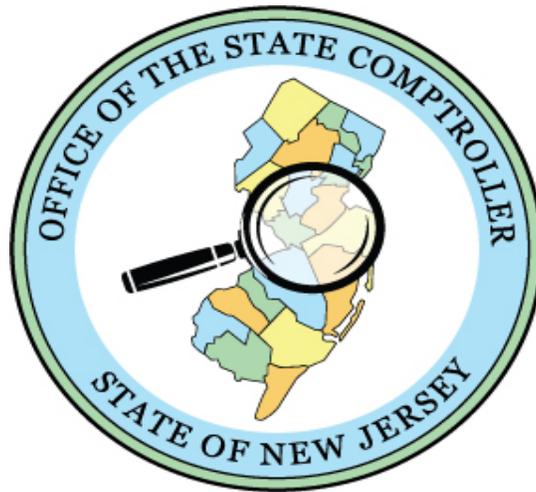


**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION**

**BI-ANNUAL REPORT OF AUDIT
FINDINGS AND RECOMMENDATIONS
AND SETTLEMENTS**



Reporting Period: July 1, 2017 to December 31, 2017

**Philip James Degnan
STATE COMPTROLLER**

Table of Contents

I.	The Office of the State Comptroller’s Medicaid Fraud Division.....	1
II.	Reporting Requirements.....	1
III.	Summaries of Audit Findings and Recommendations	1
	Passaic Pediatrics, PA.....	2
	Dr. Nagi Eltemsah	2
	Performance Orthopaedics and Sports Medicine, LLC.....	3
	Dr. Sohaila Khan	3
IV.	Medicaid Provider Settlements	3
V.	Ocean County Recipient Voluntary Disclosure Program	5
	Appendix: Audit Reports	

I. THE OFFICE OF THE STATE COMPTROLLER'S MEDICAID FRAUD DIVISION

The Office of the State Comptroller, Medicaid Fraud Division (MFD) serves as the state's independent watchdog for New Jersey's Medicaid, FamilyCare and Charity Care programs and works to ensure that the state's Medicaid funds are being spent effectively and efficiently. As part of its oversight role, MFD conducts audits and investigations of health care providers, managed care organizations and Medicaid recipients to identify and recover improperly expended Medicaid funds, and to ensure that only those who are eligible are enrolled in Medicaid.

II. REPORTING REQUIREMENTS

Pursuant to *N.J.S.A. 30:4D-60*, MFD is required to report the findings of its audits and investigations and recommendations for corrective action to the Governor, the President of the Senate and the Speaker of the General Assembly, and to the entity at issue. That statutory section further requires MFD to provide periodic reports to the Governor. In accordance with these reporting requirements, MFD respectfully submits this Bi-Annual Report of Audit Findings and Recommendations and Settlements made during the first and second quarters of Fiscal Year 2018.

III. SUMMARIES OF AUDIT FINDINGS AND RECOMMENDATIONS

During the first and second quarters of Fiscal Year 2018, MFD auditors issued four (4) audits of Medicaid health care providers located throughout the state. Collectively, these audits identified \$554,553 in improperly expended Medicaid funds. Further, some of these audits required the providers to implement corrective action plans (CAP) to ensure their ongoing compliance with federal and state Medicaid laws and regulations. The findings and recommendations for each of these audits are

summarized below and copies of the official audit reports are included in the attached appendix.¹

Passaic Pediatrics, PA

In this audit, MFD found that Passaic Pediatrics improperly submitted 6,092 separate claims for reimbursement for certain services that should have been billed together. These billings resulted in an overpayment to Passaic Pediatrics in the amount of \$198,572. Passaic Pediatrics agreed with MFD's findings and reimbursed the Medicaid program for these improperly billed and paid claims. Passaic Pediatrics also agreed to a CAP to ensure its future compliance with program billing guidelines.

Dr. Nagi Eltemsah

Pursuant to the federal Deficit Reduction Act of 2005, the Centers for Medicare and Medicaid Services (CMS) implemented a national program in which federal contractors called "Audit Medicaid Integrity Contractors" assisted the states' Medicaid oversight agencies in conducting audits of Medicaid providers. Island Peer Review Organization (IPRO) was the Medicaid Integrity Contractor that conducted audits in New Jersey in cooperation with MFD. IPRO conducted an audit of Dr. Nagi Eltemsah's submitted Medicaid claims and found that the practice had received overpayments in the amount of \$92,983. Although Dr. Eltemsah disagreed with an aspect of the audit's methodology, he subsequently repaid these funds to the Medicaid program.

¹ MFD also issued an audit report titled "Contract Compliance Review of the State of New Jersey's Personal Preference Program" during the time period covered by this bi-annual report. MFD provided notice of that audit report separately pursuant to the requirements of *N.J.S.A. 30:4D-60*.

Performance Orthopaedics and Sports Medicine, LLC

MFD auditors found that Performance Orthopaedics and Sports Medicine, LLC (Performance Orthopaedics) incorrectly submitted 1,100 separate claims for reimbursement to the Medicaid program. These billings resulted in an overpayment to Performance Orthopaedics in the amount of \$220,213. Performance Orthopaedics agreed with MFD's findings and reimbursed the Medicaid program for these improperly billed and paid claims. The practice also agreed to implement a CAP to ensure its future compliance with program billing guidelines.

Dr. Sohaila Khan

Island Peer Review Organization (IPRO) conducted an audit in cooperation with MFD of certain Medicaid claims submitted by Dr. Sohaila Khan's practice. IPRO auditors found that the practice had submitted numerous improper claims resulting in an overpayment of \$42,785. While Dr. Khan disagreed with an aspect of the audit's methodology, she has since repaid these funds to the Medicaid program.

IV. MEDICAID PROVIDER SETTLEMENTS

During the reporting period, MFD staff also identified and investigated for potential fraud, waste or abuse numerous health care providers who provided services to Medicaid beneficiaries throughout New Jersey. In addition, MFD assisted federal and state entities in their efforts to address criminal and civil wrongdoing relating to the Medicaid program. As a result of these efforts, MFD reached settlements through which providers agreed to reimburse more than \$3.2 million to the Medicaid program.² These settlements are listed below:

² Some of these settlements may have been separately reported through press releases during this time period.

<i>Provider</i>	<i>Settlement Amount</i>
Paola Escobar, Certified Nurse Midwife (Clifton, N.J.)	\$23,070
Fouad Rasheed, M.D. (Future Pediatrics Group) (Clifton, N.J.)	\$48,358
Milly's Pharmacy (Camden, N.J.)	\$82,919
Katherine Ellu (Unique Home Care and Companion Services, Inc.) (Newark, N.J.)	\$58,335
Urban Medical Center, Inc. (Jersey City, N.J.)	\$238,500
Louis Tratenberg, D.D.S. (Springfield, N.J.)	\$250,000
Jogi Discount Pharmacy (Atlantic City, N.J.)	\$17,723
Elmora Pharmacy (Elizabeth, N.J.)	\$262,500
Edison Adult Medical Daycare (Edison, N.J.)	\$1,362,000
Michael Nathan, D.O. (Paterson, N.J.)	\$480,000
Kevin Ward, D.D.S. (Union City, N.J.)	\$90,000

<i>Provider</i>	<i>Settlement Amount</i>
Wald Drugs (Somerville, N.J.)	\$2,466
Valley Pharmacy (Succasunna, N.J.)	\$309,000

V. OCEAN COUNTY RECIPIENT VOLUNTARY DISCLOSURE PROGRAM

Beginning on September 12, 2017, the Office of the State Comptroller (OSC) initiated the Ocean County Recipient Voluntary Disclosure Program (Program), which permitted individuals who believed they had improperly received Medicaid benefits, to self-report the receipt of those benefits and to enter into a settlement agreement with this Office. Pursuant to the terms of the Program, once recipients satisfied the terms of the settlement agreement, this Office agreed that their matters would not be referred to the Ocean County Prosecutor’s Office for consideration for criminal prosecution. In addition, pursuant to the terms of the Program, all participants who were enrolled were to be removed from the Medicaid program for a period of one year, and this Office was to provide the names of all participants to the State Department of Treasury – Office of Criminal Investigation for that Office’s review and appropriate action. The Program remained open for three months, closing on December 12, 2017. No new applications were accepted after the closing date. Timely applications, however, did result in settlement agreements that were finalized during the few months that followed.

With all settlements having been fully executed, OSC can report that 159 participants entered into settlement agreements through the Program.³ Over the course

³ As with this, and OSC’s previous bi-annual reports, copies of noted settlement agreements are often attached to the report. Certain statutory and privacy restrictions,

of the next several months, as defined by the terms of the agreements, OSC will track and collect the outstanding payments. Assuming the 159 participants meet the terms memorialized in each of the agreements, OSC will recover approximately \$2.2 million, which will be returned to the state Medicaid program.

however, prevent OSC from attaching the settlement agreements reached pursuant to the Ocean County Recipient Voluntary Disclosure Program.

Passaic Pediatrics, PA



State of New Jersey

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625-0025
(609) 826-4700

PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

October 25, 2017

BY ELECTRONIC and US MAIL

Dr. Antonio Camilo
Dr. Judelka Japa-Camilo
Passaic Pediatrics, PA
298 Passaic Street
Passaic, NJ 07055

Re: Final Audit Report

Passaic Pediatrics, PA – Medicaid ID: [REDACTED]

Dear Dr. Camilo and Dr. Japa-Camilo:

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid/NJFC) program, the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims submitted under your facility's Medicaid Provider Identification Number [REDACTED] by the entity you co-own, Passaic Pediatrics, PA (Passaic Pediatrics), for the period from May 1, 2015 through July 31, 2017. OSC hereby provides you with this Final Audit Report (FAR).

