Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
*Making government work better*

Official Audit Report – Issued September 24, 2019

# Office of Medicaid (MassHealth)—Review of Claims Submitted by Dr. Frederick Wagner Jr.

For the period January 1, 2014 through December 31, 2017

Commonwealth of Massachusetts
Office of the State Auditor
Suzanne M. Bump
*Making government work better*

September 24, 2019

Dr. Frederick Wagner Jr.
101 Kimball Road
Carlisle, MA 01741

Dear Dr. Wagner:

I am pleased to provide you with my office's performance audit of Medicaid claims you have submitted to MassHealth. This report details the audit objective, scope, methodology, findings, and recommendations for the audit period, January 1, 2014 through December 31, 2017. 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 for the cooperation and assistance you provided to my staff during the audit.

Sincerely,

Suzanne M. Bump
Auditor of the Commonwealth

cc: Marylou Sudders, Secretary, Executive Office of Health and Human Services
Daniel Tsai, Assistant Secretary and Director, Office of Medicaid
Alda Rego, Assistant Secretary for Administration and Finance, Executive Office of Health and Human Services
Susan Harrison, Director of Program Integrity, Office of Medicaid
Joan Senatore, Director of Compliance, Office of Medicaid
Teresa Reynolds, Executive Assistant to Secretary Sudders

# TABLE OF CONTENTS

# LIST OF ABBREVIATIONS

| | |
|---|---|
| CMR | Code of Massachusetts Regulations |
| CMS | Centers for Medicare & Medicaid Services |
| CPT Codebook | *Current Procedural Terminology Professional Edition 2014* |
| E/M | evaluation and management |
| MassCor | Massachusetts Correctional Industries |
| MMIS | Medicaid Management Information System |
| OSA | Office of the State Auditor |

# 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 Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance. 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 & Medicaid Services, within the US Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

OSA has conducted an audit of MassHealth claims for vision care services paid to Dr. Frederick Wagner Jr. for the period January 1, 2014 through December 31, 2017. During this period, MassHealth paid Dr. Wagner approximately $1,045,556 to provide vision care services for 3,741 MassHealth members. The purpose of this audit was to determine whether Dr. Wagner properly billed MassHealth for these services, including traveling to nursing facilities and ordering and dispensing eyeglasses for MassHealth members.

The audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. Several of our previously issued audit reports disclosed significant weaknesses in MassHealth's claim-processing system and improper billing practices by MassHealth providers, which resulted in millions of dollars in potentially improper payments. As with any government program, public confidence is essential to the success and continued support of the state's Medicaid program.

Below is a summary of our findings and recommendations, with links to each page listed. In addition to our findings, we identified an issue we believe warrants MassHealth's attention, which we have disclosed in the "Other Matters" section of this report.

| | |
|---|---|
| **Finding 1**<br>**Page 11** | Dr. Wagner had inadequate documentation to support at least $301,936 in vision care claims. |
| **Recommendations**<br>**Page 14** | 1. Dr. Wagner should collaborate with MassHealth to repay the $301,936 discussed in this finding.<br><br>2. Dr. Wagner should document the chief complaint or reasons for the services provided in members' medical records.<br><br>3. Dr. Wagner should properly document the required patient medical history, as well as details about the exam and medical decision-making, when billing for vision care using evaluation and management codes; otherwise, he should bill using eye exam codes.<br><br>4. Dr. Wagner should submit claims to MassHealth using the actual dates on which the vision care is provided to members. |
| **Finding 2**<br>**Page 20** | Dr. Wagner submitted improper claims for eyeglass dispensing and fitting services totaling $8,176. |
| **Recommendations**<br>**Page 21** | 1. Dr. Wagner should collaborate with MassHealth to repay the $8,176 discussed in this finding.<br><br>2. Dr. Wagner should only submit claims for dispensing services after he fits the new eyeglasses to a MassHealth member.<br><br>3. Dr. Wagner should maintain proper documentation for dispensing services, including documenting a consultation with the nursing facility, measurements, and evidence that he fitted the eyeglasses to the individual. |

# OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services, through the Division of Medical Assistance, administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services for approximately 1.9 million eligible low- and moderate-income children, families, seniors, and people with disabilities annually. In fiscal year 2017, MassHealth paid healthcare providers more than $15 billion, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

According to Section 402 of Title 130 of the Code of Massachusetts Regulations, MassHealth pays for vision care provided to eligible MassHealth members. Dr. Wagner is an optometrist and sole business proprietor who lists his home as his office. He is a certified MassHealth provider who travels to nursing facilities across the state. Dr. Wagner received a total of $1,045,556 for vision care provided to MassHealth members during the audit period, as detailed below.

## MassHealth Payments Received by Dr. Wagner

| Calendar Year | Number of Members Served | Number of Claims | MassHealth Payments |
|---|---|---|---|
| **2014** | 1,777 | 9,303 | $ 250,634 |
| **2015** | 1,755 | 9,086 | 244,004 |
| **2016** | 1,873 | 9,510 | 292,392 |
| **2017** | 1,755 | 7,486 | 258,526 |
| **Total** | 7,160* | 35,385 | $ 1,045,556 |

* The unduplicated total number of members served is 3,741.

