2007

Medi-Cal Payment Error Study

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

Fee-For Service and Dental Programs

DHCS
California Department of HealthCareServices

Table of Contents

I. MPES 2007 Executive Summary
II. MPES 2007 Background
III. Study Design and Methodology
IV. Review of Protocols
V. Summary of Payment Errors By Stratum
VI. Summary of Potential Fraud Errors
VII. Detail Summary of Errors
VIII. Final Review Error Codes
IX. Study Results and Statistical Summaries
X. MPES Comparison of 2005-2007
XI. Significant Findings and Actions Taken On Errors
XII. Review of Other Error Studies
XIII. Glossary of Acronyms

Appendix A – State Controller's Office Report on Local Education Agency

Section I
MPES 2007 EXECUTIVE SUMMARY

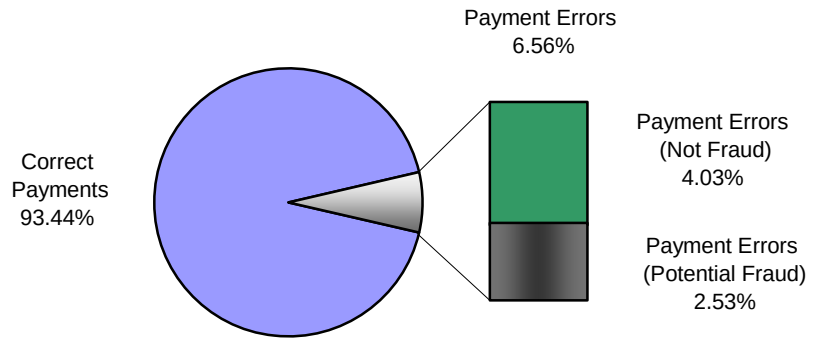
The California Department of Health Care Service (DHCS) has completed the fourth annual Medi-Cal Payment Error Study (MPES) as part of its continuing efforts to detect, identify and prevent fraud and abuse in the Medi-Cal program. The MPES helps develop fraud control strategies by identifying vulnerabilities in the Medi-Cal program.

Due to the inherent difficulties in measuring payment errors associated with medical claims, very few states have attempted to scientifically estimate a percentage of error in their health care program payments. California's MPES appears unique as it is the only study conducted by a state or federal entity that includes an estimate of potential fraud (see Section XII for details on other error rate studies).

Eight strata, or provider type groupings, compose the MPES 2007 sample of 1,148 claims. The Inpatient stratum accounted for 46 percent of the overall claim dollars in the sample. The Pharmacy stratum and the Physicians Services stratum both had 18 percent of the sample claim dollars. The other five strata (ADHC, Dental, Durable Medical Equipment (DME), Labs, and Others Services and Supplies) each had less than six percent of the overall dollars in the sample.

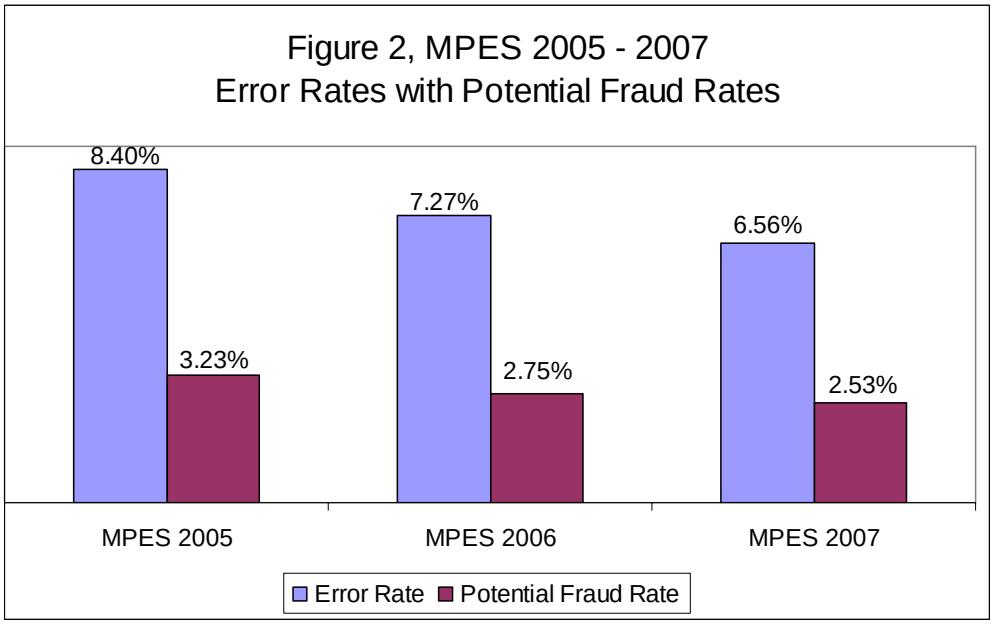
The MPES 2007 shows that an estimated 6.56 percent of the total Medi-Cal Fee-For-Service (FFS) dollars paid had some indication that they contained a provider payment error (see Figure 1). This means that 93.44 percent of total dollars were billed and paid appropriately in the FFS medical and dental programs. Claim errors ranged from simple provider mistakes, such as billing for the wrong patient, to more significant findings indicative of potential fraud, such as billing for services not provided.

Figure 1, MPES 2007
Proportion of Dollars in Sample Paid Correctly versus Paid in Error & Potentially Fraudulent



Extrapolating from the MPES sample to the program as a whole, the 6.56 percent equates to $1.05 billion of the total of $16 billion in annual payments made for FFS medical and dental services in Fiscal Year 2006-2007 covered by the MPES[1].

As shown in Figure 2, over the past three years the MPES error rate has shown a steady decline[2]. The MPES 2007 rate is almost 10 percent less than the rate for the MPES 2006, which itself was 16 percent lower than the MPES 2005 error rate of dollars. In terms of overall program dollars this means that approximately $500 million less dollars were paid for claims that contained errors[3].



The MPES 2007 also shows a continued drop in the potential fraud error rate and fraud dollars at risk. Of the total payments, 2.53 percent, or $405 million dollars, were for claims submitted by providers that disclosed characteristics of potential fraud. The term "potential fraud" is used because in order to determine exactly how much of the

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[1] *The MPES includes all of the FFS and dental claims except for that portion which is not claim driven i.e. disproportionate payments to hospitals or made through other state departments for Medi-Cal services i.e. as mental health services provided through the Department of Mental Health, as well as other costs such as Managed Care. Further explanation can be found in the Background Section.*

2 The first MPES was the MPES 2004. However, that year's results are not included in this analysis because of major differences in that study's number of strata, sample size, and the evaluation methodology).

3 The annualized MPES 2007 overall estimated dollars "at risk" of $1.05 billion is a drop of $150 million from the approximately $1.2 billion estimated "at risk" found by the MPES 2006, and a drop of $350 million compared to the estimated $1.4 billion "at risk" found by the MPES 2005.

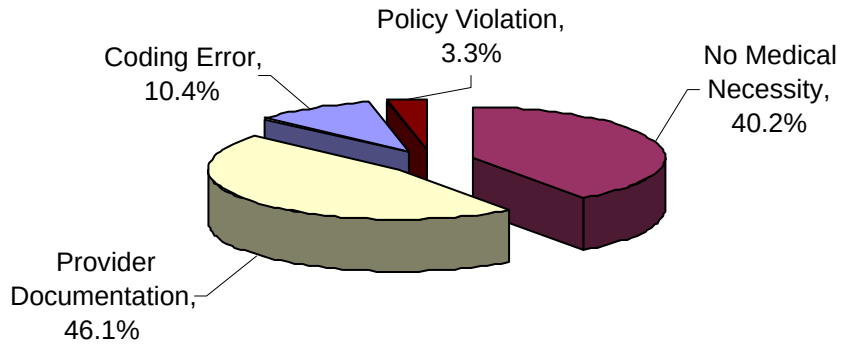
payment error is attributable to fraud requires a complete criminal investigation, which is beyond the scope of the MPES.

The potential fraud error rate has much more significance to the Medi-Cal program than the overall MPES error rate, because this rate is generated from errors that should not have been paid (i.e. such as a physician denying he wrote a prescription for X drug). This does not hold true for the MPES errors other than potential fraud errors since these errors do not change the underlying validity of the claims. They may be due to a lack of sufficient documentation or not following the appropriate policy but with the proper documentation these claims would have been paid.

ERROR TYPES

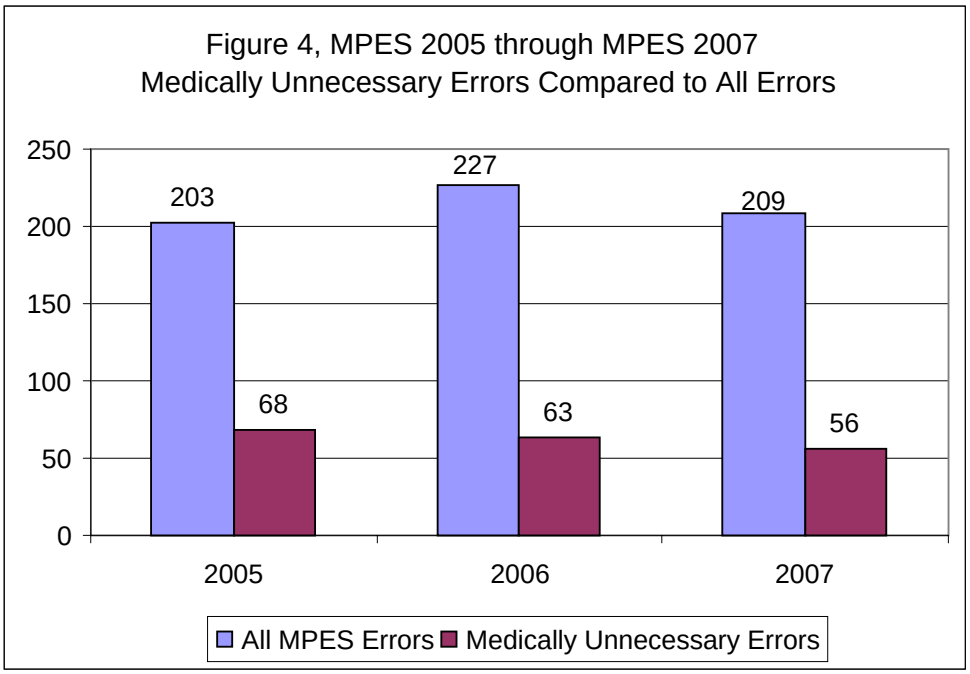
Figure 3 summarizes the percent of sample dollars estimated to have been paid in error by error type. For the MPES 2007 insufficient documentation was the largest sample dollar error type. This means that the documentation presented by the provider did not support the services claimed. But it does not mean that the services were not provided or not medically necessary, and therefore, would not represent an actual overpayment except for the lack of documentation.

Figure 3, MPES 2007
Distribution of Sample Dollars Paid in Error by Error Type



The most significant MPES error category is lack of medical necessity based on a detailed review of actual patient records, not just the documentation accompaning the claim. Medically unnecessary errors accounted for 27 percent of the total number of MPES 2007 errors. All dollars associated with a lack of medical necessity errors are at risk of being paid inappropriately as the dollars were spent for no value. While not a formal statistical estimate of the study, a rough estimate of the potential magnitude of this problem can be made by multiplying the 27 percent of the MPES 2007 errors involving lack of medical necessity times the overall estimated dollars at risk of $1.05 billion, which amounts to approximately $280 million. In terms of dollars, the reduction in errors due to lack of medical necessity represents a potential true savings to the program as it avoids spending dollars without legitimate justication.

Figure 4 shows the proportion of medically unnecessary errors in relation to the total number of errors for the MPES 2005 through MPES 2007. The percentage of errors due to medical necessity has been relatively unchanged for the past three studies: 27 percent of the errors that were medically unnecessary this year was somewhat less than the 28 percent and 33 percent for the MPES 2006 and MPES 2005, respectively. This drop in the percentage of medically unnecessary errors from MPES 2005 to MPES 2007 is estimated to be a reduction of $172 Million.[4]

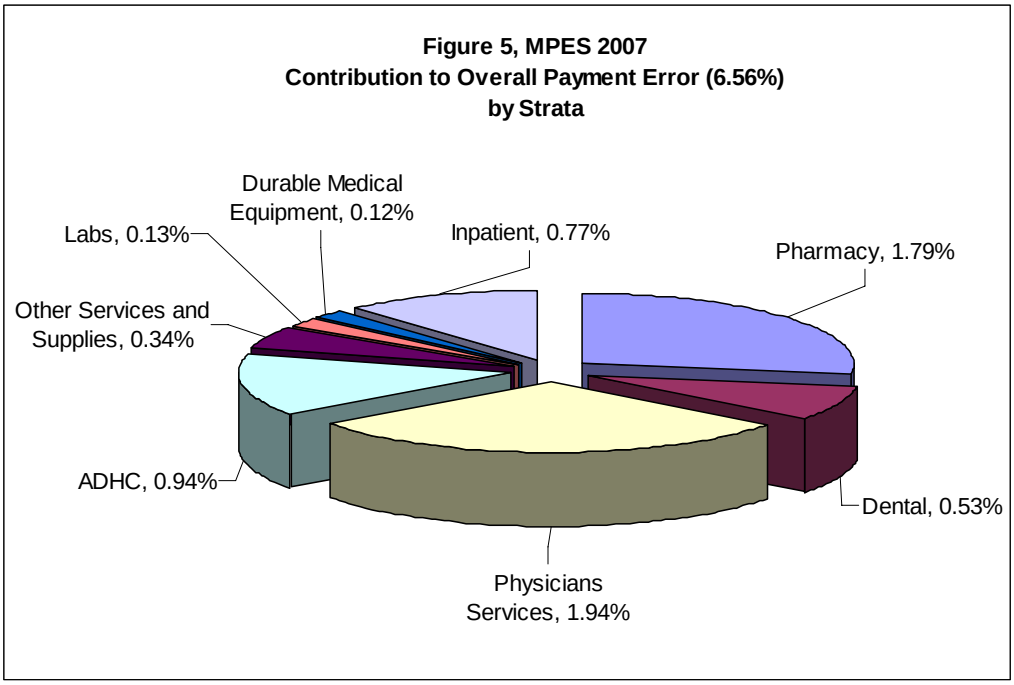


A majority of the medically unnecessary errors consists of those with characteristics of fraud as they involve deliberate efforts to exploit the Medi-Cal program for financial gain. Approximately 77 percent of the medically unnecessary errors this year were potentially fraudulent. Errors due to lack of medical necessity may or may not be fraudulently motivated. For example, a physician may choose to empirically treat a patient with an antibiotic for a simple cold, which is medically unnecessary but not fraudulent. In this case the physician did not stand to gain with the action, and the pharmacy that filled the prescription and billed the program had no control over the prescriber's action. Errors that are fraudulent very often also lack medical necessity.

[4] The extrapolated rough annual estimate for lack of medical necessity errors for the MPES 2007 was $280 million, or $172 million less than the estimated $452 million for the MPES 2005.

ERRORS BY STRATA

Figure 5 below depicts the percentage contribution to the overall MPES 2007 payment error by strata, and will serve as a basis for the following discussion of findings by order of the highest stratum contribution to the error rate.



Physician Services Stratum

Physician Services, which is a stratum composed of a variety of primary care providers and clinics, contributed the most to the overall error rate. In fact, that stratum's contribution is actually even higher considering that 43 errors in other strata were due to lack of medical necessity errors involving unneeded prescriptions or referrals by physicians. Those 43 errors combined with the existing 71 Physician Services errors means that physicians accounted for 114 errors, or 55 percent of the 209 total errors.

Pharmacy Stratum

There has been a gradual decline in the percent of Pharmacy stratum errors relative to the overall number of study errors. Pharmacy stratum errors accounted for 31 percent of the total errors in the MPES 2007, which is less than the 33 percent and 38 percent that this stratum accounted for in the MPES 2006 and MPES 2005, respectively.

In this year's study, there were less prescription splitting errors, where the quantity of medication dispensed is less than authorized, creating an opportunity for another prescription to be dispensed at a later date for the remaining medication with an additional dispensing fee tacked on. This positive result reduces inappropriate dispensing fees and is believed to be related to the site visits to nearly 2,000

pharmacies statewide conducted as part of the Pharmacy Outreach Project that focused on pharmacy vulnerabilities identified by the MPES 2005. The MPES 2007 is the first study to examine claims subsequent to that project.

Some further evidence of the beneficial impact of the Pharmacy Outreach Project is that fewer errors in the stratum are due to the pharmacies themselves, but now more are attributable to the prescriber. For the MPES 2007, prescribers accounted for 43 percent of the pharmacy errors based on the determination that the prescription was not medically necessary. In other words, pharmacies themselves accounted for 57 percent of the stratum's errors in the MPES 2007, which was less than the 69 percent for the MPES 2006 and 71 percent for the MPES 2005.

ADHC Stratum

The MPES results have consistently shown a high error rate for the ADHC stratum. The ADHC estimated error rate was 62.23% for the MPES 2005, 33.51% for the MPES 2006, and 42.54% for the MPES 2007. Even though ADHCs represented only $0.4 billion (or less than 3%) of the overall $16 billion in the Medi-Cal FFS medical and dental services budget for FY 2006-2007 covered by the MPES, their contribution to the MPES overall payment error rate has been significant in the last three annual studies. For example, in MPES 2007, ADHCs were the third largest contributors to the overall error rate, behind physicians and pharmacy. In addition, most ADHC errors found in the last three studies were for lack of medical necessity (90% in MPES 2005, 74% in MPES 2006, and 82% in MPES 2007). In other words, the large majority of beneficiaries are admitted by ADHC providers inappropriately; they don't need those services. For example, this year the ADHC stratum had one exceptionally high cost claim found to be in error (an ADHC patient received 22 days of medically unnecessary service).

The MPES 2007 percent of ADHC potentially fraudulent claims is a concern and far higher than any other stratum. For the ADHC claims in the MPES 2007 there were 20% that were potentially fraudulent (10 out of the 50 claims sampled), the same as for the MPES 2006. Though declining, the potential fraud subset of the ADHC error rate has been consistently high. The MPES 2005 potential fraud rate was 58.04%; the MPES 2006 potential fraud rate was 19.68%, and the MPES 2007 potential fraud rate was17.16%.

Inpatient Stratum

The MPES 2007 found two errors in claims submitted within the Inpatient stratum, which is comprised of institutional providers, primarily hospital and Long-Term Care (LTC) providers. Both Inpatient errors found involved LTC providers. In previous years the MPES had not found errors in this stratum. These providers generally have strong internal controls plus Medi-Cal's prior authorization processes enhance the controls over institutional services.

Even though there were only two Inpatient errors, this stratum nevertheless raised the overall error rate by nearly 1 percent (from 5.79 without these two errors to 6.56 with them) since it has the most dollars of any stratum.

Dental Stratum

Denti-Cal's MPES 2007 results show a decrease in the stratum's number of errors compared to the MPES 2006. Some of this change may be early signs of the impact of Denti-Cal's efforts to educate and inform providers on sufficient documentation vs. insufficient documentation, which has been a significant factor in prior studies.

There were no dental claims found to be potentially fraudulent in the MPES 2007, a significant improvement compared to the 12 dental errors with fraudulent characteristics in the prior 2006 MPES.

Other Services and Supplies Stratum

This stratum includes transportation, medical supplies, and LEA programs, among others, and the significant areas of concern were:

1) Local Educational Agency (LEA)

LEAs, which consist of school districts and county offices of education, may enroll as Medi-Cal providers and submit claims to be reimbursed for medical assistance they provide to Medi-Cal eligible students. This Medi-Cal billing option program, established in 1993, provides comprehensive health services to eligible Medi-Cal students in a school environment. The LEA payments are comprised of federal funds and county or school district matching funds. There were 50 percent of the LEA claims in error (16 out of 32). This matches prior MPES results. For the MPES 2005 through 2007 combined, almost half of the LEA claims have been found in error (46 out of 100). As a result, at the DHCS' request, the State Controller's Office (SCO) investigated the scope of LEA issues. After reviewing approximately 350 claims from 17 LEA providers, the SCO recommended more training for LEA providers on Medi-Cal requirements. Additionally, SCO recommends that DHCS increase its oversight of the LEA program by identifying high-risk providers, audit the most egregious providers and make financial recoveries where possible. Among the many serious problems found by the SCO were no medical assessments of students, lack of referrals for services by licensed practitioners, no or inadequate documentation for services, and services rendered to ineligible students. As a result, the Department is working work with LEA providers on focused training in program requirements and documentation as well as audits for recovery when warranted. The SCO report is included as Appendix A in this report.

2) Transportation Services

For Ground Medical Transport claims 40 percent were in error (4 out of 10) in the MPES 2007, a steep rise over the 12% in the MPES 2006 and 15% in the MPES 2005. Three of the MPES 2007 Ground Medical Transport claims were also potentially fraudulent.

Based on these findings, DHCS will be conducting statewide site visits to 215 Non-Emergency Medical Transportation (NEMT) providers to determine the scope and extent of this vulnerability. The main purpose of this review is to assure that NEMT providers are meeting Medi-Cal quality standards for Medi-Cal enrollees and that the program is free of waste, fraud and abuse.

Laboratory Stratum

Within this stratum two of the twelve lab errors involved potential fraud, but these claims on a dollar basis were less consequential than other strata and no distinct patterns of fraud were detected.

Durable Medical Equipment (DME) Stratum

The DME stratum continued to have little impact on the MPES error rate because of the low dollar and claims volume for this provider type, although it increased from last year's contribution. DME errors also had characteristics of fraud such as a high-cost wheelchair error where the beneficiary never received it and the physician never prescribed it.

Follow-Up Actions

The recent MPES findings have prompted action on several specific areas of concern:

- A Physician education effort to decrease medically unnecessary errors is underway in collaboration with the California Medical Association, the Centers for Medicare and Medicaid Services (CMS), and the American Russian Medical Association;

- Staff has been redirected toward special projects reviewing ADHCs, resulting in numerous sanctions and ADHCs discharging up to 50 percent of their beneficiaries who were not eligible.

- Drug diversion audits/reviews have been completed in Southern California and Northern California which have resulted in provider sanctions and increased Treatment Authorization Request (TAR) controls over controlled drugs;

- The high number of LEA claims in error resulted in the DHCS working with the State Controller's Office to address issues with this provider type;

- Non-Emergency Medical Transportation (NEMT) providers have been the focus of a special project with onsite reviews at 215 ground transportation providers;

Future actions will center on reenrolling incontinence supply dealers and probe audits in Long-Term Care providers to determine the prevalence of errors.

Conclusion

The MPES continues to indicate that DHCS' current focus on non-institutional providers, specifically physicians, ADHCs and pharmacies, is targeting areas of highest risk for payment errors. Errors for medically unnecessary services and potentially fraudulent errors remain the errors of most concern to the Department. Reductions in either of these types of errors will produce savings to the program since the services were either not needed or provided for personal gain, or both.

The next study will be the MPES 2009. The claims for this study will be drawn from claims paid in the second quarter of calendar year 2009. The collection of data will be accomplished in the first quarter of 2010.

Section II
MPES 2007 BACKGROUND

Combating fraud, waste and abuse in California's largest publicly funded health care program, Medi-Cal, is a priority for the DHCS. This was the impetus for the Medi-Cal Payment Error Study (MPES), with the goal of identifying the extent of fraud, waste, and abuse risks in the program while measuring the effectiveness of anti-fraud strategies.

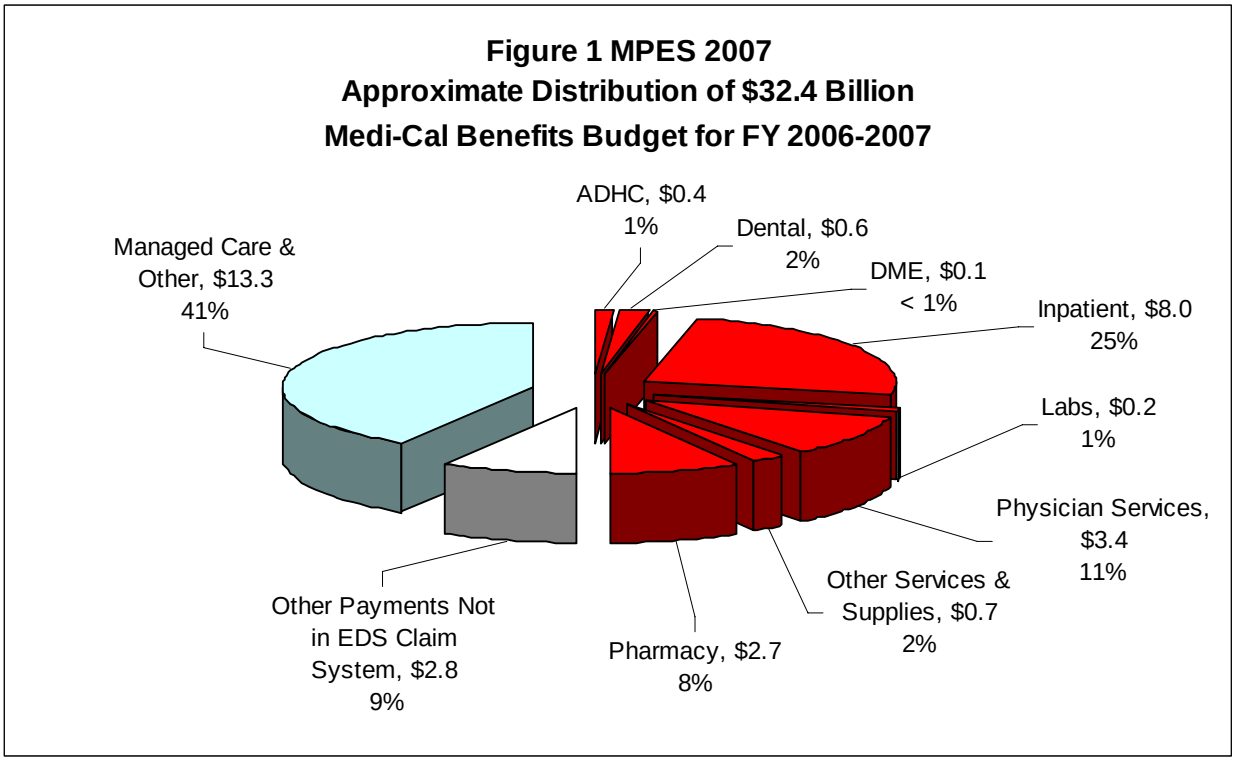
The MPES assists the Department in determining where the program is at greatest risk for payment errors and provides an estimate of the potential dollar loss to the program, including potential loss due to fraud, waste and abuse.