Executive Summary

OSC identified and reviewed instances where Passaic Pediatrics billed separately and received payment for Comprehensive Preventive Medicine Evaluation and Management services (E/M) and Preventive Counseling services (Counseling) on the same day for the same recipients. These billings are not consistent with the American Medical Association's (AMA) Current Procedural Terminology (CPT) code guidelines, which require that such services be billed together in a bundled manner. Pursuant to the New Jersey Administrative Code (N.J.A.C.) 10:54-9.1, Medicaid/NJFC uses the Centers for

Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), which follows the AMA's CPT guidelines.

Based on the audit, OSC found that Passaic Pediatrics improperly submitted claims for Preventive Counseling Services separately from Comprehensive Preventive Medicine E/M services for the same recipients on the same date of service when such claims should have been bundled or billed together. Through unbundling claims that should have been bundled, Passaic Pediatrics improperly submitted 6,092 claims for which it was paid \$198,572.02. OSC is seeking reimbursement of the amount that Passaic Pediatrics was overpaid for these claims in the amount of \$198,572.02.

Background

The AMA's CPT code guidelines designate service codes 99381 through 99429 for Comprehensive Preventive Medicine Services E/M. According to the CPT, the service codes for Preventive Counseling (Counseling) are 99401 through 99412. E/M codes are for comprehensive services, which include patient history, examination, and medical decision making. Codes for Counseling are used for areas such as family problems, diet and exercise. Under these guidelines, when a provider seeks payment from the Medicaid/NJFC program, these two services (E/M and Counseling) should be billed together in a bundled manner under just the appropriate E/M code when the service is provided to the same recipient on the same day.

As a condition of participation in the Medicaid/NJFC program, Medicaid providers are required to adhere to all applicable state and federal laws. Similarly, the state contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and the Managed Care Organizations (MCO) requires the MCOs and their providers to adhere to applicable New Jersey laws and regulations. One regulatory requirement is that providers must adhere to the AMA's standards, including the cited billing and coding requirements that were used during this audit.

Audit Objective

The objective of the audit was to evaluate claims billed by Passaic Pediatrics to determine compliance with state and federal regulations. The audit was conducted under the guidelines established by the AMA's CPT code guidelines.

Audit Scope

The scope of this audit entailed a review, discussion and evaluation of billings for claims where CPT codes for Preventive Counseling (99401 through 99412) were unbundled from Comprehensive Preventive Medicine E/M CPT codes (99381 through 99429) and were billed on the same day for the same recipients. The audit period was May 1, 2015 through July 31, 2017. The audit was conducted under the authority of *N.J.S.A. 52:15C-23* and the Medicaid Program Integrity and Protection Act, *N.J.S.A. 30:4D-53 et seq.*

Audit Findings

Incorrect Billing of CPT Codes

Through this audit, OSC identified 6,092 Medicaid claims submitted by Passaic Pediatrics in which Passaic Pediatrics improperly unbundled the services provided for billing purposes and, as a result was paid \$198,572.02 more than it was entitled to receive for these services. Preventive Counseling services, CPT codes 99401 and 99404, were unbundled and billed separately along with Preventive Medicine E/M, CPT 99382 through 99385 and 99391 through 99395, for the same recipients, on the same day.

Pursuant to the AMA's CPT code guidelines, for claim submission purposes, Preventive Counseling CPT codes (99401 through 99412) are included in Comprehensive Preventive Medicine E/M CPT codes (99381 through 99387 and 99391 through 99397) and, accordingly, should not be billed separately from those codes. Passaic Pediatrics improperly unbundled Preventive Counseling codes from Comprehensive Preventive Medicine E/M codes and billed these codes separately when they should have been billed together. OSC found that Passaic Pediatrics improperly submitted claims and was overpaid a total of \$198,572.02.

Recommendations

OSC recommends that Passaic Pediatrics reimburse Medicaid/NJFC a total of \$198,572.02 for Preventive Counseling Services billed contrary to AMA guidelines. Also, OSC recommends that Passaic Pediatrics provide training to its staff or guidance to its outside billing contractor to foster compliance with these requirements and all other applicable regulations. Finally, OSC recommends that Passaic Pediatrics remain current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.

Auditee Response

In a written response, Dr. Antonio Camilo and Passaic Pediatrics agreed with the audit findings and provided a Corrective Action Plan to address the audit's recommendations. Dr. Antonio Camilo and Passaic Pediatrics also described the specific steps they have taken or will take to implement the recommendations made in this audit report. The full text of the response letter submitted by Dr. Antonio Camilo and Passaic Pediatrics is included as an Appendix to this report.

OSC Comments

OSC notes that you and Passaic Pediatrics are in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that you reimburse the Medicaid/NJFC program \$198,572.02 and that you initiate steps to correct the findings identified in the audit. Given your agreement with the findings in this audit and your

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
Passaic Pediatrics, PA

stated intention to implement corrective actions, OSC believes that no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:



Josh Lichtblau, Director
Medicaid Fraud Division

Cc: Kay Ehrenkrantz, Deputy Director
Don Catinello, Supervising Regulatory Officer
Glen Geib, Recovery Supervisor


PASSAIC PEDIATRICS, P.A.

*Antonio Camilo, MD
 *Suprema Naim, MD
 *Joey S. Chui, PA-C

*Judelka Japa-Camilo, MD
 *Lourdes Aguayo, MD
 *Yassel M. LeGoff, PA-C

*Angel S. Ferrer, MD
 *Vanessa Montañez, FNP

298 Passaic Street, Passaic NJ 07055
 Telephone: (973) 249-8100
 Fax: (973) 249-8110

September 14, 2017

To Whom It May Concern:

This letter is to inform that we agree with the findings of the audit. After much research and review of the records that were provided to us we have come to the same conclusion as the Medicaid Fraud Division. The form in which these claims were coded was not correct.

We want to make it clear that the coding was done in error and not with the intent to commit fraud. There is no evidence that anyone advertently miscoded these visits in order to increase payments from Medicaid. Passaic Pediatrics' billing is outsourced to a third party company, Japa Billing Services. We rely on JBS to inform us of any miscoding done at our practice. To our knowledge they did not knowingly submit these claims with the intent to defraud.

Since this has come to our attention, Passaic Pediatrics immediately stopped using the CPT code 99401. This code has been removed in all instances in which it is used in combination with the Preventive Services.

Passaic Pediatrics and Japa Billing Services are committed to remain current with Coding and Billing Guideline. We would like to learn from this incident and improve the way coding is done within our office, as well as work together with JBS to assure that something of this magnitude does not occur again.

As part of our Corrective Action Plan, Passaic Pediatrics and JBS will remain current with coding and billing guidelines through CME opportunities through the AMA and AAP. In addition, we will review the monthly Newsletters provided by CMS as well as each of the HMOs.

Sincerely,

Antonio Camilo, MD

Antonio Camilo, MD, FAAP
 Passaic Pediatrics, PA

Dr. Nagi Eltemsah



State of New Jersey

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625-0025
(609) 826-4700

PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

September 25, 2017

By Certified and Electronic Mail

Dr. Nagi Eltemsah
2775 Kennedy Blvd.
Jersey City, NJ 07306

**Re: Final Audit Report
Dr. Nagi Eltemsah**

[REDACTED]

Dear Dr. Eltemsah:

Enclosed is the Final Audit Report for your medical practice, New Jersey Medicaid Provider Number [REDACTED]. Island Peer Review Organization, in conjunction with SafeGuard Services, LLC, completed the audit on behalf of the Centers for Medicare & Medicaid Services and the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division. The Final Audit Report identified an overpayment for Medicaid claims paid to you in the amount of \$92,983, for the period from January 1, 2011 through December 31, 2013.

Should you have questions about how to reimburse the Medicaid program for this overpayment, please contact Mr. Glenn Geib, Supervisor, Recovery and Exclusions, at (609) 789-5032 or by email at glenn.geib@osc.nj.gov. If you have questions regarding this Final Audit Report, you may contact Mr. Michael Morgese, Audit Supervisor, at (609) 789-5067.

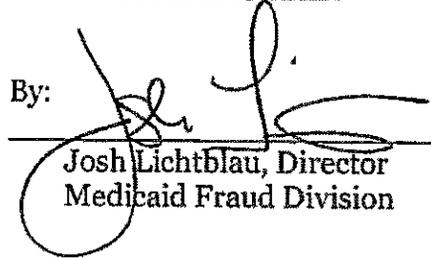
Dr. Nagi Eltemsah

September 25, 2017

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:



Josh Lichtblau, Director
Medicaid Fraud Division

JL/mmm

Enc.

cc: David L. Adelson, Esq.