## Vision Care

The vision care provided by opticians, optometrists, and ophthalmologists[1] to eligible MassHealth members includes performing eye exams; diagnosing, treating, and managing disorders of the eye and the associated structures; and fitting and ordering eyewear. MassHealth instructs providers to use specific procedure codes to bill for vision care services, such as dispensing services, eyeglass repairs,

1. Opticians specialize in filling lens prescriptions, helping patients choose eyeglasses, and fitting eyeglasses. Optometrists perform vision examinations, fit and prescribe contact lenses and eyeglasses, diagnose and treat eye-related conditions, and prescribe some medications. Ophthalmologists can perform all the same services as optometrists as well as eye-related surgeries.

comprehensive eye services, intermediate services, consultations, and problem-specific eye examinations.

**Dispensing services:** The following are considered dispensing services: assisting a member in choosing appropriate frames, taking necessary measurements for ordering lenses and frames from the optical supplier, fitting the completed eyeglasses to the member, determining whether the member can see clearly through the eyeglasses, making necessary adjustments to the lenses and/or frames, and giving the member the eyeglasses. Dispensing also includes periodic readjustments and minor repairs of eyeglasses for the first six months from the date the member receives them.

**Repairs:** Members are entitled to have their broken eyeglasses repaired with replacement parts from the optical supplier. If the replacement parts are not available from the optical supplier, members are entitled to entire replacement frames.

**Eye examinations:** Each member is entitled to an eye examination once per 12-month period if they are under the age of 21 and once per 24-month period if they are 21 or older.

## Eye Examination Procedure Codes

| Procedure Code | Description |
|---|---|
| **92002** | Intermediate eye exam, new patient |
| **92004** | Comprehensive eye exam, new patient |
| **92012** | Intermediate eye exam, established patient |
| **92014** | Comprehensive eye exam, established patient |

**Comprehensive services:** These services include patient history documentation, general medical observation, external and ophthalmoscopic[2] examination, gross visual field evaluation, and basic sensorimotor[3] examination. The services always include the diagnosis and treatment of a new problem related to possible disease of the visual system, such as glaucoma, cataracts, or retinal disease. This level of service represents the most complex and thorough service of the entire visual system.

**Intermediate services:** These services include patient history documentation, general medical observation, external examination of the eyes and the accessory structures attached to the eyes, and

2. This routine examination of the back of the eye is conducted to check for disease or other eye problems.
3. This examination evaluates the range of motion of the eyes to determine whether they move together.

other diagnostic procedures as indicated. An example of this is an established patient with a known cataract not requiring comprehensive ophthalmological services, because the patient has already been diagnosed, but requiring a review of the visual system. This level of service is the least complex and is related to existing conditions or new diagnoses that may not be related to the original diagnosis.

**Consultation:** Before a provider dispenses eyeglasses to a MassHealth member living in a nursing facility, facility staff members and the dispensing optometrist or ophthalmologist must, in consultation, agree that the member would benefit from eyeglasses. This consultation must be documented in the member's medical record. In addition, a consultation should document the member's complaints and symptoms; the condition of the eye; and, if available, the name of the person who referred the member for eyeglasses.

**Problem-specific eye examinations:** A member is entitled to an eye examination more than once per eligibility period when there is a referral from his/her physician or when his/her medical record documents a condition or chronic disease such as blurred vision, headaches, pain, redness, infection, diabetes, hyperthyroidism, human immunodeficiency virus, or cataracts.

## Massachusetts Correctional Industries

MassHealth's optical supplier is Massachusetts Correctional Industries (MassCor). For eligible Medicaid members, optometrists and opticians use MassCor's online system to order eyeglass-related materials and services produced or provided by Massachusetts inmates, including eyeglass frames, eyeglass lenses, frame cases, lens tints and coatings, and replacement parts.

## Vision Care Billing and Documentation Requirements for Evaluation and Management Procedure Codes

During the audit period, MassHealth paid Dr. Wagner for 12,005 vision care services that he billed using medical service evaluation and management (E/M) procedure codes for members living in nursing facilities. Based on the American Medical Association's *Current Procedural Terminology Professional Edition 2014* (the CPT Codebook), E/M services are divided into broad categories such as office visits, hospital visits, and nursing facility visits. Most categories are divided into two or more subcategories. For example, for office visits, there are subcategories for new patients and established patients. These subcategories are further classified into levels of E/M services, broken down by the nature of the work, the place of service, and the patient status. The more complex the service, the more the physician is

compensated; therefore, for complex services, more information must be documented. Medical providers must select the E/M procedure code that best represents the services rendered and ensure that the medical documentation for those services meets the requirements in the CPT Codebook.

During our audit period, Dr. Wagner billed the following E/M procedure codes more frequently than other E/M codes for vision care provided to MassHealth members living in nursing facilities.