The primary goal of the MPES from 2004 through 2007 has been to strategically identify fraud practices and to help ensure that DHCS' anti-fraud activities remain focused on the areas of highest risk. 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. The MPES is currently the only known study conducted by a state or federal entity that includes a potential fraud subset in its estimate of payment error.

The Medi-Cal program serves over 6.5 million beneficiaries. Approximately 3.25 million beneficiaries (50 percent) are enrolled in the Medi-Cal Fee-For-Service (FFS) system. This means that providers are paid a fee for each service provided. Not part of the MPES are the remaining 3.25 million beneficiaries (50 percent) 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 MPES 2007 reviews concentrated on claims paid through the FFS and dental systems in calendar year 2007, which are shown in red in Figure 1. They represent approximately 50 percent of the total $32.4 billion Fiscal Year 2006-2007 Medi-Cal benefits budget shown.[5]

[5] The MPES includes all of the FFS and dental claims except for the $2.8 billion show as "Other Payments Not In EDS Claim System as that portion in general includes payments which are not claim driven, e.g. disproportionate payments to hospitals, or are made through other state departments for Medi-Cal services, e.g. as mental health services provided through the Department of Mental Health.



The MPES 2007 is based on a sample of claims paid in the second quarter of calendar year 2007 (April 1 through June 30, 2007). The MPES 2007 reviewed the same types of medical and dental payments as did the MPES 2005 and MPES 2006.

The MPES 2007 is the fourth annual Medi-Cal payment error study conducted by the Department. 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 the MPES 2007 continued to be refined and improved based upon what was learned from the last three studies in order to enhance the effectiveness of both the MPES as well as the Department's fraud control activities.

SAMPLING METHODOLOGY

The MPES 2007 sampling strategy used proportional stratified random sampling to generate estimates of payment and fraud error. These were then extrapolated to determine the potential dollar loss to the program due to provider claiming errors. This is a widely accepted standard statistical technique used to measure sample estimates[6].

Other states and federal payment error studies also employ random sampling and extrapolation techniques to measure payment error for medical claims. These studies

[6] See Section III for sample plan details.

have reported payment errors ranging from 3 percent to 24 percent[7]. 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 the MPES 2007 used the same statistical sampling design as the previous studies (Section III), the review processes were further refined to minimize the non-sampling errors and improve the inter-rater reliability of the review process (details presented in Section IV). As in previous years a training program prepared all staff in the review of claims and related supporting medical records and documentation in order to provide consistent and methodical evaluation of all claims.

DHCS' review processes are generally accepted standard review procedures that other states conducting similar studies have used[8]. A multidisciplinary team of medical professionals, auditors, analysts and researchers conducted the MPES. To ensure the integrity of the study, claims data were collected from an on-site review at the providers' offices. There were six components of the claims review process to confirm the following: (1) that the beneficiary received the service, (2) that the provider was eligible to render the service, (3) that the documentation was complete and included in the medical files as required by statute or regulation, (4) that the services were billed in accordance with applicable laws and regulations and policies, (5) that the claim was paid accurately, and (6) that the documentation supported the medical necessity of the service provided. After the multidisciplinary team completed its review, findings were validated by the appropriate DHCS medical policy specialist.

Using the six review components and the characteristics[9] 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.

KEY MPES FINDINGS

- Payments for claims that were billed appropriately and paid appropriately for medically necessary services rendered by an eligible Medi-Cal provider represent 93.44 percent of total dollars paid through the Medi-Cal FFS system. Of the $16 billion in payments made through the FFS and dental system in calendar year 2007 that were part of the MPES, 6.56 percent ($1.05 billion) were identified as "at risk" of being paid inappropriately.

- The amount of payments for claims that were potentially fraudulent was projected to be $405 million, or 2.53 percent of the total FFS payments. Determinations of

[7] A detailed discussion of the studies conducted and methodologies utilized by other states and the U.S. DHHS is provided in Section XII.
[8] See Sections IV and XII for details regarding review processes.
[9] Common indicators of fraud are provided in Section VI

exactly how much of the payments are for claims that are indeed fraudulent require complete criminal investigations.

- Both the payment error and potential fraud rate continue to reflect a downward trend from the MPES 2005 through the MPES 2007.

Types of Errors:

- A total of 40.2 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. This result was a 1 percent decrease compared to the MPES 2006 finding of 41 of the sample dollars attributable to lack of medical necessity errors.

- Of the payments for claims with errors, 46.1 percent were for claims with insufficient documentation. This means that the documentation presented by the provider did not support the services claimed. This reflects a 1 percent increase in the sample dollars attributable to insufficient documentation when compared to the MPES 2006 finding of 45 percent.

- There has been a 13 percent drop between the MPES 2005 and MPES 2007 in the proportion of medical unnecessary errors compared to all errors, as well as a 22 percent drop in the potential fraud rate during that time period.

- This is the fourth consecutive MPES in which no claims processing errors were made by the fiscal intermediaries (Electronic Data Systems (EDS) and Delta Dental). This indicates that the prepayment edits, audit methods and pricing tables prescribed by DHCS were working effectively.

FINDINGS: PERCENTAGE OF PAYMENT ERROR

Sample Dollars Paid in Error by Error Type	MPES 2005	MPES 2006	MPES 2007
No Medical Necessity	45%	41%	40.2%
Insufficient Documentation	37%	45%	46.1%
Coding Error	6%	6%	10.4%
Policy Violation	10%	7%	3.3%
Ineligible Provider	1%	1%	0%
No Signature Log	1%	0%	0%

Errors by Provider Type:

- Physician Services, a stratum composed of by a variety of primary care providers and clinics, accounted for 30 percent of the overall percentage of payment error

which represents an increase from the MPES 2006 findings[10]. 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 caused by the prescribing or referring physician. The 71 Physician Services stratum errors plus the 43 errors in other strata due to unneeded prescriptions or referrals by physicians adds up to 114 errors, or 55 percent of the 209 total MPES 2007 errors.

- Pharmacies accounted for 27 percent of the MPES 2007 payment error (1.79 percent of the overall 6.56 percent as shown in Figure 5 of Section I) which is a decrease from the MPES 2005 findings[11]. 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 43 percent pharmacy errors where it was determined that the prescription was not medically necessary. This is up from the MPES 2006 where the prescriber accounted for 31 percent of the pharmacy errors.

  Out of 64 pharmacy errors, 6 appeared suspicious of drug diversion. This is where a control drug appears to be prescribed not to control pain but to support drug dependence. These errors ranged from forged prescriptions, increasing the quantity of the prescription for the controlled drug without prescriber approval, and no medical necessity documented for the controlled drug being prescribed.

  Compared to last year's study, this year had less prescription splitting errors, where the quantity of medication dispensed is less than authorized so that another prescription can be dispensed at a later date for the remaining medication with an additional dispensing fee. This reduction would appear to be evidence of the benefit of the educational outreach site visits to nearly 2,000 pharmacies statewide as part of the Pharmacy Outreach Project conducted to remedy vulnerabilities identified by the MPES 2005.

- The ADHC contribution to the MPES overall payment error rate continues to be significant. For example, in MPES 2007, ADHCs were the third largest contributors to the overall error rate, behind physicians and pharmacy. In addition, most ADHC errors found in the last three studies were for lack of medical necessity (90% in MPES 2005, 74% in MPES 2006, and 82% in MPES 2007). In other words, the large majority of beneficiaries are admitted by ADHC providers inappropriately; they don't need those services. This year the ADHC stratum had one exceptionally high cost claim found to be in error (an ADHC

[10] Physician services errors in MPES 2007 accounted for 30% of the overall percentage of payment error (1.94 percent if 6.56 percent). Physician services accounted for 14 percent of the overall percentage of the MPES 2006 payment error (1.04 percent of the 7.27 percent). The MPES 2005 physician services errors accounted for 20 percent of the overall percentage of payment error (1.71 percent of the 8.40 percent).

[11] Pharmacy errors accounted for 43 percent of the MPES 2006 payment error (3.11 percent of the overall 7.27 percent). The MPES 2005 pharmacy errors accounted for almost half of the overall percentage of payment error (4.05 percent of the 8.40 percent).

patient received 22 days of medically unnecessary service). The high percent of ADHC potentially fraudulent claims is a concern and far higher than any other stratum. In the MPES 2007 there were 20% of the ADHC claims that were potentially fraudulent (10 out of the 50 claims sampled), the same as for the MPES 2006.

- The MPES 2007 found two errors in claims submitted by institutional providers, which comprise the Inpatient stratum. In previous years the MPES had not found errors in this stratum. These providers generally have strong internal controls plus Medi-Cal's prior authorization processes enhance the controls over institutional services. Payments to Medi-Cal institutional provider types (e.g., hospitals, nursing facilities) involve the largest Medi-Cal expenditures per service so these two errors once extrapolated accounted for nearly 12 percent of the MPES 2007 error rate.

  Both of the Inpatient errors found this year were in Long Term Care (nursing facilities) and involved issues with documentation and medical necessity. One case has a discharge order written January 18, 2007 yet the beneficiary wasn't discharged home until January 29, 2007. There are no physician orders or progress notes regarding extension of the beneficiary's stay. Therefore medical necessity could not be justified for the additional days. The other case involves a beneficiary with Dementia. Orders in the medical record were for electronic monitoring, which is a device used for tracking patients who wander, and require close behavior monitoring. The medical record documentation did not indicate that "wandering" was an issue or document any behavior problems requiring close behavior monitoring.

- Dental services errors accounted for 8 percent of the overall percentage of payment error. This is a significant decrease over the findings of MPES 2006[12]. Dental errors were comprised of insufficient documentation of services, coding errors, medically unnecessary services, and policy violation errors.

- Within the Other Services and Supplies stratum, 50 percent of the Local Education Agency (LEA) claims were in error (16 out of 32). These LEA claim errors resulted from insufficient documentation to support that services were provided, a finding which is consistent with past studies.

  Also within the Other Services and Supplies stratum there was an increase in Non-emergency Medical Transportation (NEMT) claims found in error from 12 percent found in MPES 2006 to 40 percent in MPES 2007. These included errors in billing for more miles than actually provided or had no documentation on the time or mileage of the trips.

[12] Dental services errors in MPES 2007 accounted for more 8% of the overall percentage of payment error (.53 percent of 6.56percent). In MPES 2007 Dental errors accounted for more than 23% of the overall percentage (1.70 percent of the 7.27 percent). 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).

Incontinence supply errors were found within both the Pharmacy and Other Services and Supplies strata and continue to be a problem especially since all the errors had strong indicators of fraud, i.e. there was no documentation of the patient having incontinence or physician denial they wrote the prescription.

FOLLOW UP

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 the Department 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:

- A total of 209 claims were identified with errors in the 2007 study with 80 identified as potentially fraudulent. Follow up audits on the 80 have begun. Sanctions and or utilization controls will be applied to those providers identified as having submitted claims with errors after a thorough audit has been conducted and recoveries of over payments.

- Compliance and documentation problems contributed to most of this year's error rate rather than lack of medical necessity errors. DHCS will develop provider education and physician focused projects, and conduct group or individual education meetings. There will also be special projects concerning physician up-coding in emergency room and hospital settings.

- ADHCs still show a high percent of errors with no medical necessity for the services and with characteristics of potential fraud so focused reviews of this provider type will continue.

- Half of the Local Education Agency (LEA) claims had compliance errors, a finding consistent with prior studies. This high error percents has resulted in continuing education efforts by the Department for these providers and annual audits required of all LEAs by the California State Controller. The Department training for LEA providers began in March 2009 with a focus on program requirements and documentation. Audits for recovery will be conducted when warranted.

- Half of the Ground Medical Transportation claims were in error and underscore the need for conducting statewide site visits to 215 Non-Emergency Medical Transportation (NEMT) providers to determine the scope and extent of this vulnerability.

- Incontinence supply providers and pharmacy providers who disperse incontinent supply will be subject to a statewide review because of continued payment errors with characteristics of fraud.

- Because claims suspicious of drug diversion were identified there will be investigations conducted to identify and prevent possible inappropriate diversion of prescription medications by pharmacies, prescribers, and/or beneficiaries.

- Additional probe audits will be done on Long-Term Care (LTC) facilities to determine if the type of errors found in the MPES study is significant and requires additional actions.

- Efforts will be expanded to educate beneficiaries on reporting possible fraud. For example, letters such as the Explanation of Medical Benefits letter will be targeted to beneficiaries on suspected problem areas. “Stop Medi-Cal Fraud” information will be developed in pamphlet form and distributed to providers and beneficiaries as part of an expanded “Stop Medi-Cal Fraud” campaign.

CONCLUSION

The MPES 2007 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 non-institutional providers, specifically physician services, pharmacies, dental services, and ADHCs, are targeting the areas of highest risk for payment errors and potential billing fraud. Lastly, the MPES studies have identified many opportunities for new actions and processes. These have lead to positive results with providers becoming more compliant with the Medi-Cal program policy and procedures.

Section III
Study Design and 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, EDS, as well as dental claims paid, during the period of April 1, 2007 through June 30, 2007 (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	342,715	$87,735,925	1.6%	2.2%
Dental	1,067,600	$148,182,559	5.1%	3.7%
Durable Medical Equipment	217,482	$30,040,760	1.0%	0.7%
Inpatient	807,393	$1,976,905,935	3.9%	49.5%
Labs	1,326,608	$48,077,765	6.3%	1.2%
Other Practitioners & Clinics	7,891,215	$798,043,724	37.6%	20.0%
Other Services & Supplies	1,186,618	$173,554,947	5.7%	4.4%
Pharmacy	8,140,643	$729,556,010	38.8%	18.3%
Total	20,980,274	$3,992,097,625	100.0%	100.0%

Sample Size

There are 1,148 claims in the sample. This sample size was extracted from a universe of 20,980,274 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 selection[13] .

Sample Stratification

The proportional stratified random sample is divided into eight strata. Each stratum is listed below. The list includes all vendor codes associated with each stratum (or provider type). These codes are used in queries to determine the appropriate claim categories for each of the strata used in the sample[13].

- 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), vendor code = 002, not including LTC facilities (017) and certified hospice facilities (039), but including home and community based nursing service facilities (059).

- Stratum 4: Inpatient, claim type = 2 (Inpatient), and vendor codes list:

Vendor Code	Description
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

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

9	Respiratory Care Practitioner
10	Licensed Midwife
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, 2007 through June 30, 2007. 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	$10,213
Dental	54	$9,184
DME	50	$4,058
Inpatient	50	$102,375
Labs	68	$2,657
Other Practitioners and Clinics	402	$39,925
Other Services and Supplies	60	$12,680
Pharmacy	414	$39,826
Total	1,148	$220,918

Estimation

- DHCS used the ratio estimator method for stratified random sampling as the basis for estimating the payment accuracy rate and confidence limits[14]. 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).

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

Table III
Calculation of Payment Accuracy Rate by Stratum

Stratum	Amounts Paid in Stratum	Amounts Paid Correctly	Payment Accuracy Rate	Payment Error Rate
ADHC	$10,213	$5,869	57.46%	42.54%
Dental	$9,184	$7,873	85.73%	14.27%
DME	$4,058	$3,400	83.78%	16.22%
Inpatient	$102,375	$100,774	98.44%	1.56%
Labs	$2,657	$2,369	89.16%	10.84%
Other Practitioners and Clinics	$39,925	$36,045	90.28%	9.72%
Other Services and Supplies	$12,680	$11,681	92.12%	7.88%
Pharmacy	$39,826	$35,937	90.23%	9.77%

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	$87,735,925	57.46%	$50,413,063	$37,322,862
Dental	$148,182,559	85.73%	$127,036,908	$21,145,651
Durable Medical Equipment	$30,040,760	83.78%	$25,168,149	$4,872,611
Inpatient	$1,976,905,935	98.44%	$1,946,066,202	$30,839,733
Labs	$48,077,765	89.16%	$42,866,135	$5,211,630
Other Practices and Clinics	$798,043,724	90.28%	$720,473,874	$77,569,850
Other Services and Supplies	$173,554,947	92.12%	$159,878,817	$13,676,130
Pharmacy	$729,556,010	90.23%	$658,278,388	$71,277,622
Total	$3,992,097,625		$3,730,181,536	$261,916,089

- Projected annual payments made in error = payment error rate X 2nd quarter 2007 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

$x\,h$ = sample estimate of the dollar value of the total payments for stratum h

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

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

where

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

(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:

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

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

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

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

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

$S_h^2 = A_h B_h$, where

$A_h = \left[N_h^2(1 - f_h)/(n_h(n_h - 1))\right]$ 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.)

Section IV
REVIEW PROTOCOLS FOR 2007

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 reliability and consistency among staff.

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), including accurate claim adjudication resulting in appropriate payments. The claims are reviewed by comparing the provider's billing information with the beneficiary's actual 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/dental 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 attended comprehensive standardized training sessions on data collection and evaluation process. The teams then collected documentation to support the ordered services from prescribing or referring providers in person, by telephone, and/or by fax. MPES 2007 medical/dental documentation was requested via telephone with an occasional onsite. In some cases, either onsite or telephone request, more than one request will 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 DHCS 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 for this level.
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 because the provider did not comply with a statute, regulation or instruction in the Medi-Cal manual, or failed to document that services were medically necessary.

Second Level Review to Ensure Inter-rater Reliability

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

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 up held. For MPES 2007, all medical consultants in DHCS participated in the second level medical review.
- If there is a difference of opinion among the independent reviewers, all initial reviewers discuss the claim and reach a consensus. Optometry and dental claims required specialty reviews by at least two appropriate medical/dental professionals.
- The same process is repeated by clinical staff to review all claims identified as having errors not related to medical necessity. At least two different reviewers reviewed the errors and concurred with the error decision.

This was a blind[15], 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.

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 DOJ and confirmed as fraudulent.

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

II. Review Protocol for Potentially Fraudulent Claims

Level I Review: A determination by DHCS staff as to the presence or absence of medical documentation.

Level II Review: A determination as to whether the service was 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.
- 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 DHCS.
- 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 bone fide legal business and compliance issues with licensing requirements.
- Medical record discrepancies coupled with the fact that the provider had a prior negative record of sanctions or a historical record of abuse with DHCS.
- Multiple types of errors on one claim.
- Billing for a more expensive service than what is documented as rendered. This is referred to as upcoding.
- 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

Department of Justice staff review reports of all errors determined to have characteristics of potential for fraud by DHCS' staff. After review, the assigned DOJ attorney discusses all findings with DHCS staff before a final determination can be made. 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".

SECTION V
SUMMARY OF PAYMENT ERRORS BY STRATUM

Payment errors, as defined in Section II, are identified as potential dollar value loss due to payment or billing errors, including potential loss due to fraud, waste and/or abuse. Claim errors in the MPES 2007 study 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.

Of the 209 errors in the 1,148 claims sampled there were 87 unique medical providers and 12 unique dental providers. Fourteen of the unique providers had more than 1 error, 1 had 4 errors. A list of payment errors by type and by stratum is shown below. See Section VII for a description and explanation of each error and Section VIII for explanation of the error reason codes.

1. Breakdown of Payment Errors

The table below displays the different payment errors for each stratum in the MPES 2007 sample. There were a total of 209 provider payment errors identified in MPES 2007. Of these, 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.

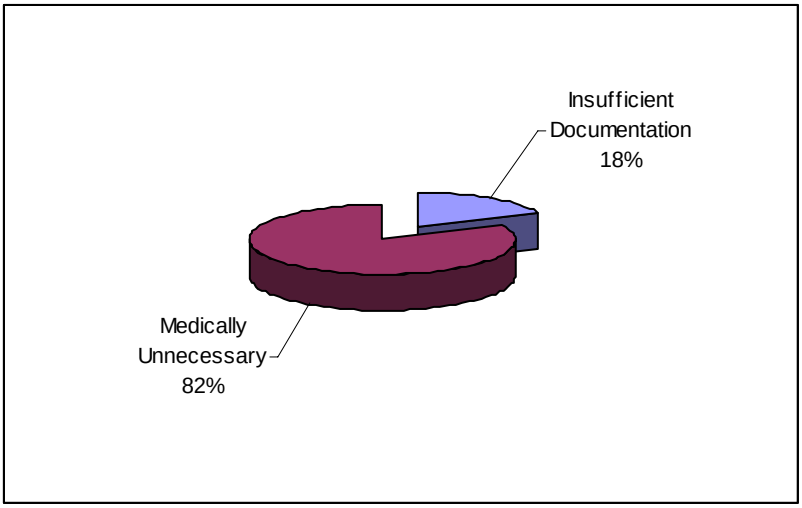
Error Type	ADHC	Dental	DME	Inpatient	Lab	Phys	Pharm	Other	Total
Insufficient Documentation (MR2)	3	12	3	1	8	20	17	16	80
Medically Unnecessary (MR5)	14	1		1	3	8	28	1	56
Coding Error (MR3)		1				39			39
Policy Violation (MR7, MR8, PH10)						1	2	7	10
No Legal Prescription (PH2)							5		5
Other Pharmacy Policy Error (PH10)							8		8
Prescription Split (PH7B)							2		2
Prescription Missing Essential Information (PH3)							2		2
Wrong Information on Label (PH5)							1		1
Other Error (0)									1
Other Medical Error (MR8)					1			1	2
Duplicate Item (P1)						1			1
Unbundling Error (MR4)						2			2
Total Number of Errors	17	14	3	2	12	71	65	25	209

Payment Errors by Stratum

Payment errors include those claims with insufficient or no documentation, claims with 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 rules and regulations. Error types are assigned depending upon the error and the most potentially costly errors. The most serious errors are: a lack of medical necessity, a legal requirement not met by the provider, insufficient or no documentation, coding errors, ineligible providers and policy violation errors. Examples within each stratum follow. A complete description of payment errors is listed in Section VII.

2. Adult Day Health Care

Seventeen Adult Day Health Care (ADHC) claims were found to have payment errors; 14 of which (82 percent) were due to lack of medical necessity and 3 of the errors (18 percent) were due to insufficient documentation (see chart below).



<u>Examples of ADHC Errors:</u>

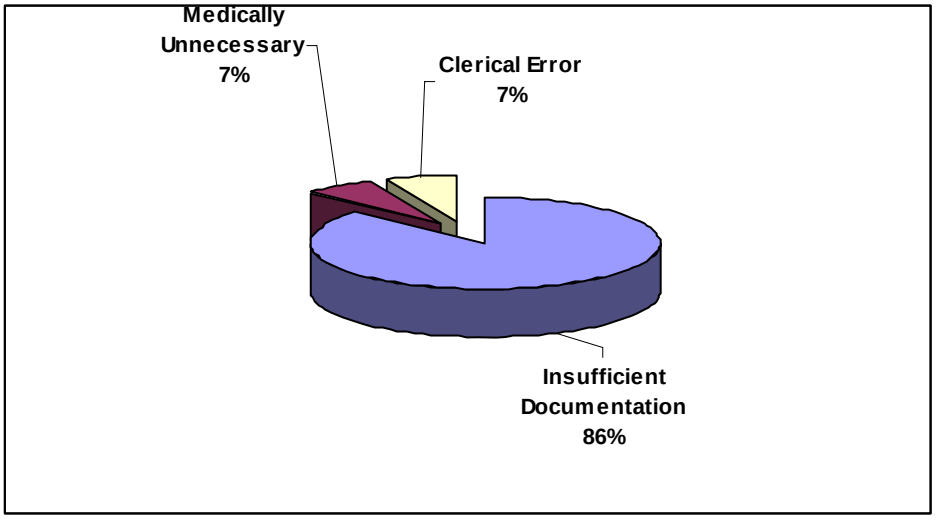
- ***Insufficient Documentation*** *- According to the Individual Plan of Care (IPC), this is a new noninsulin dependent diabetic patient who gets his blood sugar checked by ADHC staff at the center only and is non-compliant with his medication. There is no documentation for the primary care provider regarding this new condition. The center checks his blood sugar, but there is no indication any attempt was made to teach him to check his own blood sugar, nor was there an assessment of his or his primary care giver's potential to learn to check his own blood sugar. The compliance with medication is being checked once every six months. The patient is being assessed for skin integrity once every six months. The patient did not participate in physical therapy on one of the dates of service because of a reddened area above his right ankle that was referred to the nurse. The only documentation by the*

nurse regarding this reddened area was a "+" mark with initials on the flow sheet for that day. There was no documentation the nurse did any assessment of the reddened area or determined if any interventions were needed. There is little documentation to support medical necessity for this patient. With the infrequency of monitoring activities and limited assessments, there is little indication of a potential for deterioration and probable institutionalization if ADHC services were not available.

