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

Official Audit Report – November 14, 2018

Office of Medicaid (MassHealth)—Review of Claims Submitted by Dr. Ileana Berman

For the period January 1, 2014 through December 31, 2016

Commonwealth of Massachusetts
Office of the State Auditor
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November 14, 2018

Dr. Ileana Berman
24 Park Street
Attleboro, MA 02703

Dear Dr. Berman:

I am pleased to provide this performance audit of claims that you submitted to the Office of Medicaid for services provided to MassHealth members. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2014 through December 31, 2016. 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 you for the cooperation and assistance 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

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare and Medicaid Services
CPT Codebook	*Current Procedural Terminology Professional Edition 2017*
DW	Data Warehouse
E/M	evaluation and management
GAO	Government Accountability Office
ITP	individual treatment plan
MMIS	Medicaid Management Information System
NECPAD	New England Center for Psychiatric and Addiction Disorders LLC
OSA	Office of the State Auditor
SUD	substance use disorder

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.

OSA has conducted an audit of MassHealth claims for substance use disorder (SUD) treatment paid to Dr. Ileana Berman for the period January 1, 2014 through December 31, 2016. During this period, MassHealth paid $1,880,875 to Dr. Berman for services provided to 1,443 MassHealth members. The purpose of this audit was to determine whether the SUD treatment that Dr. Berman provided to MassHealth members was properly supported by documentation in accordance with MassHealth regulations. During this audit, OSA worked with MassHealth's Program Integrity Unit to obtain an understanding of MassHealth's documentation requirements.

This audit was conducted as part of OSA's ongoing independent statutory oversight of the state's Medicaid program. As with any government program, public confidence is essential to the success and continued support of the state's Medicaid program. To ensure that claims for drug tests and screens are paid properly, MassHealth must have effective controls in place, including program regulations, operating policies and procedures, control activities, claim-processing system edits, monitoring activities, and enforcement actions.

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

Finding 1 **Page 10**	Dr. Berman did not properly notify MassHealth about significant changes in her business operations.
Recommendations **Page 12**	1. Dr. Berman should work with MassHealth to ensure that the information in her provider file is properly updated to reflect the changes in her organizational structure. 2. In the future, Dr. Berman should notify MassHealth of any changes that need to be made to her provider file within the timeframe prescribed by MassHealth regulations. 3. Dr. Berman should consult with MassHealth to determine whether her business, the New England Center for Psychiatric and Addiction Disorders LLC, is properly certified.

Finding 2 **Page 12**	Dr. Berman billed MassHealth for $76,641 in drug tests that she did not use to diagnose and treat patients.
Recommendations **Page 14**	1. Dr. Berman should review all drug test results she orders to ensure that MassHealth members comply with her treatment guidelines and should refer noncompliant members to other SUD treatment options. 2. Dr. Berman should only bill MassHealth for drug tests that she will use to diagnose and treat members and should properly document them in members' medical records.
Finding 3 **Page 16**	Dr. Berman had inadequate documentation to support billing MassHealth for at least $176,737 in evaluation and management (E/M) services.
Recommendations **Page 17**	1. Dr. Berman should repay MassHealth the $176,737 that we identified as lacking the required documentation. 2. In the future, Dr. Berman should maintain proper documentation to support services billed.
Finding 4 **Page 20**	Dr. Berman did not maintain any documentation to support $31,287 in E/M services and drug tests billed.
Recommendation **Page 21**	Dr. Berman should repay MassHealth for E/M services and drug tests that were not documented in members' medical records and maintain adequate documentation to support all services claimed.
Finding 5 **Page 22**	Dr. Berman improperly billed MassHealth $75,261 for unbundled drug tests.
Recommendation **Page 23**	1. Dr. Berman should cease ordering quantitative drug tests and qualitative drug screens for the same MassHealth member on the same day. 2. Dr. Berman should collaborate with MassHealth to determine the appropriate amount to be repaid, which should be at least $75,261.

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 to 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 $15.2 billion, of which approximately 50% was funded by the Commonwealth. Medicaid expenditures represent approximately 39% of the Commonwealth's total annual budget.

Dr. Ileana Berman, owner of the New England Center for Psychiatric and Addiction Disorders LLC (NECPAD), is a certified MassHealth provider. As a limited liability company, NECPAD is required to file annual reports with the Secretary of the Commonwealth. Dr. Berman has also been licensed by the Massachusetts Board of Registration in Medicine since 2001, and she provides care to MassHealth members primarily at her office in Attleboro. She has also received certification from the federal Substance Abuse and Mental Health Services Administration to prescribe buprenorphine[1] to patients who have developed opioid dependence.

NECPAD

NECPAD is a privately held company that employs nine staff members at its main office in Attleboro and offers mental health services and treatment of substance use disorders. NECPAD states in its 2015 and 2016 annual reports that it operates as an "outpatient substance and mental health treatment facility."

NECPAD's Controlled Substance Treatment Policies state,

> *The mission of our [Suboxone] Program is to maintain patients free from using opiates and other drugs of abuse . . . each patient maintained in the program will be continuously assessed for his or her readiness to be detoxified from Suboxone.*

The policy states that if patients experience challenges with decreasing their Suboxone dosages or discontinuing their prescriptions, they will be kept in the program indefinitely because there is a high risk of relapse.

1. Buprenorphine is a controlled substance used to treat addiction to narcotic pain relievers. It is sometimes sold under the brand name Suboxone.

The policy also puts great emphasis on the importance of drug testing for members who are prescribed Suboxone. It states that a drug test is a tool that helps to provide "clinically appropriate and cost-effective treatments in patients with [substance use disorders] and those who need controlled substances."

