more appropriate methodology to set the time horizon for the length of a sanction's impact.

In contrast to costs, both CPS and DS are quite likely to accrue not only in the current year, but also in future years. For example, providers who receive utilization controls are likely to curb their fraudulent behavior years after the controls have been implemented and later lifted. As another example, a fraudulent provider who is permanently suspended is stopped from billing improperly from time of suspension, meaning that savings accumulate from this time until that time in the future when the provider would have otherwise stopped billing fraudulent claims.

Although a longer time horizon would lead to a higher estimated savings, we do expect that savings would eventually phase-out. For example, a provider could feel a sanction's impact less over time and gradually return to inappropriate billing. Similarly, a suspended provider might not have continued fraudulently billing throughout his/her Medi-Cal career had he/she not been sanctioned. This concept is referred to as a decay factor, because the impact of a sanction decays over time. Therefore, while lengthening the time horizon, the expected savings would be lower in later periods to account for this decay, until the savings phase out entirely.

To establish an appropriate decay factor for CPS, DHCS can review provider claims several years after a sanction has been applied and lifted. If DHCS analysts determine that providers continue to consistently bill appropriately, they can set the decay rate close to one, implying that savings will be greater. If providers quickly return to old behavior, then the decay should approach zero. Once DHCS has established an appropriate time horizon, it should be applied across agencies and programs. Currently, Denti-Cal savings are not considered with those of Medi-Cal because savings calculation methodologies differ. Through a consistent method, DHCS can produce a return estimation that includes both programs.

In addition to more appropriately accounting for the time horizon of a sanction's impact, DHCS should estimate the deterrence effect of its anti-fraud work. Considered by itself, not calculating DS would lead to an underestimation of the returns earned by DHCS' investments in its anti-fraud programs. While difficult to estimate, one can potentially establish reasonable ranges for DS values for many of DHCS' individual anti-fraud activities. This can be done by reviewing fraudulent claims over time, either through regular audits or the MPES. If the same methodology is applied over time and the share of claims that are found fraudulent fall, there is evidence of a notable deterrent effect.

As many of these recommendations are labor intensive, if DHCS determines that additional cost effectiveness measurement activities would be beneficial, then sufficient human and financial resources should be invested.

E. Estimating the Cost Effectiveness of Individual Anti-Fraud Activities

By estimating the cost effectiveness of the entire scope of its anti-fraud activities, DHCS can measure overall impact and be accountable to funding sources. For planning purposes, however, a more powerful tool is the ability to estimate the return on each specific type of activity. After detecting which activities generate the highest return, DHCS can more appropriately allocate resources, expanding the scope of activities that generate the most savings relative to their costs. By identifying the sanctions with the biggest payoff, the most effective audit types, and providers who should be targeted, DHCS can lower costs, while increasing impact.

Current information is not sufficient to determine what additional investments should be made in anti-fraud activities. Although a clear allocation of costs and savings would be difficult for some activities – especially activities that are part of the core Medi-Cal operations but may also have anti-fraud aspects – DHCS could feasibly identify the costs associated with some specific activities. For example, it would be particularly useful and feasible to measure the cost effectiveness of Field Audit Reviews because this activity is closely linked to CPS and DR, and A&I already tracks associated costs.

To measure the cost of Field Audit Reviews, A&I uses data on the number of hours devoted to these audits by staff working in related case development, auditing, and management activities. A&I then uses an average labor cost per DHCS employee to convert these hours into dollars. Relying only on the costs of these staff, however, underestimates the total costs of the activity. In addition to the line and management staff, this calculation also needs to include costs of sanction administration, support staff, and EDS costs. Out of the \$3.3 million contract for the EDS provider review unit, three-fourths of the cost, more than \$2.5 million, is paid for staff identifying cases for Field Audit Reviews or for incentive payments for EDS referred cases that result in sanctions. All of these costs need to be included when we compare savings to the costs associated with applying the sanctions. To be even more comprehensive in assessing the costs associated with Field Audit Reviews, analysts would also need to assess the costs that Third Party Liability incurs while collecting overpayments.

Once the costs of an activity are calculated, it is important to link the activity to our savings measures, in this case, CPS and DR. A&I's current methodology incorrectly assumes that all audit activities lead to a sanction, and therefore CPS. By simply comparing total costs of all Field Audit Reviews with the CPS and DR of only those reviews that lead to sanctions, A&I can create a more accurate estimation. A&I can conduct this activity at the provider level to determine which types of audited providers generate the greatest cost savings. In this case, A&I would have to track the time spent on individual providers to estimate costs, and then compare those numbers to future recoveries and savings.

4. What Strategies Can Medi-Cal Implement to Strengthen Its Anti-Fraud Program?

While DHCS has greatly enhanced its anti-fraud efforts within the last seven years, Medi-Cal could improve impact by strengthening technologies related to both fraud detection and the general tracking of beneficiaries, costs, and savings. In contrast, once the methodology for the MPES study stabilizes, most of the benefits from these studies, which requires extensive resources at A&I, could be achieved if conducted biannually. This would free up resources for other data-mining activities. Finally, we offer several recommendations to fine-tune front-end fraud controls.

A. Strengthen Methods to Detect Fraudulent Providers

By increasing A&I's internal capacity and introducing new tools, Medi-Cal can enhance fraud detection. As fraud schemes become more sophisticated and harder to identify with traditional methods, much of the responsibility for initial fraud detection within Medi-Cal has moved to outside contractors. Although this outsourcing has benefits, Medi-Cal should fully utilize its own personnel to maintain an internal capacity for fraud detection. In particular, A&I researchers can play a larger role in identifying emerging trends in fraud, serving as a complement to the outside contractor detecting current and past irregular billing patterns. To meet this goal, A&I needs to ensure that its staff has broad access to longitudinal data, the statistical software, and the technical resources necessary for such analyses. As new systems are put in place, DHCS should ensure that the data is still accessible in analytical formats, so the systems complement, rather than supplant, more sophisticated analyses.

A&I may also want to expand the methods used to identify potentially fraudulent providers. Currently, such providers are largely identified by looking for outliers in billing patterns. Tracking beneficiary treatment patterns could be another effective strategy. By creating beneficiary profiles, MRB could determine if a flagged provider is up-coding or just providing services to a sicker population.²⁸ Furthermore, beneficiary-centric models flag beneficiaries who are receiving an abnormally high number of services, either from a single provider or from multiple providers. This mechanism could lead to the identification of suspicious beneficiaries and collusion schemes between providers.

Analysts from the Financial Audits Branch within A&I also note that several types of institutional providers that are vulnerable to fraud, including acute care hospitals and long-term care nursing facilities. Institutional providers are rarely the target of anti-fraud activities. The main fraud detection tool for such providers is a yearly financial audit, which is intended to identify overpayments that result from differences in rates and actual costs rather than specifically investigating fraud. To expand anti-fraud activities around institutional providers, the branch would need expertise from MRB in examining medical records. On a pilot basis, data-mining efforts could also be directed more heavily toward institutional providers.

Finally, DHCS is experiencing difficulty to coordinate effectively with Medicare. Through Medicare and Medi-Cal claims data-matching, fraud detection is bolstered; and anti-fraud groups can team-up to audit networks of suspicious providers. In 2001, the Centers for

²⁸ The CMS-HCC model, currently used by CMS, has patient risk scores that could effectively adjust provider fraud scores. Ohio has also experimented with this model in a study with its Medi-Medi data.

Medicare and Medicaid Services (CMS) launched a Medicaid-Medicare (Medi-Medi) partnership to strengthen fraud detection within the two programs. Recent fraud detection and investigation activities conducted jointly with Medicare led to important utilization controls on hospice providers. However, Medi-Cal receives few referrals from Medicare and often has to wait for information on identified providers' Medicare claims. Furthermore, Medi-Cal would like to more readily join auditing resources to tackle tough cases. To increase the impact of Medi-Medi, Medi-Cal and Medicare should clearly delineate the entities' responsibilities and discuss measures to improve coordination.

B. Improve Tracking Systems for Greater Accountability

Medi-Cal anti-fraud activities would benefit from improved tracking tools. Such tools could serve several functions. First, improvements in case and cost tracking can help Medi-Cal estimate the cost effectiveness of various anti-fraud activities, while increasing general accountability. Second, better tracking systems could also streamline performance. Three systems that could use strengthening and coordination are the Case Tracking System managed by MRB, Third Party Liability's Automated Collections Management System, and the systems used for Presumptive Eligibility (PE).

Adjustments to MRB's Case Tracking System could allow DHCS to more effectively track audit findings, which could lead to CPS and DS measures. By carefully documenting the discrepancies found in audited claims, A&I can more readily identify the amount of overpayment, and in turn, the amount saved as a result of a sanction. Currently, information on audited claims is obtained but not input into the Case Tracking System in a user-friendly fashion. Analysts cannot run queries on the percent of audited claims found to be fraudulent over time. A simple adjustment to the tracking system can remedy this problem.

Third Party Liability's current tool used for tracking dollars recovered, the Automated Collections Management System, is antiquated and inadequate. Analysts must painstakingly export information from read-only reports onto Excel spreadsheets and conduct their own calculations, which is time consuming and does not allow the Branch to efficiently monitor and analyze fraud payment recoveries. The fact that cases often enter appeals processes that can last up to five years means that an up-to-date tracking system is essential to effectively pursue providers. Furthermore, numbers on total recoveries are difficult to obtain because many different actors contribute to the process. MRB makes the initial overpayment estimation; EDS withholds provider payments; and Third Party Liability tracks down any remaining debts. Current systems should be improved to allow analysts to readily compare each entity's progress and track the percent of overpayments actually collected over time.

Better beneficiary tracking in the PE program could also lead to stronger fraud controls. The PE program, which provides prenatal care coverage to women who meet certain income criteria, is vulnerable to fraud because it lacks a system to track beneficiaries. Fraudulent providers could submit claims for services never rendered because there are no mechanisms to ensure the 14-digit number on the claim corresponds to the number on the PE identification card. Furthermore, PE's antiquated computer systems cannot track the number of cards requested and used by providers and the services rendered to each beneficiary. The PE program for children is more accountable because beneficiary identification numbers are issued through the Medi-Cal eligibility system and are monitored by the claims processing edits and audits system.

Finally, to accurately evaluate the cost effectiveness of different anti-fraud efforts, such systems must build common terminologies and information-sharing mechanisms to link costs with savings. Currently, anti-fraud activities are conducted by many entities within DHCS and reported in different formats, complicating this cost effectiveness approach. For example, because the Third Party Liability system employed to monitor DR uses different terminology than other Medi-Cal anti-fraud programs, it is difficult to link recoveries to particular activities. DHCS should determine for which activities a cost effectiveness analysis would be useful and develop the tools necessary to process and link relevant information.