Kay Ehrenkrantz, Deputy Director, OSC

Michael McCoy, Manager of Fiscal Integrity, OSC

Michael Morgese, Audit Supervisor, OSC

Glenn Geib, Supervisor Recovery and Exclusions, OSC

Meghan Davey, Director Division of Medical Assistance and Health Services

Elizabeth Lindner, Director Division of Field Operations - North, CMS

**SafeGuard
Services**
LLC

**Final Audit Report of
Nagi I Eltemsah, MD
NJ Medicaid Number: [REDACTED]**

Audit Period January 1, 2011 to December 31, 2013

Date Issued: August 23, 2017

CMS Audit Number: 1-45810139

I. INTRODUCTION

Island Peer Review Organization (IPRO), the audit contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), initiated an audit of Dr. Nagi I Eltemsah (Provider) to determine whether the Medicaid services he provided from January 1, 2011 through December 31, 2013 complied with applicable federal and state laws, regulations, policies, and the Provider's Medicaid enrollment agreement.¹ Specifically, the audit focused on whether the services that the Provider billed for were, in fact, provided and whether the Provider's documentation for such services was consistent with the claims submitted for these services. From a universe of more than 33,000 claims with a total Medicaid payment of more than \$1.5 million, the auditors randomly selected 250 claims for review. From that sample, the audit found recoupable errors in 43 claims. The vast majority of these errors related to inconsistencies between the medical records and the claims submissions. The remaining errors were attributable to a complete lack of documentation to support the submitted claims. In the aggregate, the 43 errors resulted in overpayments totaling almost \$700. When that error rate was extrapolated to the universe of claims, the overpayment total increased to more than \$92,000.

As part of the audit process, the audit team met with the Provider, afforded the Provider opportunities to explain his claim submissions and, after issuing a Draft Audit Report, allowed the Provider to submit a formal response, which is attached. This Final Audit Report takes into account all of the information obtained through the audit process, including the Provider's written response to the Draft Audit Report.

A. BACKGROUND:

IPRO was contracted by CMS to audit Providers participating in the New Jersey Medicaid program. These audits were conducted in accordance with the procedures specified in federal and state laws and regulations and guidance, including the Code of Federal Regulations (*C.F.R.*), Titles 52 and 30 of New Jersey Statutes Annotated (*N.J.S.A.*), Titles 8 and 10 of the New Jersey Administrative Code (*N.J.A.C.*), and

¹ IPRO conducted all stages of the work on this audit through approximately February 2017. IPRO was the vendor for the federal Medicaid Integrity Contract (MIC), through which CMS offered to states, including New Jersey, a supplemental audit team for Medicaid related audits. CMS replaced the MIC with a regional audit contract, the Northeast Unified Program Integrity Contractor (NE UPIC), which CMS awarded to Safeguard Services (SGS) effective February 1, 2017. IPRO transitioned all of its work, including this audit, to SGS in or about February 1, 2017. Consequently, SGS completed the Final Audit Report for this audit.

“*Government Auditing Standards*” as issued by the United States Government Accountability Office. Audits under this program also utilized guidelines established by CMS.

IPRO conducted this audit in accordance with the audit plan collaboratively prepared and approved by CMS and OSC.

B. PROGRAM OBJECTIVES:

IPRO provider audits have the following objectives:

- To determine if services for which a Provider submitted claims and was paid for such claims were, in fact, provided.
- To determine whether the Provider rendered, documented and submitted claims for services in compliance with federal and state Medicaid laws, regulations and guidance as well as the Provider’s Medicaid enrollment agreement.
- To identify provider billing and/or payment irregularities within the State’s Medicaid program.
- To determine appropriateness and necessity of care.

C. AUDIT PROCESS:

IPRO conducted this audit in the following manner:

Overview

IPRO, representatives from OSC, the Provider and members of the Provider’s staff met at the Entrance Conference in July 2015 so that the audit team could obtain an understanding of the Provider’s operations. The Provider also gave the audit team requested claims information at this meeting. This process allowed the audit team to understand, among other things, how the Provider billed for services. In addition, the audit team obtained Medical and related business records. The audit team used these records to determine whether claims were coded appropriately, services were rendered, and services were medically necessary.

Statistical Sampling

The auditors drew a stratified sample of 250 claims that met the requirements for this review. The sample was taken from the universe of Medicaid claims which included 33,407 fee-for-service (FFS) and encounter services during the period January 1, 2011 through December 31, 2013.

The audit team conducted its analysis using the stratified sample of claims. The audit findings from the sample were then extrapolated to the universe of claims from which the sample was drawn. The findings are discussed in Section III of this report and the extrapolated results are outlined in Section IV.

Documentation Reviewed

For their on-site review, IPRO copied claims documents and the medical records that would support such claims. These documents included partial medical records, patient progress notes and patient sign-in sheets. IPRO did not remove original records from the premises and, for any records that were computer generated, the Provider made available the original, hard copy record for verification purposes. After the on-site review, IPRO asked for and the Provider supplied additional documents necessary to complete the audit.

As part of the on-site review, IPRO analyzed the documents to determine whether there were any billing irregularities or deviations from Medicaid laws, regulations, and guidance, or from the Provider's Medicaid enrollment agreement.

Discussion of Audit Results

After the on-site review, IPRO further analyzed copies of the Provider's documents and medical records to ascertain whether the Provider's Medicaid claims complied with applicable Medicaid laws, rules, guidelines and the Provider's Medicaid enrollment agreement. After IPRO concluded its internal analysis, it developed a summary of its findings, which it gave to the Provider. IPRO then held an exit conference on August 11, 2016 with representatives from the OSC and the Provider to discuss the summary of findings and any other issues involving the audit. At that exit conference, the Provider was given an opportunity to present its position regarding the summary of IPRO's findings. In addition, at the exit conference, IPRO and OSC representatives advised that the Provider could submit a written response to the summary of findings. The Provider submitted a response to the summary of findings in a document dated September 19, 2016. IPRO considered that response as part of its preparation of the Draft Audit Report. IPRO gave the Provider the Draft Audit Report for it to review and respond to. The Provider submitted a response to the Draft Audit Report in a document dated March 7, 2017 (which is attached as Appendix C). All of the work papers, the summary report, Draft Audit Report, and Provider responses have been considered in preparation of this report.

II. AUDIT PROFILE

A. PROVIDER PROFILE:

Name: Nagi I Eltemsah, MD

Address: 2775 Kennedy Blvd
Jersey City, NJ 07306-5515

Provider Number: 

Provider Type: Pediatrician

B. AUDIT SCOPE:

The scope of this audit was limited to determining compliance with federal and state Medicaid laws, regulations and guidance as well as adherence to the Medicaid program enrollment agreement.

The universe included 33,407 claims for services with a total Medicaid payment of \$1,503,792.14. From this universe, auditors selected a stratified sample of 250 claims for services totaling \$11,211.05 for review.

The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean that such practices are acceptable. Because of the limited nature of this review, no inferences as to the overall level of provider performance should be drawn solely from this report.

Achieving the objectives of the audit did not require the review of the Provider's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

C. ANALYSIS OF FINDINGS:

Of the 250 sampled claims for services reviewed, there were 43 claims for services with recoupable monetary findings. Section III explains the monetary findings, along with support for such findings. Appendix A lists the findings and associated sample claim information.

III. AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

1. **Incorrect Procedure Code – Evaluation & Management (E&M) Code**

Auditors identified 38 instances in which the Provider billed an incorrect E&M procedure code for the service documented in the medical record. In other words, the Provider submitted claims for E&M codes that require a greater level of service than was documented in the medical records. For purposes of assessing an overpayment amount, the auditors downcoded these E&M codes to conform to the appropriate level of service documented and used the reimbursement for that lower level of service as the amount that should have been paid for such service. Appendix A lists the incorrect E&M code billed along with the correct E&M procedure code.

It is worth noting that for instances in which claim payments were made by Managed Care Organizations (MCO), the Provider provided the MCO payment rates for such services.

IPRO could not corroborate these rates independently and, thus, asked the OSC to verify these payment rates. OSC obtained the payment rates from all of the MCOs except for Healthfirst Health Plan of NJ, which as of July 1, 2014 no longer provided service to Medicaid beneficiaries in New Jersey. Using Medicaid paid claims data, IPRO was able to ascertain the highest rate paid by Healthfirst for the respective E&M code in the year of the disallowed sampled service. For Healthfirst claims, IPRO used that highest paid rate when computing the amount of the overpayment. As explained in Section IC above, the Provider was given ample opportunity to contest the rate used and did not do so.

The legal support for the finding above is as follows.

The applicable federal regulation states that the standard medical data code sets include:

The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: (i) Physician services.

45 C.F.R. § 162.1002(a)(5) Medical data code sets

The applicable New Jersey regulation pertaining to a provider's use of procedure codes states:

(b) General policies regarding the use of HCPCS for procedures and services are listed below:

2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in the CPT and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.
3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

N.J.A.C. 10:54-9.1(b)(2) and (b)(3) Use of procedure codes

One of the state regulations regarding recordkeeping and the use of physician codes states:

(a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

N.J.A.C. 10:54-2.6 (a) and (b) Recordkeeping; general

Another state regulation that pertains to recordkeeping states:

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8 (b) Provider Certification and Recordkeeping

The authorizing statute for the regulatory requirements cited above mandates that the Medicaid program institute provider record maintenance requirements for providers in the Medicaid program. One requirement is that all such providers must properly maintain records that accurately reflect the services provided and billed to Medicaid. Specifically, the applicable statutory provision mandates that the Medicaid program:

- (d) Require that any provider who renders health care services authorized under this act shall keep and maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered, and any additional information, as the department may require by regulation. Records herein required to be kept and maintained shall be retained by the provider for a period of at least 5 years from the date the service was rendered;

(e) Require that providers who render health care services authorized under this act shall not be entitled to reimbursement for the services rendered unless said services are documented pursuant to subsection (d) of this section. Any evidence other than the documentation required pursuant to subsection (d) of this section shall be inadmissible in any proceeding conducted pursuant to this act for the purpose of proving that said services were rendered; unless the evidence is found to be clear and convincing by the finder of fact;

N.J.S.A. 30:4D-12(d)&(e). Unnecessary Use of Care and Services; Methods and Procedures; Maintenance of Records Required for Reimbursement

2. No Documentation

Auditors identified four instances in which a medical record was not provided or a portion of the medical record was missing. Specifically, auditors determined the following:

- 2a. Missing Office Visit Note:** In three instances there was missing documentation to support the E&M service billed.
- 2b. Missing Record:** In one instance, there was no medical record for the associated claim.

