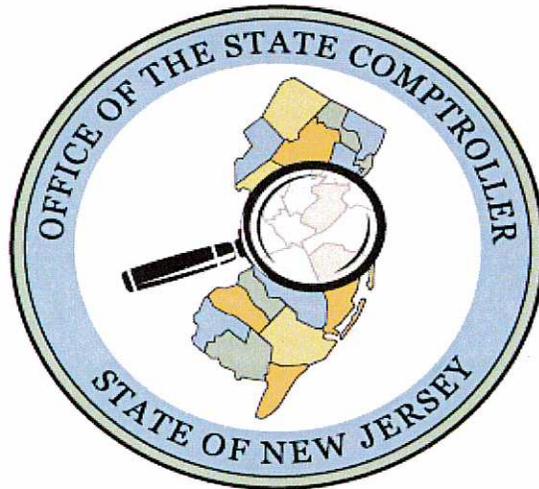


**STATE OF NEW JERSEY  
OFFICE OF THE STATE COMPTROLLER  
MEDICAID FRAUD DIVISION**

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



**Reporting Period: July 1, 2016 to December 31, 2016**

**Philip James Degnan  
STATE COMPTROLLER**

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## 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 2017.

## **III. SUMMARIES OF AUDIT FINDINGS AND RECOMMENDATIONS**

During the first and second quarters of Fiscal Year 2017, MFD auditors conducted 10 audits of Medicaid health care providers located throughout the state. Collectively, these audits identified and recovered \$182,663 in improperly expended Medicaid funds. Further, many 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.

*Newark Beth Israel Medical Center*

In this audit, MFD reviewed numerous claims for reimbursement for certain mammography services. MFD found that Newark Beth Israel had submitted 373 such claims under an incorrect billing code which resulted in it receiving an overpayment of \$25,966 from the Medicaid program. MFD recovered the full amount of the overpayment from Newark Beth Israel.

*We Care Health Services, Inc.*

We Care Health Services, Inc. is a home health care agency that provides various services to recipients at their homes. MFD auditors found that We Care Health Services had failed to properly document services performed in violation of state regulations. This audit resulted in the recovery of \$9,599 for the claims related to these services.

*Fresenius Medical Care - Southern Ocean Dialysis*

In this audit, MFD auditors reviewed claims for reimbursement for renal dialysis services where the beneficiaries were eligible for coverage under both the federal Medicare program and the state Medicaid program (*i.e.*, dual-eligible claims). MFD auditors found that Fresenius had improperly submitted 21 claims totaling \$5,918 for reimbursement to the State Medicaid program where payment should have been sought from the Medicare program. As a result, Fresenius reimbursed the state Medicaid program \$5,918 for these claims. Fresenius also agreed to adhere to a CAP requiring it to perform monthly insurance verifications and submit to quarterly MFD eligibility checks.

*Fresenius Medical Care – Saint Barnabas RCG Analysis*

Similar to the above audit of Fresenius Medical Care – Southern Ocean Dialysis, MFD auditors reviewed certain claims submitted by this provider where the beneficiaries were eligible for coverage under both Medicare and Medicaid. MFD identified 38 claims that should have been paid by Medicare. As a result, Fresenius reimbursed the Medicaid program \$10,710 for these claims. Fresenius also agreed to adhere to a CAP identical to the one described above.

*Fresenius Medical Care – Kidney Treatment Center of New Jersey*

In this third audit of dual-eligible claims, MFD auditors identified 99 claims that were improperly submitted for reimbursement to the state Medicaid program. Like the audits above, these claims should have been paid by Medicare. Fresenius reimbursed the Medicaid program \$27,903 for these claims and agreed to a CAP similar to those above.

*The Family Care Center of Montclair, LLC*

Through a review of claims for psychiatric services, MFD auditors found claims totaling \$28,663 that lacked sufficient documentation to demonstrate that the services had been provided. In addition to reimbursing the Medicaid Program for these claims, The Family Care Center agreed to a CAP requiring it to implement an electronic records system and to professionally train its staff in record keeping.

*Khalid Sawaged, D.O.*

In this audit, MFD found that Dr. Sawaged improperly submitted 1,192 separate claims for reimbursement for certain services that should have been billed together. These billings resulted in an overpayment to Dr. Sawaged in the amount of \$45,583. Dr. Sawaged agreed with the audit findings and reimbursed the Medicaid program for

these improperly billed and paid claims. Dr. Sawaged also agreed to take steps to ensure that his billing company complies with the appropriate billing guidelines.

#### *SarahCare at Watchung Square, LLC*

SarahCare is an adult day care facility that provides social services and programs for senior citizens. Through this audit, MFD auditors found that SarahCare had submitted the same 129 claims for reimbursement to both the Medicaid program and certain managed care organizations that administer portions of the Medicaid program. This double billing resulted in SarahCare receiving an overpayment of \$10,126 from the Medicaid program. This audit led to the recovery of these improperly paid funds and corrective action at the facility concerning its billing policies and practices.

#### *Metropolitan Family Health Network*

Metropolitan Family Health Network is a Federally Qualified Health Center, an entity comprised of various medical providers (physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists, and other healthcare professionals) that serve the neediest citizens regardless of their ability to pay or their health insurance coverage. MFD reviewed Metropolitan's quarterly reports for Medicaid reimbursement and found 83 instances where patient encounters were recorded inappropriately. Metropolitan agreed to reimburse the Medicaid Program \$11,796 for these claims. In addition, Metropolitan agreed to adhere to a CAP requiring it to strengthen its internal controls and provide training for its employees to avoid submitting improper claims going forward.

### *Adultcare, Inc.*

Adultcare, Inc. is an adult daycare facility that provides services and programs for senior citizens. Through this audit, MFD staff determined that Adultcare had sought reimbursement for 107 duplicate claims for services totaling \$8,399. As a result of this audit, Adultcare reimbursed the Medicaid program for these improperly submitted claims and agreed to update its billing practices and stay current with billing guidance.

#### **IV. SETTLEMENTS**

During the reporting period, MFD staff also identified and investigated numerous health care providers throughout New Jersey for potential fraud, waste or abuse, with their efforts resulting in settlements totaling more than \$4.1 million paid back to the Medicaid program. These settlements are listed below:

<i>Provider</i>	<i>Settlement Amount</i>
Bayonne Adult Medical Daycare (Bayonne, N.J.)	\$325,000
Broadway Adult Daycare (Fair Lawn, N.J.)	\$325,000
Community Health Pharmacy (Newark, N.J.)	\$19,666
Community Pharmacy (Perth Amboy, N.J.)	\$50,000
Erica David/Physical Medical Consultants (West Orange, N.J.)	\$27,000

Rodolfo Diaz, M.D. (Vineland, N.J.)	\$35,000
Excel Pharmacy (Jersey City, N.J.)	\$90,054
Giannotto's Pharmacy (Newark, N.J.)	\$37,634
Charles Haddad, M.D. (Clifton, N.J.)	\$93,000
Healthcare Pharmacy (Jersey City, N.J.)	\$15,394
Helping Hands Behavioral Health (Clayton, N.J.)	\$250,000
Herbert's Drug and Surgical (Jersey City, N.J.)	\$825,300
Arturo Jimenez, M.D. (Elizabeth, N.J.)	\$51,766
Kings Pharmacy (Newark, N.J.)	\$1,188
Lan Pharmacy (Pennsauken, N.J.)	\$105,860
Metro Pharmacy (Newark, N.J.)	\$952,162
North End Family Care (Newark, N.J.)	\$275,000
Noveck's Pharmacy (North Bergen, N.J.)	\$28,902

Pediatricare Associates (Fair Lawn, N.J.)	\$200,000
Roseville Pharmacy (Newark, N.J.)	\$70,911
Salem Pharmacy (Salem, N.J.)	\$27,980
Second Inning I Adult Day Care Center (Whippany, N.J.)	\$200,000
Mark Seglin, Ph.D. (West Orange, N.J.)	\$40,000
Nelson Turcios, M.D. (Somerville, N.J.)	\$60,000
United Drugs (Newark, N.J.)	\$71,248

# Newark Beth Israel Medical Center



# 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  
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PHILIP JAMES DEGNAN  
*State Comptroller*

JOSH LICHTBLAU  
*Director*

August 16, 2016

VIA ELECTRONIC AND CERTIFIED MAIL

Mr. Douglas Zehner  
Senior Vice President, Chief Financial Officer  
Newark Beth Israel Medical Center  
201 Lyons Avenue  
Newark, NJ 07112

RE: Final Audit Report – Newark Beth Israel Medical Center ( [REDACTED] )

Dear Mr. Zehner:

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid/NJFC) programs, the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), conducted an audit of Newark Beth Israel Medical Center (NBIMC). We are providing you with the final audit report.

## Executive Summary

The audit focused on a review of apparent anomalous claim billings for an unlisted radiological procedure. Current procedural terminology (CPT) code 76499 was primarily used to report digital mammography breast tomosynthesis services. NBIMC's billings for digital breast tomosynthesis were not consistent with guidelines established by the Centers for Medicare and Medicaid Services (CMS). The billing of CPT code 76499 was prohibited for this service by CMS during the period for which we seek recovery.

During this audit, OSC determined that NBIMC was overpaid and should reimburse Medicaid/NJFC \$25,966.66, for all CPT 76499 claims paid in 2014 for digital breast tomosynthesis services. The overpayment is attributed to NBIMC's delay in implementing billing procedures that were consistent with CMS' guidelines. Based on CMS' guidelines, NMBIC should not have billed CPT code 76499 for breast tomosynthesis for Medicaid recipients in 2014.

## **Background**

NBIMC is part of the Barnabas Health System and was established in 1901 and enrolled in the Medicaid program in 1970. This facility is located in Newark, New Jersey and primarily serves the Essex County area. Its Breast Center provides the women and men with expanded breast health services. Based on Medicaid claims data, OSC determined that NBIMC had a volume of claims billed as CPT code 76499. On that basis, OSC determined that an audit was warranted.

## **Objective**

The objective of this audit was to determine whether NBIMC billed CPT code 76499 appropriately. The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A.30:4D-53 et seq. and 52:15C-23.

## **Scope**

The scope of this review entailed a discussion and evaluation of NBIMC's fee-for-service, encounter, and Charity Care billings for CPT code 76499 for compliance with applicable New Jersey and federal regulations and guidelines. The audit period was January 1, 2012 through December 31, 2014.

## **Audit Findings**

OSC determined that for the period under review, NBIMC billed Medicaid/NJFC and was paid for 373 claims totaling \$25,966.66 for digital breast tomosynthesis in 2014, in contravention of New Jersey regulations and CMS' guidance regarding CPT code 76499, which disallowed these services. The OSC seeks to recover this amount in full.

## **Recommendations**

OSC recommends that NBIMC reimburse Medicaid/NJFC a total of \$25,966.66 for claims paid for digital breast tomosynthesis with CPT code 76499 for the year 2014. In addition, OSC recommends that the provider stay current with applicable CPT and billing guidance and update its billing policies and practices to meet current regulatory requirements.

