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Counteracting Fraud, Waste and Abuse in Drug Test Billing

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COUNTERACTING FRAUD, WASTE AND ABUSE IN DRUG TEST BILLING

Capstone Thesis

DECEMBER 13, 2014
Allison Walton
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Abstract

Medicaid, Medicare, and major insurance companies are being faced with increased costs for drug test screening. These costs are not caused by a spike in the use of narcotics by subscribers, but from unnecessary testing and overbilling by doctors and drug screening companies. Recovering drug addicts are required to have random drug tests during their treatment program, but instead of being random, the drug tests have become prescriptive. Testing is performed at specific times weekly on a single patient, for substances that return results that are unimportant to the doctors. Doctors are given drug testing kits by large drug testing companies that are very accurate and low in cost. Once the necessary drug tests are completed, the insurance companies are billed for thousands of dollars. The test results are received by the doctors who are able to confirm or deny the use of a particular drug. Next, the doctors send the exact test sample to a drug testing company or laboratory for further confirmatory testing. Medicaid, Medicare, and employers are billed twice by way of the insurance companies, for the same tests on a single patient on the same date of service; first from the doctor and then from the laboratory (The Pathology Blawg). My focus will be to examine the current drug test billing system, assess the risks and vulnerabilities faced by Medicare, Medicaid and the insurance companies and analyze and recommend strategies to detect and eliminate fraud, waste and abuse (FWA) caused from healthcare provider billing schemes.
The History of Fraud, Waste and Abuse

David Friedrichs in his book Trusted Criminals: White Collar Crime in Contemporary Society, states that medical facilities have defrauded the government of billions of dollars annually through federally funded healthcare programs. Frederichs also stated that in 1995 FBI Director Louis Freeh contended that health care fraud was the fastest growing crime in the United States. The federal government confirmed “that medical fraud accounted for between 3 and 10 percent of the annual $1 trillion U.S. health care bill.” Taxpayers have been left to foot a significant portion of this tax bill (Friedrichs).

**Fraud** is “knowingly and willingly executing, or attempting to execute, a scheme to defraud a health care benefit program.” Fraud is committed when money or property is obtained by means of false or fraudulent pretenses, promises or representations from organizations that administer health care benefit programs.

**Waste** involves the over use of services or practices that result in unnecessary costs to the health care system. Waste is the misuse of resources; the actions of waste is not considered criminally negligent.

**Abuse** includes any action that directly or indirectly results in unnecessary costs to the health care system. Incorrect payments are made for services not rendered or which did not meet professional standards. Healthcare providers and suppliers may unknowingly receive payments for which they are not legally entitled. This stems from the intentional misrepresentation of facts from subscribers, and thus makes abuse not easily identifiable. What constitutes “abuse” or “fraud” depends on specific facts and circumstances such as intent, prior knowledge, and
available evidence (Addressing Fraud, Waste and Abuse).

**The Impact of Fraud, Waste and Abuse on the Healthcare Industry**

Fraudulent claims are a big burden to the insurance industry. In 2011, The National Health Care Anti-Fraud Association (NHCAA) reported that “$2.27 trillion was spent on health care and more than four billion health insurance claims were processed in the United States.” The fraudulent claims among these processed claims are of a small percentage, yet the cost to the government is huge (NHCAA).

The Centers for Medicare and Medicaid Services (CMS) anticipated total health care expenditures to reach $2.4 trillion in 2008. With the effects of demographics and the rising cost of medical treatment, total health care spending was projected to reach $4.14 trillion by the year 2018. This amount accounts for a large amount of the gross domestic product. In 2007, the National Health Care Anti-Fraud Association estimated that health care fraud accounted for three percent or $68 billion of health care expenditure in the United States. For that same year, the Federal Bureau of Investigation (FBI) expected losses due to health care fraud was between three and ten percent; at ten percent the losses would reach $226 billion (Price).

The FBI reports that health care fraud is a rising threat that costs the country tens of billions of dollars a year. National health care expenditures were estimated to exceed $3 trillion in 2014 with spending outperforming inflation (Health Care Fraud). These CMS statistics tells us that fraud has a devastating financial impact on health care organizations. An analysis done by the ACL Services Ltd., an audit and risk management transformation company, found that not only does fraud affect a company financially, but operationally and psychologically as well. Operationally, fraud disrupts the continuous work cycle of a company and psychologically,
employees become distrusting of each other and the providers and subscribers they serve. While the monetary loss is substantial, the full impact of fraud on an organization is overwhelming as these losses demoralize a company’s reputation, goodwill, and customer relations. An effective fraud management program is a guaranteed deterrent that will protect healthcare organization’s assets and reputation (Coderre).

Fraudulent activities can be perpetrated by any employee within an organization or by external affiliates. As the NHCAA states, whether subscribers have an employer-sponsored or a self-funded insurance plan, health care fraud unavoidably translates into higher premiums and out-of-pocket expenses as well as reduced benefits or coverage. For both private and government employers, health care fraud increases the cost of providing insurance benefits for employees and the overall cost of doing business. This increased expense is an added burden, especially to households with minimal residual income, and will force many Americans to make the decision as to whether or not health insurance is purchased for their households (NHCAA).

