John Gore, LCADC An Intensive In-Community Mental Health and Behavioral Assistance Service Provider

Medicaid Fraud Division Report

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For the period June 1, 2016 through February 29, 2020

Kevin D. Walsh
Acting State Comptroller

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I. Executive Summary

As part of its oversight of the New Jersey Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of Medicaid claims submitted by and paid to John Gore, a Licensed Clinical Alcohol & Drug Counselor (Gore), for the period from June 1, 2016 through February 29, 2020 (audit period).

OSC's audit sought to determine whether Gore billed for intensive in-community mental-health rehabilitation and behavioral assistance services in accordance with applicable state regulations. Specifically, the audit evaluated whether Gore correctly billed Healthcare Common Procedure Coding System (HCPCS) codes H0036 (intensive in-community services, face-to-face, per 15 minutes), H2014 (individual behavior assistance services, per 15 minutes), and H0018 (intensive in-community assessment), which are used to seek reimbursement for intensive in-community mental-health rehabilitation and behavioral assistance services. From its audit of 32 randomly selected service days, which represents 818 claims totaling $157,536 in reimbursement to Gore, OSC determined that 30 of the 32 sampled service days, or 280 of the 818 claims (34 percent), totaling $39,567 in reimbursement, failed to comply with state regulations. The 280 failed claims contained 432 total exceptions, as some claims failed for multiple reasons.

Specifically, OSC found:

a. 14 exceptions for Gore having failed to verify professional licenses involving six servicing providers who OSC determined were not licensed during the period that they performed clinical level intensive in-community services;

b. 64 exceptions for Gore having failed to obtain criminal background checks for 19 behavioral assistants (BAs) prior to such BAs providing services;

c. 57 exceptions for Gore having failed to maintain Behavioral Assistance Training Certifications for 24 BAs;

d. 61 exceptions for Gore having failed to maintain proof of education for 23 BAs;

e. 18 exceptions for Gore having failed to maintain current and valid driver's licenses for 11 BAs;

f. 9 exceptions for Gore having failed to obtain proof of minimum age requirement for 6 BAs, prior to such BAs providing services;

g. 10 exceptions for Gore having billed for services to recipients on the same date of service at the same or overlapping times;

h. 27 exceptions for Gore having billed for travel time in the calculation of face-to-face contact with a beneficiary;

i. 154 exceptions for Gore having billed for unsubstantiated services;

j. 12 exceptions for Gore having billed for claims in which services were not documented with a progress note; and

k. 6 exceptions for Gore having billed for higher reimbursed procedure code than what was prior authorized (upcoding).

To ascertain the overpayment Gore received, OSC extrapolated the error dollars ($39,567) for the 30 service days (280 failed claims) to the total population from which the sample was drawn, which was 1,195 service dates, or 26,505 claims, with a total payment amount of $5,245,338. OSC calculated that Gore received an overpayment of at least $1,160,371.[1]

To better understand the significance of the exceptions noted above, it is helpful to discuss the qualification requirements that apply to Gore and other intensive in-community mental-health rehabilitation and behavioral assistance service providers. First, these providers must ensure that before allowing their servicing providers to render services, servicing providers who need a professional license are, in fact, licensed. This requirement ensures that intensive in-community servicing providers who are providing clinical level one-on-one care for Medicaid beneficiaries have the proper level of education and training, and have undergone appropriate state and federal criminal history background checks prior to providing such services.

Similarly, providers employing BAs must ensure that their BAs successfully completed and cleared criminal background checks, and must maintain a record showing the successful completion and clearance of these checks. This ensures that BAs who are providing one-on-one care for Medicaid beneficiaries, in this case children/youth/young adults, do not have a criminal history. This increases the assurance that the BA will not compromise the safety and security of beneficiaries. Additionally, a state regulation requires each BA to undergo extensive training and obtain a Behavioral Assistance Training Certification within six months of hire date and to recertify annually thereafter to continue providing BA services. To be certified, BAs must attend live trainings, meet 13 core competencies, and successfully pass an online review. For annual recertification, BAs must attend live training and meet core competencies. These certification requirements increase the assurance that beneficiaries receive the proper quality of care.

Further, under state regulations, providers must ensure that each BA possesses, at a minimum, a high school diploma or equivalent and is at least 21 years of age or older. These requirements provide a level of assurance that these hands-on caregivers possess the academic proficiency to have completed high school education or an equivalent thereto and that they are socially responsible enough to work in a one-on-one setting with the beneficiary population.

Finally, state regulations require providers to maintain proof that each BA possesses a valid driver's license. This ensures that BAs, who often drive beneficiaries during the course of treatment, are duly licensed drivers in good standing.

