



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

Making government work better

Official Audit Report – Issued August 16, 2017

Office of Medicaid (MassHealth)—Review of Evaluation and Management Claims Paid to Lawrence Family Doctors

For the period January 1, 2011 through June 30, 2016





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Making government work better

August 16, 2017

Joel A. Gorn, MD
Lawrence Family Doctors
101 Amesbury Street, Suite 204
Lawrence, MA 01840

Dear Dr. Gorn:

I am pleased to provide this performance audit of evaluation and management claims paid to Lawrence Family Doctors by the Office of Medicaid. This report details the audit objectives, scope, methodology, findings, and recommendations for the audit period, January 1, 2011 through June 30, 2016. My audit staff discussed the contents of this report with you, and your comments are reflected in the report.

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

Sincerely,

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

Suzanne M. Bump
Auditor of the Commonwealth

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LIST OF ABBREVIATIONS

CMR	Code of Massachusetts Regulations
CPT Codebook	<i>Current Procedural Terminology Professional Edition 2014</i>
E/M	evaluation and management
LFD	Lawrence Family Doctors
MMIS	Medicaid Management Information System
NP	nurse practitioner
OSA	Office of the State Auditor

EXECUTIVE SUMMARY

The Office of the State Auditor (OSA) receives an annual appropriation for the operation of a Medicaid Audit Unit to help prevent and identify fraud, waste, and abuse in the Commonwealth's Medicaid program. This program, known as MassHealth, is administered under Chapter 118E of the Massachusetts General Laws by the Executive Office of Health and Human Services, through the Division of Medical Assistance. Medicaid is a joint federal-state program created by Congress in 1965 as Title XIX of the Social Security Act. At the federal level, the Centers for Medicare and Medicaid Services, within the US Department of Health and Human Services, administer the Medicare program and work with state governments to administer state Medicaid programs.

OSA has conducted an audit of evaluation and management (E/M) claims paid to Lawrence Family Doctors (LFD) for the period January 1, 2011 through June 30, 2016. During this period, LFD was paid approximately \$1,233,444 to provide E/M services for 1,763 MassHealth members. The purpose of the audit was to determine whether LFD properly billed MassHealth for E/M services performed by nurse practitioners (NPs) during the audit period.

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 potentially improper payments. As with any government program, public confidence is essential to the success and continued support of the state's Medicaid program.

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

Finding 1
Page 9

LFD improperly billed MassHealth for at least \$108,232 of E/M services provided by NPs.

Recommendations Page <u>10</u>	<ol style="list-style-type: none">1. LFD should collaborate with MassHealth to establish a plan to repay the \$108,232 in overpayments it received from improper E/M service billings.2. LFD should bill for NPs' services using either the SA modifier or NPs' servicing provider identification numbers.3. LFD should periodically review all the billing requirements in MassHealth's regulations, as well as updates to these regulations that are described in MassHealth's transmittal letters and provider bulletins, and ensure that its staff members are aware of, and adhere to, these requirements when billing for services provided to MassHealth members.
Finding 2 Page <u>12</u>	LFD did not maintain proper documentation for \$2,316 of E/M services.
Recommendations Page <u>14</u>	<ol style="list-style-type: none">1. LFD should ensure that it maintains necessary documentation to support the nature, extent, and medical necessity of care provided to members, including documentation of exams, medical histories, and chief complaints.2. LFD should ensure that it can retrieve all medical records stored on computer servers.

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. In fiscal year 2016, MassHealth paid healthcare providers more than \$14 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 433 of Title 130 of the Code of Massachusetts Regulations, MassHealth pays for physician services provided to eligible MassHealth members. Dr. Joel Gorn, medical director and sole proprietor of Lawrence Family Doctors (LFD) in Lawrence, is a certified MassHealth service provider. LFD received a total of \$1,404,016 from MassHealth during the audit period for the services detailed below.