A September 2009 article in the Journal of the American Academy of Psychiatry and the Law, indicated that health care fraud is not a victimless crime. Health care companies will attempt to recoup sustained losses and all costs associated with this are passed on to the subscribers. The diversion of funds due to fraud increases the costs of providing legitimate medical services, while decreasing an organization’s net income. Providers will institute mechanisms designed to recoup these losses and these mechanisms will sometimes include unethical practices. Health insurance companies may reduce benefit coverage while self-funded individuals will pay higher premiums. The federal government may change eligibility requirements for programs such as Medicaid, and employers may request higher copays from their employees. Physicians may compromise patient safety and perform unnecessary procedures
and will bill for services never rendered. A false medical history is created and patients may later sustain difficulties obtaining disability or life insurance policies. An inaccurate medical history influences treatment decisions, and some insurance companies may deny coverage to subscribers based on a medical condition that does not exist. The medical profession is one of the most ethical professions in the United States; health care fraud tarnishes this reputation and raises questions about the ethics governing the profession as a whole (Price).

**Provider Healthcare Fraud**

The NHCAA indicates that the majority of health care fraud is committed by a small minority of dishonest health care providers. Fraudulent providers take advantage of the confidence entrusted to them by their patients. The actions of these providers destroy the reputation of perhaps the most trusted and respected physicians in our society. Physicians have access to patients’ records and a wide range of medical conditions and treatments with which to perpetrate a fraud scheme. Unlimited access to medical codes and patients who need constant treatment, gives the provider the ability to submit false claims for numerous insurers. Distributing false or fraudulent claims among insurers sponsored by public programs such as Medicare and Medicaid, increases fraud proceeds while lessening the chances of these providers being detected.

According to the NHCAA, dishonest providers commit fraud by:

- Billing for services that were never rendered. Genuine patient information may be obtained through identity theft to fabricate entire claims or legitimate claims are padded with charges for procedures or services that did not occur.
• Upcoding thus billing for more expensive services or procedures than were actually provided or performed. Providers will inflate a patient’s diagnosis to a more serious condition and falsely bill insurers for a substantially higher-priced treatment than was actually provided. Performing medically unnecessary services solely for the purpose of generating insurance payments is often seen in fraudulent nerve-conduction and other diagnostic-testing claims.

• Non-covered treatments are misrepresented as medically necessary and covered for the purposes of obtaining insurance payments. In cases such as cosmetic-surgery schemes, non-covered cosmetic procedures such as nose jobs are billed to patients' insurers as deviated-septum repairs.

• Unbundling - each step of a procedure is billed as if it was a separate procedure. This is seen in the treatment of drug addicts when drug tests from a single blood sample that detect a variety of narcotics is separated into multiple tests and billed separately.

• Patients are billed for more than, or for the co-pay amounts for services that are paid in full by the benefit plan.

• Providers may accept kickbacks from treatment facilities or hospitals for patient referrals.

• Providers may waive patient co-pays or deductibles for medical or dental care and over-bill the insurance companies. Policies set by insurers with regard to co-pay waivers are ignored by providers, thus violating the contracting process. Medicare prohibits routinely waiving co-pays unless it’s due to financial hardship (NHCAA).
The Concept of Drug Screening and Confirmatory Tests

According to the Substance Abuse and Mental Health Services Administration (SAMSHA), an agency of the U.S. Department of Health and Human Services, drug testing is typically a two-step process involving an initial drug screen done to identify possibly positive and negative specimens. A confirmatory test follows the initial screening to analyze any positive specimen detected. Screening tests, also known as initial tests, indicate the presence or absence of a specific substance or one that is chemically similar. These are qualitative analyses that confirm if the drug is absent or present in a particular specimen. Blood, urine and saliva are the most common specimens. Screening tests done in a laboratory or onsite in a physician’s office, are referred to as point-of-care tests (POCT). These tests are inexpensive, easily automated, and produce immediate results. Technological advances have led to improvements in confirmatory tests, giving laboratories the option to bypass screening tests and use confirmatory tests for specimen analysis (USDHHS).

Medicare Fraud in Drug Test Screening

The Wall Street Journal reports that medical providers are cashing in on costly drug tests that are unnecessary and billing Medicare for these costs. Doctors are conducting unnecessary drug tests on seniors for opiates such as heroin, cocaine and angel dust which few use. These tests are totally unnecessary and Medicare is billed for these test costs. Doctors are encouraged to operate by medical guidelines when treating patients, especially for pain, and test these patients to make sure they are neither abusing pills nor failing to take them. Unscrupulous pain doctors are making more from testing patients than from treating them.
Medicare became aware of abusive practices being carried out during simple urine tests and changed its billing procedures. Some doctors moved on to high-tech testing methods, where billing wasn’t limited and started testing for a variety of different drugs. Medicare or Medicaid, the federal health program for the elderly and disabled, is billed separately for each substance. In the Wall Street Journal report, the writer states that one provider who owns a laboratory and does high-tech tests for physicians, believes that testing for a broad range of drugs makes sense. High-tech tests are more accurate than single tests. These tests lessens the risk of missing substance-abusers. Medicare spent $445 million on 22 high-tech tests for drugs of abuse in 2012, and $14 million for angel dust or PCP testing; this amount increased 1,423% in five years (Weaver).