A provider that fails to meet one or more of the above-referenced regulatory requirements increases the risk that such provider is retaining an unqualified professional or BA who is

[1] OSC can reasonably assert, with 90% confidence, that the total overpayment in the universe is greater than $1,160,370.74 (11.05% precision) with the error point estimate as $1,304,462.12.

providing less than adequate quality care or potentially placing vulnerable beneficiaries into an unsafe position.

II. Background

The Division of Medical Assistance and Health Services, within the New Jersey Department of Human Services, administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low incomes receive medical assistance. The Medicaid program provides intensive in-community mental-health rehabilitation and behavioral assistance services to improve or stabilize children and young adults' level of functioning within the home and community. These services seek to prevent, decrease, or eliminate behaviors or conditions that may place the individual at an increased clinical risk or otherwise negatively affect a person's ability to function. These services are provided within the context of an approved plan of care and are restorative or preventative in nature.

Gore, located in South Plainfield, New Jersey, has participated in the Medicaid program as an intensive in-community mental health rehabilitation and behavioral assistance services provider since June 20, 2016. Gore billed the Medicaid program for such services under HCPCS codes H0036, H2014, and H0018. For the sampled claims, John Gore, using his Medicaid provider number, billed for services that he personally rendered as well as services rendered by 116 other professionals with whom he had contracted. Accordingly, references to Gore include services performed by John Gore as well as those performed by other behavioral health professionals.[2]

III. Audit Objective, Scope, and Methodology

The objective of this audit was to evaluate claims billed by and paid to Gore to determine whether Gore billed these claims in accordance with applicable state regulations.

The scope of the audit was June 1, 2016 through February 29, 2020. OSC conducted this audit under the authority of the New Jersey Office of the State Comptroller, as set forth in N.J.S.A.52:15C-1 to -23, and the Medicaid Program Integrity and Protection Act, N.J.S.A.30:4D-53 to -64.

To accomplish this objective, OSC selected a probability sample of 32 service days representing 818 claims, totaling $157,536, from a population of 1,195 service days representing 26,505 paid claims totaling $5,245,338, billed under HCPCS codes H0036, H2014, and H0018.

OSC reviewed Gore's records related to 818 claims to determine whether the documentation provided complied with the requirements of N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:49-9.8(b)(1), N.J.A.C. 10:77-4.8(b), N.J.A.C. 10:77-4.9(e), N.J.A.C. 10:77-4.9(f), N.J.A.C. 10:77-4.9(g), N.J.A.C. 10:77-4.12(d)(3), -(5), N.J.A.C. 10:77-4.12(e)(6), N.J.A.C. 10:77-4.14(c)(1), N.J.A.C. 10:77-4.14(c)(2), N.J.A.C. 10:77-4.14(c)(4), N.J.A.C. 10:77-4.14(d)(1), N.J.A.C. 10:77-4.14(d)(2), N.J.A.C. 10:77-5.7(c), N.J.A.C. 10:77-5.7(d), N.J.A.C. 10:77-5.10(b), N.J.A.C. 10:77-5.12(d)(3), -(5), N.J.A.C. 10:77-5.12(e)(6), and N.J.A.C. 10:77-5.14(b).

[2] Gore's practice may be referred to hereafter as "Gore" or as "he/his."

IV. Discussion of Auditee Comments

The release of this Final Audit Report concludes a process during which OSC afforded Gore opportunities to provide input regarding OSC's findings. Specifically, OSC provided Gore a Summary of Findings (SOF) and offered Gore an opportunity to discuss the findings in the SOF at an exit conference. Gore, represented by counsel, waived the exit conference and did not discuss the findings with OSC. Rather, Gore provided OSC written comments and additional records. After considering Gore's submission, OSC provided Gore with a Draft Audit Report (DAR). Gore provided a formal response to the DAR, which is attached as Appendix M, entitled "Gore's Response to Draft Audit Report."

Gore's response to the DAR generally agreed with OSC's audit findings, but referenced several unsupported factors that Gore claimed contributed to the audit's findings. Gore's submission did not include a Corrective Action Plan (CAP) that would have outlined the steps Gore had taken or will take to correct the identified deficiencies. Rather, Gore stated that he will take steps to install and operate a Corporate Compliance Program. OSC notes that should Gore fail to modify his behavior to adhere to the identified requirements, his actions would increase the level of risk for Medicaid beneficiaries served by Gore. Given that Gore did not submit information that contradicted OSC's findings, OSC did not adjust its audit findings, including the calculated overpayment amount. Accordingly, Gore must reimburse the Medicaid program the overpayment of $1,160,371.

OSC addresses each point raised by Gore in Appendix N, entitled "Gore's Comments and OSC's Responses."

V. Audit Findings

A. Gore Billed for Clinical Level Services Provided by Unlicensed Professionals

State regulations require all intensive in-community mental health rehabilitation providers that perform clinical services to obtain a professional license prior to rendering such services. The provider billing for these services must verify and maintain information such as current and valid license numbers authorizing each clinical person to practice in New Jersey. Verifying such information ensures that clinicians possess the proper skill set and knowledge appropriate and necessary to render the clinical level of services required.

