



Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump

Making government work better

Official Audit Report – Issued August 21, 2017

Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Submitted by Dr. Hooshang D. Poor

For the period January 1, 2012 through September 30, 2015





Commonwealth of Massachusetts
Office of the State Auditor
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Making government work better

August 21, 2017

Dr. Hooshang D. Poor
123 Baldpate Road
Newton Center, MA 02459-2853

Dear Dr. Poor:

I am pleased to provide this performance audit of claims for evaluation and management services provided to MassHealth members. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2012 through September 30, 2015. My audit staff discussed the contents of this report with you, and your comments are reflected in this report.

I would also like to express my appreciation to your employees for the cooperation and assistance provided to my staff during the audit.

Sincerely,

A handwritten signature in blue ink, appearing to read "SMBump".

Suzanne M. Bump
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

APRN	advanced practice registered nurse
CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare and Medicaid Services
DEA	Drug Enforcement Administration
DPH	Department of Public Health
E/M	evaluation and management
MFD	Office of the Attorney General's Medicaid Fraud Division
MMIS	Medicaid Management Information System
NP	nurse practitioner
OIG	Office of Inspector General
OSA	Office of the State Auditor
PA	physician assistant

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the state's Medicaid program, known as MassHealth. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services, within the federal Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, is responsible for the administration of MassHealth. MassHealth provided access to healthcare services to approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities in 2016. In fiscal year 2016, MassHealth paid healthcare providers more than \$14.8 billion, of which approximately 50%¹ was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

OSA has conducted an audit of evaluation and management (E/M) claims paid to Dr. Hooshang D. Poor (Dr. Poor) for the period January 1, 2012 through September 30, 2015. It was necessary to extend our audit period back through May 10, 2010 when examining claims paid to Dr. Poor while he was out of the United States (Finding 2) and ahead through October 31, 2016 when examining billings for E/M services that were provided by his nurse practitioners (NPs) and physician assistant (PA) (Finding 4). The purpose of this audit was to determine whether Dr. Poor billed MassHealth for E/M services using appropriate procedure codes and modifier codes, met recordkeeping requirements, and provided supervision of NPs and a PA engaged in prescriptive practices in accordance with certain laws, rules, and regulations.

1. During the federal government's fiscal year 2016, the federal medical assistance percentage for Massachusetts was 50%.

Below is a summary of our findings and recommendations, with links to each page listed.

Finding 1 Page 11	Dr. Poor provided \$176,730 of excessive E/M services for members residing in long-term-care facilities.
Recommendations Page 12	<ol style="list-style-type: none"> 1. Dr. Poor should only provide one E/M service per month for MassHealth members unless emergency services are warranted. 2. Dr. Poor should regularly review MassHealth regulations, bulletins, and updates to ensure future compliance with all coverage limitations. 3. Dr. Poor should collaborate with MassHealth to repay the \$176,730 that resulted from excessive E/M services.
Finding 2 Page 14	Dr. Poor improperly billed MassHealth for at least \$35,541 of E/M services provided by his NPs and PA.
Recommendations Page 16	<ol style="list-style-type: none"> 1. Dr. Poor should ensure that his billing staff submits claims with the required modifier codes for services performed by his NPs or his PA. 2. Dr. Poor should develop an oversight process to ensure that claims are reviewed before submission and that they include proper modifier codes. 3. Dr. Poor should collaborate with MassHealth to determine amounts due² the Commonwealth.
Finding 3 Page 17	Dr. Poor billed using the wrong procedure codes for \$12,608 of services provided to members in rest homes.
Recommendations Page 17	<ol style="list-style-type: none"> 1. Dr. Poor should use proper procedure codes when billing for services provided to members in rest homes. 2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$10,833³ that resulted from the use of improper procedure codes for services provided to members in rest homes.

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2. There could be overlap between this audit issue and others described in this report. Therefore, we have not recommended that MassHealth recover the overpayments we calculated, which were at least \$35,541. Instead, Dr. Poor should collaborate with MassHealth to review all his claims, excluding the problem claims identified in Findings 1, 3, 4, 6, and 7, and determine the amounts that are due because of his inconsistent use of modifier codes.
 3. This amount excludes all overpayments identified in Findings 1, 4, and 7.

Finding 4 Page <u>18</u>	Dr. Poor billed for \$15,477 of E/M services performed while he was outside the United States.
Recommendations Page <u>20</u>	<ol style="list-style-type: none"> 1. Dr. Poor should only bill MassHealth for E/M services he provides to members. If he arranges for other physicians to provide medical services to his patients when he is not available (e.g., when he is out of the country), he should ensure that these physicians bill MassHealth directly for the services using their unique provider identification numbers so that MassHealth can be certain that they are approved Medicaid providers who are qualified to provide the services. 2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$13,673⁴ that resulted from E/M services billed for dates when he was out of the country.
Finding 5 Page <u>21</u>	Dr. Poor did not establish guidelines for his staff to follow when prescribing medications.
Recommendations Page <u>22</u>	<ol style="list-style-type: none"> 1. Dr. Poor and his NPs and PA should immediately develop written prescriptive guidelines for his NPs and PA to follow when performing E/M services under his supervision. 2. Dr. Poor's NPs and PA should immediately cease all prescriptive practices until such guidelines have been developed. 3. Dr. Poor and his NPs and PA should immediately notify the Department of Public Health and the federal Drug Enforcement Administration of the inaccurate information they provided to these agencies while seeking authorization for the NPs and PA to prescribe controlled substances.
Finding 6 Page <u>23</u>	Dr. Poor did not maintain any supporting documentation for at least \$79,388 of E/M services.
Recommendations Page <u>24</u>	<ol style="list-style-type: none"> 1. Dr. Poor should ensure that documentation is maintained to support services claimed. 2. Dr. Poor should collaborate with MassHealth to determine amounts⁵ due the Commonwealth.
Finding 7 Page <u>25</u>	Dr. Poor did not prepare legible documentation to support at least \$24,501 of E/M services.
Recommendations Page <u>26</u>	<ol style="list-style-type: none"> 1. Dr. Poor should ensure that his handwriting is legible when recording E/M services in members' medical records. He could also consider alternative ways to document his services, such as dictated or typewritten progress notes. 2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$7,619⁶ that was related to illegible service documentation.

4. This amount excludes all overpayments identified in Findings 1, 3, and 7.

5. The overpayment amount calculated in this audit finding, and those of other findings in this report, are not mutually exclusive. Therefore, we have not recommended that MassHealth recover \$79,388. Instead, Dr. Poor should collaborate with MassHealth to review all his claims, excluding the overpayments identified in Findings 1, 2, 3, 4, and 7, and determine amounts that are due because of undocumented E/M services.