Case Study 1
Calloway Laboratories

In April 2012, Calloway Laboratories of Woburn, Massachusetts agreed to pay $20 million dollars to the state to settle charges that it defrauded Medicaid out of millions of dollars through an elaborate kickback scheme involving sham companies, fake doctor signatures, and excessive urine testing for impoverished drug addicts. Two executives of Calloway Laboratories, chief executive officer Arthur Levitan and chief operating officer Patrick Cavanaugh, as well as two employees of sober homes (group homes for recovering drug addicts) were indicted by a grand jury on charges involving the creation of straw companies. These straw companies were used to funnel bribes to the managers of sober homes, and in return for these bribes, the managers allegedly required tenants to undergo excessive urine screening. The lab work was sent to Calloway Laboratories and paid for by Medicaid. Much of the lab work was not ordered by a doctor or authorized medical provider as required by law, and claim documents included falsified doctors’ signatures (Wen).
Arthur Levitan and Patrick Cavanaugh along with William Maragioglio, an associate who owned and operated a sober home, were sentenced to four years of probation for a kickback scheme that cost the state Medicaid program millions of dollars (Conaboy). Under the settlement made by Calloway Laboratories, Arthur Levitan and Patrick Cavanaugh were no longer employed by or allowed to consult for Calloway Laboratories. The company agreed to a three-year compliance and monitoring program by the state of Massachusetts (Wen).

In May 2014, Calloway Laboratories again settled a lawsuit with the state of West Virginia for false billings submitted to West Virginia Medicaid and nationwide to Medicare. The investigation was conducted by the West Virginia Medicaid Fraud Control Unit (WV MFCU) and the United States Department of Health and Human Services, Office of the Inspector General (HHS-OIG). It was found that from March 2009 to April 2013, Calloway Labs billed Medicare and West Virginia Medicaid for false drug tests by using a pathology services code, in addition to the required code for urine drug testing. Calloway Labs performed a medical review with every urine drug screen, but billed Medicare and Medicaid for pathology services that were never rendered. Medical reviews are not covered by Medicare or West Virginia Medicaid but Calloway Labs submitted these claims under false pretenses and collected payments. A new management team brought on in 2012 by Calloway Labs’ new owners voluntarily discarded the company’s fraudulent billing practices (Justice News).

**Sober Homes**

Sober homes is an informal term used for rental homes marketed to recovering substance abusers. These homes are low-budget rooms found in apartment buildings or houses, usually in recession-plagued neighborhoods. Recovering addicts are guaranteed a safe environment which
assisted each individual with the resources necessary for recovery. Residents had to adhere to mandatory urine tests which are performed about three times weekly to uphold the zero-tolerance rule for substance abuse. Even with these stringent rules, addicts or tenants got high and were amazed to find out they were not penalized when the tests results came up positive. Contrary the house rules, the residents were not evicted by their landlords, but instead were used to keep the drug testing scheme afloat. The recovering addicts were the money-makers for the sober homes and private drug-testing labs. This was a little-known niche of the drug testing world. Landlords needed the labs so they could prove their seriousness about sobriety, and largely to get referrals so the rooms of the sober homes will be continually filled. On the other hand, the labs needed access to numerous deprived substance abusers whose drug-screening tests qualified for lucrative Medicaid reimbursements that are worth millions of dollars annually (Wen).

During a 2011 investigation by the Attorney General of Massachusetts, it was found that the owners of sober homes were accepting bribes from a renowned Massachusetts doctor, Punyamurtula Kishore. Dr. Kishore was arrested for falsely billing the State of Massachusetts $4 million in Medicaid reimbursements (Wen). The sober homes involved, required the recovering addicts housed in their facilities to submit to urine drug screens at least three times weekly. These urine tests had to be performed by the physician office laboratories owned by Dr. Kishore at a cost of approximately $100 to $200 per test (Karpinsky). (Appendix D gives the link to the author, Patricia Wen’s account of her recorded interview with Dr. Punyamurtula Kishore and his involvement of sober homes.)
Case Study 2

Preventive Medicine Associates

Dr. Kishore is the founder of Preventive Medicine Associates. Dr. Kishore owned and operated 29 treatment facilities throughout the state of Massachusetts, where each clinic specialized in opiate addiction treatment using a medication called Vivitrol. Patients suffering from opiate addiction were conventionally treated with methadone or Suboxone therapy. However, Dr. Kishore claimed that Vivitrol was a safer non-addictive form of treatment (Wen). In 2011, Dr. Kishore and Preventative Medical Associates were indicted and each charged with eight counts of Medicaid Kickbacks, eleven counts of larceny and eight counts of Medicaid False Claims to sober homes. The investigation was conducted by the Attorney General of Massachusetts and in 2013 additional charges of eleven counts of Medicaid False Claims and eleven counts of larceny were added to the original counts (Fennimore). New Horizon House is a sober home situated in a Quincy, Massachusetts. The home had strict rules against relapsing and required all residents to use Dr. Kishore, or one of his associates, as their primary care doctor. Recovering addicts were scheduled to submit three urine samples each week, with each test performed at Preventive Medicine Associates. Urine testing is typically paid for by Medicaid with remuneration ranging between $100 to $200 for each urine screen, as long as a doctor signs a form stating the test is medically necessary (Wen).

