REPORT BY THE

AUDITOR GENERAL

OF CALIFORNIA

THE CSC HAS AUTHORIZED AT LEAST $12.6 MILLION IN RECOVERABLE MEDI-CAL OVERPAYMENTS THAT AN IMPROVED QUALITY ASSURANCE PROGRAM MAY HAVE DETECTED

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REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

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California Legislature

Joint Legislative Audit Committee

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September 2, 1981 044

The Honorable President pro Tempore of the Senate
The Honorable Speaker of the Assembly
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Your Joint Legislative Audit Committee respectfully submits the Auditor General's report concerning inadequacies in the Computer Sciences Corporation's quality assurance program. These inadequacies have contributed to overpayments totaling at least $12.6 million.

Respectfully submitted,

WALTER M. INGALLS
Chairman, Joint Legislative
Audit Committee

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SUMMARY

Medi-Cal is a $4.5 billion program which is funded jointly by the State and the Federal Government. This program, authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code, provides health services to low-income and needy Californians. Since the Medi-Cal program began in 1966, the State has contracted with a fiscal intermediary to process medical billings for services received by Medi-Cal beneficiaries. In 1978, the Department of Health Services awarded a $129 million contract extending for five and one-half years to the Computer Sciences Corporation (CSC). This contract is managed and monitored by the Fiscal Intermediary Management Division (FIMD) within the Department of Health Services.

In accordance with the contract, the CSC was required to develop a quality assurance program for identifying problems in its automated system for processing Medi-Cal claims. Although the CSC has identified and responded to many system problems, its quality assurance program has been inadequate for three reasons. First, the CSC's testing of both the system design and all system modifications has not identified some basic errors. Second, the CSC's component for identifying

system problems is incomplete and thus deficient. Specifically, the EDP/Operational Audit Unit within the quality assurance program designed to actively identify errors is not functional. Because this unit is not operational, the CSC has relied primarily on other entities to report problems, a process that allows problems to exist for extended periods before they are detected. Finally, the CSC has not ensured that the data history file used for processing claims is updated and that all data are recorded accurately. An updated and accurate history file is essential to ensure that the payment of claims is accurate.

Because the CSC's quality assurance program has been inadequate, it has not detected some errors which have caused providers of Medi-Cal services to be overpaid. We identified recoverable overpayments and estimated that they total between $12.6 million and $25.3 million. Some of the system errors causing these overpayments could have been promptly detected by a comprehensive quality assurance program. Specifically, by conducting a limited number of computerized tests against a CSC paid claims history file, we found the following:

- Between $6.7 million and $10.7 million in erroneous duplicate payments to the same providers for the same services.

- Between $2 million and $2.7 million in erroneous payments due to improper deductions of payments received from third parties, such as health insurance carriers.

- Between $1.9 million and $4.8 million in unauthorized payments for claims exceeding the state-mandated deadline for submission.

- Between $990,000 and $3.9 million in unauthorized payments due to erroneously overridden edits and audits--the prepayment controls which screen claims for conformance to state policy.

- Between $840,000 and $2.3 million in erroneous payments on billings that should have been reduced because the services were rendered outside the provider's normal place of service.

- Between $170,000 and $850,000 in erroneous payments for claims in which the amount paid actually exceeded the amount billed.

We also found other types of errors which indicate the system generated additional overpayments; however, we did not estimate the magnitude of such errors because we did not specifically

test for them. Further, additional erroneous payments are possible because the CSC neglected to update the history file used for processing claims.

To correct the CSC's quality assurance deficiencies and to recover the erroneous payments detailed above, we recommend that the Department of Health Services review and approve the CSC's quality assurance plan, ensuring that it meets all contractual requirements, and conduct tests to determine whether the CSC's claims processing is accurate. Furthermore, the department should require the CSC to implement the EDP/Operational Audit Unit, to update and maintain the data history file, and, finally, to recoup all overpayments to providers.

Additionally, we found that the department has not implemented a system which sufficiently tracks the status of edits and audits in the CSC claims processing system. Without this information, the department cannot ensure that claims are processed in accordance with state policy and intent. We recommend that the department implement a system to effectively track the status of edits and audits.

INTRODUCTION

In response to Chapter 1129, Statutes of 1980 and a request of the Joint Legislative Audit Committee, we have selectively tested the accuracy of the Medi-Cal claims processing system implemented by the Computer Sciences Corporation (CSC) under contract with the Department of Health Services. This review was conducted under the authority vested in the Auditor General by Sections 10527 and 10528 of the Government Code.

This is the Auditor General's fourth report focusing on the State's Medi-Cal contract with the CSC. The first report, issued in May 1980, reviewed the CSC's compliance with the state contract's requirements.* The second report was issued in January 1981, and it evaluated the Department of Health Services' performance in monitoring the contract.** The

* A Review of the Computer Sciences Corporation and the Department of Health Services Medi-Cal Fiscal Intermediary Operations, Report P-005; Office of the Auditor General; May 1980.

** The Department of Health Services' Monitoring of the Medi-Cal Contract with the Computer Sciences Corporation, Report P-021; Office of the Auditor General; January 1981.

third report, also issued in January 1981, reviewed the CSC's compliance with the processing time standards stated within the Medi-Cal contract.*

Because this report includes several technical terms related to the processing of Medi-Cal claims, we have provided a glossary in Appendix A. We recommend that the reader review this list of terms before reading the remainder of the report.

BACKGROUND

In November 1965, the Legislature created the California Medical Assistance Program, Medi-Cal. This program, authorized by Title XIX of the Social Security Act and Section 14000 et seq. of the Welfare and Institutions Code, pays for a variety of health care services to beneficiaries. Among these services are outpatient visits to physicians' offices, dental services, drugs, inpatient and outpatient hospital services, and nursing home care. The State and the Federal Government jointly fund this program. For fiscal year 1980-81, the Medi-Cal program's budgeted cost was approximately $4.5 billion. The State's share was approximately 55 percent, and the federal share was approximately 45 percent. Budgeted program costs for fiscal year 1981-82 total $4.9 billion.

* Review of Computer Sciences Corporation's Compliance with Medi-Cal Claims Processing Time Standards, Report P-021.1; Office of the Auditor General; January 1981.

The Department of Health Services has been designated as the single state agency responsible for administering the Medi-Cal program. The department does not, however, directly process and verify the claims of those providing services to Medi-Cal beneficiaries. These functions are performed by a fiscal intermediary--an organization which contracts with the State to process and verify the claims.

In August 1978, the Department of Health Services awarded the CSC a $129 million contract for processing Medi-Cal claims. The contract, which extends five and one-half years, requires the CSC to design, develop, install, and operate the Medi-Cal claims processing system and then to turn the system over to either the Department of Health Services or a subsequent contractor.

The Department of Health Services has delegated responsibility for managing and monitoring the CSC contract to its Fiscal Intermediary Management Division (FIMD). In addition to being responsible for successfully implementing the contract, the FIMD is charged with continuously reviewing and evaluating the CSC's performance and compliance with the contract.

Overview of Claims Processing

The CSC receives claims directly from hospitals, physicians, pharmacists, and other providers of Medi-Cal services. Upon receipt, the CSC sorts and microfilms the claims and assigns each a claim control number. It then screens all claims, ensuring that each includes the provider's signature and an eligibility label. After this review, the CSC enters the claims into its computer system.

Once entered into the computer, the claims are subjected to a series of edits and audits. Edits and audits are automatic prepayment controls designed to detect errors and to check whether claims conform to state policy. Edits ensure that claims include all data required for processing; for example, an edit may verify that the provider's Medi-Cal identification number appears on a claim. Audits, on the other hand, compare claim data with the data in the history file. As an example, these audits may identify repeated billings for a one-time-only procedure. Each claim must pass through at least 200 edits and audits employed by the CSC system. Claims which fail one or more edits or audits may be suspended or denied. Additionally, claims may cause the generation of a resubmission turnaround document (RTD), which is a form sent to the provider requesting additional information.

All claims placed in suspense are manually reviewed by the Suspense Processing and Medical Review staff. These claims examiners correct errors by referring to a microfilm copy of the claim, detailed procedure manuals, and other operating procedures. Yet claims examiners may take only a limited number of actions to correct suspended claims. For example, examiners are authorized to correct key entry errors, to update beneficiary eligibility data, to deny claims, and to request more information from the provider. Examiners may also override certain error codes--that is, permit a claim to bypass the specific edit or audit that suspended it. Before overriding error codes, examiners must ensure that certain state-approved conditions exist. Certain error codes may not be overridden; those that can be are subject to state approval.

Once the claim has been reviewed and an action taken, it is reprocessed through the edits and audits to ensure that all prepayment conditions are satisfied. Only claims which successfully pass through all edits and audits should be approved for payment. However, if an edit or audit is not operating or is inappropriately overridden, the system may approve a claim that should have been denied. Claims which have reached final disposition are reviewed to determine whether the claimed amount should be adjusted. For example, if the provider had been overpaid on a previous claim, the system

will reduce the current claim to account for the earlier overpayment. Following this process, a computer tape of all approved claims is sent to the State Controller's Office, which uses the tape to generate and mail payments and remittance advices to providers.

SCOPE AND METHODOLOGY*

This review was designed to selectively test the accuracy of the CSC's claims processing system. With the consulting firm of Deloitte Haskins & Sells, we designed computer programs to test the accuracy of claims processing. We reviewed claims processed by the CSC during the period from October 1, 1979 through December 31, 1980. We tested the claims against 25 possible error conditions. We then selected six test conditions to review in detail.** These were selected because they avoided any issue of medical judgment and because

* For a detailed presentation of the scope, methodology, and limitations of this review, see Appendix B.

** The design and results of these six tests are presented in Appendix C.

they indicated potential for substantial overpayments. These are the six tests selected for further review:

- Duplicate Payments - This test checked for payment of duplicate claims.
- Third Party Liability - This test evaluated the accuracy with which the CSC records receipts from liable third parties.
- Stale Claims - This test reviewed the appropriateness of paying claims which exceeded the Medi-Cal program's allowable time limit between the date of service and the date of the claim's submission to the CSC.
- Edit/Audit Overrides - This test examined whether overrides were appropriately exercised for claims that failed the edit and audit review process.
- 20 Percent Cutback of Allowed Amount - This test determined whether claims for services rendered outside the provider's normal place of business were appropriately reduced by 20 percent.
- Paid Greater Than Billed - This test reviewed for payments that exceed the amounts billed by providers.