6. This amount excludes all overpayments already identified in Findings 1, 3, and 4.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services is responsible for administering the state’s Medicaid program, known as MassHealth. For the period January 1, 2012 through September 30, 2015, Dr. Poor submitted 36,413 claims, and was paid \$746,322, for evaluation and management services provided to 977 MassHealth members. The table below details the services Dr. Poor provided to members and the payments he received from MassHealth during the audit period.

Dr. Poor’s Paid Claims—January 1, 2012 through September 30, 2015

Procedure Code*	Procedure-Code Description	Level of Severity [†]	Total Paid Claims	Total Amount Paid
99304	Initial nursing-facility care, per day	Low	316	\$ 8,318
99305	Initial nursing-facility care, per day	Moderate	142	4,760
99306	Initial nursing-facility care, per day	High	632	39,171
99307	Subsequent nursing-facility care, per day	Low	6,611	81,384
99308	Subsequent nursing-facility care, per day	Low to Moderate	24,531	486,504
99309	Subsequent nursing-facility care, per day	Moderate to High	3,204	99,145
99310	Subsequent nursing-facility care, per day	High	78	5,867
99315	Discharge day management service, 30 minutes or less	NA	33	490
99316	Discharge day management service, more than 30 minutes	NA	141	3,879
99318	Other nursing-facility services	NA	725	16,804
Totals			<u>36,413</u>	<u>\$ 746,322</u>

* Procedure-code descriptions are based on the American Medical Association’s 2013 *Current Procedural Terminology, Professional Edition*.

† According to the American Medical Association, the level of severity is predicated on the patient’s presenting problem (disease, condition, illness, injury, symptom, or complaint).

Dr. Poor has provided physician services to members residing in long-term care facilities since 1987. Currently, approximately 80% of his patients have both Medicare and MassHealth coverage. These individuals are referred to as dual-eligible members. 10% of his patients have MassHealth coverage only, and the rest are either self-pay or covered by private health insurers.⁷

7. These statistics were provided by Dr. Poor and were not verified by the Office of the State Auditor.

During the audit period, Dr. Poor served 977 MassHealth members, including dual-eligible members, residing in at least 91 nursing facilities and rest homes. Dr. Poor does not maintain separate practice sites at these facilities; rather, he treats members at their bedsides and uses the facilities' nursing stations to coordinate care, record services, and review medical records. He employs a nurse practitioner (NP) and a physician assistant (PA) to help provide medical services in these facilities. He also serves as medical director at two facilities: Hellenic Nursing and Rehabilitation Center and Serenity Hill Nursing Center.

Services Provided by NPs and PAs

NPs and PAs are nationally certified, state-licensed medical professionals who can practice medicine on healthcare teams with physicians and other providers. They can take medical histories, conduct physical exams, diagnose and treat illnesses, order and interpret tests, develop treatment plans, counsel on preventive care, assist in surgery, write prescriptions, and make rounds in hospitals and nursing facilities.

Non-independent NPs such as those employed by Dr. Poor do not have unique MassHealth provider identification numbers as physicians do. Their services are billed using a supervising physician's unique MassHealth provider identification number with a required modifier code (SA). Likewise, PAs such as the one employed by Dr. Poor do not have unique MassHealth provider identification numbers; their services are also billed using a supervising physician's unique MassHealth provider identification number with an appropriate modifier code (HN). These modifier codes prompt MassHealth to pay 85% of the rate it would pay for a physician to provide these services.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of evaluation and management (E/M) services performed by Dr. Hooshang D. Poor for the period January 1, 2012 through September 30, 2015. It was necessary to extend our audit period back through May 10, 2010 when examining claims paid to Dr. Poor while he was out of the United States (Finding 2) and ahead through October 31, 2016 when examining billings for E/M services that were provided by his nurse practitioners (NPs) and physician assistant (PA) (Finding 4).

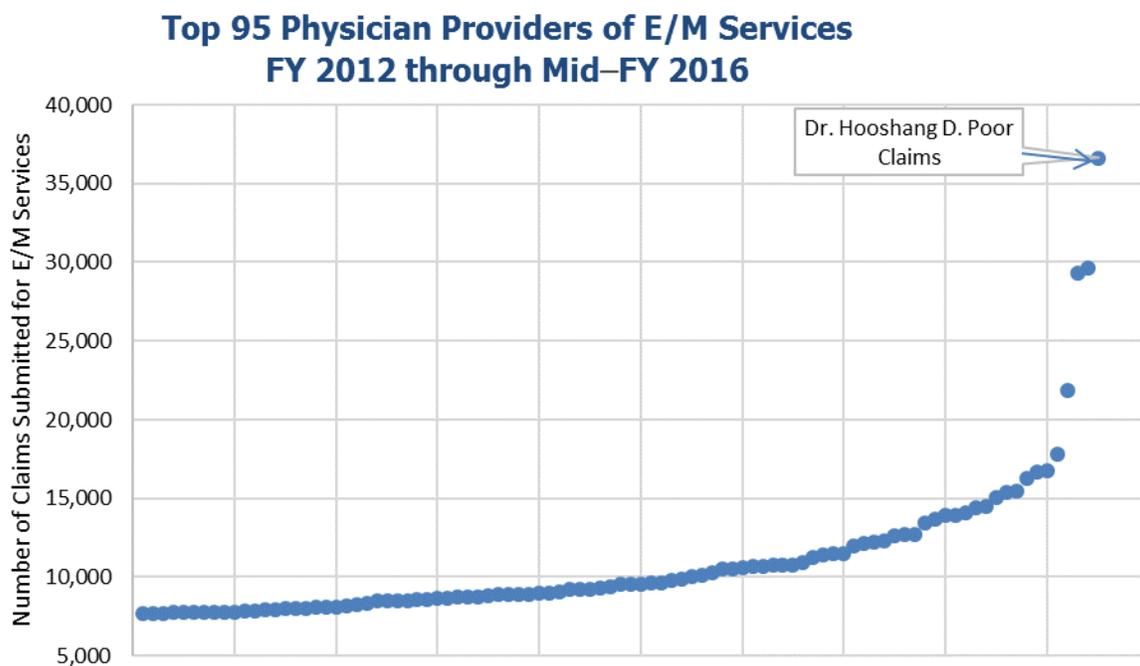
We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Below is a list of our audit objectives, indicating each question we intended our audit to answer; the conclusion we reached regarding each objective; and, if applicable, where each objective is discussed in the audit findings.

