



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

Making government work better

Official Audit Report – Issued April 19, 2018

Office of Medicaid (MassHealth)—Review of Claims for Drug Test and Screen Services

For the period March 1, 2013 through December 31, 2016





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

Making government work better

April 19, 2018

Ms. Marylou Sudders, Secretary
Executive Office of Health and Human Services
1 Ashburton Place, 11th Floor
Boston, MA 02108

Dear Secretary Sudders:

I am pleased to provide this performance audit of claims paid by the Office of Medicaid (MassHealth) for drug test and screen services. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, March 1, 2013 through December 31, 2016. My audit staff discussed the contents of this report with management of the agency, whose comments are reflected in this report.

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

Sincerely,

A handwritten signature in blue ink, appearing to read "SMB", written over a light blue circular watermark.

Suzanne M. Bump
Auditor of the Commonwealth

cc: Daniel Tsai, Assistant Secretary and Director, MassHealth
Alda Rego, Assistant Secretary, Executive Office of Health and Human Services, Administration and Finance
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

EXECUTIVE SUMMARY	1
OVERVIEW OF AUDITED ENTITY	4
AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY	7
DETAILED AUDIT FINDINGS WITH AUDITEE’S RESPONSE.....	10
1. MassHealth paid for \$2,294,369 in unallowable, unbundled drug screens and tests performed on the same day.	10
2. MassHealth improperly paid as much as \$1,888,620 for unbundled drug tests.....	16
3. MassHealth paid \$198,100 for duplicate drug tests.	22

LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare and Medicaid Services
MMIS	Medicaid Management Information System
OSA	Office of the State Auditor
PCU	Provider Compliance Unit
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 (CMS), 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's payments for drug tests and screens for the period March 1, 2013 through December 31, 2016. We expanded our audit testing through June 30, 2017 to determine how effective MassHealth's use of its NetReveal predictive modeling software was in detecting instances of unbundling before payments were made. The purpose of this audit was to determine whether MassHealth properly identified and denied payment for both duplicate and unbundled drug tests. In a previous audit (No. 2012-1374-3C), OSA identified significant weaknesses in MassHealth's claim-processing system for drug tests and screens that resulted in millions of dollars of improper claim payments.

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.

Based on our audit, we have concluded that MassHealth overpaid as much as \$4.38 million for drug tests and screens provided to its members.

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

Finding 1 Page 10	MassHealth paid for \$2,294,369 in unallowable, unbundled drug screens and tests performed on the same day.
Recommendations Page 12	<ol style="list-style-type: none"> 1. MassHealth should seek to recover as much of the \$2,294,369 in unbundled drug test payments improperly paid to laboratories as it deems appropriate. 2. MassHealth should modify the system edits in the Medicaid Management Information System (MMIS) and its NetReveal software to ensure that they properly identify and deny payment for quantitative drug tests when a member also receives a qualitative drug screen on the same day. Once modifications have been made, MassHealth should test new edits completely to make sure they are functioning correctly. 3. MassHealth should update its MMIS and NetReveal system edits as soon as possible when CMS revises procedure codes or implements new ones. 4. MassHealth should not turn off the NetReveal prepayment system edit that is designed to prevent the payment of unallowable unbundled claims.
Finding 2 Page 16	MassHealth improperly paid as much as \$1,888,620 for unbundled drug tests.
Recommendations Page 19	<ol style="list-style-type: none"> 1. MassHealth should determine how much it should recover of the \$1,888,620 that we identified in potential unbundled drug test payments improperly paid to laboratories and should take the necessary measures to recoup funds as appropriate. 2. MassHealth should monitor claim activity to identify unacceptable billing practices related to unbundled drug tests and should program system edits in MMIS and/or NetReveal to deny any unbundled claims billed.
Finding 3 Page 22	MassHealth paid \$198,100 for duplicate drug tests.
Recommendations Page 23	<ol style="list-style-type: none"> 1. MassHealth should determine how much it can recover of the \$198,100 that we identified in duplicate drug test and screen payments and should take the necessary measures to recoup these funds. 2. MassHealth should ensure that its Claims Operations staff members research its suspect-duplicates report for duplicate drug tests paid for and make recoupments for such tests. 3. MassHealth should update its NetReveal system edit to deny payment for duplicate drug tests and screens, including those that are billed by two different laboratories that are not for emergency hospital drug tests.

Post-Audit Action

MassHealth officials informed us that since May 2016, MassHealth has been using its predictive modeling software (a system that denies improper claims), known as NetReveal, to identify and deny

payments for duplicate drug tests and screens when the services are provided to the same member on the same date. This software provides a second level of system controls for laboratory services in addition to the existing system control in MMIS known as the “suspect duplicate” function. This existing system control flags and reports a suspected duplicate claim as a potentially duplicate payment, but still pays the claim. After the claim is paid, MassHealth’s Claims Operations staff is responsible for researching all reported suspected duplicate claims for future recoupment. However, with the new function in the predictive modeling software for duplicate services, claims are automatically denied.

