CALIFORNIA MMIS
ALTERNATIVE CLAIMS PROCESSING ASSESSMENT SYSTEM

The California Claims Processing and Assessment System (CPAS) is designed to monitor the Contractor's claims processing system, and to evaluate the integrity of the Medi-Cal fiscal intermediary Contractor's Quality Control (QC) system. The California CPAS uses a select random sampling process to identify and review all claim types that are processed through the claims processing system. The QC plan, as specified within the contract, allows for the State, through the Department of Health Services, to conduct special studies of the Contractor's system.

The evaluation of the selected sample claims includes review of the following potential deficiency areas:

1. Payment for incorrect, inconsistent, or incomplete claims
2. Errors which result in incorrect, inconsistent, or incomplete data entries
3. Incorrect, inconsistent, or incomplete automated system programming
4. Payment to a provider not eligible to participate in the program
5. Payment for a service furnished to an ineligible individual
6. Payment for services not authorized by regulation or policy
7. Payments above allowable charges or costs
8. Payment for which an individual was responsible
9. Duplicate payment

Once deficiencies from the claims processing system are identified, they are transmitted to the Contractor in a Problem Identification Statement. The Problem Statement (Attachment 1) provides both the State and the Contractor with a standard method for identifying problems within the claims processing system. As required in the contract, the Contractor must respond to all problem statements and generate a Corrective Action Plan when a problem has been located.

The Corrective Action Plan (CAP) is a response to a Problem Statement concerning procedural or program problems which identifies the source of the problem within the system and provides a complete analysis. A written CAP must be received from the Contractor within 30 days from error identification and notification. The CAP is reviewed by the State and the Contractor will either be notified in writing that the CAP is approved for implementation or the CAP is disapproved and a corrected version must be resubmitted. Once written notification has been transmitted, the Contractor will have a 30 days to implement the CAP.

The Contractor is required to submit a correction notification letter to the State by the 30th day to assure compliance with the CAP and resolution of the problem.

To ensure full accountability of all Problem Statements, the State requires the Contractor to submit a complete index of all problem statements generated, in progress, and resolved. This report is prepared on a weekly basis by the Contractor's QC section. The State also prepares a weekly internal problem statement work sheet that encompasses all of the essential activities that the Contractor is required to perform. Both the Contractor's Problem Statement index and the State's Problem Statement Worksheet are used to compare information and to ensure accuracy of data reported. This Problem Statement Worksheet not only provides a thorough audit trail, it also reports the full range of activities such as start dates and completion dates on all Problem Statements submitted to the Contractor. At the end of the fiscal year period, a final "open" and "closed" report is prepared. The final assessment sorts the problem statements into two categories - "open" the listing of all Problem Statements that have not been resolved and "closed" the listing of all problem statements that have been resolved with corrective action (if deemed necessary) completed. The final Problem Statement report would satisfy the CPAS annual reporting requirement (Attachment 2).

When the State or the Contractor discovers a potential erroneous payment which may require an adjustment, a Problem Statement is generated. As a direct result of the Problem Statement process, the Contractor is obligated to submit a summary of findings to the State within 10 days, and a CAP (which includes the Erroneous Payment Correction plan) within the contracted 60 days. Once the potential adjustment has been identified, the Contractor is obligated to submit to the State for approval a CAP that will specify the Erroneous Payment Correction (EPC) plan that will be implemented. The EPC has five (5) specific phases (Attachment 3) which identify the degree of the overpayment, and makes all of the necessary adjustments within the contractual timeframes.

The EPC plan allows for dialogue between the State and Contractor to discuss how to coordinate any and all possible claim adjustments. If appropriate, targeted letters may be sent to affected providers of the computed adjustments. A Provider Bulletin may be used to inform providers of adjustments that will occur, including the proposed dates for adjustment, warrant numbers, and whether off-setting balances have been established.

To ensure that all adjustments have been made, the Contractor is bound by the contract to maintain a thorough audit trail through the CP-0-07B Report (Attachment 4). This report is submitted to the State weekly for review.