## Top E/M Codes Billed by Dr. Wagner

| Procedure Code | Description in CPT Codebook |
|---|---|
| **99305** | Nursing facility visit for E/M for a new patient, which requires these three key components:<br>• a comprehensive history<br>• a comprehensive examination<br>• medical decision-making of moderate complexity<br>Typically, 35 minutes are spent at the bedside and on the patient's facility floor. |
| **99306** | Nursing facility visit for E/M for a new patient, which requires these three key components:<br>• a comprehensive history<br>• a comprehensive examination<br>• medical decision-making of high complexity<br>Typically, 45 minutes are spent at the bedside and on the patient's facility floor. |
| **99309** | Nursing facility visit for E/M for an established patient, which requires at least two of these three key components:<br>• a detailed interval history<br>• a detailed examination<br>• medical decision-making of moderate complexity<br>Typically, 25 minutes are spent at the bedside and on the patient's facility floor. |

When Dr. Wagner bills for medical services using certain E/M codes (the three shown above, as well as codes 99304, 99308, and 99310), he must ensure that his medical documentation of services rendered includes the following key components for comprehensive services:

| Comprehensive History | Comprehensive Examination | High-Complexity Decision-Making |
|---|---|---|
| • Chief complaint<br>• Extended history of present illness<br>• Complete review of systems performed<br>• Complete past, family, and/or social history | • Examination of all nine organs/systems<br>• Examination of every element of one organ or system | • Extensive number of diagnoses or management options<br>• Extensive amount and/or complexity of data to be reviewed<br>• High risk of significant complications, morbidity, and/or mortality |

# 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 certain claims by Dr. Frederick Wagner Jr. for the period July 1, 2014 through December 31, 2017.

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 our audit objective, indicating the question we intended our audit to answer, the conclusion we reached regarding our objective, and where the objective is discussed in the audit findings.

| Objective | Conclusion |
|---|---|
| 1. Did Dr. Wagner properly bill MassHealth for vision care services, including transportation and ordering and dispensing of eyewear, provided to its members? | **No; see Findings 1 and 2** |

## Methodology

We gained an understanding of the internal controls we deemed significant to our audit objective through inquiries. In addition, we performed the following procedures to obtain sufficient, appropriate audit evidence to address our audit objective.

We obtained data from MassHealth's Medicaid Management Information System (MMIS) for testing purposes. To test the reliability of these data, we relied on the work performed by OSA in a separate project that tested certain information system controls in MMIS. As part of that work, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific periods, and (5) tracing a sample of claims queried to source documents. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purposes of this report.

Effective April 6, 2018, MassHealth revised Chapter 402 of Title 130 of the Code of Massachusetts Regulations. For the purposes of our audit, OSA used the prior regulations that were in effect during the audit period, January 1, 2014 through December 31, 2017.

We selected a statistically random sample of 180 out of 35,385 paid vision care claims from the audit period, using an expected error rate of 50%, a desired precision of 15%, and a confidence level of 95%, to determine whether Dr. Wagner properly billed MassHealth for these services. The expected error rate is the anticipated rate of occurrence of the error of improper billing for services; 50% is the most conservative. Desired precision is a measure of how precise the actual error rate is. Confidence level is the numerical measure of how confident one can be that the sample results reflect the results that would have been obtained if the entire population had been tested. For this audit, we designed our sample so that we would be 95% confident that the actual error rate in the sample of 180 claims would be within a range of +/- 7.5%, or 15%, of the error in the population of 35,385 claims.

To determine whether Dr. Wagner properly billed MassHealth for vision care, we reviewed information in members' medical records for the sampled claims, including the date of service, the referring physician, the description of the chief complaint, and the other components required for evaluation and management (E/M) services. Also, we determined the number of members seen on each date of service in our sample, the number of facilities Dr. Wagner visited per day, and the hours he worked per day. Additionally, we ran queries from MMIS of all the services for each member in our sample to determine whether they also received vision care from other providers.

We performed the following additional procedures to verify that Dr. Wagner provided vision care to MassHealth members living in nursing facilities:

- We interviewed all 40 nursing facility medical directors and/or nursing directors from our sample of 180 claims about their processes for securing specialty vision care for nursing facility residents, including the services provided by Dr. Wagner. We also discussed the procedures Dr. Wagner followed when he arrived at a nursing facility, including who requested his services, what types and levels of services he provided, what types of equipment he brought, what types and amount of documentation he provided to the nursing facility, and how he dispensed eyeglasses (mailed or fitted to the member in person).
- For claims billed using procedure codes 99304, 99305, 99306, 99308, 99309, and 99310, we obtained and reviewed Dr. Wagner's supporting documentation from the facilities as well as the documentation that Dr. Wagner personally maintained. Our review consisted of examining whether Dr. Wagner properly documented the services provided, including whether his

documentation contained all of the required components for billing for higher-complexity E/M services in accordance with the Centers for Medicare & Medicaid Services' 1995 and 1997 *Documentation Guidelines for Evaluation and Management Services.*

We did not project the results of our tests related to the wrong dates of service billed (Finding 1) to the entire population because we determined that there was no monetary value to report.

To determine whether Dr. Wagner properly billed for eyeglass dispensing services, we performed the following tests:

- We compared all 1,987 paid dispensing service claims to orders for materials for the member associated with each claim to determine whether Dr. Wagner placed the material order with MassHealth's optical supplier, Massachusetts Correctional Industries, and we reviewed the timing of his submission of claims for dispensing services.
- We reviewed all member medical records provided by Dr. Wagner for our sample of 180 claims. Specifically, we looked for a documented consultation, measurements, and evidence that he fitted the eyeglasses to the member's face.
- We interviewed all 40 nursing facility medical directors and/or nursing directors from our sample of 180 claims and requested any related dispensing documentation from the facilities; we then compared it to the documentation Dr. Wagner maintained at his office.