For each of these six tests, we manually reviewed a statistical sample of claims to verify our computer test results. We confirmed our findings with FIMD officials and, in certain cases, with the CSC. In total, we reviewed over 1,100 claims. We documented erroneous payments and unauthorized payments--those in which the amount paid may have been correct but the claim itself should not have been paid. We reviewed the claim and supporting documentation to substantiate any exceptions. We also determined whether the CSC had made

payment adjustments through December 31, 1980 for any of these claims. We considered claims adjusted during the period in question as correct payments.

In reviewing the CSC's claims processing system, we also interviewed FIMD staff and directors and managers of the CSC units responsible for claims processing and program control. We examined applicable sections of the contract as well as available documents relating to quality assurance procedures. We examined files that documented system problems and that contained requests for program changes, correspondence between the CSC and the department, and reports generated by the computer system.

This was a narrowly focused audit. The CSC has over 700 edits and audits; we reviewed only 13. Additionally, our review was limited by several factors including the time-lapse problems in auditing an ever-changing system such as the CSC's, and the condition of files and records maintained by the CSC and the department. These limitations are discussed in detail in Appendix B.

Similarly, it is important to note that we restricted our review to the quality assurance program of the CSC. Thus, even though the FIMD and other units of the Department of Health Services review the CSC's claims payment accuracy, we did not address or evaluate their performance of this function. We excluded entities outside the FIMD because they do not focus on specific, critical elements of ensuring claims payment accuracy.

AUDIT RESULTS

INADEQUATE QUALITY ASSURANCE HAS CONTRIBUTED TO ERRONEOUS MEDI-CAL PAYMENTS

The CSC's quality assurance program has not adequately monitored the accuracy of Medi-Cal claims payments. Based on our selected tests of a 15-month claims processing period, we found that the CSC has allowed between $12.6 million and $25.3 million in overpayments. Some of these errors and the resulting overpayments could have been detected by a comprehensive quality assurance program such as the one specified in the CSC's technical proposal.

Although the CSC has identified and responded to many problems, its quality assurance program has been inadequate for three reasons. First, the CSC's testing of both the system design and all system modifications has not identified some basic errors. Second, the CSC's component for identifying system problems is incomplete and thus deficient. Specifically, the EDP/Operational Audit Unit within the Quality Assurance Department designed to actively identify errors is not functioning. Because this unit is not operational, the CSC has relied primarily on other entities to report problems, a process that allows problems to exist for extended periods

before they are detected. Finally, the CSC has not ensured that the data history file used for processing claims is updated and that all data are properly recorded. An updated, accurate history file is essential to ensure that claims are accurately paid.

Large data processing systems such as the CSC's are subject to frequent modification and manual processing errors. To function effectively, a processing system like the CSC's must include a quality assurance program that is both preventive and reactive. The preventive component attempts to identify problems before they can adversely affect the operation of the system. At the same time, the reactive component responds to processing problems identified internally and externally. Because the CSC's system annually processes millions of claims worth billions of dollars, it must be supported by a quality assurance program featuring both preventive and reactive components.

Development of the CSC's Quality Assurance Program

In 1979, the CSC submitted to the State a quality control plan intended to fulfill quality assurance tasks given to the CSC in the state contract. The contract requires the CSC to adapt or develop the necessary procedures and standards

that will ensure that the entire operation conforms to applicable regulations; is as free of errors or bias as possible; is effective in identifying erroneous, distorted, duplicate, or fraudulent practices by providers or recipients; and is able to identify and disclose to the State system weaknesses or sources of errors. Although the department has never formally approved the CSC's quality assurance plan, the CSC's contractual responsibility for developing and implementing a quality assurance program does not depend upon state approval.

The CSC's Quality Assurance Department assumed responsibility for claims payment accuracy after the system became fully operational in July 1980. Before the department assumed this responsibility, no single unit at the CSC was responsible for independently reviewing and monitoring overall operations. Instead, individual units throughout the CSC were responsible for developing their own standards and methods and for assuring adherence to those standards and methods. To some extent, the various units still have individual responsibilities because even now the Quality Assurance Department is not fully operational.

The Quality Assurance Department comprises three units: the Test Monitoring Unit, the Special Reporting Unit, and the EDP/Operational Audit Unit. The Test Monitoring Unit

is responsible for assuring that all program changes are thoroughly tested before being used in computer operations. The Special Reporting Unit prepares computer reports at the request of the State and the CSC.* Finally, when it begins functioning, the EDP/Operational Audit Unit will periodically audit various aspects of the CSC's claims processing system to assure that problems will be discovered and corrected.

Another unit which has responsibilities related to quality assurance but is not part of the CSC's Quality Assurance Department is the Systems Analysis Unit. Established in October 1980, this unit is responsible for analyzing and resolving problems identified by the State or the CSC. As such, it is an important contributor to the CSC's quality assurance effort.**

Testing Has Not Identified Basic Problems

Before a system is implemented and after any modifications to the system are approved, the CSC conducts tests to ensure that the system operates without error.

* In this report, we do not discuss the Special Reporting Unit because it performs service functions for other units.

** To address quality assurance issues, the CSC, the Department of Health Services, and the State Controller's Office have established a joint task force. As of July 1981, this task force had met only once.

Although the CSC conducted tests before implementing system components and continues to test system modifications, these tests have not identified some basic system errors. Specifically, we noted that the CSC's system has incorrectly recorded providers' receipts from liable third parties such as health insurance carriers. Another problem is that the computer has authorized payment of claims in excess of the amount billed. Finally, we found that the system has not consistently deducted amounts payable by other liable parties. The CSC testing program should have identified and corrected these basic system errors, which have gone undetected and have allowed significant overpayments.

Testing is a primary preventive quality assurance activity conducted before and after a claims processing system is implemented. The testing process is designed to reduce subsequent operational discrepancies such as erroneous or delayed payments, billing errors, and inaccurate management information reports. The contract between the CSC and the State requires successful completion of a detailed testing process, a responsibility that is shared by the CSC and the department. Specifically, the contract requires that the CSC first conduct a structured review of its system, called a walk-through, with department staff. The walk-through allows the CSC to better understand state requirements and permits department staff to assist the CSC in formulating a plan for

testing the system. The CSC must then develop the system test plan and submit it to the State for approval. Once this plan is approved, the CSC is required to use self-generated data to test its own system, and thus locate and correct system errors. Then the CSC turns the system over to the department for final acceptance testing, during which time the contractor uses the State's testing plan and data to check the accuracy of the system.

Although the system becomes operational after system and acceptance testing is completed, modifications are frequently made to computer programs. To ensure that these modifications work correctly and do not adversely affect other processing areas, the CSC has always required that all changes to computer programs be tested before being used to process claims. This testing function was incorporated into the Quality Assurance Department when the Test Monitoring Unit was established in August 1980.

Before a program change is approved for use in the processing of actual claims, the Test Monitoring Unit must be satisfied that the change has been thoroughly tested and that it meets the CSC's quality standards. If not completely satisfied, the Test Monitoring Unit documents deficiences noted

during the review and returns the test specifications and results to another unit for further analysis and correction. The testing and review continue until the changes are approved.

In May 1980, we reported that the CSC and the department had not adequately tested the claims processing system before implementing the various claim types.* At that time, our consultants determined that neither the CSC nor the department had followed testing procedures specified in the contract. For instance, we reported that the CSC did not use sufficiently thorough procedures to develop adequate test designs or sufficiently test its system before turning the test and the test results over to the department. Finally, the department did not enforce the required testing procedures to ensure a trouble-free system. We generally recommended that, before implementing any new claim types, the CSC and the department should complete the testing process as outlined in the contract. The officials of the department and the CSC responded that they had sufficiently tested the new claim types and that most system malfunctions had been detected and corrected.

* A Review of the Computer Sciences Corporation and the Department of Health Services' Medi-Cal Fiscal Intermediary Operations, Report P-005; Office of the Auditor General; May 1980.

The testing the CSC had conducted before processing claims and after modifying programs has successfully identified many problems; however, this testing has not identified some basic system errors. These errors relate to recording providers' receipts from liable third parties, paying claims in excess of the billed amount, and deducting amounts payable by other liable parties.

Our tests indicated that the CSC's system was incorrectly recording providers' receipts from liable third parties such as health insurance carriers. Since Medi-Cal is the payor of last resort, it is important that the CSC accurately record and deduct these liabilities so that Medi-Cal pays only its share.* We found, however, that when the third party liability was $10,000 or more, the system was reducing it by a factor of ten. This error indicates a truncation problem--a deletion of digits from dollar amounts--which testing could have identified. To illustrate, one claim in our sample had a third party liability receipt worth $18,253.62. However, it was recorded in the computer as $1,825.36. The system then subtracted this lesser amount and subsequently approved an overpayment of $16,428.26.

* Medi-Cal will only pay those portions of the claim not paid by other coverage.

To determine the extent of this problem, we scanned the 15-month Adjudicated Claims History File for all claims which indicated a third party liability and which had an amount paid exceeding $10,000. Based upon our analysis of a sample of claims, we estimate that between 134 and 171 claims were overpaid because of this error. We further estimate that the value of these overpayments ranges between $2,024,241 and $2,685,660.

The CSC approved these claims from April 23, 1980 through November 24, 1980, a fact indicating that the CSC did not discover the problem through the end of the 15-month period of the ACHF. We found that none of the claims in question had been adjusted for the error as of December 31, 1980. FIMD personnel discovered this problem and reported it to the CSC in March 1981. The CSC is developing a plan for recouping overpayments.

Our test for claims paid greater than billed revealed other system problems which testing could have detected. The system should authorize for payment the lesser of (1) the amount billed or (2) the maximum amount allowed for a procedure. We found, however, that the system authorized payments greater than the amount billed. To evaluate the extent of this problem, we selected a sample and reviewed outpatient provider claims indicating paid amounts greater than

billed and found that 86 percent of the sampled claims from Los Angeles County providers were in error. According to the department, the system was authorizing payment based on the maximum amount allowed for the particular procedure without consideration of the billed amount. For example, on one sample claim, the billed amount was $75 for a procedure with a maximum approval limit of $103. Yet the system increased the billed amount by $28 and authorized a payment of $103 to the provider. Because this was not a condition for which we specifically tested, we did not project the value of overpayments caused by this error.