The Department of Health Services' CPAS coordinates with the California State Controller's Office (SCO) to actively perform a pre and post payment audit of the Contractor's automated and manual claims system. The principal activity of the SCO is to review the electronic payment tapes and determine legality and propriety of those payments made. If the SCO identifies possible payment errors, they will submit to the Department a listing of:

1. claims in question

2. potential error amount

3. the adjusted amount

4. total of the potential overpayment

The State submits a Problem Statement that incorporates the SCO findings, thereby, notifying the Contractor of the deficiency. The Contractor has a total of 10 days to respond to the State with an analysis of the problem, and a total of 45 days to make all necessary adjustments. The Contractor is not obligated to submit an EPC plan; however, the Contractor is required to submit a CAP if deemed appropriate. The contract provides that SCO related adjustments be made within 45 days regardless of any circumstances. Once the State receives the Contractor's final summary of findings, it is reviewed for accuracy and forwarded to the SCO for information. In addition to the warrant reviews, the State will also conduct a post payment review of medical claims, professional/supplier. A random select sample is drawn and examined for propriety of payment. The objective of this study is to ascertain if any excessive dollar payments and/or duplicate payments have been made. If there are any deficiencies discovered or adjustments required, a Problem Statement is submitted, and the normal SCO/Problem Statement process is in effect.

The State compares the Contractor's data against an internal audit tracking worksheet. If there are any deficiencies within the report, the State notifies the Contractor in writing (with documentation) pointing out any and all identified deficiencies. Incorporated within the EPC worksheet is the specific dollar amount adjustment. This data is an ongoing report; therefore, at the end of the fiscal year an annual total is computed, along with those accounts that have not been resolved by year's end that will be carried over to the next fiscal period.

The EPC worksheet not only provides an audit trail on all accounts being reported, it also serves as a resource to monitor the Contractor's activities in this specific area.

CALIFORNIA DENTAL MMIS
ALTERNATIVE CLAIMS PROCESSING ASSESSMENT SYSTEM

This document adds the Alternative Claims Processing Assessment System (CPAS) Plan for California's Dental Medicaid Management Information System (CD-MMIS). The purpose of the addition is to include the State's process for monitoring the claims processing activities of its Fiscal Intermediary (FI) responsible for paying claims for dental services covered under California's Medicaid Program (Medi-Cal).

CPAS for the Medi-Cal dental program's (Denti-Cal) claims processing system assimilates the CPAS designed to monitor and evaluate the integrity of the claims processing and Quality Control (QC) systems used by the FI responsible for paying claims for the remainder of the Medi-Cal Program (all services other than dental).

Similar to the CPAS used for assessing the propriety of claims payment activities for claims paid for all other services covered by the Medi-Cal program, CPAS for Denti-Cal uses a select random sampling process to review claims which are identified through the FI's adjudicated claims monthly QC reports. The claims listed on these reports are those which have gone through an audit as part of the FI's QC system. Currently, only claims which require professional adjudication are included in the State's random sample. Approximately 90% of the dental claims fall under this category. The State is currently exploring a means by which the remaining claims can routinely be included into the sample.

In addition to the monthly random sample of claims, the Denti-Cal program relies on special studies which the Denti-Cal FI is contractually required to conduct when requested by the State. These studies provide an additional means by which the State evaluates the efficiency of the claims processing system.

RANDOM SAMPLE OF CLAIMS

The evaluation of the selected sample of claims processed by the State's Denti-Cal FI involves a review of the following potential deficiency areas:

1. Payment for incorrect, inconsistent or incomplete claims.
2. Errors which result in incorrect, inconsistent or incomplete claims.
3. Incorrect, inconsistent or incomplete automated system programming.
4. Payment to a provider not eligible to participate in the program.
5. Payment for a service furnished to an ineligible individual.
6. Payment for services not authorized by regulation or policy.