MassHealth officials informed us that since the implementation of this additional control in May 2016, MassHealth has been able to deny the payment of approximately 40,000 duplicate claims, totaling approximately \$2 million.

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 2016, MassHealth paid healthcare providers more than \$14.8 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 401 of Title 130 of the Code of Massachusetts Regulations (CMR), MassHealth covers medically necessary laboratory services, including drug tests and screens, provided to its members. The following table shows the numbers of claims and members served, as well as the amounts paid for drug tests and screens, from March 1, 2013 through June 30, 2017.

Paid Claims for Drug Tests and Screens

Year	Amount Paid	Number of Claims	Members Served
2013	\$ 9,658,373	578,219	91,284
2014	8,286,150	550,125	108,925
2015	7,414,465	464,665	92,278
2016	9,070,094	390,514	96,221
2017	4,839,077	191,874	58,457
Total	<u>\$ 39,268,159</u>	<u>2,175,397</u>	

Billing for Drug Tests and Screens

When billing for drug tests and screens, MassHealth requires providers to bill based on whether the service provided is a drug screen, a drug test, or a combination of both when allowed (e.g., when they are performed on different dates of service). MassHealth also refers to drug screens as “qualitative drug screens” or “presumptive drug screens”; their results produce a positive or negative result for each drug class tested.¹ Providers typically use such screens when treating members for substance use disorders (SUDs), since they only need to determine whether any illicit substance is present in a member’s sample.

1. A drug class is a group of medications that have the same or similar chemical structures. For example, the opioid drug class includes oxycodone, fentanyl, naloxone, morphine, heroin, and hydrocodone.

In contrast, a drug test is used to identify the quantity of a substance in a specific sample. MassHealth also refers to drug tests as “quantitative drug tests” or “definitive drug tests.” They are more expensive than drug screens and are used by providers for treating members in emergency settings and for medication management.

Sometimes providers use a combination of drug screens and drug tests to treat members. For example, in treating a member for SUDs, a drug screen may produce a positive result for the opioid drug class. After reviewing the results, the provider may want to confirm these results by ordering a quantitative drug test for specific substances in that drug class, e.g., oxycodone, fentanyl, heroin, or morphine. MassHealth allows drug tests to be used in this manner, but it cautions providers against routinely using drug tests rather than the less expensive drug screens.

Conditions and Limitations in Payment for Drug Tests

In accordance with 130 CMR 401.416(A), MassHealth pays laboratories for drug tests and drug screens as long as the laboratory has received “a written request to perform that specific service from an authorized prescriber who is treating the member and will use the tests for the purpose of diagnosis, treatment, or any otherwise medically necessary reason.”

MassHealth instructs laboratories to use specific procedure codes for each qualitative drug screen and quantitative drug test performed on its members. Additionally, MassHealth does not allow providers to bill for quantitative drug tests performed on a member on the same day as a qualitative drug screen. This practice is called unbundling and is discussed in further detail below.

Unbundling of Drug Tests

Beginning in January 2013, in response to findings from a previous Office of the State Auditor audit, MassHealth developed and implemented a system edit to prevent and deny payment for certain drug test procedure codes when billed for the same member on the same day. MassHealth intended this system edit to prevent laboratories from unbundling certain quantitative drug test procedure codes when also billing for qualitative drug screens provided to a MassHealth member on the same day. The Centers for Medicare and Medicaid Services define and describe two types of unbundling practices in Version 12.3 of the *National Correct Coding Initiative Policy Manual for Medicare Services*:

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment.

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 MassHealth for the period March 1, 2013 through December 31, 2016. We expanded our audit testing through June 30, 2017 to determine how effective MassHealth’s use of its NetReveal predictive modeling software was in detecting instances of unbundling before making payments.

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

Objective	Conclusion
1. Does MassHealth properly identify and deny the payment of unbundled drug tests?	No; see Findings <u>1</u> and <u>2</u>
2. Does MassHealth properly identify and deny the payment of duplicate drug tests and screens?	No; see Finding <u>3</u>

We gained an understanding of the design of the payment process for drug test claims and the related internal controls over this process that we deemed significant to our audit objectives. We also identified and tested key controls over the payment process for drug tests and screens that were significant to our audit objectives and evaluated the design and effectiveness of those controls.

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, 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. 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 valid data, (4) looking for dates outside specific time periods, and (5) tracing samples of claims stored in the Data Warehouse² to source documents and MMIS. Based on these procedures and other audit procedures to test system edits discussed below, we determined that the data we obtained for this audit were sufficiently reliable for the purposes of this report.

We used data analytics to test all 2,175,397 drug test claims from the audit period for duplicate service payments. Our analysis tested for any instances where MassHealth paid for the same procedure code more than once for the same member on the same day, as well as whether it paid the same billing provider or separate billing providers. Additionally, we performed data analysis on all 2,175,397 drug test claims from the audit period to identify instances of MassHealth members receiving the same drug test on the same day when different procedure codes were billed and paid for. We met with MassHealth's Provider Compliance Unit (PCU) to understand its process for identifying and recouping duplicate payments. To determine whether PCU had started recoupment efforts on any of the potentially duplicate payments we identified, we performed testing on a nonstatistical sample of 20 out of the 15,510 identified duplicate claims to determine whether MassHealth denied or recouped these improper payments.