For the sampled claims, Gore failed to verify professional licenses of 6 of the 67 licensed clinicians who accounted for 14 of the 818 claims, totaling $2,995 in reimbursement. OSC verified that these six servicing providers failed to possess professional licenses at the time they rendered services for which the Medicaid program reimbursed Gore. For example, Gore billed and was paid for clinical level of service rendered by one servicing provider on August 19, 2019, however, the servicing provider did not possess a New Jersey professional license to perform clinical services until November 1, 2019.

By failing to verify professional licenses prior to rendering services and thereby allowing unlicensed servicing providers to perform the service, Gore violated N.J.A.C. 10:77-5.7(d) and N.J.A.C. 10:77-5.14(b).

Pursuant to N.J.A.C. 10:77-5.7(d), "[c]linical services shall be delivered by a licensed clinical professional, including, but not limited to, a psychiatrist, a psychologist, an advanced practice nurse, a licensed clinical social worker or a mental health professional licensed in accordance with the Board of Marriage and Family Therapy Examiners (N.J.A.C. 13:34), who, within the scope of his or her practice, is authorized to provide or supervise the provision of mental health services."

Pursuant to N.J.A.C. 10:77-5.14(b), "[f]or licensed clinical staff members of the agency, the following information shall be maintained: 1.Verifiable written documentation of the supervising licensed behavioral health care practitioner's credentials and any other adjunct staff involved with the direct administration and/or delivery of this service as appropriate, including, at a minimum: i. His or her current and valid license number authorizing him or her to practice in New Jersey and the state where services are delivered."

B. Gore Failed to Maintain Criminal Background Checks for Behavioral Assistants Prior to Rendering Services

Pursuant to state regulation, intensive in-community mental health rehabilitation and behavioral assistance service providers must ensure that successful background checks are performed on employees who have direct contact with or render behavioral assistance services to beneficiaries. State regulations further require providers to maintain evidence that a "recognized and reputable" entity successfully completed these criminal background checks.

OSC requested documentation to determine whether Gore maintained evidence of successfully completed criminal background checks for each BA prior to each BA providing services to beneficiaries. OSC found that Gore allowed 19 of the 38 BAs in the audit sample to provide behavioral assistance services to beneficiaries prior to obtaining a criminal background check for these BAs. Specifically, OSC found that Gore billed for behavioral assistance services performed by 19 BAs, for 64 of the 818 claims, totaling $5,628 in reimbursement, without having first obtained criminal background checks for the BAs. For 9 of the 38 BAs, accounting for 41 of the 818 claims, totaling $3,286 in reimbursement, Gore obtained a criminal background check subsequent to the BA providing services. For example, in one instance, Gore billed and was paid for a sampled claim for a date of service of June 27, 2017, but did not obtain a successfully completed background check until February 4, 2021, nearly four years after the date of service. For the remaining 10 BAs, who accounted for 23 of the 818 claims, totaling $2,342 in reimbursement, Gore failed to provide supporting documentation that he ever obtained criminal background checks.

By failing to obtain successful criminal background checks before his employees provided services to Medicaid beneficiaries, and, in most cases, for the entire audit period, Gore violated N.J.A.C. 10:77-4.9(g) and N.J.A.C. 10:77-4.14(d)(2).

Pursuant to N.J.A.C. 10:77-4.9(g), "[a]ll employees having direct contact with and/or rendering behavioral assistance services directly to the beneficiaries shall be required to successfully complete criminal background checks."

Pursuant to N.J.A.C. 10:77-4.14(d)(2), the provider must maintain "[v]erified written documentation of successful completion of a criminal background check conducted by a recognized and reputable search organization for all staff having direct contact with children."

C. Gore Failed to Obtain Behavioral Assistance Training Certification for Behavioral Assistants

Pursuant to state regulation, intensive in-community mental health rehabilitation and behavioral assistance service providers must maintain written documentation showing that their BAs successfully completed the Behavioral Assistance Training Certifications required by the Department of Children and Families (DCF). As part of the Behavioral Assistance Training Certification process, every BA must attend live trainings, meet 13 core competencies, and successfully pass a 30 question multiple-choice review. To be eligible to work as a BA, each BA must obtain the certification no later than six months after the BA's hire date, and every BA must be recertified annually thereafter in order to continue providing BA services. Providers are responsible for verifying and maintaining evidence that their BAs obtained their certifications.