In addition, we determined how many days Dr. Wagner traveled during the audit period and the number of facilities to which he traveled. We then determined how much he would have been paid if MassHealth had reimbursed him for non-emergency travel based on the number of facilities visited rather than the number of members who received services at each facility.

Finally, we worked with MassHealth by communicating our audit objectives, scope, and methodology. MassHealth had previously shared with OSA its concerns about Dr. Wagner's billing practices for the period January 1, 2014 through December 31, 2017.

# DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

## 1. Dr. Frederick Wagner Jr. had inadequate documentation to support at least $301,936 in vision care claims.

We identified documentation problems with 113 of 180 sampled MassHealth vision care claims that were paid to Dr. Frederick Wagner Jr. Specifically, 70[4] of these 113 claims lacked documentation indicating the medical reason (chief complaint) for the services provided. For 24[5] of the 113 claims, Dr. Wagner did not have the required documentation, including evidence of the appropriate type of patient history, examination, and medical decision-making, to substantiate billing using evaluation and management (E/M) codes 99304, 99305, 99306, 99308, 99309, and 99310. The absence of such documentation from MassHealth members' medical records not only raises concerns about the propriety of the related billings, but also can negatively affect continuity of care for the patient.

We extrapolated the test results related to the lack of a documented chief complaint to the entire population of paid vision care claims. Based on this testing, the actual error rate in our sample was 39%, and when projecting this to the total population of paid vision care claims, we are 95% confident that at least 32.8%, or $286,738, of Dr. Wagner's claims were overpaid. In addition, we extrapolated the test results related to improperly documented E/M services to the entire population of paid vision care claims. Based on this testing, the actual error rate in our sample was 13%, and when projecting this to the total population of paid vision care claims, we are 95% confident that at least 9%, or $15,198, of Dr. Wagner's claims were overpaid. In the Office of the State Auditor's (OSA's) opinion, the lower limit (the most conservative amount, which is $301,936, the sum of these two projections) is the minimum amount that Dr. Wagner must repay to the Commonwealth.

In addition, for 19[6] of the 113 claims, the dates of service billed did not match those in the members' medical records. If the date of service is wrong, members might incorrectly be denied services for which they are eligible, or a provider might be paid for services that were not eligible for reimbursement; such overpayments could have been allocated to Medicaid or other state benefit programs.

4. This number includes E/M codes 99304, 99305, 99306, 99308, 99309, and 99310 and transportation code T2002 because Dr. Wagner should not have billed for travel if there was not a reason for the visit.
5. This is the unduplicated number of claims billed with the wrong procedure code. The total number of such claims is 55.
6. This is the unduplicated number of claims billed with the wrong date of service. The total number of such claims is 60.

We also noted that 84% of our sampled members had diagnoses such as Alzheimer's disease, dementia, or schizophrenia. These vulnerable populations of MassHealth members are often poorly served and unable to advocate for themselves. Because these members might not be able to provide a complete verbal medical history, it is imperative that Dr. Wagner maintain adequate documentation in order to maintain continuity of care for them. In addition, the lack of documentation calls into question whether some of these services were actually necessary.

## Authoritative Guidance

The Centers for Medicare & Medicaid Services' (CMS's) 1997 *Documentation Guidelines for Evaluation and Management Services* defines a chief complaint as follows:

> *A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.*

These guidelines also require that medical records clearly reflect the patient's chief complaint.

MassHealth's regulations give specific details regarding what should be included in medical records. Section 433.409(D)(1) of Title 130 of the Code of Massachusetts Regulations (CMR) states,

> *Medical records . . . must include the reason for the visit and the data upon which the diagnostic impression or statement of the member's problem is based, and must be sufficient to justify any further diagnostic procedures, treatments, and recommendations for return visits or referrals. Specifically, these medical records must include, but may not be limited to, the following: . . .*
>
> *(e) the diagnosis or chief complaint.*

Further, according to 130 CMR 450.205(A), MassHealth requires providers to clearly document the medical reason (chief complaint) for the 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 to, or prescribed for, members.*

The American Medical Association's *Current Procedural Terminology Professional Edition 2014* and CMS's *Documentation Guidelines for Evaluation and Management Services* provide guidance on billing for E/M services: physicians should use the billing code that best reflects the level of service provided

based on three key components (the complexity of medical decision-making, type of exam, and patient history).

Regarding billing using E/M procedure codes, 101 CMR 315 provides a detailed description of each code. Below is a table indicating the E/M codes Dr. Wagner used.

| Procedure Code | New or Established Patient | Type of History/Exam | Complexity of Medical Decision-Making | Number of Components Needed | Minutes Spent with Patient |
|---|---|---|---|---|---|
| **99304** | New | Detailed or Comprehensive | Straightforward or Low | 3/3 | 25 |
| **99305** | New | Comprehensive | Moderate | 3/3 | 35 |
| **99306** | New | Comprehensive | High | 3/3 | 45 |
| **99308** | Established | Expanded | Low | 2/3 | 15 |
| **99309** | Established | Detailed | Moderate | 2/3 | 25 |
| **99310** | Established | Comprehensive | High | 2/3 | 35 |

Unacceptable billing practices are explained in 130 CMR 450.307:

> *(A) No provider may claim payment in a way that may result in payment that exceeds the maximum allowable amount payable for such service under the applicable payment method.*
>
> *(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden: . . .*
>
> *(2) overstating or misrepresenting services.*

Finally, according to 130 CMR 450.231(B), providers are required to bill MassHealth with the proper date of service, which the regulation defines as "the date on which a medical service is provided to a member."

