



Commonwealth of Massachusetts  
Office of the State Auditor  
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Official Audit Report – April 17, 2013

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## Office of Medicaid (MassHealth) – Medicaid Claims for Drug Screenings

For the period July 1, 2008 through June 30, 2011



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## INTRODUCTION AND SUMMARY OF FINDINGS AND RECOMMENDATIONS

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS), through the Division of Medical Assistance (DMA), administers the state's Medicaid program, known as MassHealth. MassHealth provides access to healthcare services to approximately 1.3 million eligible low- and moderate-income individuals, couples, and families annually. In fiscal year 2011, MassHealth paid healthcare providers more than \$11.1 billion, of which approximately 40%<sup>1</sup> was funded by the Commonwealth. MassHealth's expenditures have increased, on average, 8.69% per year since 2007.

MassHealth provides drug screens<sup>2</sup> for members, including those who are receiving treatment for substance abuse disorders. Under 130 Code of Massachusetts Regulations (CMR) 401.416 and 401.457, MassHealth pays for drug tests as long as the tests are ordered and authorized by the physician who is actively treating the member and using the test results for diagnosis, treatment, or an otherwise medically necessary reason. The effectiveness of the internal controls, including regulations, policies, and procedures, that MassHealth has established over its payment process for laboratory drug tests is essential for ensuring that only claims for medically necessary drug tests are paid. Because of growing concern over increased healthcare expenditures, the Office of the State Auditor (OSA) initiated an audit of MassHealth. The objectives of our audit were to determine whether drug testing claims paid by MassHealth were for medically necessary services; whether they were accurate and properly supported by required documentation; whether services were delivered; whether billings and payments complied with applicable laws, rules, and regulations; and whether there were any opportunities for cost savings. Our audit was part of OSA's ongoing independent statutory oversight of MassHealth.

### *Highlight of Audit Findings*

- The UMass Memorial Medical Center (UMMMC) laboratory conducted drug tests for residential monitoring purposes. The orders for these tests originated from sober houses, which provide housing for people recovering from substance abuse disorders. However, 130

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<sup>1</sup> The Federal Medical Assistance Percentage (federal matching funds) for state Medicaid expenditures is 50%. However, as a result of the American Recovery and Reinvestment Act of 2009, the federal reimbursement rate during our audit period, including fiscal year 2011, was 60%.

<sup>2</sup> The terms "drug screen" and "drug test" are both used in the medical field to refer to the same process in which a specimen is analyzed using laboratory procedures to detect predetermined substances such as cocaine, methadone, and opiates. For the purposes of this audit report, the terms "drug test" and "drug testing" are used when discussing these laboratory procedures.

CMR 401.411(B)(5) precludes testing for residential monitoring. During our audit fieldwork, UMMMC officials told us that they were preparing to repay the Commonwealth \$1,339,352 for 23,882 drug tests UMMMC performed for residential monitoring.

- MassHealth allows members to be drug tested every day. Consequently, members are being tested at a high frequency – every day or every other day – for periods sometimes exceeding a year, contrary to testing guidelines recommended by the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and substance abuse treatment professionals. During our audit period, MassHealth could have saved approximately \$7.8 million had it more actively monitored the frequency with which members received drug tests, investigated providers who submitted unusually large numbers of claims for drug tests per member, and ensured that the tests were for medically necessary purposes and originated from physicians who were actively treating the member.
- Three laboratories (Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute) used a billing method known as “unbundling” when billing for drug testing services. Both federal and state regulations prohibit unbundling, which occurs when multiple procedure codes are billed separately for a group of procedures that are supposed to be billed using a single comprehensive procedure code. These three laboratories appear to have used this unallowable billing practice to circumvent drug testing limitations that MassHealth established on October 1, 2010. Unbundling by these laboratories resulted in unallowable costs to the Commonwealth totaling approximately \$4.5 million for the four fiscal years ended June 30, 2012.
- MassHealth could save millions of dollars by limiting or eliminating coverage of certain laboratory tests that are not considered medically necessary for treating substance abuse disorders. During our three-year audit period, MassHealth spent more than \$7 million on alcohol tests (performed to measure the amount of alcohol in a specimen), specimen integrity tests (performed to ensure that a specimen has not been diluted, adulterated, or substituted to obtain a negative result), and confirmatory tests (performed to verify or refute initial drug test results). Federal guidance from SAMHSA, as well as statements from Massachusetts Public Health officials and substance abuse treatment specialists, indicates that these tests are usually not medically necessary for individuals receiving treatment for substance abuse. Additionally, these experts identified alternative low-cost or no-cost methods that could be used to determine whether members are abusing alcohol, tampering with urine specimens, or abusing drugs.
- MassHealth’s claims processing system does not adequately prevent and deny payments for duplicate drug testing services. Members are currently allowed to receive one drug test per day. However, our audit found 15,606 instances, totaling approximately \$286,000, of MassHealth paying for multiple drug tests (including alcohol tests and creatinine tests) for the same member on the same day.
- Cambridge Health Alliance (CHA) and Codman Square Health Center (CSHC) physicians often ordered two drug tests for the same member on the same day. The second test was used to verify the accuracy of the member’s first test. MassHealth regulation 130 CMR 450.307(B)(1) specifically prohibits providers from billing for this type of duplicate service.

The total unnecessary costs that OSA identified for these duplicate services are \$6,196 for CHA and \$21,391 for CSHC.

- MassHealth did not promptly implement pricing changes (price and unit limitations) for drug tests; this caused overpayments of \$107,309 on 2,348 claims during our audit period. Specifically, on February 1, 2009, MassHealth reduced the price it would pay for standard multiclass drug tests, but it did not implement these price adjustments until February 9, 2009. Additionally, MassHealth reduced the number of billable units for certain tests on October 1, 2010, but it continued to pay for the former, higher number of units in some instances.
- Effective December 1, 2011, MassHealth adopted two new procedure codes. However, in adopting these new codes, MassHealth misclassified them within its claims processing system, causing underpayments totaling \$190,010. Effective April 12, 2012, MassHealth corrected its claims processing system for this error, notifying all providers of the problem and reprocessing and paying all underpaid claims.
- Some laboratories were not following MassHealth documentation requirements when submitting claims for drug tests. Laboratory order forms and test results were not available for our review at two laboratories where we conducted audit testing of services for which these labs were paid a total of \$41,258. In addition, order forms did not always include physician authorizations and diagnosis codes as required by MassHealth. Lastly, UMMMC used standing order forms in a manner contrary to MassHealth regulations. Specifically, these standing order forms were missing or incomplete in some cases and, in other cases, were being used for member testing for periods that exceeded MassHealth's 30-day limit.

#### ***Recommendations of the State Auditor***

- In order to address our concerns regarding improper drug testing for residential monitoring similar to the testing encountered at UMMMC, we recommend that MassHealth:
  - Provide UMMMC with necessary assistance and oversight to reverse the 23,882 drug test claims totaling \$1,339,352 that UMMMC recognizes were improper payments.
  - Develop system edits in the claims processing system to effectively detect and deny claims for drug tests ordered for residential monitoring.
  - Require independent laboratories to include on drug test claims the physician name and identification number, the diagnosis code, and the substance abuse treatment facility name and identification number. This will improve the quality of the claims data within the Medicaid Management Information System (MMIS). Moreover, by including this information in the Data Warehouse (MassHealth's electronic storage of all paid and denied private claims), MassHealth can more effectively detect, monitor, and investigate anomalies such as high-frequency drug testing to ensure that drug tests are for medically necessary purposes and to prevent the payment of claims for residential monitoring.
- In order to address our concerns about high-frequency drug testing, we recommend that MassHealth:

- Develop new requirements to avoid overuse of laboratory drug testing, bringing MassHealth into line with community and national standards governing appropriate clinical use of drug screening services. This will help to ensure that MassHealth pays for only medically necessary services.
- Monitor the frequency with which members receive drug tests and investigate providers who submit unusually large numbers of claims per member to ensure that the tests are for medically necessary purposes and that they originate from physicians who were actively treating the members.
- In order to address our concerns regarding unbundling of services, we recommend that MassHealth recover overpayments for unbundled billings totaling \$4,500,177 from Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute.
- In order to address our concerns about unnecessary laboratory tests, we recommend that MassHealth establish regulations and system edits, similar to those it established for drug alcohol and specimen integrity tests, disallowing claims for confirmatory drug tests performed on the same day as a drug screen.
- In order to address our concerns about duplicate payments, we recommend that MassHealth:
  - Recover overpayments for all duplicate claims submitted by the same provider. For all duplicate claims submitted by different providers, MassHealth needs to determine which payment was for medically necessary services and which should be repaid.
  - Review system edits within its claims processing system to ensure that they effectively identify and deny claims for duplicate services that violate state regulations.
- In order to address our concerns about physicians requiring external verification of in-house testing, we recommend that MassHealth:
  - Send a notification to providers that verification testing, using the same specimen or another body fluid, is duplicative and therefore not a covered procedure.
  - Recover \$27,587 of overpayments made to laboratories for disallowed drug tests used to verify initial drug tests taken on the same day.
- In order to address our concerns about pricing adjustments for drug tests, we recommend that MassHealth:
  - Develop internal controls to ensure that pricing and unit changes mandated by the Massachusetts Department of Health Care Finance and Policy (DHCFP) are instituted promptly.
  - Perform more comprehensive quality assurance testing and control procedures to ensure that system coding changes, such as pricing and unit edits, are processing properly in the system before going “live” with these changes.

- Recover the \$107,309 identified as unallowable overpayments due to rate and unit adjustments.
- As noted in the report, MassHealth has started making necessary system changes to ensure the proper payment for Procedure Codes G0431 and G0434. However, after the completion of audit field work, we identified, and referred to MassHealth, similar instances of incorrect payments. Accordingly, we recommend that MassHealth complete the research on these claims, make necessary adjustments to its claims processing system, and adjust payments to hospitals as required.
- In order to address our concerns regarding insufficient documentation for drug testing claims, we recommend that MassHealth:
  - Ensure that CHA and UMMMC develop and maintain documentation in accordance with MassHealth provider regulations for requests for laboratory services.
  - Ensure that UMMMC develops and maintains appropriate procedures for the proper use of standing orders for drug tests, including developing procedures for limiting standing orders to 30 days, proper frequency and duration, and proper physician signatures.
  - Issue a Provider Bulletin to all laboratory providers restating the documentation requirements for requesting laboratory services and for other recordkeeping requirements as detailed in 130 CMR 401.416 through 401.417 and CMR 410.455 through 410.459, including drug testing. MassHealth should remind these laboratories that they must maintain all necessary documentation and produce it upon request.

### ***Agency Progress***

- On February 9, 2013, MassHealth issued Provider Bulletins to address our findings relating to (1) billing for drug screens for residential monitoring purposes; (2) unbundled billing practices; (3) unnecessary alcohol, specimen integrity, and confirmatory tests; (4) verification testing; and (5) inadequate documentation supporting drug test claims. In these bulletins, MassHealth notifies all providers that effective January 1, 2013, it has established new claim edits for quantitative drug tests performed on the same date as a drug screen. Claims for such tests will be denied with the explanation of Benefits Code 8304 (lab conflict with each other on the same day). Specifically, when Procedure Code G0431 and/or Procedure Code G0434 is billed, providers cannot also bill for procedure codes that apply to substance-specific quantitative drug testing, e.g., tests that identify only amphetamine or methamphetamine.
- Also, in these bulletins, MassHealth notified providers of the following:
  - Alcohol and specimen integrity tests are no longer allowed to be performed on the same date as a drug screen.
  - Confirmatory drug tests must only be performed to confirm positive results for a drug screen service, on an as-needed basis, not as a routine supplement to drug screens.

- MassHealth does not pay for drug screen tests performed for residential monitoring purposes, since those purposes do not satisfy the requirement that laboratory tests be medically necessary. Additionally, MassHealth does not consider sober homes to meet the definition of authorized prescribers, as defined in 130 CMR 401.402.
- Authorized prescribers must review requests for laboratory services to ensure that the tests ordered meet the relevant payment conditions listed under 130 CMR 450.000, 401.000, and 433.000 and any other applicable requirements.
- All laboratory services provided by independent clinical laboratories require a written request from an authorized prescriber as defined by 130 CMR 401.402.
- Standing order requests must meet the requirements of 130 CMR 401.416, which, among other things, establishes that standing order requests are limited to 30 days for service related to substance-abuse testing and 180 days for all other laboratory services.
- All services should be medically necessary as defined by 130 CMR 450.204 and not be subject to the noncovered-services limitations in 130 CMR 401.411.
- MassHealth told us that it is in the process of voiding the UMMMC claims relating to testing members for residential monitoring purposes. MassHealth anticipates that this process will be completed shortly.
- MassHealth told us that it agrees that more can be done to avoid overuse of laboratory testing for drug screening. It indicated that it is examining the possibility of requiring prior authorizations for certain drug screening services. MassHealth is also considering establishing a new threshold level for drug testing based on analysis by its clinical experts, and examining the current drug testing levels for drug tests at other state Medicaid programs and private payers to establish a recommended best practice.
- MassHealth stated that it intends to further amend its regulations to require authorized prescribers to include on all order forms an explicit statement that the laboratory test is medically necessary and not being performed for residential monitoring pursuant to a court order or for another administrative purpose.
- MassHealth stated that it is in the process of implementing a requirement that the ordering and referring provider's National Provider Identifier (NPI) be provided on claims for laboratory services (and other services when a referral from a physician or other health professional is required).
- MassHealth said it plans to conduct follow-up field audits with CHA and UMMMC to ensure that these providers have developed and are maintaining adequate documentation in accordance with its regulations. MassHealth agrees that a reminder Provider Bulletin would be helpful and intends to issue one as soon as possible.