Objective	Conclusion
1. Did Dr. Poor perform visits to MassHealth members residing in nursing facilities only once a month, except in emergencies?	No; see Finding <u>1</u>
2. Did Dr. Poor properly bill for E/M services provided to MassHealth members using the following?	
a. required modifier codes for services performed by non-independent NPs or PAs	No; see Finding <u>2</u>
b. procedure codes reflecting service locations	No; see Finding <u>3</u>
3. Did Dr. Poor and his non-independent NPs and PA mutually develop written prescriptive guidelines?	No; see Finding <u>5</u>
4. Did Dr. Poor properly bill for E/M services while he was out of the United States?	No; see Finding <u>4</u>
5. Did Dr. Poor maintain proper documentation in members' medical records to support E/M services provided?	No; see Findings <u>6</u> and <u>7</u>

Auditee Selection

From fiscal year 2012 through the middle of fiscal year 2016, MassHealth paid 1,049,547 physician claims for E/M services. Because of the large volume of these claims, and because certain audits conducted by both federal agencies and other state agencies have identified instances of fraud in claims submitted for E/M services, OSA is conducting a series of audits focusing on providers of E/M services. We selected Dr. Poor for an audit because, using data analytics, we determined that the high number of claims that MassHealth paid him greatly exceeded the number of claims it paid most of his peers, as illustrated below.



Methodology

To achieve our audit objectives, we reviewed applicable state and federal laws, rules, and regulations; MassHealth provider bulletins and transmittal letters; the American Medical Association’s 2013 *Current Procedural Terminology, Professional Edition*; and the November 2014 *Evaluation and Management Services Guide* by the federal Department of Health and Human Services’ Centers for Medicare and Medicaid Services (CMS).

We also reviewed studies by the federal Department of Health and Human Services’ Office of Inspector General (OIG) on E/M services: a May 1996 OIG Special Fraud Alert bulletin and a November 2014 CMS publication, “Complying with Medical Record Documentation Requirements.” We reviewed these

documents to gain an understanding of fraudulent healthcare billing practices and improper billing activities, including ghost billings⁸ and gang visits.⁹

We interviewed Dr. Poor's former and current NPs and his current PA to gain an understanding of their respective job functions and expectations. We contacted Dr. Poor's tax preparer to validate personnel employed by Dr. Poor during the audit period. Additionally, we observed Dr. Poor's PA while she performed E/M services for members at a selected nursing facility.

We gained an understanding of, and evaluated, internal controls that we deemed significant to our audit objectives.

We contacted the Department of Public Health (DPH) Bureau of Healthcare Safety and Quality's director of Healthcare Integration to identify the requirements for physicians who supervise NPs and PAs engaged in prescriptive practices and to gain an understanding of the services¹⁰ DPH requires nursing facilities to provide to MassHealth members daily or as needed.

We worked with OSA's Bureau of Special Investigations and the federal Department of Homeland Security to identify the dates Dr. Poor traveled out of the United States. Several dates provided were outside our audit period, so we expanded the audit period to include all travel dates provided by the Department of Homeland Security.

We collaborated with OSA's Information Technology Unit to identify the unique United States Drug Enforcement Administration number¹¹ assigned to Dr. Poor's NPs and PA. We also discussed with Safeguard Services, LLC¹² an audit it had recently conducted on certain Medicare claims billed by Dr. Poor.

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8. According to the OIG Special Fraud Alert bulletin, ghost billings occur when a healthcare provider bills an insurance carrier for a procedure that never took place.
 9. According to the OIG Special Fraud Alert bulletin, gang visits occur when a healthcare provider bills an insurance carrier for seeing large numbers of residents in a single day and provides services that are medically unnecessary, of insufficient duration, or not consistent with the service billed.
 10. These services include (1) skilled services, such as observing and evaluating unstable medical conditions and administering oxygen; (2) assistance with activities of daily living, such as bathing, eating, and dressing; and (3) nursing services, such as providing and monitoring prescriptions, monitoring vital signs, and assisting with behavioral issues.
 11. Healthcare providers are required to have this type of number to prescribe controlled substances.
 12. SafeGuard Services, LLC is a recovery audit contractor hired by CMS to identify and recover improper payments from healthcare providers.

We queried E/M claims paid to Dr. Poor during the audit period¹³ from MassHealth's Medicaid Management Information System (MMIS). We reviewed a separate OSA audit (2015-8020-140) that tested information-system controls in MMIS by reviewing existing information about security policies for data, testing selected information-system controls, and interviewing knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all Dr. Poor's claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for dates outside valid time periods, and (4) tracing supporting documentation to claim data stored in MMIS. Based on the procedures performed, we determined that the data obtained were sufficiently reliable for the purposes of this report.

We performed two probe tests using claims paid in January 2015 to identify instances of potential improper billing by Dr. Poor. Specifically, we compared Dr. Poor's billing sheets to amounts paid by MassHealth to determine whether he (1) billed and was paid for services not performed and (2) billed for NP and PA services without modifier codes. Based on the results of these tests, we expanded our audit procedures and conducted the following tests using statistical sampling to project our findings to the entire population:

- We selected a random statistical sample, with a 95% confidence level, of 176 claims out of the population of 23,541¹⁴ claims to determine whether Dr. Poor properly billed for E/M services provided by his NPs and PA using the required modifiers. To complete this analysis, we compared paid claims to billing sheets maintained by Dr. Poor and to members' medical records at 12 nursing facilities.
- We selected a random statistical sample, with a 95% confidence level, of 240 claims out of the population of 36,413¹⁵ claims to determine whether Dr. Poor billed for E/M services that were not provided, i.e., ghost services. To complete this analysis, we compared paid claims to billing sheets maintained by Dr. Poor and to members' medical records¹⁶ at 14 nursing facilities.

We tested claims for 57 members¹⁷ who received six or more E/M services in any given month during the audit period to determine whether Dr. Poor complied with the MassHealth requirement of providing one visit per member per month except for emergencies. To complete our review, we examined members' medical records at seven nursing facilities to determine whether services that exceeded one

13. This included the expanded audit period while Dr. Poor was out of the United States.

14. This population excludes claims paid by MassHealth that were billed using the required modifier code.

15. This population includes all claims paid by MassHealth.

16. These records included progress notes, physician's orders, and physician's interim and telephone orders.

17. These members were covered exclusively by MassHealth.

visit per member per month were related to emergencies. In addition, for 242 members¹⁸ who received between two and five E/M visits in any given month during the audit period, we performed detailed analytics using MMIS claim data to determine whether the members had experienced emergencies warranting the additional E/M services provided by Dr. Poor and his staff.