## **Auditee Response**

NBIMC's Senior Vice President agreed with OSC's finding and stated that "NBIMC will reimburse \$25,966.66 to the Medicaid program for paid claims for digital breast tomosynthesis with CPT code 76499 for the year 2014." NBIMC's Senior Vice President further stated that "NBIMC eliminated the use of CPT 76400 in 2014. NBIMC has modified its policies and practices to ensure that all CMS and Novitas alerts are collected centrally, assessed and incorporated into

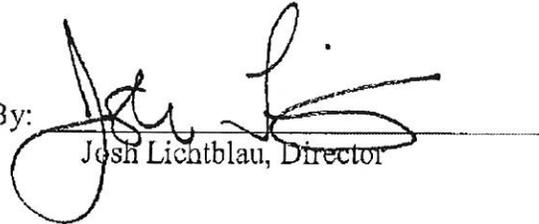
Mr. Douglas Zehner,  
Senior Vice President, Chief Financial Officer  
Newark Beth Israel Medical Center  
August 16, 2016

charging and coding procedures.” Finally, to ensure that this type of error does not recur, NBIMC’s Senior Vice President advised that “information is disseminated to all departments to educate and implement any change at the site of service.” The full text of NBIMC’s response is attached as an Addendum to this report.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:



Jesh Lichtblau, Director

Attachment

Cc: Don Catinello, Supervisor Regulatory and Recovery  
Michael McCoy, Manager Fiscal Integrity  
Michael Morgese, Audit Supervisor

**Newark Beth Israel | RWJBarnabas  
Medical Center HEALTH**

Darrell K. Terry, Sr., MHA, MPH, FACHE  
President and Chief Executive Officer

July 6, 2016

VIA ELECTRONIC MAIL

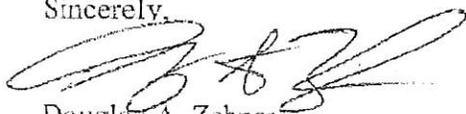
Mr. Asad Mamun  
Office of the State Comptroller  
Medicaid Fraud Division  
PO Box 025  
Trenton, NJ 08625-0025

RE: Draft Audit Report – Newark Beth Israel Medical Center

Dear Mr. Mamun

This letter is a response to your letter dated February 29, 2016. Newark Beth Israel Medical Center agrees with the OSC's findings. NBIMC eliminated the use of CPT 76499 in 2014. NBIMC has modified its policies and practices to ensure that all CMS and Novitas alerts are collected centrally, assessed and incorporated into charging and coding procedures. Additionally, information is disseminated to all departments to educate and implement any changes required at the site of service. NBIMC will reimburse \$25,966.66 to the Medicaid program for paid claims for digital breast tomosynthesis with CPT code 76499 for the year 2014. Please communicate the remittance information for the above payment. I can be reached at my office number (973) 926-6982 if you have any questions or concerns.

Sincerely,



Douglas A. Zehner  
Senior Vice President and Chief Financial Officer  
Newark Beth Israel Medical Center

201 Lyons Avenue  
at Osborne Terrace  
Newark, NJ 07112

973.926.7000

**We Care Health Services, Inc.**



# State of New Jersey

CHRIS CHRISTIE  
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PHILIP JAMES DEGNAN  
*State Comptroller*

JOSH LICHTBLAU  
*Director*

August 16, 2016

VIA ELECTRONIC AND CERTIFIED MAIL

Mr. Mitch Elman  
Administrator  
We Care Health Services, Inc.  
941 Whitehorse Ave, Suite 20  
Trenton, NJ 08610

RE: Final Audit Report – We Care Health Services, Inc. [REDACTED]

Dear Mr. Elman:

The New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), conducted an audit of We Care Health Services, Inc. (WCHS) for the period beginning January 1, 2012 through December 31, 2013. OSC selected WCHS for a limited scope review to determine whether WCHS submitted claims and was paid for home health care services when the recipients who received these services were inpatients at a hospital. If so, these claims and subsequent payments would be in violation of federal and State laws and regulations. We are providing you with this final audit report.

## Executive Summary

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid/NJFC) programs, OSC conducted an audit that focused on a review of clinical documentation for home health care services to determine whether these services were rendered simultaneously with hospital services, for the same recipients, on the same dates during our audit period. As part of this audit, OSC confirmed with hospitals as to whether WCHS recipients for whom WCHS submitted claims for payment for services rendered were hospitalized for those identical dates of service.

Using the approach, OSC determined that WCHS was overpaid for 32 claims totaling \$2,359. This determination was made after a review of 38 sample claims resulted in an error rate of 84.21 percent. OSC extrapolated the errors over the total population of 181 claims. On this basis, OSC seeks to recover the extrapolated amount totaling \$9,599. The recovery is attributed to WCHS'

failure to provide documentation to support the claims reviewed during our audit period, and WCHS' acknowledgement of claims which were billed in error, for services purportedly provided at recipients' homes when the recipients were inpatients at hospital facilities.

### **Background**

WCHS is a home health care agency located in Trenton, New Jersey. Home health care agencies provide a variety of services to Medicaid/NJFC recipients at their place of residence, including homemaker-home health aide, skilled nursing, speech therapy, physical therapy, occupational therapy, medical social services and dietary/nutritional needs. Home health care agencies also provide personal care services. These services are non-medical activities, which allow the elderly and individuals with disabilities or chronic temporary conditions to remain in their homes. The non-medical activities that are performed by personal care assistants (PCAs) include bathing, dressing, light housework, medication management, meal preparation and transportation related to daily living.

Home health care services covered by Medicaid/NJFC fee-for-service programs are limited to those services provided directly by a home health agency and/or through an arrangement by the agency for another party to provide services. Each home health care agency that provides home health care services to Medicaid recipients must be approved by the Division of Medical Assistance and Health Services (DMAHS) to participate in the Medicaid/NJFC program.

Overall, home health care services are intended to rehabilitate and/or restore recipients to their optimal level of physical and/or mental functioning, self-care and independence. In addition, these services are directed toward preventing further deterioration by maintaining the present level of functioning; or directed toward providing supportive care in declining health situations.

### **Relevant Regulations**

For the purposes of this audit, the applicable regulations for home health care services in the Medicaid program are as follows:

N.J.A.C. 10:49-9.8, Provider certification and recordkeeping, providing, in part:

- (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 5 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. 10:60-2.1, Covered home health agency services, providing, in part:

- (a) Home health care services covered by the New Jersey Medicaid and NJ FamilyCare fee-for-service programs are limited to those services provided directly by a home health agency approved to participate in the New Jersey Medicaid/NJ FamilyCare program or through arrangement by that agency for other services.
  1. Medicaid/NJ FamilyCare reimbursement is available for these services when provided to Medicaid or NJ FamilyCare fee-for-service beneficiaries in their place of residence, such as a private home, residential hotel, residential health care facility, rooming house and boarding home.
    - i. In residential health care facilities, homemaker-home health aide or personal care assistant services are excluded from Medicaid/NJ FamilyCare fee-for-service coverage.
    - ii. Home health services shall not be available to Medicaid or NJ FamilyCare fee-for-service beneficiaries in a hospital or nursing facility . . . .

N.J.A.C. 10:60-3.6, Clinical records:

- (a) Recordkeeping for personal care assistant services shall include the following:
  1. Clinical records and reports shall be maintained for each beneficiary, covering the medical, nursing, social and health related care in accordance with accepted professional standards. Such information shall be readily available, as required, to representatives of the Division or its agents.
  2. Clinical records shall contain, at a minimum:
    - i. An initial nursing assessment;
    - ii. A six-month nursing reassessment;
    - iii. A beneficiary-specific plan of care;
    - iv. Signed and dated progress notes describing the beneficiary's condition;
    - v. Documentation of the supervision provided to the personal care assistant every 60 days;
    - vi. A personal care assistant assignment sheet signed and dated weekly by the personal care assistant;
    - vii. Documentation that the beneficiary has been informed of rights to make decisions concerning his or her medical care; and
    - viii. Documentation of the formulation of an advance directive.

3. All clinical records shall be signed and dated by the registered professional nurse, in accordance with accepted professional standards, and shall include documentation described in (a)2 above.

### **Objective**

The objective of this limited scope audit was to determine whether WCHS appropriately billed for home health care services in accordance with applicable federal and State laws and regulations. The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq. and 52:15C-23.

### **Scope**

The scope of this desk audit entailed a limited review, evaluation and discussion of 181 claims totaling \$12,741.49. The 181 claims identified by OSC were for hospital and home care services, which were billed for Medicaid recipients on the same dates of service. OSC reviewed a sample of 38 statistically valid claims from the population of 181 claims. As part of the scope of this audit, to ensure that the recipients were, in fact, in a hospital on the same date of home health services having been provided and billed, OSC also obtained confirmation of recipient hospital records. The period of this audit was January 1, 2012 through December 31, 2013.

### **Audit Findings**

#### Review of Sample Claims

1. OCS's review revealed that WCHS failed to produce documentation to support the home health care or PCA services billed for 16 of the 38 (42%) sample claims reviewed, totaling \$1,059.06. This is a violation of N.J.A.C. 10:49-9.8(b)(1), which requires providers "to keep such records as are necessary to disclose fully the extent of services provided," for a minimum period of five years from the date of service.
2. OSC noted that home health aides (HHAs) failed to record the time they arrived and the time they departed to support the hours billed for 6 of the 38 claims reviewed (15.79%), totaling \$603.80, contrary to N.J.A.C. 10:60-3.6(a)(2)(vi). Also, HHAs and PCAs did not always indicate the services rendered on their activity reports contrary to N.J.A.C. 10:49-9.8(b)(1).
3. OSC's desk review of recipient hospital records confirmed that 10 of the 38 home health claims (26.31%), totaling \$696.26, were for recipients who were hospitalized during the same period of time that home health services were reportedly rendered, in violation of N.J.A.C. 10:60-2.1(a)(1)(ii), which does not permit home health services to recipients in a hospital or nursing facility setting.

Overall, OSC seeks the recovery of \$9,599.00 from WCHS for services that were not billed in accordance with Medicaid regulations. This amount was derived from the extrapolation of 32 out

of 38 sample claims that were not billed in accordance with Medicaid regulations. The 32 claims in error, which total \$2,359.12, were extrapolated to the total population of 181 claims, which total \$12,741.49, resulting in a total recovery of \$9,599.00.

### Recommendation

OSC recommends that WCHS reimburse Medicaid/NJFC a total of \$9,599.00. Also, WCHS should reinforce the requirements of applicable Medicaid regulations by training its employees regarding the Medicaid programs documentation and record retention requirements, including the prohibition against billing Medicaid for home health care services when a recipient is hospitalized.

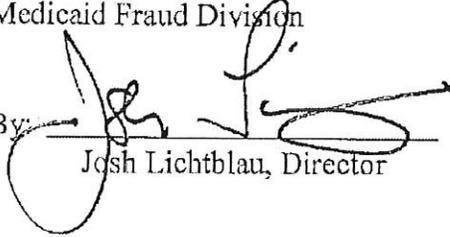
### Auditee Response

WCHS agreed with OSC's findings and stated "[i]t is troublesome of course that the audit revealed that we were not 100% compliant in keeping with the regulations put forth before us. Because our non-compliance resulted in reimbursements that we are not entitled to, we are of course in full agreement that those monies are to be returned." Additionally, WCHS indicated that it "is taking steps to improve our processes and prevent deficiencies going forward."

The full text of WCHS's response is attached to this report.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By: 

Josh Lichtblau, Director

### Attachment

Cc: Don Catinello, Supervisor Regulatory and Recovery  
Michael McCoy, Manager – Fiscal Integrity  
Michael Morgese, Audit Supervisor

# WE CARE HEALTH SERVICES, INC.

941 Whitehorse Avenue  
Suite 20  
Trenton, N.J. 08610  
Telephone (609) 581-8400  
FAX (609) 581-8600

Michael M. Morgese  
Audit Supervisor, Medicaid Fraud Division  
Office of the State Comptroller  
20W. State Street 4th Floor  
P.O. Box 024  
Trenton, NJ 08625

RE: Draft Audit Report [REDACTED]

Mr. Morgese:

Thank you for allowing me the extra time for comments regarding the audit report. It has always been the intent of We Care Health Services, Inc., to follow all of the rules and regulations regarding the operation of a Home Care Agency within the Medicaid program. As demonstrated by our reputation of serving the elderly and disabled community with quality care for nearly thirty years, we are an important part of the community and wish to serve that same community for many years to come.

It is troublesome of course that the audit revealed that we were not 100% compliant in keeping with the regulations put forth before us. Because our non-compliance resulted in reimbursements that we are not entitled to, we are of course in full agreement that those monies are to be returned. There was one point of disagreement with a specific matter of record keeping:

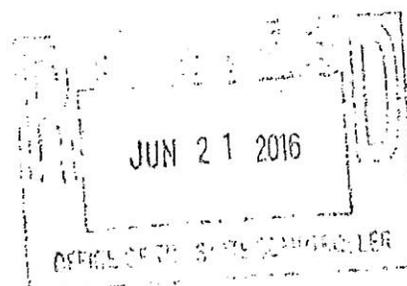
Finding 2: Client K. R.- Under normal circumstances, documentation for Time In/Time Out would have been provided. At the time, GO (MLTSS) set up a "Live-In" scenario for 24 hour care and requested to receive timesheets showing an aide in the home for 24 hours without a time in or time out.