Services Provided by LFD

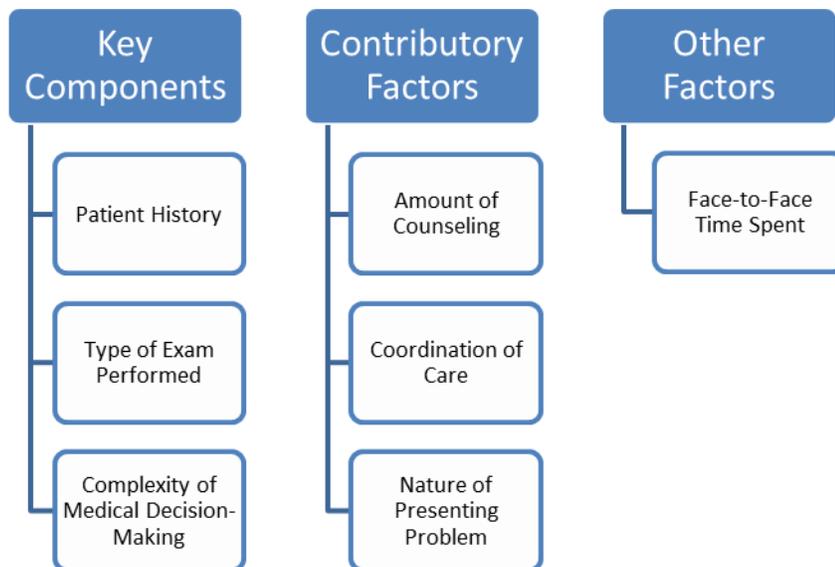
Service	Amount Paid
Family Planning	\$ 341
Office/Other Outpatient and Preventive	1,233,444
Other Services*	32,366
Physician Laboratory	17,995
Physician	116,177
Radiology	479
Surgery	3,214
Total	<u>\$1,404,016</u>

* Examples include administration of vaccines and immunizations, inhalation treatments, and developmental screenings.

Our audit focused on LFD’s billing practices for evaluation and management (E/M) claims for services performed by nurse practitioners (NPs), including office and other outpatient services (procedure codes 99201–99205 and 99211–99215) and preventive medicine services (procedure codes 99381–99397). These claims totaled \$1,233,444 during the audit period and are included in the table above.

E/M Services

Based on the American Medical Association's *Current Procedural Terminology Professional Edition 2014* (CPT Codebook), E/M services are divided into broad categories such as office visits, hospital visits, and consultations. Most categories are divided into two or more subcategories of E/M services. For example, for office visits there are subcategories for new patients and established patients. These subcategories are further classified into levels of E/M services, broken down by the nature of the work, place of service, and patient status. The more complex the service, 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 currently pays physicians \$31.59 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) that requires highly complex medical decision-making, the CPT Codebook directs providers to bill using E/M procedure code 99205. MassHealth currently pays physicians \$147.51 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.



Billing Requirements for Services Provided by NPs

NPs are nationally certified, state-licensed medical professionals who can practice medicine as part of a healthcare team and in collaboration with physicians and other healthcare professionals. Both independent NPs and non-independent NPs may take patients' medical histories, conduct physical

exams, diagnose and treat illnesses, develop treatment plans, order and interpret tests, write prescriptions, assist in surgery, provide counsel on preventive care, and make rounds in hospitals and nursing homes. Although the services they provide are the same, the billing requirements for independent and non-independent NPs differ. Independent NPs have their own unique MassHealth provider identification numbers, which they must use when billing for E/M services. In contrast, non-independent NPs do not have unique MassHealth provider identification numbers. Typically, they are employed by physicians and collaborate with them when providing E/M services. A non-independent NP's services are billed using the collaborating physician's MassHealth provider identification number with a required modifier code. This code prompts MassHealth to pay 85% of the rate it would pay for a physician to perform these services.

AUDIT OBJECTIVES, SCOPE, AND METHODOLOGY

In accordance with Section 12 of Chapter 11 of the Massachusetts General Laws, the Office of the State Auditor (OSA) has conducted a performance audit of Lawrence Family Doctors (LFD) for the period January 1, 2011 through June 30, 2016.

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

Below is 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 findings.

Objective	Conclusion
1. Did LFD properly bill MassHealth for evaluation and management (E/M) services provided by nurse practitioners (NPs)?	No; see Findings <u>1</u> and <u>2</u>

Auditee Selection

During our audit period, MassHealth paid physicians approximately \$1,035,800,273 for E/M services. Because of the significant amount of these expenditures, as well as prior OSA audits that identified potential improper billings for E/M services, OSA is continuing to audit this type of claim. To identify the providers that represented the highest risk, we performed data analytics on all E/M claims from the audit period to identify (1) the frequency and cost of E/M services performed by providers and (2) service trends and billing anomalies that indicate potential fraud, waste, and abuse. Our data analytics identified high E/M costs and a high frequency of E/M services associated with certain providers. Based on the results of this analysis, we selected LFD.

Methodology

To achieve our audit objective, we reviewed applicable state and federal laws and regulations, MassHealth bulletins and transmittal letters, the MassHealth All Provider Manual, and the MassHealth

Physician Manual. We also requested, and received when available, the following documentation from LFD:

- office policies and procedures
- member medical records
- employee list and job descriptions
- physician's work schedule
- members' scheduled appointments
- contract with third-party billing company

We evaluated the design of LFD's billing process for E/M services and the related internal control over this process that we deemed significant to our audit objective.