7. Payments above allowable charges or costs.

8. Payment for which an individual was responsible (share of costs).

9. Duplicate payment.

10. Appropriate professional adjudication.

ON-SITE CLAIMS AUDIT FOR APPROPRIATE PROFESSIONAL ADJUDICATION

The evaluation of appropriate professional adjudication, listed as Item 10 above, represents a review element which is unique to Denti-Cal due to the program's reliance on x-rays in determining whether a claim is payable. Prior to payment of any claim for which an x-ray is required (approximately 90% of all claims processed), the claim and accompanying x-ray are reviewed by a dental professional to determine if the x-ray adequately documents the need for the service(s) for which payment is requested.

In accordance with its contract, the Denti-Cal FI is required to make available to the State dental consultants an ongoing sample of contractor-processed claims which have undergone professional adjudication by the FI's dental professionals. The sample includes all supporting documentation, including x-rays as submitted by the provider. The sample includes approximately 200 claims per quarter.

State dental consultants perform a quarterly review of this randomly selected sample of fully adjudicated claims and present their findings to the FI within 15 calendar days of completion of their review. This audit is done to establish whether there is a discrepancy between what was approved by the FI's dental consultants and what should have been approved by their State counterparts. The State employs statistical definitions, procedures and formulas to compute the precision of the discrepancy between what the FI approved and paid and what the State would have approved and paid. The "Protocol for State Audit on the CD-MMIS System" describes this State audit process in more detail.

PROBLEM STATEMENT PROCESS

When deficiencies are identified in the manual or automated portion of the claims processing system, they are transmitted to the FI in a problem identification statement. The Problem Statements provide both the State and the FI with a standard method of identifying problems within the claims processing system.

CORRECTIVE ACTION PLAN

The FI is required to respond to all Problem Statements and generate a Corrective Action Plan (CAP) when the cause of the problem has been located. The CAP is a response to a Problem Statement concerning procedural or program problems and must identify the source of the problem within the system as well as provide a complete analysis of how

to resolve that problem. The FI is required to provide a written CAP within 30 days of the time that the error was identified and notification provided. If the problem relates to an error in provider payment or is identified as a priority, the CAP is required within 10 days of error identification and notification.

Upon receipt, the CAP is reviewed by the State after which the FI will be notified in writing that the CAP is either approved for implementation or disapproved, in which case, a revised version must be submitted. Once written notification of the State's approval is transmitted, the FI will have 30 calendar days to confirm correction with a written report to the State. The entire process of original notification or the FI's problem identification, must not exceed 60 days. Extensions of the 60-day time period are only granted by the State under special circumstances and on a request-by-request basis.

To ensure full accountability of all Problem Statements, the State requires the FI to submit a list of all Problem Statements generated, in progress and resolved. This report is prepared on a weekly basis by the FI's QC section. The State also prepares a weekly internal Problem Statement listing that encompasses all of the essential activities that the FI is required to perform.

FEDERAL REPORTING REQUIREMENT

At the end of the fiscal period, a final assessment of the Problem Statement activity is prepared. The final assessment sorts the Problem Statements into two categories - "open", the listing of all Problem St ements that have not been resolved, and "closed", the listing of all Pr.. lem Statements that have been resolved with corrective action (if deemed necessary) completed. This final Problem Statement report would satisfy the CPAS annual reporting requirements.

ERRONEOUS PAYMENTS

When the State or FI discover a potential erroneous payment which may require an adjustment, a Problem Statement is generated. When a Problem Statement is generated which involves potential erroneous payment, the FI is obligated to submit a CAP within 10 days of submittal of the Problem Statement and the correction notification letter within 60 days thereafter.

The Erroneous Payment Correction (EPC) plan allows for dialogue between the State and the FI to discuss how to coordinate any and all possible claim adjustments. If appropriate, letters may be sent to affected providers informing them of the computed adjustments. A provider bulletin may be used to inform providers of adjustments that will occur, including the proposed dated for adjustments, warrant numbers and whether off-setting balances have been established.

To ensure that all adjustments have been made, the FI is contractually obligated to maintain a thorough audit trail and to provide a status report to the State on a weekly basis.

