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Report of Investigation

Case Name: Murphy Medical Asc LLC

Case Number: 20200423-97657

Subject(s) Under Investigation: Murphy Medical Associates LLC; Steven Murphy MD

Date Referral Received: April 22, 2020

Date Case Created: April 23, 2020

Contract Status: Non-contracted

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Summary

Cigna's Special Investigations Unit (SIU) received a referral from an SIU Fraud Senior Manager who identified this Health Care Provider (HCP) through an SIU analytics report billing high level evaluation and management (E/M) codes with place of service (POS) 15 (mobile unit) and billing for preventative screenings on the same date of service. It was identified that the provider was also providing COVID-19 treatment. As a result, an investigation was initiated on Murphy Medical Associates. Customer interviews, Verification of Service (VOS) letters, and customer complaints revealed that the provider was performing COVID-19 testing services and telemedicine, however

high level E/M services, and preventative medicine counseling were not being performed. As a result of these findings, the provider's TIN 472075627 was placed in prepayment review to request medical records. A probe sample of ten medical records were received from the HCP as part of a retrospective review, and the clinical review identified issues of services not rendered as billed, incorrect coding, and insufficient documentation. Based on investigative findings, it was determined that the services billed by Murphy Medical Associates LLC were not supported by customer statements or medical records. A flag was placed on the HCP's Tax Identification Number (TIN) to deny all services as "Services Not Rendered as Billed" in February 2021. A damages notification letter in the amount of $468,829.28 was issued to the HCP in March 2021. The HCP filed suit against Cigna in November 2020 under case number 3:20-cv-01675 in the United States District Court for the District of Connecticut. This case is currently active and being handled by Robinson & Cole, LLP who is representing Cigna. The investigator referred the HCP to the Connecticut Department of Insurance (DOI) in addition to adding a record in NHCAA's SIRIS.

Basis of Investigation

An initial referral was received in April 2020 from Fraud Senior Manager Briana Hollenbeck who identified this HCP through an SIU analytics report. The provider was identified as billing high level E/M codes with POS 15 (mobile unit) and billing for preventative screenings on the same date of service. A second referral was submitted by Business Analytics Advisor Karen Swartz who identified this provider billing for COVID-19 testing and treatment. An additional referral was received from SIU Fraud Lead Analyst Taylor Baker who identified this HCP during COVID-19 analysis as being the provider with the highest amount of claims billed with POS 15.

Investigative Findings

Murphy Medical Associates LLC is a non-participating multispecialty practice located in Greenwich, CT, operated by Dr. Steven Murphy. A license verification search confirmed that Dr. Murphy has an active license in the state of Connecticut. A CLIA waiver was identified for Murphy Medical Associates at 1 East Putnam Ave Courtyard Suite Greenwich, CT 06830 (CLIA # 07D218229).

Cigna's SIU previously performed an investigation on this HCP which identified significant issues that resulted in the termination of Steven A. Murphy, MD from the Cigna network in 2019.

This case was linked to another Cigna SIU investigation on Steven Murphy's other TIN 271547208, Diagnostic and Medical Specialist of Greenwich.

The provider's exposure for the following tax years are outlined below (TIN 472075627):

- 2018: $80,608
- 2019: $101,340
- 2020: $478,357

- 2021 YTD: $17,144

The website for Murphy Medical Associates, www.greenwichdocs.com, advertises preventative, general health, and COVID-19 services, which leads to another website, www.coronatestct.com. This website advertises drive-thru coronavirus screening at multiple locations in Connecticut. Per the website, results were said to be delivered through telemedicine consults.

Analysis of CPT codes billed identified a total of 38 lab codes being billed by the HCP that are not considered CLIA waived per CMS.gov. These codes are: 81000, 82172, 82306, 82378, 82533, 82607, 82610, 82627, 82668, 82670, 82725, 82728, 82746, 83003, 83519, 83520, 83525, 83695, 83698, 83701, 83876, 83937, 83970, 84144, 84146, 84153, 84154, 84238, 84270, 84403, 84439, 84481, 84681, 86141, 86301, 86304, 86340, and 86376.