We selected a statistically random sample of 179 out of 13,391 E/M paid claims from the audit period, using an expected error rate of 50%, a desired precision of 15%, and a confidence level of 95%, to determine whether LFD properly billed MassHealth for these services. Expected error rate is the anticipated rate of occurrence of the error of improper billing for services; 50% is the most conservative. Desired precision is a measure of how precise the actual error rate is. Confidence level is the numerical measure of how confident one can be that the sample results reflect the results that would have been obtained if the entire population had been tested. For this audit, we designed our sample so that we would be 95% confident that the actual error rate in the sample of 179 claims would be within a range of +/- 7.5%, or 15%, of the error in the population of 13,391 claims.

To determine whether LFD properly billed MassHealth for E/M services, we reviewed information in the members' medical records for the sampled claims, including the servicing provider's name, servicing provider's credentials, supervising physician's name, description of chief complaint, and documentation of a physical exam and review of physiological systems.

The statistical sampling method described above allows us to extrapolate the sampled findings to the entire population of paid E/M claims. Based on our testing, the actual error rate in our sample was 70%, and when projecting this to the total population of paid E/M claims, we are 95% confident that at least 64% (at the lower limit) or at most 75% (at the upper limit) of LFD's E/M claims were overpaid. In OSA's

opinion, the lower limit (the most conservative amount), or 64%, is the minimum amount that LFD must repay to the Commonwealth.

We used the Executive Office of Health and Human Services' website to determine the statuses of licenses held by LFD's professional staff members during the audit period. We also reviewed the Medicaid Management Information System (MMIS) to determine whether the NPs employed by LFD were independent or non-independent. In addition, we determined whether each NP had a collaborative arrangement or prescriptive practice guidelines with Dr. Gorn. We also contacted the program analyst for the Department of Public Health's Bureau of Health Professions Licensure to verify that all NPs were properly registered with Dr. Gorn as their supervising physician, as required by state regulations.

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 the work performed, OSA reviewed existing information, tested selected system controls, and interviewed knowledgeable agency officials about the data. Additionally, we performed validity and integrity tests on all claim data, including (1) testing for missing data, (2) scanning for duplicate records, (3) testing for values outside a designated range, (4) looking for dates outside specific time periods, and (5) tracing a sample of claims queried to source documents. Based on these procedures, we determined that the data obtained were sufficiently reliable for the purposes of this report.

DETAILED AUDIT FINDINGS WITH AUDITEE'S RESPONSE

1. Lawrence Family Doctors improperly billed MassHealth for at least \$108,232 of evaluation and management services provided by nurse practitioners.

Lawrence Family Doctors (LFD) did not use the required modifier codes for non-independent nurse practitioners (NPs) or the servicing provider identification numbers for independent NPs when billing MassHealth for evaluation and management (E/M) services. Instead, it used the servicing provider identification number of the practice's owner and medical director, Dr. Gorn. MassHealth pays for E/M services provided by both types of NPs at lower rates than it pays when the same services are provided by physicians. For example, in 2015, procedure 99213 (15-minute outpatient E/M service) was paid at a physician rate of \$52.37, whereas the NP rate was only \$44.51. Because LFD did not submit claims using the required modifier codes or the appropriate servicing provider identification numbers, it was paid the standard physician rate.

Of the 179 claims in our sample, 125 (70%) were billed to MassHealth with Dr. Gorn listed as the servicing provider although the services were actually performed by his NPs according to the members' medical records. This resulted in at least \$108,232 of overpayments during the audit period that could have been allocated to Medicaid or other state benefit programs.

Authoritative Guidance

Section 450.301(A) of Title 130 of the Code of Massachusetts Regulations (CMR) states that a provider cannot make a claim for services rendered by another provider:

Except as provided in other program regulations, a claim for a medical service may be submitted only by the provider that provided the service. . . . An individual practitioner may not claim payment under his or her own name and provider number for services actually provided by another individual, whether or not the individual who provided the service is also a participating provider, or is an associate, partner, or employee of the individual practitioner.

This requirement is intended to ensure that MassHealth pays the appropriate, lower rate for NP services, which 101 CMR 317.03(4) establishes as 85% of the physician rate.