It further states that all drug tests are performed at NECPAD's on-site laboratory and that patients' drug test results are interpreted during their visits: "All patients in the Suboxone program need to wait for their results so that results are discussed with them at the time of the visit."

MassHealth Payments Received by Dr. Berman

The following table shows payments made by MassHealth to Dr. Berman each year of the audit period for services to MassHealth members:

Fiscal Year	Amount Paid	Number of Claims	Members Served
2014	$ 634,328	15,557	694
2015	613,172	20,505	748
2016	633,374	12,823	834
Total	$ 1,880,875*	48,885	

* Discrepancy in total is due to rounding.

Billing and Documentation for Evaluation and Management Procedure Codes

During the audit period, MassHealth paid Dr. Berman $860,417 for services that she billed using evaluation and management (E/M) codes. Based on the American Medical Association's *Current Procedural Terminology Professional Edition 2017* (the CPT Codebook), E/M services are divided into broad categories such as office visits, hospital visits, and domiciliary and rest home 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 more 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 of the CPT Codebook. During the audit period, Dr. Berman primarily (94% of the time) used E/M procedure code 99214 when billing for services provided to

MassHealth members. That code is described in Section 317.04 of Title 101 of the Code of Massachusetts Regulations[2] as follows:

> *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.*

When billing for medical services using procedure code 99214, physicians must ensure that their medical documentation of services rendered includes, at a minimum, all of the following key components:

Detailed History	Detailed Examination	Moderate-Complexity Decision-Making
• Chief complaint • Extended history of present illness • Extended review of systems performed • Pertinent past, family, and/or social history	• Examination of all nine organs/systems • Examination of every element of one organ or system	• Multiple diagnoses or management options • Moderate complexity of data to be reviewed • Moderate risk of significant complications, morbidity, and/or mortality

2. The quoted version of the regulation was in effect from August 2017 through March 2018.

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 claims submitted by Dr. Ileana Berman for the period January 1, 2014 through December 31, 2016.

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

Objective	Conclusion
1. Did Dr. Berman maintain proper documentation in members' files to support the services for which she billed MassHealth?	**No; see Findings 1, 2, 3, 4, and 5**

Methodology

We gained an understanding of the internal controls at Dr. Berman's practice, the New England Center for Psychiatric and Addiction Disorders LLC, and evaluated the design of controls over the billing process that we deemed significant to the audit objective.

To perform our audit procedures, we obtained data from MassHealth's Medicaid Management Information System (MMIS). 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, which is maintained by the Executive Office of Health and Human Services. As part of that project, OSA reviewed existing information about security policies for data, tested selected information-system controls, and interviewed knowledgeable agency officials about the data. During the current audit, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for valid data, (4) looking for dates outside specific time periods, (5) tracing

samples of claims stored in MassHealth's Data Warehouse[3] (DW) to source documents and MMIS, and (6) tracing a sample of prescription claims from the DW to Dr. Berman's electronic medical records. Based on these procedures, we determined that claim data obtained from MMIS were sufficiently reliable for the purposes of this report.

Out of 1,338 MassHealth members whom Dr. Berman drug tested during the audit period, we selected a judgmental sample of 25 members, based on an isolated risk factor: members who received the most drug tests. Specifically, we reviewed all documentation in the members' medical records for evaluation and management (E/M) services to determine whether Dr. Berman properly documented all the services she provided to them. Some of the documentation was maintained in hardcopy form and some was maintained in Dr. Berman's electronic medical record system, Isalus.[4] For drug tests, we reviewed the result reports in Dr. Berman's electronic laboratory system, LabTrak, and the members' medical records. Since this was not a statistical sample, we did not extrapolate any errors identified to the population of all Dr. Berman's claims.

For each of the 25 sampled members, we obtained the individual treatment plan (ITP) and reviewed it to ensure that it included the 11 elements required by Section 164 of Title 105 of the Code of Massachusetts Regulations (CMR), such as (1) a statement of the patient's strengths, needs, and abilities; (2) evidence of the patient's signature attesting agreement to the plan; (3) a list of services to be provided and goals to be achieved; (4) evidence that the ITP has been reviewed annually; and (5) a description of discharge plans and aftercare needs and goals.

For the period January 1, 2015 through December 31, 2016,[5] we selected a statistically random sample of 129 out of 8,882 E/M claims that Dr. Berman billed using procedure code 99214, using an expected error rate of 50%, a desired precision range of 15%, and a confidence level of 90%, to determine whether Dr. Berman properly documented the services provided. 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

3. The Data Warehouse is MassHealth's central repository for Medicaid member identification and claim payment information.
4. Dr. Berman began transitioning to this system in 2015.
5. Supporting documentation for services provided in 2014 could not always be located for other audit procedures we conducted during this audit. Therefore, we selected our sample from only 2015 and 2016 E/M claims billed using the 99214 code. As a result, when extrapolating the error to the population of claims, we did not consider missing documentation in our error rate regarding whether the key medical components were properly documented in members' medical records.

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 90% confident that the actual error rate in the sample of 129 claims would be within a range of +/– 7.5%, or 15%, of the error in the population of 8,882 claims.

To determine whether Dr. Berman properly documented the services for which she billed MassHealth, we reviewed members' medical records to determine whether they included all of the required key components for billing for an E/M service using procedure code 99214 in accordance with the Centers for Medicare and Medicaid Services' 1997 *Documentation Guidelines for Evaluation and Management Services*.

