



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

Making government work better

Official Audit Report – Issued April 27, 2016

Office of Medicaid (MassHealth)—
Review of Selected Outpatient Evaluation and
Management Services Claims Submitted
by Dr. Kunwar S. Singh

For the period January 1, 2010 through June 30, 2015





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

Making government work better

April 27, 2016

Kunwar Singh, MD, Medical Director
Primary Care Family Center
1127 Salem Street
Malden, MA 02148

Dear Dr. Singh:

I am pleased to provide this performance audit of claims you submitted to the Office of Medicaid (MassHealth) for selected outpatient evaluation and management services. This report details the audit objectives, scope, methodology, finding, and recommendations for the audit period, January 1, 2010 through June 30, 2015. My audit team discussed the contents of this report with you and employees of your practice, whose comments are reflected in this report.

I would also like to express my appreciation to you and your staff 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: Marylou Sudders, Secretary, Executive Office of Health and Human Services (EOHHS)
Daniel Tsai, Assistant Secretary and Director, MassHealth
Alda Rego, Assistant Secretary, EOHHS, Administration and Finance
Teresa Reynolds, Executive Assistant to Secretary Sudders
Joan Senatore, Office of Medicaid, Compliance and Program Integrity

TABLE OF CONTENTS

EXECUTIVE SUMMARY	1
OVERVIEW OF AUDITED ENTITY	3
AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY	5
DETAILED AUDIT FINDINGS WITH AUDITEE’S RESPONSE.....	8
1. Dr. Kunwar Singh improperly billed for evaluation and management services totaling approximately \$55,390.....	8

LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CMS	Centers for Medicare and Medicaid Services
CPT Codebook	American Medical Association's <i>Current Procedural Terminology Professional Edition 2014</i>
E/M	evaluation and management
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services is responsible for the administration of 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 2015, MassHealth paid healthcare providers more than \$13 billion, of which approximately 50%¹ was funded by the Commonwealth. Medicaid expenditures represent approximately 38% of the Commonwealth's total annual budget.

The Office of the State Auditor (OSA) has conducted an audit of selected outpatient evaluation and management (E/M) claims paid to Dr. Kunwar Singh for the period January 1, 2010 through June 30, 2015. During this period, Dr. Singh was paid approximately \$199,000 to provide outpatient E/M services for 296 MassHealth members. The purpose of this audit was to determine whether Dr. Singh billed MassHealth for E/M services using appropriate procedure codes and whether he properly documented E/M services in member medical records in accordance with applicable laws, rules, and regulations.

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

Based on our audit, we have concluded that Dr. Singh improperly billed MassHealth for E/M services totaling approximately \$55,390.

1. During the federal government's fiscal year 2015, the Federal Medical Assistance Percentage for Massachusetts was 50%.

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

Finding 1 Page <u>8</u>	Dr. Singh improperly billed for E/M services totaling approximately \$55,390.
Recommendations Page <u>11</u>	<ol style="list-style-type: none"><li data-bbox="441 401 1472 485">1. Dr. Singh should collaborate with MassHealth to repay the approximately \$55,390 in improper payments he received from the upcoding of claims.<li data-bbox="441 485 1472 623">2. Dr. Singh should develop internal controls to ensure that his claims are not upcoded for E/M services. At a minimum, these controls should ensure that his billing staff has sufficiently reviewed required documentation to support each claim.

OVERVIEW OF AUDITED ENTITY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services is responsible for the administration of the state’s Medicaid program, known as MassHealth. From January 1, 2010 through June 30, 2015, MassHealth paid approximately \$514.3 million to physicians for outpatient evaluation and management (E/M) services for 1,117,520 members, as detailed below.

Outpatient E/M Services

Calendar Year	Amount Paid	Members Served	Number of Claims
2010	\$ 70,804,770	453,775	2,120,210
2011	75,438,370	462,043	2,154,605
2012	77,227,950	470,731	2,221,428
2013	115,620,192	482,281	2,359,256
2014	122,431,879	565,563	2,523,865
2015*	52,734,050	414,509	1,494,281
Total	<u>\$514,257,211</u>	<u>2,848,902[†]</u>	<u>12,873,645</u>

* Data for this year are from January 1, 2015 through June 30, 2015, the end of our audit period.

† Of these 2,848,902 members, the unduplicated count is 1,117,520.