The state regulation pertaining to recordkeeping provides in pertinent part:

- (a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.
- (b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.
- (c) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.
- (d) Records of Residential Health Care Facility patients shall be maintained in the physician's office.
- (e) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid . . . program or its agents.

N.J.A.C. 10:54-2.6 (a)-(e) Recordkeeping; general

For established patients, which is the case here, there are more specific recordkeeping requirements. Specifically, the applicable regulation provides:

(a) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

1. In an office or Residential Health Care Facility:

- i. The purpose of the visit;
- ii. The pertinent physical, family and social history obtained;
- iii. A record of pertinent physical findings, including pertinent negative findings based upon i and ii above;
- iv. Procedures performed, if any, with results;
- v. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and
- vi. Prognosis and diagnosis.”

N.J.A.C. 10:54-2.8(a)(1)(i-vi) Minimum documentation; established patient

In addition to the regulations set forth immediately above (*N.J.A.C. 10:54-2.8*), there are additional regulations that require Medicaid providers to properly document the services they render and put providers on notice that when there is no such documentation or inadequate documentation, their claims may be adjusted accordingly. The specific regulations state the following:

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.

i. The following signature types are unacceptable:

- (1) Initials instead of signature;
- (2) Stamped signature; and
- (3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8(a) & (b) Provider Certification and Recordkeeping

As set forth in Section III 1 above, the New Jersey law that underpins the regulations cited in this report requires providers to properly maintain records that accurately reflect the services provided and billed to Medicaid. *N.J.S.A. 30:4D-12(d) & (e)*.

3. Two E&M Claims Billed on the Same Date of Service

In one instance, the Provider billed for two E&M claims on the same date of service, but the medical record documentation supported only one E&M claim for the service.

As set forth in Section III 1 above, the applicable federal rule sets forth the standard medical data code sets that Medicaid providers must use. *45 C.F.R. § 162.1002(a)(5) Medical data code sets*

Also, as stated above in Section III 1, the applicable regulations in New Jersey provide that the HCPCS procedure codes, including modifiers and qualifiers, “must be used in accordance with the narratives and descriptions” set forth in the New Jersey regulations. *N.J.A.C. 10:54-9.1(b)(2)*. Moreover, for services performed in the office, the regulations require providers to maintain a “progress note in the clinical record for each visit, which supports the procedure code(s) claimed.” *N.J.A.C. 10:54-2.6(b)*. The final set of regulations that applies here are the provisions in *N.J.A.C. 10:49-9.8(a) and (b)*. As explained in Section III 1 above, these regulations, in part, require providers to keep “such records as are

necessary to disclose fully the extent of services provided” and put providers on notice that “where such records do not document the extent of services billed, payment adjustments shall be necessary.”

The applicable law likewise, in pertinent part, requires providers to “maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered” and any other required information. *N.J.S.A. 30:4D-12(d)*.

IV. SUMMARY OF OVERPAYMENTS

Of the 250 claims tested, the auditors found that 43 claims failed to meet the statutory and regulatory requirements outlined above. Consequently, the auditors found that these claims constituted overpayments. Applying the principles discussed above regarding the determination of the overpayment, the auditors determined that the identified overpayments for the 43 discrepant sampled claims for services totaled \$696.63. When extrapolated to the universe of claims from which the sample was drawn, the point estimate overpayment amount totals \$92,983.00. The calculation of this amount is illustrated in Appendices A and B. Accordingly, the total amount of the overpayment that must be returned to New Jersey is \$92,983.00.

After being apprised of the findings above, the Provider, through counsel, submitted a response dated March 7, 2017 (attached as Appendix C). In that response, the Provider took issue with the underlying use of an extrapolation methodology, stating, in part, the following:

We note that any extrapolation conducted relative to the documents reviewed should only concern errors and/or omissions that transpired on more than one occasion. In the spirit of extrapolating for repeated errors and/or omissions (e.g., insufficient documentation), a random isolated event should not be part of an extrapolation as said event occurs once during the review period. Hence by definition, you cannot extrapolate for a one time random occurrence.

The Provider’s response that extrapolations cannot be used for a one time occurrence is not a supportable argument. This claim, in essence, rejects the validity of properly performed random sampling processes. By definition, a Statistically Valid Random Sample treats all errors that are a source of improper payments the same way. Whether it is a one-time occurrence or a repetitive occurrence, a sample that is randomly selected from the frame of payments does not have any way of telling what kind of errors will be encountered during the medical review. Each sampled unit is then measured against the same requirements (federal and state laws, regulations and guidance). Since the Provider’s response did not

include any sufficient reliable documentation to support his position, no adjustments will be made to the audit analysis or the extrapolation. Therefore, we stand by the original extrapolated amount. The Provider must reimburse the Medicaid program \$92,983.

V. RECOMMENDATIONS

Based on the findings cited in this audit report, the Provider is directed to repay the Medicaid program \$92,983, and to take corrective action to ensure adherence with all federal and state laws and regulations and billing instructions provided under the Medicaid program. Pursuant to *N.J.A.C. 10:49-11.1*, continued violation(s) may result in the termination or suspension of the Provider's eligibility to provide services in the Medicaid program.

VI. SGS COMMENTS

In his response, the Provider did not state whether he agreed or disagreed with the Audit findings, recommendations, or assessment. Rather, he appears to have taken issue with the application of an extrapolation method to the sample of claims. Specifically, he states that "any extrapolation ... should only concern errors and/or omissions that transpired on more than one occasion." He goes on to state that "a random isolated event should not be part of an extrapolation as said event occurs once during the review period." That position amounts to a repudiation of the essence of using an extrapolation within a data set. Given that the auditors utilized a proper sampling methodology and otherwise performed the extrapolation in an appropriate manner, the Provider has not given any supportable reason to discount or modify the audit findings. Accordingly, the Provider is directed to repay to the Medicaid program the full amount identified, \$92,983, and implement specific policies and procedures to address the Audit's Recommendations.

Dr. Nagi I Etimseah
Appendix A
Audit Findings Claim Detail

Sample #	Recipient ID	Recipient Name	Claim Service Date	Claim Processing Date (ENC)	Claim Payment Date	Claim Source Code	Claim Submitter Name	Procedure Code Billed	Amount Paid	Correct Procedure Code	Amount Per Audit	Overpayment	Federal Fiscal Year	Future Share %	Future Share Amount	4. Incorrect Procedure Code	5. No Documentation*	6. Two Evaluation & Management Charges billed on the Same Date of Service	7a. Missing Office Visit Note	7b. Missing Record
12			02/08/12	6/05/12	03/07/12	ENC	HORIZON NJ HEALTH - VSM	96213		96211										
21			02/16/13	05/01/13	03/18/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96212		96212										
34			11/11/11	12/14/11	12/01/11	ENC	HORIZON NJ HEALTH - VSM	96213		96212										
38			05/27/12	06/27/12	05/10/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96212		96211										
44			05/22/12	06/29/12	05/29/12	ENC	HORIZON NJ HEALTH - VSM	96212		96211										
56			09/18/12	11/28/12	10/17/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96212		96211										
59			05/17/12	06/22/12	05/29/12	ENC	HORIZON NJ HEALTH - VSM	96212		96211										
72			12/01/12	01/23/13	01/02/13	ENC	HORIZON NJ HEALTH - VSM	96212		96211										
82			12/01/12	01/03/13	12/31/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96213		96213										
85			03/07/13	05/22/13	04/24/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96212		96212										
102			03/13/13	05/19/13	05/15/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96212		96212										
111			12/01/11	02/20/12	01/24/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96213		96213										
121			03/07/12	06/04/12	04/17/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96213		96213										
132			07/21/13	11/05/13	08/14/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96213		96213										
139			02/21/12	04/08/12	02/28/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96213		96213										
157			03/01/13	12/01/13	11/08/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
159			03/11/12	06/27/12	05/09/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
165			01/21/12	03/20/12	02/27/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
168			06/27/13	09/20/13	10/27/13	ENC	HORIZON NJ HEALTH - VSM	96213		96212										
180			12/28/11	02/14/12	02/09/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
190			08/28/12	10/23/12	10/07/12	ENC	HORIZON NJ HEALTH - VSM	96213		96213										
172			12/05/12	01/24/13	01/02/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
176			04/26/13	02/20/13	01/29/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
177			12/20/12	01/28/13	01/29/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
181			01/20/13	11/05/13	02/29/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
187			11/29/13	01/01/14	12/10/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
190			02/28/12	12/18/12	12/12/12	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
192			05/20/11	12/28/11	11/14/11	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
197			07/18/12	08/26/12	08/09/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
198			08/27/13	10/16/13	08/29/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
201			08/26/13	10/16/13	09/25/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
204			07/21/11	11/05/11	10/17/11	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
208			08/20/13	10/16/13	08/19/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
209			11/27/11	12/14/11	12/31/11	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
250			03/03/12	06/06/12	04/17/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
210			01/30/12	02/14/12	02/17/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
213			10/28/11	12/26/11	11/14/11	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
219			02/07/13	04/02/13	03/06/13	ENC	HORIZON NJ HEALTH - VSM	96214		96214										
221			10/12/12	11/28/12	11/27/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
229			05/16/12	06/19/12	07/02/12	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
235			10/27/13	10/26/13	10/14/13	ENC	UNITECH HEALTHCARE COMMUNITY-NU	96214		96214										
246			01/23/13	04/25/13	03/07/13	ENC	HORIZON NJ HEALTH - VSM	96214		96213										
250			06/01/13	10/16/13	07/18/13	ENC	HORIZON NJ HEALTH - VSM	96214		96213										