Further data analysis revealed that the top paid codes were CPT 87633, CPT 99214, and CPT 99401. No COVID-19 related testing procedure codes were billed. A billing pattern was identified where CPT 87633 was billed with COVID-19 related diagnosis codes (Z20.828 and B97.29). The provider was also billing CPT 99214 and 99401 on the same date of service as CPT 87633. It was also identified that the HCP was typically billing follow-up telemedicine visits with an Evaluation and Management Code with CPT 99401.

Customer interviews were conducted with 10 customers. All interviews indicated that COVID-19 testing was performed at a drive-thru testing location. Customer responses indicated that preventative screenings did not occur. Customers who were billed for follow-up telemedicine appointments reported that those phone calls only consisted of a positive or negative COVID-19 test result and did not include anything else. The results of the customer interviews suggested misrepresentation of services as customers were receiving COVID-19 testing only, and did not include respiratory panels which is what was billed for these customers (CPT 87633). The interviews also suggested services not rendered as billed as customers did not receive the preventative medicine or high level E/M services that were billed.

Verification of Service (VOS) letters were sent to a random sample of 100 customers with dates of service after March 15, 2020. A total of 38 VOS letters were completed and returned. Three customer responses (8%) indicated no issues. Six customer responses (16%) were unclear as to whether or not services were rendered as billed. 29 customer responses (76%) indicated that services were not rendered as billed. Customers denied E/M services and preventative medicine counseling services. Customers also reported receiving COVID-19 antibody testing only, but were billed for a slew of lab tests by Murphy Medical Associates. Five customers indicated that the services billed never happened and that they did not see Dr. Murphy or go for COVID-19 diagnostic or antibody testing. [redacted] reported that she had inquired about COVID-19 testing but by the time they called she had received a test elsewhere. [redacted] reported that she was out of state on the DOS billed for testing. [redacted] reported "fraud"

and that he is not aware of the practice. [redacted] reported that he did not receive any of the services billed.

Additionally, Cigna received multiple customer complaints. Multiple customers reported that the HCP billed E/M and preventative medicine codes for services that never occurred. One customer reported that the HCP billed for erroneous blood testing when only COVID-19 antibody testing was requested.

[redacted]

Based on preliminary investigative findings, the provider's TIN 472075627 was flagged effective May 15, 2020 to prospectively request medical records to determine whether or not services were being rendered as billed. To date, no records were submitted to support any claims billed after the flagging date.

In July 2020, Cigna was contacted by Roy Breitenbech Esq. of Garfunkel Wild, P.C., an attorney representing Steven Murphy. A conference call was held to explain the reason for the prepayment review. As a result of the call, the HCP agreed to provide a probe sample of 10 records for claims that were already processed and paid to the HCP.

The probe sample of 10 medical records was received via email on September 8, 2020 from Roy Breitenbach. A non-clinical review found that high level E/M services were not supported by the medical record documentation, documentation of time was not included for time-based CPT codes, dietary counseling was performed by a "nurse" but there is no documentation of the name of the nurse, all E/M notes were signed on August 14, 2020 by Dr. Steven Murphy, exams were not specific to members, and records were templated and incomplete.

The medical records were subject to clinical review by an SIU Nurse Coder. Issues identified from the clinical review included services not rendered as billed, incorrect coding, and insufficient documentation.

On November 6, 2020, Murphy Medical Associates, LLC, Diagnostic and Medical Specialists of Greenwich, LLC, North Stamford Medical Associates, LLC, Coastal Connecticut Medical Group, LLC, and Steven A.R. Murphy, M.D. filed suit against Cigna (Murphy Medical Associates LLC et al. v. Cigna Health and Life Insurance Co. et al.) under case number 3:20-cv-01675 in the United States District Court for the District of Connecticut. Litigation is being handled by Robinson & Cole, LLP.