## OVERVIEW OF AUDITED AGENCY

Under Chapter 118E of the Massachusetts General Laws, the Executive Office of Health and Human Services (EOHHS) is responsible for the administration of the state's Medicaid program, known as MassHealth. For the four-year period ended June 30, 2012, MassHealth paid for more than 2.7 million drug tests for 155,976 members, at an average of 17.66 tests per member and an overall cost of approximately \$105 million, as detailed in the table below.

Fiscal Year	Number of Drug Tests	Total Cost of Drug Tests	Members	Average Number of Tests per Member
2009	547,473	\$ 29,907,440	60,155	9.10
2010	634,356	29,664,457	64,459	9.84
2011	732,938	26,485,501	62,858	11.66
2012	<u>839,004</u>	<u>18,819,397</u>	65,020	12.90
Total	<u>2,753,771</u>	<u>\$ 104,876,795</u>		
Number of Individuals Receiving Services				155,976 <sup>3</sup>
Overall Average Drug Tests per Member				17.66

### **Medicaid**

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 & Medicaid Services (CMS), within the U.S. Department of Health and Human Services (HHS), administers the Medicare program and works in partnership with state governments to administer their Medicaid programs. The Medicaid program is a major source of funding for substance abuse services in the United States. HHS projects that by 2014, Medicaid will pay for 20% of the costs for all substance abuse treatment.

Each state administers its Medicaid program in accordance with its CMS-approved state plan. States have considerable flexibility in designing and operating their Medicaid programs, but must comply with applicable federal requirements. MassHealth has created its own substance abuse program for members and also provides coverage for drug tests for diagnosis, treatment, or an otherwise medically necessary reason.

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<sup>3</sup> This figure represents the number of members who received services for drug tests during 2008 through 2012. In some cases, the same member may be counted in the total for more than one year, but is only counted once in this cumulative figure. Therefore, it is not a sum of the member counts for all four years.

### ***Drug Addiction in Massachusetts***

Combined data from the 2008 and 2009 National Survey on Drug Use and Health<sup>4</sup> revealed that 9.6% of Massachusetts residents 12 years and older either were dependent on, or abused, drugs or alcohol in the year before the survey. For 18- to 25-year-olds, this number was 23.4%.<sup>5</sup> Additionally, EOHHS reported, in its 2011 Bureau of Substance Abuse Services Substance Abuse Treatment Annual Report<sup>6</sup>, that there were 102,789 admissions to substance abuse treatment services in Massachusetts, 2,233 of which were for individuals under 18 years of age, and that alcohol remained the most reported substance used in the past year among adult clients. Of all 2011 admissions, 58.7% (58,019) reported past-year alcohol use, 43.5% (42,999) heroin, 22.1% (22,011) cocaine or crack, 23.4% (23,153) marijuana, 24.5% (24,467) other opiates or synthetics, 17.6% (17,523) tranquilizers, and 4.5% (4,534) all other drugs.<sup>7</sup>

### ***Treatment Options***

Massachusetts is committed to treating Medicaid members who have substance abuse disorders in order to help them regain productivity in their communities and reduce the high costs associated with emergency room episodic treatment and other medical costs associated with illicit drug use. There are several options a Medicaid patient has when seeking help with drug addiction. Some patients enroll in an abstinence program and receive assistance from medical professionals through counseling-only strategies. Other patients, especially those who have been abusing prescription drugs and other opioids for a long period, are typically treated via a medication-assisted program (MAP). A MAP is a program that provides prescription medication coupled with active ongoing patient counseling. MAPs use drug tests to (a) stabilize a patient on the proper dosage of methadone or buprenorphine<sup>8</sup> and (b) monitor whether the patient is abstaining from use of illicit drugs and not engaging in diversionary tactics.<sup>9</sup>

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<sup>4</sup> Published by the Substance Abuse and Mental Health Services Administration (SAMHSA).

<sup>5</sup> Massachusetts Bureau of Substance Abuse Services, Substance Abuse Treatment Annual Report FY 2011, p. 1.

<sup>6</sup> For all admissions.

<sup>7</sup> The percentages of past-year use add up to more than 100% because of multidrug use.

<sup>8</sup> Methadone and buprenorphine are medications used to wean substance abusers from opioid dependence and reduce withdrawal symptoms.

<sup>9</sup> Diversion of a prescription refers to the act of redirecting or selling prescribed medications to someone other than the intended party.

### ***Drug Testing***

Urinalysis is the testing of urine for drugs of abuse. Physicians and federal healthcare authorities such as the Substance Abuse and Mental Health Services Administration (SAMHSA) and National Institute on Drug Abuse (NIDA) believe drug testing to be a necessary tool to diagnose, assess, treat, and monitor a patient's health and progress in a substance abuse program. Urine testing is the most commonly used method of detecting drug use because it is regarded as the most accurate and least expensive method. Other testing methods, such as testing of saliva, sweat, hair, or blood, suffer from shortcomings that make them largely impractical for ongoing monitoring of drug use. Appendix I of this report shows the pros and cons of the various methods available for physicians to use for testing for drugs of abuse.

### ***Federal Regulations on Drug Testing***

In addition to monitoring, and reporting on, national drug addiction trends, SAMHSA provides medical professionals with guidance for treating drug addiction, including the purpose, benefits, limitations, and other considerations of drug testing. SAMHSA emphasizes that drug tests should be performed with sufficient frequency and randomness to assist in making informed decisions about take-home medication privileges and responses to treatment. For patients who continue to abuse drugs or test negative for treatment medication, SAMHSA recommends that MAPs institute more frequent, random tests.<sup>10</sup> Increased testing provides greater protection to patients vulnerable to relapse because only short periods pass before a therapeutic intervention can be initiated.

HHS, in 42 Code of Federal Regulations (CFR) 8.12(f)(6), promulgated federal opioid treatment standards requiring drug testing in Opioid Treatment Programs (OTPs), which are a type of MAP.

*Drug abuse testing services. OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient.*

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<sup>10</sup>SAMHSA TIP 43, Chapter 9, Drug Testing as a Tool. Urine drug testing is the most common laboratory assessment technique in addiction treatment, which involves analysis of urine samples from patients for the presence or absence of specific drugs. Originally used as a measure of program effectiveness, urine testing now is used to make programmatic decisions, monitor psychoactive substance use, adjust medication dosage, and decide whether a patient is responsible enough to receive take-home medication. Methods of urine testing vary widely.

In addition, SAMHSA provided healthcare professionals with its interpretation of these regulations in its manual on Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs:

*In the opinion of the consensus panel, this is a minimal requirement. The actual frequency of testing should be based on a patient's progress in treatment, and more testing should be performed earlier in treatment than later, when most patients are stabilized....*

See Appendix II for further details on SAMHSA's interpretation of these federal regulations.

### ***Drug Testing Regulations and Payment Limitations***

Massachusetts regulations for drug testing are detailed in 130 Code of Massachusetts Regulations (CMR) 401.000 through 401.421 for independent clinical laboratories and 130 CMR 410.455 through 410.459 for acute outpatient hospital departments. These regulations (in 130 CMR 401.416) state that drug tests are covered as long as the test is ordered and authorized by the physician "who is treating the member and will use the test for the purpose of diagnosis, treatment, or an otherwise medically necessary reason." MassHealth defines "medically necessary" in 130 CMR 450.204(A) as follows:

*(A) A service is "medically necessary" if:*

*(1) It is reasonably calculated to prevent, diagnose, prevent the worsening of, alleviate, correct, or cure conditions in the member that endanger life, cause suffering or pain, cause physical deformity or malfunction, threaten to cause or to aggravate a handicap, or result in illness or infirmity; and*

*(2) There is no other medical service or site of service, comparable in effect, available, and suitable for the member requesting the service, that is more conservative or less costly to the MassHealth agency. Services that are less costly to the MassHealth agency include, but are not limited to, health care reasonably known by the provider, or identified by the MassHealth agency pursuant to a prior-authorization request, to be available to the member through sources described in 130 CMR 450.317(C), 503.007, or 517.007.*

Furthermore, 130 CMR 401.411 details clinical laboratory services that are not covered for plan members. MassHealth will not cover drug tests "only for purposes of civil, criminal, administrative, or social service agency investigations, proceedings, or monitoring activities"; for "residential monitoring purposes"; or for purposes "that are not medically necessary as defined in 130 CMR 450.204."

As described above, drug tests must be medically necessary for coverage. However, MassHealth has yet to create regulations or Provider Bulletins on the frequency of drug testing for members

suffering from substance abuse problems. MassHealth's software currently limits that frequency to one drug test per member per day.

According to MassHealth, it implemented several initiatives to help prevent improper claims and ensure proper payment for drug testing purposes. These initiatives were implemented during the OSA audit period and included (1) reducing rates paid for drug tests; (2) limiting the number of units paid per drug test; and (3) strengthening documentation requirements for drug test authorizations, including order forms and standing orders. While these initiatives did help reduce the overall cost to the Commonwealth for drug testing, they did not effectively reduce the occurrence of high-frequency drug testing (every day or every other day) or prevent testing for residential monitoring purposes, both of which are described in our report.

### ***Elimination Rates (Detection Times) for Drugs of Abuse***

Another factor to consider when determining the frequency of drug tests is drug detection times. Each ingested substance in the human body is eliminated over time in the urine. The length of time that a substance remains in a person's body and can be detected through drug testing is called detection time or elimination rate. Detection times offer scientific benchmarks that can be used to determine how frequently a patient should be drug tested.

The elimination rate for many drugs of abuse is between two and four days (see Appendix III for SAMHSA's elimination rate chart). When considering elimination rates, substance abuse treatment professionals have concluded that testing more frequently than every third or fourth day is not medically necessary.

### ***Other State Billing Practices for Drug Tests***

To understand what is considered adequate frequency of drug testing by other states, we contacted Medicaid agencies in 20 other states to determine their service limitations on drug tests. Some states implemented service limitations, such as one test per week, on the number of drug tests they cover for a member.<sup>11</sup> Other states have no limits. The table below lists the 20 states contacted and their respective limits on drug testing for Medicaid members.

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<sup>11</sup> See, e.g., New Jersey Office of the State Auditor, *Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Enrollment, Hearing Aid Services, and Drug Testing*, Oct. 17, 2011.

State	Drug Test Limit
New Jersey	2 tests per month
Georgia	25 tests per year
Vermont <sup>12</sup>	8 tests per month
New York	2 tests per week
Washington	1 test per day
Pennsylvania	1 test per day
North Carolina	1 test per day
California	1 test per day
Texas	9 units per day
Michigan	12 units per day
Maryland	22 units <sup>13</sup> per day
Wisconsin	No limit
Virginia	No limit
Ohio	No limit
Missouri	No limit
Indiana	No limit
Illinois	No limit
Florida	No limit
Arizona	Not disclosed
Tennessee	Not disclosed

### ***Procedure Codes and MassHealth Billing Process***

CMS requires Medicaid service providers to use Health Care Procedure Coding System (HCPCS) Level I codes and descriptions when billing for services. These codes, also known as Current Procedural Terminology (CPT) codes or procedure codes,<sup>14</sup> are updated and revised by the American Medical Association (AMA). MassHealth requires providers to use these CPT codes when billing for services provided to Medicaid members. Using standardized CPT codes for billing and reporting provides for uniform and consistent billing practices.

<sup>12</sup> Vermont also disclosed that it performed a review of laboratory test results at its largest providers to gain an understanding of the types of substances abused in the state. This review resulted in the cancellation of Medicaid coverage of three substances: PCP, LSD, and propoxyphene.

<sup>13</sup> A unit is defined as one substance tested within a drug test. Currently, Massachusetts provides for one test per day, consisting of a maximum of five units.

<sup>14</sup> For the purposes of our audit report, we will use the term “procedure code” when referring to HCPCS or CPT codes.

MassHealth adjudicates, and pays for, all Medicaid claims through its Medicaid Management Information System (MMIS). MMIS employs fee schedules, developed by Massachusetts Department of Health Care Finance and Policy (DHCFP), and system edits to control the amounts paid for each claim. The fee schedules are based on CMS-recommended payment limits, which are reviewed and adjusted annually. Appendix IV is a description of the procedure codes that Medicaid providers used during our audit period when billing for drug tests.