The CSC's system has also paid inpatient hospital claims more than the billed amount because of different processing problems. For example, we found instances in which the CSC's system did not deduct amounts payable by other liable parties, such as patients, the patient's insurance carrier, or Medicare. Again, since this was not a condition for which we were specifically testing, we could not project the amount of overpayments resulting from these problems. However, our overall test results for paid greater than billed indicated total unadjusted overpayments of between $169,719 and $851,570 for inpatient and outpatient hospital claims.

Testing computer programs before processing actual claims and after modifying the system cannot detect all the problems that can occur in a system as complex as the CSC's. Therefore, the quality assurance program for the CSC's system must include procedures which can detect errors not identified and corrected during testing.

CSC's System for Identifying Processing Errors Is Deficient

In addition to testing, another critical quality control function within the CSC system is identification of processing problems. However, this identification function is incomplete, and thus deficient. Specifically, the EDP/Operational Audit Unit--the unit within the CSC's Quality Assurance Department designed to actively identify system problems--is not operational. Because this unit is not functioning, the CSC system must rely on the procedures employed by the Systems Analysis Unit to report processing problems. Yet this unit is not designed to actively identify problems; it resolves problems reported by other entities. Because of this, problems may exist a long time before they are reported to the unit. Thus, the Systems Analysis Unit alone does not adequately assure that claims processing problems are quickly reported and resolved.

EDP/Operational Audit
Unit Is Not Functioning

Although the CSC has developed the policies and procedures for its EDP/Operational Audit Unit, this unit was not functioning as of August 1981. According to CSC officials, the CSC had never intended to conduct claims sampling and internal audits until the system was fully operational; however, the CSC has now been processing all claim types for over one year. Had this unit been functioning earlier, it may have detected some of the processing errors. These errors related to claims payable by Medicare, duplicate payments, and duplicate claims. Generally, these errors resulted from inappropriate overrides of edits and audits, errors in the logic for suspending duplicate claims, and insufficient information in the data history file.

Once implemented, the EDP/Operational Audit Unit will be responsible for reviewing all data processing and operational activities within the CSC to determine whether the various operational units adhere to standards, controls, and procedures. This unit's functions will include periodically selecting a stratified sample of claims to test the accuracy of various manual operations, such as data entry and suspense processing. For example, to test the accuracy of data entry, the unit will select a stratified sample of claims and compare the original claim to the information entered into the

computer. Further, the unit has developed plans to sample claims which were suspended and subsequently overridden by a claims examiner. The unit will examine overrides to determine whether they conform with processing policies and procedures outlined in the Suspense Processing Manual.

In our sample review, we found substantial overpayments that may have been detected if the EDP/Operational Audit Unit had been functioning. These overpayments appeared to result from inappropriate edit and audit overrides by claims examiners. Several conditions can cause claims examiners to make an inappropriate or inaccurate decision to override the edit or audit which suspended the claim. Human error or misleading or inaccurate data in a particular history file could result in an inappropriate decision to continue processing a claim which should be denied.

Some of the overpayments we found related to claims for beneficiaries who are eligible for Medicare benefits. The CSC's system should suspend most claims for beneficiaries who are eligible for medical coverage under the federal Medicare program. Since Medi-Cal is the payor of last resort, the CSC has directed providers to submit these claims to Medicare for initial determination of coverage. If Medicare denies or only approves a partial payment, providers may then submit a claim to the CSC for Medi-Cal payment authorization. Except in

special cases, the CSC should not approve the claim for payment unless Medicare first denies or processes it. Claims examiners are authorized to override this edit only if a denial or payment form from Medicare is attached or if the claim is for a service that Medicare does not cover.

During our audit, we reviewed a sample of paid claims which the system had suspended because the beneficiary was eligible for Medicare. Yet, 24 of the 33 claims we reviewed did not indicate that Medicare had paid a portion of the payment or denied the claim. We submitted these 24 claims to the Medicare fiscal intermediaries to determine whether the services were covered under Medicare. Officials of the fiscal intermediaries concluded that 11 of the 24 claims were for services covered under Medicare. Based upon our analysis of the sample claims, we estimate that the CSC erroneously authorized between 14,888 and 43,490 Medicare payable claims for payment. Further we estimate the value of these payments to be between $666,548 and $1,634,881.

Our test for duplicate payments also showed inappropriate audit overrides. Periodically, providers submit more than one claim for a single service because of adminstrative billing errors or delays in payment by the CSC. To ensure that the system does not approve duplicate payments

for the same service, the CSC's system includes audits to suspend claims which contain identical or near identical data such as dates of service and procedures.

We reviewed 80 claims which these audits suspended from the claims processing system because they were possible duplicate claims. Our analysis of these claims indicated that 54 were duplicate claims; the system audit for these claims had been inappropriately overridden. We did not distinguish the dollar value of these override-related overpayments from that of all erroneous duplicate payments. However, these 54 constituted half of the duplicate payments in our sample. We estimate that the total duplicate payments in error range between $6.7 million and $10.7 million.

We found that unauthorized overrides were particularly evident for resubmitted claims. Providers occasionally resubmit claims to the CSC because their original claims were not paid. We found 44 instances in which both the original and the resubmitted claim were paid. Long-term care and inpatient claims accounted for 84 percent of these duplicates. When we brought this problem to the department's attention, FIMD officials stated that they had suspected a problem with paid duplicate resubmissions. In July 1981, FIMD staff discussed resubmissions with CSC staff and prepared a situation bulletin.

Our test for duplicate claims disclosed other overpayments which CSC officials attributed to errors in the logic for suspending duplicate claims and insufficient information in the data history file. These errors may have been detected had the EDP/Operational Audit Unit been in place. For example, of the 108 confirmed duplicate claim pairs that we identified in our test, 48 did not suspend because of several errors which hindered the duplicate suspense logic. Specifically, in August 1980, the CSC ran an incorrect suspense file. Consequently, paid claims were reprocessed and repaid. The audits for duplicate payments suspended some of these claims, but since no duplicate claim was in the history file, they were paid again. The CSC detected this suspense file error, and, after some testing estimated that it caused the system to generate duplicate payments of $2.5 million for those claims paid from June 1980 through October 1980.

In addition, the audits for duplicate claims did not suspend some duplicate claims because the CSC had not properly updated the history file. In one instance, the CSC accidentally omitted the September 29, 1980 weekly paid claims tape from the history file. This meant that if a provider submitted a duplicate claim for a service rendered during that

week, it would not have been suspended. The CSC was aware of this problem when we completed our fieldwork and had begun work to estimate the extent of any resulting overpayments.

The problems discussed above occurred because of internal control and procedural weaknesses which may have been detected by the EDP/Operational Audit Unit through its preventive role. However, as previously stated, the unit was not operational as of August 1981. Thus, 13 months after assuming responsibility for processing all claim types, the CSC's quality assurance program was still incomplete.

Systems Analysis Unit Alone Is Insufficient for Identifying Problems

Without the functioning of the EDP/Operational Audit Unit, the Systems Analysis Unit is the primary means through which the CSC identifies system problems. This unit is responsible for resolving problems identified by the providers, the department, other control agencies, or other CSC units. As a result, problems may exist for extended periods of time before being reported to the unit. As an example, the truncation problem with third party liability claims was occurring nearly one year before it was reported. And, because of a problem already discussed, the CSC's system was paying

more than the billed amount on certain claims. If such problems are not promptly identified and corrected, the State may be unable to recover overpayments.

When a problem or unusual situation is identified, the Fiscal Intermediary Management Division or the CSC staff report it on a standard form called a situation bulletin and forward it to the Systems Analysis Unit. Analysts assigned to the unit review the reported problem and attempt to resolve it. If unable to resolve the problem, the unit refers the problem to an appropriate unit within the CSC for detailed analysis and resolution. When a computer program must be modified to resolve a problem reported in the situation bulletin, the Systems Analysis Unit initiates a request for the change. The unit tracks the situation bulletin until it is resolved and notifies the bulletin's initiator of the disposition of the problem.

Although the situation bulletin procedure is detailed in the CSC's technical proposal, the CSC did not implement the procedure until October 1980.* Since that time, both the CSC and the State have used the procedure to report identified problems. In fact, over 550 situation bulletins have been

* CSC officials stated that prior to October 1980 system problems were reported through several interim measures.

referred to or initiated by the Systems Analysis Unit since October 1980. Eighty percent of these bulletins were initiated by units within the CSC. The resolution of many of the problems identified in the situation bulletins required system modifications. As of June 1981, the unit had initiated over 250 requests for system modifications; about 25 percent of these had been implemented. On the average, these changes were implemented within two months after receipt of the situation bulletin.

The Systems Analysis Unit has initiated many changes that have corrected problems identified in situation bulletins. However, the process it uses is by design reactive: it analyzes existing problems which have been identified by others through situation bulletins. Our analysis indicates that this process can be slow in notifying the unit of problems. In some cases, the problems identified in our review have never been reported in a situation bulletin.

The test we conducted to identify claims paid an amount greater than the billed amount illustrates the untimeliness of a reactive system. From December 1979 through December 1980, the CSC authorized payment to Los Angeles County for outpatient claims in excess of the amount billed because of a program logic error. In October 1980, this problem was

reported to the CSC. Although the CSC reported corrective action in November 1980, this problem existed for almost one year before it was detected and corrective action was initiated.

The third party liability truncation problem discussed earlier also shows the time delays that can occur when an operation relies on a system such as the situation bulletin process. This truncation problem was reported in a situation bulletin on March 24, 1981. However, our review indicated that the problem was occurring as early as April 1980, nearly one year before it was reported.

These delays in identifying and resolving system problems can prevent the State from recovering overpayments when adjustments are not possible. For example, if a hospital which received overpayments changes ownership or goes out of business before the error is detected, recovery becomes more unlikely. And the longer an overpayment is outstanding, the greater the interest earnings lost to the State.