C. Fine-Tune Front-End Fraud Controls

Some improvements could also be made to the front-end controls in both Medi-Cal and Denti-Cal. For example, TAR controls could be enhanced to reduce the over-utilization of hospice care and up-coding of hospital per diem rates. Hospice provider fraud has been an increasing source of concern over the last two years, especially because respite, continuous nursing, and routine level nursing levels of hospice can bill up to \$27,000 per month per beneficiary without a TAR. California should consider requiring all levels of hospice care to submit TARs as a control to the over-utilization of resources and fraudulent over-billing. Hospital stays could also be an area vulnerable to fraud. While inpatient TARs do require hospitals to distinguish between acute or sub-acute (administrative) days, they do not require more specificity within the acute day category. This introduces a possible incentive for hospitals with multiple per diem rates (mostly large hospitals) to up-code and bill a more expensive rate.²⁹ Differentiating types of hospital stays or scrutinizing claims to ensure that higher per diem rates are indeed medically justified may help control this incentive to up-code.

TARs could also play a greater role in anti-fraud through mechanisms that verify their content. Currently, TAR offices do not have the statutory authority or the resources necessary to confirm the validity of information submitted with a TAR. However, Medi-Cal may consider reviewing a targeted random sample of TARs for fraud. This extra layer of review could be conducted either by TAR or A&I field offices. While this reform would require more staff resources and a new auditing function, it could also add an important pre-payment anti-fraud measure to Medi-Cal's payment process.

Denti-Cal could also improve front-end measures, such as provisional provider status and X-Ray submissions. Approved provider applicants are placed on provisional provider status for 12 months, allowing Denti-Cal analysts to review billing patterns and remove non-compliant providers from the program more easily. However, since this policy was implemented in 2004, no providers have been deactivated during this provisional period. To make provisional provider status more effective, Denti-Cal should consider either promoting a regulation change to lengthen the 12-month period, or streamlining internal processes to get providers reviewed in a timelier manner. In addition, Denti-Cal might strike a more appropriate balance between access to care and anti-fraud by evaluating the benefits of requiring X-Rays for each procedure. By eliminating the necessity of X-Rays for less vulnerable procedures, Denti-Cal can retain more

²⁹ Hospitals that may have an incentive to up-code include non-contracted hospitals, which are cost-based, and contracted hospitals that have multiple contracted per diem rates. A minority of contracted hospitals (59 of 208 hospitals) may bill multiple per diem rates. Hospitals have been found to up-code in the past. For example, one hospital with multiple contracted per diem rates settled with the Centers for Medicaid and Medicare Services (CMS) for inappropriately billing Neonatal Intensive Care Unit (NICU) rates even though NICU services were not provided.

providers and expend fewer resources. Furthermore, more frequent use of digital X-Ray technology would hasten the TAR and claim submission process, while documenting provider billing patterns and beneficiary progress more efficiently. However, providers are slow to take advantage of this digital technology. Denti-Cal should consider offering incentives to providers who submit both X-Rays and claims electronically.

D. Enhance the MPES Methodology, but Conduct Less Frequently

A&I should develop a consistent MPES methodology and implement the study biannually to yield more benefits. MPES is extremely effective in detecting emerging trends in fraud. However, it has yet to produce comparable measures of payment error because methodologies have changed every year. This is understandable as MPES is relatively new, and analysts are consistently finding better ways to identify errant claims. Once Medi-Cal establishes an appropriate methodology, it should be consistently implemented to produce comparable results, but only on a biannual basis. Currently, the Legislature mandates that MPES be implemented every year. This represents an enormous investment of resources for MRB because field offices must dedicate a significant amount of time auditing providers who have had no indication of fraud. In the Santa Ana and San Diego field offices respectively, 22% and 14% of man hours were dedicated to MPES in 2006. In addition, MRB headquarters staff spend considerable time designing the sample, training auditors, and documenting findings. For MPES to be effective, MRB must initiate special projects to respond to its findings. By implementing MPES less often, MRB field staff could spend alternate years implementing special projects to curb emerging trends in fraud. Furthermore, MRB headquarters staff could also dedicate more time to conducting other fraud detection analyses.

Appendix

List of Acronyms

A&I	Audits and Investigations
AB	Assembly Bill
ADHC	Adult Day Health Center
CA-MMIS	California Medicaid Management Information System
CMS	Centers for Medicare and Medicaid Services
CPS	Corrected-Practice Savings
DHCS	California Department of Health Care Services
DME	Durable Medical Equipment
DR	Direct Recoveries
DS	Deterrence Savings
EDS	Electronic Data Systems
FBI	Federal Bureau of Investigation
FDA	Food and Drug Administration
FY	Fiscal Year
GAO	Government Accountability Office
MDSB	Medi-Cal Dental Services Branch
MPES	Medi-Cal Payment Error Study
MRB	Medical Review Branch
OIG	Office of Inspector General
PE	Presumptive Eligibility
PED	Provider Enrollment Division
SB	Senate Bill
SCO	State Controller's Office
SURS	Surveillance and Utilization Review Subsystem
TAR	Treatment Authorization Request

APPENDIX B –

Report on the Pharmacy Outreach Project

The MPES 2005 identified that payments to pharmacies and physicians disclosed the highest percentage of payments made to claims with errors among non-institutional providers. Pharmacy errors accounted for almost half of the overall percentage of payment error (4.05 percent of the 8.40 percent). Most pharmacy claim errors were found to be a result of absent or inadequate documentation, such as not having a valid prescription in the file or the provider violated the requirement to obtain an approved Treatment Authorization Request before dispensing a drug. The MPES 2005 also identified that pharmacies were submitting multiple claims for prescriptions in response to changes in reimbursement that increased dispensing fees. Some pharmacies provided less medication than prescribed on the initial prescription enabling the pharmacy to refill the prescription more frequently to obtain additional reimbursement.

In response to these findings DHCS conducted on-site reviews of 1,977 pharmacies by a temporary redirection of staffing resources to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified by DHCS and deter further abuse.

In summary this project did not uncover fraud and abuse schemes not previously identified by the DHCS. The types of errors identified were consistent with errors identified in all three of the Medi-Cal Payment Error Studies completed to date as well as with other audits and reviews of pharmacies that have been performed.

This project has resulted in a heightened awareness by California pharmacies of the importance of Medi-Cal compliance requirements. This project identified areas for improvement and found that most errors are concentrated within a small percentage of the pharmacies reviewed. Pharmacies with errors involving potentially abusive practices are receiving further DHCS review. This project also identified future opportunities DHCS will pursue in coordination with the Board of Pharmacy, the California Pharmacists Association and the California Retailers Association. These opportunities could provide valuable ongoing education, policy collaboration, and possible revision to existing policies, as well as system edits and/or changes to the claims processing system.

The complete Pharmacy Outreach Project report is attached immediately following this page.

2007

Pharmacy Outreach Project



Acknowledgements

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- California Board of Pharmacy
- California Pharmacists Association
- California Retailers Association
- Pharmacists and staff at all the pharmacies visited during the onsite reviews in September 2006

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PHARMACY OUTREACH PROJECT REPORT

Executive Summary

The Pharmacy Outreach Project (Project) is a direct action item responding to the findings of the Medi-Cal Payment Error Study (MPES) for 2005. The MPES 2005 found that pharmacy-related errors contributed almost half of the overall identified percentage of payment error, 4.05 percent of the total 8.40 percent. Of this 4.05 percentage of payment error, 1.12 percent was attributable to prescribing physicians, while the remaining 2.93 percent was attributable to pharmacies. As a result of the findings associated with pharmacy claims, the Department of Health Care Services (DHCS) determined it would conduct onsite reviews of approximately 2,000 pharmacies to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse. These onsite reviews were also expected to be an educational process for pharmacies as they would receive feedback regarding errors identified.

This Project did not uncover potential fraud and abuse schemes not previously identified by DHCS. The types of errors identified in the Project were consistent with errors identified in both MPES studies as well as with other audits and reviews of pharmacies that have been performed. The main objectives of the Project were to identify noncompliance and educate pharmacies regarding Medi-Cal rules and regulations. The errors identified in this Project were primarily compliance types of issues.

The onsite review of 1,977 pharmacies consisted of evaluating five paid claims submitted by each of the pharmacies. These paid claims were for dates of service of January 1, through March 31, 2006. It is important to recognize that this time period coincided with the implementation of the Medicare Part D program which created confusion to pharmacies, prescribing providers, and beneficiaries, and which may have contributed to some of the errors identified in this Project.

As stated previously, errors identified by MPES in pharmacy claims were attributable to both the pharmacies themselves and to the prescribing physicians. This Project focused on those errors for which the pharmacies were solely responsible, not the errors deemed to be the responsibility of the prescribing physicians. For example, if there was an error relating to the medical necessity of a prescribed medication, that error is considered as originating from the prescribing provider and not the pharmacy, and such an error would not be identified as a pharmacy error.

Most of the errors for which pharmacies were solely responsible were caused by insufficient documentation, or the pharmacy not having any documentation at all, such as not having a valid prescription on file or not obtaining a required approved Treatment Authorization Request (TAR) before dispensing a drug. Pharmacy errors have the potential to affect not only the financial integrity of the Medi-Cal program through overpayments, but more importantly, such errors may also jeopardize the health and safety of Medi-Cal beneficiaries if medications or dosages are not accurately provided to patients.

Approximately 5,500 pharmacies participate in the Medi-Cal program throughout California. This Project selected a non-random sample of 1,977 retail pharmacies open to the public throughout the state. Those with the highest Medi-Cal claimed and paid amounts for dates of service during the first calendar quarter of 2006 were selected for onsite reviews. The individual claims to be reviewed onsite were selected according to specific criteria based on the MPES 2005 findings. Since the claims sample focused on those types of claims identified as having been commonly in error in the MPES 2005, the selection of claims for review for this project did not utilize a statistically random sample and, therefore, the findings cannot be generalized to the entire population of pharmacies in the Medi-Cal program. A total of 9,885 (1,977 pharmacies x 5 claims = 9,885) claims were analyzed.

The onsite review methodology was developed by DHCS after input from the California Pharmacists Association and the California Retailers Association. DHCS also consulted with the Board of Pharmacy (BOP) during the course of this Project. The BOP as well as the pharmacy associations and some of their members were also afforded an opportunity to review the draft of this report and provide input prior to the report being finalized. The comments/input received from those in attendance was based on the draft report they reviewed in June 2007. Input received from the associations was evaluated and incorporated as appropriate into this report to address a number of the comments and concerns raised by the associations. The specific comments received from the associations are attached as Appendix C.

Statewide, approximately 500 staff from DHCS' Audits and Investigations (A&I) participated in the onsite reviews during two weeks in September 2006. Using a 35-item questionnaire, five claims were reviewed at each pharmacy and later re-reviewed for quality assurance by A&I Pharmacy Consultants. To further ensure the validity of the findings, a five percent sample of the pharmacy claims found to be in error was sent to the Pharmacy Consultant in the Medi-Cal Policy Division of DHCS for an additional level of review and validation of the findings.

Again, the study was designed to focus on areas where errors were likely to occur as a means of providing feedback to pharmacies. Thus, in total, 16,652 errors out of 229,332 possible errors (7.3 percent) were found. It is important to note that: (a) given the design of the survey wherein five claims for each pharmacy were examined using a 35- item questionnaire, the chance of finding an error was greatly increased, and (b) the findings in this report are based on the number and percentage of claims found to be in error and not the dollar value, i.e., amounts paid for the claims found to be in error as was used to value errors in the MPES 2005. As such, no estimated dollar value of claims potentially paid in error is included in this report.