- ***Medically Unnecessary -*** *This claim is for one day of adult day health care services. The patient's primary conditions are psychiatric however he is receiving no service for this at the ADHC. All psychiatric services are provided through the county. The patient has a history of high blood pressure that is stable on medication according to the Individual Plan of Care (IPC). The center monitors the patient's blood pressure every two weeks. The patient's blood sugar is monitored once a month so there is no instability evident with the blood pressure. According to the ADHC documents, the patient walks and stands around the center the entire time he is there not interacting or participating in therapeutic activities per the IPC. There is no indication this patient meets all four of the criteria needed to be eligible for ADHC services. There is no high potential for further deterioration and probable institutionalization if ADHC services were not available. There is no reasonable expectation that preventive services will maintain or improve the present level of physical or mental function.*

3. Dental

The MPES 2007 review found 14 payment errors in the dental stratum, 12 of which were for insufficient documentation (86 percent), one error (7 percent) for lack of medical necessity, and one error (7 percent) due to clerical error by Delta Dental when processing the claim

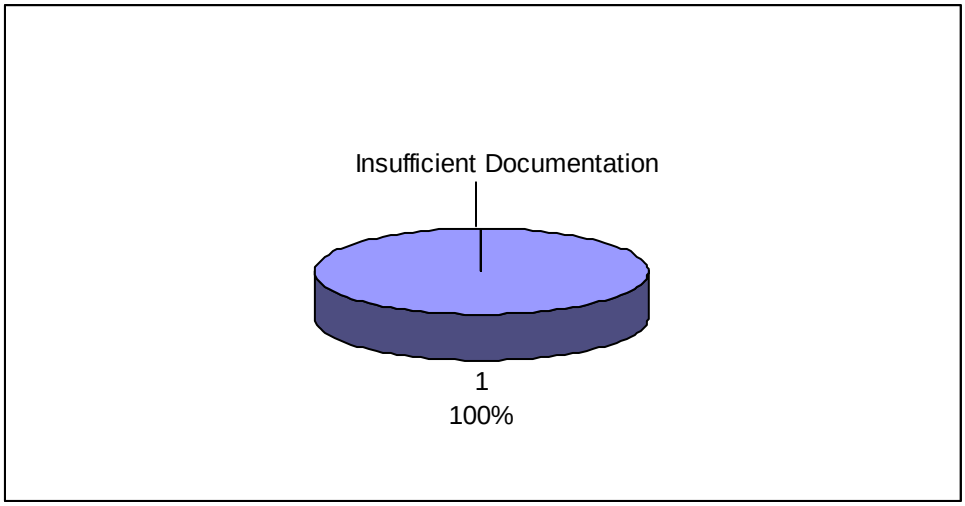


Examples of Dental Errors:

- ***Insufficient Documentation -*** *The error in this claim is for prophy with fluoride. The record indicates that sealants were done and prophy was noted. However there is no notation regarding fluoride in the record.*
- ***Medically Unnecessary –*** *The error in this claim is for several dental services, including the extraction of two teeth. There was no written documentation or X-ray present in the documentation indicating there was any need for the teeth extractions*.
- **Clerical Error –** *The error in this claim is due to a discrepancy between the date of service for the beneficiary's monthly check-up for her braces on the record and the date listed on the claims detail report. The date of service on the record, May 3, 2007 does not correspond with the date of services on the claims detail report, May 11, 2007.*

4. Durable Medical Equipment

Three DME claims were noted as having three errors in the MPES 2007 sample. Insufficient documentation is the reason for these errors.

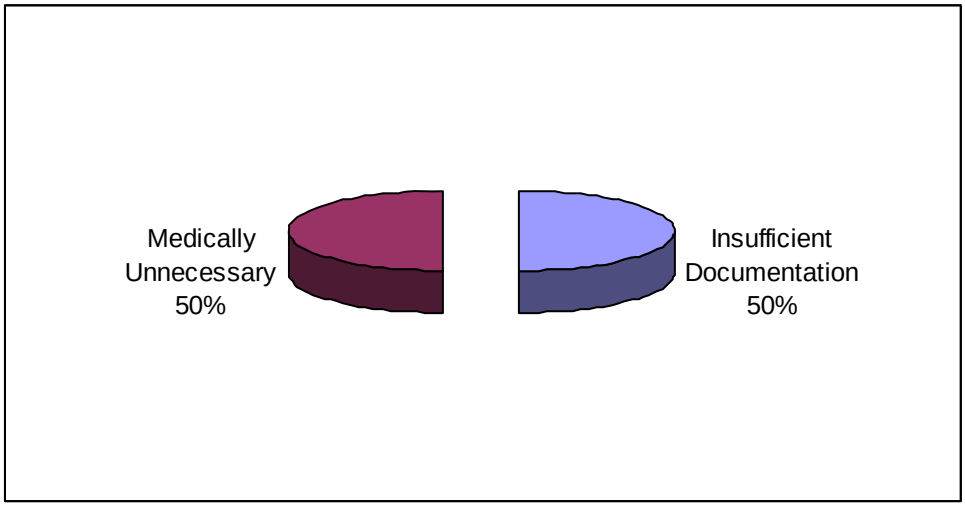


Example of Durable Medical Equipment Errors:

- ***Insufficient Documentation -*** *This claim is for a standard wheelchair. The patient has a history of a Cerebral Vascular Accident (CVA) and subsequent right sided weakness in the referring provider's record. However, this was not mentioned on the prescription to the DME provider of the wheelchair. The referring provider states patient is using a walker. The degree of the patient's impairment and definitive documentation of need for the wheelchairs are not stated in the request for the wheelchair or in the referring provider's progress notes.*

5. Inpatient Hospital and Nursing Facilities

There were two errors in the stratum comprised of hospitals and long-term care facilities. The one payment error was due to insufficient documentation, and the other was for lack of medical necessity. Both were from long term care facilities.

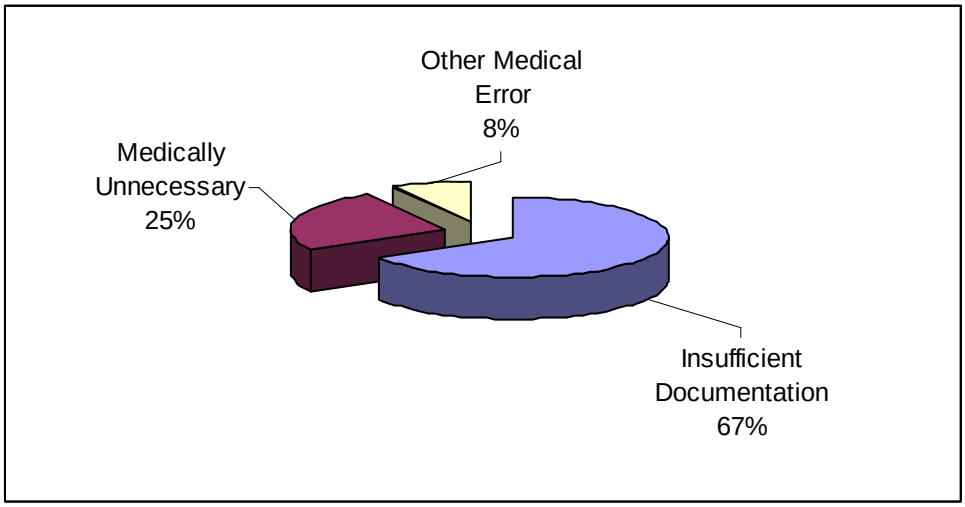


Examples of Hospital/ Nursing Facility Errors:

- ***Insufficient Documentation –*** *There was no documentation in the patient's record for the claimed date of April 5, 2007 which verifies that medical necessity criteria was met. The care plan is dated October 17, 2005 with little to no updates. The patient was diagnosed with dementia and had an order for behavior monitoring during this period but there was no documentation regarding the beneficiary's behavior.*
- ***Medically Unnecessary –*** *This claim was for 28 days at a skilled nursing facility. The physician orders written January 18, 2007 were for discharge on that day. The nurse's notes dated January 29, 2007 states patient discharged home. There are no orders to cancel the discharge or documentation to show a reason for the delay in discharging the patient. According to the nurses notes the beneficiary's son, a Licensed Vocational Nurse (LVN) worked at the facility and the beneficiary was discharged to his home. There was no therapy or medications given during this timeframe.*

6. Laboratory

Claims from 12 laboratories were noted as having payment errors; 8 of them (67 percent) were for insufficient documentation. The remaining claim errors were attributed to lack of medical necessity (25 percent) and other medical error (8 percent). The breakdown of these errors is shown on the chart below.



Examples:

- ***Insufficient Documentation*** *- This claim was for one laboratory test for HIV. There was no documentation on the requisition provided that the test was ordered. There was no documentation in the results provided by the laboratory that the test was performed and the results obtained. There was a result of the test in the referring provider's record.*

- ***Medically Unnecessary -*** *This claim was for four laboratory tests. There was no error identified in the documentation provided by the laboratory. The lab provided the service as ordered. However, the referring provider's medical records had no documentation to demonstrate medical necessity for two of the tests ordered: a fasting blood sugar and glucose tolerance test. There was also no documentation indicating the referring provider intended to order these tests.*

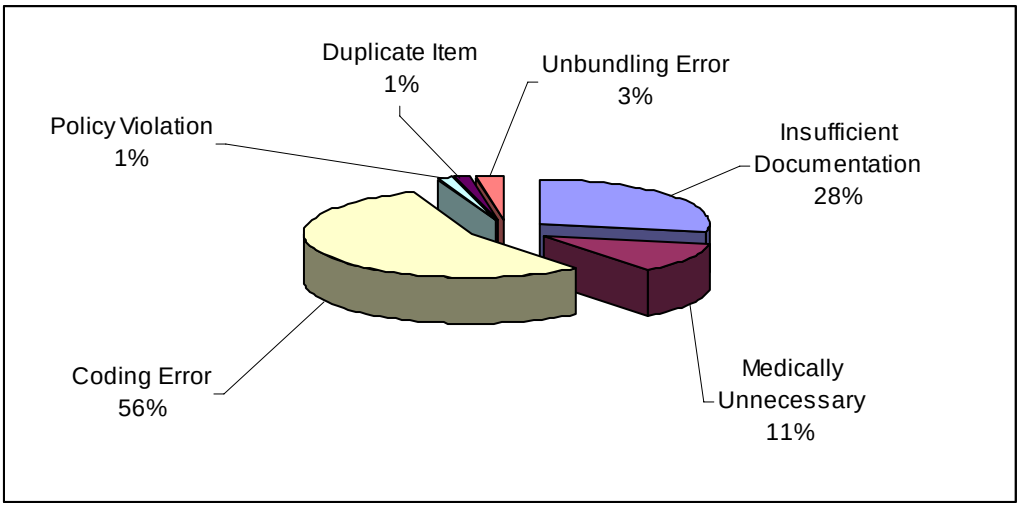
- ***Other Medical Error*** *- This claim was for a finger stick glucose test done in a Rural Health Clinic. The claim was billed using a county laboratory provider number. This test is a Clinical Laboratory Improvement Amendment (CLIA) waived test and is part of the inclusive rate for the clinic visit. The clinic had a CLIA waiver certificate to perform these waived tests. The test should not have been billed separately by the laboratory.*

7. Physician Services

There were 71 physician services payment errors in the MPES 2007 sampled claims. The physician services provider type includes physicians, clinics, emergency room visits and other licensed providers.

The majority of errors (56 percent) in this provider type were coding errors 28 percent were for insufficient documentation; (11 percent) were for lack of medical necessity. The remaining errors were (3 percent) unbundling errors, (1 percent) policy error, and 1

(1 percent) duplicate item error. The chart below shows the breakdown of the physician services errors.



Examples:

- ***Coding Errors*** *- This claim was for a level 3 emergency department visit and repair of a superficial wound. Documentation for this code requires the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided for this claim had problem focused history; problem focused examination and decision making of low complexity. Without the expanded examination the services rendered justifies that a lower level of care should have been claimed.*

- ***Insufficient Documentation*** *- This claim was for an encounter at a Federally Qualified Health Center (FHQC). The services were provided by the Comprehensive Perinatal Services Provider worker. There were no documentation of what services were provided, no sign-in sheet, and no description of perinatal education provided. There was a note stating the patient had been there for health education on dental hygiene signed by the Comprehensive Perinatal Health Worker, but there was no documentation of the nature and extent of the education, the topics covered, the patient's response to the education or the time involved.*

- ***Medically Unnecessary -*** *This claim was for intravenous (IV) hydration for a patient in the emergency department. There is documentation in the physical examination that the patient was well hydrated per skin examination. Laboratory results were not reflective of someone that was dehydrated. There is no documentation to support the need for intravenous infusion for hydration.*

- ***Unbundling Errors*** *- This claim was for a level two office visit for a new patient, use of hospital examination room and measurement of blood oxygen level that is*

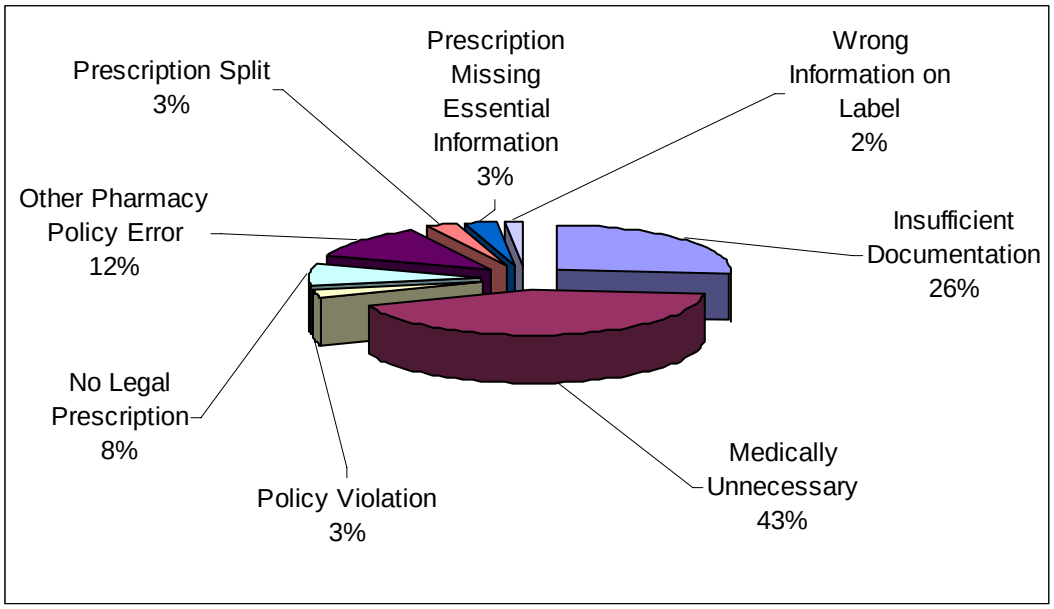
called pulse oximetry. According to the Medi-Cal Provider Manual, pulse oximetry is not separately reimbursable when done in conjunction with an evaluation and management code (CPT Code 99201-99499) by the same provider, for the same recipient, on the same date of service. Therefore, the pulse oximetry should not have been billed separately.

- ***Policy Violation*** *- This claim was for a visit to a RHC. There were two visits to two different clinics on the same day. Although the second visit was at a different location, both clinics are members of the same group of clinics. The clinics use a single computer system for patient management. There is no indication in the documentation that the second visit was for any reason different from the first visit. Since both visits were for the same problem within a system that has a single patient management system, the second visit should not have been claimed.*

- ***Duplicate item*** *- This claim was for Depo-Provera, an injection for contraception, and individual postpartum health education assessment for 15 minutes. According to the claim detail report, the individual health assessment was billed twice for the same day. There is no documentation any post partum health education was provided.*

8. Pharmacy

Errors in pharmacy claims were due to both the pharmacies making errors and errors found in the prescriber's documentation. Twenty-eight errors (43 percent) of the 65 pharmacy errors were attributed to the referring physicians in that these were deemed medically unnecessary. These medically unnecessary errors are not the fault of the pharmacy but that of the prescribing provider. Seventeen (26 percent) of the errors were due to insufficient documentation. Ten policy errors were identified, 2 (3 percent) being a policy violation and 8 (12 percent) were pharmacy policy errors. No legal prescription was the reason for 5 (8 percent) errors and 2 (3 percent) errors were from split prescriptions. Essential information was missing on 2 (3 percent) prescriptions and 1 (2 percent) label had the wrong information on it. A breakdown of all pharmacy errors in the MPES 2007 sample is shown on the chart below.



Examples:

- ***Medically Unnecessary*** *- The claim is for Codeine/Promethazine HCL, used for cold, allergies or upper respiratory tract illness. Medical necessity was not documented, only complaints of a cold. Prescriber appears to be prescribing narcotics without justification. There is a chronic refill problem with two medications; Acetaminophen/Codeine #3 and Codeine/Promethazine HCL. Violation of Title 22, CCR Sec 51458.1. The pharmacist should have called the physician to seek clarification of this problem.*

- ***Insufficient Documentation*** *- The claim is for Dicyclomine, which is used for stomach disorders. The beneficiary is a female patient with multiple sclerosis, who is wheelchair bound, and who is treated with multiple medications per day for a number of diagnoses. The faxed prescription indicated one capsule twice a day as needed for pain. However, there was lack of documentation in the medical record that would explain why the beneficiary needed this medication.*

- ***Other Pharmacy Policy Error*** *- Zantac is a medication used to treat gastro esophageal reflux disease (GERD). The prescription in this claim was written originally six months before this date of service. Five months before this date of service the prescription was changed to Nexium, another medication used to treat GERD. The prescription for Zantac and the prescription for Nexium were filled by the same pharmacy. The pharmacy's drug profile should have identified the duplicate medication and an appropriate intervention to prevent double medication should have been implemented. There is no indication any intervention, such as calling the provider or counseling the patient was accomplished. There is no documentation in the prescribing provider's record that he was aware the patient was getting both prescriptions filled.*

- ***No Legal Prescription for date of service*** *- This claim is for ferrous sulfate, an iron preparation used to treat anemia. The pharmacy has no prescription for the medication. According to the pharmacy, there was a fire and the prescriptions which were stored in cardboard boxes, had to be removed from the area. The prescriptions subsequently disappeared. Although there was sufficient documentation in the referring provider's record indicating the need for the medication, there was no evidence the referring provider intended the patient to have that medication.*

- ***Prescription Missing Essential Information*** *- This claim is for Bactrim, an antibiotic. There were two telephone prescriptions for this medication. Neither of them had a date on them. There are progress notes written by the prescribing provider for the same prescription for three consecutive months. There is no way to determine if one of the telephone prescriptions provided was the one authorizing the medication for this claim.*

- ***Policy Violation*** *- This claim is for Aspirin 81mg, used as a preventive medication for heart disease. The patient's medical history verifies the medical necessity for the medication. However, the progress note in the patient's record for the date of service for the prescription had no patient name or any other means of identifying which patient it was for. There were no signatures on any of the notes on the page of progress notes provided.*

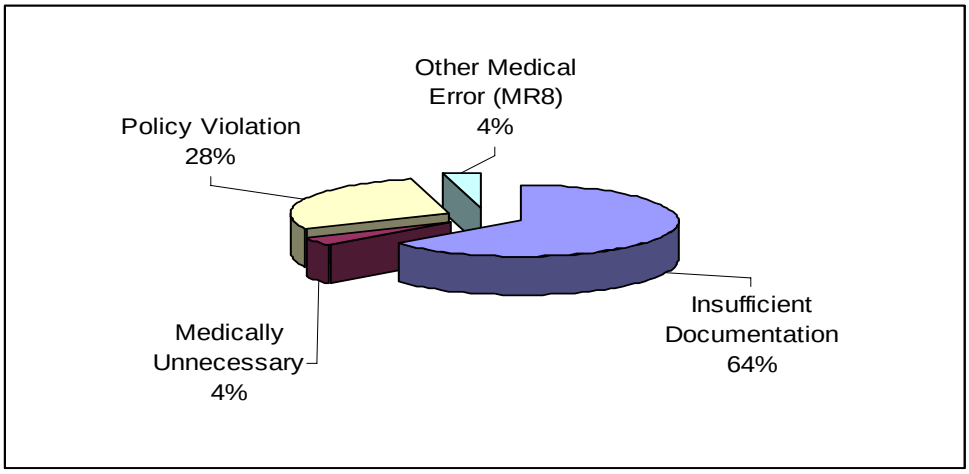
- ***Prescription Split -*** *Vicodin is a medication used to manage pain. The prescription for this claim was written for 150 tablets, but the pharmacy dispensed only 30 tablets. According to Title 22, Section 51479, a provider may not dispense a drug in an amount different than prescribed, without the prescriber's authorization. Such authorization was not documented at the pharmacy or at the prescriber's place of business. In addition, there is a Code One restriction limiting prescription to 30 tablets with a maximum of three dispensions in 75 days. By dispensing only 30 tablets, the pharmacy avoided needing to get prior authorization to fill the prescriptions.*

- ***Wrong Information on Label -*** *The claim is for Atrovent, a nebulizer used in the treatment of bronchospasms. The beneficiary resides in a nursing care center. The prescription faxed to the pharmacy identified the physician, but did not include the signature of the doctor or the nurse who received the telephone order. There is no label for the date of service. The medication administration record (MAR) and Respiratory Therapy records lack documentation the nebulizer was administered.*

- ***Wrong Referring Provider -*** *This claim is for Docusate Sodium, used to facilitate stool softening. The prescription is for 60 tablets. The claim had the wrong referring provider listed.*

9. Other Services and Supplies

Included in this category were transportation, medical supplies, and Local Education Assistance (LEA) programs, among others. The major error type in this stratum was insufficient documentation, 16 errors (64 percent) of 25 total errors in this category. The second highest error type was policy violation, with 7 errors (or 28 percent). One (4 percent) error each for medically unnecessary and one (4 percent) other medical error was noted. A detailed breakdown of errors is shown on the chart below.



Examples:

- ***Insufficient Documentation*** *- This claim was for one group speech and language therapy service through a local education agency (LEA). There is documentation on the Individual Education Program (IEP) of the intent to provide the service. There is no physician referral or physician based standard as required. The documentation provided is a page of notes covering three months with the child's name and the teacher's name at the top of the page. There is no indication who wrote the notes or if they are qualified to provide such services. The attendance roster for speech therapy was also provided.*

- ***Policy Violation*** *- This claim was for two group speech and language therapy services through a Local Education Agency (LEA). There is documentation on the Individual Education Program (IEP) of the intent to provide the service. There is no physician referral or physician-based standard as required. The documentation provided is an attendance roster for speech therapy group. There is no documentation of the nature or extent of the services provided.*

- ***Medically Unnecessary*** *- This claim was for non-emergency medical transportation and mileage. The documentation provided by the transportation provider, order, mileage log, and reason for transport was adequate. However, the documentation in the prescribing provider's record does not support the medical condition that was described in the transportation order.*

Also, there was no documentation in the prescribing provider's record that indicates the medical necessity for the transportation service.

- ***Other Medical Error*** *- This claim was for four different incontinence-related supplies. The physician whose signature is on the order for the supplies denies ordering the supplies and states the signature does not appear to be hers. The home health agency stated the patient was discharged a month before the date of service and they did not provide the billed services.*

Section VI
SUMMARY OF POTENTIAL FRAUD CLAIMS

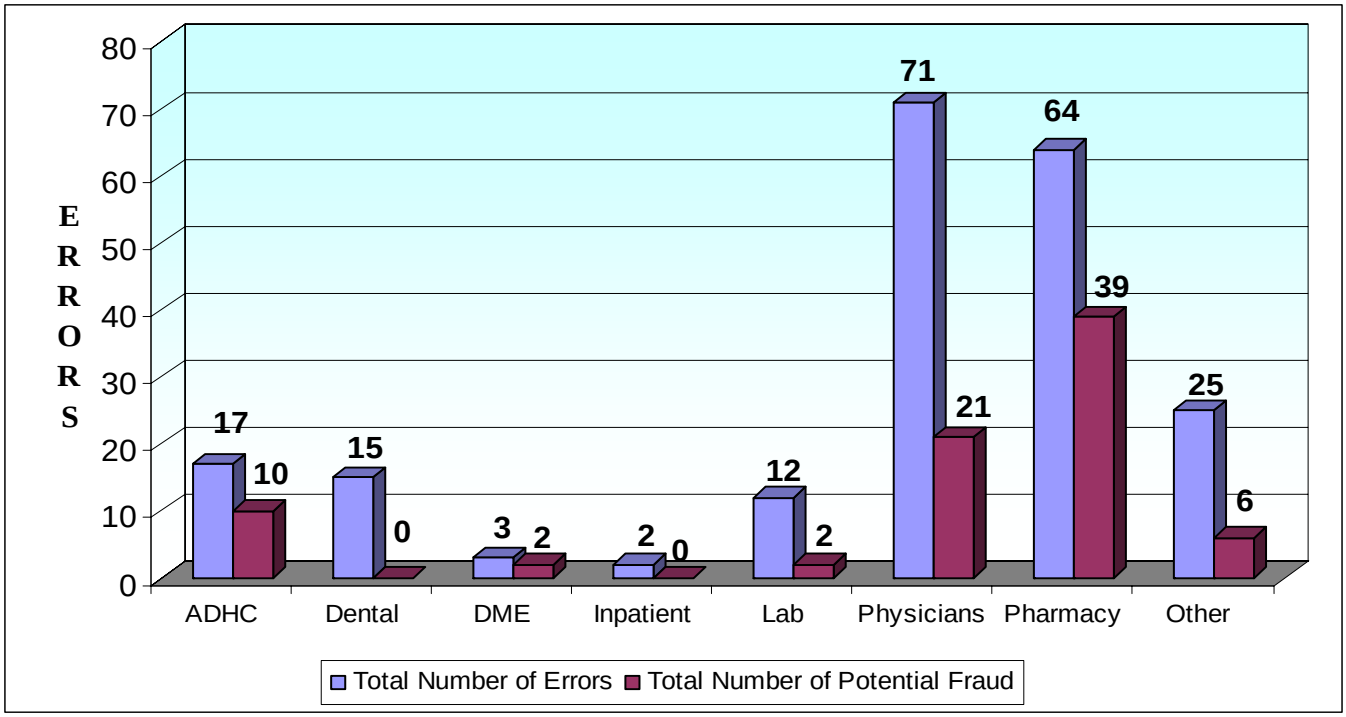
One of the goals of MPES is to identify potentially fraudulent claims. Thirty eight percent[16] of the claims in error were identified to have characteristics for potential fraud or abuse, such as claiming for services that were not medically necessary. While this finding appears significant, it needs to be interpreted with caution as a single claim does not prove fraud. Without a full criminal investigation of the actual practice of the provider, there is no certainty that fraud has occurred.