The statistical sampling method described above allows us to extrapolate the sampled findings to all the E/M claims billed using procedure code 99214 in 2015 and 2016. Based on our testing, the actual error rate in our sample was 100%, and when projecting this to the total population of paid claims, we are 90% confident that at least 92% (the lower limit) or at most 100% (the upper limit) of Dr. Berman's claims were overpaid. In OSA's opinion, the lower limit of 92% (the most conservative amount) is the minimum amount that Dr. Berman must repay to the Commonwealth.

We performed data analytics to identify any instances where Dr. Berman's laboratory billed for a qualitative drug screen and a quantitative drug test for the same member on the same day. This is considered unbundling, and MassHealth instructed providers not to bill this way in its Independent Clinical Laboratory Bulletin 9, dated February 2013.

We searched the federal Substance Abuse and Mental Health Services Administration's website to determine whether Dr. Berman obtained the proper federal certification to treat opioid dependency with buprenorphine.

We obtained and reviewed a MassHealth certified provider contract provided by MassHealth officials that lists Dr. Berman as a sole practitioner of psychiatry. We determined whether she obtained a license to provide substance use disorder counseling from the Massachusetts Department of Public Health as required by 130 CMR 408.404(A), 130 CMR 408.405, and 105 CMR 164.012.

During this audit, OSA worked with MassHealth by communicating our audit objectives, scope, and methodology. MassHealth shared with OSA the results of an earlier contracted audit review of Dr. Berman's claims for the period March 1, 2011 through February 29, 2012.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. Dr. Ileana Berman did not properly notify MassHealth about significant changes in her business operations.

In 2001, Dr. Ileana Berman became a certified sole practitioner providing psychiatric services to MassHealth members. Beginning in 2010, she changed how she conducted business. Specifically, in 2010, she incorporated her business as a limited liability corporation named New England Center for Psychiatric and Addiction Disorders LLC (NECPAD); beginning in 2011, she operated a full-service laboratory certified in accordance with the Clinical Laboratory Improvement Amendment[6] for drug testing, with three laboratory technicians; in 2015, she began hiring addiction treatment counselors; and in 2015, she indicated that she changed her primary business to a provider of substance use disorder (SUD) treatment. This is evidenced by annual reports filed with the Secretary of the Commonwealth: beginning in 2015, they describe NECPAD as an "outpatient substance abuse and mental health treatment facility." Dr. Berman did not notify MassHealth of these significant changes in her organization's structure and the types of SUD treatment she offered to MassHealth members. Because MassHealth was not provided with current information about Dr. Berman's operations, it could not effectively assess her status as a MassHealth provider.

Authoritative Guidance

According to Section 450.222 of Title 130 of the Code of Massachusetts Regulations (CMR),

> *A person or entity may become a participating provider only by submitting an Application for Provider Contract. If approved by [MassHealth], the application will be part of any subsequent provider contract between the applicant and [MassHealth]. Any omission or misstatement in the application will (without limiting any other penalties or sanctions resulting therefrom) render such contract voidable by [MassHealth].*

In addition, according to 130 CMR 450.223(B),

> *Each MassHealth provider must notify [MassHealth] in writing within 14 days of any change in any of the information submitted in the application. Failure to do so constitutes a breach of the provider contract.*

6. This amendment to the federal Public Health Services Act in 1988 provided certification regulations for laboratory testing that is performed on human specimens.

MassHealth's website provides specific details on how and when providers are required to update information in their provider files:

> *Providers are required to maintain the accuracy of their provider file information with MassHealth. . . .*
>
> *MassHealth Regulations at 130 CMR 450.223(B) require providers to submit any changes . . . to avoid any disruption in payments. . . .*
>
> *Changes may include*
>
> - *Ownership*
> - *Tax identification*
> - *Licensure*
> - *Organizational structure; and*
> - *Other credentials, such as certifications or qualifications that may affect your eligibility to participate in MassHealth.*

According to our discussions with MassHealth officials, providers are required to recertify and revalidate their contracts when the information therein changes, such as when a provider changes their organizational structure. For example, providers certified as sole practitioners (provider type 01, Physician) must notify MassHealth and recertify and revalidate their contracts to operate SUD treatment facilities (provider type 28, Substance Abuse Program).

Reasons for Lack of Recertification

Dr. Berman's legal counsel stated that the doctor is licensed by Massachusetts as a psychiatrist and, in the attorney's opinion, does not need to be recertified with MassHealth because she is still practicing as a licensed physician who treats patients with medication as needed. Further, Dr. Berman's legal counsel stated that the doctor is not operating a SUD treatment facility and that although she provides SUD treatment for some of her patients, her practice does not meet the criteria to be considered a SUD treatment facility by the Commonwealth. However, because the changes she made to her organizational structure (such as becoming a limited liability corporation) were significant, she should have notified MassHealth of them.

Recommendations

1. Dr. Berman should work with MassHealth to ensure that the information in her provider file is properly updated to reflect the changes in her organizational structure.
2. In the future, Dr. Berman should notify MassHealth of any changes that need to be made to her provider file within the timeframe prescribed by MassHealth regulations.
3. Dr. Berman should consult with MassHealth to determine whether NECPAD is properly certified.

MassHealth's Response

> *MassHealth agrees that Dr. Berman must ensure that the information in her MassHealth provider file is complete and up to date. . . .*
>
> *MassHealth agrees that Dr. Berman must notify MassHealth of any changes that need to be made to her provider files within the timeframe specified by MassHealth regulations.*

During our audit, MassHealth officials also told us that they agreed that Dr. Berman should work with MassHealth to ensure that her operation was properly credentialed.