Of the 1,977 pharmacies and 9,885 claims analyzed, 69 percent of the pharmacies were identified as having six or more claim errors out of the possible 116 errors that could be identified at a single pharmacy. Claim errors ranged from simple provider mistakes, such as no signature log or an incorrect referring provider number on the claim, to more significant errors, such as not having a prescription to support the claim at all. It is important to note that one of the factors that may have contributed to the total number of errors found is due to certain responses to questions being dependent on the responses to other questions thereby generating additional negative responses, or errors. The Project

found a prevalence of record keeping errors, however, significant noncompliance errors, such as not having a prescription or not dispensing the medication properly, was less common and concentrated in relatively few of the pharmacies reviewed. Approximately, three percent of the pharmacies were found to have errors warranting additional review as the errors were indicative of potential fraud and abuse.

There are seven categories in the 35-item questionnaire. The first category deals with whether each pharmacy is a legitimate business entity and whether its physical location and traffic patterns are consistent with a typical retail pharmacy. Seventy-eight errors were found in this category, and were identified among 58 pharmacies, or about three percent of the total pharmacies reviewed. Findings in this category revealed that the overwhelming majority of the 1,977 pharmacies were legitimate business entities.

The second category of questions assessed whether each of the pharmacies had a prescription on file for the date of service identified on the Medi-Cal claim. Again, many errors in this category were concentrated within a relatively small number of pharmacies. For instance, only five percent, or approximately 100 pharmacies accounted for 45 percent of all errors in this category, while the majority of pharmacies, 1,500 of them (or 77 percent) had no errors in this category. Some of the errors in this category may have been due to pharmacies being unclear on the different documentation requirements of the Medi-Cal program and the BOP. For purposes of this Project, an error was counted if the documentation submitted by the provider did not meet the Medi-Cal documentation requirements.

The third category dealt with the completeness of prescriptions. Incomplete prescription information, though not as severe as not having a prescription at all, may still lead to vulnerability of the Medi-Cal program to fraud or abuse. Thirty percent of pharmacies had errors in this category; however, 53 percent of all errors in this category were concentrated in seven percent of pharmacies (138 of the 1,977).

For the fourth category relating to dispensing questions, over 900 pharmacies, or 46 percent, had errors in two or more of their respective five claims reviewed.

Review of whether pharmacies retained an invoice for the purchase of drugs they dispensed was the fifth category of questions. Findings showed that 26 percent, or more than 500 of the pharmacies had errors on two or more claims, meaning the pharmacies could not substantiate the purchase of the drug dispensed and claimed.

The Project also reviewed for beneficiary signatures which are required by state law as a safeguard against fraud and to ensure beneficiaries receive prescriptions. This is the sixth category of questions. The review found that about 900 pharmacies (45 percent) lacked signatures on two or more of the claims reviewed. The claims selected for this project were paid during the first quarter of 2006, i.e., January through March. The onsite reviews were conducted during the third quarter of 2006 (September), at which time it was discovered that some pharmacies had since adopted and implemented signature procedures, thus correcting this identified deficiency.

Correct prescribing provider information, the seventh category, is critical to DHCS' ability to monitor prescribing practices in order to identify scenarios that do not make clinical sense from a medical perspective. When this information is missing, Medi-Cal is vulnerable to inappropriate and expensive prescriptions. The Project identified more than 1,000 pharmacies (53 percent) with errors in two or more claims with incomplete prescribing provider information.

The analysis of claims indicates that chain pharmacies tended to have more record-keeping errors, e.g., no beneficiary signatures acknowledging the receipt of medications, perhaps due to high volume of customers, while non-chain pharmacies were found to have fewer such errors though more significant errors in terms of compliance with rules and regulations, e.g., no valid prescriptions on file.

As a result of the findings related to noncompliance by Medi-Cal pharmacies, the DHCS makes the following recommendations:

- The findings warrant further educational efforts to encourage pharmacy providers toward compliance utilizing less resource-intensive methods of educational outreach.
- Conduct a top-to-bottom review of existing Medi-Cal controls, such as the Electronic Data Systems (EDS) Payment System Edits used to process pharmacy claims. Modifying the pre-payment claims processing currently in use could detect and eliminate several common types of compliance errors.
- Extensive consultation between DHCS and the BOP should be conducted to address any inconsistencies between the rules and regulations of the BOP and the Medi-Cal program.
- The DHCS should continue its review of pharmacies, as this Project identified three percent (58 of the 1,977) of the pharmacies reviewed as having findings warranting follow-up reviews.

As stated, this Project was the direct result of an action item from MPES 2005. It has resulted in a heightened awareness by California pharmacies of the importance of Medi-Cal compliance requirements. This Project identified areas for improvement and found that most errors are concentrated within a small percentage of the pharmacies reviewed. Pharmacies with errors involving potentially abusive practices are receiving further DHCS review. This Project also identified future opportunities DHCS will pursue in coordination with the BOP, the California Pharmacists Association and the California Retailers Association. These opportunities could provide valuable ongoing education, policy collaboration, and possible revision to existing policies, as well as system edits and/or changes to the claims processing system.

I. Introduction and Background

Consistent with its continuing efforts to detect, identify and prevent fraud and abuse in the Medi-Cal program, gauge the seriousness of the problem, and develop appropriate fraud control strategies, DHCS conducts the Medi-Cal Payment Error Study (MPES) on an annual basis. To date, two such studies (MPES 2004 and MPES 2005) have been completed. Controlling fraud, waste, and abuse in publicly-funded health care programs requires continuous assessment to monitor emerging trends and make informed decisions on the allocation of fraud control resources. Fraud, waste and abuse can have a significant impact on the Medi-Cal program due to its annual benefits budget. The Medi-Cal program budget was approximately \$31 billion in Fiscal Year 2005/06.

MPES 2005 revealed that pharmacy claims were the largest contributor, at 4.05 percent, of the overall 8.40 percentage of payment error¹⁶. Of this 4.05 percentage share, 1.12 percent was attributable to prescribing physicians, while the remaining 2.93 percent was attributable to pharmacies. MPES 2005 findings disclosed that the two most common errors in provider claims were lack of medical necessity and lack of compliance with Medi-Cal rules and regulations, including insufficient documentation by providers. Many of the pharmacy errors were due to the absence of documentation or inadequate documentation, such as not having a valid prescription on file or the pharmacy failing to obtain an approved TAR before dispensing a drug. These types of errors are under the pharmacies' control, unlike errors due to medical necessity for which the prescribing physicians are responsible. Although 28 percent of all errors identified in pharmacy claims in MPES 2005 were attributable to the lack of medical necessity¹⁷, this Project did not review claims for medical necessity errors because pharmacies have no control over such errors, as the medical necessity is determined by the prescribing provider. The pharmacist's responsibility is to fill the prescription submitted by the prescribing provider.

A newly emerging trend identified in MPES 2005 was that some pharmacies appeared to have changed their billing behavior in response to the changes in reimbursement for prescription refills. In 2004, a statutory change increased dispensing fees concurrent with state actions to assert more control over ingredient costs. Some pharmacists provided less medication to beneficiaries than had been prescribed on the initial prescription. This enabled the pharmacists to refill the prescription more frequently to obtain additional reimbursement, i.e., the dispensing fees for subsequent prescriptions. This is commonly called prescription-splitting.

¹⁶ The Medi-Cal Payment Error Study calculates the percentage of payment error attributable to Medi-Cal program dollars "at risk" of being paid inappropriately. The term "at risk" is used because the estimated dollar figure is derived from applying the percentage of payment error to the program's annual expenditure level. The estimated dollar figure cannot be considered payments made in error unless all of the individual services that are questionable are identified through a complete medical record review or audit of all services submitted for payment and found to be medically unnecessary.

¹⁷ For example, a claim was submitted for an antibiotic for an 11 year-old patient. The patient's history in the medical record consists of "runny nose sore throat." A prescription for an antibiotic was written without any physical exam or any evidence to demonstrate that the prescription was medically necessary.

Appendix A of this report provides a breakdown of pharmacy errors identified in MPES 2005. Of the 203 total errors, 77 claim errors, or 38 percent, were pharmacy errors. The three largest types of pharmacy errors identified in MPES 2005 were for medically unnecessary pharmacy claims (22 errors), claims with no legal prescriptions (22 errors), and claims that violate Medi-Cal program policies (11 errors). Except for those related to medical necessity, which are controlled by the prescribing physician, these errors are under the pharmacies' control. By emphasizing training and outreach, these types of controllable errors can be reduced.

The Project is a direct action item responding to the MPES 2005 findings. The main objective was to verify compliance with applicable regulations and policy requirements, identify overpayments, uncover potential fraud and abuse schemes not previously identified, and deter further abuse. As previously stated, these onsite reviews were expected to be an educational process for pharmacies, as they would receive feedback regarding errors and inappropriate practices and have the ability to revise their practices to avoid noncompliance issues in the future.

One of the goals of performing the onsite reviews was to provide outreach, information, and education to pharmacies on their compliance with Medi-Cal rules and regulations. Onsite reviewers identified various compliance errors and informed the pharmacists of the specific errors in order to avoid the same errors from recurring.

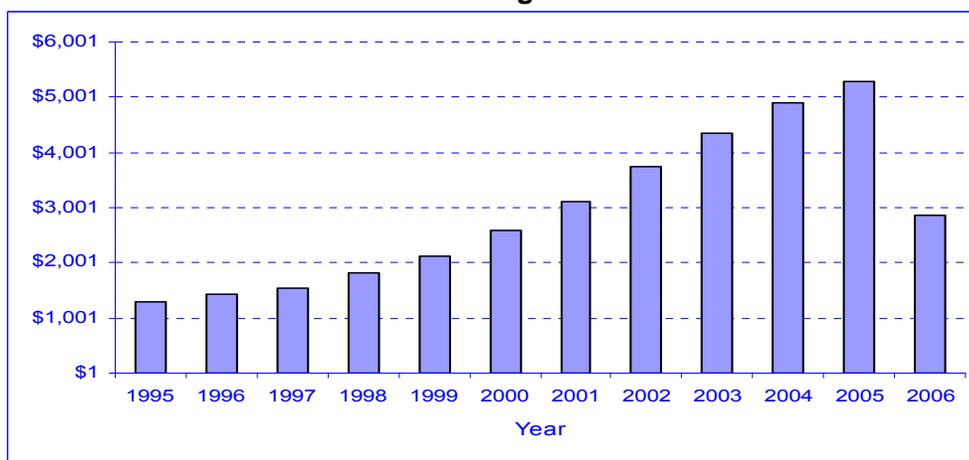
II. Historical Trends in Pharmacy Reimbursement (Payments)

Approximately 5,500 pharmacies are enrolled in the Medi-Cal program and are providing medical drugs and supplies to nearly 6.5 million Medi-Cal beneficiaries in California. Figure 1 shows that total Medi-Cal payments to pharmacies increased from \$1.3 billion in 1995 to \$5.3 billion in 2005. This represents a growth of more than 300 percent over a ten-year period. The growth is due to a number of factors, including increases in drug prices, new high-priced drugs coming to the market to treat diseases, additional beneficiaries, and the growing number of prescriptions being written. The highest growth rates during the ten-year period were 21.8 percent and 20.8 percent in the years 2000 and 2002, respectively. The year 2005 experienced a slowdown with a growth of only 7.5 percent, representing the smallest growth rate in a decade. Actions initiated by DHCS, including moratoriums on non-chain pharmacies, mandatory re-enrollment as Medi-Cal providers through the Provider Enrollment Branch (PEB) and anti-fraud focus on non-institutional providers (such as pharmacies), may be reasons for this growth reduction in pharmacy reimbursements through 2005.