To follow up on the above testing, we also contacted six nursing facilities to discuss Dr. Poor's roles and responsibilities at these facilities, including the level and frequency of E/M services he provided to members residing there.

Because MassHealth's service rates vary depending on where a member resides and the level of service provided, we analyzed all claims to determine whether Dr. Poor used appropriate procedure codes for E/M services he and his staff provided to members residing in rest homes.

During our examination of sampled members' medical records, we determined whether those records were legible and met MassHealth's recordkeeping requirements.

Our calculations of overpayments in our findings may not be mutually exclusive and do not take into account the potential for overlap between findings. However, we eliminated any potential double-counting of overpayments when recommending amounts MassHealth should consider in collaborating with Dr. Poor to recover overpayments.

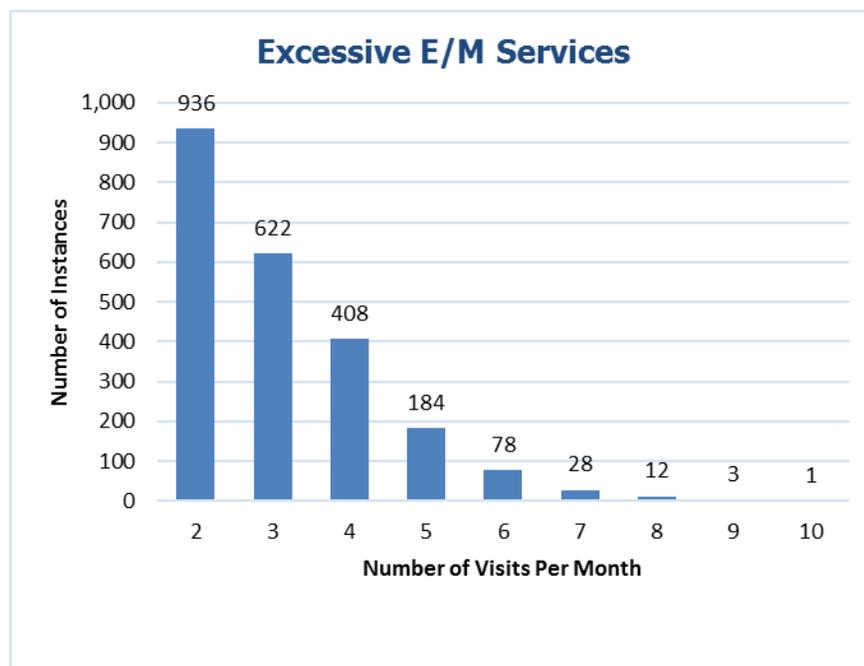
18. These members were also covered exclusively by MassHealth.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. Dr. Poor provided \$176,730 of excessive evaluation and management services for members residing in long-term-care facilities.

Dr. Hooshang D. Poor billed MassHealth for excessive evaluation and management (E/M) services provided to members residing in long-term-care facilities, including nursing facilities and rest homes. Dr. Poor routinely visited members multiple times each month; in one instance he visited a member 10 times in a single month. During these visits, Dr. Poor and his staff monitored members' chronic conditions, reviewed laboratory test results, and provided other non-emergency services. In most instances, these services were not predicated on medical emergencies, and therefore, Dr. Poor's claims for them are unallowable. Based on our analyses,¹⁹ Dr. Poor was improperly paid \$176,730 for E/M services during the audit period.

The chart below details the excessive E/M services provided by Dr. Poor during the audit period. It shows the number of instances of various numbers of visits per month. For example, there were 78 instances in which Dr. Poor visited a member six times in a month.



19. We examined claims for members with only MassHealth coverage to test compliance with Section 433.416(B) of Title 130 of the Code of Massachusetts Regulations, which allows only one visit per member per month, except in an emergency.

We concluded that Dr. Poor provided excessive E/M services to members residing in long-term care facilities based on the following factors:

- Nurse practitioner (NP) and physician assistant (PA) notations found in members' medical records stated "no acute events," "patient has no complaints," "no acute distress," "no complaints/concerns/questions," "feels good today," "doing well," and "stable." These notations indicate that these E/M services were non-emergency and routine.
- Our analyses of claim data found only a few instances in which members received emergency transportation to a hospital or urgent-care facility within the seven days before or after Dr. Poor's visit. This further indicates that these members were not experiencing medical emergencies around the time of Dr. Poor's visits.
- Nursing-facility administrators and staff members indicated that Dr. Poor routinely visited members who were not experiencing medical emergencies and, in their opinion, unnecessarily treated the members' chronic conditions, which they stated was the facility's responsibility.
- A rest-home administrator stated that Dr. Poor's weekly, biweekly, and monthly visits to members living in rest homes were not necessary.
- Dr. Poor acknowledged to the audit team that he prepared weekly schedules to visit nursing facilities. Those weekly visits allowed him and his NPs and PA to perform routine patient services including wellness checks, medical-record reviews, and follow-up care for non-emergency conditions.

Authoritative Guidance

Section 433.416(B) of Title 130 of the Code of Massachusetts Regulations (CMR) states,

Payment for a visit by a physician to members in nursing facilities or rest homes is limited to one visit per member per month, except in an emergency.

Reasons for Noncompliance

Dr. Poor stated that he and his professional staff visited nursing facilities weekly and performed E/M services regardless of patients' medical coverage limitations. He stated that he was not familiar with MassHealth's E/M service limitations because he never saw the regulations that applied to these services.

Recommendations

1. Dr. Poor should only provide one E/M service per month for MassHealth members unless emergency services are warranted.

2. Dr. Poor should regularly review MassHealth regulations, bulletins, and updates to ensure future compliance with all coverage limitations.
3. Dr. Poor should collaborate with MassHealth to repay the \$176,730 that resulted from excessive E/M services.

Auditee's Response

If there is concern that patients were being seen more than clinically appropriate, then I would like to review these specific cases with a clinical adviser and clarify the management. Specifically, I would like to know which patients they believe I should have ignored, or whose care I should have postponed to another month. . . .

And please be advised that you will not be able to enforce me to check the patient's ability to pay or type of her/his insurance before visit to avoid visiting more than once a month.

MassHealth's Response

In September 2013, MassHealth initiated an audit of Dr. Hooshang Poor, prior to the initiation of the State Auditor's investigation in 2016. The MassHealth audit period, which covered dates of service from July 1, 2012 through June 30, 2013, overlaps with part of the State Auditor's review period, which covered dates of service from January 1, 2012 through September 30, 2015. Among other things, MassHealth identified numerous issues with Dr. Poor's billing practices during this audit; the issues identified by MassHealth are substantially similar to those identified by the State Auditor's report.