Dr. Kishore’s approach to sobriety is known as The Massachusetts Model. This regimen of drug testing differed from what many top addiction specialists, including John F. Kelly of the Center for Addiction Medicine at Massachusetts General Hospital, recommend for most recovering addicts in sober home settings. Normal procedures used to prove if a substance abuser
has relapsed is doing random drug testing unbeknownst to the addict; not scheduled weekly testing as conducted by Dr. Kishore’s facilities. Dr. Kishore’s sales pitches to sober homes emphasized the fact that he was a medical doctor, and employed other doctors who could properly authorize drug tests. Dr. Kishore distributed literature that promoted his labs and compared his clinics to other commercial labs. The literature claims that commercial labs “Performs testing, then asks for referral after the fact (illegal),” while his labs “require a complete physical, obtain a complete patient history, then order and perform testing (legal).” Dr. Kishore began attracting more business from sober home managers as he was seen as a dedicated doctor willing to focus on substance abusers (Wen).

“Precision Testing Laboratories”, a competing laboratory, filed a lawsuit claiming Dr. Kishore’s labs stole a number of its sober home clients including New Horizon. Precision’s lawyers subpoenaed Dr. Kishore’s bank records and found about a dozen $1,000 checks paid to New Horizon House for “facility fees.” These payments were viewed as bribes, even though they were veiled as salaries for no-show jobs and fees for alleged bed rentals or space in sober homes. Some of these checks were drawn on an account in the name of a nonprofit institution known as the National Library of Addictions. Dr. Kishore created this institution as an educational resource for drug treatment specialists. In all, the case involved more than 860 Medicaid recipients with more than 53,000 claims. Dr. Kishore and Preventive Medicine Associates pled not guilty and defended the payments to the sober homes as legitimate business expenses (Wen).

In April 2015, Dr. Kishore pled guilty to all counts of his indictment and will serve 11 months in jail with a ten year suspended sentence. In addition, Dr. Kishore and Preventative Medical Associates will pay $9.3 million in restitution for operating a Medicaid fraud scheme.
Dr. Kishore agreed to surrender his medical license (Fennimore). (Appendix B shows the revenue stream for the companies in both case studies.)

**Oversight and Internal Controls for Drug Screening Claims in the State of Massachusetts**

The Medicaid program in the state of Massachusetts, known as MassHealth, is administered by the Executive Office of Health and Human Services (EOHHS). Between July 1, 2008 and June 30, 2011, the Office of the State Auditor conducted an audit of MassHealth due to increased fraudulent activity against Medicaid; especially the frauds committed by Preventative Medicine Associates and Dr. Punyamurtula Kishore. MassHealth was developed to provide yearly access to healthcare services for low and mid income families. MassHealth’s upsurge in healthcare costs are due particularly to claims for drug test billing, as since 2007 MassHealth’s expenditures have risen annually on average by 8.69%. According to the Official Audit Report, in 2011 MassHealth paid healthcare providers more than $11.1 billion. An estimated 40% of this expenditure was funded by the state.

MassHealth’s services include providing drug tests for subscribers with substance abuse disorders. Payments are made to physicians who directly order and authorize drug tests or to members who are being actively treated. MassHealth established internal controls over the payment process for laboratory drug tests, to ensure payments are made only for medically necessary drug tests claims. The objective of this audit on MassHealth was to ascertain:

- If drug testing claims paid by MassHealth were medically necessary for subscribers with substance abuse disorders.
- If required documentations were submitted to substantiate these claims.
• Whether the services being billed were actually provided.

• If the billing and payment process conformed to the Massachusetts’ state laws and MassHealth’s policies.

• If cost savings incentives and strategies were utilized.

The audit on MassHealth generated the following findings:

• MassHealth paid for drug tests allocated to members on a daily basis for extended periods, sometimes surpassing a year. This process deviated from the guidelines recommended by the federal Substance Abuse and Mental Health Services Administration (SAMHSA), and those of other substance abuse treatment professionals. It was found that MassHealth could have saved approximately $7.8 million if the State’s policies and procedures were adhered to.

• Three laboratories were audited and it was discovered that “unbundling” was used when billing for drug testing services. Unbundling occurs when a group of drug testing procedure codes are billed separately. Contrary to Federal and State laws, this group of procedures must be billed using an all-inclusive procedure code. For four fiscal years ending June 30, 2012, unbundling costs to the State of Massachusetts totaled approximately $4.5 million.

• A glitch in MassHealth’s claims processing system prevented claims for duplicate drug tests from being denied. Currently healthcare providers are permitted to test members with substance abuse disorders once daily. Approximately $286,000 was expended for
15,606 instances where MassHealth paid for claims submitted for the same member on the same day.

- Pricing changes for drug tests approved by the state were not effectively implemented by MassHealth. On February 1, 2009, MassHealth had a price reduction in standard multiclass drug tests, but these pricing adjustments were not implemented until 9 days later, causing overpayments of $107,309 on 2,348 claims.

- Documentation requirements instituted by MassHealth were not followed by the laboratories when submitting drug test claims. Laboratory order forms and test results were unavailable at two of the three laboratories where the audit testing was conducted. However, the laboratories were paid $41,258 for these services. Physician’s authorizations and diagnosis codes were missing, a breach of MassHealth’s policies. MassHealth’s 30-day testing period limit was violated as standing order forms were used for periods surpassing this limit. Instances were found where testing was done with incomplete or sometimes non-existent forms (Official Audit Report).

**Recommendations for Increased Oversight**

The losses incurred by MassHealth could have been avoided if its management had actively enforced its policies: seeing to it that the frequency with which members received drug tests were monitored, investigated providers who submitted unusually large numbers of claims for drug tests per member, and ensured that tests that were originated by physicians were for medically necessary purposes for the member that was actively being treated.