## **AUDIT SCOPE, OBJECTIVES, AND METHODOLOGY**

In accordance with Chapter 11, Section 12, of the Massachusetts General Laws, we conducted an audit of MassHealth drug testing claims during the period July 1, 2008 through June 30, 2011. In some instances, we extended our scope through June 30, 2012 to illustrate trends and quantify the total financial impact of our findings relating to potential fraudulent activity. 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. Our objectives were to determine whether drug testing claims paid by MassHealth were for medically necessary services; whether they were accurate and properly supported by required documentation; whether services were delivered; and whether billings and payments complied with applicable laws, rules, and regulations.

MassHealth currently does not track laboratory information by the ordering physician. Consequently, we were unable to identify and audit the physicians who ordered the most tests. Instead, our audit procedures consisted of site audits at three hospital laboratories and data analysis of all drug testing claims. Although the scope of our audit was limited by the inability to track and identify ordering physicians, we have determined that, in total, there is sufficient, appropriate evidence to support our findings, conclusions, and recommendations.

To achieve our audit objectives, we reviewed applicable state and federal laws, rules, and regulations. We obtained drug test claim information for the four-fiscal-year period ended June 30, 2012 and analyzed this data to identify (1) the type, frequency, and cost of drug testing services performed by clinical laboratories and (2) drug testing trends and billing anomalies indicative of systemic billing problems and potential instances of fraud and abuse. We assessed internal controls and identified a subset of key controls that we tested to determine the effectiveness of procedures used by MassHealth's laboratory services program to control and monitor the payment of drug tests. The key controls tested included those for frequency, pricing, and monitoring of drug testing services. We determined the risk to be high because these controls did not appear to be functioning properly. Additionally, the high volume of drug test claims is a national concern.

In addition, we conducted field audits at three acute outpatient hospitals: Boston Medical Center (BMC), including its affiliate Codman Square Health Center (CSHC); Cambridge Health Alliance (CHA); and UMass Memorial Medical Center (UMMMC). Each of these hospitals owns and operates a clinical laboratory. At each hospital, we selected a judgmental audit sample of 25 members, selecting only those members who had the highest frequency of drug tests. Each member's case file was reviewed to ensure that paid claims were properly authorized and supported by appropriate documentation, including authorized order forms, laboratory results, and patient progress notes prepared by the treating clinician, wherever applicable. We did not project the sample results to the entire population of drug test claims. Rather, wherever possible, we expanded our audit procedures to quantify the total financial impact for each audit finding.

We also consulted with officials from MassHealth, the Massachusetts Bureau of Substance Abuse Services, and the Massachusetts Behavioral Health Partnership (MBHP)<sup>15</sup>. In addition, we contacted 20 other state Medicaid agencies, as well as substance abuse professionals at Tufts University School of Medicine, Boston University School of Medicine, and Lemuel Shattuck Hospital. We used the information we obtained from these organizations and professionals while conducting audit field work and developing this audit report. At the conclusion of our field work, we discussed the results with MassHealth and applicable hospital officials and considered their comments when preparing this report.

For the purposes of this audit, we relied on electronic data files extracted from the Data Warehouse using Cognos data query tools. To assess the reliability of this data, we compared the extracted data to original source data, interviewed knowledgeable MassHealth officials about the data, and reviewed MassHealth's 2011 Claims Operations Internal Control Plan, as well as its responses to the Office of the State Comptroller's Fiscal Year 2010 Internal Control Questionnaire, which included questions about information technology security. Accordingly, for the purposes of this report, we determined the data to be sufficiently reliable.

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<sup>15</sup> MassHealth contracts with MBHP to provide behavioral health and substance abuse service for members.

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## AUDIT FINDINGS

### 1. MASSHEALTH PAID FOR UNALLOWABLE AND EXCESSIVE MEMBER DRUG TESTING TOTALING APPROXIMATELY \$9.1 MILLION

MassHealth paid for unallowable and excessive member drug testing totaling approximately \$9.1 million during the audit period, reflecting (a) unallowable drug testing for residential monitoring and (b) excessive member drug testing. MassHealth could have prevented a significant portion of this unnecessary spending had it established internal controls to ensure that payments were made solely for medically necessary drug tests. However, MassHealth does not gather specific information necessary to adequately monitor and validate the medical necessity of drug tests, including the ordering physician's name and identification number, the diagnosis code, and the name and identification number of the substance abuse treatment facility (e.g., drug treatment program and hospital). Rather, MassHealth relies on the integrity of each testing laboratory, physician, and hospital to submit claims only for tests that are used for "the purpose of diagnosis, treatment, or an otherwise medically necessary reason" (130 Code of Massachusetts Regulations [CMR] 401.416). This has allowed sober houses to order drug tests for residential monitoring purposes, contrary to 130 CMR 401.411(B)(5). In fact, UMass Memorial Medical Center (UMMMC) performed drug tests for residential monitoring purposes totaling \$1,339,352.

In addition, MassHealth could have saved millions of dollars during our audit period had it more actively monitored the frequency with which members received drug tests, investigated providers who submitted unusually large numbers of claims per member, and ensured that tests were for medically necessary purposes and originated from physicians who were actively treating the members. Currently, MassHealth allows members to be drug tested every day. Consequently, members are being tested at this frequency for extended periods – sometimes exceeding a year – contrary to testing levels recommended by the Substance Abuse and Mental Health Services Administration (SAMHSA) and substance abuse treatment professionals. During our audit period, MassHealth could have saved approximately \$7.8 million on drug tests if it had more effectively monitored its laboratory services program.

#### a. Unallowable Drug Testing for Residential Monitoring

Under Chapter 118E of the Massachusetts General Laws, MassHealth is responsible for administering the state's Medicaid program, including developing controls to ensure that only

medically necessary drug tests are paid for. To process each drug test claim, MassHealth requires laboratories to submit pertinent information about the member and the tests performed. However, as previously stated, MassHealth does not gather information about the physicians and treatment programs ordering the drug tests. Consequently, MassHealth has paid for drug tests for residential monitoring, contrary to 130 CMR 401.411(B)(5):

*401.411: Noncovered Services and Payment Limitations...*

*(B) The MassHealth agency does not pay for the following services:...*

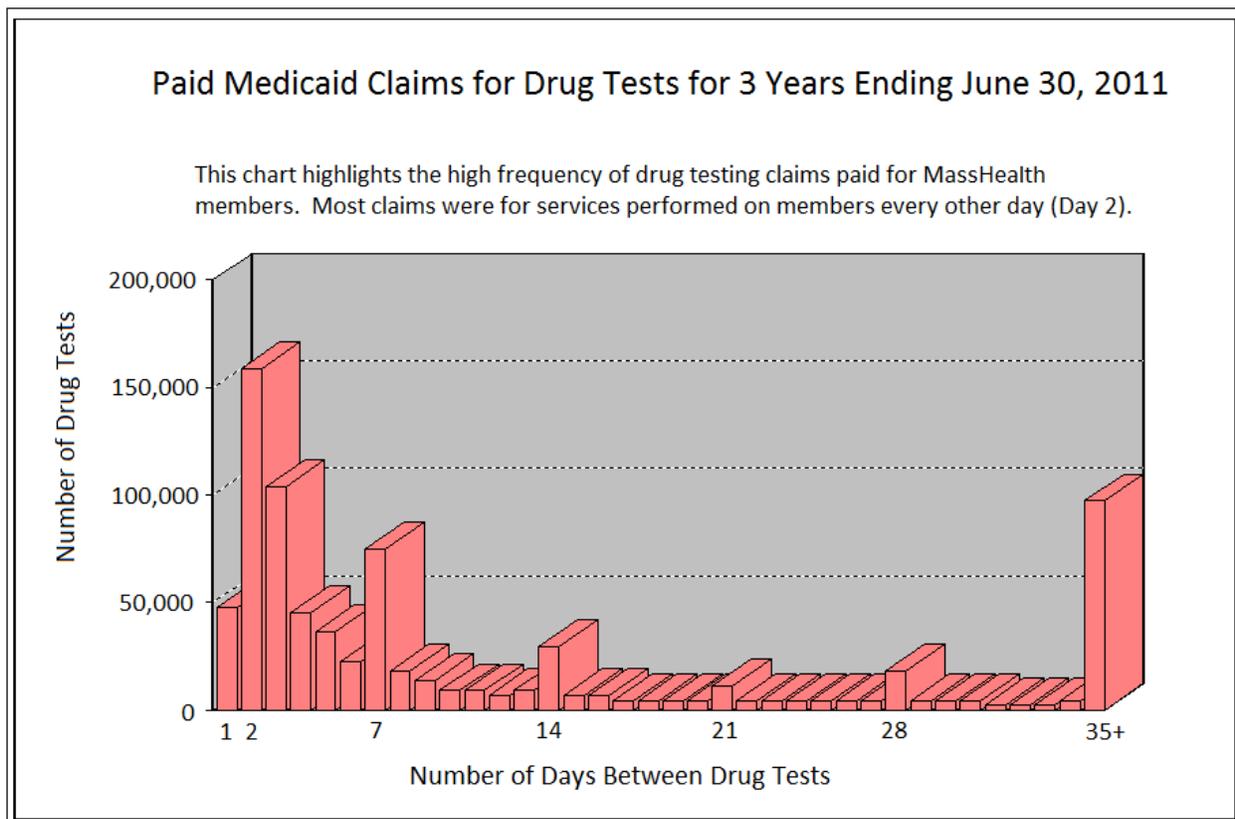
*(5) tests performed for residential monitoring purposes....*

At UMMMC, we examined a total of 2,182 drug tests for 25 members. Of these 2,182 drug tests, 1,230 (56%) had order forms indicating sober houses as the requesting facilities. Although these orders were accompanied by standing orders from licensed physicians, the test results were sent to the patients' residences (not to the ordering physician indicated on the order form), indicating that the tests were most likely used for residential monitoring. In fact, UMMMC confirmed to OSA staff that these tests and all other tests performed from orders originating from certain referring laboratories were for residential monitoring purposes. As a result, during our audit field work, UMMMC officials told us that they were preparing to repay \$1,339,352 for 23,882 drug tests UMMMC performed for residential monitoring.

Throughout our audit, other substance abuse professionals indicated that their patients were experiencing problems with sober house testing. For example, physicians and nurses from Boston Medical Center (BMC) and Codman Square Health Center (CSHC) stated that they were pressured by laboratories and sober houses to sign orders requiring testing up to four times per week for residential monitoring. These clinicians also stated that if they did not sign the orders, their patients would be removed from sober housing or directed to other physicians who would authorize the tests. The clinicians stated that they would not use the test results from these orders because they were not treating these members for substance abuse but rather served only as their primary care clinicians.

### b. Excessive Member Drug Testing

During the audit period, MassHealth paid for 869,340 drug tests.<sup>16</sup> Many of these tests were performed frequently – every day or every other day. Of the total claims paid, 45,510 (5%) were for next-day testing and 158,577 (18%) were for every-other-day testing. Medical experts we interviewed do not endorse drug testing this frequently. Additionally, this frequency is not mandated by state or federal regulations. The chart below illustrates the volume of frequent drug testing during the three-year period ended June 30, 2011.



This chart excludes the first drug test that each member received during the audit period.

In addition, individual members received this daily or every-other-day testing for extended periods of time. For example, 84 members received daily or every-other-day testing more than 120 times each, with one member having 431 such tests. The table below details the number of members and the number of times that members received daily or every-other-day testing during the audit period.

<sup>16</sup> Figures represent drug tests paid for by MassHealth using Procedure Code 80101.

Members	Daily and Every-Other-Day Tests	Total Tests	Average per Member
13,292	1 – 10	38,029	3
3,828	11 – 45	87,101	23
832	46 – 90	51,607	62
131	91 – 120	13,516	103
84	>120	13,834	165

To better understand the frequency and medical necessity of drug testing, we sought guidance from MassHealth and Department of Public Health officials, drug treatment program specialists, testing laboratory managers, Boston University School of Medicine and Tufts University School of Medicine public health instructors, and other state Medicaid programs. These experts stated that, in most instances, testing every day or every other day is not medically necessary. They referred to SAMHSA and National Institute on Drug Abuse (NIDA) drug testing and elimination rate<sup>17</sup> guidelines and federal and state regulations, which recommend less frequent testing.<sup>18</sup>

The federal regulations in 42 Code of Federal Regulations (CFR) 8.12(f)(6) state:

*Drug abuse testing services. OTPs must provide adequate testing or analysis for drugs of abuse, including at least eight random drug abuse tests per year, per patient in maintenance treatment, in accordance with generally accepted clinical practice. For patients in short-term detoxification treatment, the OTP shall perform at least one initial drug abuse test. For patients receiving long-term detoxification treatment, the program shall perform initial and monthly random tests on each patient.*

SAMHSA provided its interpretation of these federal regulations to health care professionals in its document “Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs”:

*In the opinion of the consensus panel, this is a minimal requirement. The actual frequency of testing should be based on a patient's progress in treatment, and more testing should be performed earlier in treatment than later, when most patients are stabilized.*

<sup>17</sup> Drugs of abuse remain in a patient’s system for up to four days depending on level of use. See Appendix III for further details.