Further data analysis on updated claims' data was conducted in January 2021. It was noted that preventative medicine counseling was consistently billed with modifier 33. Cigna guidance indicates that COVID-19 treatment should be billed with modifier CS. Additionally, analysis of customer claim history identified members who were billed claims from LabCorp or Quest for

serology testing, CPT 86769, on the same dates where Murphy Medical Associates billed for COVID-19 diagnostic testing. It is unclear why these two tests would be ran on the same date as an individual actively infected with the COVID-19 virus would not test positive for COVID-19 antibodies.

Claim data was reviewed for one member, [redacted], for whom the HCP billed a total $46,764.00 in COVID-19 related claims. The HCP billed a total of 60 claims between June 2020 and January 2021 with a total of 48 unique dates of services, and 22 COVID-19 related diagnostic tests. The HCP had billed for respiratory panel testing, COVID diagnostic testing, evaluation and management services, and preventative medicine counseling. The majority of claims were billed with a diagnosis of Z20.828 (Contact with and (suspected) exposure to other viral communicable diseases). An interview was conducted with the customer in question and the customer reported that they were receiving mandatory testing weekly at her place of employment in New Haven, CT. The customer reported that they only received COVID-19 diagnostic tests and denied evaluation and management services and preventative medicine counseling that was billed on the same dates as the diagnostic testing codes. When asked about telemedicine consults, the customer explained that they received brief, 15-second phone calls with their test results.

The following issues were identified through non-clinical evidence and clinical reviews of medical records:

Services Not Rendered As Billed

Evaluation and Management Services *(CPT Codes 99202, 99212, 99213, and 99214)*

The medical record documentation did not support the codes submitted for the services. Customer interviews revealed that evaluation and management visits consisted of brief, unsolicited phone calls where COVID-19 test results were received. Evaluation and management visits billed on the same day as respiratory panels did not occur as this was drive-through testing where a nasal swab was collected. Evaluation and management notes document vital signs such as temperature, heart rate, and oxygen saturation. Additional documentation provided indicated a telemedicine visit but the documentation also showed a pulse oximetry reading. It was unclear how that measurement was obtained via a telemedicine visit. Customer interviews revealed that vital signs were not taken in person at drive-through testing locations nor via telemedicine consults. The documentation was very similar between members and dates of service. It was noted that members were seen for symptoms of COVID-19, which is primarily a respiratory illness, but the physical exam does not include a more detailed lung assessment or cardiac assessment. Documentation for some members was in the form of a template and was incomplete. It was difficult to determine the place of service for the visits. All evaluation and management notes were signed and dated on 8/14/2020 regardless of the date of service. Diagnosis codes billed did not match diagnoses documented in the medical records. The frequency of telemedicine visits was questionable and exams were not specific to the members.

The following is a breakdown of the codes and correlating issues identified in the medical records:

CPT 99202 (Office or other outpatient visit for the evaluation and management of a new patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; Straightforward medical decision making)

Medical record documentation does not support the level of evaluation and management level reported.

Codes were reported with modifier 25 (Separate, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service). Modifier 95 (Synchronous Telemedicine Service Rendered via a Real-time Interactive Audio and Video Telecommunications System) should have been appended. The incorrect modifier was appended and therefore was incorrectly coded.

According to CPT guidelines, a new patient is one who has not received any professional services from the physician/qualified health care professional or another physician/qualified health care professional of the exact same specialty and subspecialty who belongs to the same group practice within the past three years. The medical record documentation indicates that members were seen within 3 years of the reported service.

An established patient visit code was also submitted for the same date of service.

CPT 99212 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused history; A problem focused examination; Straightforward medical decision making)

The code was submitted for the same member and same date of service with another evaluation and management code (99213) which was submitted on a different claim. Both visits indicated that the member presented for lab work. It is unclear if two separate visits were performed. According to Cigna Reimbursement R30, only 1 evaluation and management visit is reimbursable per day.