To identify drug tests that were billed using unbundling, we used data analytics to identify all instances out of the entire population of 2,175,397 drug test claims from the audit period in which MassHealth paid for a qualitative drug screen for a member who also received a quantitative drug test on that same day. This analysis tested whether the system edit MassHealth established in 2013 for unbundled drug tests effectively denied payments for quantitative drug tests as designed. We performed further data analyses on all 2,175,397 drug test claims to identify new instances of unbundled billing for drug tests and screens. On December 1, 2011, the then-Division of Health Care Finance and Policy³ amended Section 20 of Title 130 of the Code of Massachusetts Regulations to reduce the payment rate for drug screens from \$76.64 for up to eight drug classes to \$48.78 for an unlimited number of drug classes. Based on this information, we used the newly established rate (\$48.78) or the maximum number of

-
2. The Data Warehouse is MassHealth's central repository for Medicaid member identification and claim payment information.
 3. The Division of Health Care Finance and Policy was later abolished and its duties distributed among the Health Policy Commission, the Center for Health Information and Analysis, the Office of Medicaid, and the Commonwealth Health Insurance Connector Authority.

covered drug classes (five) for drug screens as a benchmark for identifying further unbundled billings by providers.

We performed additional analyses on all 76,727 unbundled drug test claim exceptions⁴ to determine whether this problem was associated with the same laboratory or two laboratories submitting claims for the same drug tests for the same member on the same day. Since the procedure codes for drug tests changed in January 2015 and again in January 2016, we performed separate reviews and analyses for unbundled drug test billing to determine whether the edits properly denied unbundled drug test claims. We tested a nonstatistical sample of 50 out of 68,185 identified unbundled drug tests from March 1, 2013 through December 31, 2016 to determine whether MassHealth's system edit properly recorded an adjustment hold on the claim to signify that a recoupment had occurred.

For all tests that used nonstatistical sampling, we did not project any identified errors to the population of drug test claims.

MassHealth created prepayment system edits in 2017 that were intended to deny payment of unbundled drug test claims. To assess whether the NetReveal prepayment system edits denied payment for such claims between January 1, 2017 and June 30, 2017, we performed data analyses on all 191,874 drug tests billed during this period. We found that 8,542 of the billed drug test claims were for unbundled drug tests, totaling \$487,863.

4. An exception, in this case, is any instance of a quantitative drug test being billed for the same member on the same day as a qualitative drug screen.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. MassHealth paid for \$2,294,369 in unallowable, unbundled drug screens and tests performed on the same day.

During our audit period, 260 providers (laboratories) improperly billed MassHealth a total of \$2,294,369 for qualitative drug screens and quantitative drug tests provided to the same member on the same day. MassHealth has not allowed this type of billing since 2013 because, in its opinion, it represents a form of unbundling. For example, a provider of treatment for substance use disorders (SUDs) typically orders a less expensive, qualitative drug screen to detect the presence or absence of illicit drugs in the member's sample. A positive or negative result would suffice 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 a member's treatment and represents an excessive, unallowable cost to the Commonwealth.

Of these improper payments, 67% involved situations where multiple providers submitted claims for drug screens and drug tests for the same member on the same day. For example, we found many instances in which a laboratory provider submitted a bill to MassHealth for a qualitative drug screen using one billing provider identification number, and then submitted a second bill, for the same date of service and the same member, for multiple quantitative drug tests using a second billing provider identification number. Likewise, on many occasions, referring⁵ laboratory providers submitted bills to MassHealth for qualitative drug screens, and second laboratories (referred to as testing laboratories) submitted bills for multiple quantitative drug tests for the same members and the same dates of service.

Authoritative Guidance

Unbundling is prohibited by Section 450.307 of Title 130 of the Code of Massachusetts Regulations (CMR):

- 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. . . .*

5. A referring laboratory is a laboratory that cannot perform all necessary laboratory services and refers some of the testing to a testing laboratory.

(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 Independent Clinical Laboratory Bulletin 9, 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.

In Transmittal Letters LAB-44, LAB-45, and LAB-46, MassHealth notified laboratory providers that it had updated the original Medicaid Management Information System (MMIS) system edit for unbundled drug tests in response to an official Centers for Medicare and Medicaid Services (CMS) update to the Healthcare Common Procedure Coding System⁶ for drug test procedure codes during the audit period. The MMIS system edit updates were intended to ensure that MMIS would continue to deny payments for quantitative drug test procedure codes billed in combination with qualitative drug screen procedure codes after the CMS code changes.