The State Auditor recommended that MassHealth implement simple processes to detect deficiencies in its system to improve claims processing. It was suggested that system edits,
programs designed to detect flaws in medical claim processing software, be developed to successfully prevent fraudulent claims for drug tests ordered during the residential monitoring of substance abuse patients. Claims submitted frequently for a particular member would be detected during processing, analyzed, and verified for adherence to state policies. In order to track the payment of claims for any member, it was recommended that proper identification of the provider be submitted. This includes the physician’s or treatment facility’s name, identification number, and the diagnosis code used for treatment.

All claim information is housed in MassHealth’s data warehouse. Irregularities such as high-frequency drug testing would be easily identified which could improve the quality of claims processed within the Medicaid Management Information System (MMIS). If MassHealth develops new requirements such as specific drug testing codes and patient identification numbers, it would be impossible for laboratories to continually test a single subscriber and submit unnecessary claims. MassHealth would then be in line with state and federal standards governing the use of drug screening services.

The Official Audit Report states that MassHealth should “monitor the frequency with which members receive drug tests and investigate providers who submit unusually large numbers of claims.” Constant monitoring by MassHealth will ensure that drug tests are done only when medically necessary, and are ordered by physicians who are actively treating members with substance abuse disorders. System edits for unnecessary laboratory tests will be developed to establish regulations, detect and disallow claims for same day drug screens and confirmatory drug tests.

MassHealth will frequently review the system edits programmed in its claims processing software, to ensure that claims which violate state regulations will be readily identified.
Facilitating communication between MassHealth and healthcare or laboratory providers can alleviate all misunderstandings of how payments are processed for state provided services. Providers will be notified of duplicate verification tests and will be advised if these procedures are covered. The Office of the State Auditor recommended that Provider Bulletins outlining requirements for requesting laboratory services and recordkeeping be issued to laboratory providers (See Appendix F, 130 CMR 401.416 to 401.417, 410.455 to 410.459) (Official Audit Report).

The recommendations given to MassHealth by the Massachusetts Office of the State auditor can be successfully applied not only to state administered insurance plans, but to insurance companies that administer state and employer funded plans. Having effective internal controls such as implementing system edits will prevent, detect and reduce any fraudulent claims submitted by a provider. Adding a data mining software to a claims processing system will monitor incoming claims, and reveal subscribers who have a large volume of drug test claims, over the amount considered normal for a specific period.

**Healthcare Fraud and Abuse Laws**

The Anti-Kickback Statute

Jennifer Staman’s article in the Congressional Research Service states that the government was concerned that profit was a major influence for health care providers. Statues had to be enacted to protect federal healthcare programs from being financially violated. The anti-kickback statute was passed by Congress, making it a felony for anyone to deliberately profit or generate business from a federal health care program. Payments from these programs derived from exploiting residents of sober homes or substance abusers is forbidden. Persons found guilty for arranging scheduled drug tests contrary to state or federal policies will be in
violation of the anti-kickback statute. Violators will be subject to imprisonment of up to five years or fined up to $25,000. Healthcare providers or drug testing laboratories will receive up to a one year suspension from participating in all federal health care programs (Staman).

The False Claims Act

The Federal False Claims Act (FCA) has been used to fight fraud against the U.S. government, recovering more than $12.1 billion within a four year span, from January 2009 to the June 2013 fiscal year. The FCA is used when prosecuting health care fraud cases and the Justice Department has imposed civil liabilities on providers, who knowingly submit false or fraudulent claims from billing services. These include services not provided, needless medical services, double billing or upcoding. Healthcare providers and laboratories will be fined a maximum of $11,000 per false claim filed and all additional damages incurred (Staman).

Policies Instituted by Insurance Companies

Two prominent insurance companies, AmeriHealth Caritas and Independence Blue Cross (IBC) are contracted by the government to provide cost-effective healthcare solutions for publicly-funded programs, such as Medicaid. On the company’s website, AmeriHealth Caritas states “it has made health care fraud prevention and detection a primary emphasis,” with an increased focus on preventing improper payments. Health care fraud is reduced when a prevention and detection fraud system is implemented instead of a pay and chase method of recovery for improper payments. Numerous processes are in place, all designed to prevent and detect fraud, waste, and abuse. These include:

Preventive actions

Multiple front-end system edit codes are used to detect recurring claims for specific subscribers
or drug testing providers. Claim alerts are initiated for high-dollar claims prior to disbursement. A pre-distribution review will ascertain the legitimacy of a submitted claim and authorizations must be received from subscribers or employers before payments are made to providers.

Post-payment actions

Medical claim data checks are done to analyze the frequency with which providers submit claims or use specific billing codes. Payment trend analysis is used to detect the frequency with which payments are made to providers.

Corporate and Financial Investigations (CFI)

Anti-fraud software is installed on claims processing systems to identify fraud, waste and abuse patterns. The detection of these patterns will allow the analysis of claims data to help identify improper payments. Pharmacy audits are conducted to see how often claims for high dollar drugs are made by any particular pharmacy (Fraud, Waste and Abuse).