Finding 2: Client K. R.- As far as hospital notes being confirmed for this client, although not a disagreement with the findings, We Care Health Services was deceived by the client's family into believing that the client was not in the hospital. They coerced the aide to lie about taking care of the client in the hospital. We did not actually discover this until it was revealed in the audit. We understand of course that ignorance is not an excuse. We are pursuing collection from the family.

We Care Health Services is taking steps to improve our processes and prevent deficiencies going forward. In addition to in-service training to the current staff, we have recently added and trained a new Administrative Assistant. We have also hired a home care consulting service that started in February and will continue on through the summer. All deficiencies that occurred were totally unintentional and inadvertent. With that being said, we will do our best to be 100% compliant going forward.

Sincerely,

  
Mitch Elman  
Administrator



**Fresenius Medical Center – Southern  
Ocean Dialysis**



# State of New Jersey

**CHRIS CHRISTIE**  
*Governor*

**KIM GUADAGNO**  
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**PHILIP JAMES DEGNAN**  
*State Comptroller*

**JOSH LICHTBLAU**  
*Director*

September 1, 2016

## VIA CERTIFIED AND ELECTRONIC MAIL

Nancy L. Eddy, MBA, CHC  
Director of Operations Monitoring  
Fresenius Medical Care  
920 Winter Street  
Waltham, MA 02451

RE: Final Audit Report — Fresenius Medical Care d/b/a  
Southern Ocean Dialysis

Dear Ms. Eddy:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Office of the State Comptroller's Medicaid Fraud Division (OSC) conducted an audit of Fresenius Medical Care d/b/a Southern Ocean City Dialysis (Fresenius SOCD). This Final Audit Report includes OSC's findings and your response.

### Executive Summary

The audit included a review of renal dialysis claims where beneficiaries were dual-eligible under both the Medicaid and Medicare plans. These claims were not paid consistently with the New Jersey Administrative Code (*N.J.A.C.*) 10:52-2.12 (c), which requires renal dialysis services for end stage renal dialysis (ESRD) to be reimbursed by Medicaid or NJ FamilyCare fee-for-service (FFS) only when the individual is a Medicaid or NJ FamilyCare FFS beneficiary and not a Medicare beneficiary.

During this audit, OSC determined that Fresenius SOCD was overpaid \$5,918.85 for renal dialysis services. The overpayment resulted from instances where OSC found renal dialysis claims were billed to Medicaid, when these dual-eligible claims should have been billed to Medicare, according to the Medicaid regulations.

### **Background**

Fresenius Medical Care (Fresenius) is the parent organization of Southern Ocean City Dialysis, which provides ESRD services. ESRD occurs when the kidneys are no longer able to function at a level needed for day- to-day life. Renal dialysis services are performed to improve the level of kidney function by filtering waste and fluid from an individual's blood. Fresenius services individuals who have Medicaid, Medicare, employer group health plans, and private insurance.

### **Objective**

The objective of this audit was to determine if Fresenius SOCD is appropriately billing Medicaid for renal dialysis services in accordance with Medicaid regulations.

### **Scope**

The scope of this audit entailed a review of Medicaid recipients with Medicare coverage where Medicaid paid for renal dialysis services. The period of our review was from January 1, 2011 through November 25, 2015. The review was conducted under the authority of the *Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq*, and the OSC enabling statute, *N.J.S.A. 52:15C-1, et seq*.

### **Audit Findings**

Pursuant to *N.J.A.C. 10:52-2.12 (c)*, "Renal dialysis services for ESRD and Medicare approved 'add-on' costs shall be reimbursable by Medicaid or NJ FamilyCare fee-for-service only when the individual is a Medicaid or NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable."

OSC identified 21 paid FFS claims totaling \$5,918.85 for renal dialysis services, where the beneficiary had both Medicare and Medicaid coverage. The Medicare Part A beneficiary coverage began on February 1, 2010 and the Part B coverage period began on September 1, 2010, both are still active. Fresenius SOCD should have submitted the claims for dialysis services to Medicare instead of Medicaid, since the services fall within the Medicare coverage period.

OSC seeks the recovery of \$5,918.85 from Fresenius SOCD for services that should have been billed to Medicare and not to Medicaid in accordance with *N.J.A.C. 10:52-2.12 (c)*.

### Recommendation

OSC recommends that Fresenius SOCD prepare a Corrective Action Plan (CAP) that would be submitted for OSC review and approval. The CAP will specify the processes to be implemented to address the instances where certain dialysis services were billed to New Jersey Medicaid for a beneficiary who was also covered by Medicare.

### Auditee Response

Fresenius agreed with the audit findings and has paid \$5,918.85 to the Medicaid program. In addition, Fresenius has provided OSC with a CAP that includes a process to review the status of dual-eligible beneficiaries.

Fresenius response is attached as Appendix A.

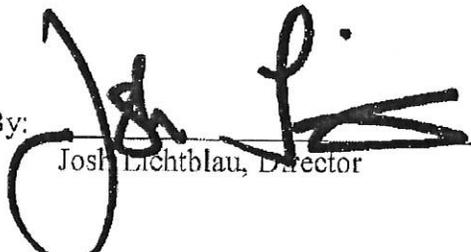
### OSC Response

Based upon OSC's audit findings, Fresenius has paid the Medicaid program \$5,918.85. In addition, Fresenius has complied with OSC's request for a CAP. The CAP, as outlined in their response (Appendix A), provided a process to check the status of dual-eligible beneficiaries to ensure compliance with *N.J.A.C. 10:52-2.12 (c)*. Based upon Fresenius' payment and submission of an acceptable CAP, no further action is necessary.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:



Josh Lichtblau, Director

Enc.

cc: Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor



Nancy L. Eddy, MBA, CHC, CHPC  
Director Operations Monitoring

June 21, 2016

Sent Via USPS Overnight Mail

Josh Lichtblau, Director  
State of New Jersey  
Office of the State Comptroller  
Medicaid Fraud Division  
P.O. Box 025  
Trenton, NJ 08625-0025

**RE: Draft Audit Report – Fresenius Medical Care d/b/a Southern Ocean Dialysis**

Dear Mr. Lichtblau:

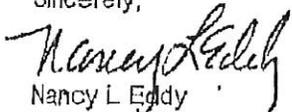
We are in receipt of the Draft Audit Report (Exhibit A) for the above referenced dialysis clinic. We have reviewed the audit findings and are in agreement with the finding. Attached is Fresenius Medical Care check number 007585387 in the amount of \$16,629.15 for services billed to NJ Medicaid, for a beneficiary that was also covered by Medicare. Please apply a portion of this check (\$5,918.85) in repayment for services provided by Southern Ocean Dialysis [REDACTED]

Correction Action Plan

As recommended by the Office of State Comptroller (OSC) we provide our Correction Action Plan which includes standard processes implemented to review the status of dual-eligible beneficiaries in the State of New Jersey. The process that has been implemented is outlined below:

- All Medicaid primary patients are identified on a worklist in our insurance verification clearinghouse
- Insurance verification is conducted twice per month
- Upon Medicaid notification of Medicare eligibility, Medicare eligibility is verified
- Quarterly review of all patients for insurance eligibility and change in work or home status

Sincerely,

  
Nancy L. Eddy  
Director Operations Monitoring

Fresenius Kidney Care, Operation Integrity, 920 Winter Street, Waltham, MA 02461  
T +1 781-699-4235, F +1 781-466-0665

**Fresenius Medical Center – Saint  
Barnabas RCG Analysis**



## State of New Jersey

**CHRIS CHRISTIE**  
*Governor*

**KIM GUADAGNO**  
*Li. 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 1, 2016

### VIA CERTIFIED AND ELECTRONIC MAIL

Nancy L. Eddy, MBA, CHC  
Director of Operations Monitoring  
Fresenius Medical Care  
920 Winter Street  
Waltham, MA 02451

RE: Final Audit Report – Fresenius Medical Care d/b/a  
St. Barnabas RCG Dialysis – Livingston

Dear Ms. Eddy:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Office of the State Comptroller's Medicaid Fraud Division (OSC) conducted an audit of Fresenius Medical Care d/b/a St. Barnabas RCG Dialysis – Livingston (Fresenius – Livingston). This Final Audit Report includes OSC's findings and your response.

#### Executive Summary

The audit included a review of renal dialysis claims where beneficiaries were dual-eligible under both the Medicaid and Medicare plans. These claims were not paid consistently with the New Jersey Administrative Code (*N.J.A.C.*) 10:52-2.12 (c), which requires renal dialysis services for end stage renal dialysis (ESRD) to be reimbursed by Medicaid or NJ FamilyCare fee-for-service (FFS) only when the individual is a Medicaid or NJ FamilyCare FFS beneficiary and not a Medicare beneficiary.

During this audit, OSC determined that Fresenius – Livingston was overpaid \$10,710.30 for renal dialysis services. The overpayment resulted from instances where OSC found renal dialysis claims were billed to Medicaid, when these dual-eligible claims should have been billed to Medicare, according to the Medicaid regulations.

### **Background**

Fresenius Medical Care (Fresenius) is the parent organization of St. Barnabas RCG Dialysis – Livingston, which provides ESRD services. ESRD occurs when the kidneys are no longer able to function at a level needed for day-to-day life. Renal dialysis services are performed to improve the level of kidney function by filtering waste and fluid out of an individual's blood. Fresenius services individuals who have Medicaid, Medicare, employer group health plans, and private insurance.

### **Objective**

The objective of this audit was to determine if Fresenius – Livingston is appropriately billing Medicaid for renal dialysis services in accordance with Medicaid regulations.

### **Scope**

The scope of this audit entailed a review of Medicaid recipients with Medicare coverage where Medicaid paid for renal dialysis services. The audit period was from January 1, 2011 through November 25, 2015. The review was conducted under the authority of the *Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq.*, and the OSC enabling statute, *N.J.S.A. 52:15C-1, et seq.*

### **Audit Findings**

Pursuant to *N.J.A.C. 10:52-2.12 (c)*, "Renal dialysis services for ESRD and Medicare approved 'add-on' costs shall be reimbursable by Medicaid or NJ FamilyCare fee-for-service only when the individual is a Medicaid or NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable."

OSC identified 38 paid FFS claims totaling \$10,710.30 for renal dialysis services, where the beneficiary had both Medicare and Medicaid coverage. The Medicare beneficiary coverage period began on October 1, 2010, and is still active. Fresenius – Livingston should have submitted the claims for dialysis services to Medicare instead of Medicaid, since the services fall within the Medicare coverage period.

OSC seeks the recovery of \$10,710.30 from Fresenius – Livingston for services that should have been billed to Medicare and not to Medicaid in accordance with *N.J.A.C. 10:52-2.12 (c)*.

**Recommendation**

OSC recommends that Fresenius – Livingston prepare a Corrective Action Plan (CAP) that would be submitted for OSC review and approval. The CAP will specify the processes to be implemented to address the instances where certain dialysis services were billed to New Jersey Medicaid for a beneficiary who was also covered by Medicare.

**Auditee Response**

Fresenius agreed with the audit findings and has paid \$10,710.30 to the Medicaid program. In addition, Fresenius has provided OSC with a CAP that includes a process to review the status of dual-eligible beneficiaries.

Fresenius' response is attached as Appendix A.