Dr. Kunwar Singh is a certified MassHealth service provider located in Malden, Massachusetts, who received \$311,427 from MassHealth during the audit period for the following services:

All Services Provided by Dr. Singh

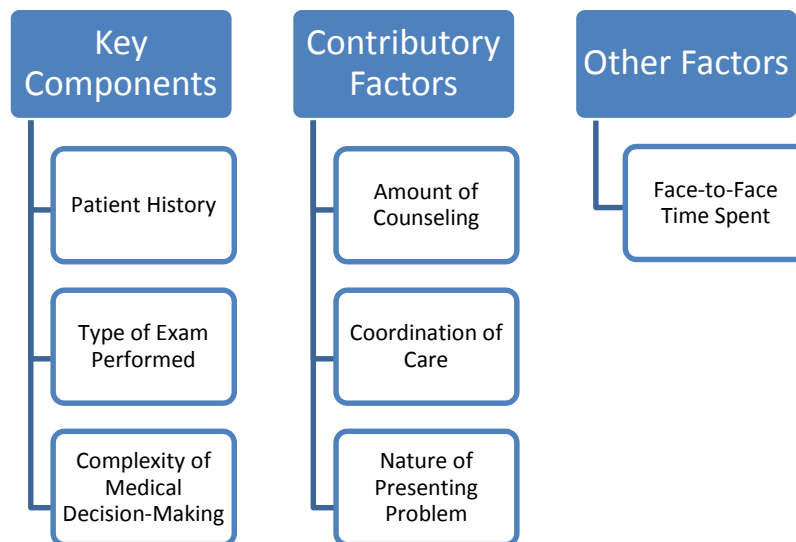
Services Provided	Amount Paid
Medical Services	\$ 258,430
Laboratory	33,094
Physician Services	15,682
Surgery	2,186
Other	2,012
Radiology	23
Total	<u>\$ 311,427</u>

Our audit focused on E/M claims for outpatient office visits for new or established members. Specifically, we selected procedure codes 99205 (initial patient visit) and 99215 (established patient visit), which are

for high-complexity cases. These claims totaled \$143,592 during the audit period and are included in the Medical Services and Physician Services categories above.

E/M Services

Based on the American Medical Association's *Current Procedural Terminology Professional Edition 2014* (the CPT Codebook),² patient visits and consultations are billed using E/M procedure codes. For new and established patients, E/M services provided in an outpatient setting are billed using 10 specifically defined E/M procedure codes.³ The more complex the services, the more the physician is compensated. For example, when a new patient presents with a minor problem (e.g., sunburn) requiring straightforward medical decision-making, the CPT Codebook directs providers to bill using E/M procedure code 99201. MassHealth pays physicians \$45.56 for this service. In contrast, when a new patient presents with a moderate- to high-severity problem (e.g., treatment for chronic obstructive pulmonary disease) requiring highly complex medical decision-making, the CPT Codebook directs providers to bill using E/M procedure code 99205. MassHealth pays physicians \$214.52 for this service. Medical providers must select the E/M procedure code that best represents the services rendered, giving consideration to the following seven factors:



2. This was the latest version applicable during our audit period.

3. The CPT Codebook defines five E/M procedure codes for services provided to new patients (99201–99205) and five for services provided to established patients (99211–99215).

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 selected outpatient evaluation and management (E/M) claims for services provided to MassHealth members by Dr. Kunwar Singh for the period January 1, 2010 through June 30, 2015.

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

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

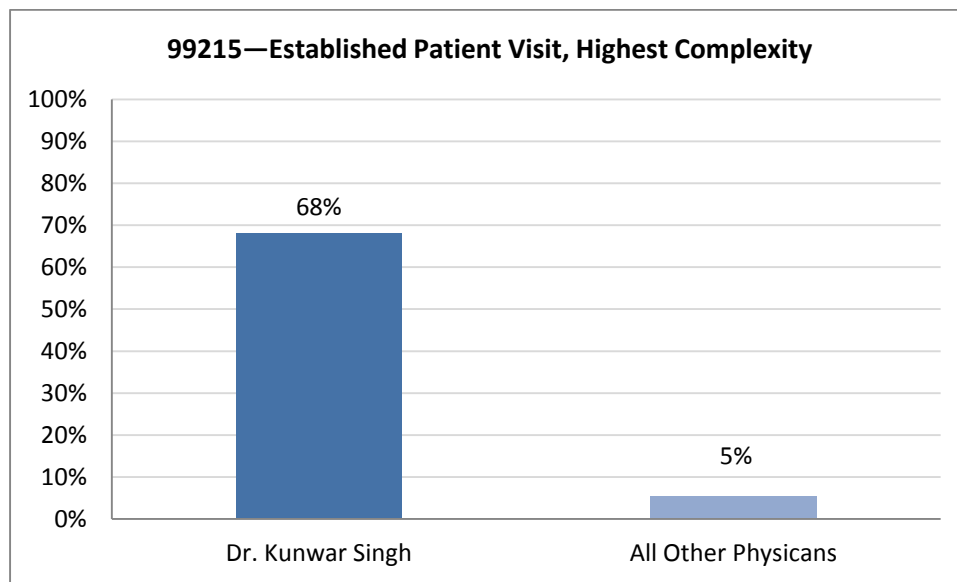
Objective	Conclusion
1. Did Dr. Singh bill for outpatient E/M services provided to MassHealth members using procedure codes that reflected the level of service provided?	No; see Finding 1