IBC has specific policies on presumptive and definitive drug testing. IBC’s decisions for coverage and payment of claims are based on the Centers for Medicare and Medicaid Services (CMS) regulations and guidelines. Presumptive drug tests are performed as baseline screenings and are done before or during a treatment process. Definitive drug tests are confirmatory tests ordered for verification if a presumptive test is positive. Providers have been successful in receiving fraudulent payments by double-billing insurance companies for negative presumptive drug tests and definitive tests on the same specimen. This is an unnecessary process as a negative presumptive test cannot result in a positive definitive test. IBC has implemented policies to eliminate double-billing by providers (IBC).
Presumptive Drug Testing
Payment for presumptive drug tests are based on standards implemented for individuals receiving treatment for pain management or substance abuse. Presumptive drug testing is considered medically necessary, covered and paid for by IBC when an initial testing is conducted, during the treatment process, when an assessment of the member’s medical history is performed and treatment for substance abuse is found to be medically necessary.

Definitive Drug Testing
Definitive drug testing is conducted when it is ordered by a treating provider or when the presumptive test results are positive. The definitive testing is also conducted when a presumptive test result is negative and this finding is inconsistent with the individual’s medical history (IBC). Drug treatment facilities test residents via a single screen for up to 15 substances which cost $100 per screen. If the test returns positive for a specific drug, the 15 samples are sent for further confirmatory or definitive tests as individual samples. The insurance company will be billed $100 for the first single screen containing 15 samples, and then $1,500.00 for the 15 individual confirmatory tests (Lynne). This constitutes both fraud and waste as definitive tests are required only for positive preliminary test results.

Covered Claims
IBC policies state that drug testing is considered medically necessary and the company will cover 16 claims per calendar year. Consideration will be given to members who are believed to be continuing a pattern of substance abuse, and coverage will be extended beyond the 16 claim maximum.
Unnecessary Drug Tests

Providers will submit claims for routine presumptive or definitive drug tests, whereby members are tested at every visit. Double testing is done by testing for the same drug with both a blood and a urine specimen at the same time. This is unnecessary and IBC has instituted system edits to detect multiple presumptive or definitive drug tests for members, and have also limited these tests to 120 times in a calendar year. (IBC).

Conclusion

Medicaid, Medicare and major insurance companies are being faced with increased costs for drug test screening. These costs are not caused by a spike in the use of narcotics by subscribers, but from unnecessary testing and overbilling by doctors and drug screening companies. The government is a major player in the healthcare industry as they are the principal payers of insurance claims and are susceptible to fraud. Employers who self-fund their employees’ insurance premiums are also vulnerable and have become joint victims to perpetrating providers. The healthcare industry needs to focus on prevention in order to eliminate fraud, waste and abuse in medical claim billing. Keeping ahead of technological advances is an effective way of reducing over billing in the industry. Diagnosis coding has been the weak link through which most fraud schemes have been perpetrated. These codes need to be updated regularly in accordance with nationally accepted coding guidelines, especially when new procedures have been implemented due to technological advances. This policy needs to be applied to all future applicable coding changes, revisions, or updates.

Having effective internal controls over billing procedures is a deterrent and thus limits the chances providers may take to overbill the insurance company or the government.
Recovering drug addicts are required to have random drug tests during or as a part of their treatment program, but instead of being random, the drug tests have become precise. Testing is performed at specific times weekly on a single patient, for substances that return results that are unimportant to the doctors. If a weakness is found in a billing procedure, precautions should be taken to immediately change the billing structure or policies governing the structure. An open forum needs to be developed that gives providers a means of discussing any issue associated with the costs of administering drug tests.

Doctors are given drug testing kits by large drug testing companies that are very accurate and low in cost. Once the necessary drug tests are completed, the insurance companies are billed for thousands of dollars. The test results are received by the doctors and they are able to confirm or deny the use of a particular drug. This exact test sample is then and there sent to a drug testing company or laboratory for further confirmatory testing. Medicaid, Medicare, and self-funding employers are billed twice by way of the insurance companies, for the same tests on a single patient on the same date of service; first from the doctor and then from the laboratory.

Medical claims from providers should be routinely checked to ensure that the proper codes are being used for patients, and all providers made aware of changes to the policies and procedures of an insurance company or the CMS. The use of data mining software is an effective tool for conducting analysis, and identifying specific patterns in claim submission from providers that may indicate fraud (The Pathology Blawg).
Bibliography

Addressing Fraud, Waste, and Abuse. (n.d.). Retrieved March 1, 2015, from


Fraud, waste, and abuse. (n.d.). Retrieved March 29, 2015, from


http%3A%2F%2Fbrookline.com%2Fdoctor-ran-cape-drug-clinics-suspended%2F


Medicaid Claims for Drug Screenings. Retrieved March 16, 2015, from


http://fas.org/sgp/crs/misc/RS22743.pdf


Appendix A

Abbreviations and Terminology

CMS – Centers for Medicare and Medicaid Services

DMA – Division of Medical Assistance

EOHHS – Executive Office of Health and Human Services

FBI – Federal Bureau of Investigation

FWA – Fraud, Waste and Abuse

IBC – Independence Blue Cross

NHCAA – National Health Care Anti-Fraud Association

MassHealth – Office of Medicaid

MMIS – Medicaid Management Information System

POCT – Point-of-Care Test

SAMSHA – Substance Abuse and Mental Health Services Administration
HHS-OIG – United States Department of Health and Human Services, Office of the Inspector General

USDHHS – U.S. Dept. of Health and Human Services

WV MFCU – West Virginia Medicaid Fraud Control Unit
Appendix B

MEDICAID PAYMENTS FOR DRUG SCREENING

Around 2007, the state Attorney General’s Medicaid Fraud Unit began to crack down on companies conducting drug-screening urine tests and took action against the two largest labs. Preventive Medicine Associates initially benefitted from the plunging billings of the two giants, but later found itself in legal trouble and is now closed. A look at their revenues from one of the most common tests:

![Graph showing revenues of Willow Labs, Preventive Medicine Associates, and Calloway Labs from 2007 to 2011.]