SPECIAL STUDIES

Edits/Audits Review. The State's contract with the Denti-Cal FI requires the contractor to produce monthly reports on the accuracy of four different edits and audits, which will be identified by the State.

Systems' Development Group. The State's contract with the Denti-Cal FI required the contractor to establish a Systems Development Group (SDG). The primary purpose of the SDG is to design, develop, test and install State required modifications to the system. This includes all modifications or enhancements initiated by the State and, with the prior approval of the State, changes initiated by the contractor. Another responsibility of the SDG is to perform testing and simulation studies to assess the impact of proposed changes to the management information and claims processing system. Such studies include, but are not limited to, the impact of incurred benefit costs, administrative costs, and automated and/or manual procedures resulting from a change in edits, audits, benefits coverage or the surveillance parameters used in the advanced Surveillance and Utilization Review System (S/URS). The State exercises full control over the work to be performed by the SDG.

Attachment 1

State of California—Health and Welfare Agency

Department of Health Se

MMIS PROBLEM STATEMENT
(STATE INITIATED)

Control No. P09 ??2443

USE TYPEWRITER ONLY

PS Type: 17

MMIS USER ORGANIZATION'S USE

1. Originated by: Mary Goodman
2. Telephone: 322-1071
3. Originating Unit: Case Development Section
4. Mailing Address: 713 K Street, 1 Floor
5. Originator's Manager Signature:
6. Performance Analysis Approval:
7. Contract Reference:
8. ☐ New PS ☐ Reopen PS ☐ Addendum
9. User Priority: ☐ Low ☐ Medium ☒ High
10. Erroneous Payment Correction Plan Due: ☒ Yes

11. Title: CLAIMS DENIALS - INCORRECTLY

12. System:

13. Overpayment (Recoup) $

14. Underpayment $

15. Problem: (Use additional pages when necessary.)

Dr. Bernard Goetz was placed on Special Claims Review on Julian Date 9345. The following claims were incorrectly denied with Denial code 229.

1) 9338202611502 Date of Service Nov. 13, 1989
2) 9333302611402 Date of Service Nov. 29, 1989
3) 9338302611102 Date of Service Nov. 25, 1989
4) 9338343009002 Date of Service Nov. 30, 1989

Also 9260420414402 - code 82565-24 was read incorrectly as 82505-24 and denied with EOB 362 (Date of service 11-11-89) and 0022420815101 - a claim for an office visit 90050 charge $50.00 was reimbursed at $5.00 (see attachment) please have these claimslines paid since they were incorrectly denied.

FOR FI's USE

Summary of Findings: (Use additional pages when necessary.)

Completed by | Date | Approved by | Date

FI—White FIMD—Yellow Originator—Pink<LBody> Other—Goldenrod

DHS 6031 (1/89)

REPORT-NO. PC-0-850 CALIFORNIA DEPARTMENT OF HEALTH SERVICES- MEDI-CAL ASSISTANCE PROGRAM PAGE 0001
REPORT-DATE 03/23/90 PROBLEM CORRECTION ONLINE REPORTS — PLOG MASTER LIST PRIOR UPDATE RUN 03/16/90