As we have demonstrated, months may elapse before a problem is identified and reported through a situation bulletin. Moreover, this procedure may not detect existing problems. Some of our tests, for instance, disclosed

inappropriate payments that had never been reported in a situation bulletin. Thus, the situation bulletin procedure does not ensure that claims processing is accurate.

Our stale claims test illustrates this point. Stale claims refer to those submitted more than 97 days after the service specified on the claim was provided. Title 22 of the California Administrative Code prohibits the Medi-Cal program from paying for claims the provider submits after the mandated deadline unless there are extenuating circumstances. In reviewing a sample of paid claims which exceeded the deadline, we found that 25 percent were inappropriately paid since they lacked necessary documentation. But because neither the CSC nor the department were aware of this problem, the CSC has approved the payment of thousands of claims which are unauthorized under Medi-Cal policy. Specifically, our statistical analysis indicates that the CSC inappropriately approved between 56,070 and 144,753 claims for payment; the payments represent amounts between $1,877,216 and $4,846,338.

To restate, the Systems Analysis Unit is not designed to actively seek to identify problems and is therefore slow in addressing them. But without the functioning of the EDP/Operational Audit Unit, the Systems Analysis Unit is the

primary unit for addressing and resolving system problems. Thus, the CSC's identification function is deficient since this unit alone does not provide adequate assurance that claims are accurately processed.

Data File Problems Not Detected by the Quality Assurance Department

The fiscal intermediary contract requires the CSC to ensure that data files critical to accurate claims adjudication are correctly maintained. To properly maintain these data files, the CSC first had to acquire claims history files from the previous fiscal intermediary, Medi-Cal Intermediary Operations (MIO), then incorporate those data into its files. Additionally, the CSC had to periodically update its files with additional history data sent by the MIO. However, we found that the CSC has not promptly updated its claims history file. Furthermore, the condition of the file is poor. We noted multiple sets of history records for several beneficiaries, files with invalid recipients' birth dates or identification numbers, and inadequate documentation of amounts billed or paid. These conditions complicate claims processing and allow inappropriate payments to occur.

When the CSC's system automatically audits a claim, it compares the claim with information contained in an abbreviated version of the 15-month Adjudicated Claims History File. This file contains information necessary for discovering problems such as duplicate billings for a previously paid claim or repeated billings for a service that has been restricted. As an example, payments may be authorized for only eight allergy treatments in 120 days. Unless all previous treatments have been recorded in the history file, the CSC cannot assure that a claim for allergy treatments will be accurately processed.

Before it could begin processing claims through system audits, the CSC had to incorporate claims history from the previous fiscal intermediary, the MIO. For a time, the CSC and the MIO were processing claims concurrently. The MIO created beneficiary history tapes for those claims it processed and periodically submitted them to the CSC which used the tapes to update its history file. As a result, the CSC not only had to incorporate the previous MIO history into its claims history file but also had to periodically update the file with new tapes from the MIO.

On January 15, 1979, the MIO sent the CSC 74 reels of tape containing beneficiary history data. At approximately one-month intervals thereafter, the MIO sent from one to seven reels each month with new adjudicated claims payment data. The last tape for November 1980 was sent to the CSC on December 9, 1980. In total, 170 reels were sent to the CSC.

To simplify its task, the CSC proposed to convert only the information required for a specific claim type before the installation of that claim type. Therefore, for pharmacy claims, the CSC would incorporate MIO drug provider and recipient history prior to June 1, 1979, the date it began processing pharmacy claims. For long-term care claims, the data were to be converted prior to September 1, 1979; for inpatient and outpatient hospital claims, prior to December 1, 1979; and for medical and vision claims, prior to June 1, 1980. The update tapes would then be incorporated as they were received.

The CSC did not meet all of these deadlines for converting history files. In April 1981, we informed the CSC and the FIMD officials that our consultants had found that the CSC was not updating MIO claims history for medical, vision, and outpatient hospital claims. CSC officials acknowledged that most of the MIO medical claims were not incorporated into

the history file. On May 15, 1981, the Department of Health Services requested that the CSC verify the status of updating the MIO claims history. On June 26, 1981, the department again requested this information from the CSC.

The CSC responded to the State's request in July 1981. That response confirms that the CSC did not meet all of the deadlines for converting and incorporating the MIO history files. According to this letter, the CSC converted the initial 74 tapes for pharmacy, long-term care, medical, and vision claims on schedule. However, the letter acknowledges that the CSC did not complete its conversion of the initial 74 tapes for inpatient and outpatient hospital claims until February 1980--over two months late. In the letter, the CSC also reported that although it began incorporating the MIO update tapes for pharmacy and long-term care claims before installing those claim types, it did not complete that process until March 1981. Finally, the letter indicates that the CSC did not begin incorporating update tapes for inpatient and outpatient hospital, medical, and vision care claims on time. Specifically, the CSC began updating inpatient and outpatient hospital claims in May 1980 and finished in March 1981. Updates for medical and vision care claims began in September 1980 and were completed in May 1981.

In addition to these delays in updating the history file, there are problems in the condition of the file. Our consultants reviewed the 15-month Adjudicated Claims History File and found multiple sets of records for beneficiaries, invalid birth dates or missing recipient identification numbers, and inadequate documentation of amounts billed or paid. First of all, we noted that for several beneficiaries there were multiple sets of history records, each of which had different birth dates. This problem complicates claim analysis because to perform historical edits and audits and to check for duplicate claims, the CSC would have to review all multiple recipient files for each claim.

Our consultants also found files and claims without critical identifying information. Many files contained invalid recipient birth dates. Without this information, the review of age-related audits is impossible. Also, we found instances in which claims in the file did not have a recipient identification number. Upon our inquiry, the CSC acknowledged that approximately 16,000 lacked this information.* Since the

* Although recognizing this condition as largely the CSC's responsibility, a CSC official stated that under certain conditions, this situation is out of the CSC's control. The official cited problems with the current Medi-Cal eligibility determination system and data missing from MIO history as examples.

claims are incorrectly located under a blank recipient record, an analysis of a recipient's history may not include all claims for that recipient and all duplicate payments might not be found.

Finally, some records and files did not include adequate documentation of amounts billed or paid. For example, the billed amount on some paid long-term care and pharmacy claim records is invalid. Because of this, the CSC is unable to ensure that the amount paid does not exceed the amount billed in any post claims processing review. Another problem is that some claim files contain no evidence that the claim was manually priced by a claims examiner. Thus, it is difficult to identify the frequency of mispayments due to manual pricing.

During our review of sample claims, we found occurrences of these types of problems. For example, in our duplicate payments test, of 35 vision care claims sampled, we found 23 instances in which the history file was incorrect. When we reviewed the actual claims, we found that although the beneficiary identification numbers were the same in the history file, the beneficiaries were different people.

In summary, the claims history file has not been properly updated or maintained, a fact which reduces the effectiveness of system audits against historical claims data.

These conditions may result in the authorization of payments of claims which the CSC should have denied. According to our consultants, the CSC has control over most of these conditions, and therefore, could make the corrections necessary to improve the condition of the file.

Summary of Overpayments Resulting from Quality Assurance Deficiencies

A complete quality assurance program will not guarantee that errors will not occur. Errors will occur in a system like the CSC's because of the complexities involved, the numerous policies, and the problems inherent in integrating such a system. However, a comprehensive quality assurance program would ensure that errors are detected as rapidly and completely as possible. We conducted only six tests and found between $12.6 million and $25.3 million in overpayments. While these six tests were selected partially because preliminary analysis indicated potential overpayments, they nonetheless constitute only a small portion of all tests which could be run against the claims processing system.

The following table summarizes the estimated number of erroneously paid claims we identified and their estimated value. The number of claims in error is a statistical estimate. That is, we are 95 percent confident that the true

number of overpayments in each extract file is between the lower and upper limits indicated.* We have estimated the value of the overpayments in the extract file by employing the various techniques described in Appendix D.

* Lower and upper limits are necessary because there are inherent risks involved in estimating the characteristics of the extract files from a sample.

TABLE 1

SUMMARY OF TESTS AND THEIR PROJECTIONS

Six Test Conditions	Total Number of Claims in Extract File	Number of Claims in Error		Percentage of Claims in Error		Estimated Value of Overpayment	
		Lower Limit	Upper Limit	Lower Limit	Upper Limit	Lower Limit	Upper Limit
Duplicate Payments	100,494	19,555	47,825	19.4	47.6	$ 6,707,361	$10,727,365
Third Party Liability [Only claims with third party liability $10,000 or greater]	202	134	171	66.3	84.7	2,024,241	2,685,660
Stale Claims	401,646	56,070	144,753	14.0	36.0	1,877,216	4,846,338
Overrides[a]	188,258	25,744	75,010	13.7	39.8	994,943	3,902,555
20 Percent Cutback	590,450	388,622	573,587	65.8	97.1	843,311	2,288,611
Paid Greater Than Billed	3,269	826	1,496	25.3	45.8	$ 169,719	$ 851,570
Total[b]						$12,616,791	$25,302,099

[a] Data includes only five of eight error codes tested.

[b] These figures are the totals for all tests. Some of the overpayments may have occurred in more than one test, a condition that would result in overestimation of the total amount overpaid. However, as indicated in Appendix D, our tests showed no redundant claims; thus, we assume that if some duplication has occurred, it is minimal.

Although staff of the FIMD and the CSC have identified and analyzed overpayment problems associated with certain tests we conducted, they have not yet determined the total extent of all problems or accurately estimated all overpayments. As an example, for duplicate payments, CSC officials estimated that between $2.5 million and $3 million had been overpaid because of one error. They are still in the process of estimating overpayments resulting from other causes. FIMD personnel estimate that duplicate claim overpayments are between $3 million and $5 million and that these overpayments occurred before September 1980. We estimate, however, that these overpayments are between $6.7 million and $10.7 million and that they occurred through December 1980.

In relation to the 20 percent cutback test--which refers to a 20 percent reduction for certain services performed outside the provider's office--the FIMD staff identified the overpayment problem and has been working with the CSC to determine the extent of the overpayments. Our testing found that the overpayments ranged between $840,000 and $2.3 million. Under the direction of the FIMD, the CSC has begun recoupment procedures on overpayments as instances are discovered. However, the majority of overpayments have not been recouped. In addition, the FIMD has instructed the CSC to present recoupment plans for errors in 20 percent cutbacks and for duplicate payments.