Sources: Massachusetts Executive Office of Health and Human Services, Medicaid data

Costly Screening

Medicare payments for high-tech tests that detect specific drugs, including pain pills and illegal substances like cocaine and PCP, have soared in recent years. Some examples:

- **Hydrocodone** (e.g. Vicodin) 2007: $45,117 2012: $16.0 million
- **PCP** (angel dust) 2007: $1.6 million 2012: $14.0 million
- **Cocaine** 2007: $1.8 million 2012: $19.7 million

Source: Centers for Medicare and Medicaid Services
The Wall Street Journal

Appendix D

Boston Globe reporter Patricia Wen, gives a precise explanation how sober homes use drug addicts to fund their lucrative fraud scheme. Ms. Wen interviewed Dr. Punyamurtula Kishore, the founder of Preventive Medicine Associates, and owner/operator of 29 treatment facilities throughout the state of Massachusetts. Dr. Kishore was arrested and charged with eight counts of Medicaid fraud, 12 counts of larceny and with eight counts of illegal kickbacks to housing programs, known as sober homes, for recovering addicts. Ms. Wen interviewed Dr. Kishore at one of his offices. Her account of the interview can be seen here:


Source: Boston Globe, April 1, 2012.
Appendix E

Preventive Medical Care – The Massachusetts Model

The Chalcedon claims that Dr. Punyamurtula Kishore is arguably the twenty-first century's greatest pioneer in the treatment of substance addiction. Dr. Kishore developed the Massachusetts Model program which is characterized by a thorough and ongoing medical assessment of drug abuse patients and of multimodal therapeutic approaches. It may include full and comprehensive physical examinations, laboratory testing, toxicology, cardiac, neurological and pulmonary evaluations, education and support, and other methods. This program was claimed to far out-perform the existing treatment paradigms at vastly lower costs. The link below shows Dr. Kishore explaining his approach on rehabilitating drug addicts:

Link: https://www.youtube.com/watch?v=OVE0hB-SJ9c

Sources: http://punyamurtulakishore.org/massachusetts-model.html
http://chalcedon.edu/research/articles/massachusetts-protects-medical-industrial-
Appendix F

130 CMR: DIVISION OF MEDICAL ASSISTANCE

401.416: Request for Laboratory Services

(A) Request Requirements. The independent clinical laboratory may not bill for a service unless it has received a written request to perform that specific service from an authorized prescriber who is treating the member and will use the test for the purpose of diagnosis, treatment, or an otherwise medically necessary reason as defined in 130 CMR 450.204. Any independent clinical laboratory billing for a service must maintain such request in its records, and make such records available to the MassHealth agency and the Attorney General's Medicaid Fraud Division upon request. If the laboratory that billed for the service cannot produce the original request, the MassHealth agency may deny or recover payment for all services the laboratory provided based on that request.

(B) Standing Orders. An authorized prescriber may request an independent clinical laboratory to perform one or more tests on a single date, or issue a standing order for such tests. Standing order requests may not exceed 180 days in length with the exception of standing order requests for substance abuse testing, which may not exceed 30 days in length. Standing order requests are not permissible unless such repeated tests are medically necessary and required as part of the member's medical or drug treatment plan.

(C) Required Information. Requests for laboratory services must be written and include the following information:

(1) the date of the request;

(2) the name or any other means of identifying the member to be tested;
(3) the name and address of the authorized prescriber (if the authorized prescriber is a Massachusetts Department of Public Health licensed substance abuse treatment program for the sole purpose allowed pursuant to 130 CMR 401.402, the request must include the names and addresses of both the substance abuse treatment program and the physician initiating the request);

(4) the name of the specific laboratory tests to be performed;

(5) the frequency for performing each laboratory test (applicable to standing orders only);

(6) the duration and maximum number of times each laboratory test or tests are to be performed (applicable to standing orders only); and

(7) a statement by the authorized prescriber that such testing is required as part of the member’s medical or drug treatment plan (applicable to standing orders only).

(D) Recordkeeping. If a laboratory refers a specimen to a testing laboratory, the referring laboratory must forward the original request to perform the service to the testing laboratory. The testing laboratory must maintain such request in its records in accordance with 130 CMR 401.416(A).

401.417: Recordkeeping Requirements

Both referring and testing laboratories must keep a record of each written request for laboratory services, each specimen, and each test result for at least six years from the date on which the results were reported to the authorized prescriber. If the testing laboratory is a subsidiary-related entity of the referring laboratory, such records may be maintained at one location, but must be made available to the MassHealth agency and the Attorney General’s Medicaid Fraud Division upon request, in accordance with 130 CMR 450.205. If an independent clinical laboratory cannot produce the record to substantiate a MassHealth claim, the MassHealth agency may deny or recover payment for that claim. The laboratory record must contain the
following information:

(A) The written request for laboratory services with all information required by 130 CMR 401.416;
(B) the identification number of the specimen;
(C) the name or any other means of identifying the person from whom the specimen was taken;
(D) the name of the authorized prescriber and, if applicable, the referring laboratory that submitted the specimen.
(E) the date on which the specimen was collected by the authorized prescriber or laboratory, the location of the collection, and the name of the collector;
(F) the date on which the specimen was received in the laboratory;
(G) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, or turbid);
(H) the specific tests performed;
(I) the date or dates on which each test was performed;
(J) the results of each test, the name and address of all persons to whom each test result is reported, and the date of reporting; and
(K) the name and address of the laboratory to which the specimen was referred, if applicable.