PROBLEM STATEMENT SUMMARY REPORT

WEEKLY TOTALS	P/S OPEN THIS WEEK STATE	CONTRACTOR	INTERM RESPONSE	CAPS GENERATED	CCRR GENERATED	OPEN PROBLEM STATEMENTS SMG	O/C	TOTAL	CLOSED ITEMS WEEK	TOTAL	TOTAL P/S
01	009	005	003	000	003	337	052	389	000	608	997
02	005	001	010	000	003	329	057	386	008	617	1003
03	005	001	000	000	004	328	061	389	003	620	1009
04	004	004	000	000	010	323	061	384	012	631	1015
05	000	000	000	000	000	000	000	000	000	000	000
MTD	023	011	013	000	020	323	061	384	023	631	1015
MAR 90	023	011	013	000	020	323	061	384	023	631	1015
FEB 90	007	014	031	000	036	327	054	381	001	608	989
JAN 90	015	024	026	001	038	317	047	364	027	608	972
DEC 89	021	037	054	001	062	315	046	361	037	579	940
NOV 89	022	020	024	000	044	311	054	365	024	535	900
OCT 89	018	013	020	000	057	299	057	356	030	513	869
SEPT 89	020	027	062	002	054	307	059	366	043	479	845
AUG 89	021	025	028	000	033	290	078	368	038	439	807
JULY 89	014	014	069	000	043	284	070	354	028	409	763
JUNE 89	057	029	057	000	045	285	069	354	045	385	739
MAY 89	029	046	055	000	050	279	041	320	016	342	662
APR 89	015	021	022	000	033	246	028	274	038	325	599
MAR 89	017	025	021	000	053	246	040	286	036	283	569

REPORT NO. CP-0-09A
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
PROCESSED ERRONEOUS PAYMENT CORRECTION REPORT

RUN ON 02/04/90 AT 10 39

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
0014770101600	5460157343101	INPATIENT	HSP30327G	DEBIT	912	9156501500500	$2,524.45+	$10,842.71+	$8,318.26+
0014770102400	3910155760160	INPATIENT	ZZR00084F	DEBIT	912	9156501502800	$7,654.73+	$6,694.70+	$960.03-
0014770104200	4369564748859	INPATIENT	ZZR00038F	DEBIT	912	9156501507300	$2,936.34+	$6,666.92+	$3,730.58+
0014770104300	3469479227813	INPATIENT	ZZR00108F	DEBIT	912	9156501400700	$1,067.76+	$6,230.26+	$5,162.50+
0014770104600	1969489263461	INPATIENT	HSP30571G	DEBIT	912	9156501507200	$2,135.52+	$2,994.84+	$859.32+
0014770104800	0469548235289	INPATIENT	ZZR00030F	DEBIT	912	9156501502600	$5,245.83+	$9,300.82+	$4,054.99+
0014770105600	3729553102629	INPATIENT	ZZT30447G	DEBIT	912	9156501402300	$3,523.20+	$5,109.82+	$1,586.62+
0014770106400	3460707130701	INPATIENT	ZZR00599G	DEBIT	912	9156501400900	$3,524.50+	$4,284.50+	$760.00+
0014770106700	2419564529310	INPATIENT	ZZR00179F	DEBIT	912	9156501502400	$5,822.45+	$14,510.90+	$8,688.45+
0014770107800	5069454646989	INPATIENT	HSP30464G	DEBIT	912	9156501502200	$8,542.08+	$25,089.85+	$16,547.77+
0014770108100	3030749856711	INPATIENT	ZZT31404F	DEBIT	912	9156501500600	$3,309.57+	$4,887.32+	$1,577.75+
0014770108200	4510092456001	INPATIENT	HSP30312H	DEBIT	912	9156501502100	$3,593.60+	$4,332.60+	$739.00+
0014770108800	2980023960101	INPATIENT	ZZR00033F	DEBIT	912	9156501501800	$704.90+	$5,770.77+	$5,065.87+
0014770112300	1966869764102	INPATIENT	ZZT30116F	DEBIT	912	9156501400500	$4,229.40+	$9,419.12+	$5,189.72+
0014770114500	5069547142851	INPATIENT	ZZR00154F	DEBIT	912	9156501501400	$9,022.72+	$16,577.72+	$7,555.00+
0014770114600	0169424245827	INPATIENT	ZZR00305F	DEBIT	912	9156501400400	$3,947.44+	$5,820.66+	$1,873.22+
0014770115400	5660377888060	INPATIENT	ZZT30082F	DEBIT	912	9156501501300	$2,402.46+	$7,971.56+	$5,569.10+
0014770115800	3730799644202	INPATIENT	ZZT30141F	DEBIT	912	9221505800900	$4,004.10+	$6,372.21+	$2,368.11+
0014770116500	1966897300101	INPATIENT	ZZT30116F	DEBIT	912	9156501400300	$3,242.54+	$11,728.33+	$8,485.79+
0014770116600	4360807525001	INPATIENT	ZZR00215F	DEBIT	912	9156501501100	$4,229.40+	$17,484.19+	$13,254.79+
0014770117100	3460726053702	INPATIENT	ZZR00599G	DEBIT	912	9156501400200	$4,229.40+	$7,042.90+	$2,813.50+
0014770118600	1969557190614	INPATIENT	HSP30571G	DEBIT	912	9156501500900	$3,665.48+	$7,326.48+	$3,661.00+
0014770118800	1915473661102	INPATIENT	ZZT30116F	DEBIT	912	9156501500800	$4,088.42+	$10,956.20+	$6,867.78+
0014770119400	3469518222289	INPATIENT	ZZR00599G	DEBIT	912	9156501400100	$4,229.40+	$8,938.40+	$4,709.00+
0014770119800	0429497347035	INPATIENT	ZZR00030F	DEBIT	912	9156501501400	$5,958.00+	$8,366.20+	$2,408.20+
0014770120000	4329586383148	INPATIENT	ZZR00125F	DEBIT	912	9156501500100	$3,965.13+	$5,[illegible]+	[illegible]3.80+