The erroneous payments we identified justify the need for a comprehensive quality assurance program. Without such a program, there is no assurance that the current system is effectively detecting errors.

CONCLUSION

The Computer Sciences Corporation's quality assurance program has not adequately monitored the accuracy of Medi-Cal claims payments. The quality assurance program is inadequate for three reasons. First, the CSC's testing of the system design and all system modifications has not identified some basic errors. Second, the CSC's component for identifying system problems is incomplete and thus deficient. Specifically, the EDP/Operational Audit Unit within the quality assurance program designed to actively identify errors is not functioning. Because this unit is not operational, the CSC has relied primarily on other entities to report problems, a process that allows problems to exist for extended periods before they are detected. Finally, the CSC has not ensured that the data history file used for processing claims is updated and that all data are recorded accurately. An updated and accurate history file is essential to

ensure that the payment of claims is accurate. These conditions have contributed to overpayments totaling between $12.6 million and $25.3 million.

RECOMMENDATION

To correct the Computer Sciences Corporation's quality assurance deficiencies and to recover erroneous payments, we recommend that the Department of Health Services:

- Require the CSC to immediately implement the EDP/Operational Audit Unit;

- Closely monitor the CSC's EDP/Operational Audit Unit and Test Monitoring Unit to ensure that the preventive quality assurance measures they employ are effective;

- Review and approve the CSC's quality assurance plan, ensuring that it meets all contractual requirements;

- Ensure that the CSC has converted all history file data and corrected file deficiencies;

- Conduct further automated tests of the CSC's claims payment accuracy using either FIMD staff or a systems monitoring contractor to sample current paid claims to ensure that the quality assurance systems are in place and operating effectively. The FIMD could initially employ tests we developed for our review; however, tests which evaluate edits and audits resolved by the CSC's medical professionals should also be conducted;

- Ensure that the CSC recoups all overpayments we identified. We will deliver our test tapes and program output on erroneous payments to the FIMD.

OTHER PERTINENT INFORMATION

THE DEPARTMENT HAS NOT IMPLEMENTED A SYSTEM TO TRACK THE STATUS OF EDITS AND AUDITS

The Department of Health Services has not implemented a system which sufficiently tracks the status of the edits and audits in the CSC processing system. These edits and audits are the basic prepayment controls which screen Medi-Cal claims for conformance to state policy. In May 1980, we reported this problem and recommended that the department correct it. Subsequently, department officials responded that a system for logging and accumulating all documents regarding edits and audits had been implemented. Although the department has improved its overall monitoring of the CSC, it still does not employ a system sufficient for tracking when it authorizes the CSC to turn particular edits and audits on or off. Consequently, it is extremely difficult to determine whether the CSC is following its instructions and, therefore, whether claims are processed in accordance with state policy and intent.

As detailed earlier in this report, edits and audits screen claims for conformance to state policy. If a claim fails an edit or audit, the system suspends it for manual review. Depending on the error condition identified, the claim

may be paid or denied. Another possibility is that the system will generate a resubmission turnaround document, which requests more information from the provider. If an edit or audit is turned off, the CSC system will not screen the claim for that particular error. Consequently, the CSC may approve the claim for payment even though it does not comply with a particular policy or requirement.

The department periodically instructs the CSC to turn edits and audits on or off for a variety of reasons. For instance, if the department is reconsidering or redesigning a certain policy, it may authorize the CSC to turn off the audit for that policy until the question is resolved. The department is then also responsible for instructing the CSC to reactivate the audit. The CSC may not change the status of an edit or audit without the department's authorization.

In May 1980 we reported that the department was not sufficiently monitoring the status of edits and audits.* We noted that the department was informally authorizing the CSC to deactivate certain edits, yet the department could not supply documentation to substantiate when it authorized changes to the

* A Review of the Computer Sciences Corporation and the Department of Health Services Medi-Cal Fiscal Intermediary Operations, Report P-005; Office of the Auditor General; May 1980.

edit/audit status. At that time, we recommended that the department adopt formal procedures for changing the status of edits and audits and that the department monitor the CSC's operation of edits and audits to ensure that they were on or off based upon department order. In subsequent responses to Report P-005, the department indicated that it was developing a system for tracking the status of edits and audits.

We found that the department has improved its procedures for directing the CSC to change the status of edits and audits. However, it still does not maintain a central log for tracking when it authorizes such changes or the dates they are to be made. Because the department does not have such a tracking system, we had to search through various files for information regarding the status of edits and audits discussed in this report. These files were located at different office sites, were incomplete, and were not systematically referenced to particular edit or audit code numbers or names. With neither an edit/audit tracking system nor readily accessible documentation, it is extremely difficult to determine whether the CSC has followed the department's instructions to deactivate or reactivate edits and audits. In addition to inhibiting post-payment review efforts, this lack of available information impedes the department's verification that deactivated edits and audits are turned back on at the time the department has instructed.

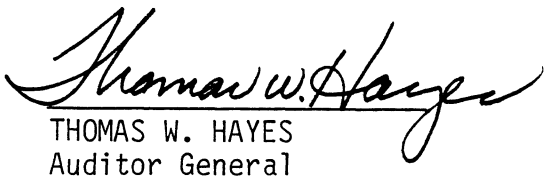
To track the status of edits and audits, the department currently uses a manually annotated version of the CSC's Error Parameter Table Listing, RF-R-510 report. This report, which logs all edits and audits and indicates whether the edit is on or off, is requested and reviewed by the department on only a periodic basis. However, because it reports the status of edits and audits only for the day it is printed, it provides a very limited record of the status of the controls. Additionally, if the department does not request the report on the day an edit is supposed to be turned back on, it would have no assurance that the edit was indeed reactivated on that day. Moreover, the 510 report does not document whether the department authorized the CSC to change the status of the edit or audit.

Because the department does not have a system which summarizes the authorized status of edits and audits, it is extremely difficult to ensure that status changes have been implemented according to department instructions. Consequently, it is equally difficult for the department to ensure that Medi-Cal claims are processed and paid in accordance with state intent.

At the end of our fieldwork, we again discussed this issue with department staff. They reported that they were designing a system to track the status of edits and audits and

expected the system to be in place in early 1982. In view of this, we recommend that the department implement a comprehensive and effective system for tracking the status of system edits and audits as soon as possible.

Respectfully submitted,



THOMAS W. HAYES
Auditor General

Date: August 31, 1981

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AUG 2 8 1981

FI# 1524

Thomas W. Hayes
Auditor General
Office of the Auditor General
660 J Street, Suite 330
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Dear Mr. Hayes:

RESPONSE TO AUDITOR GENERAL'S DRAFT REPORT 044

Thank you for the opportunity to review the draft of your August 24, 1981 report entitled "The Computer Sciences Corporation Has Authorized At Least $12.6 Million In Recoverable Medi-Cal Overpayments Which An Improved Quality Assurance Program May Have Detected." I would also like to take this opportunity to compliment your staff for the professional manner in which they performed the audit.

The report addresses a number of issues requiring significant staff time to address properly. The Department will submit a detailed response on these issues in its reply to the final report. We have discussed the draft with officials of CSC and were informed that CSC does not wish to formally respond to the report at this time.

Your staff have made themselves available to discuss the preliminary findings. I have enclosed comments here (Attachment I) regarding specific statements or conclusions with which we disagree but which were not resolved at these meetings.

QUALITY ASSURANCE

We agree CSC's quality assurance program needs improvement. The Department has requested CSC to prepare and submit to the Department appropriate documents detailing the development and activation of an effective and efficient claims payment control program. The Department requested that CSC prepare the following: (1) policy statements; (2) procedure manuals; and

(3) a quality control plan, including - quantifiable standards; measurement techniques; the roles and responsibilities of the Internal Audit staff, QA staff, and any other personnel involved in ensuring that payments are made correctly; and a schedule for conducting audits and surveys. A response from CSC is expected by October 21, 1981.

OVERPAYMENTS

I think it is important to consider the overpayments you describe in the context of the overall CSC overpayment error rate. As you may know, my Audits and Investigations Division conducts a Medi-Cal quality control program. This program measures, among other indices, the extent of overpayments in the CSC claims processing system. Monthly claim samples are drawn for eight different claim types which, when aggregated over a six month period yield highly reliable and valid statistical measurements of claims processing accuracy.

Preliminary results from the most recently completed sampling period (October 1980-March 1981) show an overpayment dollar error rate of approximately 39 hundredths of one percent (.39%) of the total paid amount for that six month period. This error rate is comparable to states with much lower claims processing volumes and much simpler programs.

It should also be noted that your report isolates $12.6 million - $25.3 million in overpayments but does not reflect this amount in the context of the $5,300,000,000 in total Medi-Cal payments made under the CSC contract as of August 7, 1981. It would seem appropriate to reflect this relationship.

Additionally, the report states that the audit was "narrowly focused" to 13 of 700 edits and audits. These edits were selected "because they indicated potential for significant overpayments" and "they avoided any issue of medical judgment." Since the criteria used to choose the 13 edits for audit were focused toward areas known to have a potential for significant overpayments, we consider it inappropriate to imply a direct relationship between the number of tests and the dollar value of overpayments discovered.

We recognize that due to time constraints your staff was unable to follow up to determine if the 284 identified overpayments had subsequently been recouped. The review period of the audit ended in December, 1980. Therefore, any overpayment identification and collection activity which may have occurred as a routine part of the CSC claims payment process was not taken into account.

Although this does not alter the fact that an overpayment may have occurred, the inference that up to $25.3 million dollars in overpayments are outstanding and remain to be recovered is not substantiated by the audit findings.

In closing, let me once again commend you and your staff for the courteous and professional manner in which the audit was conducted. Thank you for the opportunity to examine and comment on the draft report. I hope our comments will be useful in preparing your final report.

Sincerely,

Beverlee A. Myers
Director

Attachments.