\$ 998.53

38

1

4

2

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

1

Nagi I Eltemsah, MD
Appendix B
Extrapolation of Sample Findings

Number of Claims in Universe	33,407
Number of Claims in Sample	250
Total Amount Paid for Claims in Universe	\$1,503,792.14
Total Amount Paid for Claims in Sample	\$11,211.05
Number of Claims Disallowed in Sample	43
Stratified Point Estimate	\$92,983

March 7, 2017

Via E-Mail & Regular Mail

Matt.Kochanski@hpe.com

Matt Kochanski, Program Director
SafeGuard Services LLC
1250 Camp Hill Bypass, Suite 2000
Camp Hill, PA 17011

Re: Nagi Eltemsah, M.D.
NJ Medicaid Provider No.: [REDACTED]
CMS Audit No.: 1-45810139
Our File No: 61000-00031

Dear Mr. Kochanski:

As you know our firm represents Dr. Eltemsah in connection with the IPRO audit. On behalf of Dr. Eltemsah we would like for IPRO to note the following relative to the Draft Audit Report's findings and any proposed overpayment demand.

We note that any extrapolation conducted relative to the documents reviewed should only concern errors and/or omissions that transpired on more than one occasion. In the spirit of extrapolating for repeated errors and/or omissions (e.g., insufficient documentation), a random isolated event should not be part of an extrapolation as said event occurs once during the review period. Hence by definition, you cannot extrapolate for a one time random occurrence. For those such instances where the event is isolated, we would propose merely a straight dollar-for-dollar repayment.

Specifically, IPRO's audit revealed a few isolated instances that should not be part of this extrapolation:

- Where one patient was seen twice in the same day;
- Where siblings were both seen the same day but bills were submitted mistakenly for one of the brothers twice; and
- Where one patient was later discovered to not be Medicaid eligible.

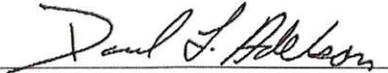
Dr. Eltemsah of course reserves his rights to respond to any overpayment demand and to submit additional responses to same.

Page 2

In the interim, should you have any questions or would like to discuss any aspect of this matter further, please do not hesitate to contact us. Thank you.

Very truly yours,

KERN AUGUSTINE, P.C.

By: 
David L. Adelson
dadelson@drlaw.com
DrLaw.com

cc: Nagi Eltemsah, M.D. (Via Certified Mail)

**Performance Orthopaedics and Sports
Medicine, LLC**



State of New Jersey

CHRIS CHRISTIE
Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625-0025
(609) 826-4700

PHILIP JAMES DEGNAN
State Comptroller

KIM GUADAGNO
Lt. Governor

JOSH LICHTBLAU
Director

September 22, 2017

BY CERTIFIED AND ELECTRONIC MAIL

David Dickerson, MD
Performance Orthopaedics & Sports Medicine, LLC
780 Route 37 West Suite 330
Toms River, NJ 08755

Re: Final Audit Report

Dear Dr. Dickerson:

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid) program, the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims that you submitted under your Medicaid Provider Identification Number [REDACTED] and National Provider Identification Number [REDACTED] for the period from January 1, 2015 through April 26, 2017. OSC hereby provides you with the Final Audit Report (FAR) which includes MFD's findings and your response.

Executive Summary

OSC reviewed instances where you billed using the incorrect codes for certain procedures and, as a result, were overpaid for those services. Specifically, OSC identified instances when you submitted claims using procedure code 76942 in conjunction with codes 20600, 20605, and 20610. Prior to January 1, 2015, pursuant to the American Medical Association (AMA) Current Procedural Terminology (CPT) code guidelines, procedure code 76942 was the appropriate code to designate that a provider performed an ultrasound and such code was properly combined with another code when a provider performed an additional procedure such as an arthrocentesis (a procedure in which a needle is used to drain fluid from a joint) with an ultrasound. However, as of January 1, 2015, the AMA revised the use of these codes.

As of January 1, 2015, the AMA revised CPT codes 20600, 20605, and 20610 to reflect that these codes are to be used for billing when the following procedures are performed without an ultrasound: arthrocentesis, aspiration and/or injection small, intermediate, major joint or bursa (fluid filled sacs that reduce friction between joints). Simultaneously, the AMA created CPT codes 20604, 20606 and 20611 to be used for billing when arthrocentesis, aspiration and/or injection small, intermediate, major joint or bursa are performed with an ultrasound.

Based on the audit, OSC has determined that you were overpaid for 1111 instances when you improperly combined CPT code 76942 with 20600, 20605, or 20610. Since January 1, 2015, these claims should have been submitted in a bundled manner using CPT codes 20604, 20606, or 20611, as applicable. Accordingly, OSC is seeking recovery of \$220,213, which represents the difference between what you were paid in these instances and what you would have been paid if you had submitted claims that reflected the proper CPT codes for these services.

Background

Effective January 1, 2015, the AMA guidelines for CPT codes 20600, 20604, 20610 stated that these codes had been revised. Pursuant to the revisions, these codes are to be billed for arthrocentesis, aspiration, and/or injection small, intermediate, major joint or bursa without ultrasound guidance. At the same time, the AMA added three codes - 20604, 20606, and 20611 - to bill for arthrocentesis, aspiration, and/or injection small, intermediate, major joint or bursa with ultrasound guidance. In addition, the AMA advised in the CPT guidelines that providers should cease using code 76942 in conjunction with both the revised and newly created codes. Accordingly, since January 1, 2015, pursuant to the AMA guidelines, when a provider seeks payment from the Medicaid program, the provider should not bill using code 76942 in conjunction with codes 20600, 20604, 20605, 20606, 20610, or 20611. Rather, the provider should bill for services rendered using the revised or newly created codes for arthrocentesis services depending upon usage of ultrasound guidance.

The State's contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) and the Managed Care Organizations (MCOs) requires adherence to applicable New Jersey laws and regulations. Pursuant to applicable Medicaid regulations, Medicaid providers must adhere to the AMA's billing and coding standards.

Objective

The objective of the audit was to evaluate your claims to determine whether these claims complied with state and federal requirements. The audit was conducted under the authority granted by state law and pursuant to guidelines established by state law and regulation, including requirements that providers adhere to the AMA's CPT guidelines.

Audit Scope

The initial audit scope entailed a review of claims that you billed for the period of January 1, 2015 through June 30, 2016. Based on the continuous use of unbundled CPT codes as explained above, the scope was expanded through April 26, 2017. The audit was conducted under the authority of the OSC enabling statute, *N.J.S.A. 52:15C-23*, and the Medicaid Program Integrity and Protection Act, *N.J.S.A. 30:4D-53 et seq.*

Audit Findings

Based on a review of claims billed on the same day for the same recipient for CPT code 76942 simultaneously with CPT codes 20600, 20605, or 20610 for the audit period of January 1, 2015 through April 26, 2017, OSC determined that in 1111 instances you submitted such claims for which you were overpaid a total of \$220,213. This amount is broken down as follows:

<u>Proper CPT Code</u>	<u>Codes Used</u>	<u>Dollar Difference</u>
20604	20600 & 76942	\$ 4,689
20606	20605 & 76942	\$ 12,452
20611	20610 & 76942	\$203,072
Total		\$220,213

As a result, OSC seeks to recover \$220,213 for the period of January 1, 2015 to April 26, 2017.

Recommendations

OSC recommends that you reimburse Medicaid a total of \$220,213 for 1111 instances inappropriately billed for CPT code 76942 simultaneously with CPT codes 20600, 20605, or 20610 because those claims were submitted and paid contrary to state regulations, the MCO Contract, and AMA CPT guidelines. Also, OSC recommends that you and your staff seek appropriate training to foster compliance with regulations. In addition, you and your staff must stay current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.

Auditee Response

In a written response, Dr. David Dickerson and Performance Orthopaedics & Sports Medicine, LLC agreed with the audit findings and provided a Corrective Action Plan to address the audit's recommendations. Dr. David Dickerson and Performance Orthopaedics & Sports Medicine, LLC also described the specific steps they have taken or will take to implement the recommendations made in the audit report. The full text of the

Dr. David Dickerson

Final Audit Report

response letter submitted by Dr. David Dickerson and Performance Orthopaedics & Sports Medicine, LLC is included as an Appendix to this report.