Additionally, 101 CMR 317.04(3) states that providers must use modifier codes for services performed by non-independent NPs. Modifier codes ensure that MassHealth pays the appropriate, lower rate for

NP services. For non-independent NPs,¹ the regulation requires the SA modifier, which it defines as follows:

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

Reasons for Improper Billing

Dr. Gorn stated that he was not aware that claims for NP services were paid at rates lower than his or that services rendered by his NPs were supposed to be billed using either the SA modifier or the NP's servicing provider identification number, if there is one.

Recommendations

1. LFD should collaborate with MassHealth to establish a plan to repay the \$108,232 in overpayments it received from improper E/M service billings.
2. LFD should bill for NPs' services using either the SA modifier or NPs' servicing provider identification numbers.
3. LFD should periodically review all the billing requirements in MassHealth's regulations, as well as updates to these regulations that are described in MassHealth's transmittal letters and provider bulletins, and ensure that its staff members are aware of, and adhere to, these requirements when billing for services provided to MassHealth members.

MassHealth's Response

1. *MassHealth agrees that LFD should repay the Commonwealth for the overpayment described in [OSA's] finding.*
2. *MassHealth agrees that LFD should ensure the accuracy of claims submitted to MassHealth, including by accurately identifying the actual service provided and by using the correct modifier when applicable.*
3. *MassHealth agrees that LFD should regularly review all the billing requirements in MassHealth's regulations, as well as updates described in MassHealth's transmittal letters and provider bulletins. LFD should ensure that its billing staff knows, and adheres to, these requirements when billing for services provided to MassHealth members.*

1. Non-independent NPs are either NPs who do not have their own MassHealth provider identification numbers or NPs who are employed by physicians or physician practices.

Auditee's Response

In response to our draft audit report, Dr. Gorn provided the following comments on behalf of LFD.

While it may appear that the NPs employed by LFD perform evaluat[ion] and management services independently, they do not. Very often the nurse practitioners come to me to present cases and more often than not I will enter the exam room to assist in the evaluation and management during these patient encounters. We formulate a care plan together. I, as the supervising MD [Doctor of Medicine] in this practice am "hands on." The NPs in many instances are acting as my scribe.

The concept of "incident to" billing. We were under the impression that MassHealth follows Medicare guidelines with regards to visits provided by NPs. The concept of "incident to" billing is one which enables practices to bill NP encounters at the physician rate if a care plan has been established by an MD and the NP is following through on the established care plan.

Additionally, LFD provides care to extremely complex patients and we do so at a fraction of the cost compared with the Greater Lawrence [Family] Health Center 4 blocks away. The GLFHC provides care to the same population as we do and they are reimbursed at a much higher rate. They are reimbursed the same rate for visits provided by NP vs MDs. This seems unfair and places us at a disadvantage.

Several important issues of note

It is extremely difficult to recruit and retain primary care providers to work in Lawrence. Lawrence is considered a health professional shortage area (HPSA). Lawrence is a community that has higher than average rates of teenage pregnancy, low birth weight infants, HIV, Hepatitis C, and chemical addiction. The majority of Lawrence residents are covered under the MassHealth program. Lawrence Family Doctors cares for a disproportionate number of MassHealth patients. We do not have a large commercial health insurance base to offset the reduced reimbursements that MassHealth provides making it extremely difficult to pay competitive salaries and benefits. . . .

We are now billing visits provided by NPs with an SA modifier. We will review periodically MassHealth bulletins, transmittal letters, and will review billing requirements in MassHealth's regulations.

In its response to our draft report, LFD also offered several recommendations to MassHealth, which we shared with MassHealth.

Auditor's Reply

In its response, LFD asserts that very often the NPs present cases to Dr. Gorn, who most often assists in evaluation and management during these patient encounters. However, LFD's records indicate that the members in question were scheduled to receive these services from NPs, not Dr. Gorn, and that NPs

actually provided the services. It should be noted that MassHealth regulations require any physicians who use NPs to provide the types of supervision Dr. Gorn describes and also require that the appropriate modifier be used when the services were actually provided by an NP under a physician's supervision, as in these cases.

LFD also asserts that it was under the impression that MassHealth followed Medicare guidelines regarding "incident to" billing, which LFD asserts allow medical practices to bill NP encounters at the physician rate if a physician has established a care plan and the NP is following through on that plan. However, MassHealth regulations specifically require its providers to bill using the SA modifier in all instances when NPs provide services to MassHealth members, even when the supervising physician works with the NPs on establishing a care plan. As a MassHealth provider, LFD should have been aware of this requirement and submitted bills according to MassHealth regulations. If it was not clear to LFD whether Medicare regulations applied to MassHealth members whose services were partially funded by Medicaid, it should have sought clarification on this matter from MassHealth.