As a result of its audit findings, MassHealth prepared an initial notice of overpayment (INOP) to Dr. Poor in 2014. However, prior to issuance of the INOP and pursuant to federal regulations and its Memorandum of Understanding with the [Office of the Attorney General's Medicaid Fraud Division, or MFD], MassHealth notified the MFD of its intention to issue the INOP. MassHealth works collaboratively with MFD to combat Medicaid fraud by providers, and to avoid potentially impeding any ongoing law enforcement action, MassHealth coordinates with MFD before sending a notice of overpayment to a provider. MassHealth notified MFD on January 15, 2015, and MFD requested that MassHealth not issue the INOP to Dr. Poor at that time. MassHealth has complied with and continues to comply with MFD's request. . . .

Generally, MassHealth agrees with the Auditor's findings in this instance, and had already identified potential issues and had affirmatively forwarded those to the Attorney General's office for further investigation and action. . . .

1. *As noted above, MassHealth . . . agrees with [OSA]'s finding that Dr. Poor billed excessive E/M services for members residing in long-term-care facilities. MassHealth also agrees that Dr. Poor should only provide medically necessary services to MassHealth members.*
2. *MassHealth agrees that Dr. Poor should regularly review MassHealth regulations, bulletins, and updates to ensure future compliance with all coverage limitations.*

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3. *MassHealth agrees with [OSA]'s finding that Dr. Poor should repay the overpayment that resulted from excessive E/M services. MassHealth will coordinate with MFD and will take action when appropriate.*

Auditor's Reply

Our conclusions are not based on clinical determinations, nor do we suggest that Dr. Poor should postpone medically necessary care to his patients. Rather, we found that he billed MassHealth for excessive E/M services provided to members residing in long-term-care facilities. MassHealth regulations limit payments to physicians for members in such facilities to one visit per member per month, except in an emergency. Despite this limitation, Dr. Poor routinely visited members multiple times each month, and the documentation for the visits did not indicate that the patients were experiencing medical emergencies. Therefore, OSA appropriately questioned, as visits that might be excessive, improper, and unallowable, all visits that (1) were billed by Dr. Poor to MassHealth during the audit period, (2) exceeded one per member per month, and (3) were not indicated in the doctor's own medical records as medical emergencies. We do not dispute Dr. Poor's assertion that neither OSA nor MassHealth can require him "to check the patient's ability to pay or type of her/his insurance before visit to avoid visiting more than once a month." However, as a MassHealth service provider, Dr. Poor is required to be aware of, and adhere to, all MassHealth regulations, including 130 CMR 433.416(B), which establishes a reasonable limit on these visits except for emergency situations to prevent abuse by medical practitioners through excessive and unnecessary billings for these services.

Before we initiated our audit of Dr. Poor, OSA contacted MassHealth to make the agency aware of our intention to begin the audit. Further, during our audit, we contacted MFD to make MFD aware of the audit and to apprise its staff of the status of our audit work. Since, according to MassHealth, both its audit and our audit identified significant problems with Dr. Poor's billings, OSA will work with MassHealth and MFD to resolve these matters.

2. Dr. Poor improperly billed MassHealth for at least \$35,541 of E/M services performed by his NPs and PA.

Dr. Poor did not consistently use required modifier codes when billing MassHealth for E/M services provided by his NPs and PA. MassHealth pays for E/M services provided by NPs and PAs at lower rates than it pays when the same services are provided by physicians. Because Dr. Poor did not always submit claims using the required modifier codes, he was paid at the standard physician rate, which resulted in at least \$35,541 of overpayments during the audit period.

We examined the medical records for a random statistical sample of 176 out of 23,541 paid claims in order to project the potential problem to the population. Of these 176 claims, 92²⁰ (52.3%) represented services provided by NPs and a PA. However, Dr. Poor billed these services as if he had performed them.

Because we performed our audit testing by using statistical sampling, we were able to project this 52.3% error rate to the entire combined²¹ population of E/M claims paid for the audit period (totaling \$632,808), resulting in an estimated overpayment of at least \$35,541.²²

Authoritative Guidance

According to 101 CMR 317.04(3), providers must use modifier codes for services performed by NPs and PAs. For non-independent NPs, the regulation requires the SA modifier, which it defines as follows:

Nurse Practitioner rendering service in collaboration with a physician. (This modifier is to be applied to service codes billed by a physician which were performed by a non-independent nurse practitioner employed by the physician or group practice.) (An independent nurse practitioner billing under his/her own individual provider number should not use this modifier.)

For PAs, it requires the HN modifier, which it defines as follows:

Bachelor's Degree Level. (Use to indicate Physician Assistant) (This modifier is to be applied to service codes billed by a physician which were performed by a physician assistant employed by the physician or group practice.)

These modifier codes ensure that MassHealth will pay the appropriate, lower rate for eligible licensed NP and PA services, which 101 CMR 317.03(4) establishes as 85% of the physician fee in 101 CMR 317.04(4) and MassHealth All Provider Bulletin 230 (December 2012).

Additionally, 130 CMR 450.301 states,

(A) Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. . . .

(1) An individual practitioner may not claim payment under his or her own name and provider number for services actually provided by another individual, whether or not the individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

20. Seventy-one claims were improperly billed, and 21 claims did not have adequate documentation to identify who provided the services and were therefore considered improperly billed for the purpose of this test.

21. The sample population consisted of two strata: Medicaid-only claims and dual-eligible claims.

22. Using the data in our sample, we calculated an overpayment of \$39,546. We are 97.5% confident that the overpayment is at least \$35,541.

Reasons for Missing Modifier Codes

Dr. Poor did not have controls in place to ensure that his billing staff used required modifier codes when submitting claims for E/M services performed by the NPs or PA. In addition, the billing staff did not perform self-checks to ensure that their work was accurate and in accordance with MassHealth regulations. Members of the billing staff stated that they were aware that modifier codes were required in billing for services provided by NPs and PAs, but could not explain why these codes were not always used as required.

Additionally, Dr. Poor explained that his billing software had been dropping the modifier code during transmission of claims to insurance carriers and that this problem had subsequently been fixed. Despite this assertion, our review of the claims²³ he submitted appeared to indicate that he still submitted claims without the appropriate modifier codes after the date that he said the billing system had been repaired.