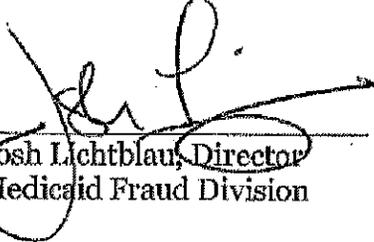
OSC Comments

OSC notes that you and Performance Orthopaedics & Sports Medicine, LLC agreed to reimburse the Medicaid program \$220,213 and provided a Corrective Action Plan that described the steps you have taken and will be taking to address the findings identified in the audit. Given these changes, no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:


Josh Lichtblau, Director
Medicaid Fraud Division

JL/mmm

Enc.

Cc: Kay Ehrenkrantz, Deputy Director
Michael McCoy, Manager of Fiscal Integrity
Don Catinello, Supervising Regulatory Officer
Glenn Geib, Recovery Supervisor



PerformanceOrthopaedics

David B. Dickerson, M.D.
780 Route 37 West Suite 330
Toms River, New Jersey 08755
Phone: 732-691-4898
Fax: 732-608-8950
E-Mail: info@performanceortho.com

September 20, 2017

To Whom It May Concern:

I am writing in response to your Draft Audit Report. We have reviewed all aspects of the report and agree to move forward in reimbursing the \$220, 213 referenced in the report. We plan to review with Horizon NJ Health personnel any further retractions of prior reimbursements outside of this report. We would like to move forward with finishing this audit.

As part of the remediation for the billing errors referenced in the report, we have changed the billing practices to encompass the AMA CPT guidelines you referenced. Also, to monitor continuing changes in the guidelines we have instituted a quarterly review of all changes in the CPT guidelines from the AMA using resources supplied by the American Academy of Orthopaedic Surgeons and the AMA. Also, [REDACTED] was sent to several courses to learn updates regarding current orthopaedic coding. We will be subscribing to an online billing and update service to keep updated on quarterly changes.

If you have any further questions, please feel free to email or call.

Sincerely,

David Dickerson MD

Dr. Sohaila Khan



State of New Jersey

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625-0025
(609) 826-4700

PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

September 25, 2017

By Certified and Electronic Mail

Dr. Sohaila Khan
11 Burlew Place
Parlin, NJ 08859

**Re: Final Audit Report
Dr. Sohaila Khan**
[REDACTED]

Dear Dr. Khan:

Enclosed is the Final Audit Report for your medical practice, New Jersey Medicaid Provider Number [REDACTED]. Island Peer Review Organization, in conjunction with SafeGuard Services, LLC, completed the audit on behalf of the Centers for Medicare & Medicaid Services and the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division. The Final Audit Report identified an overpayment for Medicaid claims paid to you in the amount of \$42,785, for the period from January 1, 2011 through December 31, 2013.

Should you have questions about how to reimburse the Medicaid program for this overpayment, please contact Mr. Glenn Geib, Supervisor, Recovery and Exclusions, at (609) 789-5032 or by email at glenn.geib@osc.nj.gov. If you have questions regarding this Final Audit Report, you may contact Mr. Michael Morgese, Audit Supervisor at (609) 789-5067.

Dr. Sohaila Khan

September 25, 2017

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:



Josh Lichtblau, Director
Medicaid Fraud Division

JL/mmm

Enc.

cc: Paul A. De Sarno, Esq.

Kay Ehrenkrantz, Deputy Director, OSC

Michael McCoy, Manager of Fiscal Integrity, OSC

Michael Morgese, Audit Supervisor, OSC

Glenn Geib, Supervisor Recovery and Exclusions, OSC

Meghan Davey, Director Division of Medical Assistance and Health Services

Elizabeth Lindner, Director Division of Field Operations – North, CMS

**SafeGuard
Services**
LLC

**Revised Final Audit Report of
Sohaila Khan MD
NJ Medicaid Number: [REDACTED]**

Audit Period January 1, 2011 to December 31, 2013

Date Issued: August 16, 2017

CMS Audit Number: 1-45809839

I. INTRODUCTION

Island Peer Review Organization (IPRO), the audit contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), initiated an audit of Dr. Sohaila Khan (Provider) to determine whether the Medicaid services she provided from January 1, 2011 through December 31, 2013 complied with applicable federal and state laws, regulations, policies, and the Provider's Medicaid enrollment agreement.¹ Specifically, the audit focused on whether the services that the Provider billed for were, in fact, provided and whether the Provider's documentation for such services was consistent with the claims submitted for these services. From a universe of more than 22,907 claims with a total Medicaid payment of \$759,308.61, the auditors randomly selected 250 claims for review. From that sample, the audit found recoupable errors in 67 claims. The vast majority of these errors related to lack of documentation to support the submitted claims. The remaining errors were attributable to a lack of documentation to support the level of Evaluation and Management (E&M) procedure code for the submitted claims. In the aggregate, the 67 errors resulted in overpayments totaling almost \$466. When that error rate was extrapolated to the universe of claims, the overpayment total increased to more than \$42,000.

As part of the audit process, the audit team met with the Provider, afforded the Provider opportunities to explain her claim submissions and, after issuing a Draft Audit Report, allowed the Provider to submit a formal response, which is attached. This Final Audit Report takes into account all of the information obtained through the audit process, including the Provider's written response to the Draft Audit Report.

A. BACKGROUND:

IPRO was contracted by CMS to audit Providers participating in the New Jersey Medicaid program. These audits were conducted in accordance with the procedures specified in federal and state laws and regulations and guidance, including the Code of

¹ IPRO conducted all stages of the work on this audit through approximately February 2017. IPRO was the vendor for the federal Medicaid Integrity Contract (MIC), through which CMS offered to states, including New Jersey, a supplemental audit team for Medicaid related audits. CMS replaced the MIC with a regional audit contract, the Northeast Unified Program Integrity Contract (NE UPIC), which CMS awarded to Safeguard Services (SGS) effective February 1, 2017. IPRO transitioned all of its work, including this audit, to SGS in or about February 1, 2017. Consequently, SGS completed the Final Audit Report for this audit.

Federal Regulations (*C.F.R.*), Titles 52 and 30 of New Jersey Statutes Annotated (*N.J.S.A.*), Titles 8 and 10 of the New Jersey Administrative Code (*N.J.A.C.*), and “*Government Auditing Standards*” as issued by the United States Government Accountability Office. Audits under this program also utilized guidelines established by CMS.

IPRO conducted this audit in accordance with the audit plan collaboratively prepared and approved by CMS and OSC.

B. PROGRAM OBJECTIVES:

IPRO provider audits have the following objectives:

- To determine if services for which a Provider submitted claims and was paid for such claims were, in fact, provided.
- To determine whether the Provider rendered, documented and submitted claims for services in compliance with federal and state Medicaid laws, regulations and guidance as well as the Provider’s Medicaid enrollment agreement.
- To identify provider billing and/or payment irregularities within the State’s Medicaid program.
- To determine appropriateness and necessity of care.

C. AUDIT PROCESS:

IPRO conducted this audit in the following manner:

Overview

IPRO and the Provider met at the Entrance Conference in July 2015 so that the audit team could obtain an understanding of the Provider’s operations. The Provider also gave the audit team requested claims information at this meeting. This process allowed the audit team to understand, among other things, how the Provider billed for services. In addition, the audit team obtained Medical and related business records. The audit team used these records to determine whether claims were coded appropriately, services were rendered, and services were medically necessary.

Statistical Sampling

The auditors drew a stratified sample of 250 claims that met the requirements for this review. The sample was taken from the universe of Medicaid claims which included 22,907 fee-for-service (FFS) and encounter services during the period January 1, 2011 through December 31, 2013.

The audit team conducted its analysis using the stratified sample of claims. The audit findings from the sample were then extrapolated to the universe of claims from which the

sample was drawn. The findings are discussed in Section III of this report and the extrapolated results are outlined in Section IV.

Documentation Reviewed

For their on-site review, IPRO copied claims documents and the medical records that would support such claims. These documents included partial medical records, patient progress notes and patient sign-in sheets. IPRO did not remove original records from the premises and, for any records that were computer generated, the Provider made available the original, hard copy record for verification purposes. After the on-site review, IPRO asked for and the Provider supplied additional documents necessary to complete the audit.

As part of the on-site review, IPRO analyzed the documents to determine whether there were any billing irregularities or deviations from Medicaid laws, regulations, and guidance, or from the Provider's Medicaid enrollment agreement.

Discussion of Audit Results

After the on-site review, IPRO further analyzed copies of the Provider's documents and medical records to ascertain whether the Provider's Medicaid claims complied with applicable Medicaid laws, rules, guidelines and the Provider's Medicaid enrollment agreement. After IPRO concluded its internal analysis, it developed a summary of its findings, which it gave to the Provider. IPRO then held an exit conference on May 18, 2016 with representatives from the OSC and the Provider to discuss the summary of findings and any other issues involving the audit. At that exit conference, the Provider was given an opportunity to present its position regarding the summary of IPRO's findings. In addition, at the exit conference, IPRO and OSC representatives advised that the Provider could submit a written response to the summary of findings. The Provider submitted a response to the summary of findings in a document dated June 1, 2016. IPRO considered that response as part of its preparation of the Draft Audit Report. IPRO gave the Provider the Draft Audit Report for it to review and respond to. The Provider submitted a response to the Draft Audit Report in a document dated November 22, 2016 (which is attached as Appendix C). All of the work papers, the summary report, Draft Audit Report, and Provider responses have been considered in preparation of this report.