**OSC Response**

Based upon OSC's audit findings, Fresenius has paid the Medicaid program \$10,710.30. In addition, Fresenius has complied with OSC's request for a CAP. The CAP, as outlined in their response, provided processes to check the status of dual-eligible beneficiaries to ensure compliance with *N.J.A.C. 10:52-2.12 (c)* (Appendix A). Based upon Fresenius' payment and submission of an acceptable CAP, no further action is necessary.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:

  
Josh Lichtblau, Director

Enc.

cc: Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor



Nancy L. Eddy, MBA, CHC, CHPC  
 Director Operations Monitoring

June 21, 2013

Sent Via USPS Overnight Mail

Josh Lichtblau, Director  
 State of New Jersey  
 Office of the State Comptroller  
 Medicaid Fraud Division  
 P.O. Box 025  
 Trenton, NJ 08625-0025

**RE: Draft Audit Report – Fresenius Medical Care d/b/a St. Barnabas RCG Dialysis - Livingston**

Dear Mr. Lichtblau:

We are in receipt of the Draft Audit Report (Exhibit B) for the above referenced dialysis clinic. We have reviewed the audit findings and are in agreement with the finding. Attached is Fresenius Medical Care check number 007585387 in the amount of \$16,829.15 for services billed to NJ Medicaid, for a beneficiary that was also covered by Medicare. Please apply a portion of this check (\$10,710.30) in repayment for services provided by St. Barnabas – Livingston, [REDACTED]

Correction Action Plan

As recommended by the Office of State Comptroller (OSC) we provide our Correction Action Plan which includes standard processes implemented to review the status of dual-eligible beneficiaries in the State of New Jersey. The process that has been implemented is outlined below:

- All Medicaid primary patients are identified on a worklist in our insurance verification clearinghouse
- Insurance verification is conducted twice per month
- Upon Medicaid notification of Medicare eligibility, Medicare eligibility is verified
- Quarterly review of all patients for insurance eligibility and change in work or home status

Sincerely,

Nancy L. Eddy  
 Director Operations Monitoring

Fresenius Kidney Care, Operation Integrity, 920 Winter Street, Waltham, MA 02451  
 T +1 781-699-4235, F +1 781-466-0665

**Fresenius Medical Center –Kidney  
Treatment Center of New Jersey**



## 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 1, 2016

### VIA CERTIFIED AND ELECTRONIC MAIL

Nancy L. Eddy, MBA, CHC  
Director of Operations Monitoring  
Fresenius Medical Care  
920 Winter Street  
Waltham, MA 02451

RE: Final Audit Report — Fresenius Medical Care d/b/a  
Kidney Treatment Center of New Jersey

Dear Ms. Eddy:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Office of the State Comptroller's Medicaid Fraud Division (OSC) conducted an audit of Fresenius Medical Care d/b/a Kidney Treatment Center of New Jersey (Fresenius KTCNJ). This Final Audit Report includes OSC's findings and your response.

#### Executive Summary

The audit included a review of renal dialysis claims where beneficiaries were dual-eligible under both the Medicaid and Medicare plans. These claims were not paid consistently with the New Jersey Administrative Code (*N.J.A.C.*) 10:52-2.12 (c), which requires renal dialysis services for end stage renal dialysis (ESRD) to be reimbursed by Medicaid or NJ FamilyCare fee-for-service (FFS) only when the individual is a Medicaid or NJ FamilyCare FFS beneficiary and not a Medicare beneficiary.

During this audit, OSC determined that Fresenius KTCNJ was overpaid \$27,903.15 for renal dialysis services. The overpayment resulted from instances where OSC found renal dialysis claims were billed to Medicaid, when these dual-eligible claims should have been billed to Medicare, according to the Medicaid regulations.

### **Background**

Fresenius Medical Care (Fresenius) is the parent organization of Kidney Treatment Center of New Jersey, which provides ESRD services. ESRD occurs when the kidneys are no longer able to function at a level needed for day-to-day life. Renal dialysis services are performed to improve the level of kidney function by filtering waste and fluid from an individual's blood. Fresenius services individuals who have Medicaid, Medicare, employer group health plans, and private insurance.

### **Objective**

The objective of this audit was to determine if Fresenius KTCNJ is appropriately billing Medicaid for renal dialysis services in accordance with Medicaid regulations.

### **Scope**

The scope of this audit entailed a review of Medicaid recipients with Medicare coverage where Medicaid paid for renal dialysis services. The period of our review was from January 1, 2011 through November 25, 2015. The review was conducted under the authority of the *Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq*, and the OSC enabling statute, *N.J.S.A. 52:15C-1, et seq*.

### **Audit Findings**

Pursuant to *N.J.A.C. 10:52-2.12 (c)*, "Renal dialysis services for ESRD and Medicare approved 'add-on' costs shall be reimbursable by Medicaid or NJ FamilyCare fee-for-service only when the individual is a Medicaid or NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable."

OSC identified 99 paid FFS claims totaling \$27,903.15 for renal dialysis services, where the beneficiary had both Medicare and Medicaid coverage. The Medicare beneficiary coverage period began on February 1, 2007, and is still active. Fresenius KTCNJ should have submitted the claims for dialysis services to Medicare instead of Medicaid, since the services fall within the Medicare coverage period.

OSC seeks the recovery of \$27,903.15 from Fresenius KTCNJ for services that should have been billed to Medicare and not to Medicaid in accordance with *N.J.A.C. 10:52-2.12 (c)*.

**Recommendation**

OSC recommended that Fresenius KTCNJ prepare a Corrective Action Plan (CAP) that would be submitted for OSC review and approval. The CAP will specify the processes to be implemented to address the instances where certain dialysis services were billed to New Jersey Medicaid for a beneficiary who was also covered by Medicare.

**Auditee Response**

Fresenius agreed with the audit findings and has paid \$27,903.15 to the Medicaid program. In addition, Fresenius has provided OSC with a CAP that includes a process to review the status of dual-eligible beneficiaries.

Fresenius' response is attached as Appendix A.

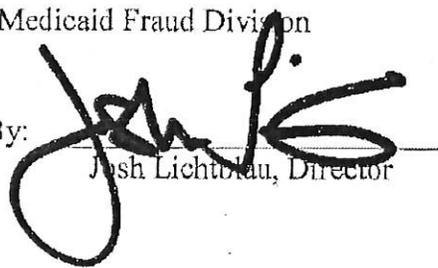
**OSC Response**

Based upon OSC's audit findings, Fresenius KTCNJ has paid the Medicaid program \$27,903.15. In addition, Fresenius has complied with OSC's request for a CAP. The CAP, as outlined in their response (Appendix A), provided a process to check the status of dual-eligible beneficiaries to ensure compliance with *N.J.A.C. 10:52-2.12 (c)*. Based upon Fresenius' payment and submission of an acceptable CAP, no further action is necessary.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:



Josh Lichtblau, Director

Enc.

Cc: Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor



**FRESENIUS  
KIDNEY CARE**

**Operations Integrity**  
920 Winter Street, Waltham, MA 02451  
T +1 781-699-4235 F +1 781-466-0665

*Nancy L. Eddy, MBA, CHC, CHPC*  
*Director Operations Monitoring*

June 21, 2016

Sent Via USPS Overnight Mail

Josh Lichtblau, Director  
State of New Jersey  
Office of the State Comptroller  
Medicaid Fraud Division  
P.O. Box 025  
Trenton, NJ 08625-0025

**RE: Draft Audit Report – Fresenius Medical Care d/b/a Kidney Treatment Center of New Jersey**

Dear Mr. Lichtblau:

We are in receipt of the Draft Audit Report (Exhibit A) for the above referenced dialysis clinic. We have reviewed the audit findings and are in agreement with the finding. Attached is Fresenius Medical Care check number 0007586510 in the amount of \$27,903.15 for services billed to NJ Medicaid, for a beneficiary that was also covered by Medicare. Please apply this full amount to [REDACTED]

Correction Action Plan

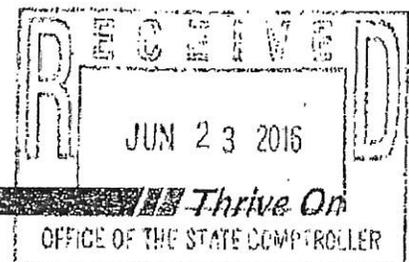
As recommended by the Office of State Comptroller (OSC) we provide our Correction Action Plan which includes standard processes implemented to review the status of dual-eligible beneficiaries in the State of New Jersey. The process that has been implemented is outlined below:

- All Medicaid primary patients are identified on a worklist in our insurance verification clearinghouse
- Insurance verification is conducted twice per month
- Upon Medicaid notification of Medicare eligibility, Medicare eligibility is verified
- Quarterly review of all patients for insurance eligibility and change in work or home status

Sincerely,

Nancy L. Eddy  
Director Operations Monitoring

Fresenius Kidney Care, Operation Integrity, 920 Winter Street, Waltham, MA 02451  
T +1 781-699-4235, F +1 781-466-0665



# **The Family Care Center of Montclair, LLC**



# 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 26, 2016

## VIA CERTIFIED AND ELECTRONIC MAIL

Kimberly-Ellen Pope and  
Joyce Mierzejewski, Co-owners  
The Family Center at Montclair, LLC  
155 Pompton Ave., Suite 106  
Verona, NJ 07044

RE: Final Audit Report – The Family Center at Montclair [REDACTED]

Dear Ms. Pope and Ms. Mierzejewski:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Office of the State Comptroller's Medicaid Fraud Division (OSC) conducted an audit of The Family Center at Montclair, LLC (FCM). This Final Audit Report includes OSC findings and your audit response.

### Executive Summary

The audit entailed a review of FCM's paid claims for psychiatric services and its compliance with Medicaid regulations. During the audit, OSC determined that FCM was overpaid \$28,663. The overpayment is attributable to documentation standards not being met as required for billings in accordance with N.J.A.C. 10:66-2.7(l). OSC found billings that did not have a corresponding progress note associated with the date of service (DOS). In addition, progress notes were incomplete, lacked required signatures, and did not support the type of service billed. OSC also found that there was inadequate documentation to support the payment of claims for the services as defined by the American Medical Association's (AMA), *Current Procedural Terminology Manual*, current procedural terminology (CPT) code 99214.

October 26, 2016

## **Background**

The FCM has been in operation since 2002, providing mental health services to residents of Essex County. FCM treats patients with mental illness and provides a variety of services geared towards the needs of the patients, e.g., assessment and evaluation, individual/group/family therapy, psychiatric evaluations and medication services. These services should be provided in a face-to-face setting with certain time requirements, and billed with the appropriate CPT codes.

## **Objectives**

The objectives of this audit were to determine whether FCM had the proper documentation to support the psychiatric services billed to Medicaid and whether the services billed were performed by the appropriate professionals.

## **Scope**

The scope of the audit was limited to psychiatric claims paid during the period of January 1, 2012 through February 29, 2012. The audit was conducted under the authority of the *Medicaid Program Integrity and Protection Act* (N.J.S.A. 30:4D-53 et seq.) and the enabling statute for the OSC (N.J.S.A. 52:15C-23 et seq.).

## **Audit Findings**

### *Progress Notes*

In accordance with N.J.A.C. 10:66-2.7(l), mental health clinics must meet certain requirements for documentation purposes. "Documentation, at a minimum, shall consist of: specific service(s) rendered, the date and time of service(s) rendered, the duration of service(s) provided and the signature of the practitioner or provider who rendered the service(s)." FCM's progress notes do not include a line item for the time of service(s) rendered. OSC requested the daily therapists' schedules for the 10 days in our sample, in order to verify the date and time the service was rendered.

In addition, OSC's testing included the following: ensuring each billed session had a corresponding progress note, the procedure codes billed by FCM matched the type of service rendered, the duration of the services performed agreed to the daily schedules, and the recipient's file included progress notes that documented they were approved by a licensed professional counselor.

Based upon our review, we noted the following exceptions:

- 141 out of 409 (34 percent) claims did not have documentation that would support the fact the recipient was at the facility on the DOS.

October 26, 2016

- The progress notes for 73 out of 409 (17.8 percent) claims did not indicate the corresponding DOS necessary for billing Medicaid.
- 21 out of 409 (5 percent) claims billed, did not agree with the supporting documentation submitted by FCM for the type of therapy service performed.
- 17 out of 409 (4 percent) claims were not supported by the associated daily schedule for the specific DOS to substantiate the time the service was rendered.
- 14 out of 409 (3 percent) claims were paid when the therapist who signed the progress note did not see the patient (according to the daily schedule).
- Four out of 409 (<1 percent) claims did not have proper documentation to support the duration of the service performed.