Auditee Selection

Medicare and Medicaid audits conducted by federal and state agencies have identified instances of fraud in claims submitted for E/M services. One type of fraud uncovered was “upcoding.” Upcoding occurs when providers bill for E/M services using a procedure code designated for highly complex, high-severity medical conditions even though the medical condition presented was self-limited (minor), requiring straightforward decision-making. For example, the federal Office of the Inspector General published the following information in its study Coding Trends of Medicare Evaluation and Management Services, issued May 2012:

In 2010, nearly 370 million E/M services were provided by approximately 442,000 physicians nationwide. . . . Among these physicians, 1,669 billed the 2 highest level E/M codes within a visit type [e.g. outpatient/inpatient/new/established] at least 95 percent of the time. These 1,669 physicians represented less than 1 percent of all physicians who performed E/M services in 2010. These physicians substantially differed from others in their billing of E/M codes.

As stated above, MassHealth paid physicians approximately \$514.3 million for outpatient E/M services during our audit period for visits by new or established patients. Because of the large total amount of these expenditures and because audits conducted by federal and other state agencies have identified fraud in claims for E/M services, OSA is conducting a series of audits focusing on providers of such services. We performed data analytics on these E/M claims to identify (1) the frequency and cost of services performed by providers of E/M services and (2) service trends and billing anomalies indicating potential fraud, waste, and abuse. Our data analytics identified the providers who billed for the highest-paying E/M services most often. We selected Dr. Singh for audit because, using data analytics, we determined that he billed the highest-paying E/M procedure code, 99215, about 68% of the time, whereas on average, physicians during this same period billed it about 5% of the time, as illustrated below.



Methodology

To achieve our audit objective, we reviewed applicable state and federal laws, rules, and regulations; MassHealth Provider Bulletins and Transmittal Letters; MassHealth’s All Provider Manual; and the Centers for Medicare and Medicaid Services’ *Documentation Guidelines for Evaluation and Management (E/M) Services*.

Also, we requested, and received when available, the following documentation from Dr. Singh:

- employee manual
- training documentation

- policies and procedures for processing claims
- contract with MassHealth
- patient medical records

We attempted to test the internal control in which the billing clerk reviews each claim for compliance with MassHealth regulations before submission for payment, to ensure that outpatient E/M services had the appropriate documentation, and denote any noncompliance issues. Specifically, we requested from Dr. Singh a list and description of these noncompliance claim issues identified and resolved by his billing clerk. However, through discussions and a review, we did not find any evidence that this internal control existed. Although we were unable to perform our planned testing of this relevant control, we still achieved our audit objectives by increasing the number of claims tested to reflect the highest level of risk.

We performed a review of MassHealth member medical records. We selected a statistically random sample of 60 of the 1,086 E/M claims for procedure codes 99205 and 99215 from the audit period to determine whether services billed were upcoded. To make this decision, we reviewed documentation regarding the sampled members' presenting problems and medical and billing histories. For this statistical sample, we projected the error rate to the population.

We assessed the reliability of the MassHealth data in the Medicaid Management Information System, which is maintained by the Executive Office of Health and Human Services. As part of this assessment, we reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific time periods, and (5) tracing a sample of claims queried to source documents. Based on the analysis conducted, we determined that the data obtained were sufficiently reliable for the purposes of this report.

Based on the evidence we gathered to form a conclusion on our objectives, we believe that all audit work, in particular the work referred to above, taken as a whole is relevant, valid, reliable, and sufficient and that it supports the finding and conclusion reached in this report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. Dr. Kunwar Singh improperly billed for evaluation and management services totaling approximately \$55,390.

Dr. Kunwar Singh did not use the correct procedure codes when billing for outpatient evaluation and management (E/M) services. Specifically, Dr. Singh billed routine, less-complex cases using codes that were designated for high-complexity cases. This billing practice is referred to as upcoding. Dr. Singh's upcoding of E/M services resulted in improper payments totaling approximately \$55,390.