OSC requested that Gore provide the Behavioral Assistance Training Certifications for each BA in OSC's sample claim to determine whether Gore satisfied the requirement that he verified and maintained this documentation. OSC found that Gore allowed 24 of the 38 BAs in the audit sample selection to provide behavioral assistance services to beneficiaries without having obtained the required certification within six months from their hire date. Specifically, OSC found that Gore allowed untrained BAs to provide behavioral assistance services and inappropriately billed for 57 of the 818 claims, totaling $4,875 in reimbursement. For example, for 23 BAs, who accounted for 56 of the 818 claims, totaling $4,797 in reimbursement, Gore failed to provide any supporting documentation that he ever obtained the required Behavioral Assistance Training Certifications. Further, for 1 of the 24 BAs, who accounted for 1 claim totaling $78 in reimbursement, Gore provided a Behavioral Assistance Training Certification that was not obtained within six months of the BA's hire date.

By failing to obtain such certificates within six months of hire date and re-certifications annually thereafter, Gore violated N.J.A.C. 10:77-4.14(c)(4).

Pursuant to N.J.A.C. 10:77-4.14(c)(4), the provider must maintain "[v]erified written documentation of the direct care staff person's successful completion of any Behavioral Health Assistance Rehabilitation Services training required by the Department of Children and Families."

D. Gore Failed to Maintain Proof of Education for Behavioral Assistants

According to state regulations, to perform behavioral assistance services, a BA must have, at a minimum, a high school diploma or equivalent. A provider must verify and maintain proof that BAs satisfy this educational requirement.

OSC requested that Gore provide copies of high school diplomas or equivalents for each BA to determine whether qualified individuals performed services and whether Gore possessed proof that these BAs had satisfied the minimum educational requirement. OSC found that Gore lacked the requisite documentation for 23 of the 38 BAs in the audit sample selection, which accounted for 61 of the 818 claims, totaling $5,480 in reimbursement.

By not obtaining and maintaining proof of education, Gore violated N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)(1).

Pursuant to N.J.A.C. 10:77-4.9(e), "[a]ll direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter."

Pursuant to N.J.A.C. 10:77-4.14(c)(1), the provider must maintain "[a] copy of the direct care staff person's high school diploma or equivalent."

E. Gore Failed to Maintain Current and Valid Driver's Licenses for Behavioral Assistants

Behavioral assistance services provided to beneficiaries, up to 21 years of age, often occurs outside of their place of residence, in playgrounds and in other in-community settings. For such services, BAs may drive beneficiaries to the service location. As such, state regulations require all BAs to have a current and valid driver's license and require providers to maintain a copy of each BA's valid driver's license.

OSC requested documentation to determine whether Gore maintained a copy of each BA's current and valid driver's license. OSC found that for 11 of the 38 BAs in the audit sample, which accounted for 18 of the 818 claims, totaling $1,570 in reimbursement, Gore failed to maintain a copy of a BA's current and valid driver's license.

By failing to maintain a copy of current and valid driver's licenses, Gore violated N.J.A.C. 10:77-4.9(f) and N.J.A.C. 10:77-4.14(d)(1).

Pursuant to N.J.A.C. 10:77-4.9(f), "[a]ll employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children/youth or young adults. Transportation is not a covered behavioral assistance service."

Pursuant to N.J.A.C. 10:77-4.14(d)(1), "[a] copy of his or her current valid driver's license, if driving is required to fulfill the responsibilities of the job," is required to be maintained by the provider.

F. Gore Failed to Maintain Proof of Minimum Age Documentation for Behavioral Assistants

Pursuant to State regulations, a BA must be at least 21 years old to perform behavioral assistance services. OSC found that for 6 of the 38 BAs in the sample selection, who accounted for 9 of the 818 claims, totaling $829 in reimbursement, Gore failed to maintain proof of age for the BAs performing services.

By failing to maintain proof of age, Gore violated N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)(2).

Pursuant to N.J.A.C. 10:77-4.9(e), "[a]ll direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter."

Pursuant to N.J.A.C. 10:77-4.14(c)(2), "[f]or the direct care staff employed by the agency, the following information shall be maintained: . . . 2. A copy of the direct care staff person's proof of age at the date of hiring."

G. Gore Billed for Services Provided to Beneficiaries at the Same or Overlapping Times

State Medicaid regulations regarding intensive in-community mental-health and behavioral assistance services require providers to maintain true, accurate and complete records for each encounter documenting the name and address of the beneficiary; the exact date, location and time of service; the type of service; and, the length of face-to-face contact time. This information is contained in the Service Delivery Encounter Documentation (SDED) form. This two-page form, which must be signed and dated both by the servicing provider who rendered the service, and the beneficiary or their parent/legal guardian, must be completed for every service encounter between a provider and beneficiary.