Based on these audit findings, OSC seeks the recovery of \$22,115 from FCM. It should be noted that a claim may have been included in one or more of the above audit findings. However, OSC has only included the recovery amount once in our audit findings.

#### *Procedure Code 99214*

In accordance with the AMA *Current Procedural Terminology Manual*, CPT code 99214 is defined as: "Office or other outpatient visit for the evaluation and management of an established patient, which requires at least two of these three key components: a detailed history; a detailed examination; medical decision making of moderate complexity." Documentation to support the billing of this CPT code must include at least two of the three key components as listed in the code descriptor above.

"Medical decision making" refers to the complexity of establishing a diagnosis and/or selecting a management option. Four types of medical decision making are recognized: straightforward, low complexity, moderate complexity, and high complexity. Further explanation of the types of medical decision making, as well as the other key components of an outpatient medical evaluation and management office visit, can be found in the Evaluation and Management (E&M) Services Guidelines section of the CPT manual.<sup>1</sup>

Based on a review of the supporting documentation, OSC noted the following:

- Three out of 11 (27 percent) claims totaling \$214 were paid without the proper documentation to support the services rendered to the recipients.
- Three out of 11 (27 percent) claims totaling \$213 were paid where the DOS did not agree to the submitted documentation.
- Five out of 11 (45 percent) claims totaling \$355 were paid where the documentation submitted for the DOS did not support the billing of CPT code 99214.

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<sup>1</sup> See 2012 *Current Procedural Terminology Evaluation and Management Services Guidelines*, p. 10

October 26, 2016

OSC seeks a recovery of \$427 for six of the 11 sampled claims that were paid without the proper documentation to support the services rendered or the DOS did not agree with the submitted documentation.

For the remaining five claims where the medical record documentation did not support the E&M procedure code billed by the provider, OSC seeks a recovery of \$131. The recovery amount represents the difference between what was paid to the provider for the five claims, and the amount that would have been paid using the correct procedure codes.

As a result of the errors found in the sample, when extrapolated against the population, OSC seeks a recovery of \$6,548 from FCM.

### **Recommendations**

OSC recommended that FCM reimburse the Medicaid program \$28,663 for payments made in which the progress notes did not support the DOS billed, and the documentation submitted for CPT code 99214 did not support the code billed. OSC requested FCM prepare and submit a Corrective Action Plan (CAP) for OSC's review and approval. The CAP should specify that documentation will be maintained in accordance with N.J.A.C. 10:66-2.7(1) and incorporate a policy that reinforces these requirements.

### **Auditee Response**

The Co-owners of FCM responded that "[t]he Family Center at Montclair is in agreement with the findings of inadequate documentation provided by the psychiatrist to support the use of (CPT) code 99214 as well as overpayments attributed to poor record keeping in accordance with N.J.A.C. 10:66-2.7 and emergency day of service scheduling changes. Therefore, The Family Center at Montclair agrees to reimburse the Medicaid program \$28,663. As recommended by the Office of State Comptroller (OSC) the Family Center at Montclair will immediately initiate a Corrective Action Plan."

The full text of FCM's written response is included as an addendum to this report.

### **OSC Response**

OSC appreciates that the owners of FCM agreed to reimburse the Medicaid program \$28,663 and provided a CAP that described the steps they have taken or will take to correct the findings identified in the audit. Based on our review, it appears that FCM's CAP should correct these findings disclosed in the audit. Therefore, no further action is necessary.

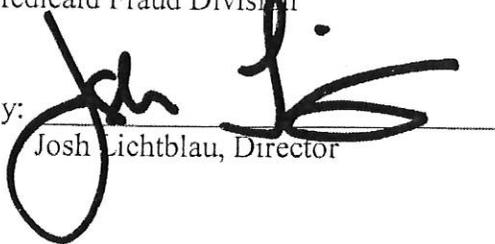
The Family Center at Montclair, LLC

October 26, 2016

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:



Josh Lichtblau, Director

JL/mmm

Enc.

cc: Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor  
Don Catinello, Supervisor Regulatory and Recovery

September 13, 2016

Dotti Henry, MST  
Medicaid Fraud Division- Auditor In Charge  
Office of the State Comptroller  
20 W. State Street, 4th Floor  
P.O. Box 025  
Trenton, NJ 08625  
Telephone 609 826-4854  
E-mail: dorothy.henry@osc.nj.gov

**RE: Final Audit Report- The Family Center at Montclair**

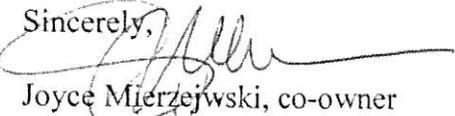
Dear Ms. Henry,

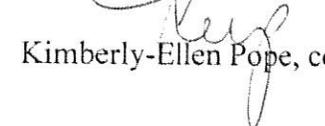
We are in receipt of the Draft Audit Report conducted by the Office of the State Comptroller's Medicaid Fraud Division for the above referenced psychiatric clinic. We have reviewed the audit findings in reference to the 2012 fiscal year. The Family Center at Montclair is in agreement with the findings of inadequate documentation provided by the psychiatrist to support the use of (CPT) code 99214 as well as overpayments attributed to poor record keeping in accordance with N.J.A.C. 10:66-2.7 and emergency day of service schedule changes. Therefore, The Family Center at Montclair agrees to reimburse the Medicaid program \$28,663.

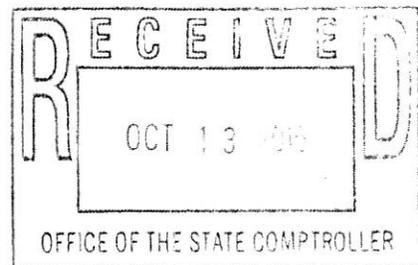
As recommended by the Office of State Comptroller (OSC) The Family Center at Montclair will immediately initiate a Corrective Action Plan, please see attached (Exhibit A).

Should you require any further information, please do not hesitate to contact our facility.

Sincerely,

  
Joyce Mierzejewski, co-owner

  
Kimberly-Ellen Pope, co-owner



# CORRECTIVE ACTION PLAN

## Progress Notes-insufficient documentation

### Data Analysis:

- 34% of claims did not have documentation that would support the fact the recipient was at the facility on the DOS.
- 17.8% claims did not indicate the corresponding DOS necessary for billing Medicaid.
- 5% of claims did not agree with the supporting documentation for the type of therapy service performed.
- 4% of claims were not supported by the daily schedule for the specific DOS to substantiate the time the service was rendered.
- 3% of claims were paid when the therapist who signed the progress note did not see the patient
- <1 % of claims did not have proper documentation to support the duration of the service performed.

### Program Analysis:

Inability to locate record

Inefficient record keeping practices

Progress note template insufficient for therapeutic practice

Inadequate office staff training to comply with emergency schedule changes

### Corrective Action

The Family Center at Montclair (FCM) proposes the following corrective action plan for review:

FCM to implement electronic records system to reduce the risk of misplaced and loose documents.

FCM office staff to undergo intense professional training in record keeping. Each of the office staff members will be sent to no less than (3) workshops a year on HIPPA compliance, confidential record keeping and computer skills. This action is to help insure the importance of documentation, sign in sheet, confidentiality, record keeping and confidentiality.

The FCM revised the current progress note template (see attached) to include time duration as well as the progress note policy. This is to be in compliance with the time in and time out policy.

The FCM has implemented a plan to change both the master schedule as well as the therapist schedule to reflect emergency changes. Should an emergency arise, office staff is instructed to document and initial all day of schedule changes. FCM progress notes were signed by therapist of who did not see the patient (according to the daily schedule) due to day of schedule changes and emergency screenings.

**Implementation and Monitoring:**

Corrective Action	Status	Target Implementation Date	Responsible Party	Effectiveness Monitoring
Electronic Records/ Supervisor document monitoring	Pricing a more cost effective EMR system/ Supervisor document monitoring complete	12/01/2016	[REDACTED]	Chart review every 4 months
Revised Progress note	Complete	Complete	[REDACTED]	To be reviewed by the OSC and DHMH
Office Staff Training	Searching for weekend workshops/ classes	12/01/2016	[REDACTED]	Review of daily schedule on a consistent basis

**Inappropriate use of CPT code 22914**

**Data Analysis:**

- 27% of claims were paid without the proper documentation to support services rendered.
- 27% of claims were paid where the DOS did not agree to the submitted documentation.
- 45 % claims were paid where the documentation Submitted by the psychiatrist for the DOS did not support the billing of CPT code 99214.

**Program Analysis:**

Psychiatrist did not exhibit documentation to support the use of code 99214 to be in accordance with the American Medical Association’s (AMA), *Current Procedural Terminology (CPT) Manual*.

**Corrective Action:**

Upon further review, the psychiatrist shall immediately stop all use of CPT code 99214 as to be in accordance with the American Medical Association’s documentation

requirements. The FCM is currently working with the division of human services to find a more appropriate code to adhere to both the American Medical Association as well as the documentation requirements of The American Psychiatric Association.

Corrective Action	Status	Target Implementation Date	Responsible Party	Effectiveness Monitoring
Psychiatrist to terminate use of CPT code 99214	Complete	Complete	[REDACTED]	Weekly Billing sheet review
Schedule meeting with the Division of Human Services to find appropriate	Waiting for call back from division of human services	12/01/2016	[REDACTED] [REDACTED] [REDACTED]	Weekly phone call
New Psychiatrist	Begin search for a new psychiatrist of whom is more familiar with AMA/ APA documentation guidelines	11/01/2016	[REDACTED] [REDACTED] [REDACTED]	Daily call to agency to inquire about psychiatrist availability

# THE FAMILY CENTER AT MONTCLAIR

## POLICY

**TITLE:** CHARTING OF PROGRESS NOTES

**CODE:** 5004

**EFFECTIVE DATE:** 9/24/16

### I. POLICY

Every patient will have a record of each therapy session that will provide accurate documentation of progress or lack of progress that will reflect

- A. A chronological picture of the patient's clinical course
- B. The services provided to the patient
- C. Implementation of the treatment plan

### II. Procedure

Progress notes must be documented for each client contact and are to be written in SOAP format. They should include:

- 1. Patient's name
  - 2. Date of service
  - 3. Type of service
  - 4. Start time and finish time of session
  - 5. Total minutes of the session
  - 6. Diagnosis
  - 7. Objective to be addressed in the session
  - 8. Mental status
  - 9. Assessment of patient's progress toward objective
  - 10. Medications
  - 11. Follow up plan or changes in treatment
  - 12. Signature and credentials of clinician
- A. All notes signed by MA intern or LAC will also be signed by a Clinical Supervisor who has the credentials LPC and ACS.
  - B. To correct errors on permanent charting, a line will be drawn through the error. "Error" will be written and initialed and dated by the clinician.
  - C. All progress notes should be entered on a daily basis and given to the Clinical Supervisor to QA.
  - D. All progress notes should be neatly written and legible in blue or black ink.