Reasons for Overpayments

The MMIS system edit established by MassHealth to detect improper, unbundled drug tests is a “report and pay” edit. This type of edit flags each instance of noncompliance, but still pays the unbundled claims. The system edit then generates a report, which requires staff members to research and determine whether recoupment is necessary. MassHealth officials stated that they did not have enough resources to effectively research each reported instance of noncompliance.

Further, the MMIS system edit cannot identify instances of unbundling in which one laboratory bills for a qualitative drug screen and a separate laboratory bills for a quantitative drug test. For this reason, in May 2016, MassHealth created a second system edit—a prepayment system edit—in its predictive modeling software, NetReveal, to detect and deny payment for quantitative drug tests billed on the same day as qualitative drug screens. However, in our additional analysis of the NetReveal prepayment

6. The Healthcare Common Procedure Coding System, which contains procedure codes, can be revised by CMS to tell providers which procedure codes are currently covered by Medicare or Medicaid.

system edit, we found 2,460 instances, totaling, \$56,884, in which it appeared to have been switched off, which allowed the payment of unbundled drug tests.

Finally, these overpayments also occurred because MassHealth did not update its MMIS and/or NetReveal system edits for revised CMS procedure codes in a timely manner so that billing irregularities could be detected even when they involved providers using the most recent codes. MassHealth told us that CMS notifications of procedure code changes were not always promptly made available to them and that they were working on ensuring that these changes were implemented in a timelier manner.

Recommendations

1. MassHealth should seek to recover as much of the \$2,294,369 in unbundled drug test payments improperly paid to laboratories as it deems appropriate.
2. MassHealth should modify the system edits in MMIS and NetReveal to ensure that they properly identify and deny payment for quantitative drug tests when a member also receives a qualitative drug screen on the same day. Once modifications have been made, MassHealth should test new edits completely to make sure they are functioning correctly.
3. MassHealth should update its MMIS and NetReveal system edits as soon as possible when CMS revises procedure codes or implements new ones.
4. MassHealth should not turn off the NetReveal prepayment system edit that is designed to prevent the payment of unallowable unbundled claims.

Auditee's Response

MassHealth has been focused on program integrity in this area while ensuring continued access to medically necessary services for MassHealth members.

MassHealth's response also states that since 2009, it has taken a number of steps to significantly curb overuse and reduce unnecessary expenditures for drug screening and drug testing. Some of these steps included the following:

- *Dec 2011: Changed drug screen rate methodology from a per unit (or per drug class tested) payment structure to a service code that paid a single daily fee*
- *Jan 2013: Established MMIS edits preventing drug screens and quantitative tests being paid [for] the same provider on the same date of service*
- *Aug 2015: Enhanced MMIS drug screen and quantitative test edits to deny claims submitted by separate providers on the same date of service*

MassHealth’s response further noted that the agency agreed with the finding of the Office of the State Auditor (OSA) and would recover any improper payments as applicable.

MassHealth responded specifically to the finding and our recommendations as follows:

After initial review of the claims OSA has characterized as unallowable, MassHealth generally agrees with OSA’s finding and will recover any improper payments once it is appropriate to do so. MassHealth has determined that the improper payments reflected in OSA’s finding occurred during time periods in which system edits were not yet in place, had not been updated to implement coding changes, or were not operating due to system maintenance. . . . MassHealth will continue to individually review and validate the claims comprising this finding and recoup improper payments once it is appropriate to do so. . . .

MassHealth has already implemented MMIS and NetReveal edits to identify and deny payment for quantitative drug tests when a member also receives a qualitative drug screen on the same day.

MassHealth implemented MMIS edits in February 2013, effective for dates of service on or after January 1, 2013, to identify situations in which both a drug screen and a quantitative test were performed on the same date of service by the same provider. Payments to providers in this situation account for \$561,171 of OSA’s finding, and likely occurred prior to implementation of code changes or during downtime for system maintenance.

Starting in August of 2015, MassHealth implemented certain drug screen detection edits in NetReveal. MassHealth implemented additional NetReveal edits in May 2016 to specifically identify and deny claims for drug screen and quantitative drug test claims billed by separate providers on the same date of service. Payments to providers in this situation account for \$1,733,198 of OSA’s finding. Approximately \$904,000 of that total was paid prior to implementation of the NetReveal edits. The remaining payments likely occurred prior to implementation of code changes or during downtime for system maintenance.

The table below identifies the dollar amount of claims NetReveal has denied for different categories of same day testing since 8/1/15.

	08/1/2015-6/30/2017	7/1/2017-1/29/2018
Drug Test Secondary/Primary	\$357,704.09	\$233,737.31
Same Day Primary and Primary Drug Test	\$108,146.89	\$81,560.09
Same Day Primary and Secondary Drug Test	\$1,545,082.58	\$999,236.57
Total	\$2,010,933.56	\$1,314,533.97*

* Primary Codes: (G0431, G0434, G0477, G0478, G0479, 80305, 80306, 80307); Secondary Codes: (80154, 80299, 82055, 82145, 82205, 82520, 82570, 82575, 83840, 83925, 83986, 83992, G6030, G6031, G6032, G6034–G6057, G0480–G0483)

Any changes to MassHealth's claim edits are, and will continue to be, thoroughly tested prior to implementation. . . .