<sup>18</sup> For further details on these criteria, refer to the Introduction section of this document.

The healthcare professionals we spoke with stated that opioid treatment programs (OTPs) have developed policies for determining the frequency of drug testing that coincide with the three phases of substance abuse treatment: induction, stabilization, and maintenance. These treatment specialists stated that they do not usually test members more than four to eight times monthly. At most, they stated, they perform drug tests two to three times per week for short periods of time to stabilize new members on an appropriate level of medication, and at reduced frequencies as treatment progresses as described below:

Treatment Phase	Frequency of Testing <sup>[1]</sup>	Duration
Induction	2 to 3 times per week	First 8 weeks
Stabilization	Weekly	Up to 2 months
Maintenance	Monthly	Ongoing <sup>[2]</sup>

[1] If a member relapses, the member is moved to back to the induction phase, with testing occurring two to three days per week, depending on the severity of the relapse.

[2] Testing using this method results in 32 to 40 tests on average for the first year of treatment.

Several state Medicaid programs have established similar drug testing frequencies. For example, Georgia's Medicaid agency will pay for no more than 25 drug tests per member per year. New York will only pay for two tests per week, Vermont for eight tests per month, and New Jersey for two tests per month.

During the three-year period ended June 30, 2011, 6,282 MassHealth members received more than eight drug tests per month, at a total cost of \$24,377,369. MassHealth could have experienced significant cost savings without compromising member care had it more effectively monitored the frequency with which members received these drug tests, investigated providers who submitted unusually large numbers of claims per member, and ensured that the tests were for medically necessary purposes and originated from physicians who were actively treating the members. We believe that by performing these control activities, MassHealth could bring its level of drug testing further into line with the levels (approximately eight per month) recommended by the medical experts we interviewed, and could have saved the Commonwealth \$7,793,238 during the audit period. The table below details this lost opportunity for savings.

Tests per Month / Frequency	Number of Occurrences <sup>19</sup>	Total Amount Paid	Cost Savings at Eight Tests per Month
9 – 12	13,475	\$ 14,257,804	\$ 3,362,685
13 – 16	6,255	8,620,245	3,540,896
17 – 20	660	976,452	544,981
Over 20	<u>295</u>	<u>522,868</u>	<u>344,676</u>
Total	<u>20,685</u>	<u>\$ 24,377,369</u>	<u>\$ 7,793,238<sup>20</sup></u>

### ***Recommendation***

In order to address our concerns regarding improper drug testing for residential monitoring similar to the testing encountered at UMMMC, we recommend that MassHealth:

- Provide UMMMC with necessary assistance and oversight to reverse the 23,882 drug test claims totaling \$1,339,352 that UMMMC recognizes were improper payments.
- Develop system edits in the claims processing system to effectively detect and deny claims for drug tests ordered for residential monitoring.
- Require service providers to include the physician name and identification number, the diagnosis code, and the requesting substance abuse treatment facility name and identification number on drug test claims. This will improve the quality of the claims data within the Medicaid Management Information System (MMIS). Moreover, by including this information in the Data Warehouse, MassHealth can more effectively detect, monitor, and investigate anomalies such as high-frequency drug testing to ensure that drug tests are for medically necessary purposes and prevent the payment of claims for residential monitoring.

In order to address our concerns about high-frequency drug testing, we recommend that MassHealth implement the following strategy:

- Develop new requirements to avoid overuse of laboratory drug testing, bringing MassHealth into line with community and national standards governing appropriate clinical use of drug screening services. This will help to ensure that MassHealth pays for only medically necessary services.
- Monitor the frequency with which members receive drug tests and investigate providers who submit unusually large numbers of claims per member to ensure that the tests are for medically necessary purposes and originate from physicians who are actively treating the members.

<sup>19</sup> A member may be counted in multiple frequency categories and multiple times within the same category.

<sup>20</sup> To prevent double counting, this figure excludes those costs that UMMMC is repaying for its residential monitoring testing.

### **Auditees' Responses**

Cambridge Health Alliance (CHA) provided the following excerpted comments:

*Cambridge Health Alliance fully supports the intent of this audit, to support efforts to conserve scarce resources for medically necessary services that the members of MassHealth require. As we described during your visit, Cambridge Health Alliance has taken steps over the past several years to monitor the use of urine drug screen testing and to develop guidance on effective use of these tests for medically necessary purposes. [CHA believes] that the very limited number of findings related to CHA reflect the efforts we have been making to support the integrity of the MassHealth program.*

UMMMC provided the following excerpted comments:

*With respect to all of the urine drug test (UDT) claims audited by the Office of the State Auditor (OSA), UMass Memorial Medical Center (UMMMC) laboratory was functioning as a referral lab for three independent toxicology laboratories. UMMMC's UDT results were sent directly to the referring toxicology laboratories, indicating the ordering physician's name. (UMMMC's result report audit confirms this transmission of reporting.) Upon internal retrospective review, UMMMC determined that the orders for these tests originated from sober houses, which provide housing for people recovering from substance abuse disorders and with whom UMMMC had no direct service relationship. 130 Code of Massachusetts Regulations (CMR) 401.411(B)(5) precludes reimbursement for testing conducted exclusively for residential monitoring purposes. In light of its internal findings, UMMMC immediately voluntarily initiated a self-report to the OSA and MassHealth and repayment of \$1,339,352 to the Commonwealth for 23,882 tests referred to it by the three independent toxicology laboratories which UMMMC determined may have been performed for residential monitoring purposes. This repayment went beyond the claims period and claims sample covered by the OSA audit; it represented repayment for all reference lab services furnished to the three independent toxicology laboratories for MassHealth beneficiaries for as long as UMMMC provided services to the three referring labs. UMMMC has worked collaboratively with MassHealth to determine the appropriate repayment process and the final claim data files have been provided to MassHealth for this purpose.*

*In September 2011 UMMMC terminated its contract with one of the independent toxicology laboratories, and the remaining two contracts were terminated in June 2012.*

MassHealth provided the following excerpted comments:

*This finding is based on two components. First, that the University of Massachusetts Memorial Medical Center (UMMMC) submitted improper claims totaling \$1,339,352 million and second, that MassHealth would save approximately \$7.8 million by limiting the number of drug tests to eight tests per member per month....*

*MassHealth does agree that more can be done to avoid overutilization of laboratory testing for drug screening by requiring prior authorization for certain drug screening services.<sup>21</sup> MassHealth*

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<sup>21</sup> Any such utilization management strategy must comply with the Federal Mental Health and Substance Use Parity Act and implementing regulations and guidance. In general, this federal law prohibits Medicaid agencies from imposing utilization management requirements on substance use services that are not comparable to the utilization management requirements imposed on non-substance abuse services. MassHealth has not yet completed its analysis of whether requiring prior authorization of certain drug screening services will be feasible in light of federal parity rules.

*is in the process of developing these prior authorization requirements. The threshold level MassHealth establishes for required prior authorization will be based on analysis by our clinical experts and detailed engagement with other state Medicaid programs and private payers to establish a recommended best practice....*

*MassHealth is in the process of voiding the UMMMC claims identified above<sup>22</sup>. MassHealth anticipates this process will be completed in or about March 2013....*

*MassHealth did issue a Provider Bulletin in February 2013 reminding laboratories and authorized prescribers that (1) MassHealth does not provide payment for services performed for residential monitoring purposes even if signed by an authorized prescriber and (2) sober homes are not authorized prescribers.*

*MassHealth intends to further amend its regulations to require authorized prescribers to include on all order forms, an explicit statement that the laboratory test is medically necessary and not being performed for residential monitoring, pursuant to a court order or for another administrative purpose. Laboratories will be required to retain this documentation in their records.*

*MassHealth is currently in the process of implementing a requirement that the ordering and referring provider's NPI number must be provided on claims for laboratory services (and other services when a referral from a physician or other health professional is required)....*

*MassHealth is in the process of developing a prior authorization requirement for these services. We anticipate amending our independent clinical laboratory regulations to establish prior authorization requirements this year.*

### **Auditor's Reply**

UMMMC and MassHealth have already taken extensive action to address many of the issues we observed during our audit. Once we informed UMMMC that we suspected that a portion of its drug testing services were performed for residential monitoring purposes, UMMMC senior management immediately acknowledged the problem and voluntarily provided full disclosure of all information to us and to MassHealth. UMMMC is currently working with MassHealth to repay the Commonwealth for these disallowed payments. MassHealth is examining the current drug testing levels at other state Medicaid programs and private payers to establish a recommended best practice, as well as considering a new requirement for prior authorizations for certain drug screening services to avoid overuse of laboratory testing. It has also issued Provider Bulletins, amended its current regulations, and required additional provider information on claim forms. These actions should help to reduce and control the frequency of drug testing and associated costs to the Commonwealth and to prevent providers from submitting drug testing claims for residential monitoring.

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<sup>22</sup> UMMMC has agreed that it should not have submitted claims totaling approximately \$1,304,000. MassHealth is investigating whether the remaining \$36,352 identified by the State Auditor was improperly paid as well and will take appropriate action to recover any overpayments identified.

Our estimate of \$7.8 million in potential savings was based on SAMHSA guidelines and discussions we had with substance abuse treatment experts. These sources recommend only performing drug tests as necessary and testing no more than four to eight times per month. By using a conservative figure, eight times per month, we calculated savings of \$7.8 million during the audit period. Additionally, as recommended, we believe that MassHealth should require providers to include diagnosis codes and requesting facility information on drug test claims. With this information, MassHealth could more easily determine whether claims originated from substance abuse treatment programs, hospitals, or sober houses and could more effectively detect, monitor, and investigate unusual billing trends and anomalies.

## **2. “UNBUNDLED” DRUG TESTING SERVICES RESULTED IN UNALLOWABLE PAYMENTS TOTALING APPROXIMATELY \$4.5 MILLION**

In October 2010, MassHealth adopted a new policy that restricted payments to laboratories for member drug testing. Specifically, MassHealth reduced the maximum allowable units, each unit representing a test for a specific substance, from 13 to eight units for each date of service. This policy brings MassHealth into line with established community and national standards governing appropriate clinical use of drug screening services and helps ensure that MassHealth pays for only medically necessary services. However, our analysis of drug testing claims showed that three laboratories (Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute) changed their billing methods in order to circumvent MassHealth’s new restrictions and to maximize their revenues. Specifically, these laboratories used an improper billing practice known as “unbundling” that violates federal and state regulations. MassHealth’s claims processing system lacks edits to detect this type of improper billing practice; this resulted in approximately \$4.5 million of unallowable costs to the Commonwealth for the four fiscal years ended June 30, 2012<sup>23</sup>.

The Centers for Medicare & Medicaid Services (CMS) defines and describes two types of unbundling practices in Version 11.3 of the *National Correct Coding Initiative Policy Manual for Medicare Services*:

*Unbundling occurs when multiple procedure codes are billed for a group of procedures that are covered by a single comprehensive code. Two types of practices lead to unbundling. The first is*

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<sup>23</sup> In accordance with Government Auditing Standard 6.32, it was necessary to expand audit procedures to address the potential that this new billing pattern indicates a pattern for fraudulent or abusive activity that may be significant within the context of our audit.

*unintentional and results from a misunderstanding of coding. The second is intentional and is used by providers to manipulate coding in order to maximize payment....*

In addition, 130 CMR 450.307(B)(2) prohibits unbundled billing:

*450.307: Unacceptable Billing Practices*

*(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....*

Moreover, in December 2011, MassHealth issued Transmittal Letter PHY-132, which specifically cautioned laboratories against using unbundled billing practices for drug testing.

*Providers should not routinely bill for the quantification of drug classes (e.g. chemistry section 82000-84999 or therapeutic drug assay section 80150-80299) being tested as part of the drug screen service....*

Before MassHealth's new policy limited allowable units to eight, some independent clinical laboratories developed drug test "panels" for testing 10 to 13 drug units. Each unit in a panel represents a specific drug class (e.g., opiates or barbiturates). These panels were marketed to clinicians involved in substance abuse treatment. As previously noted, in October 2010, MassHealth adopted a new policy that reduced the maximum allowable units from 13 to eight units for each date of service.