MPES 2007 review protocols called for the medical review team to examine each claim for potential fraud, waste, and/or abuse. See Section IV regarding the steps utilized during each level of the review process in regards to potential fraud.

MPES 2007 consisted of 982 unique providers represented in the sample of 1,148 claims. A total of 80 claims, submitted by 78 unique providers, were found to be potentially fraudulent. The 80 claims were forwarded to the DOJ who in turn reviewed all claims so designated and concurred with DHCS's assessment of potentially fraudulent activity. 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, 42 had been independently identified by DHCS prior to the MPES 2007 and were already undergoing case development and/or placed on administrative sanction when the study was conducted. A comparison between total errors in the MPES 2007 sample and the potential fraud errors in the same sample is shown on the following chart. Figure 1 below depicts the errors, total vs. potentially fraudulent, identified in the MPES 2007 per strata.

[16] 209 errors were identified of which 80 were identified as having a potential for fraud. 80 is 38 percent of the 209 errors identified.

All 209 Errors vs. 80 Potential Fraud Errors by Provider Type



The table below displays the breakdown of potential fraud errors.

Breakdown of Potentially Fraudulent Claim Errors by Type and Stratum

Error Type	ADHC	DME	Lab	Physicians	Pharmacy	Other	Total	Percent
Insufficient Documentation (MR2)	1	2	1	6	5	2	17	21.25%
Medically Unnecessary (MR5)	9		1	5	27	1	43	53.75%
Coding Error (MR3)				7			7	8.75%
Policy Violation (MR7, MR8, PH10)				1		2	3	3.75%
No Legal Prescription (PH2)					2		2	2.50%
Other Pharmacy Policy Error (PH10)					2		2	2.50%
Prescription Split (PH7B)					2		2	2.50%
Other Medical Error (MR8)						1	1	1.25%
Unbundling Error (MR4)				2			2	2.50%
Wrong Referring Provider on Claim					1		1	1.25%
Total Number of Fraud Errors	10	2	2	21	39	6	80	100%
Percent per Provider Type	12.50%	2.50%	2.50%	26.25%	48.75%	7.50%	100%	

The number of claims identified as having characteristics for potential fraud were concentrated in pharmacy, physician services, ADHC, other services and labs. Documentation errors were dominant among potentially fraudulent claims in the 2006

MPES, where as medically unnecessary potentially fraudulent errors dominated in the 2007 MPES.

Using the review protocols and the error codes described in Section V, the following are examples of how errors were classified as fraudulent.

Error Type	**Potential Fraud Identified**	**No Potential Fraud Identified**
Medically Unnecessary (MR5)	**Physician/Clinic Claim** This claim is for four encounters for acupuncture with stimulation/15 minutes each. Acupuncture is "limited to the treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition." Each 15 minutes are for personal one-on-one contact with the patient. There was no documentation to support the time spent with the patient. There was no documentation to support the patient has a medical condition that the acupuncture is being used for. The only documentation in the record for this date of service was "He felt better no pain in the hip." The remainder of the progress note was not completed. There was no documentation the patient has a medical condition that requires acupuncture, what services were provided, or the time spent providing the service.	**Physician/Clinic Claim** **This claim is for an X-ray of the abdomen. The patient was complaining of "swelling." The patient denied any pain or gastrointestinal symptoms. The physical examination showed no distension or other abnormal findings. There was no medical indication for the X-ray. The error is calculated as the total amount paid for this claim.**
Insufficient Documentation (MR 2-A, MR2-B)	**Pharmacy Claim** This pharmacy claim is for test strips to measure blood glucose levels for people with diabetes. The pharmacy supplied 50 test strips a month every month. The patient resides in a skilled nursing facility and has an order to check blood sugar once a week every Thursday. This would require at the most five test strips	**Pharmacy Claim** This claim is for Imitrex, a medication used to treat migraine headaches. The pharmacy that filled the prescription has been sold so some of the required documentation was not available. There is no copy of the dispensing label which supports the medication was dispensed. There also was no signature of

Error Type	**Potential Fraud Identified**	**No Potential Fraud Identified**
	a month, 45 fewer than had been supplied. The pharmacy was aware of the frequency of testing since the weekly testing requirement was on the label for the test strips. The director of nursing at the skilled nursing facility told DHCS staff she had attempted to get the pharmacy to send fewer test strips, but to no avail. This order has been in effect for five years so many more strips than are needed have been supplied.	receipt for the medication. The referring provider's record has no mention of the patient taking the medication other than a two year old listing on the medication refill list. The record mentions another medication being taken by the patient for migraine headache. There is no evaluation of the patient's migraine headache or assessment of the effectiveness of any of the medications. The error is calculated as the total amount paid for this claim.
Coding Error (MR3)	**Physician/Clinic Claim** This claim is for a level four office visit for an established patient. To be a level four office visit the documentation must contain two of the three following components: a detailed history, a detailed examination, and a medical decision making of moderate complexity. The documentation supplied by the provider had no history; no vital signs, and the chief complaint was "family planning". The examination section is a pre printed detailed examination with no documentation to support an examination was actually done. Decision making is minimal. With no history, a question as to whether or not an examination was done and the minimal medical decision making, does not support more than a level one visit.	**Other Services Claim** This claim is for an injection of Ketamine an anesthetic agent. The medical record documents an intra-articular injection of Kenalog with Lidocaine for the treatment of a knee injury. This claim should have been for the Kenalog. The error is calculated as the difference between the amount that was paid for the Ketamine injection and the amount that would have been paid for the Kenalog injection.
Policy Violation (MR 7, PH10)	**Pharmacy Claim** This claim is for Phenergan with Codeine cough syrup. The prescription was written for one eight ounce bottle of cough syrup. The pharmacy dispensed	**Dental Claim** This claim is for dental services at a Federally Qualified Health Center (FQHC). FQHCs are required to follow Medi-Cal/Denti-Cal policy and provide services in

Error Type	**Potential Fraud Identified**	**No Potential Fraud Identified**
	and claimed for two eight ounce bottles. This doubles the size of the prescription of this frequently misused medication. There was no documentation in the pharmacy or at the prescribing provider's office to indicate the pharmacy received authorization to change the prescription.	the same manner as the Medi-Cal/Denti-Cal program. FQHCs bill by encounter and details of the service provided is 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
No Legal Prescription (PH2)	**Pharmacy Claim** This claim is for Celexa an antidepressant used for the treatment of depression. No prescription was available at the pharmacy. The incorrect referring provider identification number was entered on the billing claim. The services could not be verified as ordered or medically necessary.	**Pharmacy Claim** This claim was for contraceptive foam. The pharmacy claiming for the service is no longer in business. The pharmacy closed several months after this prescription was filled and most records and patients were transferred to a chain supermarket pharmacy. The pharmacy was unable to find the records for this prescription. Since the billing pharmacy is now closed the required records were not available. The patient's medical record stated an intent to provide condoms but there was no mention of contraceptive foam.
Prescription Splitting (PH7B)	**Pharmacy Claim** This claim is for Vicodin, a medication used to manage pain. The prescription was written for 150 tablets. The pharmacy dispensed 30 tablets. According to Title 22, section 51479, a provider may not dispense drugs in an amount different than prescribed without the prescriber's authorization. There is no such authorization documented at the pharmacy or the prescriber's place of business. There is a code one	There is no example of this type of error because prescription splitting to increase reimbursement is always considered a potential for fraud.

Error Type	**Potential Fraud Identified**	**No Potential Fraud Identified**
	restriction on this medication limiting prescriptions to 30 tablets with a maximum of three dispensings in 75 days, unless a Treatment Authorization Request is obtained. By dispensing only 30 tablets, the pharmacy avoided needing to get authorization prior to filling the prescriptions.	
Other Medical Error (MR8)	**Other Services Claim** This claim is for four different incontinence related supplies. The physician whose signature is on the order for the supplies denies ordering the supplies and states the signature does not appear to be hers. The home health agency stated the patient was discharged a month before the date of service and they did not provide the billed services.	**Laboratory Claim** This claim is for a finger stick glucose done in a RHC. It was billed using a county laboratory provider number. This test is a Clinical Laboratory Improvement Amendment (CLIA) waived test and is part of the inclusive rate for the clinic visit. The clinic had a CLIA waiver certificate to perform these waived tests. The test should not have been billed separately by the laboratory.
Unbundling Error (MR4)	**Physician/Clinic Claim** This claim is for a level two office visit for a new patient, use of hospital examination room and measurement of blood oxygen level which is called pulse oximetry. According to the Medi-Cal manual, pulse oximetry is not separately reimbursable when done in conjunction with an evaluation and management code by the same provider, for the same recipient on the same date of service. Therefore, the pulse oximetry should not have been billed separately.	There is no example of this type of error because unbundling a service to increase reimbursement is always considered a potential for fraud.

Section VII
DETAIL OF REASONS FOR ERROR

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0002	Dental	MR2B	No documentation	This claim is for several dental services including a prophylaxis. There was no documentation of prophylaxis in the record. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the prophylaxis.	$474.00	$434.00	$40.00
0003	Dental	MR2B	No documentation	This claim is for several dental services which included four photographs. The photographs were not included in the documentation obtained from the provider. The error is calculated as the difference between the total amount paid for this claim and the amount paid for the four photographs.	$68.75	$53.00	$15.75
0008	Dental	MR2B	No documentation	This claim is for several dental services. There is no documentation the five fillings claimed were done on this date of service. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the five fillings.	$305.00	$110.00	$195.00
0019	Dental	MR5	Medically unnecessary service	This claim is for several dental services including the extraction of two teeth. There is no written documentation or X-rays indicating the need for the extractions. The error is calculated as the difference between the total amount paid for this claim and the amount paid for the two extractions.	$159.00	$76.00	$83.00
0020	Dental	MR2B	No documentation	This claim is for several dental services including three photographs. There were no photographs in the dental records. The error was calculated as the difference between the amount paid for the entire claim and the amount that was paid for the three photographs.	$535.00	$513.00	$22.00

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0023	Dental	MR2A	Poor/insufficient documentation	This claim is for dental services. The provider did not sign the medical record for the claimed date of service. The documentation from the record did not have any identifying information, only the X-rays were noted with patient name and birth date. The progress notes were difficult to read and did not have a name or birth date on them. The error was calculated as the total amount paid for this claim.	$265.00	$0.00	$265.00
0028	Dental	MR2A	Poor/insufficient documentation	This claim is for periodic dental examination and prophylaxis. The documentation for this service is not signed by the provider. Therefore, cannot determine if the person providing these services is appropriately licensed and qualified. The error is calculated as the total amount paid for this claim.	$40.00	$0.00	$40.00
0030	Dental	MR2B	No documentation	This claim is for several dental services including six X-rays. There was only one X-ray in the record for the date of service. The error is calculated as the difference between the total amount paid for this claim and the amount paid for the five X-rays not in the record.	$85.00	$70.00	$15.00
0031	Dental	MR2B	No documentation	This claim is for a complete dental examination and prophylaxis with fluoride. There is no documentation the fluoride treatment was provided. The error is calculated as the difference between the total amount that was paid and the amount that should have been paid for prophylaxis rather than prophylaxis with fluoride.	$60.00	$55.00	$5.00
0033	Dental	MR2A	Poor/insufficient documentation	This claim is for dental services. The provider did not sign the medical record documentation. The patient's name is not on the medical record pages. The error was calculated as the total amount paid for this claim.	$50.00	$0.00	$50.00

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0042	Dental	MR2B	No documentation	This claim is for a filling on two surfaces of a tooth and a photograph. There is no documentation this service was provided on the date of service claimed. The error is calculated as the total amount paid for this claim.	$55.00	$0.00	$55.00
0044	Dental	MR2B	No documentation	This claim is for a cast metal dowel post and porcelain with metal crown for a tooth. There is no documentation in the dental record for the date of service claimed or that the patient received the items. The error is calculated as the total amount paid for this claim.	$415.00	$0.00	$415.00
0045	Dental	MR2A	Poor/insufficient documentation	This claim is for dental services. The record shows that the examination and sealants claimed were done. The documentation for the date of service is illegible and does not mention that prophylaxis with fluoride was done as billed and paid. The error is calculated as the difference between the amount paid and the dental prophylaxis with fluoride.	$286.00	$246.00	$40.00
0046	Dental	O	Other error found	This claim is for dental services. The patient's history is incomplete and there is no informed consent signed. Patient consent for the procedure performed an informed consent is required. The error is calculated as the total amount paid for this claim.	$70.00	$0.00	$70.00
0055	ADHC	MR2A	Poor/insufficient documentation	This claim is for five days of Adult Day Health Care (ADHC) services. According to the Individual Plan of Care (IPC), this is a newly diagnosed non-insulin dependent diabetic patient who gets his blood sugar checked at the center only and is non compliant with his medication. There is no documentation regarding the primary care provider's knowledge of caring for this new condition. The center checks his blood sugar but there is no indication any attempt was made to teach him to check his own blood sugar. Nor was there an assessment of his or his primary care giver's, potential to learn to check his blood sugar. The compliance with	$381.10	$0.00	$381.10

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
		(Potential for fraud or abuse noted.)		medication is being checked once every six months. The patient is being assessed for skin integrity once every six months, as well.. The patient did not participate in physical therapy on one of the dates of service because of a reddened area above his right ankle that was referred to the nurse. The only documentation the nurse saw this reddened area was a "+" mark with initials on the flow sheet for that day. There was no documentation the nurse did any assessment of the reddened area or determined if any interventions were needed. There is little documentation to support medical necessity for this patient. With the infrequency of monitoring activities and limited assessments there is little indication of a potential for deterioration and probable institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.			
0056	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC services. The planned services were provided. However, the beneficiary attended sporadically. The beneficiary lives with family and receives medication management from her daughter. She attends the center two times a week and cares for herself all day at home alone the other days of the week. Her medical conditions appear stable. There is no indication this beneficiary would deteriorate and need institutional care without the ADHC. This is one of four required criteria the beneficiary does not meet. The beneficiary is required to meet all four criteria to be eligible for ADHC services. This error was calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0062	ADHC	MR5	Medically unnecessary service	This claim is for one day of ADHC service. The beneficiary's most serious medical condition seems to be Type II Diabetes with insulin and oral medication for control. The beneficiary lives alone and manages her own blood sugar checks and medication administration. There is some reference to the beneficiary also having osteoarthritis but there is no documentation to show any changes in this condition after planned interventions. There is no documentation the beneficiary participated in any center activities and there is no indication the ADHC services are preventing deterioration that would lead to institutionalization. The beneficiary does not appear to meet the criteria therefore is not eligible for ADHC services. The error was calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22
0064	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC services. This beneficiary lives alone with an intermittent care giver and attends the center two days a week. She manages with her care giver the other days of the week. Her blood pressure is within normal limits. She complains of back and leg pain but there does not seem to be any change in this as the result of the ADHC interventions. She self administers medication to manage this pain, as well as her other medications. There is no documentation the beneficiary participated in any of the activities planned on the IPC. There is no indication in the documentation the beneficiary is at risk of Institutional Care with out the ADHC intervention. This is one of the four required criteria that the beneficiary does not meet. The error was calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0065	ADHC	MR5	Medically unnecessary service	This claim is for four days of ADHC services. Documentation on flow sheets was generic with no indication what specific services were provided or the beneficiary's response to the services. The beneficiary's blood pressure was stable on medication which she self administered. She lived with family and was independent in most Activities of Daily Living (ADL). There was no indication in the documentation the beneficiary was at risk of institutionalization without ADHC services. The error was calculated at the total amount paid for this claim.	$304.88	$0.00	$304.88
0068	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for five days of ADHC services. The beneficiary's primary medical condition is schizophrenia with paranoid psychosis. These conditions are being well managed by the county's mental health program. The center is monitoring the beneficiary's hypertension and diabetes. There is no documentation in the medical records the beneficiary has high blood pressure. His diabetes is stable enough that he is receiving no medical management. There is no documentation of a high potential for further deterioration or possible institutionalization if ADHC services were not available for this beneficiary. The ADHC is providing no services for the beneficiary's stable psychiatric conditions. The error is calculated as the total amount paid for this claim.	$381.10	$0.00	$381.10

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0069	ADHC	MR5	Medically unnecessary service	This claim is for two days of ADHC services. The beneficiary has psychiatric conditions that are cared for by the patient's psychiatrist. The ADHC does not provide services for these conditions except for the required quarterly reviews by the ADHC. The assistance that was documented by the ADHC as needed for activities of daily living and medication administration was done at the board and care where the beneficiary lives so these services were not needed again at the ADHC. There was no documentation provided by the ADHC that demonstrates a high risk for deterioration and institutionalization without ADHC services. The error was calculated as the total amount paid for this claim.	$152.44	$0.00	$152.44
0073	ADHC	MR2B	No documentation	This claim is for one day of ADHC services. There is documentation the beneficiary meets the eligibility and medical necessity criteria for eligibility. There is no documentation many of the services listed on the IPC used to gain authorization to bill for services are being provided to the beneficiary. The beneficiary, with a recent history of frequent falls, was not receiving assistance when moving about the center. There was no indication his environment was kept clutter free for his safety, nor is there documentation he was assisted in toileting due to incontinence as planned in the IPC. The error is calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22
0074	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for two days of ADHC services. The documentation does not support that the patient meets all four criteria for eligibility for services or medical necessity. There is no documentation to support a potential for deterioration and institutionalization without ADHC services. The error is calculated as the total amount paid for this claim.	$152.44	$0.00	$152.44

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0079	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC services. This patient's primary diagnosis is schizoaffective disorder, high blood pressure and dementia. The primary care physician described the patient's conditions as stable on the History and Physical exam completed for admission to the center in February 2007. There are no blood pressures taken by the center for the month of this claim. The beneficiary is independent in all activities of daily living except bathing and dressing for which supervision is needed and is provided outside the center. The beneficiary does not meet all four criteria for eligibility and therefore is not eligible for ADHC services. The ADHC did not provide any documentation that substantiated the patient was at high risk for institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22
0081	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for three days of ADHC services. The patient has several medical conditions that are stable and well controlled by her primary care provider. The ADHC did not provide any documentation that substantiated the patient was at high risk for institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.	$228.66	$0.00	$228.66
0090	ADHC	MR2B	No documentation	This claim is for three days of ADHC services. Medical necessity is established in the medical record for ADHC services. However, there is no documentation any of the activities identified on the Individual Plan of Care (IPC) were provided. The error was calculated as the total amount paid for this claim.	$228.66	$0.00	$228.66

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0094	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for three days of ADHC services. The beneficiary has high blood pressure that is stable and diabetes type II which is controlled. The beneficiary also has depression according to the ADHC. There are no special services other than services routinely provided by the center's social worker and the beneficiary is not receiving medical management. There is no indication in the center's documentation the beneficiary has a high potential for further deterioration and probably institutionalization if these services were not provided. The error is calculated as the total amount paid for this claim.	$228.66	$0.00	$228.66
0095	ADHC	MR5	Medically unnecessary service	This claim is for one day of ADHC services. The beneficiary provides care for her grandchildren which questions her meeting the criteria for eligibility and medical necessity for ADHC services. The blood pressure was planned on the individual plan of care to be done twice a week. It was done only once a week. The physical therapist documented the participant was independent in doing her low back massage for 15 minutes once a week. There was no progress note to describe one-to-one counseling done by the social worker. The ADHC did not provide any documentation that substantiated the patient was at high risk for institutionalization if ADHC services were not available.	$76.22	$0.00	$76.22

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0099	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC services. The patient's primary conditions are psychiatric however he is receiving no service for this at the ADHC. All psychiatric services are provided through the county. The patient has a history of high blood pressure that is stable on medication according to the IPC. The center monitors the patient's blood pressure every two weeks which indicates the blood pressure is stable. The patient's blood sugar is monitored once a month so there is no instability evident with the blood sugar. According to the ADHC documents, the patient walks and stands around the center the entire time he is there not interacting or participating in therapeutic activities per the IPC. There is no indication this patient meets all four of the criteria needed to be eligible for ADHC services. There is no high potential for further deterioration and probable institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22
0101	ADHC	MR5	Medically unnecessary service	This claim is for 22 days of ADHC services. The beneficiary's diagnoses are high blood pressure, diabetes mellitus type II and depression. The blood pressure and diabetes are well managed by the primary care provider. There is no medical indication the patient has depression. There is no documentation by the ADHC that the beneficiary is at risk of deterioration and institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.	$1,676.84	$0.00	$1,676.84

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0103	ADHC	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC services. According to the documentation provided by the ADHC, the beneficiary is independent in all Activates of Daily Living (ADL). The beneficiary must meet all four criteria for eligibility to receive ADHC services. The beneficiary does not meet criteria two - "A physical or mental impairment that handicaps ADLs but is not so serious to require 24-hour institutional care." The error is calculated as the total amount paid for this claim.	$76.22	$0.00	$76.22
0122	Durable Medical Equipment	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is for supplies for a Transcutaneous Electrical Nerve Stimulator (TENS) unit. The documentation recommends the use of a TENS unit, but there was no evaluation of the effectiveness of the device noted since 7/12/04. The error was calculated as the total amount paid for this claim.	$3.00	$0.00	$3.00
0132	Durable Medical Equipment	MR2A	Poor/insufficient documentation	This claim is for a standard wheelchair. The patient has a history of a Cerebral Vascular Accident (CVA) and subsequent right sided weakness in the referring provider's record. However, this was not mentioned on the prescription to the Durable Medical Equipment (DME) provider for the wheelchair. The referring provider states patient is using a walker. The degree of the patient's impairment and definitive documentation of need for the wheelchair is not stated in the request for the wheelchair or in the referring provider's progress notes. The error was calculated as the total amount paid for this claim.	$639.24	$0.00	$639.24
0154	Durable Medical Equipment	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for DME, a bath tub wall rail. The DME was unable to find any documentation related to this claim. According to the referring provider, the product was never provided to the beneficiary. The wrong referring provider was listed on the claim. The error was calculated as the total amount paid for the claim.	$15.83	$0.00	$15.83

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0191	Inpatient	MR2A	Poor/insufficient documentation	This claim is for one day of service at a Skilled Nursing Facility. Minimal documentation from the patient's record was supplied for review. The care plan care is dated 10/7/05 with little to no updates. With a diagnosis of Dementia and an order for behavior monitoring, the documentation did not address her behavior problems. The error is calculated as the total amount paid for this claim.	$144.86	$0.00	$144.86
0203	Inpatient	MR5	Medically unnecessary service	This claim is for a month in a Skilled Nursing Facility. Medical necessity was documented in the record for the first 18 days. The physician wrote an order to discharge the patient home on January 18, 2007, no orders or physician progress notes were written after this date. The documentation in the records, including the nurses notes states the patient was discharged home on January 29, 2007. Medical necessity was not documented from January 19th through January 29th 2007 The error is calculated as the difference between the total amount paid for this claim and the amount for the days after the order was written for discharge.	$4,075.24	$2,619.84	$1,455.40
0206	Labs	MR2A	Poor/insufficient documentation	This claim is for laboratory tests for Chlamydia and a vaginal infection. There was no error identified with the documents provided by the laboratory. There is insufficient documentation in the medical record to determine the need for these tests. The error was calculated as the total amount paid for the claim.	$43.52	$0.00	$43.52
0214	Labs	MR8	Other medical error	This claim is for a finger stick glucose done in a Rural Health Clinic. It was billed using a county laboratory provider number. This test is a Clinical Laboratory Improvement Amendment (CLIA) waived test and is part of the inclusive rate for the clinic visit. The clinic had a CLIA waiver certificate to perform these waived tests. The test should not have been billed separately by the laboratory. The error is calculated as the total amount paid for the claim.	$3.50	$0.00	$3.50

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0218	Labs	MR2A	Poor/insufficient documentation	This claim is for two laboratory tests a Complete Blood Count (CBC) and a C-Reactive Protein (CRP). The referring physician requested a CBC and a Chemistry Panel before the patient received general anesthesia. Both of these were medically appropriate. When the prescription from the referring provider was transcribed, the CRP was drawn by the lab in error. There was no medical indication for this test and it was not ordered by the referring provider. The error was calculated as the difference between the amount that was paid for the entire claim and the amount that was paid for the CRP.	$14.31	$8.59	$5.72
0221	Labs	MR2A	Poor/insufficient documentation	This claim is for laboratory tests for Chlamydia and gonorrhea. There were no errors found in the documents provided by the laboratory. There was no indication in the referring provider records why the tests were ordered. There was no beneficiary signature verifying the source of the biological specimen. The error was calculated as the total amount paid for this claim.	$77.60	$0.00	$77.60
0226	Labs	MR2A	Poor/insufficient documentation	This claim is for two laboratory tests. There was no error in the documentation provided by the laboratory. There is no documentation in the progress note ordering the test. The laboratory requisition copy form the provider office has the tests ordered. The time and date of the specimen collection was not noted. The error is calculated as the total amount paid for this claim.	$77.60	$0.00	$77.60

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0229	Labs	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is for a laboratory test for serum amylase. There is no indication in the medical record the patient had symptoms, or a condition that would make this test medically necessary. There is no mention in the referring provider progress note for the date of service that the test should be ordered. The beneficiary did not sign verifying the source of the biological specimen for this test. The error is calculated as the total amount paid for this claim.	$7.17	$0.00	$7.17
0246	Labs	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim was for four laboratory tests, one being fasting blood sugar. There were no errors identified in the documentation provided by the laboratory. The referring provider's medical records had no documentation to demonstrate medical necessity for the fasting blood sugar. There was also no documentation to indicate the referring provider intended to order this test. The error is calculated as the difference between the total amount paid for this claim and the amount that paid for the test that weren't justified by the documentation	$60.04	$42.33	$17.71
0247	Labs	MR2B	No documentation	This claim is for a chorionic gonadotropin laboratory test. This test was ordered to be done serially for three consecutive weeks. The order was dated one week after the date of service noted on the claim. The records from the referring provider included a laboratory requisition with no date, a laboratory result dated two weeks before the date of service, and a only progress note for a date of service about four weeks after the date of service on the claim. This progress note was unsigned. There was no documentation the test was ordered for the date of service on the claim. The error is calculated as the total amount paid for the claim.	$14.07	$0.00	$14.07