ATTACHMENT I

CLARIFICATION ON ITEMS OF FACT OR INTERPRETATION

1. **Audit Report Discussion:**

> "...the department did not enforce the required testing procedures to ensure a trouble-free system." (p. 16)
>
> "...testing computer programs before processing actual claims and after modifying the system cannot detect all the problems that can occur in a system as complex as the CSC's." (p. 19)

1. **State Comment:**

Statements on page 16 and 19 appear to be inconsistent. We are in agreement with the statement on page 19. To achieve "a trouble-free system" as you specified is impossible. To develop the number of testing procedures based on all possible combinations and permutations would be both cost prohibitive and impossible to accomplish within the imposed time constraints.

2. **Audit Report Discussion:**

> "Although staff of the FIMD and the CSC have identified and analyzed overpayment problems associated with certain tests we conducted, they have not yet determined the total extent of all problems or to accurately estimate all overpayments. As an example, for duplicate payments, CSC officials estimated that between $2.5 million and $3 million had been overpaid because of one error. They are still estimating overpayment from other causes. FIMD personnel estimate that the duplicate claim overpayments are between $3 million and $5 million and that these overpayments occurred before September 1980. We estimate, however, that these overpayments are between $6.7 million and $10.7 million and that they occurred through December 1980." (p. 40)

2. **State Comment:**

The statement that FIMD and CSC "have not yet determined the total extent of all problems or accurately estimate all overpayments" is technically correct.

However, both CSC and the Department are, on an ongoing basis, determining the extent of the overpayment problems, developing appropriate select criteria, conducting test runs, analyzing the results of these runs, correcting error conditions, and adjusting provider accounts accordingly. I can agree with you that it is extremely difficult to "accurately estimate all overpayments." In your report you state: "...we cannot estimate the total overpayments with an overall level of confidence." (page D-3). Your concern about variations in the overpayment estimates made by CSC, the Department and your auditors may in part be due to (1) differences in definition and (2) the use of differing data bases from which overpayment samples were drawn (e.g., one data base may reflect adjustments made to overpayments another may not).

3. **Audit Report Discussion**:

Recommendation

. To correct the Computer Sciences Corporation's quality assurance deficiencies and to recover erroneous payments, we recommend the Department of Health Services:
  - Require the CSC to immediately implement the EDP/Operational Audit Unit
  - Closely monitor the CSC's EDP/Operational Audit Unit and Test Monitoring Unit to ensure that the preventive quality assurance measures they employ are effective (p. 42).

3. **State Comment**:

The Department has requested that CSC submit to the Department by October 21, 1981, quantifiable standards and measurement techniques, including "preventive quality assurance measures". We will evaluate those measures to ensure their effectiveness. The EDP/Operational Audit Unit is in a start-up mode. We will monitor their activities.

4. **Audit Report Discussion**:

"Recommendation

...Review and approve CSC's quality assurance plan, ensuring that it meets all contractual requirements;" (p. 42)

4. **State Comment:**

The Department is presently reviewing CSC's quality assurance plan and the disposition of this matter is expected by the end of October 1981.

5. **Audit Report Discussion**:

"The Department of Health Services has not implemented a system that sufficiently tracks the status of edits and audits in the CSC processing system... Consequently it is extremely difficult to determine whether the CSC is following its instructions and, therefore, whether claims are processed in accordance with state policy and intent" (Page 44).

5. **State Comment:**

We do not believe to be completely correct, the statement that the Department has not implemented a system that sufficiently tracks the status of edits and audits and, as result, is unable to determine whether CSC is following instructions or whether claims are being processed in accordance to State policy. From the inception of the program, State policy has been translated in appropriate system programs and applied to the processing of claims through reference files, hard coded sub-systems, and edits and audits. Each of these system applications, including edits and audits, have been reviewed, modified and ultimately approved by the State prior to their incorporation. The status of these applications in the system has always been documented, formally, with a letter from the FIM officer to the manager of CSC.

6. **Audit Report Discussion:**

"However, it (the department) does not maintain a central log for the tracking when it authorizes such changes or the dates they are to be made" (Page 45).

6. **State Comment:**

The statement that the Department does not maintain a central log of its authorization to activitate or deactivate edits and audits is only partially correct. Directives to change the status of an edit or audit from "off" to "on" or "on" to "off" are always in writing. Because of the numbers of edits and audits involved, the incorporation of groups of edits and audits in individual pieces of correspondence and the complexity of cross-referencing letters by edit or audit number, it is difficult for an auditor to obtain copies of specific directives quickly and easily. This problem is being corrected with the establishment of an edit/audit correspondence tracking system. The report tends to construe this correspondence tracking system as being an edit/audit monitoring system

which it is not. Edit/Audit monitoring is accomplished by review of the RFR510 reports, review of the MCD250, 210, 270, 230 and 290 programs and the weekly MCW 310 and 320 program monitoring supplemented by continuing review of the RFR520 (combination audit table). From an operating standpoint, the information necessary to make operational decisions and maintain control is readily available. From an auditing standpoint, the information appears in a less orderly form.

7. Audit Report Discussion:

"...because it (the RF-R-510) reports the status of edits and audits only for the day it is printed, it provides a very limited record of the status of the controls." (Page 47).

7. State Comment:

We consider the RF-R-510 to be a significant edit/audit monitoring tool even though it represents the status of the edits/audits only for the day it is printed. This report is printed anytime on request and is reviewed by monitoring, operations, and policy staff within the Department on a continuing basis. Each printout is compared with previous printouts and with standing correspondence related to each error code. The information obtained from this review combined with review of the MR-0-010, 011, 133 and the 154 and the CPO-026 listing the action related to edits/ audits on test provide comprehensive cross-checks to the status of edits/audits and their function in applying the policy to claims processing. These activities do not appear to have been adequately reflected in the conclusions of the report.

8. Audit Report Discussion:

"Because the Department does not have a system which summarizes the authorized status of edits and audits it is extremely important to ensure that status changes have been implemented according to ...instructions" (Page 47).

8. State Comments:

The edit/audit record now occupies eight volumes which are organized to be useful for operational purposes. The file reveals, sequentially, the status of correspondence but more importantly, the decision matrix for actions taken, status of edits/audits under active evaluation; edits/audits that

are static and policies under revision. This log combined with the computer print-outs, and day-to-day liaison between staff, permits response to the needs of the program from a monitoring standpoint. The structuring of the log to the system of operation sacrifices to some extent the ease of auditing.

GLOSSARY OF TERMS

ACHF: See Adjudicated Claims History File.

Adjudicated Claims History File (ACHF): A record of every claim processed as paid, denied, or returned.

Adjudication: The disposition of a claim; that is, the determination to pay, suspend, or deny a claim.

Beneficiary: A person eligible to receive Medi-Cal benefits.

CCN: See "Claim Control Number."

Claim Control Number (CCN): A unique number used to identify each claim while it is processed. The number includes the Julian date of receipt; that is, the sequential day of the calendar year.

Claim Type: One of six classifications of Medi-Cal claims based on the type of service provided:

Inpatient Hospital	Medical	Pharmacy
Long-Term Care	Outpatient Hospital	Vision

Crossover Claim: A bill presented to a recipient of benefits from both Medicare and Medi-Cal.

EDP: Electronic Data Processing.

Error Code: A numeric code which indicates what type of discrepancies have occurred on a claim. The automated system assigns these codes during edits and audits.

Inpatient Hospital Claim: A bill for services rendered to recipients who require hospitalization.

Long-Term Care Claim: A bill for inpatient medical care extended to a patient for over one month following the date of admission.

Medical Claim: A bill for services provided by a medical practitioner.

Medicare: The Title XVIII Federal Hospital and Medical Insurance Program intended for disabled persons or for those age 65 or older.

Outpatient Hospital Claim: A bill for all services and procedures in a hospital or clinic for which the recipient does not require hospitalization.

Override: To bypass an edit or audit which orginally caused a claim to suspend.

Pharmacy Claim: A bill for all drug-related services, drugs, and drug paraphernalia.

Resubmission Turnaround Document (RTD): A claim copy returned to the provider because of errors noted during processing. The provider corrects the claim and then resubmits it to the fiscal intermediary.

RTD: See "Resubmission Turnaround Document."

TAR: See Treatment Authorization Request."

Third Party Liability (TPL): Liabilities of entities (i.e., health insurance carriers) which may be responsible for payment of all or a portion of a recipient's health care costs.

Title 22: The official State of California Adminstrative Code for Social Security; this title embodies the rules and regulations for medical services under the Medi-Cal program.

TPL: See "Third Party Liability."

Treatment Authorization Request (TAR): Prior approval for a particular service given to provider by a Medi-Cal consultant.

Vision Claim: A bill for vision care and eyeglasses, contact lenses, or other vision aids.

DETAILED SCOPE, METHODOLOGY, AND LIMITATIONS OF REVIEW

This review was designed to evaluate the accuracy of the Computer Sciences Corporation's Medi-Cal claims processing system. In cooperation with our consultant, Deloitte Haskins & Sells, we developed an automated auditing approach to evaluate claims payments authorized by the CSC over the 15-month period from October 1, 1979 through December 31, 1980.

Scope and Methodology of Review

From the CSC's 15-month Adjudicated Claims History File (ACHF)--a magnetic tape of all claims paid, denied, or returned--we selected a random sample of Medi-Cal beneficiaries. Our sample represented 1 percent of all beneficiaries listed on that file. We then pulled from the ACHF all the claims for these beneficiaries and tested this extracted data against 23 possible error conditions. We tested the entire ACHF for two other possible error conditions. These conditions were based on findings from previous Auditor General reports, recommendations from our consultant, and comments from the Department of Health Services. Although some tests indicated few or no problems, other tests indicated potentially significant problems.

Based on the results of the 25 tests, we selected six tests for detailed review.* These six tests were chosen because they avoided any issues of medical judgment and because they indicated potential for significant overpayments. As noted in the Introduction, these are the tests we reviewed in detail:

- Duplicate Payments - This test checked for payment of duplicate claims.

- Third Party Liability - This test evaluated the accuracy with which the CSC records receipts from liable third parties.

- Stale Claims - This test reviewed the appropriateness of paying claims which exceeded the Medi-Cal program's allowable time limit between the date of service and the claim's date of submission to the CSC.

- Edit/Audit Overrides - This test examined whether overrides were appropriately exercised for claims that failed the edit and audit review process.

- 20 Percent Cutback of Allowed Amount - This test determined whether claims for services rendered outside the provider's normal place of business were appropriately reduced by 20 percent.