THE FAMILY CENTER AT MONTCLAIR

PROGRESS NOTE

DATE: \_\_\_\_\_ CLIENT \_\_\_\_\_

DIAGNOSIS: \_\_\_\_\_ OUTPATIENT SERVICES

MODALITY: GROUP PSYCHOTHERAPY INDIVIDUAL PSYCHOTHERAPY FAMILY PSYCHOTHERAPY

TIME IN \_\_\_\_\_ TIME OUT \_\_\_\_\_ TOTAL MIN. \_\_\_\_\_

OBJECTIVE: TO IMPROVE SELF ESTEEM IMPROVE ANGER MANAGEMENT IMPROVE ATTENTION  
TO EXPLORE FEELINGS OF DEPRESSION OTHER: \_\_\_\_\_

S: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MENTAL STATUS:**

APPEARANCE	MOOD	ATTITUDE	AFFECT	SPEECH	MOTOR ACTIVITY
well kept	normal	cooperative	appropriate	normal	relaxed and calm
unkept	depressed	friendly	labile	slow	restless
unusual	anxious	exaggerated	expansive	detailed	agitated
bizarre		guarded	constricted	pressured	tense
		minimizes	flat	incoherent	tremors
		suspicious		slurred	tics
		hostile			
		uncooperative			

ORIENTATION: person time place completely disoriented

RISK TO SELF: YES NO RISK TO OTHERS: YES NO

HALLUCINATIONS: YES NO KIND \_\_\_\_\_

MEDICATION: \_\_\_\_\_

A: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

PLAN: \_\_\_\_\_

THERAPIST \_\_\_\_\_ Supervisor \_\_\_\_\_

**Khalid Sawaged, D.O.**

# 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*

December 2, 2016

## BY CERTIFIED AND ELECTRONIC MAIL

Khalid Sawaged, D.O.  
671 Mount Prospect Ave.  
Newark, NJ 07104

RE: Final Audit Report – Khalid Sawaged, DO (Medicaid-2015-00154)

Dear Dr. Sawaged:

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 (MFD) conducted an audit of claims submitted under your Medicaid Provider Identification [REDACTED] covering the period from July 6, 2011 to July 11, 2016. This Final Audit Report (FAR) includes OSC's findings and your response.

### Executive Summary

This audit entailed the review of anomalous claim billings, where Comprehensive Preventive Medicine Evaluation and Management services and Preventive Counseling Services were billed separately on the same day for the same recipients. These billings are not consistent with guidelines established by 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 uses the Centers for Medicare and Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS), which follows the AMA's CPT guidelines.

During this audit, MFD determined that you were overpaid for Counseling and Comprehensive Services for which MFD requests reimbursement of \$43,583.78 for 1,192 claims improperly billed and paid. According to the relevant CPT guidelines, you billed for providing Preventive Counseling Services in addition to Comprehensive Preventive Medicine Evaluation and

Management (E/M) services for the same recipients on the same day. These services should have been billed together in a bundled manner when seeking payment from the Medicaid/NJFC program. As a result, you were overpaid for the separately billed services.

### **Background**

The AMA's CPT code guidelines designate service codes 99381 through 99429 for the billing of Comprehensive Preventive Medicine Services Evaluation and Management (E/M). Proper service codes for Preventive Medicine Services for 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 should be billed together in a bundled manner when the service is provided to the same recipient on the same day.

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, requires adherence to applicable New Jersey (NJ) laws and regulations which include adherence to the AMA's standards, including billing and coding, referenced in NJ regulations and used during this audit.

The MFD's Data Mining Unit (DMU) uses a variety of analytical tools and data mining techniques to identify providers for audits. The DMU looks for unusual patterns or anomalies in claim reimbursement to providers and refers cases to the MFD's Audit or Investigations Units for further analysis. Once the anomalies are identified, Audit will determine whether an overpayment was made.

Khalid Sawaged, D.O., (Dr. Sawaged) was referred to the Audit Unit for review. The referral was the result of a data analytic review performed by the DMU to determine whether, in contravention of the AMA CPT guidelines, Dr. Sawaged improperly billed and received payments for both Preventive Comprehensive Medicine E/M Service codes and Preventive Counseling Service codes for services performed on the same day to the same recipients. Dr. Sawaged enrolled in the Medicaid/NJFC program and became a Medicaid provider effective June 1, 1998.

### **Objective**

The objective of the audit was to evaluate claims billed by Dr. Sawaged to determine compliance with State and Federal Regulations. The audit was conducted under the guidelines established by the AMA CPT code guidelines.

### **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 July 6, 2011 through July 11, 2016.

The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A.30:4D-53 et seq. and 52:15C-23.

### **Audit Findings**

#### **Incorrect Billing of CPT Codes**

MFD identified 1,192 claims totaling \$43,583.78 for Preventive Counseling Services, CPT code 99402 that were unbundled and billed separately in addition to Preventive Medicine E/M, CPT codes 99384 through 99387 and 99394 through 99397 for the same recipients, on the same day.

Pursuant to the AMA's CPT code guidelines, 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 should not be billed individually. Consequently, Dr. Sawaged was overpaid \$43,583.78.

### **Recommendations**

MFD recommends that Dr. Sawaged reimburse Medicaid/NJFC a total of \$43,583.78 for Preventive Counseling Services that were not billed in accordance with AMA guidelines. Also, MFD recommends that Dr. Sawaged provide training to his staff or guidance to its outside billing contractor to foster continued compliance with regulations. In addition, Dr. Sawaged should stay current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.

### **Dr. Sawaged Response**

"I am in receipt of the audit findings and I am not in disagreement. The funds that were inadvertently overpaid will be refunded and the appropriate steps have been taken as per your recommendations. The billing company has been advised and the coding and billing guidelines put out by the AMA have been reviewed. We will stay current with these guidelines and consult with the insurance companies from time to time as needed."

Dr. Sawaged's response is included as Appendix A.

### **OSC Comments**

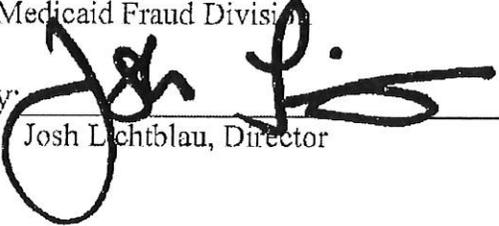
In his response, Dr. Sawaged agreed with the MFD's audit findings and recommendations. Based upon Dr. Sawaged's agreement to reimburse Medicaid/NJFC \$43,583.78 and the steps he has taken to implement the audit's recommendations, no further action is necessary.

Khalid Sawaged, D.O.  
December 2, 2016

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:

  
\_\_\_\_\_  
Josh Lichtblau, Director

JL/mmm

Enc.

cc: Kay Ehrenkrantz, Deputy Director  
Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor

Office of the New Jersey State Comptroller  
Medicaid Fraud Division  
Email Response From Dr. Khalid Sawaged – Dated November 16, 2016  
MFD2015-00154

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-----Original Message-----

From: Khalid And Nancy [mailto: [REDACTED]]  
Sent: Wednesday, November 16, 2016 3:47 PM  
To: Malik, Mohammad < [REDACTED] >  
Subject: Re: Dr. Sawaged

Please use the following.

I am in receipt of the audit findings and I am not in disagreement. The funds that were inadvertently overpaid will be refunded and the appropriate steps have been taken as per your recommendations. The billing company has been advised and the coding and billing guidelines put out by the AMA have been reviewed. We will stay current with these guidelines and consult with the insurance companies from time to time as needed.

Thank you.

**SarahCare at Watchung Square, LLC**



# 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*

December 9, 2016

## VIA CERTIFIED AND ELECTRONIC MAIL

Dr. Juan Grana  
President and Executive Director  
SarahCare at Watchung Square, LLC  
103 RT 22 East  
North Plainfield, NJ 07060

RE: Final Audit Report – SarahCare at Watchung Square, LLC (MFD-2015-00938)

Dear Dr. Grana:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD) conducted an audit of claims submitted under SarahCare at Watchung Square, LLC (SarahCare) Medicaid Provider Identification No. [REDACTED] covering the period from July 1, 2011 to August 4, 2016. This Final Audit Report includes MFD's findings and your audit response.

### Executive Summary

The audit entailed a review of anomalous claims, where Adult Day Health Services were billed and paid as both fee for service (FFS) and encounter (ENC) claims. Pursuant to the New Jersey Administrative Code (N.J.A.C.) 10:54-9.1, the New Jersey Medicaid program utilizes the Health Care Financing Administration's Common Procedure Coding System (HCPCS), which follows the American Medical Association's (AMA) Physician's Current Procedural Terminology (CPT) code guidelines.

During this audit, MFD determined that SarahCare was overpaid for 129 Adult Day Health Services claims totaling \$10,126.50; thus, MFD is seeking a recovery of \$10,126.50 from SarahCare. This overpayment is attributed to instances where SarahCare billed and claims were paid for Adult Day Health Services as both FFS and ENC, for the same recipient, on the same day,

which means that in those instances, SarahCare was paid for the same claim twice. Some Medicaid recipients are served through a FFS system where health care providers are paid for each service (i.e. office visit, test, or procedure) by Medicaid. When a Medicaid recipient is enrolled in an MCO and has a face-to-face visit (encounter) with a provider, the provider is paid by the MCO for the service(s).

### **Background**

SarahCare is an adult day care facility that provides social services and programs for seniors. In addition, SarahCare provides in-home care that includes medical and non-medical support services. Pursuant to N.J.A.C. 10:164-1.1 "Adult Day Health Services is a program that provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living."

The MFD's Data Mining Unit (DMU) uses a variety of analytical tools and data mining techniques to identify providers for audits. The DMU looks for unusual patterns or anomalies in claim reimbursement to providers and refers cases to the MFD's Audit or Investigations Units for further analysis. Once the anomalies are identified, Audit will determine whether an overpayment was made.

SarahCare was referred to the Audit Unit for review. The referral was the result of a data analytic review performed by the DMU to determine whether SarahCare improperly billed and received payments for claims as both FFS and ENC for the same recipients and services on the same dates of service.

### **Objective**

The objective of this audit was to evaluate claims billed by SarahCare to determine compliance with State and Federal regulations. The audit was conducted under the guidelines established by the AMA's CPT code guidelines.

### **Scope**

The scope of this audit entailed a review, discussion and evaluation of billings for claims where HCPCS code S5102, Adult Day Health Services were paid as both FFS and ENC for the same services. The audit period was July 1, 2011 through August 4, 2016. The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq. and 52:15C-23.

### **Audit Findings**

#### **Duplicate Billing of HCPCS Code**

MFD identified 129 claims totaling \$10,126.50 for Adult Day Health Services that were billed and paid as both FFS and ENC, with dates ranging from October 3, 2011 to April 13, 2012. Pursuant to N.J.A.C. 10:164-1.6, "The facility providing adult day health services shall agree to accept the reimbursement rates established by the Department [State of New Jersey Department of Human Services] as the total reimbursement for services provided to eligible Medicaid beneficiaries." A facility is not permitted to bill and receive payment for FFS and ENC claims for the same service, for the same recipient, on the same date of service.

#### **Recommendations**

MFD recommended that SarahCare:

1. Reimburse Medicaid a total of \$10,126.50 for Adult Day Health Services for duplicate claim payments that were billed for the same services and paid as both FFS and ENC claims.
2. Reconcile payments received to claims billed and reimburse the Medicaid program for any overpayments that may be attributable to claims submitted as both FFS and ENC for the same recipients on the same dates of service.
3. Stay current with applicable CPT and billing guidance and update its billing policies and practices to meet current regulatory requirements.

#### **SarahCare Response**

SarahCare's Administrator responded that he "agree[s] with the findings and will be reimbursing Medicaid the funds overpaid." To address Recommendations 2 and 3, the Administrator stated that SarahCare "has since installed a very thorough system where every single penny is accounted for."

#### **MFD Response**

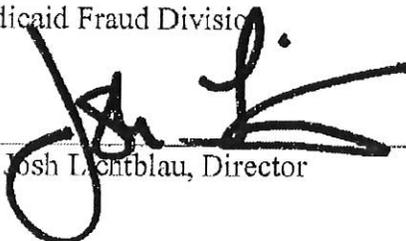
MFD appreciates that SarahCare has agreed to reimburse the Medicaid program \$10,126.50 for duplicate payments that were billed for the same services and paid as a FFS and as an ENC claim. Although SarahCare's Administrator advised MFD that SarahCare installed a "very thorough system", he did not include a Corrective Action Plan to address how SarahCare would implement each recommendation to ensure that the audit issues would be corrected. Accordingly, MFD suggests that SarahCare implement specific policies and procedures to address Recommendations 2 and 3.