We cannot comment on the rates of reimbursement that LFD receives for providing these services compared to other healthcare providers or on their effect on LFD's ability to recruit and retain primary care providers to work in Lawrence, as this was not part of our objectives. Although this may be a valid concern, our finding relates to the way LFD billed for these services.

2. LFD did not maintain proper documentation for \$2,316 of E/M services.

For 27 (totaling \$2,316) of the 179 sampled claims from the audit period, members' medical records did not contain proper documentation of the services provided. Incomplete patient medical records not only raise concerns about the propriety of the related billings but also can negatively affect continuity of care for the patient.

Specifically, for 11 out of the 27 questioned claims, the medical records did not contain documentation of the nature, extent, and medical necessity of services provided to members. Additionally, the medical records were missing components required for E/M claims, including documentation of examinations, medical histories, and/or descriptions of chief complaints, to justify using the codes billed. For the remaining 16 questioned claims, LFD could not provide the medical records to validate the nature, extent, and medical necessity of care provided to the members.

Authoritative Guidance

MassHealth's Physician Manual, 130 CMR 433.409(B), establishes recordkeeping requirements for medical records:

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.

In addition, according to 130 CMR 450.205(A), providers are required to maintain adequate documentation of services provided to their members:

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

Additionally, MassHealth's regulations give specific details of what should be included in the medical records in 130 CMR 433.409(D)(1):

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

- (e) the diagnosis or chief complaint;*
- (f) clear indication of all findings, whether positive or negative, on examination;*
- (g) any medications administered or prescribed, including strength, dosage, and regimen;*
- (h) a description of any treatment given;*
- (i) recommendations for additional treatments or consultations, when applicable;*
- (j) any medical goods or supplies dispensed or prescribed;*
- (k) any tests administered and their results.*

Reasons for Lack of Documentation

Dr. Gorn stated that the missing documentation for 11 claims was caused by an issue he had during the audit period with one NP, whose employment he eventually terminated. For the remaining 16 claims,

Dr. Gorn could not retrieve necessary supporting documentation from an old server that is currently inoperable.

Recommendations

1. LFD should ensure that it maintains necessary documentation to support the nature, extent, and medical necessity of care provided to members, including documentation of exams, medical histories, and chief complaints.
2. LFD should ensure that it can retrieve all medical records stored on computer servers.

MassHealth's Response

LFD could collaborate with MassHealth to establish a repayment plan for the \$2,316 overpayment based on improper recordkeeping. . . .

1. *MassHealth agrees that LFD should ensure that appropriate documentation is maintained to support submitted claims.*
2. *MassHealth agrees that LFD should ensure that it can retrieve all medical records stored on computer servers.*

Auditee's Response

In response to our draft audit report, Dr. Gorn provided the following comments on behalf of LFD.

I take issue with this portion of the audit. The audit period January 1, 2011 to June 30th, 2016 reflects a period of time when LFD was using a first generation EMR (Electronic Medical Record) This system was not a web based system and required that LFD maintain all servers, software updates, backups, and workstations in perfect working order. LFD is a small private practice and this was a monumental task for us at the time. The server for which this data resides is quite old and was disconnected several years ago when LFD transitioned to a web based EMR. Our inability to gain access to older records on an old server that were documented on an antiquated first generation EMR should be forgiven. This applied to 16 of the 27 questioned claims.

Additionally 11 of 27 claims were provided by an NP who failed to document several of his patient encounters adequately. I had brought this issue up in his evaluations and eventually had to terminate his employment. I feel that this NP's failure to document adequately is an aberration for LFD. My practice is steadfast in its proper documentation and access to patient historical data. Our current providers are more thorough and our web based EMR is more robust and easier to use. These 11 claims should also be overlooked. . . .

We will ensure that LFD maintains proper documentation for all E/M services.

We will also ensure that we can access and retrieve all medical records in a timely manner.

Auditor's Reply

Although, according to its response, LFD is taking measures to improve its documentation, 130 CMR 433.409(B) and (D)(1) and 130 CMR 450.205(1) define recordkeeping and record-maintenance requirements for providers to follow when rendering services to MassHealth members. As a MassHealth provider, LFD is required to take the measures necessary to ensure that its records are maintained in accordance with these regulations, including making sure it can promptly retrieve medical records from any storage device used to store this information. Even if the retrieval of some of the records in question was an issue with LFD, MassHealth still disallows payment for services that a provider cannot demonstrate are properly documented. Based on its response, LFD is taking measures to address our concerns in this area.