Medi-Cal reimbursements (or payments) to pharmacies declined sharply (46 percent) in 2006, due primarily to the implementation of Medicare Part D that took effect on January 01, 2006. Medicare Part D is a federal program that was designed to cover the cost of prescription drugs incurred by Medicaid (Medi-Cal) beneficiaries who are dually eligible for Medicare, often referred to as *Medi-Medi* beneficiaries. This shifting of

pharmacy prescription drug payments from Medi-Cal to Medicare likely contributed to the slow down in Medi-Cal reimbursements to pharmacies beginning in 2006.

Figure 1
Pharmacy Reimbursement (in Millions) in California
1995 through 2006



Data provided by Fiscal Forecasting and Data Management Branch (Fee-for-Services only). This does not include payments made by Medi-Cal managed care plans for pharmacy services.

III. Methodology and Review Process

Prior to conducting the onsite reviews, DHCS sought and obtained input from its stakeholders, the California Pharmacists Association, the California Retailers Association, and the BOP regarding the type of review that was planned. These associations worked cooperatively with DHCS and assisted in informing their respective members of the Project. Additionally, the BOP issued bulletins to their members describing the project and seeking their assistance and contribution with the reviews to assist in making this a successful Project.

The Project was a major undertaking for DHCS' A&I, as it involved staff from all three of its Branches, i.e., Financial Audits, Investigations and Medical Review during a two-week period in September 2006. Some pharmacy providers hired temporary staff during the review period to help retrieve files and records needed by A&I staff for the onsite reviews. In addition, some pharmacies dedicated resources to this Project by conducting internal reviews of their own processes to ensure compliance.

Approximately 500 A&I staff were involved in the onsite reviews. The reviews consisted of A&I staff visiting 1,977 open-door pharmacies¹⁸ throughout 57 counties in California and

¹⁸Open door pharmacies are those retail pharmacies that are open to the public. There are also "closed door pharmacies" which are not open to the public and whose primary business is to provide prescribed drugs and supplies to patients who are institutionalized in nursing facilities. This project did not include a review of claims submitted by closed door pharmacies because they operate much differently than a community pharmacy (open door). The errors identified in open door pharmacies have not been previously identified in closed door pharmacies.

spending, on average, three hours reviewing pharmacy records and other relevant documents to assess compliance. Each onsite pharmacy review required the examination of five Medi-Cal claims that had been submitted by each pharmacy for dates of service during the first quarter of calendar year 2006. Thus, a total of 9,885 claims were examined by A&I staff. Each claim was subjected to a review using the 35-item questionnaire to assess compliance. As a result, multiple errors for each claim were possible, and were identified.

Criteria for Selection of Pharmacies

DHCS identified the total universe of 5,479 pharmacies statewide that submit claims to the Medi-Cal program. From this universe, a non-random sample of open-door pharmacies was selected using a minimum dollar threshold of \$76,000 or more per quarter in reimbursements (claims paid) for each pharmacy. The goal was to identify at least one pharmacy in each of the 58 counties in California. In instances where a county did not have a pharmacy meeting the \$76,000 threshold, that threshold was lowered to \$50,000. Alpine County is the only county not represented as it did not have a pharmacy that submitted claims to the Medi-Cal program. A pharmacy in Lake Tahoe (El Dorado County), which is frequently used by Alpine County beneficiaries, was added to the list of pharmacies to receive an onsite review. Table 1 displays the 10 counties with the greatest number of pharmacies used in the sample, including their respective percentage share of the total number of pharmacies.

**Table 1
Top 10 Counties with Largest Number of Pharmacies**

Counties	Number	Percentage
Los Angeles	650	32.9
San Bernardino	125	6.3
San Diego	119	6.0
Riverside	84	4.2
Sacramento	82	4.1
Alameda	74	3.7
San Francisco	64	3.2
Fresno	61	3.1
Orange	59	3.0
Kern	56	2.8
Total of Top 10 Counties	1,374	69.5
All Other Counties	603	30.5
Grand Total	1,977	100%

Data provided by EDS

Six of the 10 counties with the greatest numbers of pharmacies in the sample are located in Southern California as shown in Table 1 above. Los Angeles County accounted for the

most pharmacies in the sample (32.9 percent) followed by San Bernardino and San Diego Counties. These 10 counties, together, account for 1,374 pharmacies (or 69.5 percent) out of the 1,977 that received onsite reviews.

Criteria for Selection of Claims

Each review included the evaluation of five Medi-Cal claims submitted by the pharmacy using a 35-item questionnaire, divided into seven categories (see Appendix B for details). The claims were selected from pharmacy claims with dates of service of January 1, 2006 through March 31, 2006. It is important to recognize that this time period coincided with the implementation of the Medicare Part D program which created confusion to pharmacies, prescribing providers, and beneficiaries, and which may have contributed to some of the errors identified in this Project.

The criteria for the claims selection were developed to increase the likelihood of selecting claims with the greatest potential for compliance type errors. The types of claims were selected based on known problem areas identified in MPES 2005 and therefore do not represent a random sample. As such, the findings do not reflect the prevalence of errors that can be generalized to the entire population of pharmacies enrolled in the Medi-Cal program. The purpose, instead, was to highlight potential problems as they apply to their respective pharmacies.

It is also important to note that the findings in this report are based on the numbers and percentages of claims found to be in error and not the dollar value, i.e., amounts paid, for the claims found to be in error. As such, no estimated dollar value of claims potentially paid in error is included in this report.

Specifically, the five claims were selected based on the following five criteria:

1. Code 1 Restricted Drugs

A common error found in both MPES studies was that of pharmacies not complying with Code 1 restrictions. The Medi-Cal program limits Code 1 restricted drugs for use in certain situations. If the drug is to be used outside of the specified situation, prior approval must be obtained in the form of a TAR. For example, the Code 1 restricted drug Hydralazine and Isosorbide Dinitrate is “restricted to the treatment of heart failure as an adjunct to cardiovascular medications.” The pharmacy is expected to secure documentation from the prescribing provider indicating that the restriction has been met or obtain a TAR. Not complying with Code 1 restrictions circumvents the intent of Medi-Cal policies regarding these drugs and defeats attempts to limit use of expensive pharmaceuticals to situations when their use is truly warranted. Code 1 restriction errors accounted for a significant number of pharmacy errors in MPES 2005.

2. Maintenance drugs given for an extended period (over 2 years), usually for chronic conditions.

Potential errors are attributable to the absence of a valid prescription for the dispensing of medications paid for by Medi-Cal. This criterion was used to see if a prescription is valid and has valid refills. Both of these occurrences were problem areas identified by MPES 2005. The initial error or problem can be perpetuated by refills if the initial prescription is wrong.

3. Claims which had early refill alerts (pharmacies filling prescriptions too frequently).

Example: a prescription intended to be filled once a month might be filled every two weeks, or as in the following error case identified in MPES 2005:

The claim is for incontinence supplies (240 At Ease disposable inserts). This number (240) was also dispensed for each of the previous three months. The prescription was for "up to" three changes per day (93 per month). Therefore, 240 should have lasted almost three months.

These practices increase costs to the Medi-Cal program and circumvent professional standards of care by giving patients too much of the prescription drugs intended by definition to be used under supervision of the prescribing physician. This can result in medications ending up in the hands of unauthorized persons and possibly finding their way to the "black market."

4. Maintenance drugs dispensed for less than 30-day supply (pharmacies "splitting" prescriptions).

Example: a drug prescribed for 90 tablets might be dispensed in three sets of 30 tablets rather than one set of 90 tablets. In MPES 2005, this type of error accounted for 12 percent of pharmacy errors identified. Payments to pharmacies are based on the cost of the drug plus a dispensing fee, so breaking up a prescription into multiple smaller dispensing amounts increases the cost to the Medi-Cal program, increases the payments to the pharmacies, and causes the beneficiary to make unnecessary trips to the pharmacy to obtain prescriptions. This Project attempted to select claims which were suspect for this scenario by focusing on drugs usually given for at least once a month and focusing on claims for those drugs dispensed in less than 30 day quantities.

5. Claims that included "unknown" in the "referred by" field.

These errors involve incorrect information about who prescribed the medication. The Medi-Cal program relies on this information to monitor the prescribing practices of its providers and identify wasteful or even fraudulent prescribing. MPES 2005 identified a prescription written by a physician suspended from Medi-Cal, which is inappropriate. As such, claims were selected for this Project to assess the accuracy of the "referred by" field. This Project identified claims with "unknown" in the "referred by" field and discussed them with the provider in order

to emphasize the importance of including accurate information about the prescriber.

Second and Third Level Reviews by DHCS Pharmacists

The nearly 500 staff that conducted the pharmacy onsite visits were trained on the use of the questionnaire in preparation for their reviews, however the majority of staff performing the onsite reviews were not pharmacy experts. In addition, a call center, staffed with DHCS pharmacists and Medical Consultants, was established to help A&I reviewers with technical questions encountered during onsite reviews. Also, all 9,885 claims received second level re-reviews for quality assurance by A&I Pharmacy Consultants. To further ensure the validity of the review process, a five percent sample selected from those pharmacies found to have significant compliance errors was sent to pharmacists in the Medi-Cal Policy Division for a third level of review. In addition, to better identify the Project findings as a result of these reviews by licensed professionals in the field, the second and third level reviews further informed DHCS pharmacists about issues relating to this critical provider type.

IV. Findings

As previously stated, the onsite reviews collected information using a 35-item questionnaire, divided into seven categories¹⁹. Each category of the questionnaire focused on a specific area of compliance. Answers to each of the 35 questions were analyzed in terms of the most significant violations potentially affecting the patient's health and the fiscal integrity of the Medi-Cal program. A summary of all findings with respect to claims and pharmacies that were identified as having errors is provided in Appendix B of this report. The findings provided for discussion with each pharmacist about DHCS' requirements regarding compliance with Medi-Cal rules and regulations.

It is important to understand that at least three factors increased the likelihood of identifying errors in the pharmacies/claims reviewed. First, the Project was intended to highlight areas of possible noncompliance and did so by selecting claims based on previously known or identified types of errors. Second, given the design of the survey wherein five claims for each pharmacy were examined using a 35-item questionnaire, the chance of finding an error was greatly increased. The third factor that may have contributed to the total number of errors found is due to certain responses to questions being dependent on the responses to other questions thereby generating additional negative responses, or errors. For example, a negative response to question 12 (*Is there a prescription with correct patient's name on it?*) will have generated a "No" response to question 13 (*Is the prescription for the same drug as the dispensing label and claim?*). If the prescription did not exist in response to question 12, then the response to question 13 defaults to a negative response.