410.455: Laboratory Services: Introduction

(A) 130 CMR 410.455 through 410.459 establish the requirements and procedures for clinical laboratory services provided by hospital outpatient departments. A clinical laboratory service includes the following types of services: microbiological, serological, chemistry, hematological, radioimmunoassay, cytological, immunological, pathological, or other examinations of materials
derived from the human body to provide information for the assessment of a medical condition or for the diagnosis, prevention, or treatment of any disease.

(B) The MassHealth agency does not pay separately for routine specimen collection and preparation for the purpose of clinical laboratory analysis (for example, venipuncture; urine, fecal, and sputum samples; Pap smears; cultures; and swabbing and scraping for removal of tissue.) Specimen collection and preparation is considered part of the laboratory service.

410.456: Laboratory Services: Payment

(A) Maximum Allowable Fee. The maximum allowable payment for an acute or nonacute hospital outpatient department or hospital-licensed health center laboratory service is the lowest of the following:

(1) the amount in effect for the date of service in the DHCFP Clinical Laboratory Services fee schedule at 114.3 CMR 20.00 and 114.3 CMR 16.00;

(2) the amount that would be recognized under 42 U.S.C. 1395l(h) for tests performed for a person with Medicare Part B benefits; or

(3) the usual and customary fee.

(B) Usual and Customary Fee. The term usual and customary means the lowest fee charged by a hospital outpatient department laboratory for any laboratory service (including both individual and profile tests) specified in the hospital outpatient department’s charge book or by such hospital, with the exception of a fee offered for a bulk purchase. (A bulk purchase is a single purchase of a laboratory service (one or more tests) to be uniformly and concurrently performed on a minimum of 40 specimens of the same type. A single purchase of various, non-uniform
laboratory services, such as by a physician, is not considered a bulk purchase, regardless of the number of specimens presented by such a purchaser to the hospital outpatient department laboratory.)

(C) Profile or Panel Tests.

(1) A profile or panel test is any group of tests, whether performed manually, automatically, or semiautomatically, that is ordered for a specified recipient on a specified day and has at least one of the following characteristics.

(a) The group of tests is designated as a profile or panel by the hospital outpatient department laboratory performing the tests.

(b) The group of tests is performed by the hospital outpatient department laboratory at a usual and customary fee that is lower than the sum of that hospital outpatient department laboratory’s usual and customary fees for the individual tests in that group.

(2) In no event shall a hospital outpatient department laboratory bill or be paid separately for each of the tests included in a profile test when a profile test has either been performed by that hospital outpatient department laboratory or requested by an authorized person.

410.457: Laboratory Services: Request for Services

The hospital outpatient department must have either a written requisition or a written order for the laboratory service signed by an authorized prescriber (that is, a licensed physician or dentist, or a registered nurse practitioner) before performing the service. A written requisition signed only by an unauthorized prescriber is not acceptable. Any failure or inability to make the authorized requisition or order available to the Division for review will be sufficient reason to
deny or recover payment for all services based on that requisition or order. The hospital outpatient department may send disclosures concerning the test only to the prescriber, to the referring laboratory, if applicable, to the Division, and, at the written request of the prescriber, to the recipient.

410.458: Laboratory Services: Recordkeeping Requirements

In addition to meeting the recordkeeping requirements specified in 130 CMR 410.409, the hospital outpatient department must keep a suitable record of each specimen and laboratory test result for at least six years from the date on which the results were reported to the prescriber. Such a record must contain the following information:

(A) the name and any other means of identification of the person from whom the specimen was taken;

(B) the name of the prescriber or laboratory that submitted the specimen;

(C) the authorized requisition or order, or both;

(D) the location where the specimen was taken, if other than the hospital outpatient department;

(E) the date on which the specimen was collected by the prescriber or laboratory;

(F) the date on which the specimen was received in the laboratory;

(G) the condition of unsatisfactory specimens when received (for example, broken, leaked, hemolyzed, turbid, or insufficient sample size);

(H) the date on which the test was performed;
(I) the test name and the results of the test, or the cross reference to results and the date of reporting; and

(J) the name and address of the laboratory to which the specimen was referred, if applicable.

410.459: Laboratory Services: Specimen Referral

A hospital outpatient department may refer a specimen to an independent laboratory that is eligible to participate in the Medical Assistance Program, or to another hospital laboratory that is eligible to participate in the Medical Assistance Program. To be eligible, a hospital laboratory must be in a hospital that is licensed by the Massachusetts Department of Public Health and that is an approved Medicare provider. The referring hospital outpatient department laboratory must inform the prescriber of the name and address of the testing laboratory. The testing laboratory must inform the referring hospital outpatient department laboratory of the results of the test. Only the referring laboratory is authorized to bill the Division.

Source: Commonwealth of Massachusetts Provider Manual Series