Auditee's Response

Dr. Berman's legal counsel provided the following comments on this issue on her behalf:

> *Dr. Ileana Berman previously notified MassHealth's vendors . . . of her changes in staff and structure since her employees are credentialed with the MassHealth vendors. Dr. Berman has only billed MassHealth itself in her individual capacity as a provider.*

Auditor's Reply

We cannot confirm that Dr. Berman notified MassHealth's vendors of her changes in business operations; however, she was required to notify MassHealth of these changes and did not do so.

2. Dr. Berman billed MassHealth for $76,641 in drug tests that she did not use to diagnose and treat patients.

Our review of the medical records for a sample of 25 members found that in many instances, Dr. Berman's medical records did not correctly reflect the results of the drug tests she had ordered. According to NECPAD's Controlled Substance Treatment Policies, members are required to comply with drug testing requirements in order to continue receiving medications to help them recover from SUDs. Since the actual drug test results we examined conflicted with those Dr. Berman documented in the

members' records, her medical decision-making may have been based on inaccurate information when she was writing prescriptions for Suboxone.

Out of 1,338 MassHealth members whom Dr. Berman drug tested during the audit period, we selected a judgmental sample of the 25 members who received the most drug tests to determine whether Dr. Berman properly documented all services provided to them. We reviewed all drug test orders and results, as well as member medical records for each date of service each member was drug tested and given a new prescription to treat opioid dependence. In total, out of the 4,171 drug test results we reviewed, we found that 1,856, or 44%, were not accurately documented in the 25 members' medical records we tested:

	Number of Drug Tests	Amount Paid
Drug test results were abnormal (failed) but medical record stated either "in compliance" or "[results] pending"	714	$ 30,144
Drug tests results were normal but medical record stated "pending"	1,142	46,497
Total Conflicting Drug Test Results	1,856	$ 76,641

Authoritative Guidance

According to 130 CMR 433.409(D)(1), results of drug tests must be documented in members' medical records:

> *Medical records corresponding to office . . . services provided to members 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 . . .*
>
> *(k) any tests administered and their results.*

Without properly documenting the results of drug tests she ordered in members' medical records, Dr. Berman cannot determine when it is time to refer them for alternative treatments, as described in her Controlled Substance Treatment Policies:

> *Patients who repeatedly fail to comply with the program requirements will be discharged from the program:*

a. *failure to provide [urine drug test, or UDT] in compliance with treatment despite reasonable attempts made to help the client achieve recovery (i.e., medication adjustment, frequent medication visits, referral to therapy, visiting nurses, community support program, partial hospitalization or [Intensive Outpatient Program] etc.).*

The policies state that patients who are discharged will be provided with other treatment alternatives, such as admission to a detoxification center, transfer to a methadone clinic, or referral to a sober home.

Reasons for Noncompliance

Dr. Berman told us her records were not always updated to reflect drug test results received from the laboratory. She also stated that when a patient produces an abnormal drug test result but she knows that the patient typically produces normal drug test results, she gives them the "benefit of the doubt." She further noted that she records patients with abnormal drug tests as compliant in her notes if, for instance, they tell her they have taken cough syrup with codeine.

Recommendations

1. Dr. Berman should review all drug test results she orders to ensure that MassHealth members comply with her treatment guidelines and should refer noncompliant members to other SUD treatment options.
2. Dr. Berman should only bill MassHealth for drug tests that she will use to diagnose and treat members and should properly document them in members' medical records.

MassHealth's Response

MassHealth agrees that Dr. Berman should review all drug test results she orders to improve MassHealth members' adherence with her treatment guidelines. . . .

MassHealth agrees that Dr. Berman may only bill MassHealth for medically necessary drug tests, and must maintain records to support the medical necessity of those services.

Auditee's Response

Counsel for Dr. Berman objects to the use of a "judgmental sample" for the results of this finding. Reviewing 25 patients out of 1,338 patients reflects only 1.8% of the overall patients that were drug tested during the audit period. Such a percentage is not statistically significant. Also, selecting the 25 MassHealth beneficiaries who received the most drug tests during the audit period is to cherry pick the extremes of patients treated, and it is misleading to use those 25 patients as indicative of the typical treatment Dr. Berman provides.

Dr. Berman orders and signs each presumptive drug test for patients according to need; NECPAD does not use standing orders for its patients for these tests. All results are reviewed directly by Dr. Berman. If drug testing is necessary for a particular patient, such as for patients who are

coming in for a random appointment for opioid treatment, NECPAD's goal is to have the drug test results ready prior to seeing Dr. Berman for the medical appointment; this is accomplished by having the patient leave a sample upon checking in for the appointment. Dr. Berman utilizes the results from drug testing in her treatment of patients, discussing the results of the drug tests with them and determining treatment of patients based on these tests. If the "pending results" ultimately come back abnormal, NECPAD reaches out to the patient as soon as possible and the patients must come back as soon as possible. The treatment plan is changed as necessary and future prescriptions may be put on hold, depending on the nature of the medication. Dr. Berman will confront the patient as soon as s/he comes back to discuss the incident and possible relapse. This process is one of the ways Dr. Berman strengthens the therapeutic relationship with patients and fosters honesty to allow more effective treatment of these difficult patients.

Dr. Berman has not and does not write prescriptions for Suboxone based on inaccurate information. Dr. Berman acknowledges that, in the past, she has not always been consistent with overtly documenting when the drug test results are no longer pending, and she has taken actions to prevent this for the future.

Auditor's Reply

The Office of the State Auditor's (OSA's) sampling method was sound and consistent with applicable professional standards. To assess overall risk, OSA first used data analytics to analyze all the drug tests billed by Dr. Berman for MassHealth members during our audit period. Out of 1,338 MassHealth members whom Dr. Berman drug tested during the audit period, we selected a judgmental sample of 25 members, based on an isolated risk factor: members who received the most drug tests.