## Reasons for Inadequate Documentation

Dr. Wagner stated that each component (including medical history, examination, and medical decision-making) is clearly included in his medical record. He said that he documents patients' medical history, the result of his medical exam, and his medical decision-making by recording his findings, recommendations, and/or proposed plan of care in their medical records. Although we did find some evidence of these components in members' medical records, it was not adequate to support the level of E/M service billed.

Dr. Wagner also stated that he begins filling out documentation for a MassHealth member's exam, including the date of service and other member information, before visiting the nursing facility. He said that if he does not perform the services as anticipated because the MassHealth member is ill or he does not have enough time, he returns on another day to perform the service but does not update the date of service in the documentation.

## Recommendations

1. Dr. Wagner should collaborate with MassHealth to repay the $301,936 discussed in this finding.
2. Dr. Wagner should document the chief complaint or reasons for the services provided in members' medical records.
3. Dr. Wagner should properly document the required patient medical history, as well as details about the exam and medical decision-making, when billing for vision care using E/M codes; otherwise, he should bill using eye exam codes.
4. Dr. Wagner should submit claims to MassHealth using the actual dates on which the vision care is provided to members.

## Auditee's Response

On Dr. Wagner's behalf, his legal counsel provided the following written response, dated June 28, 2019, and supporting documentation where indicated in the response:

> ***A. Dr. Wagner's Standard Medical Record Form Has Consistently Included Documentation of the "Chief Complaint"***
>
> *The [report] properly quotes the definition of the term "chief complaint" as set forth in the Current Procedural Terminology ("CPT") Code published by the American Medical Association. Specifically, the CPT Code states that the "chief complaint" is:*
>
> > *A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words. . . .*
>
> *The chief complaint is a short statement of the reason why the health care provider is seeing the patient on the date of the visit. Such documentation is included in every one of Dr. Wagner's medical records. . . . The medical records speak for themselves, and consistently document the reason why Dr. Wagner is seeing the patient. . . . Dr. Wagner has developed—and over time refined—a standard form of medical record that helps ensure that he captures all of the documentation requirements imposed by MassHealth and other payors. Since we received the spreadsheet identifying which claims the audit team believed lacked a chief complaint, Dr. Wagner has been able to locate the records for 27 of . . . 31 encounters, and we are attaching copies of those records. . . . On each of the attached records you will see that there [is] either a*

*reported problem, such as "decreased coordination," "blurred vision," "fall," and "accident right eye," or an underlying diagnosis, such as "cataracts," "diabetes," "high blood pressure," and "pseudoaphakia," that is documented as the medical reason for the visit.*

*As is plain from the very definition cited by the [report], the chief complaint does not need to be an actual "complaint" stated by the patient, and it is not uncommon for Dr. Wagner to see patients who do not have sufficient mental capacity to seek out his care. As the [report] notes, 84% of the patients in the audit sample "had a diagnosis such as Alzheimer's disease, dementia, or schizophrenia." . . . Such patients very often are unable to articulate their need for a visit with an optometrist. Accordingly, it is common that the reason for Dr. Wagner's visit is the patient's current eye diagnosis or a request from a physician or nurse at the facility that the patient's vision be evaluated. These all fall within the definition of chief complaint cited above. When a nurse or doctor's request is the basis for the visit, Dr. Wagner always documents who made the request. . . .*

***B. Lack of a "Chief Complaint" Is Not a Basis for MassHealth to Deny Payment***

*Although Dr. Wagner denies the conclusion that his medical records lack documentation of a chief complaint, it should be noted that MassHealth regulations do not mandate this for reimbursement. Instead, as the [report] itself states, MassHealth regulations require that the medical record include "the diagnosis **or** chief complaint." . . . Accordingly, MassHealth regulations are satisfied if Dr. Wagner documents the chief complaint **or** the pertinent medical diagnosis. . . . Dr. Wagner also routinely documents the patient's pertinent medical diagnoses.*

***C. Dr. Wagner's Documentation Supports the Evaluation and Management Codes He Used***

*Dr. Wagner's medical records appropriately document the required elements of medical history, examination, decision-making, and proposed plan of care. [Attached are examples.] Dr. Wagner is unable to more specifically respond to this finding . . . as the report does not discuss what the Auditor's Office found to be lacking for any particular patient. It does not even offer a single patient example, instead simply states that while the audit team found some of the needed components in the medical records, the documentation "was not adequate to support the level of E/M service billed." . . . Based on this broad, conclusory statement, it is unknowable what the audit team found lacking in any particular encounter.*

*It is also unclear what standard the audit team applied to determine whether the proper E/M code was used. In explaining its understanding of E/M coding . . . the [report] only lists the components required for a "comprehensive evaluation" and erroneously states that a comprehensive history, a comprehensive exam, and high-complexity decision-making are required for 99306, 99308, and 99310. . . . This is incorrect. . . .*