Recommendations

1. Dr. Poor should ensure that his billing staff submits claims with the required modifier codes for services performed by his NPs or his PA.
2. Dr. Poor should develop an oversight process to ensure that claims are reviewed before submission and that they include proper modifier codes.
3. Dr. Poor should collaborate with MassHealth to determine amounts²⁴ due the Commonwealth.

Auditee's Response

Dr. Poor did not provide comments on this finding.

MassHealth's Response

- 1. As noted above, MassHealth . . . agrees with [OSA]'s finding that Dr. Poor should ensure that his billing staff submits claims with the required modifier codes for services performed by his NPs or his PA.*

23. Our review consisted of performing data analytics using claims billed after our audit period, from April 1, 2016 through October 31, 2016. We found that Dr. Poor used modifier codes during this period for 8.8% of all the claims he billed. That percentage is substantially lower than the 52.3% that should have been billed with these modifier codes during our audit period based on our statistical sample. This indicates that he still may not always be appropriately using modifier codes.

24. The overpayment amount calculated in this audit finding and the other findings in this report are not mutually exclusive. Therefore, we have not recommended that MassHealth recover \$35,541. Instead, Dr. Poor should collaborate with MassHealth to review all his claims, excluding the overpayments identified in Findings 1, 3, 4, 6, and 7, and determine the amounts that are due because of his inconsistent use of modifier codes.

2. *MassHealth agrees that Dr. Poor should develop an oversight process to ensure that claims are reviewed before submission and include proper modifier codes.*
3. *MassHealth agrees with [OSA]'s finding that Dr. Poor should repay MassHealth for overpayments resulting from claims submitted without appropriate modifiers. MassHealth will coordinate with MFD and will take action when appropriate.*

3. Dr. Poor billed using the wrong procedure codes for \$12,608 of services provided to members in rest homes.

Dr. Poor improperly billed MassHealth for services provided to members residing in rest homes. Instead of billing for E/M services using procedure codes designated for members residing in rest homes, he billed using procedure codes exclusively designated for nursing facilities.

We analyzed the places of service for all members Dr. Poor treated and determined that 31 members lived in rest homes during the audit period. He submitted 423 claims for those members, but billed using codes designated for services provided in nursing facilities. As a result, he received \$12,608 of improper payments from MassHealth.

Authoritative Guidance

According to 101 CMR 317.02, procedure codes are not interchangeable because the levels of complexity for services provided in rest homes differ from those provided in nursing facilities and therefore require different payment rates. In 101 CMR 317.04(4), MassHealth has promulgated a fee schedule for E/M services provided in rest homes and nursing facilities.

Reasons for Questionable Payments

Dr. Poor stated that using the incorrect procedure codes was an oversight and that he would bill for E/M services using proper procedure codes in the future.

Recommendations

1. Dr. Poor should use proper procedure codes when billing for services provided to members in rest homes.
2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$10,833²⁵ that resulted from the use of improper procedure codes for services provided to members in rest homes.

25. This amount excludes all overpayments identified in Findings 1, 4, and 7.

Auditee's Response

In response to this finding, Dr. Poor gave us a written statement prepared by a member of his billing staff, who said she had contacted MassHealth's provider helpdesk on this matter on March 27, 2017. According to the billing staff member, the MassHealth representative said "that the procedure codes were the same for place of services 31, and 32 [and] the reimbursement was the same for each place of service code."

MassHealth's Response

1. *As noted above, MassHealth . . . agrees with [OSA]'s finding that Dr. Poor should use proper procedure codes when billing for services provided to members in rest homes.*
2. *MassHealth agrees that Dr. Poor should repay the overpayment that resulted from the use of improper procedure codes for services provided to members in rest homes.*
3. *MassHealth agrees with [OSA]'s recommendation that Dr. Poor should repay MassHealth any amounts due because of his incorrect use of procedure codes. MassHealth will coordinate with MFD and will take action when appropriate.*

Auditor's Reply

The response Dr. Poor's billing staff received from MassHealth did not address our concerns about using the wrong procedure codes for E/M are provided to members residing in rest homes. Instead, the conversation between the billing staff and the MassHealth helpdesk was related to place-of-service codes²⁶ for skilled nursing facilities (31) and nursing facilities (32). It did not address the procedure codes that should be billed when services are provided in rest homes. Moreover, despite any information Dr. Poor's staff may have received from MassHealth's helpdesk, MassHealth's official response agrees with our findings and recommendations on this issue. It is important that providers use the correct E/M procedure codes for the place where the E/M services are provided to ensure that they receive proper payment.

4. Dr. Poor billed for \$15,477 of E/M services performed while he was outside the United States.

Dr. Poor was paid for E/M services that were performed when he was outside the United States. Between May 14, 2010 and April 24, 2016, he took 10 trips abroad. He billed 1,079 claims for \$15,477 in

26. This code identifies where medical services were provided. Unlike a procedure code, which is used to determine the amount to be paid, it does not reflect the medical, surgical, and other procedures or services provided.

E/M services that took place during the dates of those trips. These 1,079 claims represent an average of 86% of the overall claims billed for those travel dates and exclude claims for services provided by Dr. Poor’s NPs and PA. Moreover, not only did he bill for these claims, but in several instances, his medical records (progress notes) indicated that he had provided services to members while he was out of the country.

The table below details Dr. Poor’s travel and the claims submitted for dates when he was traveling.

Services Provided While Dr. Poor Was out of the Country

Place Visited	Travel Dates	Total Claims	Amount Paid	Dr. Poor Claims	Amount Paid (Dr. Poor)	Percentage of Claims That Were for Dr. Poor
Amsterdam, Netherlands	5/14/10–5/25/10	99	\$ 702	84	\$ 430	85%
Paris, France	6/14/11–6/24/11	207	1,978	178	1,116	86%
Madrid, Spain	5/16/12–5/27/12	21	206	21	206	100%
Quito, Ecuador	2/3/13–2/13/13	254	7,978	244	7,795	96%
Paris, France	9/6/13–9/16/13	130	3,728	115	2,907	88%
Zurich, Switzerland	7/30/14–8/8/14	162	3,958	129	2,107	80%
Frankfurt, Germany	5/19/15–5/28/15	213	2,075	174	696	82%
International Cruise, Canada/Alaska	6/11/15–6/21/15	82	706	68	134	83%
Punta Cana, Dominican Republic	11/5/15–11/10/15	2	76	1	22	50%
Peru, South America	4/16/16–4/24/16	79	610	65	64	82%
Total/Average		<u>1,249</u>	<u>\$ 22,017</u>	<u>1,079</u>	<u>\$ 15,477</u>	86%

Authoritative Guidance

According to 130 CMR 450.301(A), providers may only submit claims for medical services they actually performed:

Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. . . .