OSC reviewed Gore's records, including the SDED forms, to determine whether Gore sufficiently documented the services rendered. Specifically, OSC compared the encounter dates and times recorded on the SDED forms to determine if claims overlapped in time. OSC found that for 10 of the 818 sample claims, totaling $1,276 in reimbursement, Gore billed for services provided by the same servicing provider to several beneficiaries or by different servicing providers to the same beneficiary at the same or overlapping time(s). For example, one SDED form documented that one servicing provider rendered services on January 25, 2019, from 6:00 PM to 8:30 PM. A second SDED form for that same date documented that the same servicing provider provided services to a different Medicaid beneficiary from 6:00 PM to 8:30 PM, resulting in an overlap of the entire encounter for two hours and thirty minutes (6:00 PM to 8:30 PM). In another instance, one SDED form documented that one servicing provider rendered services on August 19, 2019, from 3:00

PM to 5:00 PM. A second SDED form for that same date documented that a different servicing provider rendered services to the same Medicaid beneficiary from 4:00 PM to 6:00 PM, resulting in an overlap of one hour (4:00 PM to 5:00 PM).

By improperly billing for overlapping services, Gore violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:77-4.12(d)(3), -(5), and N.J.A.C. 10:77-5.12(d)(3), -(5).

Pursuant to N.J.A.C. 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to N.J.A.C. 10:77-4.12(d)(3), -(5) and N.J.A.C. 10:77-5.12(d)(3), -(5), providers shall maintain documentary support of all behavioral assistance services and intensive in-community mental-health rehabilitation services claims including "[t]he exact date(s), location(s) and time(s) of service." In addition, this provision states that providers must maintain documentary support for "[t]he length of face-to-face contact [time], excluding travel time to or from the location of the beneficiary contact."

H. Gore Improperly Billed for Travel Time

OSC reviewed records to determine whether Gore improperly billed for travel time that was included within the length of face-to-face time that the servicing provider interacted with the beneficiary. OSC found that for 27 of the 818 claims, totaling $946 in reimbursement, Gore improperly billed for travel time to and/or from the location of the beneficiary as part of his billing for face-to-face services. For example, one SDED form documented that one servicing provider rendered services to a beneficiary on July 19, 2019, from 8:30 AM to 10:30 AM. A second SDED form for that same date documented that the same servicing provider rendered services to a different beneficiary from 10:30 AM to 12:30 PM. According to Google Maps, the two service encounter locations were 62.2 miles apart, requiring approximately one hour and five minutes of travel time. In that instance, Gore improperly billed travel time as part of his face-to-face services and, as such, did not account for any time needed for travel.

By improperly billing for travel time for the services provided, Gore violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:77-4.12(d)(3), -(5), and N.J.A.C. 10:77-5.12(d)(3), -(5).

Pursuant to N.J.A.C. 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to N.J.A.C. 10:77-4.12(d)(3), -(5) and N.J.A.C. 10:77-5.12(d)(3), -(5), providers shall maintain support of all behavioral assistance services and intensive in-community mental health rehabilitation services claims including "[t]he exact date(s), location(s) and time(s) of service." In addition, this provision states that providers must maintain support for "[t]he length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact."

I. Gore Billed Unsubstantiated Services and/or Maintained Inaccurate and Incomplete Records

The purpose of the SDED form is to provide documentation for all encounters of intensive in-community and behavioral assistance services. This two-page form must be accurately completed and maintained for every service encounter between a provider and beneficiary. OSC reviewed records to determine whether Gore maintained true, accurate, and complete documentation for the services billed to Medicaid. OSC found that for 152 of the 818 sample claims, totaling $27,792 in reimbursement, Gore billed for services for which Gore failed to possess adequate documentation. The 152 failed claims contained 154 total exceptions.

- For 45 of the 154 exceptions, Gore failed to provide SDED forms that would support the claims for which Gore billed and was paid.

- For 29 of the 154 exceptions, Gore provided SDED forms that were missing signatures of the servicing providers attesting that the services were rendered.

- For 68 of the 154 exceptions, OSC noted that Gore submitted SDED forms on which the service delivery date noted on page two was outside of the prior authorization date (start and end date) specified on page one of the SDED form.

- For 1 of the 154 exceptions, Gore provided an SDED form that was missing the first page and thus did not contain necessary information, such as attestations, etc.

- For 11 of the 154 exceptions, the hours of service on the SDED conflicted with the hours billed and paid.

Recording correct prior authorization information on page one is important because, when compared to the service delivery date on page two, it ensures that the provider who is attesting to the accuracy of the information contained in the form actually delivered services during the authorized service delivery period. Additionally, by affixing a signature, the servicing provider attests that the provider delivered the services. OSC determined that, taken together, Gore's SDED documentation was deficient because OSC could not determine whether the information contained on page one properly belonged to the document identified as the corresponding page two, and whether the attestations on page one properly belonged to the service delivery date captured on page two of the form. For example, page one of an SDED form noted that the prior authorization date range was March 12, 2019 (start date) through March 26, 2019 (end-date); however, the service date noted on page two was July 15, 2019, which occurred more than three months after the specified date range, thus making the SDED form unreliable. In sum, based on these issues, OSC determined that for these 152 claims, Gore's SDED forms were not a reliable basis to support the claims.

