



# News Release

CALIFORNIA DEPARTMENT OF HEALTH SERVICES

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**NUMBER:** 05-01      **DATE:** January 7, 2005  
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## **TWO STUDIES OF MEDI-CAL PAYMENT ERRORS SHOW LOW RATES COMPARED TO OTHER STATES, MEDICARE**

SACRAMENTO - Two new studies of Medi-Cal billing and payment errors have found that the program compares favorably to similar programs in other states and the federal Medicare program, State Health Director Sandra Shewry announced today.

The Medi-Cal Payment Error Study (MPES) showed that 3.57 percent of the amount paid for services in Medi-Cal's fee-for-service program involved some type of billing or payment error. The figure is less than half of the federal Medicare program's estimate that 9.3 percent of its payments in 2004 involved errors. The federal Payment Accuracy Measurement study (PAM) identified 1.6 percent of Medi-Cal payments that involved some type of billing or payment error in 2003. As compared with 10 other states involved in the PAM study for 2002, California had the fourth lowest percentage.

"Medi-Cal has a zero tolerance policy for fraud, waste and abuse," Shewry said. "With more than 224 million claims processed annually, Medi-Cal must continue to explore new mechanisms to aid in the prevention and timely correction of errors."

MPES, the first study of its kind in California, was designed to compute the potential loss to Medi-Cal due to billing or payment errors and fraud or abuse, identify where Medi-Cal is at greatest risk for billing or payment errors and establish how to best deploy Medi-Cal anti-fraud resources. The study examined a sample of 800 bills for reimbursement from Oct. 1 through Dec. 31, 2003. The study focused only on the Medi-Cal fee-for-service program, and not Medi-Cal managed care or other programs funded by Medi-Cal, because the fee-for-service program directly pays a larger number of individual providers and has a greater risk for fraud, waste and abuse.

If extrapolated to cover the entire calendar year, the estimate that 3.57 percent of payments involved billing or payment errors would equal \$568 million of the \$15.9 billion in annual payments in the fee-for-service program that were at risk of being paid inappropriately.

More than half of the amount estimated to have been billed or paid in error involved insufficient documentation from health care providers. However, insufficient documentation does not necessarily mean that the services were not provided or were not medically necessary and, therefore, may not represent overpayments. Determining whether the payments were, in fact, paid inappropriately would require a complete medical record review or audit of all claims submitted for payment.

The study also included an estimate of payments that had characteristics of potential fraud. Of the \$568 million in payments that involved errors, \$250 million -- or 1.57 percent of total annual payments -- were identified as potentially fraudulent. However, it is not possible to definitively

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determine whether any suspicious payments were inappropriate or fraudulent without a complete medical record review or audit of all services and a complete criminal investigation.

The PAM study found that Medi-Cal's rate of 1.6 percent of payments that involved some type of billing or payment error in 2003 compared favorably with the average rate of 4.3 percent among 10 other states that participated in the same study in 2002. Those rates are: Louisiana, .3; North Dakota, .6; Indiana, 1.2; New York, 1.5; California, 1.6; Washington, 2.6; Oklahoma, 3.1; North Carolina, 3.8; Wyoming, 3.8; Nebraska, 4.0; and Texas, 18.6.

In contrast with MPES, PAM reviewed billings for both the Medi-Cal fee-for-service program and managed care, but only to determine whether the bills were paid appropriately. PAM's error rate was lower than MPES because MPES focused on providers who were at a higher risk for fraud. In addition, MPES looked more closely to identify potential characteristics of fraud and to verify whether the medical services were necessary.

The California Department of Health Services (CDHS) is reviewing all providers in the studies that had claims that were potentially paid in error and pursuing collection of any overpayments.

"Both studies show that the majority of Medi-Cal providers are billing and being paid appropriately," Shewry said. "The studies also show that by focusing our anti-fraud efforts on non-institutional providers, specifically physicians, physician groups and pharmacies, we are targeting the areas of highest risk for billing errors and potential fraud."

Medi-Cal provides medical services to 6.6 million low-income and disabled Californians at an annual budget of more than \$34 billion. CDHS will use the results of these studies to focus its anti-fraud efforts on the areas identified as being at the highest risk for potential loss. Those efforts include:

- Complete the work on cases involving providers identified as potentially engaging in fraudulent activity and take appropriate action.
- Review the claiming patterns of all providers who had claims identified as having errors with a significant financial impact.
- Expand the number of investigational and routine compliance audits.
- Include physician groups in the re-enrollment plan for fiscal years 2004/05 and 2005/06 to improve the accuracy of the department's provider information.
- Develop a plan for educating providers on appropriate billing documentation.
- Work with the department's fiscal intermediaries to develop additional ways to verify the accuracy of claims prior to payment.
- Evaluate the results of the study to identify laws, regulations and policies that can be enhanced to prevent and detect billing or payment errors.
- Explore new technological solutions to combat fraud.