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0253	Labs	MR2B	No documentation	This claim is for a laboratory test that was part of a series of three. There was appropriate documentation of the request for the three tests at the laboratory and in the referring provider's records. There is no documentation the test was done for the date of service on the claim. The only results provided were for a test two months before the date of service The error is calculated as the total amount paid for this claim.	$3.47	$0.00	$3.47
0254	Labs	MR5	Medically unnecessary service	This claim is for laboratory drug screening on a pregnant woman. There is no error in the documentation provided by the laboratory. There is no documentation in the medical record to demonstrate this patient is part of a high risk population. There is no personal history of drug use. The protocol from the clinic does not address a drug screen as part of new obstetrical services. Therefore, there is no medical indication for the tests. The error is calculated as the total amount paid for this claim.	$15.22	$0.00	$15.22
0256	Labs	MR2B	No documentation	This claim is for one laboratory test for HIV. There is no documentation on the requisition provided that the test was ordered. There is no documentation in the results provided by the laboratory that the test was done and results obtained. There was a result of the test in the referring provider's record. The error is calculated as the total amount paid for the claim.	$9.82	$0.00	$9.82
0272	Labs	MR5	Medically unnecessary service	This claim was for laboratory tests on a prenatal patient. The prenatal screening that was run includes an HIV test therefore it should not be billed separately. There is no justification in the documentation to run another/ subsequent test. The error is calculated as the total amount paid for the additional HIV test on this claim.	$16.15	$3.50	$12.65

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0281	Other Practices and Clinics	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for one day of ADHC at a Rural Health Clinic. To be eligible for ADHC services the beneficiary must meet all four eligibility criteria. The beneficiary had several medical conditions all of which were stable and well controlled by the beneficiary's primary care provider. Therefore, there is no high potential for further deterioration and probable institutionalization if ADHC services were not available. The error is calculated as the total amount paid for this claim.	$152.56	$0.00	$152.56
0282	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit the documentation requires at least two of these three key components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. The documentation for this claim included a problem focused history and examination and straightforward medical decision making. These are components of a level two office visit. The error is calculated as the difference between a level three office visit and a level two office visit.	$19.20	$14.48	$4.72
0283	Other Practices and Clinics	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for eleven laboratory tests. There is no medical indication for some of the tests. The patient requested tests for Sexually Transmitted Diseases (STD). There is no history or physical examination or documentation of any counseling related to sexual activities that could have led to needing these tests. The patient has hypothyroidism so the three tests related to thyroid could be justified. The four STD tests can be justified because the patient asked for them. There is no documentation to support the remaining tests. There was no signature verifying the source of the specimens. The error is calculated as the difference between the total amount paid for the claim and the amount paid for the tests that weren't	$257.25	$227.19	$30.06

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				medically necessary (CBS, urinalysis, hepatitis panel and metabolic panel).			
0284	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for eight different services for a patient in the emergency department. These services included three laboratory tests, one radiological exam along with an electrocardiogram, other treatments and the use of the emergency exam room. The physician did not write orders for the chest X-ray, electrocardiogram, and two of the laboratory tests. The error is calculated as the difference between the total amount paid for the claim and the amount that was paid for the tests that weren't ordered by the physician.	$129.15	$64.24	$64.91
0286	Other Practices and Clinics	MR3	Coding error	This claim is for a level four emergency department visit. The documentation must contain all three components: a detailed history; a detailed examination and medical decision making of moderate complexity. The documentation for this visit has an expanded problem focused history; an expanded problem focused physical examination and medical decision making of moderate complexity. These are two required components of a level three emergency department visit. The error is calculated as the difference between the amount that was paid and the level of care justified by the documentation.	$68.35	$44.60	$23.75

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0289	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. A level three office visit requires two of the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation for this date of service included a problem focused history, problem focused examination and straightforward decision making. This is consistent with a level two office visit. This error is calculated as the difference between the amount paid for the level three office visit and the level two office visit.	$13.09	$9.86	$3.23
0296	Other Practices and Clinics	MR2B	No documentation	This claim is for a level four office visit for a new patient, family planning individual education and a cervical biopsy. There is documentation of the biopsy which was done by a nurse practitioner. The modifier for nurse practitioner was not used on the claim as required. There is no documentation of an office visit or any family planning education. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the level four office visit and family planning education.	$167.76	$86.14	$81.62
0302	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit, two of the three following components must be present: An expanded problem focused history; An expanded problem focused examination; and medical decision making of low complexity. The documentation in the medical record was problem focused history and examination with straightforward decision making, which is consistent with a level two office visit. The error is calculated as the difference between what was paid for a level three office visit and what would have been paid for a level two office visit.	$24.00	$18.10	$5.90

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0305	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level three emergency department (ER) visit and repair of a superficial wound. Documentation for this code requires the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided for this claim had a problem focused history, a problem focused examination and decision making of low complexity. The error is calculated as the difference between the total amount paid for the claim and the amount that was paid for the level three ER visit and the amount that would be paid a level one ER visit.	$136.62	$107.20	$29.42
0307	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level four visit to the ER. To be a level four visit, there must be all three of the following components: a detailed history, a detailed examination, and medical decision making of moderate complexity. The examination in the record was expanded, problem focused, and the decision making was low complexity. The documentation supports a level two emergency department visit. The error is calculated as the difference between what was paid for the level four ER visit and the amount that would have been paid for a level two ER visit.	$68.35	$24.38	$43.97
0308	Other Practices and Clinics	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Intravenous hydration for a patient in the ER. There is documentation in the physical examination that the patient was well hydrated per skin examination. Laboratory results were not reflective of someone that was dehydrated. There is no documentation to support the need for intravenous infusion for hydration. The error is calculated as the total amount paid for this claim.	$33.61	$0.00	$33.61

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0309	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level four visit to the ER. The documentation must include the three following components to support a level 4 emergency department visit. A detailed history; a detailed examination; and medical decision making of moderate complexity. The history documented in the medical record was problem focused and the documented medical decision making of low complexity. The documentation supported a level one emergency department visit. This error is calculated as the difference between the amount that was paid for the level four ER visit and the amount that would have been paid for a level two ER visit.	$68.35	$15.18	$53.17
0314	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for an ante partum office visit, non-stress test and obstetrical (OB) ultrasound done in the physician's office. There is insufficient documentation to support the need for the ultrasound and there is no order or plan documented for the ultrasound as required. The error is calculated as the difference between the total amount that was paid for this claim and the amount that was paid for the OB ultrasound.	$135.12	$83.28	$51.84
0315	Other Practices and Clinics	MR3	Coding error	This claim is for a level two office visit for a new patient; collection and handling of blood specimen; and Family Planning Access Care Treatment (FPACT) individual family planning education. The patient was seen in the clinic by the same provider a month before this date of service. Therefore, this is a level two established patient visit. There is no documentation of family planning education being provided. The error is calculated as the difference between the amount paid for the new patient office visit and the amount that would have been paid for an established patient visit and the amount paid for the family planning education.	$50.65	$21.73	$28.92

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0327	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit. To support a level three office visit the documentation must have two of the following three components: An expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. The documentation provided has a problem focused history, an expanded problem focused examination and no medical decision making. The documentation supports only a level two office visit. The error is calculated as the difference between the amount paid for the level three office visit and the amount that would have been paid for a level two office visit.	$26.18	$19.73	$6.45
0335	Other Practices and Clinics	MR3	Coding error	This claim for a level three office visit for an established patient. A level three office visit must have at least two of the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The patient came in for a medication refill. There was no history, no physical and only a refill was provided. Since there was no history or physical and the presenting problem was minimal. The documentation supports a level one visit. This error was calculated as the difference between the total amount paid for the level three office visit and the amount that would have been paid for a level one office visit.	$24.00	$12.00	$12.00

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0344	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for 30 minutes of health education assessment through the Comprehensive Prenatal Services Program (CPSP). The patient was provided education on ultrasound by the CPSP worker. The only documentation of any training was a printed handout with the date of service, with a date of birth that was the same as this patient's. The patient's name was not on the form. The form had the CPSP worker's name typed on the form with initials. The time out on the form was altered to read 30 minutes. There was no documentation of type and extent of the education provided or the patient's response. The patient had had ultrasounds previously so there is some question of the need for 30 minutes of education at this time. The error is calculated as the total amount paid for this claim.	$16.82	$0.00	$16.82
0370	Other Practices and Clinics	MR3	Coding error	This claim is for a level four office visit. For a level four office visit the documentation must have two of the three following components: a detailed history; a detailed examination; medical decision making of moderate complexity. The documentation provided for this office visit consisted of an expanded problem focused history; a problem focused examination and medical decision making of moderate complexity. The documentation supports a level three office visit. The error is calculated as the difference between the amount that was paid for the level four office visit and the amount that would have been paid for a level three office visit.	$23.22	$14.86	$8.36
0372	Other Practices and Clinics	MR2B	No documentation	This claim is for six outpatient surgery services. All of the services were provided and medically appropriate except one. There is no documentation the patient received the intravenous (IV) solution claimed. The error is calculated as the difference between the amount that was paid for the claim and the amount that	$231.21	$218.21	$13.00

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				was paid for IV solution.			
0376	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. For a level three office visit the documentation must have two of the three following components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The documentation for this visit has the following components: a problem focused history; a problem focused physical examination and straightforward medical decision making. The documentation supports a level two office visit. The error is calculated as the difference between the amount paid for the level three office visit and the amount that would have been paid for an office two level visit.	$64.14	$56.75	$7.39
0377	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. For a level three office visit the documentation must have two of the three following components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The documentation for this visit has the following components: a problem focused history; a problem focused physical examination and straightforward medical decision making. The documentation supports a level two office visit. The error is calculated as the difference between the amount paid for the level three office visit and the amount that would have been paid for a level two office visit.	$26.10	$20.20	$5.90

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0378	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for family planning counseling up to 15 minutes through Family PACT. There was no documentation of the nature or extent of the counseling provided to this beneficiary. There were checks on a list of topics only. The time used for this counseling was not documented either. The error is calculated as the total amount paid for this claim.	$19.07	$0.00	$19.07
0390	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. For a level three office visit the documentation must have two of the three following components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The documentation for this visit has the following components: a problem focused history; a problem focused physical examination and straightforward medical decision making. The documentation supports a level two office visit. The error is calculated as the difference between the amount paid for the level three office visit and the amount that would have been paid for a level two office visit.	$24.00	$18.10	$5.90
0391	Other Practices and Clinics	MR3	Coding error	This claim is for one day of subsequent sub-acute care for the evaluation and management of a patient that requires at least two of the three following components: an expanded problem focused interval history; an expanded problem focused examination and medical decision making of moderate complexity. The documentation provided for this claim contained a problem focused interval history; a problem focused examination and decision making of moderate complexity. This documentation supports a lower level of care. The error is calculated as the difference between the amount paid for higher level of care and the amount that would have been paid for the lower level.	$37.80	$28.60	$9.20

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0409	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. For a level three office visit the documentation must have two of the three following components: an expanded problem focused history; an expanded problem focused examination; medical decision making of low complexity. The documentation for this visit has the following components: a problem focused history; a problem focused physical examination and straightforward medical decision making. The documentation supports a level two office visit. The error is calculated as the difference between the amount paid for a level three office visit and the amount that would have been paid for a level two office visit.	$24.00	$18.10	$5.90
0414	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit the documentation must include two of the three following components: a detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation for this date of service had a problem focused history, no examination and medical decision making of low complexity which is consistent with a level two office visit. The provider did not sign the progress note. The error is calculated as the difference between the amount paid for a level four office visit and the amount that would have been paid for a level two office visit.	$29.71	$22.39	$7.32

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0415	Other Practices and Clinics	MR3	Coding error	This is a claim for a level three office visit for a new patient. To meet the requirements for a level three office visit, the documentation must have the three following components: a detailed history; a detailed examination; medical decision making of low complexity. The documentation for this date of service has an expanded problem focused history; expanded problem focused examination; and straightforward medical decision making which supports a level two office visit for a new patient. The error is calculated as the difference between the amount paid for a level three office visit and the amount that would have been paid for a level two office visit.	$62.41	$37.42	$24.99
0417	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level four office visit for an established patient. This is one of seven visits for an infant and his mother during the same month. To be a level four office visit the documentation must have the two of the three following components: A detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation provided contains a problem focused history; detailed examination and straightforward medical decision making. The documentation supports a level two office visit. The error is calculated as the difference between the amount paid for a level four office visit and the amount that would have been paid for a level two office visit.	$26.18	$19.74	$6.44

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0418	Other Practices and Clinics	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for four encounters for acupuncture with stimulation/15 minutes each. Acupuncture is "limited to the treatment performed to prevent, modify or alleviate the perception of severe, persistent chronic pain resulting from a generally recognized medical condition." Each 15 minutes are for personal one-on-one contact with the patient. There is no documentation to support the time spent with the patient. There is no documentation to support the patient had a medical condition that required acupuncture. The only documentation in the record for this date of service was "He felt better no pain in the hip." The remainder of the progress note was not completed. There is no documentation the patient has a medical condition that requires acupuncture, what services were provided or the time spent providing the service. The error is calculated as the total amount paid for this claim.	$23.16	$0.00	$23.16
0423	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit the documentation must have two of the three following components: an expanded problem focused history; and expanded problem focused examination; and medical decision making of low complexity. The documentation provided for the claimed date of service was comprised of a problem focused history; problem focused examination and straightforward decision making which is consistent with a level two office visit. The error is calculated as the difference between the amount paid for a level three office visit and the amount that would have been paid for a level two office visit.	$26.18	$19.74	$6.44

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0426	Other Practices and Clinics	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for a level three office visit for an established patient with a podiatrist. The claim also includes X-ray examination of the foot and partial debridement of the skin. There is no documented evidence the X-ray was reviewed or interpreted. There is no evidence the patient had any problems related to her skin that would have required debridement. Furthermore, there is no documentation the debridement was accomplished. The documentation provided meets only a level two office visit. To be a level three office visit, the documentation must have two of the three following components: an expanded problem focused history; and expanded problem focused examination; and medical decision making of low complexity. The documentation provided had a problem focused history and physical and medical decision making of low complexity which would support a level two office visit. The error is calculated as the total amount paid for the claim.	$59.22	$0.00	$59.22
0429	Other Practices and Clinics	MR5	Medically unnecessary service	This claim is for an X-ray of the abdomen. The patient was complaining of "swelling." The patient denied any pain or gastrointestinal symptoms. The physical examination showed no distension or other abnormal findings. There was no medical indication for the X-ray. The error is calculated as the total amount paid for this claim.	$16.14	$0.00	$16.14
0435	Other Practices and Clinics	MR3	Coding error	This claim is for a level two subsequent hospital care visit. To bill for this level inpatient services, the documentation must include two of the three following components: an expanded problem focused interval history; an expanded problem focused examination; and medical decision making of moderate complexity. The documentation for this hospital visit contained a problem focused interval history; a problem focused examination and medical decision making of low	$37.80	$27.50	$10.30

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				complexity. The error was calculated as the difference between the amount that was paid for a level two subsequent hospital care visit and the amount that would have been paid for a level one visit.			
0436	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for a new patient. The provider had three other face-to-face encounters with this patient during the month preceding this visit. Therefore, this is a level three office visit for an established patient. The error is calculated as the difference between the amount paid for an office visit for a new patient and the amount that would have been paid for an established patient.	$62.41	$26.19	$36.22
0447	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit, the documentation must contain two of the following three components: an expanded problem focused history; an expanded problem focused examination; and medical decision making of low complexity. The documentation provided has a problem focused history; problem focused examination and straightforward decision making. The error is calculated as the difference between the amount paid for a level three office visit and the amount that would have been paid for a level one visit.	$26.18	$19.74	$6.44
0462	Other Practices and Clinics	MR5	Medically unnecessary service	This claim is for several acupuncture encounters with and without electrical stimulation each for 15 minutes. There is no history, examination or other documentation to establish a condition for the acupuncture. The notes for each visit amount to a procedure code, date of service, body part and diagnosis code. There is no indication of length of one-on-one time spent with patient as required by procedure code. The remaining documentation is not legible and is mostly ditto marks. The error is calculated as the total amount paid for this claim.	$34.74	$0.00	$34.74

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0466	Other Practices and Clinics	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for a Rural Health Clinic (RHC) patient encounter. The record for the date of service states the patient was at the clinic for a workup for attention deficit hyperactivity disorder. There was no examination or any service provided to the patient by the RHC. There was no work up done by the RHC. The error is calculated as the total amount paid for this claim.	$126.35	$0.00	$126.35
0467	Other Practices and Clinics	MR3	Coding error	This claim is for six days of level three provider visits to a patient in an acute care hospital. To be a level three inpatient hospital visit the documentation must have two of the three following components: a detailed interval history; a detailed examination and medical decision making of high complexity. The documentation provided for all six days of services had an expanded problem focused interval history; an expanded problem focused examination and medical decision making of moderate complexity. This documentation supports level two inpatient visits. The error is calculated as the difference between the amount that was paid for the six level three inpatient visits and what would have been paid for six level two inpatient visits.	$274.80	$226.80	$48.00
0470	Other Practices and Clinics	MR3	Coding error	This claim is for several services and medications provided in an emergency department. All of the services were medically appropriate and correctly documented except for the intravenous (IV) injection of medications. There is conflicting documentation in the record about the route of administration of the medications. The physician stated the medications were administered intravenously. The nurse administering the medications documented it was given intramuscularly. Therefore, intravenous medication administration should not have been claimed. The error is calculated as the difference	$100.94	$78.34	$22.60

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				between the total amount paid for the claim and the amount that was paid for the IV administration.			
0473	Other Practices and Clinics	MR2B	No documentation	This claim is for nine services related to an ER visit. All of the services were appropriate and correctly documented except the claim for 1000 cc's of IV fluid and the electrocardiogram. The documentation supports the placement of an IV catheter with a port for medication administration and the subsequent removal of the port and catheter. There is no documentation any IV fluids were given to the patient. There is no tracing to support a 12 lead Electrocardiogram (EKG) was done as claimed on this date of service. The error is calculated as the difference between the total amount that was paid for this claim and the amount that was paid for EKG and the IV fluids.	$150.22	$101.73	$48.49
0477	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established Patient. To be a level three office visit the documentation must contain at least two of the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided contained no history; a detailed examination and straightforward medical decision making. This documentation supports a level two office visit. The error is calculated as the difference between what was paid for a level three office visit and	$26.18	$19.73	$6.45

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				what would have been paid for a level two office visit.			
0483	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three visit, the documentation must contain two of the three following components: an expanded problem focused history; an expanded problem examination and medical decision making of low complexity. The documentation provided has no history, a problem focused examination and medical decision making of low complexity. This documentation supports a level two office visit. The error is calculated as the difference between what was paid for a level three office visit and what would have been paid for a level two office visit.	$24.00	$18.10	$5.90

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0490	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for a new patient, specimen handling and Family PACT individual education. The specimen handling and individual education are appropriately documented. To be a level three office visit for a new patient the documentation must contain the three following components: a detailed history, a detailed examination and medical decision making of low complexity. The documentation provided has an expanded problem focused history; an expanded problem focused examination, which does not include a genital examination which is important part of an examination for a family planning patient, and straightforward decision making. This documentation supports a level two office visit. The error is calculated as the difference between what was paid for a level three office visit and what would have been paid for a level two office visit.	$87.16	$58.81	$28.35
0507	Other Practices and Clinics	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for two services: the attendance of the pediatrician at the delivery of an infant; and a newborn history and examination. The newborn history and examination is documented appropriately. There is no documentation to support the pediatrician was present in the delivery room for the birth of the infant. The birth documentation was done by the registered nurse and Apgar scores were assigned by the registered nurse. The newborn history and physical were accomplished by the pediatrician 30 minutes after delivery. The error is calculated as the difference between the amount paid for the entire claim and the amount that was paid for the pediatrician in the delivery room.	$93.28	$40.34	$52.94

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0508	Other Practices and Clinics	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for a level five office visit for an established patient. The clinic was unable to provide documentation to support the patient was seen and received services for the date of service. The only document available was a "superbill" which is a billing form completed by the provider. There is no medical record for this claimed encounter. The error is calculated as the total amount paid for this claim.	$37.45	$0.00	$37.45
0512	Other Practices and Clinics	MR7 (Potential for fraud or abuse noted.)	Policy violation	This claim is for a visit to a Rural Health Clinic (RHC). This visit is the second visit to a RHC on the same day. Although it is at a different location the clinics are members of the same group of clinics. The clinics use a single computer system for patient management. There is no indication in the documentation the second visit was for reasons different from the first visit. Since both visits were for the same problem within a system that has a single patient management system, the second visit should not have been claimed. The error is calculated as the total amount paid for this claim.	$116.29	$0.00	$116.29
0519	Other Practices and Clinics	MR2B	No documentation	This claim is for a level three office visit for an established patient. There is no documentation to support the visit ever occurred. The other office visits before and after this date of service, were claimed and paid so it was not an error in the date of service. Therefore, the error is calculated as the total amount paid for this claim.	$24.00	$0.00	$24.00
0527	Other Practices and Clinics	MR3	Coding error	This claim is for comprehensive ophthalmological services for a new patient. The documentation in the record supports an intermediate level of services. The error was calculated as the difference between the amount that was paid for this claim, and the amount that would have been paid for an intermediate level eye examination.	$39.44	$32.80	$6.64

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0530	Other Practices and Clinics	MR3	Coding error	This claim is for three services provided in a Community Clinic. All services were appropriately documented except the trans-vaginal obstetrical ultrasound. The documentation did not include adnexa (the region adjoining the uterus that contains the ovary and fallopian tube) or information related to the placenta as expected for this level of service. The error is calculated as the total amount paid minus the difference between the amount that was paid for ultrasound and the amount that would have been paid for a lower level office visit.	$309.13	$289.00	$20.13
0541	Other Practices and Clinics	MR2B	No documentation	This claim is for four services received through the Family PACT program. The evaluation and management services, individual education and emergency contraceptive were well documented and medically appropriate. There is no documentation the patient received the contraceptive supplies as claimed. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the supplies.	$90.89	$80.01	$10.88
0544	Other Practices and Clinics	MR2B	No documentation	This claim is for a level three office visit for a new patient, Family PACT Individual Education, specimen blood handling and condoms. The documentation is appropriate for all services except the condoms. There is no documentation the condoms were supplied to the patient. The error is calculated as the difference between the amount that was paid for the entire claim and the amount that was paid for the condoms.	$99.16	$87.16	$12.00

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0547	Other Practices and Clinics	MR3	Coding error	This claim is for several services: a level two office visit for an established patient; blood collection/handling; Holter monitor EKG monitoring for 24 hours, and an EKG with interpretation and report. There is adequate documentation for the level two office visit, the blood collection; and the 24 hour EKG monitoring. There is an EKG tracing in the record, however, there is no interpretation or report to accompany the EKG tracing. The error is calculated as the difference between the total amount paid for this claim and the difference between what was paid for the EKG with interpretation and report, and the amount that would have been paid for the EKG tracing only.	$133.70	$125.50	$8.20
0548	Other Practices and Clinics	MR5	Medically unnecessary service	This claim is for the radiologist review of an X-ray of the humerus and X-ray of the ankle. There were no errors identified in the documentation provided by the radiologist. The patient presented with complaints of cough and chest congestion. The referring provider's documentation is difficult to read, mostly illegible. A prescription for the x-rays is legible but the reason for them is not discernable in the medical record. There is no documentation to justify the X-rays. The error is calculated as the total amount paid for this claim.	$15.57	$0.00	$15.57
0551	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit the documentation must contain two of the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation for this claim has a problem focused history; problem focused examination and straightforward medical decision making. The patient services were provided by a physician assistant. The modifier for services provided by a physician assistant was not used on the claim. This documentation supports a level two office	$24.00	$18.10	$5.90

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				visit. The error is calculated as the difference between what was paid for a level three office visit and what would have been paid for a level two office visit.			
0561	Other Practices and Clinics	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is for a patient encounter at a Rural Health Clinic (RHC). The only encounter this patient had at the RHC is with the chiropractor. The office manager verified she provided all of the records for this patient. The only documentation for the last two years was for chiropractic services several times each month. According to the Medi-Cal manual for RHCs, Chiropractic services are subject to Medi-Cal service limitations and are limited to a maximum of two services per calendar month. The date of service for this claim is the fourth documented paid claim form the RHC in the same month. The documentation does not demonstrate how the chiropractic services over several years have provided any benefit to the patient. There is no assessment/reassessment or plan to continue or change treatment to meet the patient's health needs. The error is calculated as the total amount paid for this claim.	$78.86	$0.00	$78.86
0567	Other Practices and Clinics	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is for new obstetrical orientation and individual education 15 minutes each through the Comprehensive Perinatal Services Program. There is documentation that orientation and information was shared with the patient. Education is marked on a flow sheet but there is no documentation what the education consisted of or the patient's response to that education as required. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for education.	$25.23	$16.82	$8.41

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0572	Other Practices and Clinics	MR3	Coding error	This claim is for a level five office visit for an established patient, nine laboratory tests and use of hospital examination room. The patient came to the clinic for an employment physical. The laboratory tests are appropriate for pre employment. To be a level five office visit the documentation must contain two of the three following components: a comprehensive history; a comprehensive examination and medical decision making of high complexity. The documentation includes an expanded problem focused history; a detailed examination and medical decision making of low complexity which supports a level three office visit for an established patient. This documentation supports a level two office visit. The error is calculated as the difference between what was paid for a level five office visit and what would have been paid for a level three office visit.	$198.23	$183.47	$14.76
0573	Other Practices and Clinics	MR2B	No documentation	This claim is for three administrations of Neuporgen and one administration of Cisplatin. Both of these medications are given in the treatment of malignancy. There is good documentation the Cisplatin was administered. There is no documentation the three doses of Neuprogen were administered. There is no documentation the medication and supplies were sent home with the patient to be given by her or to have a friend administer. There is documentation the friend was taught to give the injections. The laboratory results indicate the medication was probably given. The error is calculated as difference between the total amount paid for this claims and the amount that was paid for the Neuprogen	$705.70	$33.04	$672.66