SarahCare at Watchung Square, LLC  
MFD-2015-00938  
December 9, 2016

The full text of SarahCare's written response is included as an addendum to this report.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By: 

Josh L. Chtblau, Director

JL/mmm

Enc.

cc: Kay Ehrenkrantz, Deputy Director  
Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor

Addendum

# *SarahCare*<sup>®</sup>

*Adult Day Care Services*

130 Route 22 East  
North Plainfield, NJ 07060  
Phone (908) 561-8888  
Fax (908) 222-3481  
[www.SarahCareWS.com](http://www.SarahCareWS.com)

November 23, 2016

Mr. Michael Morgese  
Audit Supervisor  
Medicaid Fraud Division

Re: Draft Audit Report Response  
SarahCare @ Watchung Square MFD-2015-00938

Dear Mr. Morgese and staff,

I have read the Draft Audit Report. I agree with the findings and will be reimbursing Medicaid the funds overpaid SarahCare.

In explanation of this occurrence, I would like to point out that SarahCare was audited from July, 2011 to August 2016 and this was the only instance of an error. This period covers several thousand claims over those 5 years.

At the time, Medicaid was switching to an HMO system and there was a lot of confusion. Making the confusion worse was when there was a dual eligible under the same HMO, as was in this case. Also, this particular person we had billed for, did not start with her HMO until months after the July date. We were billing Medicaid directly for several weeks until we did the monthly check on the Molina website and realized we should not have been charging Medicaid, we should have been charging UHC.

We started doing that and most of our claims were rejected, bounced back, underpaid or denied. We sent a large batch that had not been paid to Medicaid. When we received the Medicaid payment, there was an error in logging that payment and attributing it to the correct person, so it went unnoticed.

We have since installed a very thorough system where every single penny is accounted for. As you can tell by the audit, our system is working very well now, since this was the only error.

Please let me know who to write the check to and where to mail it. I would like to do that as soon as possible as well as send my apologies to you, your staff, Medicaid and the State of NJ for this mistake.

Please let me know how to proceed. Thank you

Juan Grana  
Administrator  
SarahCare Adult Medical Day Care

# **Metropolitan Family Health Network**



## State of New Jersey

**CHRIS CHRISTIE**  
*Governor*

**KIM GUADAGNO**  
*Lt. Governor*

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MEDICAID FRAUD DIVISION  
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**PHILIP JAMES DEGNAN**  
*State Comptroller*

**JOSH LICHTBLAU**  
*Director*

December 12, 2016

VIA CERTIFIED AND ELECTRONIC MAIL

Mr. Scott Carey  
Chief Operating Officer  
Metropolitan Family Health Network  
935 Garfield Ave.  
Jersey City, NJ 07304

RE: Final Audit Report – Metropolitan Family Health Network

Dear Mr. Carey:

The New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), conducted an audit of Metropolitan Family Health Network (MFHN) covering the period July 1, 2014 through December 31, 2014. OSC selected MFHN for a limited scope review to determine whether MFHN received proper Medicaid wrap-around payments for services rendered. This final audit report includes OSC's findings and MFHN's response.

### Executive Summary

As part of its oversight of the Medicaid and New Jersey FamilyCare (Medicaid/NJFC) programs, OSC conducted a limited scope audit of MFHN that focused on the reconciliation of "wrap-around" payments made to MFHN. In order for a Federally Qualified Health Center (FQHC) to be reimbursed for services rendered, the FQHC first seeks payment from the appropriate Managed Care Organization (MCO). Based on the level of coverage, the MCO may pay the FQHC all, a portion or none of the claim. If the MCO reimbursement is less than the total amount of the encounter claim, the FQHC will then submit a claim for the balance due to the Medicaid program, which will then make a supplemental payment (wrap-around) to the FQHC for the difference. As part of this audit, OSC confirmed with the MCOs whether MFHN received payments for the encounter claims that correlate with information on MFHN's quarterly wrap-around reports. Using this approach, OSC determined that MFHN was overpaid for 83 encounter claims totaling \$11,796.79. This overpayment is attributed to instances where MFHN's wrap-

around reports did not reconcile with reports that MFHN submitted to the MCOs or to reports indicating that the MCOs denied payments.

### **Background**

FQHC services are provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists and clinical social workers in accordance with State and Federal regulations. FQHCs operate in underserved communities, servicing individuals who have Medicaid, Medicare, private insurance, or no health insurance. FQHCs must provide services regardless of a patient's ability to pay or health insurance status.

Under federal Medicaid law, based initially on the Medicare payment system, FQHCs are guaranteed a specific reimbursement amount for every Medicaid recipient encounter billed. A billable claim occurs when a patient visits an FQHC, has face-to-face contact with a qualified practitioner and receives medically necessary services. FQHCs receive reimbursement for billable claims either solely on a fee-for-service (FFS) basis directly from the Medicaid program, the Division of Medical Assistance and Health Services (DMAHS), or, as in the majority of cases, jointly on a managed care (Encounter) and Medicaid/NJFC basis. FFS payments occur when a Medicaid recipient prior to enrollment in an MCO receives a medically necessary service from a FQHC or for particular services that DMAHS has carved out of MCO contracts for payment as FFS services. For Medicaid recipients who are enrolled in an MCO, the FQHC bills the MCO for the encounter. Based on the level of coverage, the MCO may pay the FQHC all, a portion, or none of the encounter claim. When an MCO pays the FQHC for a portion of an encounter claim, the FQHC is entitled to submit the remaining portion of the claim (wrap-around) to the Medicaid/NJFC program for payment. In such cases, the Medicaid/NJFC program will make a supplemental payment to the FQHC to make up the difference.

FQHCs are required to submit quarterly wrap-around reports to the Medicaid/NJFC program in order to receive supplemental payments for MCO encounter claims. This quarterly report documents the number of MCO encounters multiplied by the reimbursement rate per encounter, less the payments received by an FQHC from an MCO for each encounter, during the quarter. Overpayments to an FQHC may occur when the FQHC submits overstated numbers of MCO encounters, understated MCO payments, or both.

MFHN is an FQHC provider located in Jersey City, New Jersey. MFHN enrolled in the Medicaid/NJFC program effective September 1, 2006.

### **Objective**

The objective of this limited scope audit was to determine whether MFHN's quarterly wrap-around reports were supported by the appropriate documentation. The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D et seq. and 52:15C-23.

## **Scope**

The scope of this desk audit entailed a limited review and reconciliation of MFHN's quarterly wrap-around reports to corresponding MCO information for the period beginning July 1, 2014 through December 31, 2014.

## **Audit Methodology**

The audit methodology entailed the reconciliation of the quarterly wrap-around reports MFHN submitted to Medicaid/NJFC to the documentation MFHN submitted to the MCOs for the period audited.

## **Audit Finding**

### **Wrap-Around Encounter Reconciliation**

OSC's review revealed that MFHN's wrap-around reports did not reconcile with the MCO documentation as follows:

1. OSC identified 43 encounters with payments totaling \$6,111.59 that were reported to Medicaid/NJFC on quarterly wrap-around reports that were not indicated on the encounter data that MFHN submitted to the MCOs. Consequently, OSC seeks to recover the overpayment totaling \$6,111.59.
2. OSC identified 40 encounters with payments totaling \$5,685.20 that were reported to Medicaid/NJFC on quarterly wrap-around reports for payment by DMAHS that were denied by the MCOs without question by the FQHC and not identified as denied to DMAHS. Consequently, OSC seeks to recover the overpayment totaling \$5,685.20.

Overall, OSC seeks the recovery of \$11,796.79 for 83 encounters that were reported inappropriately on wrap-around reports.

## **Recommendations**

OSC recommends that MFHN reimburse Medicaid/NJFC a total of \$11,796.79. Also, OSC recommends that MFHN strengthen its internal controls over the review of encounter data submitted to the MCOs by reconciling encounter data submitted to the MCOs with encounter data submitted to the Medicaid/NJFC and by advising Medicaid/NJFC of any errors in subsequent quarterly submissions. Additionally, OSC recommends that MFHN should reinforce the requirements of wrap-around reporting by training its employees in this facet of MFHN's operations.

### MFHN Response

MFHN's Chief Operating Officer (COO) submitted a response, which included a corrective action plan (CAP). As part of its CAP, MFHN took issue with OSC's finding regarding referenced Horizon NJ Health claims. Specifically, MFHN stated that "[d]espite the fact that the Horizon NJ Health claims are capitated and should not be included in this calculation (19 out of 83), MFHN will reimburse Medicaid/NJFC the amount due \$11,796.79." MFHN's CAP also outlined a process for improving internal controls over reporting wrap-around payments and a plan for training those employees responsible for these activities.

The full text of MFHN's response is included as an Attachment to this report.

### OSC Response

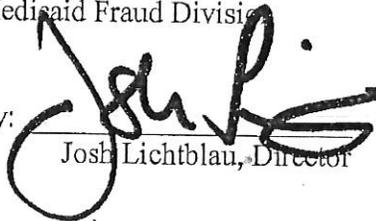
Although MFHN agreed to reimburse the Medicaid Program \$11,796.79, it claimed that the Horizon NJ Health claims should not be included in the calculation because Horizon's claims are capitated. MFHN's position is incorrect. OSC's analysis was based upon a post-payment review of the quarterly wrap-around reports, which only included the MCO encounter claims that MFHN reported to the State and for which MFHN subsequently received supplemental wrap-around payments from the Medicaid/NJFC program in excess of the federally determined payment amount. Therefore, OSC maintains its finding that MFHN misreported the 83 encounters, including the 19 Horizon NJ Health encounters, on the quarterly wrap-around reports and improperly received an overpayment of \$11,796.79. Notwithstanding that issue, MFHN has agreed to fully reimburse the Medicaid/NJFC program for the overpayment MFHN received.

In sum, MFHN provided a CAP that outlined processes to strengthen its review of encounter data submitted to the MCOs and to provide staff additional training regarding the requirements of wrap-around reporting. In addition, based upon MFHN's agreement to reimburse the Medicaid/NJFC program for the full amount identified in this audit and to initiate steps to improve the wrap-around reporting process, OSC believes that no further action is necessary.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:



Josh Lichtblau, Director

### Attachment

Cc: Kay Ehrenkrantz, Deputy Director  
Michael Mc Coy, Manager – Fiscal Integrity  
Michael Morgese, Audit Supervisor  
Glenn Geib, Supervisor, Recovery

NJ Office of the State Comptroller - Medicaid Fraud Division  
 Wrap-around Encounter Reconciliation Summary  
 For the Audit Period: July 1, 2014 through December 31, 2014

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**1 Encounters not Reconciled**

Managed Care Organization	3Q2014	4Q2014	TOTAL
HealthFirst	2		
Horizon NJ Health	9	2	
UnitedHealth Care	18	11	
Scion	1		
<b>Total Encounters</b>	<b>30</b>	<b>13</b>	<b>43</b>
PPS Rate	\$142.13	\$142.13	
<b>Total Recovery (Total Enc. X PPS rate)</b>	<b>\$4,263.90</b>	<b>\$1,847.69</b>	<b>\$6,111.59</b>

**2 Encounters Denied**

Managed Care Organization	3Q2014	4Q2014	TOTAL
Amerigroup	1	1	
Horizon NJ Health	1	7	
UnitedHealth Care	1	20	
Scion	5	4	
<b>Total Encounters</b>	<b>8</b>	<b>32</b>	<b>40</b>
PPS Rate	\$142.13	\$142.13	
<b>Total Recovery (Total Enc. X PPS rate)</b>	<b>\$1,137.04</b>	<b>\$4,548.16</b>	<b>\$5,685.20</b>

<b>TOTAL ENCOUNTERS</b>	<b>83</b>
<b>TOTAL RECOVERY</b>	<b>\$11,796.79</b>



METROPOLITAN  
FAMILY HEALTH  
NETWORK, INC.  
CORPORATE OFFICE

September 16, 2016

BY CERTIFIED MAIL

State of New Jersey  
Office Of The State Comptroller  
Medicaid Fraud Division  
P.O. Box 025  
Trenton, NJ 08625-0025  
Attn: Michael M. Morgese, Audit Supervisor

Re: Draft Audit Report - Metropolitan Family Health Network (Provider ID# [REDACTED])

Dear Mr. Morgese:

The enclosed Corrective Action Plan is being submitted in response to your Draft Audit Report letter dated 8/31/16 and the recommendations contained in the letter.