By failing to maintain appropriate records, Gore violated N.J.A.C. 10:49-9.8(a) and N.J.A.C. 10:49-9.8(b)(1).

Pursuant to N.J.A.C. 10:49-9.8(a), “providers shall certify that the information furnished on the claim is true, accurate, and complete.”

Pursuant to N.J.A.C. 10:49-9.8(b)(1), providers are required “[t]o keep such records as are necessary to disclose fully the extent of services provided.”

J. Gore Failed to Document Services for Progress Notes

For both intensive in-community mental health rehabilitation and behavioral assistance services, the servicing provider must document services provided through progress notes. These notes provide relevant information regarding the treatment provided, the beneficiary’s response to the treatment, significant events that may affect the beneficiary’s condition or treatment, and other information pertinent to the beneficiary’s plan of care. The progress note differs from the SDED form in that the servicing provider completes the progress note, whereas the parent/guardian signs the SDED as an attestation as to the session’s date, duration, and location.

OSC reviewed Gore’s records to determine whether Gore maintained progress notes that supported his billed services. OSC found that for 12 of the 818 claims, totaling $2,226 in reimbursement, Gore failed to document services with a progress note.

By failing to maintain appropriate records for these claims, Gore violated N.J.A.C. 10:49-9.8(b)(1), N.J.A.C. 10:77-4.12(e)(6), and N.J.A.C. 10:77-5.12(e)(6).

Pursuant to N.J.A.C. 10:49-9.8(b)(1), providers are required “[t]o keep such records as are necessary to disclose fully the extent of services provided.”

Pursuant to N.J.A.C. 10:77-4.12(e)(6), the provider shall maintain “[w]eekly quantifiable progress notes toward defined goals as stipulated in the child/youth adult’s BASP.”

Pursuant to N.J.A.C. 10:77-5.12(e)(6), the provider shall maintain “[f]or each discrete contact with the child/family, progress notes which address the defined goals stipulated in the child/youth or young adult's plan of care must be completed.”

K. Gore Upcoded Services Provided

For each Medicaid beneficiary receiving intensive in-community services, the provider must perform a need assessment and clinical evaluation to determine the level and type of service that is medically necessary to address the identified issues. Intensive in-community services include three different levels of service: supportive services; professional services; and, clinical services. Similarly, for those in need of behavioral assistance services, the provider must develop a service plan based on an evaluation of the beneficiary’s needs. From that plan, the provider must obtain prior authorization to bill specific services.

OSC reviewed Gore’s records to determine whether Gore billed for services at the appropriate level using the proper billing procedure code. OSC found that for 6 of the 818 claims, totaling $428 in reimbursement, Gore billed for services using a higher reimbursed procedure code and/or modifier than appropriate, which resulted in Gore receiving overpayments. For example, on July

5, 2018, a BA rendered service to a Medicaid beneficiary who was prior-authorized to receive behavioral assistance services. Gore billed this encounter as intensive in-community service, though, using a billing code designed for clinical level services. Such billing resulted in Gore receiving the highest reimbursement amount for the lowest level of services actually provided.

By billing an inappropriate level of services and/or by upcoding, for these claims, Gore violated N.J.A.C. 10:49-9.8(a).

Pursuant to N.J.A.C. 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

L. Summary of Medicaid Overpayment

OSC determined that from its audit of 32 randomly selected service days for the period from June 1, 2016 through February 29, 2020, Gore billed 30 service days that contained errors. In terms of claims, Gore improperly billed and received payment for 280 of the 818 sample claims, totaling $39,567 in reimbursement. These 280 failed claims contained 432 total exceptions, as some claims failed for multiple reasons. To ascertain the overpayment Gore received, OSC extrapolated the error dollars ($39,567) for the 30 service days, or 280 unique claims that failed to comply with applicable regulations, to the total population of claims from which the sample service days were drawn, which in this case was 1,195 service days, or 26,505 claims, with a total payment amount of $5,245,338. From this extrapolation, OSC calculated that Gore received an overpayment of at least $1,160,371 that he must repay to the Medicaid program.[3]

VI. Recommendations

Gore shall:

1. Reimburse Medicaid the overpayment amount of $1,160,371.

2. Adhere to state regulations for all Medicaid services provided by Gore and his health care professionals.

3. Verify licensures before assigning health care professionals case referrals, and maintain documentation that ensures compliance with the state regulations.

4. Obtain and maintain required documentation for each behavioral assistant (i.e., successfully completed criminal background checks, valid driver's licenses, proof of education and proof of age) before behavioral assistants are assigned any case referrals, to ensure compliance with state regulations.