MassHealth will identify claims for code changes that processed without being subject to the MMIS and NetReveal edits and will recover payment as it determines is appropriate. In addition, MassHealth has been reviewing the process used to adopt code changes and will make any changes as needed.

There were three code set changes impacting these drug screen services during the audit period. In order to incorporate code changes, MassHealth has established formal subregulatory processes to ensure that providers have adequate notice of any changes to covered codes, limits and billing rules impacting those codes. These processes include formally adopting the new codes through an administrative bulletin, making changes to the MassHealth coverage list through a transmittal letter, and updating the MMIS and NetReveal systems. MassHealth strives to implement these changes as quickly as possible, but there is an inevitable and unavoidable delay between the date of a code change and the MMIS and NetReveal update that implements the change. The finding identifies claims that would have been subject to certain MMIS and NetReveal edits if not for that delay. MassHealth is exploring how best to address claims paid during a delay. . . .

The NetReveal system is occasionally shut down for system maintenance or upgrades that are necessary for enhancement and development. MassHealth has taken steps to minimize the number of missed claims, by having downtime scheduled later in the day and working with its vendor to minimize downtime.

Auditor's Reply

We acknowledge that over the past several years, MassHealth has taken measures to reduce the overall costs associated with drug screens and tests; however, our audit focused on determining whether MassHealth properly identified and denied payment of unbundled billings for these services. As noted above, during our audit period, problems still existed in this area, resulting in millions of dollars in improper payments. Based on its response, MassHealth is taking measures to address many of our concerns in this area.

MassHealth states in its response that \$561,171 of improper payments cited in our report occurred before it implemented system edits in February 2013. However, this is not the case. Our audit period begins on March 1, 2013 and did not include any payments made before that date. The entire \$2,294,369 represents improper drug testing payments made by MassHealth after March 1, 2013, as illustrated below.

Period	Amount Improperly Paid	Number of Claims
March 1, 2013–December 31, 2013*	\$417,036	17,167
2014	\$440,806	17,113
2015	\$327,032	22,594
2016	\$621,632	11,311
January 1, 2017–June 30,2017	\$487,863	8,542

* Edits were first implemented on February 1, 2013.

We found that one of the main reasons these improper payments occurred was that until May 2016, MassHealth used “report and pay” edits rather than edits that would simply deny improper payments. “Report and pay” edits would detect potential improper billings and flag them for review. However, according to MassHealth officials, resources were not available to research all the questionable claims identified by the system edits to determine whether they were appropriate, and therefore they were eventually paid.

Also, in its response, MassHealth states that it was necessary to shut down NetReveal occasionally for system maintenance, enhancement, and development. Although this may be true, OSA believes that in order to avoid improper payments, MassHealth either should not process any claims that are subject to the NetReveal or MMIS edits during this shutdown or should reprocess all claims that were processed during the shutdown once all the edits are back online.

MassHealth states that it sometimes experiences unavoidable delays when adopting new coding changes from CMS. We do not dispute that there may sometimes be reasons for delaying the implementation of new procedure codes, but during our audit, we found that some of these delays appeared to be excessive, as illustrated below.

Effective Date of New Codes per CMS	Date of MassHealth Transmittal Letter / System Edit Implementation	Number of Days Delayed
January 1, 2015	July 2015	181
January 1, 2016	April 2017	456
January 1, 2017	April 2017	90

In some cases, when MassHealth does not implement new CMS codes promptly, it appears to allow providers to bill using codes that are no longer valid well after the codes’ expiration dates. For example,

according to data in MMIS, MassHealth processed and paid 3,680 claims submitted by laboratories using codes 80100 and 80101 for five years after CMS discontinued these codes on January 1, 2010. Therefore, we again recommend that MassHealth update its MMIS and NetReveal system edits as soon as possible when CMS revises procedure codes or implements new ones. This will not only facilitate the timely processing of bills submitted by MassHealth providers but also ensure that any system edits that MassHealth has established to detect improper billings will function properly, because they will be based on the procedure codes that are currently used by its providers.

In its response, MassHealth also provided a table illustrating improper claim submissions for which NetReveal denied payment, totaling \$2,010,934 since August 1, 2015. However, it should be noted that OSA identified an additional \$1,124,374 in improperly paid claims for drug testing from this period, which indicates that there are still deficiencies in MassHealth's claim-processing system that need to be addressed.

Finally, MassHealth states that in May 2016, it implemented new NetReveal system edits to identify and deny drug screen claims and quantitative drug test claims billed for the same date of service by the same provider or different providers. However, these system edits do not appear to be fully effective in addressing this problem: in the first half of calendar year 2017, they did not detect and deny the 8,542 drug tests, totaling \$487,863, shown in the table above.