II. AUDIT PROFILE

A. PROVIDER PROFILE:

Name: Sohaila Khan MD
Address: 11 Burlew Place
Parlin, NJ 08859

Provider Number: 

Provider Type: Pediatrician

B. AUDIT SCOPE:

The scope of this audit was limited to determining compliance with federal and state Medicaid laws, regulations and guidance as well as adherence to the Medicaid program enrollment agreement.

The universe included 22,907 claims for services with a total Medicaid payment of \$759,308.61. From this universe, auditors selected a stratified sample of 250 claims for services totaling \$8,079.23 for review.

The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean that such practices are acceptable. Because of the limited nature of this review, no inferences as to the overall level of provider performance should be drawn solely from this report.

Achieving the objectives of the audit did not require the review of the Provider's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

C. ANALYSIS OF FINDINGS:

Of the 250 sampled claims for services reviewed, there were 67 claims for services with recoupable monetary findings. Section III explains the monetary findings, along with support for such findings. Appendix A lists the findings and associated sample claim information.

III. AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

1. No Documentation

Auditors identified 53 instances in which the medical record provided was missing thermography test results.

The state regulation pertaining to recordkeeping provides in pertinent part:

- (a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

(c) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

(d) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

(e) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid . . . program or its agents.

N.J.A.C. 10:54-2.6 (a)-(e) Recordkeeping; general

For established patients, which is the case here, there are more specific recordkeeping requirements. Specifically, the applicable regulation provides:

(a) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

1. In an office or Residential Health Care Facility:

- i. The purpose of the visit;
- ii. The pertinent physical, family and social history obtained;
- iii. A record of pertinent physical findings, including pertinent negative findings based upon i and ii above;
- iv. Procedures performed, if any, with results;
- v. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and
- vi. Prognosis and diagnosis.”

N.J.A.C. 10:54-2.8(a)(1)(i-vi) Minimum documentation; established patient

In addition to the regulations set forth immediately above (*N.J.A.C. 10:54-2.8*), there are additional regulations that require Medicaid providers to properly document the services they render and put providers on notice that when there is no such documentation or inadequate documentation, their claims may be adjusted accordingly. The specific regulations state the following:

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program

regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.

i. The following signature types are unacceptable:

- (1) Initials instead of signature;
- (2) Stamped signature; and
- (3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8(a) & (b) Provider Certification and Recordkeeping

As set forth in Section III 1 above, the New Jersey law that underpins the regulations cited in this report requires providers to properly maintain records that accurately reflect the services provided and billed to Medicaid. *N.J.S.A. 30:4D-12(d) & (e)*.

2. **Incorrect Procedure Code – Evaluation & Management (E&M) Code**

Auditors identified 14 instances in which the Provider billed an incorrect E&M procedure code for the service documented in the medical record. In other words, the Provider submitted claims for E&M codes that require a greater level of service than was

documented in the medical records. For purposes of assessing an overpayment amount, the auditors downcoded these E&M codes to conform to the appropriate level of service documented and used the reimbursement for that lower level of service as the amount that should have been paid for such service. Appendix A lists the incorrect E&M code billed along with the correct E&M procedure code.

It is worth noting that for instances in which claim payments were made by Managed Care Organizations (MCO), the Provider failed to provide the MCO payment rates for such services. IPRO could not corroborate these rates independently and, thus, asked the OSC to verify these payment rates when necessary. OSC obtained the payment rates from all of the MCOs. As explained in Section IC above, the Provider was given ample opportunity to contest the rate used and did not do so.

The legal support for the finding above is as follows.

The applicable federal regulation states that the standard medical data code sets include:

The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: (i) Physician services.

45 C.F.R. § 162.1002(a)(5) Medical data code sets

The applicable New Jersey regulation pertaining to a provider's use of procedure codes states:

(b) General policies regarding the use of HCPCS for procedures and services are listed below:

2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in the CPT and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.

3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

N.J.A.C. 10:54-9.1(b)(2) and (b)(3) Use of procedure codes

One of the state regulations regarding recordkeeping and the use of physician codes states:

(a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

N.J.A.C. 10:54-2.6 (a) and (b) Recordkeeping; general

Another state regulation that pertains to recordkeeping states:

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8 (b) Provider Certification and Recordkeeping

The authorizing statute for the regulatory requirements cited above mandates that the Medicaid program institute provider record maintenance requirements for providers in the Medicaid program. One requirement is that all such providers must properly maintain records that accurately reflect the services provided and billed to Medicaid. Specifically, the applicable statutory provision mandates that the Medicaid program:

(d) Require that any provider who renders health care services authorized under this act shall keep and maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered, and any additional

information, as the department may require by regulation. Records herein required to be kept and maintained shall be retained by the provider for a period of at least 5 years from the date the service was rendered;

(e) Require that providers who render health care services authorized under this act shall not be entitled to reimbursement for the services rendered unless said services are documented pursuant to subsection (d) of this section. Any evidence other than the documentation required pursuant to subsection (d) of this section shall be inadmissible in any proceeding conducted pursuant to this act for the purpose of proving that said services were rendered; unless the evidence is found to be clear and convincing by the finder of fact;

N.J.S.A. 30:4D-12(d)&(e). Unnecessary Use of Care and Services; Methods and Procedures; Maintenance of Records Required for Reimbursement

IV. SUMMARY OF OVERPAYMENTS

Of the 250 claims tested, the auditors found that 67 claims failed to meet the statutory and regulatory requirements outlined above. Consequently, the auditors found that these claims constituted overpayments. Applying the principles discussed above regarding the determination of the overpayment, the auditors determined that the identified overpayments for the 67 discrepant sampled claims for services totaled \$465.20. When extrapolated to the universe of claims from which the sample was drawn, the point estimate overpayment amount totals \$42,785.00. The calculation of this amount is illustrated in Appendices A and B. Accordingly, the total amount of the overpayment that must be returned to New Jersey is \$42,785.00.

After being apprised of the findings above, the Provider, through counsel, submitted a response dated December 21, 2016 (attached as Appendix C). In that response, the Provider took issue with the underlying use of an extrapolation methodology, stating, in part, the following:

“The statistical problem which arises in the analysis of the draft report is that, in fact, of the 22,907 patient visits a full 57% of them had insurance which under no circumstances would pay for temperature gradient or thermography [93740] and therefore could not under any circumstances form the basis of an overcharge.” The Provider also stated, “[a]dditionally that 9821 visits as a universe includes the visits covered by Horizon New Jersey Health. As my client has explained Horizon New Jersey health codes office visits as 99212 through 99215 all of those code numbers are paid and the fixed amount of [REDACTED], therefore all such visits should also be excluded from the universe figures.”

The Provider's response that patient visits for thermography (93740) should not form the basis for an overcharge, because 13,086 claims for 93740 from 2011 to 2013 were denied by the MCO, is not a supportable argument. The 22,907 claim universe for this audit included only paid claims of which 4,381 were for procedure code 93740.

In addition several of the Horizon NJ Health office visits, 99212 through 99215, included in this audit universe were paid an amount other than [REDACTED]; therefore this is also not a supportable argument. Since the Provider's response did not include any sufficient reliable documentation to support her position, no adjustments will be made to the audit analysis or the extrapolation. Therefore, we stand by the original extrapolated amount. The Provider must reimburse the Medicaid program \$42,785.

V. RECOMMENDATIONS

Based on the findings cited in this audit report, the Provider is directed to repay the Medicaid program \$42,785, and to take corrective action to ensure adherence with all federal and state laws and regulations and billing instructions provided under the Medicaid program. Pursuant to *N.J.A.C. 10:49-11.1*, continued violation(s) may result in the termination or suspension of the Provider's eligibility to provide services in the Medicaid program.

VI. SGS COMMENTS

In her response, the Provider did not state whether she agreed or disagreed with the Audit findings, recommendations, or assessment. Rather, she appears to have taken issue with the application of an extrapolation method to the sample of claims. Specifically, she states that "of the 22,907 patient visits... 13,086 of them had insurance which under no circumstances would pay for temperature gradient or thermography (93740) and therefore could not under any circumstances form the basis of an overcharge." She goes on to state that "Horizon New Jersey Health codes office visits as 99212 through 99215..are paid...the fixed amount of [REDACTED]...therefore...should be excluded from the universe figures." These positions do not account for the fact that only paid claims were included in the claims universe as well as several Horizon New Jersey Health office visits "99212 through 99215" for amounts other than [REDACTED]. Given that the auditors utilized a proper sampling methodology and otherwise performed the extrapolation in an appropriate manner, the Provider has not given any supportable reason to discount or modify the audit findings. Accordingly, the Provider is directed to repay to the Medicaid program the full amount identified, \$42,785, and implement specific policies and procedures to address the Audit's Recommendations.