- Paid Greater Than Billed - This test reviewed for payments that exceed the net amounts billed by providers.

* The design and results of the six tests are presented in Appendix C.

We tested these six conditions against the CSC's complete 15-month Adjudicated Claims History File. Further, we restricted our analysis to paid claims. The table on the next page provides more information on the paid claims in the file we used.

TABLE 1

DESCRIPTION OF PAID CLAIMS IN 15-MONTH ADJUDICATED CLAIMS HISTORY FILE[a]

Claim Type[b]	Month CSC Began Processing Claim Type	Total Number of Claims	Total Amount Billed	Total Amount Paid
Pharmacy	June 1979	30,613,113	$ 261,408,338	$ 244,781,981
Long Term Care	September 1979	1,185,561	834,502,183	818,163,885
Inpatient Hospital	December 1979	567,857	1,305,770,675	985,569,071
Outpatient Hospital	December 1979	10,571,644	316,911,132	197,845,018
Medical	June 1980	16,630,521	465,574,570	283,785,788
Vision	June 1980	310,019	8,627,950	7,253,266
TOTAL		59,878,715	$3,192,794,848	$2,537,399,009

[a] These summary data exclude resubmissions, adjustments, resubmission turnaround documents and treatment authorization requests as indicated on the fifth and sixth digits of the CCN.

[b] Our analysis was limited to these six claim types.

From the ACHF, we extracted and placed on magnetic tape file all the paid claims which appeared to meet our six test conditions. Then, from these files, we printed information on between 200 to 1,800 suspect claims for each test. From these printouts, we randomly selected claims for manual review.

In total, we manually reviewed 1,165 claims. The number of claims we reviewed for each test enabled us to statistically project a range of erroneous payments in the extract file. We manually reviewed the claims, the related remittance advices or explanations of benefits, and our computer output to document erroneous payments and to verify our computer test results. We reviewed the claim and the supporting documentation to substantiate any exceptions. We also determined whether the CSC had made payment adjustments through December 31, 1980 for any of these claims. We confirmed the erroneous payments identified in the manual review with department officials, and, in some cases, with the CSC.

Additionally, we determined whether the CSC had an edit or audit for the particular test conditions and whether the edit or audit was authorized to be on or off at the time

the claims were processed. We also reviewed the override status of each claim to determine whether overrides were appropriately exercised.

Limitations of Review

Our review was limited by several factors including the time-lapse problems in auditing an ever-changing system such as the CSC's, the condition of files and records maintained by the CSC and the department, and the narrow focus of this audit.

One limitation in evaluating the CSC's system was that it is continually changing; thus conditions that existed during the period we examined may no longer exist. Our review included claims processed during the period from October 1, 1979 through December 31, 1980. Both the CSC's claims processing system and its quality assurance program have undergone substantial changes since the claims in our review were processed.

Additionally, because we only examined transactions processed through December 31, 1980, we could not consider any payments adjusted after that date. We did take into account claims in our sample that were adjusted during the period of our review. Of the 1,165 claims we reviewed, 323 were in error

and required adjustment. Only 39 of these claims were adjusted within the fifteen month period we reviewed; this left 284 erroneous claims in our sample.

We also encountered problems with files and records maintained by the CSC and the Department of Health Services. For example, FIMD personnel were unable to substantiate when the department had authorized various edits and audits to be turned on or off. Additionally, they could not fully document certain policy decisions. In all of these instances, we gave the CSC the benefit of the doubt regarding the accuracy of claims processing.

Furthermore, we found discrepancies in the CSC's claims history file we used to conduct our audit. For example, different claims had the same claim control number and some claims had blank recipient numbers. Those discrepancies made it difficult to perform some of our tests. The CSC has problems adjudicating claims, since it is difficult or impossible to perform many of the edits and audits without this information. As a result of these problems we discarded a substantial number of claims from our initial sample. Thus, our projections of errors and overpayments may be conservative.

Finally, because of time constraints, we restricted the focus of this review. The CSC has approximately 700 edits and audits, yet our six tests reviewed only 13 of these.

APPENDIX C

DESCRIPTION AND RESULTS OF THE SIX TESTS CONDUCTED

In this section, we present details on the six tests that form the basis of this report. Specifically, we discuss the purpose and results of each test. The tests are ordered as follows:

DUPLICATE PAYMENTS

The purpose of this test was to determine if the CSC had authorized any duplicate payments--those paid to the same provider for the same service rendered on the same day to the same beneficiary. Periodically, providers submit more than one claim for a single service because of administrative billing errors or delays in payment by the CSC. To ensure that multiple payments for the same service are denied, the CSC's system includes audits to suspend claims which contain identical or near identical data such as beneficiary identification number, date of service, and procedure code.

We reviewed all claim types and found duplicate payments for all. For long term care and inpatient hospital claims, we tested only for claim pairs which we suspected were duplicates. Specifically, we examined those pairs for which the paid amount of the second claim was at least 70 percent of the first to avoid sampling non-duplicates such as subsequent charges for services rendered at the same time.

The 100,494 claim pairs which met our test criteria involved Medi-Cal payments totaling $15,576,771.* Of those claim pairs, we randomly selected and reviewed 255. We found that 108 of the 255 pairs (42 percent) were duplicate payments.

Test Results

Table 2 on the following page summarizes our findings. The number of claims in error is a statistical estimate; that is, we are 95 percent confident that the true number of overpayments in each extract file is between the lower and upper limits indicated. Lower and upper limits are necessary because there are inherent risks involved in estimating the characteristics of the files from a sample. We have estimated the value of the overpayments in the extract file by multiplying the estimated number of duplicate claims by the mean (average) value of claims in the extract files.**

* This figure is an approximation. We divided the amount of the total extract file by two to determine only the amount of the duplicate claim.

** See Appendix D for detailed description of our sampling and projection methodologies.

TABLE 3

DUPLICATE PAYMENT TEST RESULTS

Claim Types	Claim Pairs in Extract File	Amount of Potential Duplicate Payments in Extract File	Claim Pairs Reviewed	Confirmed Duplicate Claim Pairs	Amount of Confirmed Duplicate Payments	Percentage of Confirmed Duplicate Claim Pairs	Estimated Number of Duplicate Claims	Estimated Range of Overpayments
Pharmacy	29,840	$ 349,123	32	9	$ 162	28	3,670 to 13,115	$42,935 to $153,449
Long-Term Care	2,862	1,829,741	35	27	16,538	77	1,804 to 2,612	$1,153,269 to $1,669,776
Inpatient	5,339	11,301,242	60	35	63,850	58	2,443 to 3,786	$5,171,171 to $8,013,940
Outpatient	31,347	683,045	48	19	476	40	8,025 to 16,791	$174,876 to $365,869
Medical	30,277	1,394,822	45	11	694	24	3,556 to 11,246	$163,826 to $518,094
Vision	829	18,798	35	7	157	20	57 to 275	$1,284 to $6,237
Total	100,494	$15,576,771	255	108	$81,877	42	9,555 to 47,825	$6,707,361 to $10,727,365

We were unable to verify duplication for 34 claim pairs because the recipient identification information in the 15-month history file was incorrect. Thus, we considered them to be correct payments.

A misunderstanding between the FIMD and the CSC may have contributed to the duplicate payments we identified for inpatient and outpatient hospital claims. At the request of the CSC, the FIMD authorized a logic change for a certain audit of inpatient hospital claims in February 1980. This logic change, intended to prevent the suspension of a large volume of legitimate claims, meant the CSC did not have to review possible duplicates unless the billed amounts were identical. Although the FIMD authorization letter covered only inpatient hospital claims for the two week period, the CSC interpreted the authorization to also include outpatient claims. Moreover, since the FIMD did not notify the CSC whether the logic changes were to continue, the CSC assumed it had authority to extend the change beyond the two week period. As a result, the logic change remained in effect for several months.

THIRD PARTY LIABILITY

This test evaluates the accuracy with which the CSC records (and allows for) providers' receipts from liable third parties such as health insurance carriers. Since Medi-Cal is the payor of last resort for covered services, it is important that the CSC accurately record third party liability deductions so that Medi-Cal pays only its share.

We identified third party liability as a potential problem during the survey stages of our audit. After reviewing monthly paid claims tapes, we found that providers' receipts from liable third parties were incorrectly recorded. The recording of these receipts erred by a factor of 10. For example, a $14,000 TPL receipt would be recorded as $1,400. This record indicated that the computer program was omitting an end digit--a truncation problem.

To confirm this problem, we examined the 15-month Adjudicated Claims History File, identifying all claims with liable third party receipts. We limited our review to those with a Medi-Cal paid amount of $10,000 or more.

Test Results

Overall, 202 inpatient hospital claims met our test criteria. These claims had Medi-Cal payments totaling $3,388,418. After randomly selecting and reviewing 61 of these 202 claims, we found that third party liability was incorrectly recorded on 46 (75 percent) of the claims. As a result of this error, we calculated overpayments totaling $702,529.30 for the 46 claims. We noted that warrants were issued for the 46 claims within the period we examined; thus, the problem had not been discovered through the duration of the 15 months reviewed. Further, none of the 46 claims in question has been adjusted for the error. All 46 erroneously paid claims had a third party liability of $10,000 or more. Those claims that were correctly paid had a third party liability of less than $10,000.

We are 95 percent confident that between 134 and 171 of the 202 claims were erroneously paid. Using the proportion of erroneous payments to total amount paid, we estimate overpayments of between $2,024,241 and $2,685,660.

In March 1981, FIMD personnel detected that the CSC was authorizing erroneous payments because it was recording third party liability incorrectly. The FIMD staff promptly

informed the CSC personnel and requested that the CSC take corrective action and provide a recoupment plan. However, the FIMD had not identified the extent of the problem as of June 1981.

STALE CLAIMS

This test reviews the appropriateness of paying claims after the deadline for provider submission stated in Title 22 of the California Administrative Code. A claim must be received and numbered by the CSC no more than two months from the month in which the service it represents was rendered. The policy of the Fiscal Intermediary Management Division also allows for a six-day grace period. Depending upon the date of service in a given month, a claim may exceed the time limitation in as few as 66 days or could remain valid for up to 97 days. We included in our analysis only those claims paid after the 97-day maximum, thereby omitting any possible stale claims paid in less than 97 days but after more than 66 days.