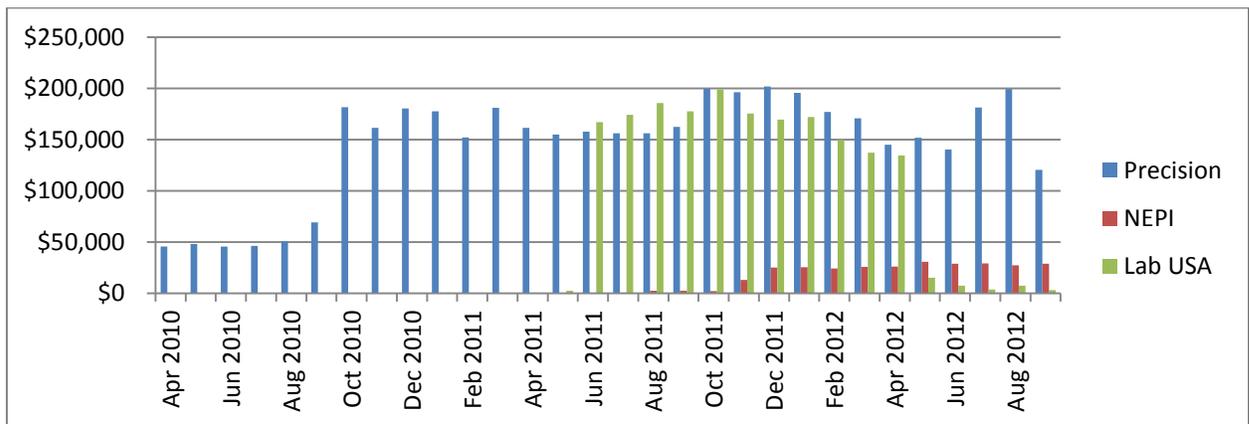
After MassHealth's policy change, certain laboratories began unbundling their drug test claims. Specifically, Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute billed MassHealth for up to the maximum of eight drug units allowed using procedure codes that covered testing for multiple drugs. They also began submitting additional claims using procedure codes for testing specific substances (e.g., cocaine and PCP). These laboratories thus billed for as many as 16 drug tests for the same member on the same day, thereby increasing their revenues.

MassHealth's policy change effectively limited payments for drug tests to a maximum of \$76.64 (\$9.58 x 8 units/tests) per member per day. By unbundling procedure codes, these three laboratories received payments between \$155.96 and \$200.42 for each test billed. This resulted in overpayments

of as much as \$123.78 per member per day. The table below provides an example of unbundled billing by Precision Testing Laboratories, Inc., resulting in unallowable payments of \$88.90 for one test.

Date of Service	Procedure Code	Procedure Code and Description	Number of Units Billed	Amount Billed	Amount Paid
12/22/10	80101	Drug, screen; single drug class, each D	4	\$ 120.00	\$ 38.32
12/22/10	80154	Benzodiazepines	1	\$ 30.00	19.29
12/22/10	82055	Alcohol (ethanol), blood; chemical	1	\$ 30.00	11.28
12/22/10	82145	Amphetamine or methamphetamine, chemical	1	\$ 30.00	16.22
12/22/10	82205	Barbiturates; quantitative	1	\$ 30.00	11.95
12/22/10	82520	Cocaine, quantitative	1	\$ 30.00	15.81
12/22/10	83840	Methadone	1	\$ 30.00	17.03
12/22/10	83925	Opiates (e.g., morphine, meperidine)	1	\$ 30.00	20.30
12/22/10	83992	Phencyclidine (PCP)	1	\$ 30.00	<u>15.34</u>
<u>Total</u>					<u>\$165.54</u>

Before MassHealth’s policy change, these three laboratories rarely billed for any of the substance-specific drug tests identified above. However, Precision Testing Laboratories, Inc. began using an unbundled billing strategy beginning in November 2010, followed by Lab USA Inc. in June 2011 and New England Pain Institute in November 2011. The chart below illustrates the sudden spike in dollars paid to these three laboratories for substance-specific drug tests.



Below is a summary of estimated unallowable costs resulting from unbundling of drug test claims by Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute.

Provider	Total Number of Unbundled Substance-Specific Claims <sup>24</sup>	Total Amount Paid for Unbundled Claims
Precision Testing Laboratories, Inc.	221,896	\$ 3,554,713
Lab USA Inc.	47,248	751,430
New England Pain Institute	<u>12,128</u>	<u>194,034</u>
Total	<u>281,272</u>	<u>\$ 4,500,177</u>

During our audit field work, we informed MassHealth about the unbundling of drug testing claims by these three laboratories and recommended that MassHealth establish system edits to detect and deny unbundled drug testing claims. MassHealth was not aware of this problem and concurred that the unbundling billing practices by these laboratories violated state and federal regulations. After this discussion, MassHealth took action to prevent further unbundling of drug testing claims by these and all other laboratories. MassHealth notified us of its action in its response to our draft audit report:

*...effective for dates of service beginning January 1, 2013, MassHealth established new drug screen claim edits that cause claims for certain quantitative drug tests [substance-specific drug tests] billed on the same date of service as a drug screen service [standard drug test] to be automatically denied. At the same time, MassHealth issued a Provider Bulletin explicitly prohibiting billing for quantitative tests when a drug screening test is medically sufficient....*

### **Recommendation**

In order to address our concerns regarding unbundling of services, we recommend that MassHealth recover overpayments for unbundled billings totaling \$4,500,177 from Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute.

### **Auditee's Response**

MassHealth provided the following excerpted comments:

*MassHealth is reviewing the State Auditor's documentation regarding \$4,500,177 in claims from Precision Testing Laboratories Inc., Lab USA Inc., and New England Pain Institute to determine if any of the above identified providers submitted improper claims for quantitative testing billed in conjunction with drug screen services and will initiate recovery if appropriate.*

<sup>24</sup> The amounts were determined by analyzing MassHealth's database of drug test claims for the four years ended June 30, 2012. We did not examine patient files at these sites.

***Auditor's Reply***

MassHealth has promptly addressed this issue by restricting unbundled drug testing billing practices by developing system enhancements to its claims edits and by issuing Provider Bulletins. In addition, OSA will work with MassHealth and share our calculations for the \$4,500,177 in unbundled drug tests billed by Precision Testing Laboratories, Inc.; Lab USA Inc.; and New England Pain Institute.

**3. LIMITING OR ELIMINATING CERTAIN LABORATORY TESTS COULD SAVE APPROXIMATELY \$2.3 MILLION ANNUALLY**

Our audits of three laboratories found that claims for (a) alcohol, (b) specimen integrity, and (c) confirmatory tests were routinely paid to laboratories that were conducting drug tests on MassHealth members. Massachusetts law does not prohibit or significantly limit these types of test, but they are not always considered medically necessary by SAMHSA, MassHealth, the Massachusetts Bureau of Substance Abuse Services, substance abuse program directors, and other state Medicaid programs. MassHealth could save millions of dollars annually by limiting or eliminating coverage of these tests. During our audit period, MassHealth spent approximately \$7 million (i.e., on average, approximately \$2.3 million annually) on these tests.

**a. Alcohol Tests**

For the three years ended June 30, 2011, MassHealth paid 417,263 claims for alcohol tests,<sup>25</sup> totaling \$4,399,862, to laboratories that also conducted drug tests on MassHealth members. According to information from SAMHSA, state officials, and substance abuse program professionals, alcohol tests are not medically necessary in treating members for drug addiction. Those experts who favor alcohol testing at all prefer more cost-effective methods of alcohol testing, such as breathalyzers, rather than urine alcohol testing, which is more expensive and less reliable. MassHealth currently covers urine alcohol testing; in one case, a single member received 674 urine alcohol tests, costing a total of \$7,621, during our audit period. But we believe that, as suggested by the information below, MassHealth should eliminate alcohol testing.

- According to SAMHSA<sup>26</sup>, “Urine tests for alcohol are highly variable and not an appropriate tool for testing for alcohol . . . . The window of detection [elimination rate] for alcohol is 7–12 hours. . . . Because breath tests are much simpler and faster and are

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<sup>25</sup> Sometimes members were tested only for alcohol. Those tests are not included in these figures.

<sup>26</sup> Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs, TIP Series, No. 43, Ch. 9, Drug Testing as a Tool, p. 144.

less invasive than blood tests, they are the most common alcohol testing method used in OTPs.”

- MassHealth and Massachusetts Department of Public Health specialists indicated that alcohol tests are only effective for members who consume alcohol within the few hours before providing a urine sample.
- Drug treatment program specialists and administrators stated that clinicians can smell alcohol on a patient’s breath when engaging in treatment. Therefore, urine testing for alcohol is unnecessary.
- Vermont’s Medicaid program canceled coverage of all alcohol tests effective July 1, 2010. Vermont recommended that other testing for alcohol, such as breathalyzers, be used by providers.

The table below details the top seven laboratories that were paid more than \$100,000 for alcohol testing during the audit period.

Provider Name	Claims Billed for Three Years Ended June 30, 2011	Total Amounts Paid for Alcohol Tests
Willow Street Medical Laboratory	168,419	\$1,898,895
Precision Testing Laboratories, Inc.	41,617	469,197
Franey Medical Labs	21,678	226,203
Calloway Laboratories, Inc.	18,207	204,734
Clinical Science Laboratory, Inc.	13,816	155,844
Preventive Medicine Associates	14,256	154,935
UMass Memorial Medical Center	<u>11,953</u>	<u>132,155</u>
Total	<u>289,946</u>	<u>\$3,241,963</u>

These seven providers received approximately 74% of the total \$4,399,862 MassHealth paid for alcohol tests during the audit period. The top billing provider, Willow Street Medical Lab, received approximately 43% of this total.

During our audit field work, we asked MassHealth officials about the medical necessity of alcohol tests in treating members for drug addiction. We noted that these tests were ineffective according to information provided by SAMHSA, Department of Public Health (DPH), and MassHealth officials as well as drug treatment program specialists and administrators. At that time, we recommended that MassHealth consider eliminating coverage for this service when a

standard drug test was performed on the same day of service. In response, MassHealth issued Provider Bulletins dated February 2013 that eliminated coverage of certain quantitative drug screens, including alcohol tests, when performed on the same day as a drug screen service.

#### **b. Specimen Integrity Tests**

During our audit period, MassHealth paid 159,260 claims, totaling \$845,671, for specimen integrity tests for members who sought treatment for substance abuse. Specimen integrity tests, consisting of creatinine<sup>27</sup> and pH tests, are performed to ensure that a urine sample has not been diluted, adulterated, or substituted to obtain a negative result.

According to information from SAMHSA and the drug treatment professionals we contacted, specimen integrity testing is not routinely necessary. Rather, specimen integrity testing should only be used in rare instances, such as when a physician suspects that a patient is tampering with a sample. There are other means of determining specimen validity, such as supervised sample collection and observations of patient mannerisms and physical attributes of the urine specimen (color and temperature).

In Technical Assistance Publication (TAP) No. 32, *Clinical Drug Testing in Primary Care*, SAMHSA advises that integrity testing of specimens is “not required in clinical settings, it is sometimes advisable when...” a physician suspects illicit drug use. Additionally, SAMHSA addresses the issue of potential adulteration or substitution of a urine sample in its Technical Improvement Protocol (TIP) 43, *Medication Assisted Treatment for Opioid Addiction and Opioid Treatment Programs*. In Chapter 9 of this document, SAMHSA states:

*Strategies to minimize sample falsification should be balanced by sound treatment ethics and the overall goals of the program—recovery and rehabilitation. Common strategies include*

- *Turning off hot water in bathrooms to prevent patients from heating specimens brought from elsewhere (although not feasible in States where other regulations prohibit this step)*
- *Using bathrooms within eyesight of staff to preclude use by more than one person at a time and feeling specimen containers for warmth as soon as received (freshly voided specimens should be near body temperature [37°C])*

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<sup>27</sup> Creatinine tests measure the concentration of the waste product creatinine in the blood or urine. Low levels of creatinine may indicate kidney disease, muscular or neuromuscular disorders, or urinary tract infections. More frequently, creatinine concentrations are checked in conjunction with drug tests. Low levels of creatinine may indicate that a urine sample has been manipulated (e.g., diluted).

- *Using temperature and adulterant strips or collection devices that include temperature strips*
- *Using a temperature "gun" (infrared thermometer...) to measure the temperature of urine specimens*
- *Using direct observation by staff of specimen collection.*

*The consensus panel believes that falsification is reduced when patients understand that urine test results are not used punitively to lower doses of addiction treatment medication.*

For each of the 75 members in our audit sample, we found that all the laboratories we audited performed specimen integrity tests on urine specimens during the audit period. For example, CHA received \$27,499 for 5,969 specimen integrity tests; UMMMC received \$54,061 for 10,007 specimen integrity tests; and BMC received \$12,143 for 2,831 specimen integrity tests. These hospital laboratories stated that they were performing these tests on every specimen as part of their standard laboratory drug testing procedures. CHA and UMMMC began performing specimen integrity tests on all urine specimens during March 2009 and March 2010, respectively, and continue to perform these tests for all specimens. BMC started specimen integrity testing January 2009, but discontinued these tests after 10 months because only a few cases of diluted specimens were ever identified. BMC officials said they easily recognized problems with these diluted specimens because they were cold or looked like water.

As with alcohol testing, during our audit field work we questioned MassHealth officials about the medical necessity of specimen integrity tests in treating members for drug addiction. We noted that these tests were ineffective according to information provided by SAMHSA, DPH, and MassHealth officials as well as drug treatment program specialists and administrators. At that time, we recommended that MassHealth consider eliminating coverage for this service when a standard drug test was performed on the same day. In response, MassHealth issued Provider Bulletins dated February 2013 that eliminated coverage of certain quantitative drug screens, including specimen integrity tests, when performed on the same day as a drug screen service.