It is important to analyze the findings in this report based on the relative importance of the violations or errors identified within each category and across categories. For example, the level (or relative importance) of noncompliance is not the same when a pharmacist is

¹⁹ See Appendix B for all items in the questionnaire

unable to produce the original prescription when compared to a more minor situation when a pharmacist misspells or does not write the full name of the beneficiary.

Overall Findings

Generally, errors to questions in the first several categories are considered more serious in terms of the potential for patient health being at risk, as well as the risk to the fiscal integrity of the Medi-Cal program, than are those questions in the last few categories of the questionnaire. Therefore, not all questions in the questionnaire have the same weighted value. Each must be evaluated for its relative importance. For example, question 16 (*Is the drug/device prescribed by a licensed provider?*) is much more important and carries more weight than question 32 (*Did the beneficiary sign for receipt of the medication?*). The former is significant in terms of the health of the patient, while the latter question deals essentially with record keeping procedures inside the pharmacy.

In total, 16,652 errors (out of 229,332 possible errors), or 7.3 percent, were found during the performance of this Project. Each onsite pharmacy review of five claims can generate up to 116 errors (11 errors for Category 1 questions and 105 possible errors for all other claim-related questions). Claim errors ranged from simple provider mistakes, such as not having a signature log or the correct referring provider number on the claim, to more significant findings indicative of potential fraud, such as not having a prescription to support the claim.

Of the 1,977 pharmacies and 9,885 claims analyzed, 69 percent of pharmacies and two percent of claims were found to have at least six or more errors. To put these numbers in context, the number of possible errors is 229,332 (21,747 possible errors for questions 1 through 11 and 207,585 possible errors for questions 11 through 34)

²⁰

Figure 2 lists the distribution of the 16,652 errors by category and shows that 86 percent of them are concentrated in four major areas of noncompliance, including incorrect name or identification number of prescribing provider (22 percent), documentation that the beneficiary received the drug/product (20 percent), not maintaining readily retrievable records of the drugs/device inventories (15 percent), and lack of compliance with proper dispensing of the drug/product (29 percent). The latter error, the dispensing error, is by far the most significant error in magnitude and could potentially affect the health of patients. In summary, the findings of the Project validate the noncompliance concerns highlighted in MPES 2005.

²⁰ As stated, eleven of the 35 questions were non-claim questions and 24 were claim-related questions. The 11 non-claim questions (1-11) may yield a maximum of 21,747 errors (11x1, 977=21,747). Per pharmacists' advice, the remaining 24 claim-related questions were reduced to 21 by: (a) combining questions 14 and 15 into one and questions 32 and 33 into another, and (b) by dropping question 35 altogether (*Is the referring prescriber licensed and in good standing?*) as onsite reviewers could not determine whether the prescriber was in good standing. These 21 questions could generate a maximum of 207,585 errors (5x21x1, 977=207,585).

**Figure 2
Distribution of Errors by Category of Service**

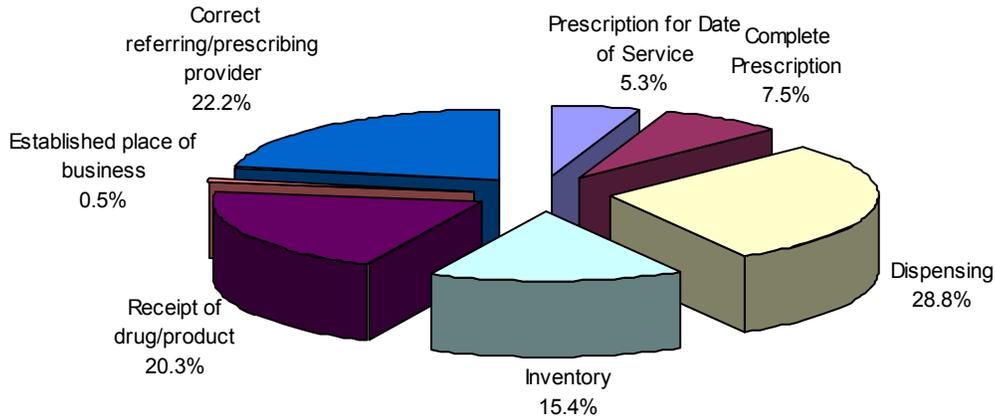


Table 2 shows the concentration of errors by pharmacies and by category of error. The total number of errors appears to be concentrated in a few pharmacies, specifically for errors related to significant noncompliance indicative of potential fraud and abuse. For example, on the critical issue of whether there was a prescription for the date of service, five percent of the pharmacies were responsible for 45 percent of the errors.

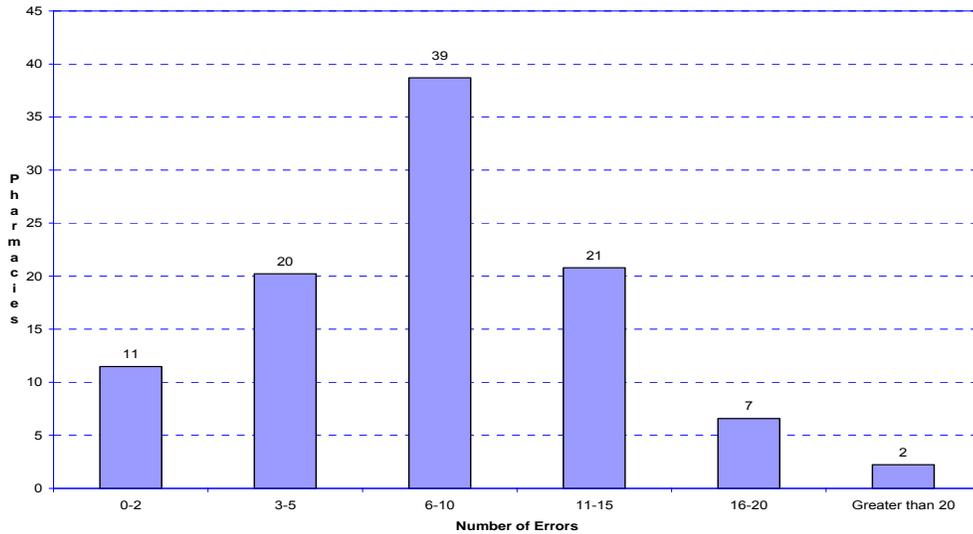
**Table 2
Pharmacies Accounting for Most Errors**

Category of Noncompliance	Percent of Pharmacies	Percent of Errors Concentrated Among High Error Pharmacies
Prescription for Date of Service	5	45
Completeness of Prescription	7	53
Dispensing	41	79
Inventory	18	67
Receipt of drug/product	29	71
Correct referring/prescribing provider	35	69

Less significant errors related to minor policy violations or record-keeping tend to be spread out over a relatively larger number of pharmacies. This is shown by the receipt for drug/product category where 71 percent of the errors were distributed among 29 percent of pharmacies. This finding indicates the prevalence of noncompliance with Medi-Cal rules and regulations rather than the incidence of potential fraud and abuse in pharmacies.

As displayed in Figure 3, 39 percent of pharmacies were found to have between 6 and 10 errors and 21 percent had between 11 and 15 errors. The complete distribution of those errors is shown below.

Figure 3
Percent of Pharmacies in Different Error Ranges



Findings by Category

This section presents findings relating to each of the seven categories with specific examples of noncompliance identified during both the onsite review and/or re-review of identified errors by Pharmacy Consultants. A summary of the results regarding each of the seven category questions, related to all 1,977 pharmacies, is presented in Appendix B.

1. Established Place of Business

This first category focuses on whether a given pharmacy is a legitimate business and whether its physical plant and traffic patterns are consistent with a typical retail pharmacy. The objective is to identify pharmacies engaged in fraudulent activities. Established place of business requirements are contained in the California Code of Regulations, Title 22, Section 51200. Because this category relates to a more general evaluation of whether the pharmacy is functioning as a legitimate entity, it did not involve an evaluation of the five claims selected for each pharmacy. This category is comprised of eleven questions.

Seventy-eight errors, generated by 58 pharmacies, were found in this category. The most frequent error was question 10. Seventeen pharmacies (about one percent) had questionable activities taking place in or around the premises during the DHCS onsite review. Examples:

- *One pharmacy had the phone disconnected during business hours, and had no customers on the premises during the three hour period during which the onsite review was conducted.*
- *Another pharmacy was found to have no customers, no sign on the door, and a disconnected phone. The pharmacist was ill, actually bedridden and seeking to sell the business. DHCS' PEB reported that the provider did not have a supplemental application to deactivate the provider number. A&I issued a temporary suspension of this provider number.*

The second most frequent error identified in the first category is whether or not the pharmacist had a valid pharmacist license (question 7). There were 10 such errors (half a percent), generated by 10 pharmacies. Example:

- *The pharmacist did not have her license with her, nor did she have a copy on the premises. Although DHCS staff verified with the BOP that the pharmacist had a license, the fact that the license was not available at the pharmacy constituted a compliance error.*

Ten pharmacies (0.5 percent) were found to have errors with the validity of the pharmacist license and 11 pharmacies (0.6 percent) had errors with the validity of their permits.

Pharmacies having errors in any of the other nine questions of this category amount to less than one half of one percent. In summary, findings in this category conclude that the overwhelming majority of pharmacies reviewed were legitimate business entities.

2. Prescription for Date of Service

The purpose of this category is to verify whether the pharmacy had a prescription for the date of service identified on the Medi-Cal claim. This was the single most common pharmacy error in MPES 2005.

**Table 3
Pharmacies by Number of Claims in Error**

Category of Error	Number/Percentage of Pharmacies with No errors	With One Claim in Error	With Two or more Claims in Error	Total Number of Pharmacies
Prescription for date of service	1,520 (77%)	295 (15%)	162 (8%)	1,977
Completeness of prescription	1,380 (70%)	385 (19%)	212 (11%)	1,977
Dispensing	503 (25%)	566 (29%)	908 (46%)	1,977

Inventory	1,016 (51%)	464 (23%)	497 (26%)	1,977
Receipt of drug/product	720 (36%)	372 (19%)	885 (45%)	1,977
Correct referring/prescribing provider	513 (26%)	412 (21%)	1,052 (53%)	1,977

As shown in Table 3 above, 457 (295+162) pharmacies (23 percent) had errors in this category, with 15 percent found to have errors in only one of five Medi-Cal claims and eight percent having errors in two or more claims.

A pharmacy is in violation of Business and Professions Code 4081(a) if it does not retain the prescription for three years. This category is comprised of four questions (see Appendix B for list of questions and error breakdown).

Twenty-three percent (or 458) of pharmacies had 887 errors in this category. As indicated in Table 2, many errors in this category were concentrated within a small percentage of pharmacies. For instance, only five percent of pharmacies accounted for 45 percent of all errors in this category.

Questions 14 (*If the prescription is a refill, was the refill authorized with the original prescription?*) and 15 (*If not, was there a current refill authorization either by phone or fax?*) were combined into one single question for analytical purposes. This combined question had the highest number of claim errors (399) for the category and was identified among 263 pharmacies (13 percent).

During the second level review by DHCS pharmacists, an issue was raised about a possible difference between the BOP and the Medi-Cal program about how much documentation each respective organization requires for refill authorizations.²¹ Below are examples of errors in this category.