We tested a random, statistical sample of 60 out of 1,086 claims paid during the audit period for procedure codes 99205 and 99215 in order to project the potential problem to the population. Of these 60 claims, we identified 50 as billed using an incorrect procedure code. These 50 claims were billed using E/M procedure codes 99205 and 99215, but Dr. Singh's medical records did not contain documentation as to the nature, extent, and medical necessity of care provided to the member in order to justify using those codes.

E/M codes 99205 and 99215 are used for moderately to highly severe and complex cases. However, the 50 improper claims were for minor- or low-complexity cases. For example, Dr. Singh billed E/M code 99215 for minor medical conditions such as coughs / sore throats and headaches. In some instances, Dr. Singh improperly billed 99215 for follow-up visits that by nature would not require a high level of decision-making because that would have been performed at the initial visits. Dr. Singh should have billed for these types of services using lower-level E/M procedure codes 99211 through 99213.

We projected our results to the population of claims for procedure codes 99205 and 99215 using a confidence level of 90% and a tolerable error rate of 10.32%, resulting in projected overpayments of approximately \$55,390 during the audit period.

Authoritative Guidance

MassHealth has issued regulations to ensure that claims paid for medical services reflect actual services provided. Specifically, Section 450.223(C) of Title 130 of the Code of Massachusetts Regulations (CMR) indicates that providers entering into a contract with MassHealth agree to the following:

The submission of any claim by or on behalf of the provider constitutes a certification (whether or not such certification is reproduced on the claim form) that . . . the information submitted in, with, or in support of the claim is true, accurate, and complete.

Additionally, 130 CMR 450.307 states,

(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 or procedures provided as components of a more-comprehensive service for which a single rate of payment is established.

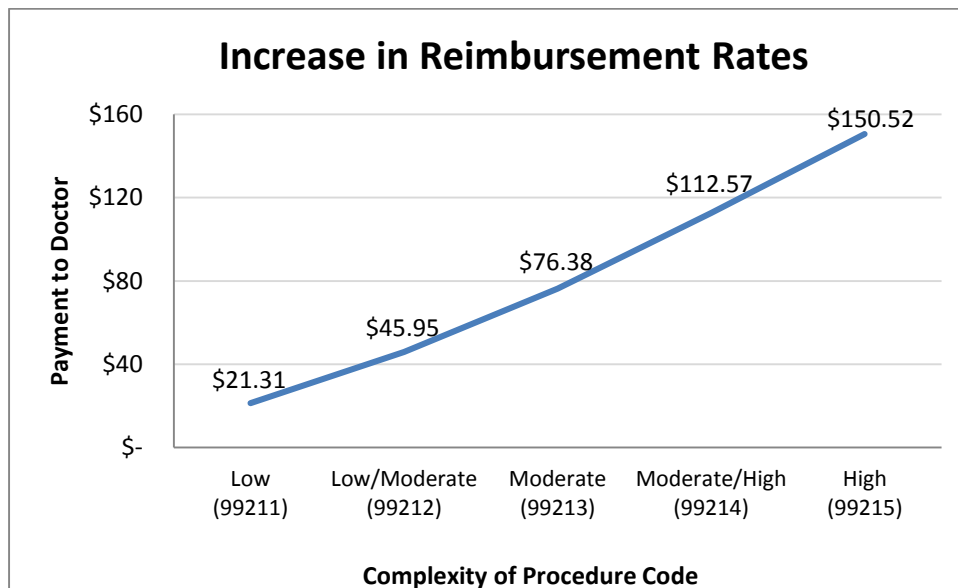
The American Medical Association’s *Current Procedural Terminology Professional Edition 2014* (the CPT Codebook) and the Centers for Medicare and Medicaid Services’ (CMS’s) *Documentation Guidelines for Evaluation and Management (E/M) Services* provide guidance on billing for E/M services provided to new or established patients: Of the 10 E/M procedure codes for such patients, physicians should bill using the one that best reflects the level of service provided given the seven factors previously described (see [Overview of Audited Entity](#)), including complexity of medical decision-making, nature of presenting problem, and face-to-face time. In addition, MassHealth’s rate schedule for E/M codes defines specific payment amounts for each code, as shown below.