5. Ensure that all professionals employed by Gore receive training to foster compliance with applicable state regulations.

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[3] See Footnote 1.

6. Provide OSC with a CAP indicating the steps Gore will take to implement procedures to correct the deficiencies identified herein.

OBERHEIDEN P.C.

ATTORNEYS-AT-LAW

FIRM ATTORNEYS

DR NICK OBERHEIDEN
Managing Partner - Wash D C, New York
LYNETTE S BYRD
Partner - Texas
ELIZABETH K STEPP
Partner - New York, Texas
WILLIAM H NEWMAN
Partner - New York
PASCUAL C MEYER
Partner - Texas
ELLEN COMLEY
Senior Counsel - Texas
ALINA VENEZIANO
Counsel - New York
PAUL STRICKLAND
Counsel - California

LOCAL COUNSEL

HON JOE BROWN
Texas
HON AMANDA MARSHALL
Oregon
JOHN W SELLERS
Maryland
SAMER B KORKOR
Washington D C
COREY STEINBERG
Florida
JOANNE FINE DELENA
Mass, Florida
RICHARD T SIMMONS
Louisiana
WILFRED S RATTIGAN
New York, Conn
DAVID RABEN
Florida
ERICK CRUZ
Florida
DON A LYKKEBAK
Florida
KAREN PICKETT
Mass
MICHAEL A RATAJ
Michigan
STEVEN DILLON
Mass
BILL TUNKEY
Florida
KAMILLE DEAN
Ariz, Utah, Cal, Minn, Col
AARON L WILEY
Texas
JOSEPH NASCIMENTO
Florida
CAMERON J BLAZER
S Carolina
PETER T PHILLIPS
S Carolina
TERRY C FRANK
Virginia, North Carolina
JOSEPH J REINKE
Oklahoma
DANIEL A SMITH
Florida
JEFFREY HOWELL
Florida

440 LOUISIANA ST, SUITE 200
HOUSTON, TX 77002

WWW.FEDERAL-LAWYER.COM

Nick Oberheiden - Direct Dial: (310) 873-8140

October 30, 2022

State of New Jersey
Office of the State Comptroller
Acting State Comptroller: Kevin Walsh
Medicaid Fraud Division
P.O. Box 025
Trenton, NJ 08625-0025

By Electronic Mail
: Audit Manager-
: Chief Auditor-

RE: October 18, 2022 Correspondence - John Gore, Medicaid Provider No. .

Dear Mr. Walsh,

On behalf of our client, Clear Conscience Counseling, LLC ("Company"), we thank you for the opportunity to respond to your October 18, 2022, correspondence. We respectfully note that no part of this letter attempts to question your methodology. The purpose of this letter is to highlight certain existing and attached documentation for your consideration regarding some of your findings. We hope that this letter provides for additional consideration as may be relevant to your draft audit report.

A. DISAGREEMENTS

Gore Billed for Clinical Level Services Provided by Unlicensed Professionals.

None of the employees working on the Company's behalf during the Audit period remain at the Company making it extremely difficult to locate and seek assistance from such severed employees. We note that the Company outsourced its Human Resources function to a third-party firm called Zenefits. However, according to the correspondence dated October 18, 2022, the New Jersey Office of the State Comptroller (OSC) found:

(1) 14 exceptions for Gore having failed to verify professional licenses involving six servicing providers who OSC determined were not licensed during the period that they performed clinical level intensive in-community services;

(2) 64 exceptions for Gore having failed to maintain criminal background checks for 19 behavioral assistants (BAs) prior to such BAs providing services;

(3) 57 exceptions for Gore having failed to maintain Behavioral Assistance Training Certifications for 24 BAs;

(4) 61 exceptions for Gore having failed to maintain proof of education for 23 BAs;

(5) 18 exceptions for Gore having failed to maintain current and valid driver's licenses for 11 BAs; and

(6) 9 exceptions for Gore having failed to obtain proof of minimum age requirement for 6 BAs, prior to such BAs providing services.

Through research conducted by the Oberheiden, P.C. ("Firm"), Zenefits did provide a record of the "on boarding complete" to the Company. This "on boarding" did include the following items:

1. Professional licenses
2. Criminal background checks
3. Behavioral Assistance training
4. Proof of education
5. Valid driver's license
6. Birthdate

However, Zenefits told the company that they do not maintain archives or backups of data. Perhaps the OCS would have better fortune at gathering the Human Resources information. See Exhibits A1. Efforts were made to evaluate the Company's backups and archives to some, but limited effect.

Furthermore, some documents were stolen during a December 2020 burglary at Company. Please refer to the documentation of the burglary in the prior submission.