### **c. Confirmatory Drug Tests**

Confirmatory drug tests are performed on specimens to verify or refute initial drug test results. Confirmatory tests are typically performed using more complex machinery, producing more specific and sensitive test results. Therefore, confirmatory tests are more expensive than

standard drug tests. According to SAMHSA guidelines, confirmatory tests should be ordered only by physicians and should not be part of a predesigned laboratory panel of tests.

Substance abuse treatment specialists we contacted stated that they do not typically order confirmatory tests. They stated that they only need to screen whether an illicit substance is present or not and that this information is provided through the initial drug test. However, in rare instances, if the accuracy of the first test is questioned (e.g., if a member strongly disagrees with a positive result), these specialists indicated that a confirmatory test may be warranted. They stated that they do not confirm positive results for methadone or buprenorphine for members who are currently receiving those drugs as part of their treatment. The positive results of these substances in the primary drug test provide the expected appropriate result.

SAMHSA's TAP No. 32, *Clinical Drug Testing in Primary Care* 2012, provides guidance on confirmatory drug testing:

*In clinical settings, confirmation is not always necessary. Clinical correlation is appropriate. For example, if the patient or a family member affirms that drug use occurred, a confirmation drug test is not usually needed...*

*In addition, a confirmatory test may not be needed; patients may admit to drug use or not taking scheduled medications when told of the drug test results, negating the necessity of a confirmatory test. However, if the patient disputes the unexpected findings, a confirmatory test should be done.*

During the audit period, UMMMC's laboratory frequently received drug test orders requiring confirmation of all positive results. In fact, our sample of 25 patient files revealed that MassHealth paid for 723 confirmatory tests totaling \$11,181. According to SAMHSA's guidance, confirming every positive result is not medically necessary. Additionally, 330 of these confirmatory tests confirmed the presence of methadone or buprenorphine. As noted above, substance abuse treatment specialists stated that confirmatory testing for these substances is not necessary, since their presence is expected to be positive.

For the three-year period ended June 30, 2011, MassHealth paid a total of 95,869 claims, costing a total of \$1,724,882, to all laboratories performing confirmatory drug tests for members who also received an initial drug test. Based on SAMHSA guidelines and information we gathered from healthcare professionals, many of these tests may have been unnecessary.

**Recommendation**

In order to address our concerns about unnecessary laboratory tests, we recommend that MassHealth establish regulations and system edits, similar to those established for alcohol and specimen integrity tests, disallowing claims for confirmatory drug tests when performed on the same day as a drug screen.

**Auditees' Responses**

UMMMC provided the following excerpted comments:

*UMMMC does not routinely perform specimen integrity testing on UDTs. Specimen integrity testing is only performed when it is a custom order received from the referring doctor or laboratory.*

*UMMMC does not routinely perform confirmatory drug testing on all positive UDTs. Confirmatory testing is determined either by institutional policy (for positive Neonatal Intensive Care Unit drug screens and positive meconium drug screens) or custom orders received from the referring doctor or laboratory.*

MassHealth provided the following excerpted comments:

*MassHealth does not agree with the savings projected in this audit recommendation.... The audit lists seven laboratories that were the highest billers for alcohol tests during the audit period, including Franey Medical Labs. Following a referral of a physician by MassHealth to Medicaid Fraud Division (MFD), the Attorney General on or about March 8, 2013, obtained an indictment of that physician and Franey Medical Labs for Medicaid kickbacks and False Claims. MassHealth is in the process of following up with appropriate action.*

**Auditor's Reply**

We concur with UMMC that its physicians did not routinely order specimen integrity and confirmatory drug tests. However, our audit found that UMMC's laboratory received a significant number of drug test orders from unaffiliated physicians that routinely contained instructions for specimen integrity and confirmatory testing. Based on our findings at UMMC, we expanded our work in this area and found that other laboratories were similarly performing routine specimen integrity and confirmatory tests. Since industry best practices do not include this type of frequent testing, we recommended MassHealth establish frequency limits for specimen integrity and confirmatory drug tests.

The \$2.3 million savings amount mentioned in this finding is not a projection based on possible future testing costs, but was based on the amount that MassHealth actually spent on alcohol,

specimen integrity, and confirmatory tests during our audit period: approximately \$7 million over three years, i.e., \$2.3 million per year.

MassHealth issued Provider Bulletins emphasizing that confirmatory drug tests will only be paid when these tests are performed on an as-needed basis, only when medically necessary, and not as part of a routine supplement to drug screens. MassHealth's efforts will help to eliminate unnecessary confirmatory testing, but more controls are needed to prevent any unnecessary payments for these tests. Specifically, MassHealth should establish regulations and system edits, similar to those established for drug alcohol and specimen integrity tests, disallowing claims for confirmatory drug tests performed on the same day as a drug screen. As noted in our report, substance abuse treatment specialists do not typically order confirmatory tests regardless of whether the initial drug screen produces a positive result. The specialists we interviewed stated that they do enough testing and clinical correlation with their members and their families that confirmatory testing is not necessary. Members are tested, on average, two to three times per week upon entering a substance abuse treatment program, and weekly thereafter. This frequent testing provides sufficient evidence of a member's drug history without the need for additional confirmatory tests.

MassHealth should also follow up with appropriate action to ensure that potentially fraudulent activities, similar to those occurring at Franey Medical Labs, have not occurred at the other six laboratories noted in our report as receiving the largest payments for alcohol tests.

#### **4. MASSHEALTH PAID FOR DUPLICATE DRUG TESTING SERVICES TOTALING APPROXIMATELY \$313,623**

In 130 CMR 450.307(B)(1), MassHealth providers are specifically prohibited from receiving reimbursement for duplicate services, including drug tests:

*450.307: Unacceptable Billing Practices...*

*(B) Without limiting the generality of 130 CMR 450.307(A), the following billing practices are forbidden:*

*(1) duplicate billing, which includes the submission of multiple claims for the same service by the same provider or multiple providers....*

During the audit period, MassHealth paid for duplicate drug testing services totaling approximately \$313,623, both (1) duplicate tests processed by MassHealth's claims system and (2) duplicate tests ordered for verification purposes. Currently, MassHealth allows members to receive one drug test

per day and prohibits providers from billing for duplicate services. However, our audit found 16,441 instances in which MassHealth paid for two drug tests (including alcohol tests and creatinine tests) for the same member for the same day. MassHealth paid these duplicate claims, contrary to state regulations, as follows.

**a. Duplicate Tests Processed by MassHealth’s Claims System**

Within the sample of 75 member files at BMC, CHA, and UMMC, we identified 25 instances, totaling \$1,648, in which these hospitals submitted duplicate drug test claims using Procedure Code 80101<sup>28</sup> for the same member for the same day. MassHealth’s claims processing system did not identify and deny these duplicate claims. The table below summarizes these duplicate payments.

Location	Number of Duplicate Payments	Amount Paid
Boston Medical Center	2	\$ 82
Cambridge Health Alliance	21	1,549
UMass Memorial Medical Center	<u>2</u>	<u>17</u>
Total	<u>25</u>	<u>\$ 1,648</u>

Based on these findings, we expanded our audit scope and analyzed all drug test claims for Procedure Codes 80100<sup>29</sup> and 80101 to identify any additional duplicate payments. In total, we identified 14,088 duplicate payments totaling an estimated<sup>30</sup> overpayment of \$269,440. Of this amount, 119 duplicate payments, totaling \$2,438, resulted from the same laboratory submitting more than one claim for the same member on the same day.<sup>31</sup> The chart below details these duplicate claims.

<sup>28</sup> MassHealth defines this procedure code as “drug test, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class.”

<sup>29</sup> MassHealth defines this procedure code as “drug test, qualitative; multiple drug classes chromatographic method, each procedure.”

<sup>30</sup> Our estimate, for duplicates of procedure code 80101, was calculated using a conservative approach. During the audit period, MassHealth allowed up to 13 units to be tested daily per member. Therefore, if two laboratories submitted claims totaling 15 units, our estimate considered the excess, two units, as duplicates. It is possible that the entire test submitted by one of these labs was duplicative and therefore unallowable. This can only be determined by examining each laboratory’s documentation.

<sup>31</sup> Duplicate billings from the same laboratory for the same day of service may be due to two different physicians in different practices (e.g., substance abuse program and obstetrician/gynecologist) requesting the same tests.

Provider	Instances	Claims Paid	Units Billed	Paid Amount	Estimated Overpayment
Beth Israel Deaconess Hospital – Milton	63	126	629	\$ 6,026	\$ 1,198
Brigham & Women's Hospital	33	301	301	2,884	354
Athol Memorial Hospital	1	2	2	145	20
Milford Hospital	1	2	6	459	334
South Boston Community Health Center	11	32	131	1,048	205
Waterbury Hospital	1	2	8	365	241
Tufts Medical Center	<u>9</u>	<u>18</u>	<u>126</u>	<u>1,207</u>	<u>86</u>
Total	<u>119</u>	<u>483</u>	<u>1,203</u>	<u>12,134</u>	<u>\$ 2,438</u>

The remaining \$267,002 of overpayments involved 13,969 instances of duplicate payments in which two different laboratories submitted separate claims for the same type of testing, the same member, and the same day. Based on our audit work, we determined that one possible reason that this occurred is that duplicate tests were ordered on the same day for the same member by the member's addiction treatment program and sober house.

In addition, our analysis of claims submitted by laboratories identified 1,120 instances in which MassHealth paid for more than one alcohol test for the same member on the same day and 373 instances in which MassHealth paid for more than one creatinine test<sup>32</sup> for the same member on the same day. These duplicate tests for alcohol and creatinine caused overpayments of \$12,985 and \$1,963, respectively.

#### **b. Duplicate Tests Ordered for Verification Purposes**

At CHA, physicians ordered two sets of drug tests for members: one from an in-house laboratory and another from a reference laboratory. CHA referred to these second tests as "send-out" tests. CHA officials stated that these send-out tests were used as a means of authenticating the accuracy of the in-house tests. Our audit identified 525 instances, totaling \$6,196, in which CHA billed MassHealth for these send-out tests. CHA officials stated that this practice was discontinued in March 2009 after the in-house test was found to be reliable.

At CSHC, staff collected both urine and oral swab specimens on the same day from the same member. CSHC's in-house laboratory performed a drug test on the urine specimen and sent the

<sup>32</sup> Creatinine tests measure the level of the waste product creatinine in blood or urine. See Footnote 30 for further details.

oral swab to an external laboratory for a second drug test. Both CSHC and the external laboratory individually submitted claims to MassHealth for the tests. CSHC ordered the oral swab tests to confirm that members did not dilute, substitute, or tamper with their urine specimens. Our audit identified 310 instances in which these reference laboratories submitted claims for an oral swab test on the same day CSHC submitted a claim for its drug testing services; these occurrences caused a total overpayment of \$21,391.

### **Recommendation**

In order to address our concerns about duplicate payments, we recommend that MassHealth:

- Recover overpayments for all duplicate claims submitted by the same provider. For all duplicate claims submitted by different providers, MassHealth needs to identify which payment was for medically necessary services and which should be repaid.
- Review system edits within its claims processing system to ensure that these edits effectively identify and deny claims for duplicate services that violate state regulations.

In order to address our concerns about physicians requiring external verification of in-house testing, we recommend that MassHealth:

- Send a notification to providers that verification testing using the same specimen or another body fluid is duplicative and therefore not a covered procedure.
- Recover overpayments made to laboratories for disallowed drug tests used to verify initial drug tests taken on the same day totaling \$27,587.

### **Auditees' Responses**

BMC provided the following excerpted comments:

*[BMC] reaffirms its commitment to comply with all regulations and standards governing state health care programs. In addition, should MassHealth confirm that a duplicate payment was made to the Hospital as identified in the draft report (i.e., in the sum of \$82), then the Hospital shall cooperate with MassHealth and promptly return the duplicate payment.*

CHA did not respond to this issue. However, when we brought this matter to its attention, CHA contacted MassHealth to repay all duplicate claims for drug tests.