CPT 99213 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused history; An expanded problem focused examination; Medical decision making of low complexity)

Medical record documentation does not support the level of evaluation and management level reported.

Codes were reported with modifier 25 (Separate, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service). Modifier 95 (Synchronous Telemedicine Service Rendered via a Real-time Interactive Audio and

Video Telecommunications System) should have been appended. The incorrect modifier was appended and therefore was incorrectly coded.

CPT 99214 (Office or other outpatient visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed history; A detailed examination; Medical decision making of moderate complexity)

Medical record documentation does not support the level of evaluation and management level reported.

Codes were reported with modifier 25 (Separate, Separately Identifiable Evaluation and Management Service by the Same Physician or Other Qualified Health Care Professional on the Same Day of the Procedure or Other Service). Modifier 95 (Synchronous Telemedicine Service Rendered via a Real-time Interactive Audio and Video Telecommunications System) should have been appended. The incorrect modifier was appended and therefore was incorrectly coded.

Respiratory Panel Testing *(CPT Code 87633)*

The medical record documentation was insufficient to support the code submitted for the service. All respiratory panel lab work was signed and dated on 8/14/2020 regardless of the date of service. Customer interviews revealed that no customers were aware of additional respiratory testing aside from COVID-19 testing and the only test results communicated to customers were for COVID-19 testing. Additional respiratory panel results were not relayed to the patients. Customers reported that only one specimen was collected despite additional COVID-19 antigen testing performed by outside laboratories. The following is a description of the code and correlating issues identified in the medical records:

CPT 87633 (Infectious agent detection by nucleic acid (DNA or RNA); respiratory virus (e.g., adenovirus, influenza virus, coronavirus, metapneumovirus, parainfluenza virus, respiratory syncytial virus, rhinovirus), includes multiplex reverse transcription, when performed, and multiplex amplified probe technique, multiple types or subtypes, 12-25 targets)

Medical record documentation does not indicate the source of the specimen. There is no documentation of who collected or performed the testing.

According to Medicare guidance (MLN article MM11318), the following code is more appropriate effective 7/1/2019: CPT 0098U (Respiratory pathogen, multiplex reverse transcription and multiplex amplified probe technique, multiple types or subtypes, 14 targets (adenovirus, coronavirus, human metapneumovirus, influenza A, influenza A subtype H1, influenza A subtype H3, influenza A subtype H1-2009, influenza B, parainfluenza virus, human rhinovirus/enterovirus, respiratory syncytial virus, Bordetella pertussis, Chlamydophila pneumoniae, Mycoplasma pneumoniae). In addition, according to EncoderPro, CPT 0098U includes BioFire® FilmArray® Respiratory Panel (RP) EZ, BioFire® Diagnostics.

Preventative Medicine Counseling *(CPT Code 99401)*

The medical record documentation did not support the code submitted for the service. Medical record documentation identifies dietary counseling, exercise counseling, and counseling related to COVID-19 precautions and hygiene and documentation is similar across all patient records suggesting medical record cloning. You reported preventative medicine counseling with most evaluation and management services. Customer interviews revealed that these services did not occur and the customers specifically denied receiving the types of counseling that was documented in their medical records. The following is a description of the code and correlating issues identified in the medical records:

CPT 99401 (Preventive medicine counseling and/or risk factor reduction intervention(s) provided to an individual (separate procedure))

Medical records supplied did not include documentation of time for a timed code.

The code was reported with an evaluation and management code for members who presented for COVID-19 testing with symptoms. The counseling documented included diet, exercise, hygiene, handwashing and disinfection precautions which would be inclusive to the services provided for COVID-19 testing. There was no separately identifiable preventive medicine counseling service documented.

Medical record documentation indicates that counseling was provided by a nurse with no documentation of the name of the nurse who provided the counseling nor their credentials.