*Only 99306 requires a comprehensive history, a comprehensive exam, and high complexity decision-making. Moreover, all of the subsequent visit codes only require two of the three listed elements. For example, the 25 claims reviewed that were coded as 99309 only required documentation of two of the following three: (1) a detailed interval history, (2) a detailed exam, and (3) medical decision making of moderate complexity. Additionally, the [report] cites to codes*

*92002, 92004, 92012, and 92014 as codes available to Dr. Wagner. However, the Vision Care manual makes clear that these four codes are to be used by optometrists working from their own office. Dr. Wagner does not see his patients in his own office; he sees patients in nursing homes. . . .*

***D. The [Report] Erroneously Finds Transportation Claims Were Miscoded***

*After the Draft Report was provided, I requested the detail showing which specific claims the audit team had found to be miscoded and why. In response I received a summary spreadsheet that showed which of five potential "errors" each of the reviewed claims was found to have suffered. The chart includes 80 claims for transportation costs, which are coded as T2002. Of those 80 claims, the chart asserts that 39 fail to document a chief complaint and 67 fail to properly document the E/M code. This is nonsensical. The Vision Care Manual establishes that T2002 is properly billed "once per member per date of service for each member for whom the provider delivered or picked up eyeglasses, or to whom vision care services were provided out of the office." There is no requirement for a chief complaint or for an E/M code for T2002. Accordingly, none of the T2002 codes were erroneously paid on the basis that they lacked either a chief complaint or proper E/M coding.*

***E. Concerns Regarding Extrapolation Methodology***

*We have not received adequate information about the extrapolation methodology to determine whether it was properly carried out. As an initial matter, we were not provided any information detailing how the 180 sample claims were chosen, so we have no way to ensure that they were randomly selected. More importantly, given the errors noted above regarding the transportation claims, we are concerned that these were incorrectly included in the extrapolation leading to an exaggerated "error rate" for the consultations and examinations.*

## MassHealth's Response

*In this case, MassHealth previously identified a number of potential issues with this provider through an internal audit, and in May 2017, MassHealth referred the information it had gathered to the OSA so that the OSA could pursue the case further through this audit. MassHealth appreciates the OSA's collaboration in this matter and generally agrees with the OSA's findings, which are consistent with MassHealth's initial concerns. MassHealth will recoup overpayments from Dr. Wagner as a result of the audit findings. . . .*

1. *Consistent with MassHealth's identification of similar issues with Dr. Wagner and referral of this matter to the OSA, MassHealth agrees with the OSA's finding that Dr. Wagner should repay MassHealth the [$301,936] in identified overpayments.*

2. *MassHealth agrees with the OSA's finding that Dr. Wagner must document the chief complaint or reasons for the services provided in the members' medical records in accordance with 130 CMR 402.417 and 130 CMR 450.205.*

3. *MassHealth agrees with the OSA's finding that Dr. Wagner must properly document the required patient medical history in accordance with 130 CMR 402.417 and 130 CMR*

*450.205, as well as details about the exam and medical decision-making, when billing for vision care using evaluation and management codes.*

4. *MassHealth agrees with the OSA's finding that Dr. Wagner must submit claims to MassHealth using the actual dates on which the vision care is provided to members.*

## Auditor's Reply

As noted above, CMS guidelines define a chief complaint as follows:

> *A concise statement describing the symptom, problem, condition, diagnosis, physician recommended return, or other factor that is the reason for the encounter, usually stated in the patient's own words.*

Despite the assertion of Dr. Wagner's legal counsel, our review of a sample of Dr. Wagner's medical records showed that for 70 of the 180 claims we reviewed, the corresponding patient records did not contain the details necessary to clearly articulate the medical necessity of the services provided. Specifically, in each of these 70 instances, Dr. Wagner did not provide any type of statement or description that explains the reason he provided vision care services or the reason for the encounter, in either his or the member's own words. Rather, he simply listed the member's eye care history as the reason for the visit. We reviewed the documentation Dr. Wagner provided regarding the 27 patient encounters in which he asserts that he adequately documented the chief complaint and found that although he included keywords like "cataracts" or "high blood pressure," there is no documented description of why the services were necessary. As stated above, Dr. Wagner simply provided the member's vision care history as the reason for the visit. It is especially important to document the reason for a visit to a member in a nursing home, because such services are unallowable unless the nursing home specifically requests the doctor's services and that is clearly documented in the member's record at the facility.

Dr. Wagner's legal counsel also states that the chief complaint does not always have to be in the patient's words and that it was common for Dr. Wagner to receive a request from a physician or nurse at a facility to evaluate a patient's vision. For 59 out of the 70 claims where we found problems, Dr. Wagner did record a physician's or nurse's name on the documentation he provided to us; however, there was no documented reason that his services were requested. During our audit, OSA spoke with staff members at 40 of the nursing facilities Dr. Wagner visited, and staff members at the majority of these facilities told us that Dr. Wagner routinely came to their facility every six months unrequested and saw all of the Medicaid patients there. Further, officials at these facilities could not provide us with any

documentation to substantiate that the facilities had requested any of the services related to the claims in our sample; therefore, Dr. Wagner was not entitled to be paid by MassHealth for these services under 130 CMR 402.418(B),[7] which states the following about services performed outside a provider's office:

> *Nursing Facility. The MassHealth agency pays an optometrist or an ophthalmologist for performing an eye examination for a member residing in a nursing facility only when the optometrist or ophthalmologist is* ***specifically requested*** *to do so by the medical director, the nursing director, or responsible staff member at the facility, or by the member's personal physician.* ***The request must be documented in the member's record at the facility****.* [Emphasis added.]