This type of judgmental sampling is provided for in Section 6.64 of the United States Government Accountability Office's (GAO's) *Government Auditing Standards*, which recommends that auditors obtain judgmental samples based on isolated risk factors in certain situations:

When a representative sample is not needed, a targeted selection may be effective if the auditors have isolated risk factors or other criteria to target the selection.

Additionally, in accordance with audit sampling rules, we did not project the results of our testing in this area to the overall population. Rather, our conclusions were based solely on the documentation we reviewed that was related to our tested sample.

Dr. Berman's legal counsel states that Dr. Berman reviews all drug test results that she signs for and that her goal is to have all drug test results available for review before patient appointments. Although this may be her goal, her medical records for MassHealth members did not always contain documentation of her review and discussion of drug test results with members. Further, as noted above, 1,856 (44%) of

the 4,171 drug test results we reviewed were not accurately documented; this calls into question what results were actually discussed with members.

Dr. Berman's legal counsel asserts that when pending results are abnormal (i.e., when results are positive for illicit substances and/or negative for prescribed drugs, such as Suboxone), Dr. Berman contacts the patient for an immediate appointment and changes the patient's individual treatment plan (ITP) as necessary. However, OSA found no evidence in member medical records that she contacted members to set up appointments when pending drug test results were abnormal.

Finally, Dr. Berman's legal counsel states that Dr. Berman revises members' ITPs if members' drug test results come back abnormal. However, during our audit, we performed an analysis comparing the 714 abnormal drug test results for the 25 members in our audit sample with information documented in the members' ITPs and found that this was not always the case. Specifically, for 15 members, Dr. Berman could not locate any ITPs. On average, 47% of the drug tests provided to these 15 members during the audit period were abnormal. One member was drug tested 149 times, and 113 (76%) of the test results were abnormal, but none of them were documented as abnormal in the member's medical record or in an ITP. For the 10 sampled members for whom we were able to obtain and review ITPs, abnormal drug tests averaged approximately 58% of all drug tests during the audit period. One of these members was drug tested 196 times, and 151 (77%) of the test results were abnormal, but none were documented as abnormal in the member's medical record or ITP.

3. Dr. Berman had inadequate documentation to support billing MassHealth for at least $176,737 in evaluation and management services.

Dr. Berman did not have the required documentation to substantiate the level of evaluation and management (E/M) services she provided to MassHealth members when using E/M code 99214. We reviewed a statistical sample of 129 out of 8,882 claims, totaling $484,449, that Dr. Berman billed using the E/M code 99214 from January 1, 2015 through December 31, 2016.[7] Dr. Berman used the 99214 E/M code for all 129 claims, but she did not document the required detailed medical history and detailed medical examination for any of them, and she could not substantiate that members' services had the level of complexity at which they were billed. Therefore, she received overpayments totaling approximately $176,737 from MassHealth during the audit period.

7. We chose to review only claims from 2015 and 2016, because Dr. Berman could not locate most of the documentation for these services from 2014.

In further support of our conclusion, during our audit we asked a certified professional coder[8] at MassHealth to review information about 15 out of the 129 claims in our statistical sample, and for all 15, the coder agreed with OSA's determination that the E/M services would have been more appropriately billed using procedure code 99213 rather than procedure code 99214.

Authoritative Guidance

According to 130 CMR 450.205(A), to be paid by MassHealth, providers must maintain proper documentation supporting the services billed:

> *[MassHealth] 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.*

Additionally, 101 CMR 317.04[9] lists the required documentation for procedure code 99214:

> *Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.*

These documentation requirements for procedure code 99214 are also in the 1997 Centers for Medicare and Medicaid Services (CMS) document *Documentation Guidelines for Evaluation and Management Services.*

Reasons for Lack of Proper Documentation

Dr. Berman stated that she believes her documentation for these services complied with the requirements for billing under procedure code 99214.

Recommendations

1. Dr. Berman should repay MassHealth the $176,737 that we identified as lacking the required documentation.
2. In the future, Dr. Berman should maintain proper documentation to support services billed.

8. A certified professional coder is certified in medical coding by the American Academy of Professional Coders.
9. The quoted version of the regulation was in effect from August 2017 through March 2018.

MassHealth's Response

MassHealth agrees with this finding, and notes that the sample of Dr. Berman's records reviewed by MassHealth at the request of [OSA] supports this finding. MassHealth will recover any overpayments related to this finding after the auditor's final report has been issued. . . .

MassHealth agrees [that Dr. Berman should maintain proper documentation to support services billed].

Auditee's Response

Counsel for Dr. Berman objects to the sampling performed by the OSA for this finding. The OSA stated the following for Finding 3: "We reviewed a statistical sample of 129 claims out of 8,882 claims, totaling $176,737, that Dr. Berman billed using the E/M code 99214 from January 1, 2015 through December 21, 2016." However, 129 claims out of 8,882 claims represents only 1.45% of the claims; 1.45% is not a statistically significant percentage. It is misleading to characterize the findings in this manner.

Counsel for Dr. Berman also objects to the inclusion of a determination by a "Certified Professional Coder" [at MassHealth] regarding 15 of the 129 claims sampled. By including this information, the Office of the State Auditor intentionally misleads the reader into believing that Dr. Berman's documentation was insufficient for billed E/M claims. However, 15 claims out of 8,882 claims represents only 0.001% of all of the claims of the audit period. This "Certified Professional Coder's" opinion is based on a statistically insignificant number of claims, and therefore should not be included in this report. While this information should not be included in the final report, if the Office of the State Auditor insists on including this information in the final report, the Office of the State Auditor must include more information on the individual identified as "a Certified Professional Coder," including a [curriculum vitae] of his/her credentials so that expert status can be ascertained objectively.