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0588	Other Practices and Clinics	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for a level three office visit for an established patient. There were no records to review. The shelves in the office were empty. According to the building security staff, the records had all been confiscated by law enforcement the day before the auditor visited. This was later verified by the provider. The error is calculated as the total amount paid for this claim.	$24.00	$0.00	$24.00
0589	Other Practices and Clinics	MR3	Coding error	This claim is for a level four office visit for a new patient, eyeglass frames, and fitting the glasses. The claim for the frames and fitting of the glasses is appropriate. Claim for the level four office visit should have been for a comprehensive eye examination. The error is calculated as the difference between what was paid for the level four office visit and what would have been paid for a comprehensive eye exam.	$111.75	$92.63	$19.12
0610	Other Practices and Clinics	MR3	Coding error	This claim is for an injection of Ketamine an anesthetic agent. The medical record documents an intra-articular injection of Kenalog with Lidocaine for the treatment of a knee injury. This claim should have been for the Kenalog. The error is calculated as the difference between the amount that was paid for the Ketamine injection and the amount that would have been paid for the Kenalog injection.	$15.15	$5.95	$9.20
0614	Other Practices and Clinics	MR4 (Potential for fraud or abuse noted.)	Unbundling error	This claim is for a level two office visit for a new patient, use of hospital examination room and measurement of blood oxygen level which is called pulse oximetry. According to the Medi-Cal manual, pulse oximetry is not separately reimbursable when done in conjunction with an evaluation and management code by the same provider, for the same recipient on the same date of service. Therefore, the pulse oximetry should not have been billed separately. The error is calculated as the difference between the total amount paid for this claim and the amount that	$55.63	$48.33	$7.30

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				was paid for pulse oximetry.			
0624	Other Practices and Clinics	MR2B	No documentation	This claim is for nine different medications given during dialysis on four different dates of service. The medications for the first two dates of service and the fourth date of service are well documented. There is no documentation of the medications for the third date of service on the claim being administered. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the medications on the third date of service on the claim.	$221.57	$113.85	$107.72
0639	Other Practices and Clinics	P1	Duplicate item (claim)	This claim is for a Depo-Provera injection and Individual Post-Partum Health Education Assessment for 15 minutes. There is adequate documentation to support the injection. According to the claim detail report, the Individual Health Assessment was billed twice for the same day. There is no documentation any Post-Partum Health Education was provided. The error is calculated as the difference between the total amount paid for this claim and the amount paid for the health education.	$77.95	$69.54	$8.41

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0654	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for a routine prenatal visit and use of an examination room. The examination room charge is allowed for hospital based outpatient services. The progress note referred to the American College of Obstetricians and Gynecologists (ACOG) form for documentation of the prenatal visit. However, there was no such form in the record. There was no documentation of the fundal height, fetal heart tones, presenting part, etc., that would be expected for a routine prenatal visit for a patient 36+ weeks pregnant. The error is calculated as the difference between the total amount paid for this visit and the amount that was paid for a routine prenatal visit.	$103.50	$43.02	$60.48
0658	Other Practices and Clinics	MR2A	Poor/insufficient documentation	This claim is for an encounter at a Federally Qualified Health Center (FQHC). According to the claim the services were provided by the Comprehensive Perinatal Services worker. There is no documentation of what services were provided. There is no sign in sheet or description of perinatal education provided. There is a note stating the patient was there for health education on dental hygiene signed by the Comprehensive Perinatal Services Worker. There is no documentation of the nature and extent of the education, the topics covered, the patient's response to the education or the time involved. The error is calculated as the total amount paid for this claim.	$115.84	$0.00	$115.84

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0661	Other Practices and Clinics	MR3	Coding error	This claim is for a level three office visit for an established patient. To be a level three office visit the documentation must contain two of the three following components: an expanded problem focused history; an expanded problem focused examination and medical decision making of low complexity. The documentation provided for this date of service included a problem focused history; and expanded problem focused examination and straightforward decision making which is consistent with a level two office visit. This documentation supports a level two office visit. The error is calculated as the difference between what was paid for a level three office visit and what would have been paid for a level two office visit.	$24.00	$18.10	$5.90
0663	Other Practices and Clinics	MR3	Coding error	This claim is for a chest X-ray, two views, frontal and lateral. The X-ray taken was a single anterior view portable X-ray. The date of service on the claim is different by one day for the date of service in the medical record. The error is calculated as the difference between the amount that was paid for the portable anterior view x-ray and the amount that would have been paid for the frontal and lateral chest x-ray.	$8.57	$6.92	$1.65
0667	Other Practices and Clinics	MR3	Coding error	This claim is for 15 minutes of Family PACT family planning counseling. The provider documented they spent 10 minutes providing counseling for the beneficiary. This claim should have been for 10 minutes of counseling rather than for 15 minutes of counseling. The date of service in the medical record was different from the date of service on the claim. There was no documentation of services on the claimed date of service. The error was calculated as the difference between the amount paid for this claim and the amount that would have been paid for a 10 minute counseling session.	$19.07	$6.35	$12.72

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0672	Other Practices and Clinics	MR4 (Potential for fraud or abuse noted.)	Unbundling error	This claim is for the global services for obstetrical care and inpatient visit after delivery. To be eligible to claim for global services the provider must provide all prenatal care, delivery, hospital and post delivery care for up to 6 weeks after delivery. This patient's obstetrical care was transferred to this provider from a Federally Qualified Health Center during the last two months of her pregnancy. The inpatient services which are documented as a post delivery service is not separately billable under the global obstetrical service. The error is calculated as the total amount paid for this claim.	$1,161.76	$0.00	$1,161.76
0674	Other Practices and Clinics	MR3 (Potential for fraud or abuse noted.)	Coding error	This claim is for a level four office visit for an established patient. To be a level four office visit the documentation must contain two of the three following components: a detailed history; a detailed examination; and medical decision making of moderate complexity. The documentation supplied by the provider had no history or vital signs and chief complaint was "family planning". The examination section is a pre printed detailed examination with no documentation to support an examination was actually accomplished. Decision making was minimal. With no history, a question as to whether or not an examination was done and the minimal medical decision making, this documentation does not support more than a level one visit. This documentation supports a level one office visit. The error is calculated as the difference between what was paid for a level four office visit and what would have been paid for a level one office visit.	$37.50	$12.00	$25.50

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0675	Other Services and Supplies	MR2B	No documentation	This claim is for five different physical therapy services provided during one month of service. Four of the claims are supported in the documentation. The service for August 29, 2006 was for physical therapy case consultation and report. According to the staff this was for documenting the patient called and cancelled the appointment due to illness. No services were provided. The error is calculated as the difference between the total amount paid for this claim and the amount that was paid for the missed therapy.	$88.62	$72.73	$15.89
0677	Other Services and Supplies	MR8 (Potential for fraud or abuse noted.)	Other medical error	This claim is for four different incontinence related supplies. The physician whose signature is on the order for the supplies denies ordering the supplies and states the signature does not appear to be hers. The home health agency stated the patient was discharged a month before the date of service and they did not provide the billed services. Since there is no verification the supplies were ordered by the physician, the error is calculated as the total amount paid for this claim.	$71.96	$0.00	$71.96
0678	Other Services and Supplies	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for six incontinence related supplies. There is no documentation in the medical record the patient had a problem with incontinence. There is documentation by both the ordering physician and the patient's oncologist that there is no genitourinary problem. The request for incontinence supplies states urge and stress incontinence as the reason for the supplies. There is no mention of or assessment of either problem in the medical record. The error is calculated as the total amount paid for the claim.	$168.42	$0.00	$168.42
0688	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for three multipurpose senior services program services. There is documentation the beneficiary received 20 bus tickets on the date of service claimed. However the quantity billed were 21. There is no documentation any case management was	$351.00	$179.24	$171.76

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				provided for the dates of service claimed. The error is calculated at the difference between the total amount paid for this claim and the amount paid for case management, and the difference between 20 and 21 bus tickets.			
0691	Other Services and Supplies	MR2B	No documentation	This claim is for basic life support ambulance transport and mileage. The transportation company was unable to provide documentation to support this transport occurred or the accuracy of the mileage claimed. The transportation company was recently purchased by another company and the new owners were unable to locate the records required to support this claim. According to the patient's medical record, the transportation appears to be medically appropriate. The error is calculated as the total amount paid for this claim.	$128.85	$0.00	$128.85
0694	Other Services and Supplies	MR7 (Potential for fraud or abuse noted.)	Policy violation	This claim is for non-emergency ground transportation and mileage. The trip log odometer reading and mileage calculation shows five miles were driven for this round trip service to the patient's doctor's office. The Treatment Authorization Request (TAR) allowed up to eight miles for this trip. The provider billed for eight miles instead of the five miles which was the actual documented length of the roundtrip. The error is calculated as the difference between the total amount paid for this claim and the amount that would have been paid for five miles instead of eight miles.	$45.70	$41.80	$3.90

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0695	Other Services and Supplies	MR7 (Potential for fraud or abuse noted.)	Policy violation	This claim is for six non-emergency medical transportation trips (3 round-trips) and the associated mileage. The trip log does not have odometer readings so mileage cannot be calculated. The driver just wrote the mileage in the space for the odometer reading. The mileage documented added up to 16 miles. The provider billed for 24 miles. There is no pickup or destination addresses on the trip log as required. According to the generally accepted on line mapping services the actual roundtrip mileage was 4.2 miles or 12.6 miles for the three round trips. The Treatment Authorization Request allowed billing up to 24 miles for these three round trips. The provider billed for the maximum allowed rather than the actual mileage driven. The only documented source for the mileage lists the mileage at 12.6 miles. The error is calculated as the difference between the total amount paid for this claim and the difference between the amount billed for 24 miles and the amount that should have been billed for 12.6 miles.	$137.10	$122.28	$14.82
0698	Other Services and Supplies	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for four non-emergency medical ground transportation trips and the associated mileage. The provider has no trip log, schedule, odometer readings, addresses or any other documentation to support any of these trips occurred. He has pages from a calendar with first names written on them. The error is calculated as the total amount paid for this claim.	$91.40	$0.00	$91.40
0699	Other Services and Supplies	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for a prenatal follow-up visit and thirty minutes of perinatal education. There is documentation to support the prenatal visit. There is no documentation of any perinatal education. The error is calculated as the difference between the total amount paid for the claim and the amount that was paid for perinatal education.	$77.30	$60.48	$16.82

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0704	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for targeted case management through a Local Education Agency (LEA). Documentation of case management and review reflect "progress" but there is no indication which goals this term pertains to. The service plan is incomplete, it lists the needs but the objectives and actions sections are not completed. The time is indicated as two units which is 30 minutes but there is no indication how that determination was made. The error is calculated as the total amount paid for this claim.	$14.40	$0.00	$14.40
0706	Other Services and Supplies	MR2B	No documentation	This claim is for a nursing assessment/evaluation through a LEA. There is documentation the hearing test, vision test, and weight and height were done three months before they were entered into computerized report. There is no documentation of the performance of the tests listed on the date of service or the qualifications of the person performing those tests. There is no assessment of these test results as they relate to this child. The error is calculated as the total amount paid for this claim.	$48.16	$0.00	$48.16
0710	Other Services and Supplies	MR2B	No documentation	This claim is for 18 services over a several months time provided by a LEA. These services include speech and language treatment, therapeutic procedures intended to develop strength, endurance, range of motion and flexibility; and face-to-face health and behavior interventions. There was documentation to support 15 of the 18 services. There was no documentation to support one speech and language service. There was no documentation to support two health and behavior interventions. The error is calculated as the difference between the total amount paid for this claim and the amount for one speech and language therapy session and two health and behavior interventions.	$369.20	$307.72	$61.48

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0711	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for one group speech therapy session for a child through a LEA. There is no physician order or physician approved standard provided for this service. There is no documentation of the nature and extent of the services provided on this date of service. There is no indication this therapy was being provided by an appropriately qualified speech/language specialist or therapist. The only documentation provided is the school attendance roster and the Individual Education Program (IEP). The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00
0712	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for one group speech and language therapy service through a LEA. There is documentation on the IEP of the intent to provide the service. There is no physician referral or physician based standard as required. The documentation provided is a page of notes covering three months with the child's name and the teacher's name at the top of the page. There is no indication who wrote the notes or if they are qualified to provide such services. The attendance roster for speech therapy was also provided. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00
0713	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for one group speech and language therapy service through a LEA. There is documentation on the IEP of the intent to provide the service. There is no physician referral or physician based standard as required. The documentation provided is a page of notes covering four months. The only identifying information on the page is the child's name at the top. There is no indication who wrote the notes or if they are qualified to provide such services. The attendance roster for speech therapy was also provided. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00

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0714	Other Services and Supplies	MR2B	No documentation	This claim is for targeted case management through LEA. After several attempts, the provider was unable to find documentation to support this claim. . The error is calculated as the total amount paid for this claim.	$7.20	$0.00	$7.20
0715	Other Services and Supplies	MR7	Policy violation	This claim is for five group speech and language therapy services provided during one month through a LEA. There is an IEP which includes speech therapy. There is no physician referral or physician based standard for the service. The only documentation related to the service was an attendance roster for speech therapy group. The nature and extent of services provided for each service was not documented. The error is calculated as the total amount paid for this claim.	$45.00	$0.00	$45.00
0717	Other Services and Supplies	MR7	Policy violation	This claim is for one group speech and language therapy session through a LEA. There is no physician order or physician based standards for this service. The only documentation of the service is a therapy attendance log. There is no documentation of the nature and extent of services provided on this date of service. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00

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0718	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for one group speech and language therapy session through a LEA. The documentation provided is the IEP supporting the speech therapy, physician based standards and the attendance sheet for group therapy demonstrating the child was in attendance. Progress notes were provided, however the notes had incomplete dates with only the month and day and no signature of the person providing the service. Without the signature identifying who provided the services and their qualifications and with the incomplete dates, the documentation is insufficient to support the service was provided on the claimed date of service by an appropriately qualified speech and language professional. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00
0721	Other Services and Supplies	MR2A	Poor/insufficient documentation	This claim is for one individual health/behavior intervention provided through a LEA. The documentation provided was the IEP addressing the health/behavior intervention, school attendance sheet and the attendance log for the specific counseling session. There was no documentation of the nature and extent of the services provided or by whom, as is required, on this date of service. A referral for assessment for psychological services can only be done by select licensed health care providers. This referral can be done through the IEP process. The IEP presented does not demonstrate any of the appropriately licensed personnel participated in the process. The psychologist signing the IEP was a credentialed school psychologist, not a licensed school psychologist as required. The error is calculated as the total amount paid for this claim.	$26.24	$0.00	$26.24

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0723	Other Services and Supplies	MR7	Policy violation	This claim is for two group speech and language therapy services through a LEA. There is documentation on the IEP of the intent to provide the service. There is no physician referral or physician based standard as required. The documentation provided is an attendance roster for speech therapy group. There is no documentation of the nature or extent of the services provided. The error is calculated as the total amount paid for this claim.	$18.00	$0.00	$18.00
0724	Other Services and Supplies	MR2B	No documentation	This claim is for one occupational therapy service for a student through a LEA. The documentation provided was the IEP addressing therapy, physician signed request for services and an attendance log covering the date of service. There were two progress notes by the occupational therapist dated seven months after the date of service. There was no documentation to support the occupational therapy was provided on the date of service claimed. There is no documentation describing the nature and extent of services provided. The error is calculated as the total amount paid for this claim.	$26.40	$0.00	$26.40
0727	Other Services and Supplies	MR2B	No documentation	This claim is for nursing aid services for 30 minutes for a student through a LEA. The service was a tube feeding. There is documentation in the IEP of the assessed need for the service. There is an attendance log showing the student was at school on the date of service. There is documentation the tube feeding was provided. There was no order for the tube feeding with the type of feeding, amount and time frame for administration from a physician. The error is calculated as the total amount paid for this claim.	$5.78	$0.00	$5.78

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0729	Other Services and Supplies	MR7	Policy violation	This claim is for one group speech and language therapy service through a LEA. There is documentation on the IEP of the intent to provide the service. The physician based standard that was provided was signed and dated 10 months after the date of service. The attendance roster for speech therapy was also provided. There is no documentation of the nature or extent of the services that were provided on this date of service. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00
0731	Other Services and Supplies	MR7	Policy violation	This claim is for one group speech and language therapy service through a LEA. There is documentation on the IEP of the intent to provide the service. There is no physician referral or physician based standard as required. The documentation provided was a speech therapy attendance roster with the number of minutes annotated. There is no documentation of the nature or extent of services provided. The error is calculated as the total amount paid for this claim.	$9.00	$0.00	$9.00
0735	Pharmacy	MR8	Other medical error	This claim is for Aspirin 81mg. tablets which are used as preventive medication for heart disease. The pharmacy had no signature verifying the prescription was received by the patient or their representative. The remainder of the pharmacy documentation was without error. The patient's medical history verifies the medical necessity for the medication. The progress note in the patient's record for the date of service for the prescription had no patient name or any other means of identifying which patient it was intended for. There was no signature on any of the notes on the page of progress notes provided. The error is calculated as the total amount paid for this claim.	$5.56	$0.00	$5.56

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0737	Pharmacy	PH7B (Potential for fraud or abuse noted.)	Prescription split	This claim is for Vicodin, a medication used to manage pain. The prescription was written for 150 tablets. The pharmacy dispensed 30 tablets. According to Title 22, section 51479, a provider may not dispense drugs in an amount different than prescribed without the prescriber's authorization. There is no such authorization documented at the pharmacy or the prescriber's place of business. There is a Code 1 restriction limiting prescription to 30 tablets with a maximum of three dispensing in 75 days. By dispensing only 30 tablets, the pharmacy avoided needing to get prior authorization to fill the prescription. The error is calculated as the total amount paid for this claim.	$9.75	$0.00	$9.75
0741	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for several incontinence related supplies. The prescriber's records show the history and physical examination most current before the prescription date does not indicate an exam or history related the patient's genitourinary system. The two previous visits lacked the same documentation. There is no indication in the patient's medical record of any problem with incontinence. There is no verification the patient received the products. The delivery form stated the supplies were left at the door. The error is calculated as the total amount paid for this claim.	$146.20	$0.00	$146.20
0754	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Hydrocodone BIT/Acetaminophen, a medication used for relieving pain. There were no errors noted in the documentation provided by the pharmacy. There is no documentation in the patient's record of any of the conditions this medication may be used for. There is no indication of medical necessity documented. The error is calculated as the total amount paid for this claim. (Possible Drug Diversion)	$9.75	$0.00	$9.75

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0759	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Neurontin, a medication used for seizures and post therapeutic neuralgia. It may also be used to treat other nerve related pain. There were no errors noted in the documentation provided by the pharmacy. There is no documentation in the patient's record of any of the conditions this medication may be used for. There is no indication of medical necessity documented. The error is calculated as the total amount paid for this claim.	$139.68	$0.00	$139.68
0760	Pharmacy	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for Oxycodone a medication used for moderate to severe pain. There was no documentation at the pharmacy since the pharmacy board had collected the prescription for an investigation. The prescribing provider stated about 200 of the provider's controlled substance prescription blanks had been stolen. This had been reported and an investigation is being conducted. The error is calculated as the total amount paid for this claim. (Possible Drug Diversion)	$864.81	$0.00	$864.81
0761	Pharmacy	PH10	Other pharmacy policy error	This claim was for Ativan, a medication used to anxiety. There is a Code 1 restriction limiting each fill to no more than 30 tablets and three fills in 75 days without prior authorization. The prescriber wrote the prescription for 60 tablets of Ativan. The pharmacy dispensed 30 tablets. There is no documentation at the pharmacy or the prescribing provider's office that the prescriber authorized this change, as required. By changing the number of pills dispensed, the pharmacy avoided needing to get prior authorization. The pharmacy was also able to collect an extra dispensing fee with the extra fills on the prescription. The error is calculated as the total amount paid for the claim.	$24.40	$0.00	$24.40

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0768	Pharmacy	MR2B	No documentation	This claim is for Colace, a stool softener. The physician prescribing the medication did not submit any medical records to support the need for this medication. She submitted only a letter describing the patient's need for the medication. The person signing for the medication was not the patient and the relationship to the patient is not noted. The wrong referring provider is noted on the claim. The error is calculated as the total amount paid for the claim.	$4.79	$0.00	$4.79
0772	Pharmacy	PH2	No legal Rx for date of service	This claim is for Risperdal, a medication used to manage dementia. The original prescription was written one year before this fill and had no refills authorized. The pharmacy was unable to provide any documentation to support a refill had been authorized for this claim. There was no documentation in the prescribing provider's record of the refill authorization either. The error is calculated as the total amount paid for this claim.	$318.20	$0.00	$318.20
0775	Pharmacy	PH2	No legal Rx for date of service	This claim was for contraceptive foam. The pharmacy claiming for the service is no longer in business. The pharmacy closed several months after this prescription was filled and most records and patients were transferred to a chain supermarket pharmacy. That pharmacy was unable to find all the records for this prescription. The patient's medical record stated intent to provide condoms but there was no mention of contraceptive foam. Since the billing pharmacy is now closed the required records were not available. The error is calculated as the total amount paid for this claim.	$16.09	$0.00	$16.09

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0781	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Zithromax, an antibiotic used to treat bacterial infections. There were no errors identified in the documentation provided by the pharmacy. The prescribing provider's records documented the patient had had a cough for two days. There was no indication any tests or examinations were done to determine if the cough was the result of a bacterial respiratory infection or any infection at all. The error is calculated as the total amount paid for this claim.	$55.15	$0.00	$55.15
0788	Pharmacy	PH3	Rx missing essential information	This claim is for Bactrim, an antibiotic. There are two telephone prescriptions for the medication. Neither of them had a date on them. There are progress notes written by the prescribing provider for the same prescription for three consecutive months. There is no way to determine if one of the telephone prescriptions provided was the one authorizing the medication for this claim. The error is calculated as the total amount paid for this claim.	$9.62	$0.00	$9.62
0795	Pharmacy	MR2B (Potential for fraud or abuse noted.)	No documentation	This claim is for two incontinence related supplies. There is no quantity ordered on the prescription or documentation form the prescribing provider to support the need for incontinence supplies. There is no record provided by the pharmacy that these supplies were received by the patient or their representative. The error is calculated as the total amount paid for this claim.	$27.05	$0.00	$27.05
0798	Pharmacy	PH3	Rx missing essential information	This claim is for Acetaminophen, a medication used for mild to moderate pain and fever. The telephone prescription for this medication does not include the number to be dispensed. A copy of the dispensing label was not provided by the pharmacy. The error was calculated as the total amount paid for this claim.	$12.64	$0.00	$12.64

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0800	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Atarax tablets, a medication used for anxiety and itching from allergies. The documentation from the pharmacy lists an incorrect referring provider on the claim and the beneficiary did not sign for receipt of this medication. The actual referring provider has no documentation in any of the provided records to indicate the patient had any condition or complaints that atarax would be prescribed for. The progress notes for all the visits reviewed were typed, had no plan of care for the patient and were unsigned. Without a signature there is no indication to whom actually provided the services. The error is calculated as the total amount paid for this claim.	$27.48	$0.00	$27.48
0801	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Tricor, a medication used to treat high cholesterol. The documentation from the pharmacy lists an incorrect referring provider on the claim and the beneficiary did not sign for receipt of this medication. The actual referring provider records give no indication this patient has been evaluated for elevated cholesterol or the need for this medication. There is no indication any labs were ordered, reviewed or discussed with the patient. There is a consult from a cardiologist that lists high cholesterol as a condition but there is no work up to support this. Per Policy Division review medical necessity was justified by a specialist's prior evaluation of the beneficiary. However, the referring provider's medical records are typed, with no plan of care for the patient and are unsigned and no justification for medication is given. The chief complaint and medical impression for the visit the day before the date of service for this claim is "billed." The error is calculated as the total amount paid for this claim.	$105.60	$0.00	$105.60

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0806	Pharmacy	PH10 (Potential for fraud or abuse noted.)	Other pharmacy policy error	This claim is for Phenergan with codeine cough syrup. The prescription was written for one eight ounce bottle of cough syrup. The pharmacy dispensed and claimed for two eight ounce bottles. This doubles the size of the prescription of this frequently misused medication. There was no documentation in the pharmacy or at the prescribing provider's office to indicate the pharmacy received authorization to change the prescription, which is required. The error is calculated as the difference between the total amount paid for this claim and the amount that would have been paid for one eight ounce bottle of cough syrup. (Possible Drug Diversion)	$34.26	$20.75	$13.51
0808	Pharmacy	MR2B	No documentation	This claim is for Amitriptyline, a medication for depression. The pharmacy was closed for business when visited. There was a lease sign in the window with no forwarding information. Since the pharmacy is no longer in business, no documentation to support the claim could be obtained. The error is calculated as the total amount paid for this claim.	$9.21	$0.00	$9.21
0827	Pharmacy	PH2	No legal Rx for date of service	This claim is for Ferrous Sulfate, an iron preparation used to treat anemia. The pharmacy has no prescription for the medication. According to the pharmacy, they had a fire and the prescriptions, which were stored in cardboard boxes needed to be removed from the area. They subsequently disappeared so no prescription was available. There was sufficient documentation in the referring provider's record to indicate the need for the medication but there was no indication the referring provider intended the patient have the medication. The error is calculated as the total amount paid for the claim.	$5.99	$0.00	$5.99