Rates and Descriptions of E/M Codes

E/M Procedure Code	Payment Amount	Face-to-Face Time	Description
99201	\$45.56	10 minutes	New patient, self-limited or minor presenting problem, requiring the presence of a physician or other qualified healthcare professional
99202	\$78.04	20 minutes	New patient, low- to moderate-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional
99203	\$112.75	30 minutes	New patient, moderate presenting problem, requiring the presence of a physician or other qualified healthcare professional
99204	\$172.34	45 minutes	New patient, moderate- to high-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional

E/M Procedure Code	Payment Amount	Face-to-Face Time	Description
99205	\$214.52	60 minutes	New patient, moderate- to high-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional
99211	\$21.31	5 minutes	Minimal presenting problem, which may not require the presence of a physician
99212	\$45.95	10 minutes	Self-limited or minor presenting problem, requiring the presence of a physician or other qualified healthcare professional
99213	\$76.38	15 minutes	Low- to moderate-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional
99214	\$112.57	25 minutes	Moderate- to high-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional
99215	\$150.52	40 minutes	Moderate- to high-severity presenting problem, requiring the presence of a physician or other qualified healthcare professional

There are significant differences in the reimbursement amounts among these E/M codes. The chart below illustrates these differences for office visits for established patients.



E/M reimbursement rates increase significantly, as much as 110%, with every increase in procedure-code level.

Reasons for Upcoded Claims

In our review of Dr. Singh's billing procedures and discussions with his billing clerk, we found that the level of visit (procedure code) billed was not reviewed for appropriateness. Although the procedures required a review of patient documentation to ensure that levels of visits, diagnoses, and procedures were appropriate, the review was not sufficient to catch billing inaccuracies.

Also, Dr. Singh routinely provided medical services to his patients that were not related to their specific problems or the reasons for their visits, and were therefore of questionable medical necessity, which resulted in a higher billing rate. Dr. Singh's view, as documented in his procedures, is that billing for high-complexity initial and established office visits (procedure codes 99205 and 99215) would accomplish the following:

- a decrease in the number of admissions to inpatient facilities
- a decrease in the number of emergency-room visits
- a decrease in the number of "specialty consultations"
- an increase in self-management, to help make lifestyle changes (e.g., nicotine aid, counseling, treatments for obesity and depression)

Also, Dr. Singh stated that he preferred to bill a single more-complex code instead of multiple less-complex codes in order to save the Commonwealth money.

However, irrespective of Dr. Singh's personal views, he must follow state regulations, the CPT Codebook, and the CMS *Documentation Guidelines for Evaluation and Management (E/M) Services*.

Recommendations

1. Dr. Singh should collaborate with MassHealth to repay the approximately \$55,390 in improper payments he received from the upcoding of claims.
2. Dr. Singh should develop internal controls to ensure that his claims are not upcoded for E/M services. At a minimum, these controls should ensure that his billing staff has sufficiently reviewed required documentation to support each claim.

MassHealth's Response

1. *MassHealth agrees with [the Office of the State Auditor's, or OSA's] finding that Dr. Kunwar Singh improperly billed for Evaluation and Management (E/M) services totaling*

approximately \$55,390. MassHealth's Program Integrity Unit will work with Dr. Singh to recover the overpayment once the final report has been issued.

- 2. MassHealth agrees with [OSA's] finding that Dr. Singh should develop internal controls to prevent upcoding on future claims. MassHealth will work with Dr. Singh and his employees to provide education on MassHealth policies and to improve the process by which Dr. Singh's office reviews and submits claims. To ensure Dr. Singh implements proper billing procedures going forward, MassHealth will monitor his claims utilizing data analytics to detect possible upcoding. Based on the monitoring results, MassHealth may request medical records or conduct unannounced on-site audits to ensure that Dr. Singh has correctly billed for the services rendered.*

Auditee's Response

Government Auditing Standards Not Met

First, it does not appear the OSA's performance audit of the selected outpatient medical evaluation and management ("E/M") claims for the services Dr. Singh provided to his MassHealth patients was conducted in accordance with generally accepted government auditing standards. At a meeting with OSA staff on December 29, 2015, Dr. Singh was informed his performance audit was conducted by members of OSA staff who were not medical professionals. According to the United States Government Accountability Office's Government Auditing Standards (2011 revision), the staff assigned to a performance audit should collectively possess "skills appropriate for the work being performed; for example, . . . specialized knowledge in subject matters, such as . . . medical . . . if the work calls for such expertise." GAO Standard 3.72. If the auditing staff does not possess the required technical expertise, it may be required to use specialists such as "medical professionals." GAO Standard 6.42. As set forth below, medical expertise was required for a determination of the appropriate level of E/M services.