UMMMC provided the following excerpted comments:

*UMMMC has policies and procedures in place to avoid duplicate billing. UMMC will further research the two claims in question related to this finding. It is most likely that UMMC received*

*two separate UDT orders for two separate specimens for the same beneficiary on the same day of collection from the referring doctor or laboratory. In any event, repayments for these claims are subsumed in the repayment discussed in reference to Finding 1. As noted there, UMMMC has worked collaboratively with MassHealth to determine the appropriate repayment process, and the final claim data files have been provided to MassHealth for this purpose.*

CSHC provided the following excerpted comments:

*Codman Square Health Center ("Health Center") appreciates the opportunity to comment on the Government's draft report. It does so following consultation with Boston Medical Center ("Hospital").*

*The Health Center reaffirms its commitment to comply with all regulations and standards governing state health care programs. It is working closely with the Hospital to ensure that it follows the Hospital's protocols for drug screening. As part of this effort, physicians have been instructed not to order two drug screens testing for the same substances for the same patient on the same day.*

*Lastly, please be assured that the Health Center agrees to cooperate fully with MassHealth and any follow-up that it may conduct in regard to payments connected to testing ordered at the Health Center.*

MassHealth provided the following excerpted comments:

*MassHealth's claims processing system currently has duplicate claims logic that denies claims for the same service code when billed by the same provider for the same member on the same date of service. MassHealth relies on this edit to avoid inappropriate duplicate payments submitted by laboratories saving MassHealth millions of dollars in 2012 alone.*

*Our system also tracks when the same service has been paid to two different providers on the same date of service. Currently, program staff review these suspect duplicates and manually void inappropriate claims. Beginning this summer, MassHealth is rolling out the Predictive Modeling System, which will substantially increase our ability to systematically identify and avoid claims that are inappropriate or that may be fraudulent. This prepayment detection system is utilized by premier private sector payers and is designed to identify and prevent a range of improper payments, including the types identified in this audit. Massachusetts will be one of the first states in the nation to implement such a system.*

*As stated above, MassHealth instructed providers via provider bulletin in February 2013 that MassHealth payment is available only for medically necessary confirmatory (i.e. verification) testing following a positive drug screen....*

*The draft audit report does not provide sufficient information for MassHealth to investigate potential overpayments mentioned in this finding. MassHealth respectfully requests additional information so that we can investigate and recover any overpayments.*

### **Auditor's Reply**

We are encouraged by the fact that each of the healthcare providers has agreed to fully cooperate with MassHealth to repay any amounts due the Commonwealth as a result of receiving multiple

payments for drug testing services they provided to the same member on the same day. Additionally, we believe that CSHC's efforts to ensure that physicians no longer order verification tests will help it to eliminate duplicate drug testing claims in the future.

MassHealth's response states that its claims processing system currently has duplicate-claims logic that denies claims for the same service code, or the same service, when billed by the same provider or by different providers, respectively, for the same member on the same day of service. However, it appears that this system functionality was either not in place or ineffectual during our three-year audit period, since our examination of drug test claims – based on provider identification numbers, member identification numbers, dates of service, and procedure codes – identified 16,441 duplicate claims totaling \$313,623. The details of these duplicate payments will be provided to MassHealth, as requested.

MassHealth's plan to roll out a predictive modeling system this summer should improve its ability to detect and deny claims for unallowable services, including duplicate claims for drug testing services.

#### **5. DELAYED IMPLEMENTATION OF REQUIRED PRICING CHANGES RESULTED IN OVERPAYMENTS TOTALING \$107,309**

Our audit revealed that MassHealth's system did not process the correct payment amount for drug tests in that it paid amounts that exceeded the rate and unit limitations required under 114.3 CMR 20.00 and adopted by the Massachusetts Department of Health Care Finance and Policy (DHCFP). Beginning February 1, 2009, DHCFP reduced the rates that MassHealth was allowed to pay laboratories for drug tests. For standard multiclass drug tests, the rate was reduced from \$11.81 to \$11.77 per unit<sup>33</sup> tested. For standard single-class drug tests, the rate changed from \$13.61 to \$9.58 per unit tested. In addition, on October 1, 2010, DHCFP reduced the number of billable units for these single-class drug tests from 13 units to eight units per member per day.

However, MassHealth did not fully implement these pricing changes in a timely manner. It did not implement the rate changes scheduled for February 1, 2009 until February 9, 2009. This delay resulted in MassHealth's overpaying 60 laboratories for 1,894 drug tests totaling \$76,875. In addition, during the audit period, another 351 claims totaling \$28,218 were paid at incorrect rates.

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<sup>33</sup> Units represent drug classes, or types of drug tests, e.g., opiates.

Additionally, during the audit period, MassHealth had not correctly implemented the reduction in allowable billable units from 13 to eight. Consequently, MassHealth overpaid 17 laboratories for 103 claims totaling \$2,216.

State regulations (130 CMR 450.259) require repayment for overpayments due to rate adjustments, as noted below:

*(A) Whenever an overpayment occurs due to a rate adjustment that is certified by DHCFP or otherwise established by the MassHealth agency in accordance with applicable law, the MassHealth agency notifies the provider in writing by issuing a remittance advice identifying the impact of the rate adjustment on all previously paid claims and stating the amount of the overpayment.*

*(B) A provider must pay to the MassHealth agency the full amount of any overpayment attributable to a rate adjustment within 30 calendar days after the date of issuance of a remittance advice under 130 CMR 450.259(A), unless the provider enters into a payment arrangement with the MassHealth agency under 130 CMR 450.260(H).*

### **Recommendation**

In order to address our concerns about pricing adjustments for drug tests, we recommend that MassHealth take the following actions:

- Develop internal controls to ensure that pricing and unit changes mandated by DHCFP are instituted promptly.
- Perform more comprehensive quality assurance testing and control procedures to ensure that system coding changes, such as pricing and unit edits, are processing properly for all classes of Medicaid claims before going “live” with these changes.
- Recover the \$107,309 identified as unallowable overpayments due to rate and unit adjustments.

### **Auditee's Response**

MassHealth provided the following excerpted comments:

*As stated above, MassHealth laboratory rates are tied to Medicare laboratory rates. Medicare does not provide advance notice to states of rate changes. As a result, there is a necessary delay before state rates are modified once Medicare rates change.*

*To the extent appropriate, this delay has been minimized through the use of administrative bulletins to announce simple changes. However, when a change is more significant, such as when a code is newly added or deleted, it is necessary to amend state regulations to properly reflect the rate change. Notice and public hearing is required when an amendment to state regulations is required. M.G.L. c. 118E s. 13D. This process necessarily creates some delay of the implementation of rate changes.*

*The draft audit report does not provide sufficient information for MassHealth to investigate potential overpayments mentioned in this finding. MassHealth respectfully requests additional information so that we can investigate and recover any overpayments.*

### ***Auditor's Reply***

MassHealth's response provides an explanation of why the rate and unit change were not implemented in a timely manner. However, once the system was updated to reflect these changes, MassHealth should have taken prompt action to recover any resulting overpayments. We will provide MassHealth with the additional information it needs to investigate and recover any overpayments, as requested.

### **6. IMPROPER CLASSIFICATION OF NEW PROCEDURE CODES CAUSED UNDERPAYMENT OF \$190,010**

MassHealth uses two methods for paying hospital claims: Fee for Service (FFS) and Payment Amount per Episode (PAPE). FFS payments are made in accordance with fee schedules listing individual rates for specific services. PAPE payments are flat rates for groups of services provided for members on a given day. MassHealth uses FFS to pay laboratories for drug tests. However, our audit revealed that MassHealth's software incorrectly classified two newly adopted<sup>34</sup> drug test procedure codes, G0431 and G0434, as PAPE services, resulting in underpayments to hospitals totaling \$190,010.

During our audit, we notified MassHealth of this error. MassHealth corrected the system error, reprocessed all the miscoded G0431 and G0434 claims, notified the hospitals affected by this error, and paid the \$190,010 due to these hospitals.

### ***Recommendation***

As noted in the report, MassHealth corrected the system error we found, which should help to ensure the proper payment for Procedure Codes G0431 and G0434. However, after the completion of audit field work, we identified, and referred to MassHealth, similar instances of incorrect payments. MassHealth should complete the research on these claims, make adjustments to its claims processing system, and adjust payments to hospitals, as necessary.

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<sup>34</sup> MassHealth adopted these procedure codes effective December 1, 2011.

**Auditee's Response**

MassHealth provided the following excerpted comments:

*MassHealth has reprocessed claims for drug screen services billed under procedures codes G0431 and G0434 that were incorrectly paid according to the acute outpatient departments PAPE payment methodology. These claims were reprocessed in April 2012.*

**Auditor's Reply**

As noted in our report, MassHealth took action during the audit to correct the system error that was causing the incorrect payment for G0431 and G0434 claims. However, after our meeting with MassHealth on May 25, 2012, when MassHealth disclosed that the system error was corrected, we identified additional drug test claims that still appeared to be processing incorrectly. On June 11, 2012, we provided a detailed spreadsheet of these 63 claims to MassHealth, but we have not received any feedback to date. MassHealth needs to complete its research on these claims; if needed, we can provide the details on these claims again.

**7. LABORATORIES' CLAIMS FOR \$41,258 IN DRUG TESTING SERVICES ARE NOT SUPPORTED BY ADEQUATE DOCUMENTATION**

During the audit period, two hospital laboratories did not maintain required documents necessary to support their drug testing claims totaling \$41,258. In 130 CMR 410.457 and 410.458, hospital laboratories are provided with specific guidance on requests for laboratory services and recordkeeping:

*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.

In addition, 130 CMR 401.416(B) applies to standing orders<sup>35</sup> for laboratory services, as follows:

*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.*

We examined a total of 75 member files at BMC, CHA, and UMMMC to ensure that these laboratories were complying with MassHealth regulations. At BMC, all 25 member files examined met all of these requirements. However, at CHA, we identified two deficiencies involving missing test results. At UMMMC, we identified 609 deficiencies involving standing orders, order forms, and test results. The following table details these deficiencies, which total \$41,258.

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<sup>35</sup> A standing order is a request by an authorized prescriber for an independent clinical laboratory to repeat one or more tests over a specified period of time.

Deficiency	CHA Claims	CHA Questionable Payment	UMMMC Claims	UMMMC Questionable Payment
Standing Order Deficiencies <sup>36</sup>	-	-	179	\$ 8,867
Missing Test Results	2	\$ 177	132	3,638
Unidentified Recipient of Test Results	-	-	125	13,891
Missing Order Forms	-	-	84	6,682
Missing Diagnosis Code	-	-	43	4,128
Missing Specimen Collector Name, Location, and/or Date	-	-	24	2,462
Incomplete Order Forms	-	-	<u>22</u>	<u>1,413</u>
Totals	<u>2</u>	<u>\$ 177</u>	<u>609</u>	<u>\$ 41,081</u>
Total CHA and UMMMC Questionable Payments				<u>\$ 41,258</u>

We discussed these matters with officials from CHA and UMMMC. CHA officials agree that member files were missing the required information. UMMMC did not follow up on the deficiencies because it is planning to repay MassHealth for all drug tests related to residential monitoring, including these tests.

Additionally, at UMMMC, contrary to 130 CMR 401.416(C)(7), standing orders did not include the required statement “such testing is required as part of the member’s medical or drug treatment plan.” Without this statement from the treating physician, UMMMC cannot ensure that these tests are medically necessary and meet MassHealth’s requirements for covered services.

### ***Recommendation***

In order to address our concerns regarding insufficient documentation for drug testing claims, we recommend that MassHealth take the following actions:

- Ensure that CHA and UMMMC develop and maintain documentation in accordance with regulations on provider requests for laboratory services.

<sup>36</sup> Deficiencies with standing orders include 119 missing standing orders or orders exceeding the 30-day limit, 50 incomplete standing orders missing information such as duration and frequency, and 10 standing orders with questionable physician approvals.

- Ensure that UMMMC develops and maintains appropriate procedures for the proper use of standing orders for drug tests, including developing procedures for limiting standing orders to 30 days, proper frequency and duration, and proper physician signatures.
- Issue a Provider Bulletin to all laboratory providers restating the documentation requirements for requesting laboratory services and for other recordkeeping requirements as detailed in 130 CMR 401.416 through 401.417 and 401.455 through 401.459, including drug testing. MassHealth should remind these laboratories that they must maintain all necessary documentation and produce it upon request.

### ***Auditees' Responses***

CHA provided the following excerpted comments:

*After reviewing the draft report, CHA provided additional information in response to the findings. All missing information was provided to the auditor, with the exception of two tests that were cancelled by CHA, but were billed to MassHealth....*

*Therefore, CHA feels that this audit confirms that CHA has complied with MassHealth requirements and has acted responsibly to insure drug screen testing is conducting only when medically necessary. CHA will continue to monitor our compliance with MassHealth regulations in order to maintain a high standard of accuracy and completeness.*

UMMMC provided the following excerpted comments:

*All of the 609 documentation deficiencies identified in the OSA audit related to claims for tests referred to it by the three independent toxicology laboratories which UMMMC determined may have been performed for residential monitoring purposes. As noted in response to Finding 1, UMMMC has agreed to repay the Commonwealth all MassHealth reimbursements for reference lab services furnished to the three independent toxicology laboratories for as long as UMMMC provided such services to them, which would include the \$41,081 of "Questionable Payment" shown for UMMMC in the draft OSA report. UMMMC has worked collaboratively with MassHealth to determine the appropriate repayment process, and the final claim data files have been provided to MassHealth for this purpose.*

*UMMMC has addressed the standing order requirements for substance abuse testing by amending its existing policy on Standing Orders and communicating this change to its ordering physicians. Standing orders for UDT are an uncommon practice at UMMMC and were primarily related to the three independent toxicology laboratories for which UMMMC had acted as the reference laboratory. The three independent toxicology laboratories did not send their standing orders with either the electronic or paper UDT orders to UMMMC.*

*As a matter of standard practice UMMMC maintains policies and procedures in accordance with the Massachusetts Department of Public Health recordkeeping requirements for all testing it directly obtains. UMMMC requested appropriate documentation for the tests referred to it from the three independent toxicology laboratories, which are contractually required to provide this documentation to UMMMC, however the toxicology laboratories failed to provide the requested records in a timely manner.*

MassHealth provided the following excerpted comments:

*While the draft audit report does not provide enough detail for MassHealth to independently verify the concerns raised about CHA and UMMMC, Mass Health will conduct follow up field audits with CHA and UMMMC to ensure that these providers have developed and are maintaining adequate documentation in accordance with our regulations.*

*MassHealth agrees that a reminder Provider Bulletin would be helpful and intends to issue such Bulletin as soon as possible.*

***Auditor's Reply***

We acknowledge that after we completed our audit field work, CHA provided additional information to support all but two of the drug test claims we found deficient. However, to completely resolve this matter, CHA should cooperate with MassHealth and repay the amounts it received for tests it did not perform. In addition, CHA should develop policies and procedures to ensure that its laboratory notifies its billing department when physicians cancel drug test orders. This will help prevent improper payments by the Commonwealth.