00147701208000 **C 01**

REPORT NO. CP-0-09A
REPORT DATE 02/06/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
PROCESSED ERRONEOUS PAYMENT CORRECTION REPORT

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
00147701208000	19659036171O1	INPATIENT	HSP30581G	DEBIT	912	9156501500[illegible]	$4,229.40+	$11,972.50+	$7,743.10+
00147701216000	19695571906I4	INPATIENT	HSP30571G	DEBIT	912	9156501500[illegible]	$1,973.72+	$6,079.02+	$4,105.30+
00147701[illegible]700	19695571906I4	INPATIENT	HSP30571G	DEBIT	912	915650150020[illegible]	$4,229.40+	$7,009.40+	$2,780.00+
00147701218000	19695571906I4	INPATIENT	HSP30571G	DEBIT	912	9156501[illegible]00[illegible]	$4,229.40+	$7,269.71+	$3,040.31+
ADJ RSN TOTAL		912 ADJ RSN RC	30				$122,490.74+	$262,679.54+	$140,188.80+
FINAL TOTALS		ADJ RSN RC	30				$122,490.74+	$262,679.54+	$140,188.80+

REPORT NO. CP-0-09A
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
PROCESSED ERRONEOUS PAYMENT CORRECTION REPORT

CLAIM CONTROL NO.	RECIPIENT NUMBER	CLAIM TYPE	PROVIDER NUMBER	ADJ TYPE	ADJ RSN	ORIG. CLAIM CONTROL NO.	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT

TOTAL ACTIVITY RECORDS READ	2,483,843			
TOTAL ADJUSTMENTS	4,803			
TOTAL DEBIT ADJUSTMENTS PROCESSED	1,748			
RETROACTIVE DEBITS	29	DOLLAR VALUE	$141,148.83+	
RETROACTIVE CREDITS	01	DOLLAR VALUE	$960.03-	
TOTAL PROCESSED VOIDS	00			
STANDARD	00	DOLLAR VALUE	$00.00+	
RETROACTIVE	00	DOLLAR VALUE	$00.00+	
TOTAL APPROVED BILLABLE LINES	5,614			

0014770108800 H 01

REPORT NO. CP-0-09B
REPORT DATE 02/04/90
PROVIDER NUMBER ZZR00033F

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER REPORT

RUN ON 02/04/90 AT 10 39

CLAIM CONTROL NO	CLAIM TYPE	ORIG. CLAIM CONTROL NO.	DATE OF SERVICE	ADJ TYPE	WARRENT DATE	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
0014770108800	INPATIENT	9156501501800	86/10/21	912	87/01/20	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+
** ADJ RSN TOTALS	912		CLAIMS R/C		1	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+
** PROVIDER TOTALS			CLAIMS R/C		1	$15,945.48+	$704.90+	$5,770.77+	$5,065.87+