2. MassHealth improperly paid as much as \$1,888,620 for unbundled drug tests.

During our audit period, MassHealth paid 148 providers as much as \$1.8 million for drug tests that may represent unbundled billing (the practice of billing using multiple procedure codes instead of a single designated comprehensive code). These funds could have been used to pay for other medical services to MassHealth members.

As part of our audit, we performed data analytics on all drug test claims processed by MassHealth during our audit period to obtain an understanding of the payment trends in this area. For the most part, as illustrated below, the amounts paid for testing of more than seven drug classes significantly increased during the years covered by our audit.

	Amount Paid 2013	Amount Paid 2014	Amount Paid 2015	Amount Paid 2016	Amount Paid January–June 2017*
1–7 classes	\$ 8,730,925	\$ 8,417,783	\$ 7,354,594	\$ 1,907,061	\$ 1,310,623
8–14 classes	1,115,328	55,013	111,749	346,148	219,724
15–21 classes	621	0	881	210,632	156,297
22 or more classes	0	0	0	255,982	75,716
Total	<u>\$ 9,846,874</u>	<u>\$ 8,472,796</u>	<u>\$ 7,467,224</u>	<u>\$ 2,719,823</u>	<u>\$ 1,762,360</u>

* While performing these audit procedures, we were only able to review claims from January 1, 2017 through June 30, 2017 because they were the only ones available for analysis.

Based on these results and the fact that MassHealth established a requirement that providers bill using comprehensive procedure codes for bundled drug tests rather than billing for individual drug tests, we performed detailed reviews of laboratory billing patterns for evidence of potential unbundling. Our analysis seemed to indicate that in most cases, when we found potential unbundling of drug tests, a provider appeared to have billed for multiple drug tests for a member on the same day rather than using one comprehensive billing procedure code established by MassHealth. We also identified another type of unbundled billing, in which providers billed for drug tests using two different comprehensive procedure codes rather than the appropriate single comprehensive procedure code. For example, as illustrated below, some providers billed for both G0480 (1–7 drug classes) and G0481 (8–14 drug classes) for the same member on the same day, but should have only billed one procedure code, G0482 (15–21 drug classes).

Potential Unbundled Billings Scenarios	Years	Number of Instances	Amount Improperly Paid
Five or more quantitative drug test procedure codes in place of a qualitative drug screen procedure code	2013–2015	121,801	\$ 1,869,005
G0480 (1–7 drug classes) and G0481 (8–14 drug classes)	2016–2017	184	9,485
G0480 (1–7 drug classes) and G0482 (15–21 drug classes)	2016–2017	129	5,000
G0480 (1–7 drug classes) and G0483 (22+ drug classes)	2016–2017	17	716
G0481 (8–14 drug classes) and G0482 (15–21 drug classes)	2016–2017	5	459
G0481 (8–14 drug classes) and G0483 (22+ drug classes)	2016–2017	6	513
G0482 (15–21 drug classes) and G0483 (22+ drug classes)	2016–2017	45	3,442
Total		<u>122,187</u>	<u>\$ 1,888,620</u>

Authoritative Guidance

From March 1, 2013 through December 31, 2015, laboratories were required to bill in accordance with 130 CMR 450, which states that unbundled billing is an unacceptable billing practice:

- 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 [e.g., multiple drug test procedure codes] for services or procedures provided as components of a more-comprehensive service [e.g., the comprehensive drug screen procedure code] for which a single rate of payment is established.*

Additionally, in December 2011, MassHealth issued Transmittal Letter PHY-132, which specifically cautions laboratories against using unbundled billing for drug tests:

Providers should not routinely bill for the quantification of drug classes [using multiple drug test procedure codes] . . . being tested as part of the drug screen service [one procedure code].

Retroactively effective for the period January 1, 2016 through December 31, 2016, in Transmittal Letter LAB-45 (issued in April 2017), MassHealth instructed laboratories to bill for drug testing using procedure codes newly approved by CMS (presumptive/qualitative drug screen procedure codes and definitive/quantitative drug test procedure codes):

Effective for dates of service beginning January 1, 2016, providers are instructed to bill drug screening using the following new codes for presumptive [qualitative] drug testing:

- *G0477—Drug test(s), presumptive, any number of drug classes; . . . read by direct optical observation only (e.g., dipsticks, cups, cards, cartridges) . . .*
- *G0478—Drug test(s), presumptive, any number of drug classes; . . . read by instrument-assisted direct optical observation (e.g., dipsticks, cups, cards, cartridges) . . .*
- *G0479—Drug test(s), presumptive, any number of drug classes; . . . procedures by instrumented chemistry analyzers. . . .*

In addition, providers are instructed to bill quantitative related drug testing using the following new codes for definitive drug testing:

- *G0480—Drug test(s), definitive, . . . 1–7 drug class(es) . . .*
- *G0481—Drug test(s), definitive, . . . 8–14 drug classes . . .*

- G0482—Drug test(s), definitive, . . . 15–21 drug classes . . .
- G0483—Drug test(s), definitive, . . . 22 or more drug classes.