Counsel for Dr. Berman would like to indicate that they and Dr. Berman were misled when inquiring about whether this audit would be independent. While the representatives from the Office of the State Auditor were conducting the informal exit conference interview of Dr. Berman, they overtly held themselves out to be an independent entity separate from MassHealth, in so much as stating that their office was separate from MassHealth. However, the use of MassHealth's own "Certified Professional Coder" . . . directly contradicts the statement that the two entities are independent of one another. . . .

Dr. Berman has provided E/M services that qualified for CPT Code 99214 because she typically documented the detailed medical examination and medical decision making of moderate to high complexity as required by the 1997 CMS Guidelines for E/M Services. In order for a provider to bill CPT Code 99214, a provider must document 2 out of 3 of the following: a detailed history, detailed examination, and/or medical decision making of moderate to high complexity. Dr. Berman bills her E/M services using the 1997 CMS Guidelines for E/M services. The E/M services Dr. Berman provided qualified for the codes billed. The patients to whom Dr. Berman provided services required at least moderate clinical decision making because the patients had at least some of the following: 1) have at least 2 two chronic diagnoses, 2) require ordering and

reviewing of tests, 3) require prescription of medication, and 4) need coordination of care with other providers. . . . See 1997 Evaluation and Management Guidelines, 43–47. All of the mental health examinations that Dr. Berman bills under CPT Code 99214 are detailed, including at least 9 elements required by CMS criteria for detailed examination. See 1997 Evaluation and Management Guidelines, 37–38.

Since Dr. Berman hired counsel in April 2018, Dr. Berman has been taking steps to adjust her documentation to better reflect the complexity of the patient care she performed for services billed at CPT Code 99214. While Dr. Berman's claims previously qualified for CPT Code 99214, her new documentation format will better reflect the complexity of the services as required by the E/M Services guidelines.

Auditor's Reply

As noted above, for our testing of E/M claims billed by Dr. Berman during our audit period, we reviewed a statistical sample of claims that totaled $484,449, not the $176,737 that Dr. Berman's legal counsel cites in her response. In conducting our sampling in this area, OSA used RATS-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 sampling software determines a statistically appropriate sample, giving consideration to the total size of the population, expected error rate,[10] confidence level,[11] and desired precision.[12] RATS-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.

OSA is independent of MassHealth; in fact, MassHealth is one of our auditees. In addition, Section 6.41 of GAO's *Government Auditing Standards* states that in certain situations, auditors may determine that it is necessary to use the work of a specialist. During our audit, OSA determined that MassHealth's coder had the expertise necessary to provide a secondary level of review of claims that OSA was questioning. Before accepting the coder's assistance, OSA in accordance with generally accepted government auditing standards, documented the coder's qualifications and assessed their independence.

During our review of the medical records of the members in question, there was no evidence that Dr. Berman documented a detailed history or conducted a detailed medical examination at the time of their visit. Such an examination would include recording vital signs such as heart rate, blood pressure, body

10. Expected error rate is the anticipated rate of occurrence of the error of improper billing for services.
11. Desired precision is a measure of how precise the actual error rate is.
12. 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.

temperature, or respiratory rate; recording prescriptions ordered; and recording and reviewing drug test results. As discussed above, when billing for services using E/M code 99214, providers must document both a medical examination and a detailed medical history, and Dr. Berman did not do so. Therefore, she received overpayments totaling approximately $176,737 from MassHealth during the audit period for the services discussed in this finding.

4. Dr. Berman did not maintain any documentation to support $31,287 in E/M services and drug tests billed.

Dr. Berman did not maintain any documentation in members' medical records to support her billing for $31,287 in E/M services and drug tests provided to MassHealth members during the audit period. We selected a judgmental sample of the top 25 members for whom MassHealth paid Dr. Berman for the most drug tests during the audit period to determine whether she maintained the necessary documentation for all services for which she billed. We determined that she had not retained any of the required documentation for some E/M services and drug tests in members' medical records. As a result, MassHealth may have paid Dr. Berman for E/M services she did not provide.

Further, in our review of documentation for E/M services and drug tests, we determined that a total of 650 records were missing, as illustrated below.

Year	Number of Missing E/M Services	Amount Paid	Number of Missing Drug Tests	Amount Paid
2014	181	$ 12,793	151	$ 6,584
2015	29	2,221	145	4,262
2016	20	1,596	124	3,830
Totals	230	$ 16,610	420	$ 14,677*

* Discrepancy in total is due to rounding.

Authoritative Guidance

According to 130 CMR 450.205(A), to be paid by MassHealth, providers must maintain proper documentation supporting the services billed:

> *[MassHealth] 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 Lack of Proper Documentation

In a letter to OSA, Dr. Berman explained that throughout 2014, her staff did not scan all paper medical records into her new electronic recordkeeping system. She also cited laboratory instrument failures in 2014 as a reason for the missing documentation. However, OSA's review of these claims noted documentation issues in every year of our audit period. Additionally, on February 5, 2018, Dr. Berman provided a letter to OSA acknowledging the 650 missing records.

Recommendation

Dr. Berman should repay MassHealth for E/M services and drug tests that were not documented in members' medical records and maintain adequate documentation to support all services claimed.

MassHealth's Response

MassHealth agrees with this finding and will recover any overpayments related to this finding after the auditor's final report has been issued.