912

B 01

REPORT NO. CP-O-ORC
REPORT DATE 02/06/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION ADJUSTMENT REPORT

RUN ON 02/06/90 AT 10 39

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
912	30	$714,650.25	$122,490.74	$262,679.54	$140,188.80
* TOTALS	30	$714,650.25	$122,490.74	$262,679.54	$140,188.80

B 01

REPORT NO. CP-O-09D
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION RESUB REPORT

PAGE
RUN ON 02/04/90 AT 10

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
	CP-O-09D	NO TRANSACTIONS THIS REPORT			

B 01

REPORT NO. CP-O-09E
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION INTERNAL DENIAL RPT

RUN ON 02/04/90 AT 10 39

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
CP-O-09E	NO TRANSACTIONS THIS REPORT				

B 01

REPORT NO. CP-0-09F
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER TOTAL REPORT

PROVIDER NUMBER	PROVIDER NAME	CLAIMS	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
HSP30312H	REDDING MEDICAL CENTER	1	$8,066.20	$3,593.60	$4,332.60	$739.00
HSP30327G	LOMA LINDA UNIVERSITY	1	$29,852.73	$2,524.45	$10,842.71	$8,318.26
HSP30464G	DOCTORS MEDICAL CENTER	1	$61,789.53	$8,542.08	$25,089.85	$16,547.77
HSP30571G	CHARTER SUBURBAN HOSPIT	5	$114,328.76	$16,233.52	$30,679.45	$14,445.93
HSP30581G	DOCTORS HOSP OF LAKEWOOD	1	$35,478.10	$4,229.40	$11,972.50	$7,743.10
22R00030F	ORGVILLE HOSPITAL	2	$36,599.49	$11,203.83	$17,667.02	$6,463.19
22R00033F	MT ZION HOSPITAL	1	$15,945.48	$704.90	$5,770.77	$5,065.87
22R00038F	SANTA CLARA VLY MED CEN	1	$14,246.58	$2,936.34	$6,666.92	$3,730.58
22R00084F	ST JOSEPHS HOSPITAL	1	$26,773.75	$7,654.73	$6,694.70	$960.03-
22R00108F	SUTTER GENERAL HOSPITAL	1	$12,452.50	$1,067.76	$6,230.26	$5,162.50
22R00125F	ALEXIAN BROTHERS HOSP	1	$18,850.63	$3,995.13	$5,628.93	$1,633.80
22R00154F	MEMORIAL HOSP CERES	1	$39,127.00	$9,022.72	$16,577.72	$7,555.00
22R00179F	EMANUEL MEDICAL CENTER	1	$37,906.85	$5,822.45	$14,510.90	$8,688.45
22R00215F	SAN JOSE HOSPITAL	1	$34,865.59	$4,229.40	$17,484.19	$13,254.79
22R00305F	ALTA BATES HOSPITAL	1	$22,826.22	$3,947.44	$5,820.66	$1,873.22
22R00599G	U C DAVIS MEDICAL CENTER	3	$41,966.50	$11,983.30	$20,265.80	$8,282.50
22T30082F	ST JOHNS HOSPITAL	1	$12,677.45	$2,402.46	$7,971.56	$5,569.10
22T30116F	NORTHRIDGE HOSP FOUNDATI	3	$93,436.49	$11,560.36	$32,103.65	$20,543.29
22T30141F	AMI CLAIREMONT COMM HOSP	1	$13,494.11	$4,004.10	$6,372.21	$2,368.11
22T30447G	VILLA VIEW COMM HOSPITAL	1	$25,635.54	$3,523.20	$5,109.82	$1,586.62
22T31404F	CHILDRENS HOSP OF ORANGE	1	$18,330.75	$3,309.57	$4,887.32	$1,577.75
*** TOTAL		30	$714,650.25	$122,490.74	$262,679.54	$140,188.80