Human error will occur in healthcare. Out of 818 claims audited, there were only 10 errors translating to a greater than 98.5% error free claims. The standard ***allowed*** error rate for Medicare is 95%. For such a far-reaching scope of the draft audit, we find it notable that absolute perfection is the ultimate goal.

B. COMPLIANCE

To ensure that the Company reaches and maintains compliance with the New Jersey Medicaid Program, Dr. Gore will take steps to install and operate a Corporate Compliance Program under the Affordable Care Act Section 6401 and the United States Sentencing Guidelines 8B2.1. The Seven Elements of an effective compliance program include Standards and Procedures; Governance and Oversight; Education and Training; Monitoring and Auditing; Reporting; Internal Enforcement and Discipline; and Response and Prevention.

C. CONCLUSION

We appreciate the time and effort devoted by the OSC in analyzing the Company and our client understands that it needs to perform better when it comes to performing services for Medicaid. Again, our reliance upon an outsourced Human Resources vendor and a burglary are two reasons behind this failure. Both circumstances pre-date the Audit. Accordingly, we respectfully request a reexamination and reconsideration of the Audit.

Sincerely,

Oberheiden P.C.

APPENDICES:

Appendix A – Zenefits exhibits

OSC Note - Appendix A was omitted to maintain confidentiality

Gore's Comments and OSC's Response to Draft Audit Report

Gore, through Counsel, submitted comments to the Draft Audit Report. OSC summarizes each comment and provides a response to each below.

Outsourced Human Resources

"Gore Billed for Clinical Level Services Provided by Unlicensed Professionals.

"None of the employees working on the Company's behalf during the Audit period remain at the Company making it extremely difficult to locate and seek assistance from such severed employees. We note that the Company outsourced its Human Resources function to a third-party firm called Zenefits. . . ."

"Through research conducted by the Oberheiden, P.C. ('Firm'), Zenefits did provide a record of the 'on boarding complete' to the Company. This 'on boarding' did include the following items:

1. Professional licenses
2. Criminal background checks
3. Behavioral Assistance training
4. Proof of education
5. Valid driver's license
6. Birthdate

"However, Zenefits told the company that they do not maintain archives or backups of data. Perhaps the OCS would have better fortune at gathering the Human Resources information. See Exhibits A1. Efforts were made to evaluate the Company's backups and archives to some, but limited effect."

OSC's Response

Gore stated that a third-party to whom Gore outsourced its human resources function did not maintain the documentation that Gore needed to refute the audit findings. Gore's effort to assign blame to a third-party for its own failure to maintain legally required documentation is unavailing. As the party that provided services to Medicaid beneficiaries and billed and received Medicaid payments for these services, Gore, not a third-party, is solely responsible for maintaining all documentation needed to support these claims. Accordingly, OSC will not modify these findings.

Burglary

"Furthermore, some documents were stolen during a December 2020 burglary at Company. Please refer to the documentation of the burglary in the prior submission."

OSC's Response

Just as with its effort to deflect blame to a third party vendor, Gore's effort to evade responsibility based on its claim that its records were stolen is also unavailing. Gore is solely responsible for maintaining these legally required records and it cannot escape responsibility by

pointing to a burglary, for which OSC notes Gore failed to provide a police report or a list of stolen records. Therefore, OSC's position remains unchanged.

Medicare Error Rate

"Human error will occur in healthcare. Out of 818 claims audited, there were only 10 errors translating to a greater than 98.5% error free claims. The standard ***allowed*** error rate for Medicare is 95%."

OSC's Response

Gore's effort to evade responsibility by claiming that OSC only found "10 errors" is false and its comparison to the Medicare error rate is without merit because that rate does not apply to this Medicaid audit. OSC determined that 30 of Gore's 32 sampled service days, or 280 of the 818 claims (34 percent), failed to comply with state regulations. Gore's 280 failed claims contained 432 total exceptions, as some claims failed for multiple reasons. In addition to using a baseline error rate that was far lower than OSC found, Gore pointed to a Medicare error rate that is not applicable to this Medicaid audit.

Compliance

"To ensure that the Company [Gore] reaches and maintains compliance with the New Jersey Medicaid Program, Dr. Gore will take steps to install and operate a Corporate Compliance Program under the Affordable Care Act Section 6401 and the United States Sentencing Guidelines 8B2.1. The Seven Elements of an effective compliance program include Standards and Procedures; Governance and Oversight; Education and Training; Monitoring and Auditing; Reporting; Internal Enforcement and Discipline; and Response and Prevention."

OSC's Response

Through its response, Gore did not provide OSC with a CAP but submitted a vague compliance statement indicating that Gore will take steps to install and operate the Corporate Compliance Program. Additionally, Gore does not mention whether it intends to repay the overpayment to the Medicaid program.

Gore must provide OSC with the corrective actions it will take to address the audit findings and recommendations and Gore must repay the overpayment amount.