The State has authorized the CSC to pay a stale claim under certain conditions. For example, if a recipient has other medical coverage, the provider must wait to find out how much the third party will pay before billing the residual amount to Medi-Cal. If this waiting period delays the CSC's receipt of the claim, the provider must submit with the claim documentation verifying when the third party payment was received. We included a review for all allowable exceptions as part of our manual review methodology.

We reviewed only medical claims for this test, excluding pharmacy, long-term care, and vision claims because these indicated relatively few stale claims. Edit Number 025, which suspends stale claims, had been turned off for inpatient and outpatient hospital claims since December 1979, as authorized by the FIMD. Therefore, we also omitted these claim types from our analysis.

Test Results

The 401,646 medical claims which met our test criteria involved Medi-Cal payments totaling $13,447,527. Of those claims, we randomly selected and reviewed 60 and found that 15 (25 percent) were unauthorized payments. The unauthorized payment for the 15 claims totaled $540.

Statistical projections enabled us to state with 95 percent confidence that between 56,070 and 144,753 of the 401,646 claims meeting the test criteria were unauthorized payments. Further, we estimate that these stale claims have a value of between $1,877,216 and $4,846,338.

Edit Number 025 suspends a stale claim so that a claims examiner can review it for state-specified attachments or explanations which authorize an override. We found that all

60 claims in our sample were suspended by Edit Number 025. The 15 claims we identified as unauthorized payments did not meet the state-authorized criteria for override.

EDIT/AUDIT OVERRIDES

This test evaluates whether the CSC authorized payment of claims by erroneously overriding certain error codes which cause claims to suspend during processing. In the preliminary phase of our audit, we identified by error code all claims which the CSC overrode. More than 10 million claims suspended; these claims represent a paid amount of nearly one billion dollars for the 15 month period we reviewed.

We manually examined eight of these error codes for override accuracy. We selected these codes for review because they met one or more of the following criteria:

- They involved large dollar amounts;
- They were easy to manually review;
- They correlated with a large increase in overrides during the months reviewed.

Test Results

Table 3 lists the eight error codes, the number and types of claims which suspended for each error condition, and their paid amounts.

TABLE 3

ERROR CODE OVERRIDE ANALYSIS

Error Code	Description	Claim Type	Number of Claims Suspended for Each Error	Paid Amount
084	Primary diagnosis code missing	Medical	51,725	$ 1,182,369
222	Professional Standards Review Organization certification invalid for provider	Inpatient/ Outpatient Hospital	68,596	45,163,743
313	Recipients ineligible for Medi-Cal benefits until Medicare provides information	Medical	87,576	2,849,715
409	Service units billed exceed maximum allowed	Medical	158,737	10,181,473
428	Ancillary codes invalid	Inpatient Hospital	4,633	12,263,058
545	Diagnosis incompatible with emergency certification	Inpatient Hospital	30,152	23,230,372
602	Services units billed exceeds number of days in billing period	Inpatient Hospital	9,319	17,433,342
861	Service period exceeds Treatment Authorization Request period	Inpatient Hospital	35,005	102,217,570
	Total		445,743	$214,521,642

Our manual review found that the Suspense Processing Unit did not always correctly override edits and audits. For each of the eight error codes, we manually examined a random sample of claims. Of the 407 total claims in our review, we found that 49 or 12 percent were incorrectly overridden. These improper overrides resulted in unauthorized payments of $6,793. The following table illustrates the results of our analysis by error code:

TABLE 4

CLAIMS SAMPLED BY ERROR CODE

Error Code	Claims Sampled			Amount of Overpayment
	Total	In Error	%	
084	59	19	32.2	$ 307
222	56	0	0	0
313	33	11	33.3	475
409	40	2	5.0	0
428	57	6	10.5	1,003
545	60	2	3.3	1,552
602	59	5	8.5	1,512
861	43	4	9.3	1,944
Total	407	49	12.0	$6,793

Table 4 shows that five of the eight error codes we reviewed had sample error rates of 8.5 percent or greater. For these five error codes, the erroneous overrides allowed for substantial unauthorized payments. Based upon our random sampling of claims, we estimate that the CSC made between $994,943 and $3,902,555 worth of unauthorized payments.

Because this test was limited to only eight of the more than 700 error conditions which could cause the CSC's system to suspend a claim, we could not accurately assess the magnitude of the Suspense Processing Unit's override errors. However, based upon the results of this test and the erroneous overrides we found through tests like duplicate payments and stale claims, we conclude that a problem in controlling overrides may exist.

20 PERCENT CUTBACK OF ALLOWED AMOUNT

This test evaluates whether the CSC has calculated a 20 percent cutback in payments to outpatient and medical providers for services performed in hospital outpatient facilities. Generally, Medi-Cal policy requires a reduced payment for certain services performed in a hospital outpatient emergency, hospital examination, or hospital treatment room.

Our computer analysis initially identified approximately 1.3 million claims in the 15-month Adjudicated Claims History File eligible for the 20 percent cutback allowance. Since over 90 percent of our sample claims were for outpatient services, we excluded medical claims from this review. Manual review indicated that although the CSC accurately and consistently reduced all sampled claims after July 18, 1980, most claims processed before that date had not been properly reduced. Therefore, we retested the file and identified 590,450 claims eligible for reduction. These claims, which were valued at $10,008,748, were adjudicated between January 25, 1980 and July 18, 1980.

Test Results

Our manual review of 27 claims and remittance advices adjudicated between March and July 1980 indicated that the claims processing system had reduced 5 claims as required. However, the CSC system failed to reduce 22 claims, an error which resulted in overpayments of $68. Each of these claims was adjudicated prior to July 18, 1980. These claim reductions were not promptly implemented because of a lack of agreement about special procedures applicable for the reduction and because of a delay in system programming.

Based on the retested file of claims paid between January and July 1980, we are 95 percent confident that between 388,622 and 573,587 of the total claims were paid erroneously. Furthermore, we are 95 percent confident that the mean value of overpayments is between $2.17 and $3.99. We therefore estimate total overpayments of between $843,311 and $2,288,611.

FIMD personnel said they discovered in early 1980 that the CSC had not properly reduced all outpatient hospital claims. However, they were still attempting to determine the extent of the overpayments as of the end of our fieldwork. The FIMD staff has discussed a recoupment plan for these overpayments with the CSC.

PAID GREATER THAN BILLED

This test examined all claims payments which appeared to exceed the net amount billed by the provider. During the initial phase of our audit, we identified claims paid greater than billed as a potential problem that could involve at least $1.2 million in overpayments. To verify this problem, we reviewed the 15-month Adjudicated Claims History File to identify those claims for which the amount authorized for payment by the CSC appeared to exceed the net amount billed by the Medi-Cal provider. We limited our review to outpatient and inpatient hospital claims.* The number of potentially paid greater than billed claims identified and their paid amounts is as follows:

Claim Type	Number	Amount Paid
Outpatient Hospital	756	$126,471.73
Inpatient Hosptial	2,513	$4,174,165.70

* We did not analyze crossover claims because of difficulties in getting Medicare's copies. However, our test results indicated that payments for 103,881 claims could have exceeded the amount billed. The paid amount for these claims totaled $5,261,973.

To verify that these claims were accurately paid, we randomly chose a sample of 36 outpatient and 64 inpatient hospital claims from a computer list of all claims meeting our test criteria.

Test Results

We manually reviewed a random sample of 36 of the 756 outpatient hospital claims indicating a paid amount greater than billed. As a result, we found that 31 claims or 86 percent were paid greater than billed. This error resulted in overpayments of $1,752.73 for our sample. Based upon this sample, we are 95 percent confident that the number of erroneously paid claims is between 566 and 736. In using the percentage of sample overpayments to project the total amount of overpayments, we estimate that overpayments range between $36,563 and $77,262.

The number of inpatient hospital claims meeting the criteria of this test totaled 2,513. We manually reviewed a random sample of 64 claims and determined that 13 or 20.3 percent were paid greater than billed. This error resulted in sample overpayments of $14,916.39. Projecting from the sample, we are 95 percent confident that between 260 and 760 of the 2,513 inpatient claims meeting the test criteria

were paid in error. We used the percentage of sample overpayments to project the total amount of overpayments. Based on this, we estimate that the overpayments range from $133,156 to $774,308.

SAMPLING AND PROJECTION METHODOLOGIES

To confirm the results of our tests and to estimate the number and value of overpayments associated with each test, we manually verified random samples of claims from extract files.

For all samples, we confirmed erroneous payments by reconciling copies of suspect claims with remittance advices, explanations of benefits, and test printouts. We then determined the percentage of claims in the sample which were paid erroneously. Using this percentage and its standard error, we estimated at 95 percent confidence ranges (intervals) for the total number of overpayments in each extract file.

We used Chi-Square and Difference Between Means tests to enable us to estimate overpayments. In cases where the properties of the sample permitted, we used both tests to ensure that our results were valid. The purpose of each test is described below:

- The Chi-Square analysis enabled us to determine whether a claim's status as a correct or erroneous payment was significantly related to its dollar value.

- The Difference Between Means test enabled us to test whether the mean (average) values of payments made correctly and those made erroneously were significantly different.

By conducting these tests, we were able to determine whether the claim's status was related to its dollar amount. In most instances, we found no significant difference between the average value of erroroneous claims and those paid correctly in our sample. This observation enabled us to assume the average value per erroneous payment in the extract file was not significantly different from the average value of the correct payments. We therefore estimated the range of erroneous payments based on the average paid value of the extract file.*

To test whether an erroneous payment could be reflected in two or more tests, we entered data on all erroneous claims sampled into a computer for elimination of duplicates. We found no duplicates. Therefore, we did not

* Although this was the standard technique we applied, in some cases, the amount of erroneous payment was less than the amount paid on the claim. In these instances, we applied a similar technique using the proportion of erroneous payments to the total sample amount.

adjust our estimate of overpayments. However, this test does not guarantee that duplicate overpayments are not present in the extract files.

Finally, we cannot estimate the total overpayment with an overall level of confidence. While for some tests the levels of confidence are known and estimable, for others they are not. However, in all cases, we used the best available estimates.

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