B 01

REPORT NO. CP-0-09G
REPORT DATE 02/04/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
ERRONEOUS PAYMENT CORRECTION PROVIDER TOTAL REPORT

RUN ON 02/04/90 AT 10 10

PROVIDER NUMBER	PROVIDER NAME	CLAIMS	AMOUNT BILLED	ORIGINAL PAYMENT	ADJ/VOID PAYMENT	NET ADJUSTMENT
ZZRU0084F	ST JOSEPHS HOSPITAL	1	$26,773.75	$7,654.73	$6,694.70	$960.03-
HSP30312H	REDDING MEDICAL CENTER	1	$8,066.20	$3,593.60	$4,332.60	$739.00
ZZT314047	CHILDRENS HOSP OF ORANGE	1	$18,330.75	$3,309.57	$4,887.32	$1,577.75
ZZT30447G	VILLA VIEW COMM HOSPITAL	1	$25,635.54	$3,323.20	$5,109.82	$1,586.62
ZZR00125F	ALEXIAN BROTHERS HOSP	1	$18,850.63	$3,995.13	$5,628.93	$1,633.80
ZZR00305F	ALTA BATES HOSPITAL	1	$22,826.22	$3,947.44	$5,820.66	$1,873.22
ZZT30141F	AMI CLAIREMONT COMM HOSP	1	$13,494.11	$4,004.10	$6,372.21	$2,368.11
ZZ 00038F	SANTA CLARA VLY MED CEN	1	$14,246.55	$2,936.34	$5,666.92	$3,730.58
ZZR00033F	MT ZION HOSPITAL	1	$15,945.48	$704.90	$5,770.77	$5,065.87
ZZR00108F	SUTTER GENERAL HOSPITAL	1	$12,452.50	$1,067.76	$6,230.26	$5,162.50
ZZT30082F	ST JOHNS HOSPITAL	1	$12,677.45	$2,402.46	$7,971.56	$5,569.10
ZZR00030F	OROVILLE HOSPITAL	2	$36,599.49	$11,203.83	$17,667.02	$6,463.19
ZZR00154F	MEMORIAL HOSP CERES	1	$39,127.00	$9,022.72	$16,577.72	$7,555.00
HSP30581G	DOCTORS HOSP OF LAKEWOOD	1	$35,478.10	$4,229.40	$11,972.50	$7,743.10
ZZR00599G	U C DAVIS MEDICAL CENTER	3	$41,966.50	$11,983.30	$20,265.80	$8,282.50
HSP30327G	LOMA LINDA UNIVERSITY	1	$29,852.73	$2,524.45	$10,842.71	$8,318.26
ZZR00079F	EMANUEL MEDICAL CENTER	1	$37,906.85	$5,822.45	$14,510.90	$8,688.45
ZZR00215F	SAN JOSE HOSPITAL	1	$34,865.59	$4,229.40	$17,484.19	$13,254.79
HSP30521G	CHARTER SUBURBAN HOSPIT	5	$114,328.76	$16,233.52	$30,679.45	$14,445.93
HSP30464G	DOCTORS MEDICAL CENTER	1	$61,789.53	$8,542.08	$25,089.85	$16,547.77
ZZT30116F	NORTHRIDGE HOSP FOUNDATI	3	$93,436.49	$11,560.36	$32,103.65	$20,543.29
*** TOTAL		30	$714,650.25	$122,491.74	$262,679.54	$140,188.80

L 08

REPORT NO. CP-0-07B
REPORT DATE 03/17/90

CALIFORNIA DEPARTMENT OF HEALTH SERVICES - MEDI-CAL ASSISTANCE PROGRAM
RETROACTIVE RATE CHANGE IMPACT

ADJUSTMENT REASON	NUMBER OF ADJUSTMENTS	TOTAL BILLED AMOUNT	TOTAL ORIGINAL PAYMENT	TOTAL ADJUSTED PAYMENT	TOTAL NET PAYMENT
829	1	$1,145.23	$988.25	$1,145.23	$156.98
* TOTALS	1	$1,145.23	$988.25	$1,145.23	$156.98