We are encouraged by the fact that UMMMC has amended its existing policy on standing orders and communicated this change to its ordering physicians. However, UMMMC's laboratory needs to have controls in place to ensure that these policies and procedures are followed by both hospital-affiliated and non-hospital-affiliated physicians. In so doing, UMMMC will ensure that claims for drug screenings are supported by adequate documentation and comply with MassHealth regulations.

We agree with MassHealth's plan to issue a Provider Bulletin restating the documentation requirements for laboratory services, including drug tests. We will provide MassHealth with the documentation it needs to follow up independently with CHA and UMMMC to ensure that these providers are maintaining adequate documentation in accordance with state regulations.

## APPENDIX I

### Pros and Cons of Different Specimen Sources for Testing for Drugs of Abuse

We used the following schedule to determine whether Medicaid providers were using the most cost-effective source when testing for drugs of abuse.

Table 1: Pros and Cons of Different Specimen Sources			
Specimen	Window of Detection	Pros	Cons
<b>Urine</b>	<ul style="list-style-type: none"> <li>● Up to 2-4 days</li> </ul>	<ul style="list-style-type: none"> <li>● Most accurate results</li> <li>● Least expensive</li> <li>● Most flexibility for testing different drugs</li> <li>● Most likely to withstand legal challenge</li> </ul>	<ul style="list-style-type: none"> <li>● Specimen can be adulterated, substituted, or diluted</li> <li>● Limited detection window</li> <li>● Collection can be invasive or embarrassing</li> <li>● Specimen handling and shipping can be hazardous</li> </ul>
<b>Oral Fluid</b>	<ul style="list-style-type: none"> <li>● Up to 48 hours</li> </ul>	<ul style="list-style-type: none"> <li>● Collecting the oral fluid specimen can be observed</li> <li>● Minimal risk of tampering</li> <li>● Noninvasive</li> <li>● Can be collected easily in virtually any environment</li> <li>● Can be used to detect alcohol use</li> <li>● Can be used to detect recent drug use</li> </ul>	<ul style="list-style-type: none"> <li>● Drugs and drug metabolites do not remain in saliva as long as in urine</li> <li>● Less efficient than other testing methods for detecting marijuana use</li> <li>● pH changes can alter specimen</li> <li>● Moderate to high cost</li> </ul>
<b>Sweat</b>	<ul style="list-style-type: none"> <li>● FDA cleared for 7 days</li> </ul>	<ul style="list-style-type: none"> <li>● Relatively noninvasive</li> <li>● Sweat patch typically worn for 7 days</li> <li>● Quick application and removal of sweat patch</li> <li>● Patch seal tampering minimized</li> <li>● Longer window of drug detection than urine and blood</li> <li>● Relatively resistant to specimen adulteration</li> <li>● No specimen substitution possible</li> </ul>	<ul style="list-style-type: none"> <li>● Only a few laboratories offer sweat patch testing</li> <li>● Those with sensitive skin may react to the patch</li> <li>● Possible time-dependent drug loss from the patch</li> <li>● Possible external drug contamination from improper skin cleansing prior to application</li> <li>● For marijuana, current use by a naïve user may not be detected</li> <li>● For marijuana, positive sweat results are possible in current abstinent, but previously chronic high dose, users</li> <li>● Sweat production dependent</li> <li>● Moderate to high cost</li> </ul>
<b>Hair</b>	<ul style="list-style-type: none"> <li>● Up to 4-6 mths</li> </ul>	<ul style="list-style-type: none"> <li>● Collecting the hair specimen can be observed</li> <li>● Long detection window</li> <li>● Does not deteriorate</li> <li>● Can be used to measure chronic drug use</li> <li>● Convenient shipping and storage; needs no refrigeration</li> <li>● Noninvasive</li> <li>● More difficult to adulterate than urine</li> </ul>	<ul style="list-style-type: none"> <li>● Moderate to high cost</li> <li>● Cannot be used to detect alcohol use</li> <li>● Cannot be used to detect drug use 1-7 days prior to drug test</li> <li>● Not effective for compliance monitoring</li> <li>● External contamination</li> </ul>
<b>Breath</b>	<ul style="list-style-type: none"> <li>● Up to 12-24 hours</li> </ul>	<ul style="list-style-type: none"> <li>● Minimal cost</li> <li>● Reliable detector of presence and amount of alcohol</li> <li>● Noninvasive</li> </ul>	<ul style="list-style-type: none"> <li>● Very limited detection window for alcohol</li> <li>● Can only be used to detect presence of alcohol</li> </ul>
<b>Blood</b>	<ul style="list-style-type: none"> <li>● Up to 12-24 hours</li> </ul>	<ul style="list-style-type: none"> <li>● Can be used to detect presence of drugs and alcohol</li> <li>● Test produces accurate results</li> </ul>	<ul style="list-style-type: none"> <li>● Invasive</li> <li>● Moderate to high cost</li> </ul>
<b>Meconium</b>	<ul style="list-style-type: none"> <li>● Up to 2-3 days</li> </ul>	<ul style="list-style-type: none"> <li>● Can be used to detect long-term use</li> <li>● Can be used to detect presence of drugs and alcohol</li> <li>● Easy to collect and highly reliable</li> </ul>	<ul style="list-style-type: none"> <li>● Short detection window after infant's birth</li> </ul>

(Office of National Drug Control Policy, 2002; Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, 2006)

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## APPENDIX II

### Additional SAMHSA Drug Testing Guidelines

In SAMHSA's *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*, Treatment Improvement Protocol (TIP) Series, No. 43, there is a discussion of how and when drug testing should be used when treating patients for substance abuse disorders. An excerpt of this discussion is provided below to substantiate the level of testing that is appropriate.

*Given concerns about the cost and reliability of drug tests, some OTPs limit testing and others assume that results are unreliable in many cases. Decisions about how to use drug testing require thought and balance. In addition to conforming to Federal and State regulations, the frequency of testing should be appropriate for each patient and should allow for a caring and rapid response to possible relapse. Drug tests should be performed with sufficient frequency and randomness to assist in making informed decisions about take-home privileges and responses to treatment.*

*For patients who continue to abuse drugs or test negative for treatment medication, the consensus panel recommends that OTPs institute more frequent, random tests. Increased testing provides greater protection to patients vulnerable to relapse because only short periods pass before a therapeutic intervention can be initiated. However, as emphasized throughout this chapter, programs should avoid making treatment decisions affecting patients' lives that are based solely on drug test reports.*

*SAMHSA requires eight drug tests per year for patients in maintenance treatment (42 CFR, Part 8 § 12(f)(6)). In the opinion of the consensus panel, this is a minimal requirement. The actual frequency of testing should be based on a patient's progress in treatment, and more testing should be performed earlier in treatment than later, when most patients are stabilized. Most OTPs develop policies and procedures on testing frequency that meet or exceed Federal requirements and accreditation standards to assist staff in planning treatment, assessing patient progress, and granting take-home privileges.*

*Some States require more frequent testing than that required by SAMHSA. Some also require that specific drug-testing methodologies or decision matrices be followed. OTPs must adhere to the more stringent of either the Federal or State regulations. In States with no specific requirements, Federal regulations are the only applicable standard, but, as previously noted, these requirements should be considered minimal and regulatory.*

*The consensus panel recommends at least one drug test at admission to an OTP. Onsite testing kits are available so that admission can continue while test results are pending (see "Onsite Test Analysis" below), although some States may disallow these kits. For patients in short-term detoxification, one initial drug test is required, whereas patients receiving longer term MAT are required to have initial and monthly random tests.*

## APPENDIX III

### Elimination Rates for Drugs of Abuse

This information was obtained from SAMHSA's Treatment Improvement Protocol (TIP) 43: *Medication-Assisted Treatment for Opioid Addiction in Opioid Treatment Programs*. It summarizes necessary minimum (or cutoff) concentrations for detection of some illicit and prescription drugs in urine, as well as their reliable detection times for both initial patient testing and confirmation of positive results.

#### Exhibit 9-1

#### Typical Testing and Confirmation Cutoff Concentrations and Detection Times for Various Substances of Abuse

Drug	Initial Testing Cutoff Concentrations (ng/mL*)	Analytes Tested in Confirmation	Confirmation Cutoff Concentrations (ng/mL)	Urine Detection Time (Days)
Amphetamine	1,000	Amphetamine	500	2–4
Barbiturates	200	Amobarbital, secobarbital, other barbiturates	200	2–4 for short acting; up to 30 for long acting
Benzodiazepines	200	Oxazepam, diazepam, others	200	Up to 30 for long acting
Cocaine	300	Benzoylcegonine	150	1–3 for sporadic use; up to 12 for chronic use
Codeine	300	Codeine, morphine	300, 300	1–3
Heroin	300	Morphine, 6-acetylmorphine	300, 10	1–3
Marijuana	100, 50, 20	Tetra-hydrocannabinol (THC)	15	1–3 for casual use; up to 30 for chronic use
Methadone	300	Methadone	300	2–4
Methamphetamine	1,000	Methamphetamine, amphetamine	500, 200	2–4
Phencyclidine	25	Phencyclidine	25	2–7 for casual use; up to 30 for chronic use

\*ng/mL: nanograms per milliliter.

Adapted from Cone 1997.

## APPENDIX IV

### Procedure Codes Used for Drug Tests During the Audit Period

Procedure Code	AMA Description	Specific Use and Other Information
80100	Drug test, qualitative; multiple drug classes chromatographic method, each procedure	<p>Qualitative tests produce positive/negative results.</p> <p>Uses a chromatographic<sup>37</sup> method.</p> <p>Allows billing for each unit (drug class) tested.</p> <p>No longer active after December 1, 2011.</p>
80101	Drug test, qualitative; single drug class method (e.g., immunoassay, enzyme assay), each drug class	<p>Qualitative tests produce positive/negative results.</p> <p>Uses enzyme immunoassay or other complex method.</p> <p>Most frequently billed drug test code for our audit period.</p> <p>Allows billing for each unit (drug class) tested.</p> <p>No longer active after December 1, 2011.</p>
80102	Drug confirmation, each procedure	<p>Usually quantitative results and more complex than initial drug tests.</p> <p>Only performed if providers have reason to doubt a positive result from an initial drug test (very rare).</p>
G0431	Drug test, qualitative; multiple drug classes by high complexity test method (e.g., immunoassay, enzyme assay), per patient encounter	<p>Adopted on December 1, 2011, as a replacement for code 80101.</p> <p>Used for high-complexity drug tests.</p> <p>Set rate (\$48.78) for every G0431 claim, regardless of how many units (drug classes) are tested.</p>
G0434	Drug test, other than chromatographic; any number of drug classes, by CLIA waived test or moderate complexity test, per patient encounter	<p>Adopted on December 1, 2011, as a replacement for code 80100.</p> <p>Used when billing for relatively simple to moderately complex initial drug tests.</p> <p>Set rate (\$12.51) for every claim, regardless of how many units (drug classes) are tested.</p>

<sup>37</sup> Chromatography involves inserting a specimen into a high-pressure column and passing an electric current through the sample. Most substance abuse providers do not use chromatography because of the relatively high cost.

Procedure Code	AMA Description	Specific Use and Other Information
82055	Alcohol (ethanol); any specimen except breath	Specific chemistry test. Some providers perform and bill for alcohol tests along with every drug test. Other providers perform alcohol testing but bill it as a unit of 80101. Still other providers have abandoned alcohol testing altogether.
82570	Creatinine <sup>38</sup>	Used to check for creatinine levels in urine samples to determine whether a urine specimen has been tampered with (i.e., specimen dilution or alteration).
80150-80299	Therapeutic drug assays	Quantitative drug tests for specific substances, e.g., 80154 (benzodiazepines).
82000-84999	Chemistry drug tests	Specific chemistry tests for specific substances, e.g., 82520 (cocaine).

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<sup>38</sup>Creatinine is a waste product of creatine, an amino acid contained in muscle tissue and found in urine, most commonly used to gauge renal health. More recently, physicians have been using results to determine whether a patient may have attempted to foil the results of a drug test.