For example, a determination of the appropriate level of medical care provided to a patient is based upon the physician's clinical judgment. According to the Center for Medicare and Medicaid Service's 1997 Documentation Guidelines for Evaluation and Management Services ("CMS Guidelines"), which the OSA relies upon in its report, "[t]he type . . . and content of examination are selected by the examining physician and are based upon clinical judgment, the patient's history, and the nature of the presenting problem(s)." . . . The OSA concluded that in 38 cases, the comprehensive examination conducted by Dr. Singh was "excessive based on the [chief complaint] and previous visit," although it did not provide any of the facts on which it based its belief. . . . At a minimum, therefore, the staff assigned to the audit should have possessed medical expertise in order to properly assess the clinical judgment exercised by Dr. Singh, as well as the patient's history and nature of presenting problems, to determine the appropriate level of examination.

Further, the Draft Audit report concludes, in part, that Dr. Singh did not use the correct procedure codes when billing for certain outpatient E/M services because the MassHealth patients had "minor- or low-complexity cases." . . . However, a determination of the complexity of medical decision making—one of the key components which define the level of E/M service—cannot be made by an individual who does not have medical expertise. Indeed, the determination of risk, which is a factor in the complexity of decision making, "is complex and not readily quantifiable." CMS Guidelines at

p. 46. Medical expertise is required for a determination of risk not only because it is not readily quantifiable, but also because, for example, "[t]he assessment of risk of the presenting problems(s) is based on the risk related to the disease process anticipated between the present encounter and the next one." *Id.* An individual who does not have medical expertise regarding disease processes cannot make a determination regarding the relevant risks for the patient based on the patient's presenting problems. In order to competently assess the complexity of a patient's case, which involves an assessment of medical decision making and a determination of risk factors based on the patient's presenting problems and history, the expertise of a medical professional is required. For these reasons, based on the lack of medical expertise in performing the audit, the OSA's audit does not conform to generally accepted government auditing standards, e.g. GAO Standards 3.72 & 6.42, and its findings cannot be deemed to be a determination of overpayment for purposes of 130 CMR 450.237.

Dr. Singh Met CMS and CPT Guidelines . . .

The complexity of medical decision making is not the sole component used in selecting the level of an outpatient E/M visit as the Draft Audit Report implies. There are six additional components which are used in defining the levels of E/M services: history, examination, counseling, coordination of care, nature of presenting problem(s), and time. CMS Guidelines at p. 4. In sum, the level of E/M service corresponds to the amount of skill, effort, responsibility, time and medical knowledge required for the physician to deliver the services to the patient.

The component of counseling is considered to be an "important" E/M service. [American Medical Association's Current Procedural Terminology Professional Edition 2016, or CPT Guidelines] at p. 4. Counseling is a discussion with a patient and/or family concerning one or more of the following areas: diagnostic results, impressions, and/or recommended diagnostic studies; prognosis; risks and benefits of management (treatment) options; instructions for management (treatment) and/or follow-up; importance of compliance with chosen management (treatment) options; risk factor reduction; and patient and family education. *Id.* In cases where the visit consists predominantly of counseling or coordination of care, time is the key or controlling factor to qualify for a particular level of E/M services. CMS Guidelines at p. 48.

Face-to-face time with the patient, which is another component defining the level of E/M service, includes "time spent performing such tasks as obtaining a history, examination, and counseling the patient." CPT Guidelines at p. 8. "The face-to-face time associated with the services described by any E/M code is a valid proxy for the total work done before, during, and after the visit." *Id.* "The nature of the presenting problem and time are provided in some levels to assist the physician in determining the appropriate level of E/M service." *Id.* at 9. Typically, 60 minutes is spent face-to-face with the patient and/or family for a 99205 level visit and 40 minutes for 99215 level visit. *Id.* at 12, 13.

To be sure, the complexity of medical decision making, history and examination are considered to be key components. *Id.* However, for E/M code 99215, which was the code used in the majority of claims reviewed by the OSA, only two of these three key components are required. CPT Guidelines at p. 13. In Dr. Singh's case, in 18 of the 44 cases the OSA alleges were incorrectly coded as 99215 visits, the OSA does not dispute Dr. Singh conducted a comprehensive history and a comprehensive examination—the two key components required for a 99215 level visit. It is also undisputed that

in all but one of the 50 claims contested by OSA, Dr. Singh provided his patients with a documented comprehensive examination. Indeed, the CPT Guidelines recognize that a comprehensive multi-system examination as performed by Dr. Singh is part of the preventive medicine E/M service physicians provide to their patients. CPT Guidelines at p. 9.