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0834	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Topamax, a medication used to manage seizures. An unknown person signed for the medication. According to the documentation, the medication was signed for by "self". The written signature does not reflect the type of writing you would expect from a seven year old child. The documentation from the referring provider consisted of a four year old neurology consult, which indicated the medical necessity for the medication and a progress note for a visit two months after the date of service on the claim. There was no documentation provided to support the medical management of this patient's seizure disorder. The error is calculated as the total amount paid for this claim.	$248.28	$0.00	$248.28
0846	Pharmacy	PH10	Other pharmacy policy error	This claim is for Haloperidol, a medication to manage psychosis. The prescription was written for 124 tablets. The pharmacy dispensed and claimed for 168 tablets. There is no documentation the prescriber authorized this change in the prescription. The signature of receipt and dispensing label provided was for the wrong date of service. The error is calculated as the difference between the amount that was paid and the amount that would have been paid for 124 tablets.	$116.01	$87.53	$28.48
0847	Pharmacy	MR2B	No documentation	This claim is for Metformin, a medication used to manage type II diabetes. The signature log provided did not identify who signed for the prescription and the date of receipt was not noted. A dispensing label was not provided for the date of service. The prescribing provider had misplaced the medical records for this patient. Therefore, review staff was unable to verify the need or intent for this medication at the time of the date of service. The error is calculated as the total amount paid for this claim.	$28. 9	$0.00	$28.59

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0849	Pharmacy	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is for test strips to measure blood glucose levels for people with diabetes. The pharmacy supplied 50 test strips a month, every month for this patient. The patient resides in a skilled nursing facility and has an order to check blood sugar once a week every Thursday. This is the order that is used to request the needed number of test strips to accomplish the testing. This totals at the most five test strips a month, 45 fewer than had been supplied. The pharmacy was aware of the frequency of testing since the weekly testing requirement was on the label for the test strips. The director of nursing at the skilled nursing facility stated she had attempted to get the pharmacy to send fewer test strips, but told not it was not available. This order has been in effect for about five years so many more strips than are needed have been supplied. Therefore, the error is calculated as the total amount paid for this claim.	$41.90	$0.00	$41.90
0850	Pharmacy	PH10	Other pharmacy policy error	This claim is for Zantac, a medication used to treat Gastro Esophageal Reflux Disease (GERD). This prescription was written originally six months before this date of service. Five months before this date of service the prescription was changed to Nexium, another medication used to treat GERD. The prescription for Zantac and the prescription for Nexium were filled by the same pharmacy. The pharmacy's drug profile should have identified the duplicate medication and an appropriate intervention to prevent double medicating should have been implemented. There is no indication any interventions such as calling the provider or counseling the patient where accomplished. There is no documentation in the prescribing provider's record that he was aware the patient was getting both prescriptions filled. The error is calculated as the total amount paid for this claim.	$10.51	$0.00	$10.51

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0862	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for extra strength acetaminophen, a medication used to manage pain and fever. No errors were identified in the documentation provided by the pharmacy. The referring provider had not documented his intent to prescribe the medication. There is no documentation in the referring provider's record of any pain or fever which would require the medication. Since there is no documentation of medical necessity for this medication, the error is calculated as the total amount paid for this claim.	$15.43	$0.00	$15.43
0866	Pharmacy	MR2B	No documentation	This claim is for Levothyroxine, a medication used to treat low thyroid. There were no errors identified in the documentation provided by the pharmacy. The listed referring provider and the provider identified as the primary care provider for this patient we unable to provide documentation of need or intent for this patient to be taking this medication. The error is calculated as the total amount paid for this claim.	$13.15	$0.00	$13.15
0867	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Ativan, a medication used to manage anxiety. No errors were identified in the documentation provided by the pharmacy. The medical record from the referring provider had the medication mentioned in the office visit before the one on the same date of service of the claim. There was no documentation in either progress note provided that demonstrated a need for the medication. Neither of the progress notes provided was signed and the one for the same date of service as this claim is written in two different hand writings. The error is calculated as the total amount paid for this claim. (Possible Drug Diversion)	$32.70	$0.00	$32.70

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0890	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Flomax, a medication used to treat urinary retention. There were no errors identified in the documentation provided by the pharmacy. There was documentation form the board and care that the patient was receiving the medication, The discharge sheet from the rehabilitation center stated urinary retention as a diagnosis. There was no documentation from the prescribing provider addressing the intent to give the medication or an evaluation of the patient's condition and his response to the medication. The error is calculated as the total amount paid for this claim.	$74.20	$0.00	$74.20
0895	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for phenergan, a medication used to manage nausea. There is no documentation in the prescribing provider's record to support the medical necessity for this medication. An incorrect prescribing provider was listed on the claim. The error is calculated as the total amount paid for this claim.	$11.45	$0.00	$11.45
0898	Pharmacy	PH10	Other pharmacy policy error	This claim is for diflucan a medication used to treat yeast infections. Medi-Cal restricts the use of this medication to patients with caner and Human Immunodeficiency Virus (HIV) without prior authorization. There is no documentation in the referring provider's records or the pharmacy records the patient has either cancer or HIV. There is no documentation prior authorization was obtained. The error is calculated as the total amount paid for this claim.	$35.74	$0.00	$35.74

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0903	Pharmacy	MR2A	Poor/insufficient documentation	This claim is for Imitrex, a medication used to treat migraine headaches. The pharmacy that filled the prescription has been sold therefore; some of the required documentation was not available. There is no copy of the dispensing label which supports the medication was dispensed. There also was no signature of receipt for the medication. The referring provider's record has no mention of the patient taking the medication other than a two year old listing on the medication refill list. The record mentions another medication being taken by the patient for migraine headache. There is no evaluation of the patient's migraine headache or assessment of the effectiveness of any of the medications. The error is calculated as the total amount paid for this claim.	$178.77	$0.00	$178.77
0919	Pharmacy	MR2B	No documentation	This claim is for Temazepam, a medication used to manage insomnia. There were no errors identified in the documentation provided by the pharmacy. The referring provider records document the medication was prescribed. There is no documentation of insomnia in any of the patient's' medical record provided or medical indication for this medication. The error is calculated as the total amount paid for this claim.	$4.10	$0.00	$4.10
0942	Pharmacy	PH10	Other pharmacy policy error	This claim is for glucose test strips for a diabetic to test their glucose levels. The prescription was for 50 test strips, with a refill as needed for 1 year. The pharmacy dispensed 100 test strips on this date of service. There is no documentation in the pharmacy or referring provider of the change was authorized. Per order the beneficiary would use 50 test strips per month. Review of the CDR for the pharmacy the prescription was filled monthly. Except the month after dispensing 50. Although the beneficiary received the correct number of test strips, it is against policy for a pharmacy to	$116.06	$0.00	$116.06

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				dispense a different amount than what is ordered with out notifying the prescriber. The error is calculated as the total amount paid for the claim.			
0948	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Lorazepam, a medication used to manage anxiety. The prescription was written for 60 tablets. The pharmacy dispensed 30 tablets. This is Code 1 drug restricted to 30 tablets per filling. There was no documentation the pharmacy attempted to obtain authorization for this prescription change as per Title 22 section 51479. There was no documentation if the prescriber's medical record that the patient had anxiety. There is a three year old note documenting depression. There is no work up of the depression, services or follow-up evaluation for this condition. Lorazepam is not an appropriate medication to treat depression. The error is calculated as the total amount paid for this claim.	$20.30	$0.00	$20.30
0950	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Lipitor, a medication used to reduce cholesterol. The beneficiary resides in a Guest Home, records were available there; Lab results dated 2005, 2006 and 2007 indicate no evidence of elevated cholesterol. The history and physical list (hypercholesterol) under diagnosis with no explanation. Prescribing physician did not have medical records for the beneficiary. The prescription does not have a date. A FAX refill request has no physician information. The error is calculated as the total amount paid for this claim.	$82.80	$0.00	$82.80

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0952	Pharmacy	MR2B	No documentation	This claim is for Ambien, a medication used for sleep. This is a Code 1 restricted drug limited to use in patients with insomnia. There is no documentation at the pharmacy, the patient has insomnia. The medical records from the prescribing provider were not available. He has retired and moved out of state. Therefore, there were no records to review to support the need for the medication. The error is calculated as the total amount paid for this claim.	$433.81	$0.00	$433.81
0953	Pharmacy	PH10 (Potential for fraud or abuse noted.)	Other pharmacy policy error	This claim is for Bacitracin Zinc ointment, used for localized skin irritations. The prescription was written for 14gm. The pharmacy dispensed 28 gm. There is no documentation in the pharmacy or at the prescribing provider's office that this change in the prescription was authorized by the prescribing provider. The error is calculated as the total amount paid for this claim.	$10.00	$0.00	$10.00
0962	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Meclizine, a medication to treat motion sickness. The prescription and label for the medication was missing essential information. There were no directions for use on the prescription or the label placed on the container for the patients. The prescribing provider's medical record is illegible. There is no discernible indication for the medication. Since medical necessity could not be determined, the error is calculated as the total amount paid for this claim.	$8.93	$0.00	$8.93
0964	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Clarithromycin, an antibiotic used to treat H-Pylori infection preventing a recurrence of peptic ulcers. There were no errors identified in the documentation provided by the pharmacy. There was no documentation in the medical records to support a work up for or a final diagnosis for H-Pylori. There was no medical necessity identified. The error is calculated as the total amount paid for this claim.	$73.68	$0.00	$73.68

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0968	Pharmacy	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	This claim is Ibuprophen, a medication used to manage pain. There were no errors identified in the documentation provided by the pharmacy. There was no documentation related to paid management for four years in the prescriber's medical record. The only documentation available from the referring provider was copies of the medication reorder faxes. The error is calculated as the total amount paid for this claim.	$14.33	$0.00	$14.33
0980	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	The claim is for Colace, a stool softener. Most recent record 7/12/05, the date of service on the claim was 3/30/07. There is no documentation the patient was seen by the physician for evaluation with in a year, the referring physician left the clinic and took the chart (medical record) when the patient transferred her care to him. Later the physician transferred again, the patient was seen a year ago by the physician however there is no chart. There is no documentation the patient still needs the prescription. The pharmacy is dispensing medication to frequent. The prescription is for 60 tablets twice a day, however 100 tablets were dispensed. No dispensing label or signature for prescription pick-up. The error is calculated as the total amount paid for this claim.	$11.39	$0.00	$11.39
0983	Pharmacy	MR2A	Poor/insufficient documentation	The claim is for Micro K 40 meq, used in potassium deficiency. The beneficiary resides in a convalescent hospital. There is no mention in the physician's notes as to why the beneficiary is taking the medication. Medical records identified nausea and vomiting in the doctor's order which would justify potassium replacement but no nausea and vomiting noted in the nurse's notes. Original prescription was not signed by prescribing physician. The refill was not signed by the physician but by his representative, a nurse. The error is calculated as the total amount paid for this claim.	$14.62	$0.00	$14.62

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0988	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Claritin, a medication used for symptoms of hay fever and other allergies. The prescription was not legible. There were no directions for use on the dispensing label. The prescribing provider's office visit note for the date of service was illegible. There is no discernible indication why the medication was prescribed. The error is calculated as the total amount paid for this claim.	$13.25	$0.00	$13.25
0990	Pharmacy	MR2A	Poor/insufficient documentation	The claim is for Clozapine, used for treatment of schizophrenia. The beneficiary resides in a board and care. The original prescription order was a telephone order, had no refills and was ordered by a physician, the actual physician order is signed by another physician and does not include quantity and number of refills therefore can not be viewed as a legal refill authorization. The physician that signed the physician order was contacted and states when he visits the patient at the board and care, he does not bring the chart and he does not document any progress notes. Limited documentation for the medical necessity of the medication. The error is calculated as the total amount paid for this claim.	$123.26	$0.00	$123.26
0994	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	The claim is for Miconazole 2% cream, used for fungal infection. The medical record from the prescribing physician had no documentation for medical necessity noted. The prescription was written for "1 tube" without package size. Monistat cream is available in 15 gm and 30 gm, the pharmacist dispensed 30 gms. The error is calculated as the total amount paid for this claim.	$7.20	$0.00	$7.20

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
0995	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Reglan, a medication used to manage nausea. There were no errors identified in the documentation provided by the pharmacy. The documentation provided by the prescribing provider did not have justification for the medication. According to the prescriber's staff what was provided is all that was available relating to the medication. The record provided had no indication why the patient needed the medication. The error is calculated as the total amount paid for this claim.	$18.30	$0.00	$18.30
1008	Pharmacy	MR2A	Poor/insufficient documentation	The claim is for Dicyclomine, used for stomach disorders. The beneficiary is a female with multiple sclerosis who is wheelchair bound and treated with multiple medications a day for a number of diagnoses. The faxed prescription indicates take one capsule twice a day as needed for pain, dated 5/30/07. There is a lack of documentation in the medical record that explains why the beneficiary needs this medication. The error is calculated as the total amount paid for this claim.	$12.14	$0.00	$12.14
1011	Pharmacy	PH2 (Potential for fraud or abuse noted.)	No legal Rx for date of service	This claim is for Metformin Hydrochloride used in the treatment of type II diabetes. No prescription and no signature of receipt available at the pharmacy. The error is calculated as the total amount paid for this claim.	$46.39	$0.00	$46.39
1017	Pharmacy	PH10	Other pharmacy policy error	This claim is for Ritonavir, a medication used to treat HIV. The medication prescription was written for 30 tablets and filled with 10 tablets. There is no documentation this change was authorized by the prescriber. According to the pharmacist in charge, Med-Cal beneficiaries receive 10 day supply of medications at the time of discharge. Title 22 section 51313(e) (1) (2). Allow for up to 10 days of medication at discharge as part of the contracted daily rate for the hospital stay. The medication should not have been	$12.27	$0.00	$12.27

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
				billed separately. The error is calculated as the total amount paid for the claim.			
1032	Pharmacy	PH5	Wrong information on label	The claim is for Atrovent, used in the treatment of bronchospasms. The beneficiary resides in a nursing care center. The prescription was faxed to the pharmacy identified the physician, but did not include the signature of the doctor or the nurse who received the telephone order. There is no label for the date of service. During the period of review, the medical record and Respiratory Therapy records lack documentation the nebulizer was administered. The error is calculated as the total amount paid for this claim.	$14.75	$0.00	$14.75
1036	Pharmacy	PH7B (Potential for fraud or abuse noted.)	Prescription split	This claim is for Dapsone, a medication used to treat HIV. The prescription is written for 30 tablets, a month's supply. The pharmacy gives the patient the medication every 14 days with no indication the change was authorized by the prescribing provider. The error is calculated as the difference between the total amount paid for this claim and the amount paid for dispensing fee of $7.25.	$9.73	$2.48	$7.25

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
1038	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Miconazole cream, a medication used to treat yeast infections. There are no errors in the documentation provided by the pharmacy. There was no documentation of medical necessity for this medication. There is no documentation of any yeast infection in the patient's medical record. The error is calculated as the total amount paid for this claim.	$10.99	$0.00	$10.99
1048	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	The claim is for Dical-D, used for calcium replacement. The beneficiary is a 65 year old male the medical record has no clear indication for the prescription. The Progress Notes dated 1/8/07 documents osteopenia, there is no further documentation to support the diagnosis, no laboratory or bone density tests. The error is calculated as the total amount paid for this claim.	$25.31	$0.00	$25.31
1063	Pharmacy	PH2 (Potential for fraud or abuse noted.)	No legal Rx for date of service	The claim is for Celexa an antidepressant, used for the treatment of depression. No prescription documentation was available at the pharmacy, the pharmacist said they had a leak in the storage and some prescriptions were damaged. The incorrect referring provider identification number was entered on the claim, therefore medical necessity could not be verified. The error is calculated as the total amount paid for this claim.	$16.52	$0.00	$16.52
1071	Pharmacy	MR2A (Potential for fraud or abuse noted.)	Poor/insufficient documentation	Claim is for Promethazine with Codeine Syrup, used for upper respiratory infection, sedation and nausea and vomiting. The beneficiary did have an upper respiratory infection/pharyngitis but related cough and/or pain was not documented. The provider prescribed medication frequently without appropriate indication. The error is calculated as the total amount paid for this claim. (Possible Drug Diversion)	$27.91	$0.00	$27.91

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
1077	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Ambien, used for insomnia. Ambien is a Code 1 drug restricted to use in the treatment of insomnia. The medication was prescribed to a 46 year old female with a note of fatigue in the medical documentation. There is no documentation confirming the medical necessity for this drug. There is no mention of diagnosis at the pharmacy or prescription for Code 1. The error is calculated as the total amount paid for this claim.	$11.52	$0.00	$11.52
1091	Pharmacy	PH10 (Potential for fraud or abuse noted.)	Other pharmacy policy error	This claim is for Docusate Sodium, used to facilitate stool softening. The prescription is for 60 tablets. The claim is for 100 pills and the label shows 100 were dispensed. The patient suffers from schizoaffective disorder and is documented as having problems with constipation. The claim lists the wrong referring provider. The error is calculated as the difference between the number of tablets ordered and the number dispensed.	$11.39	$6.83	$4.56
1092	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Prednisone used for severe inflammation, medical necessity is not documented for the medication, a diagnosis of possible mastoiditis and post auricular swelling. As the description and diagnosis pertaining to the swelling are non-specific, it cannot be concluded that Prednisone is appropriate. The prescription did not have the demographics or license number of the referring provider. The error is calculated as the total amount paid for this claim.	$7.62	$0.00	$7.62

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
1093	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Cephalexin Monohydrate, an antibiotic used for treating bacterial infections. The child presented with complaint of a burning sensation all over her body. She was afebrile, complained of headache and constipation. Glycerine suppositories were given for the constipation. A progress note, later the same day, states parent was called and the prescription was called to the pharmacy. There is no documentation that mentions an infection or abnormal lab values. The error is calculated as the total amount paid for this claim.	$54.32	$0.00	$54.32
1102	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Acetaminophen, used as a pain reliever. The last clinical evaluation was 2/13/07. There is no documentation of a chronic pain condition to justify multiple refills for Acetaminophen. The error is calculated as the total amount paid for this claim.	$6.79	$0.00	$6.79
1112	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Diclofenac sodium which is a nonsteroidal anti-inflammatory drug used to relieve the inflammation, swelling, stiffness, and joint pain associated with rheumatoid arthritis, osteoarthritis, and ankylosing spondylitis (arthritis and stiffness of the spine). The documentation does not mention arthritis and states “no pain”. The need for this medication is not documented. The error is calculated as the total amount paid for this claim.	$65.75	$0.00	$65.75
1121	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for NPH, Human Insulin a medication used to manage type I diabetes. There was no documentation that the patient had diabetes and the medical necessity for this medication was not justified. The error is calculated as the total amount paid for this claim.	$37.99	$0.00	$37.99

ID	Stratum	Primary Error/ Potential for fraud or abuse	Error Type Description	Final Comments	Stratum Header Paid Amount	Stratum Correct Amount	Amount in Error
1141	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	The claim is for Codeine/Promethazine HCL, used for cold, allergies or upper respiratory tract illness. No medical necessity was documented just complaints of a cold, prescriber appears to be prescribing narcotics without justification. There is a chronic refill problem with two medications Acetaminophen/Codeine #3 and Codeine/Promethazine HCL. Violation Title 22, CCR Sec 51458.1 Pharmacist should have called the physician to seek clarification of this problem. This is in violation of H&S Code 11153. The prescriber's demographics were not on the prescription. Per Policy Division review this is a Treatment Authorization Request (TAR) item requiring medical justification which was not submitted. The error is calculated as the total amount paid for this claim. (Possible Drug Diversion)	$17.53	$0.00	$17.53
1143	Pharmacy	MR5 (Potential for fraud or abuse noted.)	Medically unnecessary service	This claim is for Lorazepam, used for anxiety. Prescription reads, "nightly as needed for insomnia". The prescribing physician does not clearly document the indication and does not address whether the drug has been effective. Review of other records (urology) documents urinary frequency at night gets 7 hours sleep. The medication does not seem necessary. The error is calculated as the total amount paid for this claim.	$20.30	$0.00	$20.30
1144	Pharmacy	MR5	Medically unnecessary service	The claim is for Temazepam, used for insomnia. Physician Orders indicate temazepam use as needed insomia. There is no supporting documentation noted for the need of the medication or status of sleeping situation. The error is calculated as the total amount paid for this claim.	$12.67	$0.00	$12.67

VIII
REVIEW OF ERROR CODES

Three primary issues were encountered when conducting the study: (1) maintaining consistency in the document collection and review processes; (2) obtaining complete documentation from the providers; and (3) the error codes that differentiate the errors.

With multiple teams statewide conducting the first level medical review, maintaining consistency in the review decisions was imperative. To ensure consistency all efforts were made to collect necessary documentation from the providers and standardized error codes were established. The error codes that were used were developed and refined to closely represent errors that have been seen in prior studies. Multiple re-reviews were needed to ensure consistency utilizing the same error codes. The error codes used are defined as:

I. Administrative Error Codes

1. ***NE - No Error***

2. ***WPI - Wrong Provider Identified on the Claim***

2a. Wrong Rendering Provider Identified on the Claim

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

2b. 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.

2c. 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.

3. **WCI - Wrong Client Identified**
   A provider submits a claim for services with either no beneficiary or the wrong beneficiary listed.

4. **O - Other**
   Administrative errors not otherwise identified.

II. Processing Validation Error Codes

1. **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.

2. **P2 - Non-Covered Service**

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

3. **P3 - MCO Covered Service**

   Medicaid Managed Care Organization (MCO) should have covered the service and it was inappropriate to bill FFS Medi-Cal.

4. **P4 - Third Party Liability**

   Claims inappropriately billed to Medi-Cal. Claims should have been billed to other health coverage.

5. **P5 - Pricing Error**

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

6. **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.

7. **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 not eligible for services at all.

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

8. **P9 - Ineligible Provider**

This code includes the following situations:

8a - 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 which limited the provider's scope of practice.

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.

8b - 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.

9. **P10 – Other**

If this category is selected, a written explanation is provided

III. Medical Review error Codes

1. **MR1 – No Documents Submitted**

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

2. MR2 – Documentation Problem Error

2a. 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.

2b. 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.

3. 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.

4. MR4 – Unbundling Error

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

5. 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.

6. 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.

7. 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.

8. 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 This code is used for lack of DME and Laboratory signatures. This error is considered a compliance error with no dollar impact.

IV. 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, the calculated error was based on the claim which was paid on that date, even though a different claim control number was assigned. In this way, the latest positive adjustment for the claim selected for MPES review was manually identified.

1. PH1 - No Signature Log

Statute is in place requiring a beneficiary or their representative sign for the receipt of medication or other item. This is considered a compliance error with no dollar amount.

2. 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.

3. 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.

4. **PH4 - Wrong National Drug Code (NDC) Billed**

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

5. **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.

6. **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.

7. **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.

8. **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.

V. Compliance Error Codes

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

2. 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, or C. If the wrong provider was identified (WPI) yet the service is medically-appropriate, it is considered a compliance error.

VI. 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. See Section IV for a detail description of fraud characteristics on claims with error.

Section IX
STUDY RESULTS AND STATISTICAL SUMMARIES

This Section consists of nine tables, three tables for each of the last three MPES studies (2005-2007). They summarize the main findings, including the overall payment error rate, the error rates for each stratum (provider type), the payments amounts in error, and projected annual payments in error, and calendar year Medi-Cal total payments. In addition, the tables show the computed margins of errors and confidence intervals per stratum, for each of the three MPES studies. A detailed explanation on how all these amounts were computed and the statistical methodology used in MPES is described in Section III of this report.