- An individual practitioner may not claim payment under his or her own name and provider number for services actually provided by another individual, whether or not the*

individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

In addition, 130 CMR 450.235(A) states that overpayments to providers include “services that were not actually provided.”

Finally, according to Section 3729(a)(1) of Title 31 of the United States Code, a false claim occurs when a person “knowingly presents, or causes to be presented, a false or fraudulent claim for payment or approval [or] knowingly makes, uses, or causes to be made or used, a false record or statement material to a false or fraudulent claim.”

Reasons for Questionable Payments

Dr. Poor stated that other physicians cover his patients while he travels. However, if that is the case, these physicians should have used their unique provider identification numbers to bill MassHealth.

Recommendations

1. Dr. Poor should only bill MassHealth for E/M services he provides to members. If he arranges for other physicians to provide medical services to his patients when he is not available (e.g., when he is out of the country), he should ensure that these physicians bill MassHealth directly for the services using their unique provider identification numbers so that MassHealth can be certain that they are approved Medicaid providers who are qualified to provide the services.
2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$13,673²⁷ that resulted from E/M services billed for dates when he was out of the country.

Auditee's Response

Your report claims that there was billing under my name as the provider while I was out of the country, but there are discrepancies between my own passport and the report you received from the Department of Homeland Security. . . . There are discrepancies in the dates you found and those in my itinerary and passport. My passport indicates that I was out of the country—2/10/13–1/16/13 [sic] in Ecuador, and 6/18/11–6/24/11 in France.

MassHealth's Response

1. *As noted above, MassHealth . . . agrees with [OSA]'s finding that Dr. Poor should only bill MassHealth for E/M services he provides to members.*
2. *MassHealth agrees that Dr. Poor should collaborate with MassHealth to repay the overpayment that resulted from E/M services billed for dates when he was out of the country. MassHealth will coordinate with MFD and will take action when appropriate.*

27. This amount excludes all overpayments identified in Findings 1, 3, and 7.

Auditor's Reply

We obtained information about Dr. Poor's travel between May 14, 2010 and April 24, 2016 from the United States Department of Health and Human Services' Office of Inspector General, the United States Department of Homeland Security, and OSA's Bureau of Special Investigations, including passenger activity reports of travel dates and locations from each of his passport numbers. From this information, we determined that he was paid \$15,477 for E/M services that were performed when he was outside the United States. In his response, the doctor asserts that the dates of travel we obtained from those sources are inaccurate. Since he did not mention this to us when we discussed the matter with him during our audit, we cannot comment on the assertion. However, Dr. Poor will have the opportunity to collaborate with MassHealth on the amount of funds that he will need to reimburse MassHealth in relation to this issue.

5. Dr. Poor did not establish guidelines for his staff to follow when prescribing medications.

Dr. Poor did not collaborate with his NPs and PA to develop written prescriptive guidelines during the audit period. Such guidelines, if developed, would have ensured that the NPs and PA received proper guidance from Dr. Poor on matters related to prescribing, such as types and classes of medications to prescribe, medication limits, frequency of medication reviews, and managing medication emergencies. As a result of providing inaccurate information on their applications about having prescriptive guidelines in place, the NPs and PA received certification from the Department of Public Health (DPH) Drug Control Program. According to DPH's Drug Control Unit, this enabled them to register with, and receive authorization from, the federal Drug Enforcement Administration (DEA) to write prescriptions for controlled substances. Without prescriptive guidelines, the NPs and PA acted under their own authority and, in doing so, may have compromised members' health and wellbeing when writing the 657 prescriptions they wrote during the audit period. Of these prescriptions, 211 were for narcotics, including fentanyl, oxycodone, and methadone.

Authoritative Guidance

According to 244 CMR 4.07(2)(a), supervising physicians must collaborate with advanced practice registered nurses (APRNs), a group that includes NPs, to develop written guidelines for prescriptive practices:

An APRN engaged in prescriptive practice will do so in accordance with written guidelines mutually developed and agreed upon with the APRN and the physician supervising the APRN's prescriptive practice.

In addition, 244 CMR 4.07(2)(b)(8) states that prescriptive guidelines for NPs must "be kept on file in the workplace and be reviewed and re-executed every two years."

In the case of PAs, 263 CMR 5.07(4) requires the following:

All physician assistants shall issue prescriptions or medication orders in accordance with written guidelines governing the prescription of medication which are mutually developed and agreed upon by the physician assistant and his or her supervising physician(s). . . .

(c) All such guidelines must be in writing and must be signed by both the supervising physician and the physician assistant. Such guidelines shall be reviewed annually and dated and initialed by both the supervising physician and the physician assistant at the time of each such review. The physician assistant and his or her supervising physician may alter such guidelines at any time and any such changes shall be initiated by both parties and dated.

Reason for Noncompliance

Dr. Poor stated that he was unaware of the requirements to prepare written prescriptive guidelines with his NPs and PA. However, this contradicts information that he and his NPs and PA provided to DPH. NPs and PAs are required to annually file an Application for Massachusetts Controlled Substances Registration for Advanced Practice Nurses and Physician Assistants with DPH. On this form, the NPs and PA annually responded affirmatively to the question "Are there written prescriptive guidelines in place?" Additionally, Dr. Poor was required to sign and date these annual applications as their supervising physician.

Recommendations

1. Dr. Poor and his NPs and PA should immediately develop written prescriptive guidelines for his NPs and PA to follow when performing E/M services under his supervision.
2. Dr. Poor's NPs and PA should immediately cease all prescriptive practices until such guidelines have been developed.
3. Dr. Poor and his NPs and PA should immediately notify DPH and DEA of the inaccurate information they provided to these agencies while seeking authorization for the NPs and PA to prescribe controlled substances.

Auditee's Response

With his response, Dr. Poor provided a copy of a completed 2017 Application for Massachusetts Controlled Substances Registration for Advanced Practice Registered Nurses and Physician Assistants for his NP. This completed 2017 form was not properly completed: the question "Are there written prescriptive guidelines in place?" was left blank. He also gave us the following response:

A . . . copy of application for prescribing medicine has been requested. I have a copy of this form for [my] NP as I signed it recently. I will not be able to provide the form for [my] PA as she no longer works with me. She was a physician in [another country] and working with me as a PA.