- *The pharmacy did not have an original prescription that corresponded to the particular claim number of the refill submitted to Medi-Cal for reimbursement. A review of the patient history file revealed the provider had generated a new prescription number for refills rather than using the original prescription number.*

²¹ The Board of Pharmacy and Medi-Cal both require that that all prescription refills must be authorized, but Medi-Cal regulations regarding documentation on this matter appear to be stricter. For both Medi-Cal and the Board of Pharmacy, Business and Professional Code 4063 is the basic statutory clause requiring that refills must be authorized. Medi-Cal's requirement for the documentation of refill authorization is based on the following language in the California Code of Regulations (Title 22, section 51476 (a)): "Each provider shall keep, maintain, and have readily retrievable, such records as are necessary to fully disclose the type and extent of services provided to a Medi-Cal beneficiary....Such records shall include, but not be limited to the following:...(4) Records of medications, drugs, assistive devices, or appliances prescribed, ordered for, or furnished to beneficiaries."

- *The pharmacist stated that the prescription for a claim had been lost and that his pharmacy was later purchased by new owners. After the purchase was completed, the pharmacist realized that several documents with the logo of the original pharmacy could not be found. The pharmacist believes these missing documents may have been destroyed, along with the missing prescription.*

There were some instances when the patient's prescription was found at the pharmacy, but it was determined not to be a valid prescription. Two such examples are:

- *The 2nd level Project reviewer, the A&I pharmacist, determined that there was an error resulting from a different name on the claim when compared to the prescription and dispensing label.*
- *The Pharmacist-In-Charge claimed he received a verbal authorization by the prescribing physician for a refill, but there was no documentation of the original prescription.*

3. Completeness of Prescription

A common pharmacy error reported in MPES 2005 and identified again in this Project was that of noncompliance with the legal requirements for a standard prescription. Incomplete prescriptions may lead to the Medi-Cal program being vulnerable to fraud or abuse. This category is comprised of six questions.

Thirty percent of pharmacies (597) had errors in this category; 19 percent had errors in only one of the five Medi-Cal claims reviewed and 11 percent of the pharmacies had errors in two or more claims (Table 3).

One important question in this category is Question 16 (*Is the drug/device prescribed by a licensed provider?*). There were 94 errors generated by 75 pharmacies (or 4 percent). This indicates that, with regard to this question, the vast majority of pharmacies follow the Medi-Cal rules.

As in the previous category, many of the errors were concentrated within a relatively small number of pharmacies. Seven percent of pharmacies, for example, accounted for 53 percent of the total errors for this category (Table 2). Example:

- *The prescribing physician's first name, address and license number could not be provided by the pharmacy.*

4. Dispensing

This category is comprised of eight questions. Federal law requires that California pharmacies participating in the Medi-Cal program must provide prospective Drug Use Review (DUR). DUR requirements assist in screening for potential drug therapy problems. The Code of Federal Regulations addresses the labeling of drug products from a regulatory

perspective. The series of eight questions listed in this category not only refer to the Federal Regulations, but seek to ensure the fiscal integrity of the program.

Many questions in this category relate to whether the prescriber instructions are carried out in the dispensing of medicine as indicated on the dispensing label and on the Medi-Cal claim submitted by the pharmacy provider. Two questions address some of the most important pharmacy errors found in MPES 2005. One concerns potential policy violations with regard to the Code 1 drug restrictions or the obtaining of a TAR, and the second tests whether medications were refilled too frequently.

There were 1,474 pharmacies (nearly 75 percent) with errors in this category. This category had the highest number of errors. Again, this is the most significant finding, not only in the magnitude of the error, but also due to its potential negative impact on patients' health and Medi-Cal program costs.

Of these 1,474 pharmacies, 427 (or 29 percent) had errors in only one of the five Medi-Cal claims reviewed and 678 (or 46 percent) had errors in two or more claims (Table 3). Approximately, 41 percent of all 1,977 pharmacies accounted for 79 percent of all errors in this category. The following two examples illustrate errors found in this category:

- *Pharmacist dispensed a greater or lesser quantity of the medication than prescribed by the physician. For example, a physician prescribed two Epoetin Alfa (commonly known as Epogen or Procrit) injections of 10,000 units each, but the pharmacist dispensed 12 at a reimbursement rate of \$126 each. In another case, a physician prescribed 40,000 units of Epoetin Alfa also, but the pharmacist dispensed only 4,000 units, thus potentially jeopardizing the patient's health.*
- *Prescription was written for Prevpac (combination of Prevacid (30 mg), Amoxicillin (500 mg) and Biaxin (500 mg)), but Prevacid (30 mg) was dispensed. Prevpac required a TAR, But Preacid did not.*

5. Inventory

This fifth category verifies whether the pharmacy has retained an invoice for the acquisition of the drug identified on the claim submitted to the Medi-Cal program.²² The lack of invoices is another common pharmacy problem identified in MPES 2005. DHCS estimates that a third of its pharmacy audits for recovery have resulted in a demand for overpayments based on material inventory shortages. Pharmacies are required to keep the invoice on the pharmacy premises for at least three years. Failure by the pharmacy to maintain these records constitutes a violation of Business and Professions Code section 4081(a). This category is comprised of two questions.

Nearly 961 pharmacies (49 percent) had errors in this category; 23 percent had errors in only one of the five Medi-Cal claims reviewed and 26 percent of the pharmacies had errors

²² An invoice or another similar document had to be obtained during the time of the onsite pharmacy audit, except with respect to over-the-counter drugs, the documentation of which could be faxed later.

in two or more claims (Table 3). Eighteen percent of the pharmacies accounted for 67 percent of all errors for this category.

In this category, question 31 (*Does the [National Drug Code] (NDC) or item number for drug/device on the invoice match that on the claim?*) identified 745 pharmacy errors by 38 percent of the total pharmacies.

Questions 30 and 31 describe how these errors can impact the fiscal integrity of the Medi-Cal program and can cause potential health problems to patients. Below are two examples of errors in this category:

- *In several instances, pharmacists dispensed one-half of the amount that was prescribed because of insufficient inventory for the drug. For example, only one-half of the prescribed antibiotic Amoxicillin was dispensed and the patient was told to come back later to pick up the rest of it. The patient never returned to pick up the balance of the prescription.*
- *When comparing NDC numbers billed to Medi-Cal and NDC numbers on wholesale invoices, they do not match for many pharmacies. This could be a potential fraud issue and can affect rebate reimbursements to the DHCS because rebates are based on the volume of the specific drugs sold.*

6. Receipt of drug/product

Welfare and Institutions Code 14043.341 mandates beneficiary signatures partly as a safeguard against fraud. The question in this category was designed to identify compliance with keeping the beneficiary signature on the pharmacy premises. The *Receipt of drug/product* category serves to confirm adherence to this requirement, as well as to identify the reason for the missing signature.

There were 1,257 pharmacies (64 percent) that had errors in this category; 19 percent of pharmacies had errors in only one of the five Medi-Cal claims reviewed, and 45 percent of the pharmacies had errors in two or more claims (Table 3). Twenty-nine percent of the pharmacies accounted for 74 percent of the total errors for this category²³. An example in this category follows:

- *The beneficiary's signature was not on the pharmacy log book. The pharmacist stated that she could not locate the book (and the signature evidence) due to the pharmacy's ownership change. The pharmacy could not demonstrate that the patient received the prescription.*

7. Correct referring/prescribing provider

²³ The project selected paid claims for the dates of service during the first calendar quarter of 2006. By the time of the onsite reviews conducted in September 2006, at least one large chain pharmacy had already adopted and implemented signature procedures, thus correcting the beneficiary signatures deficiency identified in claims paid earlier.

MPES 2005 identified that some pharmacies were not providing correct information relating to referring or prescribing provider. This information is critical to monitoring prescribing practices and identifying scenarios that do not make clinical sense. When this information is missing, the Medi-Cal program is vulnerable to potentially inappropriate and expensive prescriptions. In order to confirm that a prescription contains essential information, there are several required criteria, including the status of the referring prescriber. The California Code of Regulations Title 22, Section 51000.30 (e) mandates that the practitioners be licensed and be rendering healthcare services in accordance with corresponding laws, rules and regulations. The intent of the two questions in this category was to address these requirements.

There were 1,464 pharmacies (74 percent) with errors in this category; 21 percent of pharmacies had errors in only one of the five Medi-Cal claims reviewed, and 53 percent had errors in two or more claims (Table 3).

Thirty-five percent of the pharmacies accounted for 69 percent of the total errors for this category. Among the most common errors in this category were instances when the provider's Drug Enforcement Agency number was written on the claim in place of the provider's license number. Transcription errors were also common when, for example, two digits of the provider license number were reversed. Two specific examples of errors in this category are:

- *The prescribing identification number on the claim did not match that of the prescription or the pharmacy's database. According to the pharmacist, the pharmacy may have entered a default physician number (i.e. any number that works...).*
- *The claim shows a prescribing provider number that differs from both the Medical Board website and the pre-printed prescription pad.*

V. Chain and Non-chain Pharmacies

The pharmacies reviewed during this Project were split into two groups for further analysis: 947 pharmacies were identified as members of chains and 1,030 pharmacies were identified as non-chain or independent pharmacies. Chain pharmacies are comprised of members of the five major chains in California: Longs, Walgreens, Rite-Aid/Thrifty/Payless, and CVS, Sav-On/Albertsons, as well as those of several other retailers - Safeway/Vons, Wal-Mart, and Raley's. Non-chain pharmacies are those that are independently owned and operated.

Overall, chain pharmacies accounted for 10 percent more errors than independent pharmacies after adjusting for the relative size of the two groupings. Chain pharmacies had a substantially lower error rate than the non-chain pharmacies with respect to the following categories: Prescription for Date of Service, Complete Prescription and Dispensing. Chain pharmacies, on the other hand, had a substantially higher error rate

than the non-chain pharmacies with respect to the receipt of drug/product and correct prescribing provider ID. These findings indicate that non-chain pharmacies tended to make more significant compliance errors, while chain pharmacies were found to make more errors considered less significant or minor, such as incomplete record-keeping. Examples of significant errors are: the pharmacist is not able to produce original prescription for the drug or device dispensed or the pharmacist is not dispensing the drug or product in accordance with the prescription.

The most pronounced difference between the two pharmacy groupings is found in the results of the combined question involving refill authorization (questions 14 and 15). Errors of non-chain pharmacies were over four times greater than those of chain pharmacies with regard to refill authorizations. Twenty percent of the non-chain pharmacies had errors in this question, compared to six percent of chain pharmacies.

VI. Referrals

As a result of this project, a total of fifty-eight pharmacies were referred for further review of questionable activities. A pharmacy Field Audit Review (FAR)²⁴ was recommended forty-seven times. Five pharmacies received BOP referrals and one pharmacy received a dual FAR/BOPS referral. Three pharmacies received recommendations for an Audit for Recovery (AFR). Additionally, DHCS' PEB and Department of Justice each received one pharmacy referral. The fifty-eight referrals had one or more of the following concerns:

Prescription splitting, early refills, Code 1 restriction not met, incomplete prescription information, no prescription refill authorization, no beneficiary signature logs, prescribing at inappropriate intervals, dosage error, directions for use not listed on the dispensing label, wrong medicine dispensed, dispensing pharmacy and billing pharmacy not the same, no invoice, NDC on claim and dispensing label do not match, pharmacist's conduct of professional standards (e.g., no prescriptions, no directions for use, copy of Rx was with six other medications,) paid claim prescriptions returned to stock, telephone prescriptions with no hard copy documentation, physicians who prescribe medications outside their scope of practice, suspended physicians, pharmacy ownership changes not reported to the DHCS, a pharmacy with disconnected phone number, no customers during review, no sign on store front.