Reasons for Improper Payments

The MMIS and NetReveal system edit established by MassHealth to detect unbundled billing for drug screens and tests was based on a specific set of procedure codes that MassHealth determined were used by certain providers for this purpose. However, since that time, based on our analysis of billing for these tests, it appears that some providers have begun using new combinations of procedure codes to unbundle billings for these services. The system edits MassHealth originally designed to detect this are no longer effective. In addition, MassHealth did not perform any other monitoring of drug screen and drug test claim activity for new combinations of claims billed.

Recommendations

1. MassHealth should determine how much it should recover of the \$1,888,620 that we identified in potential unbundled drug test payments improperly paid to laboratories and should take the necessary measures to recoup funds as appropriate.
2. MassHealth should monitor claim activity to identify unacceptable billing practices related to unbundled drug tests and should program system edits in MMIS and/or NetReveal to deny any unbundled claims billed.

Auditee's Response

MassHealth reviewed the methodology and data used by OSA, and determined that \$1,869,004.83 of the \$1,888,620 OSA identified in its finding did not constitute improper payment for unbundled services. However, MassHealth agrees that \$19,615.17 of the payments OSA identified potentially constitute payment for duplicate claims. MassHealth will validate the remaining claims comprising this finding and recoup payments as it deems appropriate.

MassHealth has determined that a majority of the claims OSA has characterized as unbundled drug tests are for multiple quantitative (definitive) drug test codes performed on the same date of service and paid collectively at a rate greater than \$48.78. . . . MassHealth disagrees with that characterization. It assumes that a provider submitting claims for any combination of quantitative drug tests paid for at a rate greater than the drug screen rate was required to submit a claim for a drug screen instead. To support this assumption, OSA cites Transmittal Letter PHY-132, which instructs: "Providers should not routinely bill for the quantification of drug classes (e.g., chemistry section 82000-84999 or therapeutic drug assay section 80150-80299) being tested as part of the drug screen service." OSA has ignored a critical limitation on this instruction: It only applies to drug tests being performed as part of the drug screen service. In fact, drug tests serve medical purposes other than the purposes served by drug screens. . . . There are clinical scenarios in which a provider would require a quantitative drug test that was not "part of the drug screen service." One example is testing patients who have been prescribed controlled substances to

assess adherence to a medication regimen. A test to determine the amount of a controlled substance is needed, and a determination that the substance is present is not sufficient. As long as the drug tests being performed were medically necessary, such that a drug screen would not be sufficient, the claims were not "unbundled," and MassHealth's payment for the tests is not improper.

MassHealth does agree with OSA's finding on scenarios in which multiple providers were paid for multiple definitive drug test codes (procedure codes G0480–G0483) performed on the same date of services. Those scenarios involve potentially duplicate services. MassHealth will be establishing edits within the NetReveal system to systematically deny such claims. MassHealth anticipates the edits will be incorporated in March 2018. . . .

The way in which the data is displayed in the table [on p. 17] is . . . potentially misleading because procedure codes corresponding to the drug class divisions in the table above (1–7 classes, 8–14, and so on) only became effective on January 1, 2016, likely explaining the negligible payment amounts in the first three years of the audit period. . . .

MassHealth agrees with the auditor's recommendation to monitor claim activity to identify unacceptable billing practices. MassHealth has been identifying providers with aberrant billing patterns, providers exhibiting unusual claims activity relative to their peers, and providers who consistently bill high level definitive testing. For certain providers in the first two categories, MassHealth has been suspending claims prior to payment and requiring submission of additional documentation prior to payment to ensure compliance with regulations and medical necessity. MassHealth intends to do the same for certain providers in the third category. MassHealth has also been reviewing utilization to identify those members that receive a high volume of drug testing and discussing strategies to ensure that the members' claims are medically necessary.

Auditor's Reply

MassHealth is correct in stating that that our analysis focused on any combinations of drug tests that were paid at a rate greater than \$48.78 (generally five or more drug tests). However, as discussed with MassHealth officials, we applied the \$48.78 threshold only in instances where providers billed any combination of quantitative drug tests listed in MassHealth's Independent Clinical Laboratory Bulletin 9, dated February 2013. We used this bulletin, which lists all quantitative drug tests that providers should not unbundle, to design our tests to identify new unbundling scenarios. Also, when determining whether a billing might have involved unbundling, OSA applied the definition of unbundling in Version 12.3 of CMS's *National Correct Coding Initiative Policy Manual for Medicare Services*:

Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code.

Two types of practices lead to unbundling. The first is unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment.

Based on this definition and the design of our audit testing, we determined that during our audit period MassHealth paid 148 providers as much as \$1.8 million for drug tests that might represent unbundling. For example, one laboratory in our sample routinely billed several combinations of six or more quantitative drug tests that should have been billed under one comprehensive code.