MassHealth's Response

- 1. MassHealth agrees with [OSA]'s finding that Dr. Poor and his NP and PA should immediately develop written prescriptive guidelines for his NPs and PA to follow when performing E/M services under his supervision.*
- 2. MassHealth agrees that Dr. Poor's NPs and PA should immediately cease all prescriptive practices until such guidelines have been developed.*
- 3. MassHealth agrees with [OSA]'s finding [that] Dr. Poor and his NPs and PA should immediately notify the Department of Public Health and the US Drug Enforcement Administration of any inaccurate information they provided to these agencies while seeking authorization for the NPs and PA to prescribe controlled substances.*

Auditor's Reply

Although Dr. Poor indicated that he had filed an application for Massachusetts Controlled Substances Registration for Advanced Practice Registered Nurses and Physician Assistants for his NP, he did not indicate that he was taking any measures to address our recommendations on this matter. Most notably, he has yet to develop written prescriptive guidelines for his NP to follow when performing E/M services under his supervision. Therefore, we again recommend that he develop the required prescriptive guidelines and have his NP cease all prescriptive practices until such guidelines have been developed.

6. Dr. Poor did not maintain any supporting documentation for at least \$79,388 of E/M services.

Dr. Poor billed, and was paid for, at least \$79,388 of E/M services in cases where members' medical records did not contain any evidence to support that the services were actually provided.

We tested a random statistical sample of 240 out of 36,413 claims for E/M services purportedly provided by Dr. Poor to members at 14 nursing facilities. Our review of the related billing sheets and members' medical records showed that 34 claims (14%) were not supported by any documentation.

Because we performed our audit testing by using statistical sampling, we were able to project this 14% error rate to the entire population of E/M claims paid for the audit period (totaling \$746,322), resulting in an estimated overpayment of at least \$79,388.²⁸ We are 97.5% confident that the actual amount of the overpayment is greater than the lower confidence limit.

Authoritative Guidance

According to 130 CMR 450.205(A), providers must maintain adequate supporting documentation for claimed services:

The MassHealth agency will not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of services payable under MassHealth. All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided.

Reasons for Noncompliance

Dr. Poor stated that he documents all E/M services provided in each member's medical record. He also stated that since members' medical records are maintained at the nursing facilities where they live, he is not responsible for missing documentation. However, Dr. Poor is ultimately responsible for maintaining adequate documentation to support all his billings to MassHealth. He declined to meet us at one of the nursing facilities where he provided some of the services in question to jointly look for documentation that the services were provided.

Recommendations

1. Dr. Poor should ensure that documentation is maintained to support services claimed.
2. Dr. Poor should collaborate with MassHealth to determine amounts²⁹ due the Commonwealth.

28. We projected a statistical point estimate overpayment of \$111,753. We are 97.5% confident that the overpayment is at least \$79,388.

29. The overpayment amount calculated in this audit finding and those of other findings in this report are not mutually exclusive. Therefore, we have not recommended that MassHealth recover \$79,388. Instead, Dr. Poor should collaborate with MassHealth to review all his claims, excluding the overpayments identified in Findings 1, 2, 3, 4, and 7, and determine amounts that are due because of undocumented E/M services.

Auditee's Response

I would like to see the specific reports from the clinical adviser that stated that notes . . . lacked supporting documents.

MassHealth's Response

- 1. As noted above, MassHealth previously identified similar issues and agrees with [OSA]'s finding that Dr. Poor should ensure that appropriate documentation is maintained to support services claimed.*
- 2. MassHealth agrees with the OSA finding that Dr. Poor should repay MassHealth amounts due the Commonwealth. MassHealth will coordinate with MFD and will take action when appropriate.*

Auditor's Reply

OSA did not need a clinical advisor to assess the adequacy of the clinical notes that Dr. Poor maintained. According to 130 CMR 450.205(A), "All providers must keep such records, including medical records, as are necessary to disclose fully the extent and medical necessity of services provided." As noted above, for a certain percentage of Dr. Poor's medical records that we reviewed, there was no evidence to support that the services billed were actually provided, and therefore no clinical interpretation was necessary. During our audit, OSA offered to review this matter with Dr. Poor at one of the nursing facilities where this problem occurred, but he declined.

7. Dr. Poor did not prepare legible documentation to support at least \$24,501 of E/M services.

While reviewing member medical records at 15 nursing facilities, we found that Dr. Poor did not prepare legible supporting documentation to validate E/M services provided to members. Specifically, we reviewed the documentation to support 822 claims for E/M services. In 455 instances (55%), the documentation prepared by Dr. Poor was, in OSA's opinion, illegible. This problem resulted in the doctor receiving at least \$24,501³⁰ of questionable payments.

30. While performing other audit procedures, we identified the problem of illegible records. The error we are reporting is not based on a statistical sample; therefore, we did not project the errors to the population of all E/M claims.

Authoritative Guidance

According to 130 CMR 450.205(D), providers must prepare legible documentation to support E/M services provided to members: "All records . . . must, at a minimum, **be legible** and comply with generally accepted standards for recordkeeping." (Emphasis added.)

Reasons for Noncompliance

Dr. Poor believes that his penmanship was legible and that he met MassHealth's recordkeeping requirements. However, we believe that examples of his progress notes illustrate that his handwriting is not always legible; when it is illegible, it does not constitute adequate records to support his claims for E/M services.

Recommendations

1. Dr. Poor should ensure that his handwriting is legible when recording E/M services in members' medical records. He could also consider alternative ways to document his services, such as dictated or typewritten progress notes.
2. Dr. Poor should collaborate with MassHealth to repay the overpayment of \$7,619³¹ that was related to illegible service documentation.

Auditee's Response

I would like to see the specific reports from the clinical adviser that stated that notes were deemed illegible.

MassHealth's Response

1. *As noted above, MassHealth previously identified similar issues and agrees with [OSA]'s finding that Dr. Poor should ensure that his handwriting is legible when recording E/M services in members' medical records.*
2. *MassHealth agrees with the OSA finding that Dr. Poor should repay MassHealth for overpayments resulting from illegible documentation. MassHealth will coordinate with MFD and will take action when appropriate.*

Auditor's Reply

OSA did not need a clinical advisor to assess the legibility of Dr. Poor's medical notes. During our review of his documentation supporting E/M services, OSA determined that it was not possible to read and understand his medical/progress notes, in contrast to those of his clinical staff members, who prepared

31. This amount excludes all overpayments already identified in Findings 1, 3, and 4.

legible handwritten and/or typed progress notes. According to MassHealth regulations, all documentation supporting medical services provided must be legible. If documentation is not legible, then it is not sufficient for proper billing.