In addition to the comprehensive examination and comprehensive history provided to his patients, it is undisputed Dr. Singh provided counseling to these patients and their families (up to 30 minutes), which included a discussion of diagnostic results, recommended diagnostic studies, the importance of compliance with treatment options, risk factor reduction, and patient and family education, as detailed in the medical records he provided to OSA. Dr. Singh also spent at least 40 to 60 minutes of face-to-face time with each patient, depending on whether the E/M visit was for a new or existing patient, obtaining a history, performing an examination, and counseling to the patient. Again, the documentation in Dr. Singh's records supports that he provided the amount of face-to-face time with each patient that would warrant the billing of a 99205 or 99215 E/M visit. The amount of time Dr. Singh spends with his patients is also indicative of the complexity of their medical issues. Again, as set forth in the patient records provided to OSA, these patients had numerous presenting problems and comorbidities requiring extensive management and expertise, not just a simple cough, sore throat, or headache as the Draft Audit Report suggests.

The time intensive and comprehensive level of care Dr. Singh provided to his patients as a 99205 or 99215 level E/M visit not only met the CMS Guidelines and CPT Guidelines, but has greatly improved the overall quality of his patients' health and in all cases reduced or eliminated the need for hospitalizations. From the OSA summary previously provided to Dr. Singh, it appears OSA did not even consider or simply disregarded the important factors of counseling, coordination of care and face-to-face time in these cases, and yet conceded he performed a comprehensive examination in virtually all cases and conducted a comprehensive history in many cases. . . . To the extent OSA considered the comprehensive examinations to be "excessive" or the complexity of his patients' medical issues to not require a high level of decision making, it did not have the medical expertise to make such a determination. For all of these reasons, these claims cannot be deemed to be "upcoded" to a 99205 or 99215 visit, and, more importantly based on this evidence, cannot amount to a determination as an overpayment pursuant to 130 CMR 450.237. . . .

Lack of Detailed Findings . . .

The OSA's Draft Audit Report and summary include its conclusions, but fails to provide Dr. Singh with the requisite facts on which it bases its belief or identify the amount believed to be overpaid for each claim or the reasons therefor such that he has a reasonable opportunity to submit additional data and argument to MassHealth to support his claim for reimbursement. Indeed, there is no transparency in the Draft Audit Report with regard to the calculation of overpayment. Accordingly, OSA's conclusions in its Draft Audit Report cannot be a determination of overpayment for purposes of 130 CMR 450.237.

Randomness of Audit

In its audit, OSA did not calculate the amount of alleged overpayment based upon a review of a representative sample of Dr. Singh's MassHealth claims drawn from the total number of claims submitted during the time period. Instead, OSA conducted its audit by selecting only certain claims

for E/M services coded as 99205 or 99215 during the time period. Consequently, OSA's calculation does not meet the random sampling requirements of 130 CMR 450.236, and, therefore, cannot be considered to be a determination of overpayment for purposes of 130 CMR 450.237.

Recommendations Regarding Internal Controls

Dr. Singh will review his internal controls to ensure that his claims for E/M services are billed at the appropriate level and adequate checks and balances are in place. In the near future, he anticipates his office will be switching to new medical record software, which will include artificial intelligence to code each visit as documented in the medical record. This coding will be further reviewed and verified by both the physician and billing staff.

In addition, Dr. Singh is a physician member of the Hallmark Health System ("Hallmark"), an affiliate of Partners Community Healthcare Inc. As a benefit to the physician members of its network, Hallmark hired a medical record compliance specialist to provide guidance on documentation and coding to its members. Dr. Singh is receiving regular feedback from the specialist and expects to meet with her shortly to discuss best practices with regard to the coding of E/M services. Finally, Dr. Singh welcomes any outreach provided by MassHealth to educate physicians on proper billing for E/M services.

Auditor's Reply

In his response, Dr. Singh asserts that the audit was not conducted in accordance with generally accepted government auditing standards because OSA personnel were not medical professionals and did not collectively possess skills appropriate for the work being performed. This is not correct. The audit team did have the necessary expertise to audit Dr. Singh's billing practices. The Massachusetts Legislature gives OSA an annual appropriation for the operation of the Medicaid Audit Unit. The goal of the unit is to prevent and identify fraud in the MassHealth system. To accomplish this goal, OSA has hired and trained a unit staff that focuses solely on the MassHealth program, including contracted service providers such as Dr. Singh. OSA has conducted numerous provider audits, including audits of dentists, physicians, nurse practitioners, laboratories, and others. When audit teams require assistance with issues related to medical decision-making, they obtain assistance from relevant medical experts as well as MassHealth. As part of this audit, we met with MassHealth's Office of Clinical Affairs' medical management director and his staff to discuss Dr. Singh's medical records, supporting documentation, billing practices, and member claims. Thus, by using specially trained audit staff and obtaining MassHealth's assistance, OSA has complied with generally accepted government auditing standards on this audit.