Of particular concern is that some of the documentation Dr. Wagner provided to us did not match the documentation maintained by the facility. For example, in at least one instance, Dr. Wagner's documentation included the name of a referring physician, but the documentation maintained by the facility did not indicate that the member had been referred by a physician or other healthcare provider for vision care.

In addition, although Dr. Wagner's legal counsel asserts that "Lack of a 'Chief Complaint' Is Not a Basis for MassHealth to Deny Payment," 130 CMR 450.205(A) states that MassHealth will not pay a provider who does not document the reason for a service:

> *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 to, or prescribed for, members [i.e., their chief complaint].* [Emphasis added.]

Despite what Dr. Wagner's legal counsel asserts, our audit found that for 24 of the 180 sampled claims, Dr. Wagner did not have the required documentation to substantiate billing using E/M codes 99304, 99305, 99306, 99308, 99309, and 99310. Such documentation would have included evidence of the appropriate type of patient history, examination, and medical decision-making—the three components required to bill for E/M codes above low-complexity decision-making. We reviewed the provided documentation related to the 25 medical records billed under code 99309 and still conclude that they do not include a detailed interval history, a detailed exam, or medical decision-making of moderate complexity. The "Authoritative Guidance" section above presents the specific definitions of each E/M

7. The 2008 version of this regulation was in effect during the audit period but was subsequently revised. Quotations of the regulation throughout this report are from the 2008 version.

code, as documented in 101 CMR 315, for each code billed by Dr. Wagner during our audit period, and this was the standard that OSA used in conducting this analysis. This matches Dr. Wagner's response about the definition of E/M codes, specifically 99306. We reviewed the three medical records provided by Dr. Wagner related to the claims billed using codes 99309, 99305, and 99306, but they do not include the required documentation, including evidence of appropriate history, examination, or medical decision-making.

Although Dr. Wagner's legal counsel states that MassHealth does not allow the use of procedure codes 92002, 92004, 92012, and 92014 for nursing home visits, Dr. Wagner used those codes to bill for both Medicaid and Medicare services he provided to MassHealth members living in nursing homes during our audit period.

The audit sampling method OSA used to select and extrapolate our sample to obtain our results is clearly described in the "Audit Objectives, Scope, and Methodology" section of this report and is based on sound statistical sampling techniques. OSA will share this information with MassHealth and Dr. Wagner in the process of resolving the issues identified in this report. Dr. Wagner's legal counsel also questions our inclusion of transportation claims (service code T2002) in the extrapolation. OSA adjusted the overpayment to exclude transportation costs related to visits for which E/M codes were not properly documented. However, our overpayment calculation does include transportation claims related to visits that lacked a documented chief complaint, because Dr. Wagner should not have billed for travel if there was not a reason for the visit.

Lastly, Dr. Wagner's legal counsel questions the method of projecting the overpayment and whether the sample was in fact random. In conducting our sampling, OSA used RAT-STATS, a statistical sampling program created by the Office of Audit Services within the US Office of Inspector General in the US Department of Health and Human Services. This software determines a statistically appropriate sample, giving consideration to the total size of the population, expected error rate, confidence level, and desired precision, which are defined in the "Audit Objectives, Scope, and Methodology" section of this report. RAT-STATS is widely used by audit agencies and is recognized by MassHealth as the sampling software of choice for evaluating provider claims using a statistical sampling method. Once the sample size was determined, OSA used Audit Command Language, which is a data analysis software program recognized statewide, to select a random sample of claims paid to Dr. Wagner. OSA's sampling method was sound and consistent with applicable professional standards.

Dr. Wagner's legal counsel did not provide comments regarding Dr. Wagner billing for the wrong dates of service.

## 2. Dr. Wagner submitted improper claims for eyeglass dispensing and fitting services totaling $8,176.

Dr. Wagner submitted improper claims for $8,176 of eyeglass dispensing and fitting services. Incomplete patient medical records not only raise concerns about the propriety of the related billings, but also can negatively affect continuity of care for the patient.

We found problems with 226 claims, totaling $5,847, that Dr. Wagner submitted to MassHealth for dispensing eyeglasses to members during our audit period. Specifically, we reviewed 1,987 claims, totaling $81,114, and found that for 226 claims, Dr. Wagner received payments from MassHealth for dispensing services and associated transportation that could not have occurred because the eyeglasses were never ordered from the optical supplier.

In addition, for 19 of the 180 claims sampled (10.6%), Dr. Wagner did not maintain documentation indicating that he took measurements for eyeglasses, verified the lens characteristics, described the materials ordered and dispensed, fitted the eyeglasses to the members, and conducted the required consultations with nursing facility staff members. We extrapolated the test results related to improperly documented dispensing services to the entire population of paid vision care claims. Based on this testing, the actual error rate in our sample was 10%, and when projecting this to the total population of paid vision care claims, we are 95% confident that at least 7%, or $2,329, of these 180 claims were overpaid.