The recommended reimbursement to Medicaid/NJFC totaling \$11,796.79 will be submitted separately.

If you have questions about the corrective action plan or reimbursement, please feel free to contact me at 201-478-5829.

Thank you for your help.

Sincerely,

  
Scott Carey, C.O.P.

cc: J. Dublin, CEO  
P. Beaty, CMO  
I. Rothblut, CPA

935 Garfield Avenue • Jersey City, NJ 07304

RECEIVED		Page 1 of 1
SEP 22 2016		
P: (201) 478-5877		F: (201) 478-5814
OFFICE OF THE STATE COMPTROLLER		

Metropolitan Family Health Network, Inc.  
 Corrective Action Response Work Plan

Issue/Requirement	NJ OSC Recommendation(s)	Response/Action Plan	Responsible Individual(s)	Time Frame
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Wrap-Around Encounter Reconciliation	<p>1) OSC recommends that MFHN reimburse Medicaid/NJFC a total of \$11,796.79.</p> <p>2) MFHN needs to strengthen its internal controls over the review of encounter data submitted to the MCOs</p>	<p>1) Despite the fact that the Horizon NJ Health claims are capitated and should not be included in this calculation (19 out of 83): MFHN will reimburse Medicaid/NJFC the amount due \$11,796.79.</p> <p>2) Internal control on data submitted to the MCOs will be strengthened by conducting quarterly audits on a sample basis to verify the encounter data submitted to MCO's. From these sample audits we will conduct training and provide additional logic in our IT system to prevent additional errors in data</p>	CFO	10/2016  On going
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**Metropolitan Family Health Network, Inc.  
Corrective Action Response Work Plan**

Issue/Requirement	NJ OSC Recommendation(s)	Response/Action Plan	Responsible Individual(s)	Time Frame
	<p>3) MFHN should reinforce the requirements of wrap-around reporting by training its employees in this facet of MFHN's operations.</p>	<p>3) Front Desk/registration personnel will be trained to reinforce the importance of proper collection of patient demographic information especially in the area of insurance verification. Insurance verification will be given extra consideration in the daily processing of patient scheduling. Additionally, Metropolitan has recently hired a new front desk supervisor (registration) well versed in New Jersey reimbursement to conduct additional training.</p>	<p>Front Desk/Billing Manager</p>	<p>On going</p>

**Adultcare Inc.**



# 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*

December 15, 2016

## VIA CERTIFIED AND ELECTRONIC MAIL

Ms. Iris Negron  
Administrator  
Adultcare, Inc.  
1607 Manhattan Ave.  
Union City, NJ 07087

RE: Final Audit Report – Adultcare, Inc. (MFD-2015-00936)

Dear Ms. Negron:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD) conducted an audit of claims submitted under Adultcare, Inc. (Adultcare) Medicaid Provider Identification No. [REDACTED] covering the period from July 1, 2011 to August 4, 2016. This Final Audit Report includes MFD's findings and Adultcare's audit response.

### Executive Summary

The audit entailed a review of anomalous claims, where Adult Day Health Services were billed and paid as both fee for service (FFS) and encounter (ENC) claims. Pursuant to the New Jersey Administrative Code (N.J.A.C.) 10:54-9.1, the New Jersey Medicaid program uses the Health Care Financing Administration's Common Procedure Coding System (HCPCS), which follows the American Medical Association's (AMA) Physician's Current Procedural Terminology (CPT) code guidelines.

Through this audit MFD determined that Adultcare was overpaid for 107 Adult Day Health Services claims totaling \$8,399.50; thus, MFD is seeking a recovery of \$8,399.50 from Adultcare. This overpayment is attributed to instances where Adultcare improperly billed and Medicaid paid claims for Adult Day Health Services as both FFS and ENC, for the same recipient, on the same day which means that in those instances, Adultcare was paid twice for the same claim. Some

Medicaid recipients are served through a FFS system where health care providers are paid for each service (i.e. office visit, test, or procedure) by Medicaid. However, when a Medicaid recipient is enrolled in a managed care organization (MCO) and has a face-to-face visit (encounter) with a provider, the provider is paid by the MCO for the service(s).

### **Background**

Adultcare is an adult day care facility that provides social services and programs for seniors. In addition, Adultcare provides in-home care that includes medical and non-medical support services. Pursuant to N.J.A.C. 10:164-1.1 "Adult Day Health Services is a program that provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living."

The MFD's Data Mining Unit (DMU) uses a variety of analytical tools and data mining techniques to identify providers for audits. The DMU looks for unusual patterns or anomalies in claim reimbursement to providers and refers cases to the MFD's Audit or Investigations Units for further analysis. Once the anomalies are identified, Audit will determine whether an overpayment was made.

Adultcare was referred to the Audit Unit for review. The referral was the result of a data analytic review performed by the DMU to determine whether Adultcare improperly billed and received payments for ENC and FFS claims for the same recipients and services on the same dates of service.

### **Objective**

The objective of this audit was to evaluate claims billed by Adultcare to determine compliance with State and Federal regulations. The audit was conducted under the guidelines established by the American Medical Association's Current Procedural Terminology code guidelines.

### **Scope**

The scope of this audit entailed a review, discussion and evaluation of billings for claims where HCPCS code S5102, Adult Day Health Services were paid as both FFS and ENC for the same services. The audit period was July 1, 2011 through August 4, 2016. The audit was conducted under the authority of the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq. and 52:15C-23.

## **Audit Findings**

### **Duplicate Billing of HCPCS Code**

MFD identified 107 claims totaling \$8,399.50 for Adult Day Health Services that were billed and paid as both FFS and ENC, with dates ranging from July 1, 2011 to October 11, 2011. Pursuant to N.J.A.C. 10:164-1.6, "The facility providing adult day health services shall agree to accept the Reimbursement rates established by the Department [State of New Jersey Department of Human Services] as the total reimbursement for services provided to eligible Medicaid beneficiaries." A facility is not permitted to bill and receive payment for FFS and ENC claims for the same service, for the same recipient, on the same date of service.

### **Recommendations**

MFD recommended that Adultcare:

1. Reimburse Medicaid a total of \$8,399.50 for Adult Day Health Services for duplicate claim payments that were billed for the same services and paid as both FFS and ENC claims.
2. Reconcile payments received to claims billed and reimburse the Medicaid program for any overpayments that may be attributable to claims submitted as both FFS and ENC for the same recipients on the same dates of service.
3. Stay current with applicable CPT and billing guidance and update its billing policies and practices to meet current regulatory requirements.

### **Adultcare Response**

On behalf of Adultcare, Robert J. Fogg, Esquire, responded that "Adultcare has reconciled its billing records for the audit period, and my client has confirmed the 107 billing errors that were identified through your recent claims review did occur. . . . Per your recommendations, Adult care agrees to send a check to your office to reimburse the Office of the [State] Comptroller for these billing errors in the amount of \$8399.50 in full satisfaction of these claims." As part of this response, Adultcare added that it "...has reconciled its accounts and has not identified any further billing errors from this period. Adultcare has also revised its billing procedures since 2011 to ensure that all claims filed are verified by at least two parties that the client was present, received five hours of services, that services were documented properly, and that services were authorized."

The full text of Adultcare's written response is included as an addendum to this report.

Adultcare, Inc.  
MFD-2015-00936  
December 15, 2016

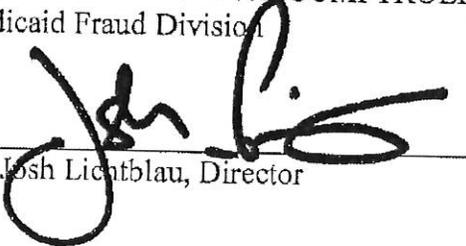
**MFD Response**

MFD appreciates that Adultcare has agreed to reimburse the Medicaid program \$8,399.50 for duplicate payments that were billed for the same services and paid as a FFS and as an ENC claim. Although Adultcare's attorney advised MFD that there were no further billing errors and revised billing procedures were put in place, a formal Corrective Action Plan was not provided to address how Adultcare would implement each recommendation. Accordingly, MFD suggests that Adultcare implement specific policies and procedures to address Recommendations 2 and 3.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:

  
Josh Lichtblau, Director

JL/mmm

Enc.

cc: Kay Ehrenkrantz, Deputy Director  
Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor  
Glenn Geib, Recovery Supervisor

ADDENDUM



Robert J. Fogg  
Member of New Jersey  
and Pennsylvania Bars  
rfogg@archerlaw.com  
609-580-3702 Direct  
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Archer & Greiner, P.C.  
101 Carnegie Center, Suite 300  
Princeton, NJ 08540  
609-580-3700 Main  
609-580-0051 Fax  
[www.archerlaw.com](http://www.archerlaw.com)

November 21, 2016

SENT VIA FEDERAL EXPRESS

Mr. Michael N. Morjese  
Audit Supervisor  
Medicaid Fraud Division  
Office of the State Comptroller  
20 W. State Street, 4th Floor  
Trenton, NJ 08625

RE: Adultcare, Inc. (MFD-2015-00936)

Dear Mr. Morjese:

This firm represents Adultcare, Inc., a medical day care center located in Union City, New Jersey. We are writing in response to your Draft Audit Report dated November 14, 2016, and your request for repayment of reimbursement in the amount of \$8,399.50 paid to Adultcare for 107 claims between the period of July 1, 2011, through August 4, 2016.

I am confirming that Adultcare has reconciled its billing records for the audit period, and my client has confirmed the 107 billing errors that were identified through your recent claims review did occur. While we were not aware of these errors until this time, the cases you found were limited to a few months during 2011 when adult medical day care centers were transitioning from the Medicaid fee for service system to managed care/MCO payments.

To put this into context, Adultcare, like most adult medical day care centers, were not getting paid by either Molina for (Medicaid fee for service claims), or by the Medicaid Managed Care Organizations ("MCO's") for several months after the transition date of July 1, 2011. AMDC's in general received little or conflicting instructions on how or who to bill for services after July 1<sup>st</sup>, and beneficiaries were just being enrolled in MCO's and waiting for Prior Authorizations.

As such, at least for these 107 days of service, claims may have been filed by Adultcare to both Molina and to the new Medicaid MCO out of confusion and in order to get paid timely so that they could continue to meet payroll and other expenses. It was assumed that one or the other of the payers would reconcile the claims electronically and only the correct payer would reimburse the facility for services rendered.

Mr. Michael N. Morjese

November 21, 2016

Page 2

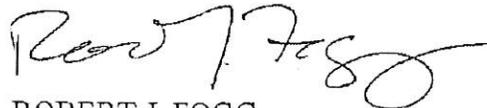
From our records, consistent with your review, Adultcare ended this practice as soon as the Medicaid MCO's began paying claims, no later than October 2011. Adultcare was never contacted either by DMHAS or the HMO's at that time about duplicate payments, and many have been previously reconciled properly. However, for these 107 days of service, it appears that neither the payers, Adultcare's billers or accountants identified the errors given the limited number of claims involved.

Per your recommendations, Adultcare agrees to send a check to your office to reimburse the Office of the Comptroller for these billing errors in the amount of \$8399.50 in full satisfaction of these claims. This is of course subject to it being confirmed that Adultcare is not admitting that it engaged in any actions that were intentional, and subject to our review of any final settlement agreement you will send.

As noted, Adultcare has reconciled its accounts and has not identified any further billing errors from this period. Adultcare has also revised its billing procedures since 2011 to ensure that all claims filed are verified by at least two parties that the client was present, received five hours of service, that services were documented properly, and that the services were authorized.

If you have any questions concerning this, please let me know, but we would request that you confirm that this has resolved this specific matter to your office's satisfaction.

Sincerely,



ROBERT J. FOGG

RJF/

cc: Ms. Carolyn Zakrevsky (via e-mail)  
Ms. Iris Negron (via e-mail)

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