VII. Conclusions and Recommendations

A major area of concern highlighted by MPES 2005 with regard to pharmacies was the lack of compliance with rules and regulations of the Medi-Cal program. The compliance-related violations can generally be grouped into two broad categories; one, where the violations can potentially be harmful to the health of the patient and two, where the violations may harm the fiscal integrity of the Medi-Cal program.

²⁴ Audits and Investigations conducts onsite field reviews of providers with abnormal or suspicious billing patterns and/or related concerns. Such an onsite visit is referred to as a Field Audit Review (FAR)

In part, the DHCS recommended the Project as an effort to remedy the situation by reaching out to the pharmacists, educating them regarding the expectations of the DHCS and providing them with an opportunity to correct their business practices.

This Project intended to highlight areas of possible noncompliance by selecting the most suspicious types of claims submitted by each provider during the period in question and using those as a basis for discussion of how each provider could improve compliance. The Project was successful in this respect. Since the Project focused on areas likely to be noncompliant, errors were readily identified, but this should not be construed to suggest that problems in California pharmacies are worse than identified in the MPES. Simply stated, the study was designed to find noncompliance and to provide an educational opportunity to pharmacists. The Project was a success in increasing the awareness and sensitivity to these noncompliance issues.

As a result of the major findings related to noncompliance by Medi-Cal pharmacies, DHCS makes the following recommendations:

A. Initiate more educational outreach efforts.

The findings warrant further educational efforts to encourage pharmacy providers toward compliance utilizing less resource-intensive methods of educational outreach, including:

- conducting seminars and issuing periodic newsletters explaining specific compliance issues identified through existing anti-fraud activities,
- creating technology-based educational solutions, such as a web-based interactive teaching tool in collaboration with the BOP that would provide pharmacists with easy and convenient access to compliance information, and
- issuing “Report Cards” to individual pharmacies. Such “Report Cards” could be used to compare particular pharmacies to their peers on a range of compliance issues and could highlight specific problems, such as prescription-splitting or the importance of putting proper prescribing provider numbers on claims.

B. Conduct a top-to-bottom review of existing Medi-Cal controls, such as the EDS Payment System Edits used to process pharmacy claims.

In collaboration with the California Pharmacists Association and the California Retailers Association, such a review could be developed to simplify Medi-Cal rules and regulations and assist pharmacy providers to become compliant without undermining Medi-Cal fraud and abuse efforts. For example, the efficacy of Code 1 restrictions and TAR procedures is one topic that should be considered. Modifying the pre-payment claims processing currently in use could detect and eliminate several common types of compliance errors, such as not putting the proper prescriber ID on the claim or not documenting that a Code 1 restriction is met. However, this may have a significant impact in the timely processing of claims and payments to providers if payments were to be denied on a larger number of claims. This, in turn, may result in the unwanted effect of pharmacies becoming unwilling to provide services.

C. Consultation with the BOP regarding documentation of refill authorizations

According to the law, Business and Professional Code 4063, that both Medi-Cal and the BOP abide by, refill authorization must be obtained from the prescribing provider to refill prescriptions. Nevertheless, there appears to be some ambiguity by pharmacies regarding the documentation requirements of a refill authorization. Extensive consultations should be conducted with the BOP to correct any inconsistencies between the rules and regulations of the BOP and the Medi-Cal program with regard to the documentation needed for refill authorizations.

D. Continue DHCS' investigative review of pharmacies

Coincidentally, the reviews conducted through the Project have identified three percent of pharmacies (58 of the 1,977) with serious issues warranting follow-up reviews. These pharmacies have been referred for investigative reviews.

Appendix A
Pharmacy Errors in MPES 2004 and MPES 2005

	MPES 2004 *		MPES 2005 *		Both Studies	
	Errors	Percent	Errors	Percent	Errors	Percent
Total errors	73		203		276	
Pharmacy stratum size	416		561		977	
Pharmacy errors	36	49.3%	77	37.9%	113	41%
Medically unnecessary	7	19.4%	22	28.6%	29	26%
No legal prescription			22	28.6%	22	19%
Policy violation	10	27.8%	11	14.3%	21	19%
Refills too frequent			9	11.7%	9	8%
Prescription missing information			9	11.7%	9	8%
Insufficient documentation	8	22.2%			8	7%
No documentation	7	19.4%			7	6%
Pricing errors	2	5.6%			2	2%
Ineligible provider			1	1.3%	1	1%
No record of drug/supply acquisition			2	2.6%	2	2%
No beneficiary signature			1	1.3%	1	1%
Coding errors	2	5.6%	0		2	2%
Total	36	100.0%	77	100.0%	113	100%

*Sample size for MPES 2004 and MPES 2005 was 800 claims and 1,123 claims, respectively.

Appendix B
Number of Errors and Number of Pharmacies with Errors by Question

Categories and Related Questions	Errors		Number of Pharmacies with Errors*	
	Number	Percent	Number	Percent
1. Established place of business Subtotal	78	0.5%	58	2.9%
1. Is there an established pharmacy at the address?	3	0.0%	3	0.2%
2. Were any customers present?	15	0.1%	15	0.8%
3. Was there electricity and working phones?	1	0.0%	1	0.0%
4. Were the doors unlocked during the posted operating hours?	3	0.0%	3	0.2%
5. Was there a sign identifying the pharmacy?	7	0.0%	7	0.4%
6. Is the business stocked like a pharmacy?	4	0.0%	4	0.2%
7. Does the pharmacist have a valid license? (Title 22 §51227)	10	0.1%	10	0.5%
8. Does the pharmacy have a valid permit? (Title 22 §51226)	11	0.1%	11	0.6%
9. If there are pharmacy technicians, are they supervised by the pharmacist?	6	0.0%	6	0.3%
10. Are there suspicious activities in or around the pharmacy? (Inducements, selling Rx's outside of pharmacy, etc.)	17	0.1%	17	0.9%
11. Is the pharmacist actively engaged in the activities in the pharmacy?	2	0.0%	2	0.1%
2. Prescription for Date of Service Subtotal	887	5%	458	23.2%
12. Is there a prescription with the correct patients name on it?	294	2%	202	10.2%
13. Is the prescription for the same drug as the dispensing label and claim?	194	1%	135	6.8%
14. If it's a refill, was the refill authorized with the original prescription?	399	2%	263	13.3%
15. If not, was there a current refill authorization either by phone or fax?				
3. Complete Prescription Subtotal	1,247	7%	597	30.2%
16. Is the drug/device prescribed by a licensed provider?	94	1%	75	3.8%
17. Is the correct patient name and address on prescription or refill?	185	1%	116	5.9%
18. Is the prescription dated?	222	1%	177	9.0%
19. Are the prescribed drug or device, strength, quantity, refills, and specific directions for use on prescription?	315	2%	235	11.9%
20. Did the prescriber sign the written prescription? Did oral or electronic Rx must contain name of provider and/or authorized agent of who transmitted order for prescriber?	205	1%	135	6.8%

21. Is the name, address, phone number and license number of prescriber, and DEA number for controlled substance, on prescription (paper) or readily retrievable in pharmacy for oral or electronic prescription?	226	1%	153	7.7%
4. Dispensing Subtotal	4,797	29%	1,474	74.6%
22. Was a copy of the dispensing or trailer label provided?	210	1%	131	6.6%
23. Was the correct number/amount of product dispensed according to prescription?	987	6%	723	36.6%
24. Was the correct strength of drug dispensed?	102	1%	86	4.4%
25. Did the prescription number on the claim match the prescription number on the label?	79	0%	64	3.2%
26. Was the quantity billed by the pharmacy the same as ordered by the prescriber on the prescription?	996	6%	737	37.3%
27. Is the day's supply of product correct?	520	3%	419	21.2%
28. Were limitations or Code 1 restrictions adhered to or a TAR obtained?	876	5%	673	34.0%
29. Was the prescription filled/refilled within appropriate interval?	1,027	6%	695	35.2%
5. Inventory Subtotal	2,565	15%	961	48.6%
30. Was a copy of invoice for drug/device dated on or preceding date of service obtained?	1,072	6%	484	24.5%
31. Does the NDC or item number for drug/device on the invoice match that on the claim?	1,493	9%	745	37.7%
6. Receipt of drug/product Subtotal	3,376	20%	1,257	63.6%
32. Did the beneficiary sign for receipt of the medication?	3,376	20%	1,257	63.6%
33. If someone else signed for the beneficiary, are their printed name and relationship to beneficiary included with their signature?				
7. Correct prescribing provider Subtotal	3,702	22%	1,464	74.1%
34. Is the referring provider on the claim the same as the referring/prescribing provider on the prescription?	3,702	22%	1,464	74.1%
35. <i>Is the referring prescriber licensed and in good standing?）**</i>				
Total errors and total pharmacies with errors	16,652		1,914	
Total number of pharmacies reviewed	1,977			
Total number of Claims reviewed	9,885			

* The sum of pharmacies for questions within a particular category may not add to the subtotal because a given pharmacy may have errors in more than one specific question.

** Questions 14-15 are combined, as are questions 32-33. Question 35 was not used as onsite reviewers did not determine whether the prescriber was in good standing.

Appendix C

Comments from Pharmacy Associations

In June 2007 DHCS conducted a meeting to present the findings of the Pharmacy Outreach Project to the California Pharmacists Association, the California Retailers Association and the California Board of Pharmacy. A number of pharmacy representatives were also present at the meeting. A draft version of the Pharmacy Outreach Project report was presented at the meeting in June. The comments/input received from those in attendance was based on the draft report.

The associations and their members raised a number of concerns regarding several of the findings identified by the Pharmacy Outreach Project, as well as how the findings were portrayed in the draft report presented in June. Input received from the associations was evaluated and incorporated as appropriate into this report to address a number of the comments and concerns raised by the associations.

The comments provided by the associations are attached following page 30 of this report.



July 9, 2007

David Botelho
Deputy Director
Audits & Investigations
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Sacramento, CA 95899-7413

Re: Comments on Pharmacy Outreach Project (POP) Draft Report

Dear Mr. Botelho:

The California Retailers Association appreciates the opportunity to provide comments on the Pharmacy Outreach Project (POP) draft Report. CRA members expressed concerns during our meeting at the California Department of Health Care Services (DHCS) about some of the conclusions and findings in the POP draft Report on June 18. Based on the June 18 discussions, it is our understanding that that DHCS is going to attempt to address the concerns raised that day in the final POP Report. As CRA will not be able to review the final POP Report prior to its release, we offer our comments based on that understanding.