MassHealth states that our use of Transmittal Letter PHY-132 as a criterion to question some of the billings was not entirely accurate. We agree that this criterion may only apply to certain billings. However, in our analysis of the billings for these services, we applied MassHealth Independent Clinical Laboratory Bulletin 9, dated February 2013, which states,

*Providers should not bill for quantitative tests **in lieu** [emphasis added] of drug screen services or as a routine supplement to drug screens.*

This criterion warns providers not to routinely bill for multiple quantitative drug tests "in lieu of" a qualitative drug screen. Using this criterion, we tested for scenarios in which drug tests were billed this way and found that 99% of the questioned \$1,888,620 related to this type of billing.

In its response, MassHealth states that our analysis of drug tests did not consider clinical scenarios in which a provider would require quantitative drug tests only. However, OSA did consider such scenarios. In fact, when performing our analysis of the billing data, we specifically excluded certain quantitative drug tests that appeared to be related to specific clinical treatments. For example, we filtered out billings for drug tests related to crisis intervention (when providers test for alcohol, salicylate, and acetaminophen).

Further, when a provider requires a quantitative drug test that is not part of the drug screen service, the provider typically orders drug tests to detect different drugs within one drug class. For example, if a provider wanted to test a member for evidence of opioid substances if s/he were undergoing chronic opioid therapy, the drug test would involve testing for substances such as morphine, oxycodone, fentanyl, or hydrocodone. However, the majority of our questioned billings were for laboratories that billed for a wide range of drug classes, not just different types of drugs within one class, as when they billed repeatedly for the following different drug classes:

- amphetamines
- barbiturates
- benzodiazepines
- cocaine
- creatinine
- opiates
- methadone

Finally, we do not agree with MassHealth that the information in the table on p. 17 of our report is misleading because there were no drug test procedure codes that covered some drug classes between 2013 and 2016. Although we acknowledge that there were no procedure codes for some drug classes during the period in question, OSA used the “number of units” data field in MassHealth’s claim-processing system when creating this table. The “number of units” data field was widely used by laboratories before 2016 to identify how many drug classes were tested; it was similar to the newly activated procedure codes that have been available since 2016. Therefore, we believe the table in question presents an accurate depiction of drug testing during this period.

Based on its response, MassHealth is taking measures to address some of our concerns in this area.

3. MassHealth paid \$198,100 for duplicate drug tests.

During our audit period, MassHealth paid \$198,100 for duplicate drug tests provided to members on a single date of service. Our audit found instances in which MassHealth paid a single laboratory for duplicate drug tests, in addition to instances in which two different laboratories were paid for the same tests for the same member on the same day. In both types of case, MassHealth paid for more than one drug test per member per day of service.

The results of our analysis are outlined below.

Duplicate Payment Problem	Total Amount Paid	Amount of Overpayment
Same drug tests paid to the same laboratory	\$ 46,421	\$ 25,282
Same drug tests paid to two different laboratories	385,432	172,818
Total	<u>\$ 431,853</u>	<u>\$ 198,100</u>

Authoritative Guidance

According to 130 CMR 450.307(B)(1), MassHealth does not allow duplicate billing, which it defines as follows:

[Duplicate billing] includes the submission of multiple claims for the same service, for the same member, by the same provider or multiple providers.

Reasons for Overpayments

MassHealth officials told us that MMIS has a system edit function that identifies and flags potential duplicate billings as “suspect duplicates” and that this function does not deny or delay the payment of the identified potential duplicate services. The officials told us that this edit was programmed to allow MassHealth’s Claims Operations staff to research the reported suspected duplicates later, but that this is not done because of resource constraints.

As discussed in the Post-Audit Action section of this report, MassHealth is using NetReveal to detect and deny duplicate drug tests. However, MassHealth officials told us that in certain situations, such as when drug tests are performed by hospital emergency departments, it does not want to deny payments for drug tests that may appear to be duplicate but are medically necessary. Therefore, they explained, NetReveal is not programmed to deny duplicate drug tests and screens billed by two different laboratories for the same member on the same day.

Recommendations

1. MassHealth should determine how much it can recover of the \$198,100 that we identified in duplicate drug test and screen payments and should take the necessary measures to recoup these funds.
2. MassHealth should ensure that its Claims Operations staff members research its suspect-duplicates report for duplicate drug tests paid for and make recoupments for such tests.
3. MassHealth should update its NetReveal system edit to deny payment for duplicate drug tests and screens, including those that are billed by two different laboratories that are not for emergency hospital drug tests.

Auditee's Response

MassHealth is investigating the potential duplicate claim scenarios provided by OSA. For instances in which a provider was paid for the same service code on the same date of service, MassHealth will recoup any payments determined to be duplicate payments. For other suspected duplicate claim scenarios, MassHealth will review and take further action if necessary. . . .

Claims Operations continues to review lab codes on a post payment basis in order to identify possible duplicate claims. MassHealth is in the process of cross training additional staff members in order to improve the review time to better align with the 90 day claim submission deadline. . . .

MassHealth will review its duplicate claim logic concerning drug tests and make any appropriate updates.