Dr. Sohaila Khan
Appendix A
Audit Findings Claim Detail

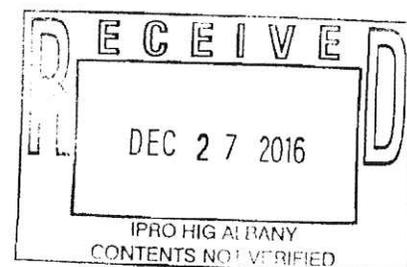
Sample #	Recipient ID	Recipient Name	Claim Service Date	Claim Pay Processing (FNS) (FNC) Date	Claim HMO Payment Date	Claim Source Code	Clm Submitting Prov Name	Procedure Code Billed	Amount Paid	Correct Procedure Code	Amount Per Audit *	Over Payment	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. No Documentation (Missing Thermography Test Results)	2. Incorrect Procedure Code - Evaluation & Management (E&M) Code
70			11/09/12	12/19/12	12/03/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
72			07/26/12	09/26/12	09/05/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
73			07/14/12	09/14/12	09/14/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
74			10/18/12	01/30/13	12/11/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
77			11/08/11	12/07/11	11/19/11	ENC	AMERIGROUP CORPORATION	93740								X	
78			07/12/11	09/24/11	08/03/11	ENC	AMERIGROUP CORPORATION	93740								X	
79			09/25/12	11/28/12	11/09/12	ENC	AMERIGROUP CORPORATION	93740								X	
80			03/19/12	06/06/12	04/19/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
82			01/21/13	05/08/13	02/20/13	ENC	AMERIGROUP CORPORATION	93740								X	
84			12/27/11	02/29/12	01/30/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
85			04/25/11	05/25/11		FFS		93740								X	
86			01/31/13	03/20/13	02/19/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
196			11/22/11	12/21/11	12/03/11	ENC	AMERIGROUP CORPORATION	99214								X	
204			04/02/13	05/22/13	04/29/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
205			07/10/12	09/25/12	09/13/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
208			01/28/13	03/20/13	02/18/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
214			08/06/12	09/26/12	08/27/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213								X	
215			12/07/13	02/26/14	12/28/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
219			03/08/12	06/08/12	03/29/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
221			10/08/11	11/30/11	11/07/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
226			08/25/11	10/26/11	10/04/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99215								X	
230			12/07/12	01/09/13		FFS		99215								X	
235			09/03/13	01/08/14	10/10/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99215								X	
246			10/23/12	12/19/12	11/28/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
249			12/12/13	03/26/14	01/08/14	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
249			02/04/12	03/14/12	03/01/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214								X	
															\$ 465.20	53	14

Dr. Sohaila Khan
Appendix B
Extrapolation of Sample Findings

Number of Claims in Universe	22,907
Number of Claims in Sample	250
Total Amount Paid for Claims in Universe	\$759,308.61
Total Amount Paid for Claims in Sample	\$8,079.23
Number of Claims Disallowed in Sample	67
Stratified Point Estimate	\$42,785

Paul A. De Sarno, Esq.

207 Washington Road
Sayreville, New Jersey 08872
732-238-0404 (fax) 732-238-0330
DeSarnoLawOffice@gmail.com



December 21, 2016

Via certified mail #7013 3020 0002 2414 3727
Ravi Kunnakkat, CPA, Audit Manager
IPRO healthcare integrity group
20 Corporate Woods Blvd.
Albany, NY 12211-2370

RE: CMS audit number 1-45809839

Dear Mr. Kunnakkat:

Please be advised I am the Attorney representing Dr. Sohaila Khan, MD with regard to the above referenced audit. I refer you to my client's correspondence to you dated December 6, 2016 and December 13, 2016 both forwarded to you by certified mail which indicate certain corrections to the assumptions contained within the draft audit findings forwarded to my client on November 22, 2016. I am attaching additional copies of my client's letters, and her internal audit of claims dated 11/30/16 for your reference. The information contained in her letters should clear up some of the questions you had posed in your draft report and I would urge you to take the new information to account in your calculations.

Clearly the error in coding a patient as having received temperature gradient (having the patient's temperature taken) was not intended to represent that the patient had received a thermography which is clearly a much more involved procedure. In some significant part the language provided by the insurers was the source of some of the confusion. There is no allegation being made that my client deliberately intended to receive payment for services she did not render. Nevertheless my client wishes to rectify the situation in a manner which makes logical and mathematical sense in full compliance with the regulations.

To that end I am requesting that you take into consideration that the calculations made in the draft report grossly overestimate the maximum possible amount of medical patients who might have even possibly been subject to the overcharge. On page 4 of your draft report the audit scope is central to this inadvertent exaggeration. The universe used in your report was 22,907 which is in fact the total number of patient visits to my client over the last 3 years. It is my understanding that from that universe, 250 claims were randomly chosen for review. The main finding was that in 53 instances a code for thermography was entered for which in fact there was no thermography, there was in fact a temperature gradient taken for each of those patients.

The statistical problem which arises in the analysis of the draft report is that, in fact, of the 22,907 patient visits a full 57% of them had insurance which under no circumstances would pay for temperature gradient or thermography and therefore could not under any circumstances form the basis of an overcharge. In other words it is simply impossible for my client to have generated an overcharge (as unintentional as that may have been) because there was no insurance payable regardless of whether the coding for taking the patient's temperature was in fact in error for that 57% of the total universe.

Therefore of the 22,907 patient visits, some 13,086 (57%) could not possibly have generated an overcharge. For the remaining 9,821 visits the possibility of an overcharge exists, but it is highly unlikely to have occurred with any great frequency. In your random sampling of 250 cases your finding was in 53 of them this error in coding occurred. That would be roughly one in 5 or 21% of the time there was this coding error. Assuming the 21% is accurate and utilizing only those visits for which an overcharge for this code is even possible that would indicate the possibility of overcharges occurring for 2,062 (rounding up) patient visits.

It is grossly unfair to include in the universe such a large number of patient visits which could not possibly have generated any payment regardless of how or if "temperature gradient" was coded because those insurers simply do not compensate doctors for it in any event. The universe of claims should not include patient visits which could not possibly have generated an overcharge; therefore the universe should be 9,821 at most, and not 22,907. This results in a more accurate and much lower payment amount which I am unable to calculate due to my not knowing whether or not you're taking into consideration my clients other updates and the additional factual material she has provided.

Additionally that 9821 visits as a universe includes the visits covered by Horizon New Jersey Health. As my client has explained Horizon New Jersey health codes office visits as 99212 through 99215 all of those code numbers are paid and the fixed amount of [REDACTED], therefore all such visits should also be excluded from the universe figures.

Many of the other areas of concern raised by your draft report are addressed in my client's direct correspondence with you. My client's correspondence also corrects factual assumptions with regard to the reports finding numbers 1, 1B, and 2. Please advise if you will be taking the additional information we have given you into account in revising your audit report. Both I and my client are ready, willing and able to discuss this matter with you at any time should you determine that it would be helpful towards generating the most accurate final report possible.

Very truly yours,



Paul A. De Sarno

PAD/pad

cc: Dr. Sohaila Khan, MD

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859
[REDACTED]

DATE: 11/30/16

CLAIMS SUBMITTED TO HORIZON NJ HEALTH & OTHER INSURANCES THAT DID NOT PAY FOR CODE 93740. FROM 2011 TO 2013	
<u>HORIZON NJ HEALTH</u>	
2011:	4181
2012:	4155
2013:	4316

<u>OTHER INSURANCES</u>	
2011:	72
2012:	194
2013:	168
TOTAL CLAIMS	13086

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859

DATE: 12/06/16

BY CERTIFIED MAIL

RAVI KUNNAKKAT, CPA, AUDIT MANAGER
IPRO HEALTHCARE INTEGRITY GROUP
20 CORPORATE WOODS BLVD.
ALBANY, NY 12211-2370

RE; CMS AUDIT NUMBER: 1-45809839

Dear Mr. Kunnakkat,

We acknowledge receipt of IPRO's letter dated 11/22/16. We will be sending additional information/documents regarding the above matter.

Mr. Paul De Sarno , Esq who will be representing us, will be contacting you. Please feel free to contact him at the following address/ telephone number, should you have any questions.

PAUL A. DE SARNO, ESQ
ATTORNEY AT LAW
207 WASHINGTON RD.
SAYREVILLE, NJ 08872
TEL: 732- 238-0404 FAX: 732-238-0330

Sincerely,



Sohaila Khan MD

cc: Paul De Sarno ESQ

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859
[REDACTED]

DATE: 12/13/16

BY CERTIFIED MAIL

RAVI KUNNAKKAT, CPA, AUDIT MANAGER
IPRO HEALTHCARE INTEGRITY GROUP
20 CORPORATE WOODS BLVD.
ALBANY, NY 12211-2370

RE; CMS AUDIT NUMBER: 1-45809839

Dear Mr. Kunnakkat,

Enclosed please find additional documents/ information regarding the following samples number.

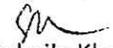
- (1) Audit finding 2.
18,196,204,205,210,214,218,221,223,226,230,241,246 & 249.
- (2) Audit finding 1b.
3,21,7,10,14
- (3) Audit finding 1.
234, 116

With reference to sample # 223. Based on our recollection of Healthfirst claim payments, the difference between codes 99212 & 99213 was approximately [REDACTED]. Please correct the charged amount from [REDACTED] to [REDACTED].

Please also be advised that Horizon NJ Health and Healthfirst did not pay for code 93740 and also, Horizon NJ Health has a standard fee schedule for 99212-99215 and therefore, these should not be included in the "number of claims in universe" when calculating for the above codes.

Please contact us at [REDACTED], should you have any questions.

Sincerely,


Sohaila Khan MD

cc: Paul De Sarno ESQ.

Number of pages including cover letter: 36