In September 2006, the Department of Health Services Audits and Investigations Department launched the "Pharmacy Outreach Project." The POP was intended to be an education-only program so that DHS could ensure that pharmacies and pharmacists are aware of proper billing procedures within the Medi-Cal system.

CRA's chain drug members are supportive of making sure that everyone in the pharmacy industry is educated on proper Medi-Cal billing procedures and following those procedures. To that end, CRA's chain drug members were pleased to cooperate as proactive participants in the POP educational effort, voluntarily contributing additional personnel hours to help with the process, assist DHCS auditors, and to offset the possibility of disruption to pharmacies.

Through our participation with DHCS and in the POP effort, pharmacies have come to a better understanding of the challenges being presented to the Medi-Cal program due to the outdated Medi-Cal claims adjudication system. We believe that a high percentage of the errors for which DHCS reviewed claims could be stopped automatically by the Medi-Cal adjudication system if it was programmed to do so. Our members believe that the State of

California could save a significant amount of money if their adjudication system was updated and/or improved.

Though the POP Report was intended as an educational outreach to pharmacies, CRA appreciates the opportunity to clarify the following points for POP Report readers:

Not a Random Sampling of Claims: Any reading of the POP Report must be mindful of the fact that the POP effort did not review a random sampling of Medi-Cal claims. Based on the intent that the POP review was an educational outreach effort to pharmacies, DHCS intentionally targeted those claims which were believed to be the most likely to contain billing errors. The POP Report should not be viewed as scientific findings or representative of pharmacy practice as a whole. It was *expected* that the claims reviewed would reveal Medi-Cal billing discrepancies. It should also be noted that any “variance” in billing was recorded as “non-compliance” in the POP review, even in those cases where the variance resulted in savings to the State.

Problematic Quarter of Claims to be Reviewed: The POP effort only reviewed claims submitted during the first quarter of 2006 (January 2006 through March 2006). This particular quarter is notable because this was also the time period during which pharmacy providers were challenged with overcoming the considerable confusion and frustration associated with the implementation of the new Medicare Prescription Drug Benefit, Medicare Part D. The first part of 2006 and the implementation of Medicare Part D presented immense complications for pharmacies in ensuring that beneficiaries were properly enrolled and/or recognized in the new system(s), while attempting to ensure that beneficiaries did not experience a disruption in their prescription drug benefits. Our members believe that the claims reviewed during this period will not be representative of standard pharmacy practice, and instead, will be negatively skewed.

Discrepancy in Standard Pharmacy Practice: Through the POP review process, it was discovered that discrepancies exist between DHCS requirements and California Pharmacy Law. For example, there is a discrepancy about what constitutes proper retention of invoices and how quickly they must be produced, and what constitutes proper documentation of a refill authorization. Many “errors” in the POP Report could be attributed to such inconsistencies in interpretation. We are appreciative of the recognition of these discrepancies by DHCS and their recommendation that DHCS work directly with the Board of Pharmacy to address these issues.

Caution against Conclusions absent Evidence: CRA has serious concerns about conclusions being drawn in the POP Report that were not measured by the POP effort. Specifically, our members believe that it is not accurate to state that certain billing issues cause harm to patients. The POP effort in no way evaluated if any harm occurred to a beneficiary as a result of a billing error. DHCS only evaluated if the claims were billed correctly and should be limited to conclusions based on billing accuracy. Similarly, we are concerned that the POP Report’s reference to “serious errors” could be easily misinterpreted. The draft POP Report identified “serious errors” relative to the number of errors, rather than the severity or significance to the Medi-Cal program. Since the POP

review was designed in such a way that a negative response to one audit question would dictate negative responses to numerous other audit questions, CRA believes that there is a likelihood of many billing errors being miscalculated or interpreted as “serious errors.”

Again, the California Retailers Association appreciates the opportunity to offer the comments of our members for inclusion in the final Pharmacy Outreach Project Report. We look forward to working with the California Department of Health Care Services to evaluate the information gleaned through the Pharmacy Outreach Project to identify the most efficient means to address Medi-Cal billing accuracy.

Sincerely,

A handwritten signature in cursive script that reads "Heidi Barsuglia".

Heidi Barsuglia
Director, Government Affairs

July 9, 2007

David Botelho
Deputy Director
Audits & Investigations
Department of Health Care Services
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Sacramento, CA 95899-7413

Re: Comments on Pharmacy Outreach Project (POP) Draft Report

Dear Mr. Botelho:

The California Pharmacists Association (CPhA) would like to thank the California Department of Health Services (DHS) for giving us the opportunity to review and provide comments on its draft report regarding the Pharmacy Outreach Project (POP). From the outset of the project, CPhA worked with DHS to encourage pharmacies and pharmacists to cooperate with the auditors. The main goal of the project, to educate Medi-Cal Pharmacy providers about the current billing procedures and requirements, will benefit pharmacies as well as the State. CPhA is pleased to be part of the team in helping with the educational effort.

As we shared with DHS at the stakeholder meeting on June 18, the draft report presented several concerns. DHS has indicated that these concerns will be addressed to the extent possible in the final report. Given that we will not have an opportunity to review the final report before it is public, we feel that this letter is better directed toward general comments about the report. Where appropriate, specific issues may be described, but are most often intended to be for the purpose of illustration rather than as a commentary or criticism of any particular section of the report.

With that in mind, we submit the following comments:

I. THE CLAIMS CHOSEN FOR REVIEW FOR THE POP WERE TAKEN FROM THE INITIAL QUARTER OF IMPLEMENTATION OF MEDICARE PART D.

The POP was conducted in September 2006. The claims which were reviewed by the auditors were chosen from the period January 2006 through March 2006. January 2006 was the initial implementation of the new Medicare Prescription Drug Benefit, Medicare Part D. During the initial implementation and for many months thereafter, Medicare Part D presented an enormous amount of problems for everyone in the healthcare system, most especially the patients and the pharmacists. CPhA feels very strongly that this time period (January – March 2006) does not represent a typical sample of claims processed in the ordinary course of business for a pharmacy. The time period chosen creates a significant negative bias in the data being collected.

II. THE POP CATEGORIZATION “SERIOUS ERRORS” SHOULD BE RECONSIDERED AND NO CONCLUSIONS REGARDING PATIENT HARM SHOULD BE DRAWN WITHOUT DIRECT EVIDENCE.

CPhA suggests that the use of the categorization “serious errors” in the POP report be eliminated. The criteria used in the POP to determine what constitutes a “serious error” is related to the number of errors, and not to the significance of the errors to the Medi-Cal Program

or to patient health. DHS admits that the POP design was such that a “no” response to one

question in the audit survey would dictate the response to several other questions. In addition, the POP audits were designed to research the incidence of errors and not the causes nor consequences of those errors.

III. THE REPORT SHOULD REFLECT THE PURPOSE AND SCOPE OF THE POP: TO RESEARCH MEDICAL PAYMENT ERRORS, IDENTIFY THE SCOPE OF PROBLEMS AND PURSUE METHODS TO CORRECT THEM THRU EDUCATIONAL EFFORTS.

The Department met with CPhA in July 2006 to discuss the POP and seek our assistance in preparing community pharmacies for the audits that would follow. In the materials provided at that time, the objective of the program was identified as the following: to inform and educate providers of Medi-Cal requirements and to provide them with an opportunity to correct any errors identified through this review. This was consistent with the training provided to the DHS staff who conducted the audits, who were told the purpose of POP was to “provide information on procedure compliance errors to pharmacies.” The POP report needs to maintain this focus and emphasize to readers that the POP was intended to be a research and education tool.

IV. THE REPORT SHOULD PRIMARILY FOCUS ON FACTS SUPPORTED BY THE RESEARCH AND SHOULD RECOGNIZE THAT THERE ARE A VARIETY OF EXPLANATIONS FOR THOSE FACTS.

The draft report reviewed by CPhA contained a wide range of facts based in the research done during the POP. These facts provide very useful information on common pharmacy billing practices. Analysis of these facts in the report will be very helpful in identifying how corrective action should be directed. However, because these facts can be explained in a number of different ways, they should not be used to draw conclusions about the intentions of pharmacy providers. For example, the draft report we reviewed said that “64% of pharmacies were found to have errors related to documenting receipt of the drug by the Medi-Cal beneficiary.” There are several explanations of why this type of error would occur. The POP audits identify only that the documentation was lacking but not why the documentation was lacking.

V. THE DRAFT REPORT REFLECTS SOME ISSUES WHERE THE VIEW OF LEGAL REQUIREMENTS BY DHS DIFFERS FROM THE STANDARD FOR PHARMACY PRACTICE.

The most obvious instance of this is in the documentation of refill authorizations. The California Pharmacy Law does not require pharmacies to keep written documentation of refill authorizations from prescribers; a notation in the computer is all that is usually kept by pharmacies. Additionally, physician’s offices often do not chart refill authorizations. Many of the “errors” for “lack of prescription for date of service” may be related to this inconsistent interpretation of the law. To their credit, DHS has identified this as a factor in the errors in this area, and their recommendations include working with the Board of Pharmacy to address the issue.

VI. IN THE DRAFT REPORT, THERE APPEAR TO BE SOME INCONSISTENCIES BETWEEN FINDINGS BY AUDITORS AND WHAT DHS ASSUMED ABOUT THOSE FINDINGS.

One finding in the draft report is that 74% of pharmacies had process errors related to the proper identification of the prescriber – there are various reasons for these process errors, including the prescriber ID on the billing did not match the prescriber on the prescription. CPhA and others suggested that this finding could be accounted for by the use of nurse practitioners and physician assistants, whose prescriptions are billed using the ID number of their supervising physician. DHS felt this was not a factor for the auditors, but several of the pharmacy

representatives present indicated the auditors routinely identified this situation as an error. We cannot identify other findings that may be similar, but the report should emphasize that most of the auditors were working outside their usual scope of work, with minimal training and little or no

background in pharmacy operations. As such, this type of unexpected finding regarding errors should be looked at in more detail.

VII. THE DRAFT POP REPORT SHOULD IDENTIFY CURRENT BILLING REQUIREMENTS THAT ARE NEW AND DIFFERENT FROM BILLING PRACTICES THAT EXISTED FOR YEARS IN THE MEDI-CAL PROGRAM.

The draft report contains a finding that 49% of pharmacies had errors related to producing invoices to support billed claims. We expect many of these errors are related to billing using an NDC number for another package size. The requirement to bill the NDC actually dispensed is relatively new and is a departure from prior policy that required billing using standard package sizes (100's, pints or pounds). Pharmacies certainly need to bill claims properly, but CPhA feels the report should not place too much importance on this and other errors related to new requirements that will require pharmacies to modify practices that have been in place for decades.

VIII. DRAFT POP REPORT RECOMMENDATIONS

CPhA supports the recommendations we found in the draft report. We believe these recommendations reflect a reasoned and reasonable method of follow up that will result in improvements in provider claim submission. In addition, we suggest the addition of a "Provider Self-Assessment" document, similar to the one used by the Board of Pharmacy, tailored to the requirements of the Medi-Cal Program.

Again, the California Pharmacists Association very much appreciates the opportunity we were provided by DHS to review and provide comments on the draft report of the Pharmacy Outreach Project.

Best regards,



Lynn Rolston Chief Executive Officer