### Authoritative Guidance

According to 130 CMR 402.416, providers should submit claims for dispensing services only after the eyeglasses have been ordered from the optical supplier and properly fitted to the member (i.e., the doctor has ensured that the member can clearly see with the new glasses):

> *(D) In order for a dispensing practitioner to be paid for dispensing a prescription involving ophthalmic materials [including eyeglasses] and services available through the optical supplier, all such materials and services must be ordered from the optical supplier. . . .*
>
> *(E) In order to receive payment for dispensing an item, the dispensing practitioner must take all necessary measurements, verify lens characteristics, and adjust the completed appliance [eyeglasses] to the individual.*

Regarding the recordkeeping requirements for member vision care medical records, including dispensing services, 130 CMR 402.417(A) states,

> *The record must fully disclose all pertinent information about the services furnished, including the date of service, the dates on which materials were ordered and dispensed, and a description of materials ordered and dispensed (including the frame style and the manufacturer's name).*

In addition, according to 130 CMR 402.418(B), a consultation is required and must be documented in MassHealth members' records if eyeglasses are dispensed to them in nursing facilities:

> *If eyeglasses are to be dispensed to a member in the facility, the facility must document in the member's record that a consultation has occurred between the facility's staff member and the optometrist or ophthalmologist, and that they have determined that the member is able to benefit from eyeglasses.*

## Reasons for Improper Billing

Dr. Wagner stated that he must have mistakenly billed for dispensing services in the instances where no glasses were ordered. He said that he did have additional documentation regarding the questioned claims, but he did not provide us with that documentation.

## Recommendations

1. Dr. Wagner should collaborate with MassHealth to repay the $8,176 discussed in this finding.
2. Dr. Wagner should only submit claims for dispensing services after he fits the new eyeglasses to a MassHealth member.
3. Dr. Wagner should maintain proper documentation for dispensing services, including documenting a consultation with the nursing facility, measurements, and evidence that he fitted the eyeglasses to the individual.

## Auditee's Response

Dr. Wagner did not provide a response to this finding.

## MassHealth's Response

1. *. . . Consistent with MassHealth's identification of similar issues with Dr. Wagner and referral of this matter to the OSA, MassHealth agrees with the OSA's finding that Dr. Wagner should repay MassHealth the $8,176 in identified overpayments.*
2. *MassHealth agrees with the OSA's finding that Dr. Wagner may only submit claims for dispensing services for eyeglasses actually ordered from the optical supplier and in accordance with other applicable requirements of 130 CMR 402.416.*

3. *MassHealth agrees with the OSA's finding that Dr. Wagner should maintain proper documentation for dispensing services, including the documentation required in 130 CMR 402.417 and 418.*

# OTHER MATTERS

## Non-Emergency Transportation for Services out of the Office

Before June 2007, MassHealth regulations allowed providers who traveled to nursing facilities to bill for non-emergency transportation (service code T2002) once per facility per day, regardless of how many patients they saw. At that time, Section 402.418(D)(2) of Title 130 of the Code of Massachusetts Regulations (CMR) stated,

> *[MassHealth] will pay once per facility per date of service for the following services: the delivery and adjustment of eyeglasses; the pickup of broken eyeglasses; or the delivery of repaired eyeglasses.*

In 2007, MassHealth revised its non-emergency transportation regulation in Vision Care Bulletin 14:

> *Effective **June 1, 2007**, MassHealth pays for Service Code T2002 **once per member per date of service** for each member for whom the provider delivered or picked up eyeglasses, or to whom eye exam services were provided, in a nursing-home or home setting.*

Subsequently, on June 1, 2008, MassHealth revised 130 CMR 402.418(E)(2) as follows:

> *The MassHealth agency pays separately for transportation once per member per date of service for each member for whom the provider delivered or picked up eyeglasses, or to whom vision care services were provided out of the office.*

In the Office of the State Auditor's opinion, this amended regulation can create situations where MassHealth will incur unnecessary transportation costs, because it allows providers such as Dr. Frederick Wagner Jr. to bill for transportation costs for each member even if multiple members are treated at the same facility. For example, on September 24, 2014, Dr. Wagner billed for 27 non-emergency transportation claims for traveling to only two nursing facilities to provide vision care. For that date, Dr. Wagner was paid $250.02 for travel because he was allowed to bill once per member, for 27 trips, rather than once per location, which would have required MassHealth to pay him only $18.52, or $231.50 less.

During the audit period, Dr. Wagner submitted 14,149 claims, totaling $131,020, for non-emergency transportation. These claims represented Dr. Wagner traveling on 930 days to approximately 1,383 nursing facilities. If Dr. Wagner had billed non-emergency transportation by facility, he would have been paid $12,807, or $118,213 less. Therefore, we believe that MassHealth should consider amending this

transportation reimbursement regulation to provide for more fair and equitable reimbursement amounts.

## MassHealth's Response

*Prior to 2007, MassHealth paid once per nursing facility per day, and in 2007 MassHealth changed its methodology to a per-member per-day rate. The reason for the change was in fact to enhance program integrity because MassHealth's [Medicaid Management Information System] cannot enforce a per-facility-per-day methodology, but it can enforce a per-member-per-day methodology and includes edits to ensure that this limit is not exceeded. If MassHealth were to revert to the old methodology, it would have to address operational and systems challenges that may carry significant additional cost. Therefore, MassHealth does not concur that it would be more cost-effective to pay a per-facility-per-day rate.*