Claims submitted with modifier 33 (Preventive Services). There was no documentation of a preventive service performed. According to Administrative Policy A004, *Preventive care services are dependent upon claim submission using preventive diagnosis and procedure codes in order to be identified and covered as preventive care services*. The claims were not submitted with preventive diagnosis or procedure codes and did not support modifier 33.

Laboratory Testing *(CPT Codes 82306, 82378, 82533, 82607, 82627, 82668, 82670, 82728, 82746, 83001, 83002, 83003, 83525, 83937, 83970, 84144, 84146, 84238, 84270, 84403, 84439, 84443, 84481, 86301, 86304, 86340, and 86376)*

The medical record documentation was insufficient to support the codes submitted for the services. There was no date indicating when the testing was performed in the medical records. There was no specimen collection date documented in the lab report. In addition, members were specifically seen for COVID-19 testing however there was no documentation for the rationale of the additional testing. The testing was submitted with diagnosis code U07.1 (COVID-19). A customer interview revealed that the customer was under the impression they were receiving only COVID-19 antibody testing, the customer did not give consent for this testing, and the customer reported that the testing was not necessary. The following codes were not supported based on medical records supplied:

CPT 82306 (Vitamin D; 25 hydroxy, includes fraction(s), if performed)
CPT 82378 (Carcinoembryonic antigen (CEA))
CPT 82533 (Cortisol; total)
CPT 82607 (Cyanocobalamin (Vitamin B-12) - 1 claim line
CPT 82627 (Dehydroepiandrosterone-sulfate (DHEA-S))
CPT 82668 (Erythropoietin)
CPT 82670 (Estradiol)
CPT 82778 (Ferritin)
CPT 82746 (Folic acid; serum)
CPT 83001 (Gonadotropin; follicle stimulating hormone (FSH))
CPT 83002 (Gonadotropin; luteinizing hormone (LH))
CPT 83003 (Gonadotropin; luteinizing hormone (LH))
CPT 83525 (Insulin; total)
CPT 83937 (Osteocalcin (bone g1a protein))
CPT 83970 (Parathormone (parathyroid hormone))
CPT 84144 (Progesterone)
CPT 84146 (Prolactin)
CPT 84238 (Receptor assay; non-endocrine (specify receptor))
CPT 84270 (Sex hormone binding globulin (SHBG))
CPT 84403 (Testosterone; total)
CPT 84439 (Thyroxine; free)
CPT 84443 (Thyroid stimulating hormone (TSH))
CPT 84481 (Triiodothyronine T3; free)
CPT 86301 (Immunoassay for tumor antigen, quantitative; CA 19-9)
CPT 86304 (Immunoassay for tumor antigen, quantitative; CA 125)
CPT 86340 (Intrinsic factor antibodies)

Venipuncture *(CPT 36410)*

The medical record documentation was insufficient to support the code submitted for this service. There was no documentation of a venipuncture performed by the provider. Below is a description of the code that was billed:

CPT 36410 (Venipuncture, age 3 years or older, necessitating the skill of a physician or other qualified health care professional (separate procedure), for diagnostic or therapeutic purposes (not to be used for routine venipuncture)) with modifier CS (Cost sharing waived for specified COVID-19 testing related services)

Based off of the aforementioned findings, an overpayment letter was issued to the HCP in the amount of $468,829.28 on March 4, 2021. This dollar amount reflects all claims paid from the beginning of the COVID-19 pandemic period, March 1, 2020, through February 4, 2021.

The provider's TIN 472075627 was flagged effective February 4, 2021 to deny all claims as services not rendered as billed.

A response to the damages letter that refuted all of Cigna's findings was received on April 5, 2021 from John Martin and Barry Cepelewicz of Garfunkel Wild, P.C. As this matter is currently in litigation, the SIU was advised by Cigna's external counsel, Robinson & Cole, LLP, to cease communications with the HCP or their attorneys and they will pursue the matter.

A record was added to NHCAA's SIRIS (SIRIS Record # 9925243) and this matter was referred to the Connecticut Department of Insurance.

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Reviewed by:

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