List and Description of each Table

Table 1A	MPES 2007 Payment Error Rates and Projected Annual Payments Made in Error by Stratum (using claims paid in second quarter of Calendar Year 2007)
Table 1B	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 1C	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 2007 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum (using claims paid in second quarter of Calendar Year 2007)
Table 2B	MPES 2006 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum (using claims paid in second quarter of Calendar Year 2006)
Table 2C	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 2007 Medi-Cal Fee-For-Service and Dental Payments by Quarter
Table 3B	Calendar Year 2006 Medi-Cal Fee-For-Service and Dental Payments by Quarter
Table 3C	Calendar Year 2005 Medi-Cal Fee-For-Service and Dental Payments by Quarter

Table 1A
MPES 2007 Payment Error Rates and Projected Annual Payments Made in Error by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2007)

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

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

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

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

Table 1B
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
Totals				*$4,044,314,079	*$294,130,412	*$1,176,521,646
Overall Payment Error Rate	7.27%	±	1.60%			

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

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

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

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

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

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

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

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

Table 2A
MPES 2007 Potential Fraud Rate and Projected Annual Potential Fraudulent Payments by Stratum
(Using Claims Paid in Second Quarter of Calendar Year 2007)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Table 3A
Calendar Year 2007 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	CY 2007 Fee-for-Service (FFS) and Dental Payments by Quarter				Total
	First	Second	Third	Fourth	
Dental	$145,452,656.21	$153,629,906.84	$154,662,453.09	$152,388,630.29	$ 606,133,646
ADHC	$108,131,879.76	$ 87,712,953.68	$104,482,682.16	$107,034,032.39	$407,361,548
Durable Medical Equipment	$33,398,483.47	$25,457,659.18	$34,241,033.17	$32,761,891.37	$125,859,067
Inpatient	$2,054,635,806.20	$1,963,153,453.30	$2,169,976,368.60	$2,162,549,291.30	$8,350,314,919
Labs	$50,758,808.47	$48,044,832.44	$57,311,520.15	$ 55,649,622.52	$211,764,784
Other Practices & Clinics	$ 883,459,577.04	$798,233,864.43	$911,732,194.61	$894,170,227.59	$3,487,595,864
Other Services & Supplies	$182,215,056.92	$173,040,911.97	$200,885,993.87	$195,361,246.27	$751,503,209
Pharmacy	$697,381,996.43	$ 649,651,080.27	$764,498,078.25	$738,314,781.21	$2,849,845,936
FFS Subtotal	$4,009,981,608	$3,745,294,755	$4,243,127,871	$4,185,841,093	$16,184,245,327
Total Dental & FFS	$4,155,434,265	$3,898,924,662	$4,397,790,324	$4,338,229,723	$16,790,378,973

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

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

Table 3C
Calendar Year 2005 Medi-Cal Fee-for-service and Dental Payments by Quarter

Stratum	CY 2005 Fee-for-Service and Dental Payments by Quarter				Total
	First	Second	Third	Fourth	
Dental	$143,822,337	$159,571,995	$153,301,248	$148,804,324	$605,499,904
ADHC	$83,353,271	$93,143,673	$102,707,342	$95,227,597	$374,431,883
Durable Medical Equipment	$27,384,599	$31,632,590	$33,265,845	$28,671,897	$120,954,930
Inpatient	$1,511,613,400	$1,710,600,634	$1,815,489,961	$1,881,662,618	$ 6,919,366,612
Labs	$43,624,490	$53,305,564	$54,870,472	$52,662,561	$204,463,086
Other Practices & Clinics	$687,497,066	$809,282,635	$833,059,577	$743,278,861	$3,073,118,139
Other Services & Supplies	$155,431,736	$185,317,786	$193,830,666	$173,600,428	$708,180,617
Pharmacy	$1,187,428,813	$1,336,486,673	$1,425,372,612	$1,434,810,950	$ 5,384,099,046
FFS Subtotal	$3,696,333,374	$4,219,769,553	$4,458,596,476	$4,409,914,910	$16,784,614,313
Total Dental & FFS	$3,840,155,711	$4,379,341,548	$4,611,897,724	$4,558,719,234	$17,390,114,217

Section X
2005-2007 MPES STUDY COMPARISON OF SIGNIFICANT ITEMS

Item Study Objective	The study objective remains the same for 2005-2007 1. Measure the amount of errors in 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.
Study Universe	The study's universe has remained the same for 2005-2007: FFS claims which are processed by EDS for one quarter. The quarter selected has changed from the last quarter in MPES 2005 (October 1, 2004 – December 31, 2004) to the second quarter in MPES 2006-2007 (April 1 – June 30 of 2006 and 2007).
Sampling Design	Methodology has been unchanged: proportioned stratified random sampling which is dollar weighed. This means a hospital claim in error has more of an impact than a DME claim because of the dollars associated with the stratum. All other design items, i.e.; sample size, units, confidence level, precision level, and stratum composition had no significant changes.
Beneficiary Reviews for Eligibility and Product Verification	This item was dropped after 2005 because of the duplicative process with a federal error rate study on beneficiary eligibility (PERM). The product verification was eliminated because it did not produce significant results.
Error Rate & Fraud Error	The payment error rates are decreasing: Error Rate — Fraud Error Rate 2005 – 8.40 percent — 2005 – 3.23 percent 2006 – 7.27 percent — 2006 – 2.75 percent 2007 – 6.56 percent — 2007 – 2.53 percent
Trends	The MPES studies have been successful in identifying vulnerabilities in the Medi-Cal Program and in redeploying resources to decrease their impact. MPES 2005 identified ADHC providers as being a significant risk to the program with the highest percentage of claims completely in error and the greatest number of errors with no medical necessary, 31 and 28, respectively). The Department initiated large exercises involving ADHC field reviews resulting in numerous sanctions and utilizations being placed on providers. MPES 2006 and 2007 demonstrated a decrease in number of errors in ADHC (10 errors in each study). MPES 2006 showed dental claims with the highest percentage of errors – 57 percent or 29/51 claims. The increased focuses were directed to the area of dental provider education and increased dental provider reviews,

	as well as in a "top to bottom" review of anti-fraud activities to assess the appropriateness of anti-fraud errors. MPES 2007 showed a decline in the number of dental errors (29 vs. 14 or a reduction of 15). MPES 2007 identified the following areas of risk: • This is the first MPES study to find Inpatient errors (two in Long Term Care facilities). • Physician Services, which contributed the most errors (71), have an even higher rate when those errors are combined with those in other strata caused by physicians (primarily due to lack of medical necessity and non-needed prescriptions or referrals by physicians – an additional 43 errors). When combining Physician Services errors with other strata errors caused by prescribing providers, they account for 55 percent of all errors. • Fifty percent of all LEA claims had errors. • Half of Ground Medical Transportation Claims (Other Services and Supplies) had errors. • One hundred percent Incontinence Supplies errors also were associated with fraud characteristics.
Types of Errors	Types of errors have changed from more serious errors of medical necessity of 45 percent in MPES 2005 to less serious of errors in insufficient document to support the claim in MPES 2007 of 46 percent. Error types by MPES Study 2005: Medical Necessity 45%; Inadequate Doc. 37%; Policy Violation 10%; Coding Error 6%; Other Errors 2% 2006: Inadequate Doc. 45%; Medical Necessity 41%; Policy Violation 7%; Coding Error 5%; Other Errors 2% 2007: Inadequate Doc 46%; Medical Necessity 40%; Coding Error 10%; Policy Violation 3%; Other Errors 1%
Fraud Trends	• ADHC stratum had more characteristics of Fraud in MPES 2005 than in 2007. • Physical services and physician prescribing actions in MPES 2007 have replaced ADHC as the greatest risk for fraud. • MPES 2007 also identified a possible new area with characteristics of fraud – Incontinence Supplies.

Conclusion	MPES studies have successfully been able to measure the impact of payment errors to the Medi-Cal program, identified payment vulnerabilities, and evaluating effectiveness of the Department actions to migrate these vulnerabilities.

Section XI
SIGNIFICANT FINDINGS AND ACTIONS TAKEN ON ERRORS

The following two tables display updated actions taken as a result of MPES 2005 and 2006 findings.

Summary of Provider Actions Planned Based on the MPES 2006

Actions Planned	Number
Total errors in MPES 2006	227
Number of unique providers with errors that will be sent Civil Money Penalty letters explaining errors	141
Number of providers assigned for possible Field Audit Reviews	33
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	2
To be reviewed by A&I staff for further action	25
AFR	11
After investigation, no further actions warranted	1

Summary of Provider Actions Planned Based on the MPES 2005

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	111
Number of providers assigned for Field Audit Review	37
Providers placed on Special Claims Review requiring manual review of claims	23
Ongoing investigations taking place	12
Providers whose Medi-Cal payments are being withheld	10
Providers Temporarily Suspended from the Medi-Cal Program	2
Providers placed on Procedure Code Limitation	3
Provider cases submitted to State Controllers Office for evaluation of Audits for Recovery	2
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
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

For MPES 2007, actions will be reported in the MPES 2009. Currently, all errors are being reviewed to determine if follow-up reviews on audits should be done.

Section XII
REVIEW OF PAYMENT ERROR STUDIES

This section provides a review of recent studies that measured payment and medical necessity errors in the Medicare and Medicaid programs. The scope of this section describes the methodologies utilized, 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 studies cited indicate that the most predominant payment error was no documentation that the service was provided on the claimed date of service or there was insufficient documentation to substantiate medical necessity, although it 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. It is for this reason the 2007 MPES uses the term "potential fraud".

1. Improper Medicare Fee-For-Service Payments Report – May 2008

The Centers for Medicare and Medicaid Services (CMS) established two programs that monitor the accuracy of payments made in the Medicare Fee-for-Service (FFS) program: the Comprehensive Error Rate Testing (CERT) program and the Hospital Payment Monitoring Program (HPMP). The national paid claims error rate is a combination of error rates calculated by the CERT program and HPMP; the CERT program represents approximately 60% of the payments from which the error rate is calculated while the HPMP represents the remaining 40%. The CERT program calculates the error rates for all Medicare Administrative Contractors (MACs) which are the new claims processing entities created under the Medicare Prescription Drug Improvement and Modernization Act of 2003. Until the transition to MACs is completed, the CERT program will also report on Carriers, Durable Medical Equipment Regional Carriers (DMERCs), and Fiscal Intermediaries (FIs). HPMP calculates the error rate for the Quality Improvement Organizations (QIOs).

Both programs are designed to be a measurement of improper payments. Any claim that was paid when it should not have been is an improper payment. This includes claims that may have been fraudulent.

Neither program can be considered a measure of fraud. Both programs use random samples to select claims; however, the providers included in the sample are not selected due to suspicious billing patterns that indicate a potential for fraud. The CERT program does not, and cannot, label a claim fraudulent. However, one scenario of potential fraud that the CERT program is able to identify occurs when the CERT documentation contractor is unable to verify that the paid service was actually provided because the contractor is unable to locate a provider or supplier when requesting medical record documentation. The national error rate calculated for the May 2008 report to Congress shows that 3.7% of the payments made nationally did not comply

with one or more Medicare coverage measures: coding, billing, and payment rules. Projected overpayments were $9.3 billion and the underpayments were $0.9 billion. Thus, gross improper payments were projected as $10.2 billion.

“Medically Unnecessary Service” errors accounted for 1.3% of the total payments allowed during the reporting period. “Medically Unnecessary Services” includes situations where the CERT or HPMP claim review staff identify enough documentation in the medical record to make an informed decision that the services billed to Medicare were not medically necessary. In the case of inpatient claims, determinations are also made with regard to the level of care. If a Quality Improvement Organization determines that a hospital admission was unnecessary due to not meeting an acute level of care, the entire payment for the admission is denied.

However, it should be noted, that the reported error rates are understated because medical necessity was only a one factor out of multiple factors in the review of hospital claims. The other claims were reviewed for coding accuracy and compliance with Medicare reimbursement policies.

2. Federal Payment Error Rate Measurement (PERM) - Federal Fiscal Year 2007

California is one of 17 states randomly selected by CMS for the Payment Error Rate Measurement (PERM) initiative for Federal Fiscal Year (FY) 2007 (October 1, 2006 - September 30, 2007). For FY 2007, CMS measured Medicaid Fee-For-Service (FFS), managed care, and the State Children Health Insurance Program (SCHIP), as well as Medicaid and SCHIP beneficiary eligibility, claim payments and premium payments made on behalf of beneficiaries for accuracy.

PERM is required by CMS pursuant to the Improper Payments Information Act of 2002 (IPIA; Public Law 107-300). The IPIA directs Federal agencies to annually review their programs and report the improper payment to Congress. Medicaid is a Federal program (called Medi-Cal in California) that is potentially identified as a program at risk for significant erroneous payments. CMS must provide estimates of the accuracy of medical payments made by Medicaid as part of their annual budget request using PERM. States are required to participate under the statutory provisions of Section 1902(a) (27) of the Social Security Act (the "Act"). The Act requires states to: 1) submit expenditures, claims data, medical policies and processing manuals and other necessary information for, among other purposes, identifying improper payments; and 2) submit corrective action reports for the purpose of reducing payment error rates. A claim will be reviewed to determine if it was processed correctly, the service was medically necessary, coded correctly, and properly paid or denied. However, this process excludes the review of prescribing physician’s records for medical necessity. The Data Processing Review examines the accuracy of the claims processing system. The Medical Review validates the accuracy of the claim information to the documentation in the medical record. The data processing reviews began in May 2008. The medical record reviews began in April 2008.

The FY 2008 Agency Financial Report (AFR) published by the U. S. Department of Health and Human Services reported that the FY 2007 Medicaid Fee-For-Service

component error rate was 8.9 percent. The FY 2008 AFR reported that the FY 2006 Medicaid FFS error rate was 4.7 percent. In contrast, on November 16, 2007, CMS Office of Public Affairs announced that the FY 2006 Medicaid FFS preliminary component error rate was 18.5 percent.

The PERM error rate is not accurate because it is both over/under stated. It is overstated due to unclear guidance to providers about the PERM process, as well as the lack of knowledge of the contractors regarding each state's policies and regulations so many claims are called an error when they are not. The PERM error rate is also understated because claims are not reviewed for medical necessity.

For FY 2007, a total of 199 errors, a combination of medical and data processing review errors, were originally found. A majority of these errors were modified or reversed through the Difference Resolution Process, resulting in a lower error rate. California's revised FY 2007 FFS error rate, published in March 2008, was 4.47 percent for Medicaid and 7.80 percent for SCHIP.

Due to the differences of approach and methodology, the results of the FY 2007 PERM cannot be directly related to the results of the 2007 MPES. Medical necessity is a component of the claim review process for MPES, but not so for the PERM. In addition, the MPES claim universe is derived from all FFS and dental claims adjudicated through the State's Fiscal Intermediary, EDS, in a 3 month time period, whereas the universe and sample of claims for PERM were all Medicaid claims paid in a Federal Fiscal Year which includes other state departments such as the Department of Mental Health who administers programs for Medicaid services. Additionally, the MPES includes multiple levels of review for validity and medical necessity, which is completed for all claims, and a potential fraud estimate, both of which are not included in the PERM.

The PERM also conducts an eligibility review to identify ineligible beneficiaries. California's revised FY 2007 Eligibility error rate, published in March 2008, was 1.17 percent for Medicaid and 0.10 percent for SCHIP. The MPES does not cover eligibility.

3. Improper Fiscal Year 2002 Medicare Fee-for-Service Payments (A-17-02-02202)

This final report from the Office of the Inspector General (OIG) represents the results of its review of FY 2002 Medicare FFS claims. The objective of this review was to estimate the extent of FFS payments that did not comply with Medicare laws and regulations. This is the seventh year that OIG has estimated these improper payments. As part of its analysis, OIG profiled the last seven years' results and identified specific trends where appropriate.

OIG review of 4,985 claims valued at $6.2 million disclosed that 1,030 did not comply with Medicare laws and regulations. Based on its statistical sample, it is estimated that improper Medicare benefit payments made during FY 2002 totaled $13.3 billion, or about 6.3 percent of the $212.7 billion in processed FFS payments reported by the CMS. These improper payments, as in past years, could range from reimbursement for services provided, but inadequately documented, to inadvertent mistakes to outright fraud and abuse. The overwhelming majority (95 percent) of the improper payments

were detected through coordinated medical record reviews. These claims contained no visible errors when sent to Medicare contractors for payment.

FY 2002 estimate of improper payments was significantly less than the $23.2 billion that was first estimated for FY 1996. As a rate of error, the current 6.3 percent estimate is the same as FY 2001's rate, which was the lowest to date-and less than half of the 13.8 percent reported for FY 1996. However, OIG cannot conclude that it was statistically different from the 1998-2000 estimates, which ranged from 6.8 to 8 percent. The decrease may be due to sampling variability; that is, selecting different claims with different dollar values and errors will inevitably produce a different estimate of improper payments. In addition, the error rate is understated because claims were not reviewed for medical necessity.

To accomplish its objective, OIG used a multistate, stratified sample design. In order to determine whether Medicare FFS benefit payments were made in accordance with the provisions of Title XVIII and implementing regulations in 42 Code of Federal Regulations, OIG verified that services were furnished by certified Medicare providers to eligible beneficiaries, services were reimbursed by Medicare contractors in accordance with Medicare laws and regulations, and that services were medically necessary, accurately coded, and sufficiently documented in the beneficiaries' medical records.

4. 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 Tem Care, Individual Practitioners/Clinics, Prescription Drugs, Home and Community Based Services, Other Services and Supplies, and Medicare crossover cases. SCHIP strata included: Healthy Kids, MediKids, Children's Medical Services Network, and B-Net cases. Accuracy of payment was determined by reviewing 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.

5. Texas Error Rate Study (2001)

Unlike Medicare (2003) and Illinois (1998), Texas took a different approach to measuring the 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; it identified a 7.24

percent error rate with lack of documentation and insufficient documentation as the most common types of errors.

6. Kansas Error Rate Study (1999)

The Kansas Medicaid payment error rate study was 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 the 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 inaccurate payments was associated to documentation errors, which represented 78 percent of all dollars paid in error.

7. 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.

8. Summary

As reflected above, the design of these studies is evolving; some studies focus on payment accuracy and others 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 3.7 percent (CMS) to 24 percent (Kansas). Based on the lessons learned from their prior experiences, the states that have undertaken subsequent studies 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 prior studies. The California MPES is more complex

than all the previous studies because information is obtained on-site, a contextual analysis is performed, multiple levels of review for validity are performed, and medical necessity is completed for all claims. All of these processes result in a more accurate measurement of overpayments and potential fraud.

Section XIII
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
CBC	Complete Blood Count
CCR	California Code of Regulations
CDHCS	California Department of Health Care Services
CFR	Code of Federal Regulations
CLIA	Clinical Laboratory Improvement Amendment
CMS	Centers for Medicare and Medicaid Services
CPSP	Comprehensive Prenatal Services Program
CPT	Current Procedural Terminology
CRP	C-Reactive Protein
CVA	Cerebral Vascular Accident
DHHS	U. S. Department of Health and Human Services
DHCS	Department of Health Care Services
DME	Durable Medical Equipment
DOJ	Department of Justice
EDS	Electronic Data Systems
EKG	Electrocardiogram
ER	Emergency Department/Room
FFS	Fee-For-Service
FPACT	Family Planning, Access, Care and Treatment
FQHC	Federally Qualified Health Centers
GERD	Gastro Esophageal Reflux Disease
HALT	Health Authority Law Enforcement Team
HIV	Human Immunodeficiency Virus
IEP	Individual Education Plan
IPC	Individual Plan of Care
IV	Intravenous
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
MRB	Medical Review Branch

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

Appendix A – State Controller's Office Report on Local Education Agency

JOHN CHIANG
California State Controller

February 5, 2009

Jan Inglish, NP, Chief
Medical Review Branch
Audits and Investigations
Department of Health Care Services
P.O. Box 997413, MS 2000
Sacramento, CA 95899-7413

Dear Ms. Inglish:

As requested by the Department of Health Care Services (DHCS), the State Controller's Office (SCO) has completed a review of the Local Educational Agency (LEA) Medi-Cal Billing Option Program. Following is a summary of our review.

BACKGROUND

The LEA Medi-Cal Billing Option Program, established in 1993, provides comprehensive health services to eligible Medi-Cal students in a school environment. The LEA program's Medi-Cal providers are usually made up of school districts and/or county offices of education.

In general, services covered must be medically necessary, follow federal and state regulations, and must be included in the state plan. The four major components of the program are an Assessment/Individualized Education Plan (IEP), Treatment, Transportation, and Targeted Case Management.

REASON FOR THE REVIEW

As part of its 2006 Medi-Cal Payment Error Study (MPES), DHCS identified problems of inadequate documentation within the LEA Medi-Cal Billing Option Program. The main objective of the study was to identify emerging fraud practices and identify in which areas the Medi-Cal program is at the greatest risk for payment errors. LEA claims under the category of "Other Services and Supplies" comprised the largest number of errors.

As a result, the DHCS requested the SCO to conduct an in-depth study of the program and to make recommendations addressing problems identified by the 2006 MPES review.

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PURPOSE, OBJECTIVES, AND SCOPE

The purpose of the review was to provide follow-up to the DHCS's 2006 MPES review and determine how widespread LEA provider errors are. Our objective was to determine the legality and propriety of Medi-Cal payments to the provider by determining whether or not:

- Claims were supported by adequate documentation;
- Claims were consistent with federal and state regulations;
- Services were provided for LEA eligible students; and
- Claims were consistent with services performed.

Our review period covered payments made for the period of January 1, 2006, through December 31, 2007. To accomplish the objectives and scope of the review, we selected 17 LEA Medi-Cal providers and reviewed approximately 350 claims. We conducted field visits on the 17 LEAs and interviewed officials representing the LEA providers.

FINDINGS

Assessment/Individualized Education Plan (IEP)

1. No examination by a medical practitioner

In many cases, there was either no documentation or inadequate documentation of a medical examination prior to initiation of services. While a medical diagnosis may be listed, usually there is no indication that a licensed medical practitioner ever did a history, physical examination, or assessment of the student.

2. Inadequate information on the IEPs

- In 153 of 358 (43%) cases, pertinent information—such as an assessment or proper signature—was missing from the IEP. In some cases, an assessment was present, but did not cover the date of service claimed.
- In 183 of 353 (52%) cases, the medical service claimed was not properly authorized in the IEP. In addition to the medical services claimed, in many cases, the medical frequency and duration were not indicated on the IEP.

Treatment

1. Lack of treatment authorization/written referral

Both federal and state regulations (including the state plan) require a treatment authorization/written referral by a licensed practitioner before medical services are rendered. The person authorizing treatment depends on the medical service provided. We found:

- In 180 of 297 (61%) cases, no treatment authorization/written referral was present. In some cases, a treatment authorization/written referral was present, but the authorization was outdated or signed after the medical service was provided.

- In 72 of 297 (24%) speech cases, treatment authorization was given by a licensed speech pathologist. Physician-based standards were used for establishing medical necessity. We took exception to this practice for the following reasons:

  - These standards are not consistent with the requirements of both federal and state regulations, which require a licensed practitioner to authorize treatment.

  - In most cases, we did not see evidence of direct involvement from a licensed practitioner other than a physician signature on the standards.

  - Physician-based standards do not meet federal requirements and, in some cases, are too broad and general for establishing medical necessity.

  - In some cases, the physician-based standards were signed after the date of service.

2. **Lack of documentation supporting medical necessity (excluding TCM)**

   In 107 of 357 (30%) cases, the medical necessity was not adequately documented. Either there was no diagnosis or the diagnosis documented did not support the medical needs for the medical services rendered. The diagnosis provided usually came from a person other than a licensed practitioner.

3. **Lack of documentation supporting nature and extent of services claimed.**

   In 196 of 359 (55%) cases, there was either no documentation or inadequate documentation describing the nature and extent of the services claimed. In many cases, the documentation provided was a log or schedule with checkmarks indicating that services were provided. We had difficulty determining what services were provided. In other cases, the provider informed us that records were either with staff members who had left the program or that the records had been destroyed.

4. **Lack of documentation identifying licensed or certified staff rendering service.**

   In 60 of 272 (22%) cases, we were unable to determine who provided the services.

Transportation

1. **Lack of documentation supporting transportation (trips and mileage)**

   In general, transportation between home and school is covered when the following conditions are met: (1) the student receives a Medi-Cal-covered service at the service site; and (2) both the covered service and the transportation are authorized in the student's IEP.

Our review disclosed the following exceptions:

- In 14 of 63 (22%) cases, transportation services claimed were not authorized in the IEP.
- In 103 of 107 (96%) cases, there was either no documentation or inadequate documentation supporting trips (58 cases) and mileage (45 cases). Some providers acknowledged that, rather than maintain transportation documents (i.e., transportation logs), transportation services were claimed based on either attendance or the date on which medical services were provided.
- In 21 of 63 (33%) cases, we did not see adequate evidence that a Medi-Cal-covered health service was provided on the day of transportation.
- Some LEA providers claimed either a trip or mileage, but not both. Medi-Cal regulations entitle providers both trip and mileage reimbursement.

Targeted Case Management (TCM)

TCM services assist eligible students in accessing needed medical, social, educational, and other services when TCM is covered by the student's IEP. The TCM components include determining needs, developing a plan, accessing services outside the school system, assisting with crises, and reviewing progress.

1. **Lack of documentation for TCM**

- In 48 of 48 (100%) cases, there was either inadequate documentation or no documentation to support one, some, or all of the following attributes tested: (1) service claimed; (2) rate (low, medium, and high) billed; (3) units (time allotment) billed; and (4) TCM authorized in the IEP.
- In addition to inadequate documentation, some claims for TCM did not meet the billing intent of the procedure code. Costs claimed were neither based on costs incurred nor reasonable. One provider (89% of its billings was TCM) consistently and inappropriately billed six hours of TCM for each IEP it developed. The provider claimed $307,989 in TCM but the only documentation provided was the IEPs. Another provider (71% of its billings were TCM) claimed TCM by incorrectly treating the code as a group code. The TCM rate developed for claiming is based on direct hours and should be for one-on-one instruction. The provider is using an inappropriate methodology and billing under a one-on-one code for group treatment instruction. For example, billing the program for 125 hours of instruction (per instructor/per day) for providing five hours of instruction to 25 Medi-Cal-eligible students in a group setting violates the intent of the procedure codes, and would be unreasonable and excessive.

Other Issues

1. **Provider is claiming other ineligible services.**

   - Eight out of 17 LEAs claimed personal-care services such as toileting and diapering. Personal-care services are not in the state plan and are not a Medi-Cal benefit.

   - We identified 15 cases of student ineligibility. For example, the students either moved prior to the date of service claimed or were not enrolled in the district or program. We also found a few cases in which the provider claimed for dates of service on a holiday, when no school was in session.

   - In one case, the LEA provider did not know why TCM was claimed. More than 300 hours of TCM was claimed by the LEA provider's previous biller. As a result of billing issues, this LEA provider currently has in-house staff preparing the Medi-Cal billings.

RECOMMENDATIONS

Oversight

To improve LEA compliance with both federal and state requirements, we recommend that the DHCS increase its oversight efforts of the LEA program. In almost all cases, the providers either have not been audited or, if a review was done, it was very limited in scope. DHCS 2006 MPES and our review suggest that significant programmatic problems exist with the LEA program. We recommend:

- DHCS use the information obtained by the SCO review and perform its own risk analysis to identify high-risk providers.

- An audit for recovery should be performed on high-risk providers, including providers identified by the SCO.

Training

Based on our discussions with the LEAs and our review, we believe inadequate training is provided to the LEA providers on Medi-Cal requirements. We recommend training to ensure that:

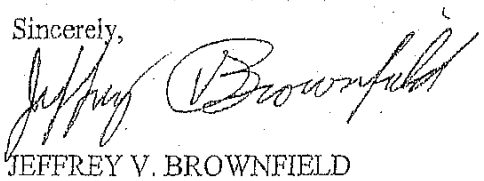
- Medi-Cal requirements in the area of eligible program reimbursements, record retention, regulations, and documentation are met.

- LEA providers are held accountable for the program, including overseeing independent contractors performing the billings.

- LEA providers are claiming for what they are entitled to. Our discussions with providers suggest that some are not clear as to what they could claim. Medi-Cal regulations, including the LEA manual, should be revised.

Additional details on our study are available for review by your staff. If you have any questions, please contact Les Lombardo, Chief, Special Audits Bureau, at (916) 323-1770.

Sincerely,



JEFFREY V. BROWNFIELD
Chief, Division of Audits

JVB/vb:wm

cc: David Maxwell-Jolly, Ph.D., Director
Department of Health Care Services
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RE: S08-MPA-903