Auditee's Response

The Office of the State Auditor's representatives informed Dr. Berman and her counsel that the auditors were unable to locate documents for approximately 650 claims. Dr. Berman's staff was able to locate approximately half of the missing documentation, which Dr. Berman faxed to the Office of the State Auditor, but it does not appear that the final data was updated. According to Dr. Berman's data, NECPAD is missing the following documentation.

Year	*Number of Missing E/M (Reported)*	*Number of Missing E/M (Corrected)*	*Number of Missing Drug Tests (Reported)*	*Number of Missing Drug Tests (Corrected)*
2014	*181*	*181*	*151*	*137*
2015	*29*	*19*	*145*	*60*
2016	*20*	*19*	*124*	*11*
Total	*230*	*219*	*420*	*208*

. . .

Dr. Berman notes that there are two primary reasons for the remaining lost documentation. One of these reasons is the actions of Dr. Berman's two employees, her office manager and her lab technician, who were largely responsible for the lack of organization of patient documentation at NECPAD. As a corrective action, both employees were terminated in early 2015 due to poor performance. Dr. Berman acknowledges that the other main cause for the remaining lost documentation was that the documentation was lost in the process of transitioning from paper records to electronic medical records in 2014.

NECPAD has continuously improved the system of providing clinical care and storing and retrieving documentation. NECPAD is developing processes to ensure that documentation is stored correctly and that documentation will no longer be lost. NECPAD also identified a possible future cause of lost documentation, and implemented a procedure that will help ensure all documentation is filed properly with each patient file. Because Dr. Berman has some patients come randomly for appointments to ensure compliance with drug treatment, there is a chance that the patient may leave prior to checking out with the front desk. As a corrective action, NECPAD has developed an improved system to verify that the schedule is fully reconciled each day with the type of services rendered on that date.

Auditor's Reply

Although Dr. Berman's legal counsel states that Dr. Berman was able to provide us with approximately 50% of the 650 missing documents, this statement is not accurate. In fact, our audit originally identified 769 missing documents, of which Dr. Berman could only locate 119, or 15%. Our final audit report accurately states the number of missing documents as 650.

Dr. Berman's legal counsel responded that most of the missing documentation was due to two employees of Dr. Berman who did not maintain the necessary medical documentation, as well as her office's transition in 2014 to electronic medical records. However, regardless of the reasons, MassHealth does not pay a provider for services if the provider does not have adequate documentation to substantiate the provision of the services, as noted above. Our audit found that Dr. Berman had not retained any of the required documentation for some E/M services and drug tests for the members whose records we reviewed; therefore, she should not have been paid for these services.

5. Dr. Berman improperly billed MassHealth $75,261 for unbundled drug tests.

During our audit period, Dr. Berman improperly billed MassHealth a total of $75,261 for 7,129 quantitative drug tests ordered on the same dates she ordered qualitative drug screens for the same members. MassHealth has not allowed this type of billing since 2013 because it believes the practice is a form of unbundling. For example, a provider of SUD treatment typically orders a less expensive, qualitative drug screen to detect the presence or absence of illicit drugs in a member's sample. A positive or negative result suffices in this case. Providers who routinely require members to receive multiple, more expensive quantitative drug tests, or combinations of qualitative drug screens and

quantitative drug tests, may be ordering testing that is not needed for member treatment and that represents an excessive, unallowable cost to the Commonwealth.[13]

Authoritative Guidance

Unbundling is prohibited by 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, including submitting separate claims for services [in this case, quantitative drug test procedure codes] or procedures provided as components of a more-comprehensive service [in this case, a qualitative drug screen procedure code] for which a single rate of payment is established.*

Further, MassHealth has issued Physician Bulletin 94, dated February 2013, to inform providers that billing for both qualitative drug screens and quantitative drug tests on the same day is not allowed and will be denied by newly modified claim payment system edits:

> *MassHealth has established new claim edits for quantitative drug tests billed on the same date of service (DOS) as a drug screen service effective for dates of service on or after January 1, 2013.*
>
> *Quantitative drug tests billed on the same DOS as a drug screen service will be denied with explanation of benefits (EOB) code 8304 (lab conflict w/each other on the same day).*

Reasons for Overpayments

Dr. Berman could not explain why she improperly billed MassHealth for quantitative drug tests ordered on the same day as qualitative drug screens.

Recommendations

1. Dr. Berman should cease ordering quantitative drug tests and qualitative drug screens for the same MassHealth member on the same day.
2. Dr. Berman should collaborate with MassHealth to determine the appropriate amount to be repaid, which should be at least $75,261.

13. The total amount of Dr. Berman's unbundled drug tests quantified in this finding were reported as MassHealth overpayments in OSA Audit Report No. 2017-1374-3M2A.

MassHealth's Response

MassHealth agrees with this finding. MassHealth implemented claim edits in January 2013 and further amended in August 2015 to prevent providers from getting paid for quantitative drug tests performed on the same date of service as qualitative drug screens. . . .

MassHealth will recover any overpayments related to this finding after the auditor's final report has been issued.

Auditee's Response

Currently, when ordering drug testing, NECPAD follows the MassHealth recommendations for Medicaid Claims for Drug Screenings, (http://www.mass.gov/auditor/docs/audits/2013/201213743c.pdf) and CMS guidelines (LCD L36037).

Since the drug screen is just a presumptive test, it is clinically necessary to conduct confirmatory testing. CMS specifically warns that at no time a test performed by an [immunoassay, a laboratory test that measures the presence and concentration of a substance within a sample] analyzer should be considered confirmatory. See Local Coverage Determination L36037.