In order to assess the validity of Dr. Singh's claims, the audit team performed a detailed review of sampled members' medical records, including documentation for complexity of medical decision-making, history,

examination, counseling, coordination of care, nature of presenting problem(s), and time. Our review found that Dr. Singh's records were inconsistent and unclear and appeared to carry over medical information from previous visits, making it difficult to determine what services were actually performed for members on a particular day. This is contrary to 130 CMR 433.409, which states,

(A) Payment for any service listed in 130 CMR 433.000 is conditioned upon its full and complete documentation in the member's medical record. . . .

(B) In order for a medical record to document completely a service or services to a member, that record must set forth the nature, extent, quality, and necessity of care provided to the member. When the information contained in a member's medical record is not sufficient to document the service for which payment is claimed by the provider, the MassHealth agency will disallow payment for the claimed service.

MassHealth's Office of Clinical Affairs staff confirmed that Dr. Singh's medical records were deficient and did not support the claims he submitted using procedure codes 99205 and 99215. MassHealth also confirmed that in most cases, a comprehensive visit, which included Dr. Singh's examination of eight body areas, was excessive based on the member's presenting problem.

In addition, MassHealth pointed out many instances of questionable patient care. For example, Dr. Singh would denote an acute disorder in a member's medical record, but did not document any referral to a specialist or provide any detailed notes on the disorder in the record. This practice would make it difficult to determine the severity of the presenting problem or justify the use of procedure codes 99205 and 99215. MassHealth concluded that Dr. Singh did not bill appropriately and that his quality of care to some patients was questionable.

Our audit work identified other factors supporting our conclusion that Dr. Singh improperly billed for member services, as described below.

- Dr. Singh stated that he prefers to see his patients less often for longer periods of time rather than seeing them more often for short periods. He said that this resulted in a few claims for high-complexity procedure codes rather than many claims for low-complexity procedure codes. He added that this type of scheduling was easier for members to keep and saved money for the Commonwealth. However, our review found cases in which Dr. Singh billed high-complexity codes for the same members on multiple occasions over a short period of time, which contradicts his assertion that the practice results in fewer high-complexity codes billed. For example, for one member, Dr. Singh submitted five claims for procedure code 99215 over a two-month period.
- Dr. Singh's documented procedures state that billing for high-complexity initial and established office visits (procedure codes 99205 and 99215) will decrease the numbers of emergency-room visits, "specialty consultations," and admissions to inpatient facilities and increase self-

management to help members make lifestyle changes (e.g., nicotine aid, counseling, treatments for obesity and depression). However, these procedure codes are for problem-focused, medically necessary office visits to address members' chief complaints. Dr. Singh used them improperly to reflect his preventive medicine services. Separate procedure codes are available to providers for such services.

- Dr. Singh stated that insurance companies and his own peers (Hallmark Health System) advised him to adjust his billing practices because of his frequent use of procedure codes 99205 and 99215.

During the audit, we discussed Dr. Singh's questionable billing practices with him and provided him with a list of claims that were potentially paid contrary to state regulations. We also offered Dr. Singh an opportunity to review these claims in detail; however, he expressed no interest in meeting with us to review the finding.

As to the issue of random sampling, our audit focused on E/M claims billed using procedure codes 99205 and 99215. Therefore, our sample was not drawn from all Dr. Singh's claims. Instead, we appropriately selected a statistically random sample only from codes 99205 and 99215 and extrapolated these results to the total claims made for these two procedure codes.

In addition, 130 CMR 450.236 does not contain sampling requirements for audit purposes or any reference to random sampling. It states that "the *MassHealth* agency *may* ascertain the amount of overpayments by reviewing a representative sample" of claims (emphasis added). This does not constrain OSA to use a particular sampling method; it merely lists one method by which MassHealth may determine or recover overpayments. OSA is free to use its professional judgment to determine the most effective method of sampling. In this case, we determined that statistical sampling, which allows us to project our testing results to all claims submitted for these procedure codes, would be the best way to give MassHealth a valid estimate of improper claims. Ultimately, MassHealth will make the final determination of what overpayments, if any, should be recovered. During this process, Dr. Singh will be afforded an opportunity to defend his billing practices and contest any questioned payments as noted by OSA.