Presumptive drug testing is associated with various limitations as recognized by CMS:

Presumptive UDT testing is limited due to:

- *Primarily screens for drug classes rather than specific drugs, and therefore, the practitioner may not be able to determine if a different drug within the same class is causing the positive result;*
- *Produces erroneous results due to cross-reactivity with other compounds or does not detect all drugs within a drug class;*
- *Given that not all prescription medications or synthetic/analog drugs are detectable and/or have assays available, it is unclear as to whether other drugs are present when some tests are reported as positive;*
- *Cut-off may be too high to detect presence of a drug.*

This information could cause a practitioner to make an erroneous assumption or clinical decision.

LCD L36037. CMS further advises:

Presumptive UDT may be ordered by the clinician caring for a beneficiary when it is necessary to rapidly obtain and/or integrate results into clinical assessment and treatment decisions. Definitive UDT is reasonable and necessary for the following circumstances:

- *Identify a specific substance or metabolite that is inadequately detected by a presumptive UDT;*
- *Definitively identify specific drugs in a large family of drugs;*

- *Identify a specific substance or metabolite that is not detected by presumptive UDT such as fentanyl, meperidine, synthetic cannabinoids and other synthetic/analog drugs;*
- *Identify drugs when a definitive concentration of a drug is needed to guide management (e.g., discontinuation of [tetrahydrocannabinol] use according to a treatment plan);*
- *Identify a negative, or confirm a positive, presumptive UDT result that is inconsistent with a patient's self-report, presentation, medical history, or current prescribed pain medication plan;*
- *Rule out an error as the cause of a presumptive UDT result;*
- *Identify non-prescribed medication or illicit use for ongoing safe prescribing of controlled substances; and*
- *Use in a differential assessment of medication efficacy, side effects, or drug-drug interactions.*

Definitive UDT may be reasonable and necessary based on patient specific indications, including historical use, medication response, and clinical assessment, when accurate results are necessary to make clinical decisions. The clinician's rationale for the definitive UDT and the tests ordered must be documented in the patient's medical record. . . .

A misinterpretation of presumptive results could irreversibly affect the life of a patient, especially when the patient is on probation or is having child custody issues. An example of the negative effects of relying solely on presumptive drug tests follows: a young client on Suboxone came to NECPAD from another provider because her child was taken away from her shortly after the child was born. The Massachusetts Department of Children and Families (DCF) took the child away from her immediately after birth because her test came positive for methadone. The test was a presumptive drug screen done in the doctor's office. After evaluating the patient's history, we determined that she had been treated with Suboxone and that she had recently begun using diphenhydramine. Diphenhydramine can cause false positive results for methadone. After enrolling into our program, she complied with all random appointments, which included drug testing, pill count, and individual and group therapy. The NECPAD team worked with DCF to provide updates about the patient's progress and provided documentation to demonstrate the diphenhydramine drug testing interference that could cause false positive results for Methadone. She and her boyfriend were able to get her newborn back after several weeks. This is just an example of how not performing clinically necessary confirmatory tests could affect patients' lives.

Due to the nature of the services NECPAD provides, it is clinically necessary to conduct definitive testing. Dr. Berman orders drug testing based on each individual patient's history and presumptive drug test results. Dr. Berman disputes that the "combination of drug screens and quantitative drug tests, may be . . . testing that is not needed for member treatment." The definitive drug test results are a critical component of the treatment that NECPAD provides.

Auditor's Reply

Dr. Berman's legal counsel states that NECPAD follows MassHealth recommendations for Medicaid claims for drug screenings, referring to a 2013 OSA audit on laboratory drug tests. However, this OSA

audit resulted in MassHealth's creation of an edit in its claim-processing system that disallows payment for exactly the type of drug testing OSA is questioning in this finding. Specifically, as of February 2013, MassHealth no longer allows laboratories or physicians to bill and be paid for definitive drug tests for a member who also receives a presumptive drug screen on the same day. MassHealth disallowed this type of drug testing because it determined that definitive drug tests were not necessary when a presumptive drug screen was medically sufficient and because it believed the practice was a form of unbundling.

Dr. Berman's legal counsel states that NECPAD also follows the CMS document *Local Coverage Determination (LCD): Urine Drug Testing L36037* when ordering and billing for drug tests and further states that presumptive[14] urine drug screens are limited and may cause practitioners to make erroneous decisions. However, this CMS document states that definitive testing[15] (rather than presumptive) is only necessary when the test's prescriber needs to know the quantity of a specific substance in a member's urine sample:

> *Presumptive UDT may be ordered by the clinician caring for a beneficiary when it is necessary to rapidly obtain and/or integrate results into clinical assessment and treatment decisions.*

During our audit, Dr. Berman provided us with her treatment protocols and policies, which state that patients are drug tested to determine whether they are abstaining from illicit substances. According to guidelines from the federal Substance Abuse and Mental Health Administration and the American Society of Addiction Medicine, a presumptive drug screen that identifies the presence or absence of a drug is more appropriate for treating patients who have SUDs.

Dr. Berman's legal counsel outlines eight circumstances from LCD L36037 and asserts that the circumstances prove that definitive drug tests are reasonable and necessary for Dr. Berman to bill. However, as stated above, this type of drug testing is not practical for treating patients who have SUDs because SUD treatment providers are primarily concerned with the presence, rather than the quantity, of illicit drugs and with obtaining the results quickly. Obtaining results for definitive drug tests takes longer than obtaining results for presumptive drug screens, and as previously noted, MassHealth does not pay for definitive tests performed on the same day as presumptive tests. Therefore, Dr. Berman should not bill this way for these services.

14. Presumptive drug screens, also known as qualitative drug screens, produce a positive or negative result for each type of drug for which a sample is tested.
15. Definitive drug tests, also known as quantitative drug tests, provide the specific quantity of a substance for which a urine sample is tested.