State of New Jersey

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February 1, 2021

BY ELECTRONIC MAIL

Jaime (Kaplan) Epstein, LCSW
ADV Counseling Services, LLC
113 Mt. Vernon Ave.
Northfield, NJ 08225

RE: Final Audit Report: ADV Counseling Services, LLC

Dear Ms. Epstein:

As part of its oversight of the New Jersey Medicaid program (Medicaid), the Office of the State Comptroller, Medicaid Fraud Division (MFD) conducted an audit of Medicaid claims submitted by and paid to ADV Counseling Services, LLC (ADV), owned by Jaime (Kaplan) Epstein, LCSW (Licensed Clinical Social Worker) for the period from March 1, 2014 through February 15, 2019 (audit period). MFD hereby provides ADV with this Final Audit Report.

Executive Summary

MFD conducted an audit of Medicaid claims paid to ADV to determine whether ADV billed for intensive in-community mental-health rehabilitation and behavioral assistance services in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether ADV correctly billed Healthcare Common Procedure Coding System (HCPCS) codes H0036 (intensive in-community services, face-to-face, per 15 minutes), H2014 (individual behavior assistance services, per 15 minutes), and H0018 (intensive in-community assessment), which are used to seek reimbursement for intensive in-community mental-health rehabilitation and behavioral assistance services. From its audit of 523 statistically selected claims totaling $95,061.09, MFD determined that 47 of the 523 claims, totaling $3,042.59 in reimbursement, failed to comply with state and federal regulations. The 47 failed claims contained a total of 52 exceptions, or reasons why such claim failed to comply with a requirement, as some claims failed for multiple reasons.

Specifically, MFD found: a) 6 exceptions for ADV having failed to obtain criminal background checks for behavioral assistants (BAs) prior to such BAs providing services; b) 1 exception for ADV having failed to maintain proof of education for BAs; c) 9 exceptions for ADV having billed services to multiple recipients on the same date of service, at the same or overlapping times; d) 8 exceptions for ADV having billed for travel time in the calculation of face-to-face contact with a beneficiary; e) 7 exceptions for ADV having billed for claims where services were not documented with a progress note; f) 19 exceptions for ADV having billed for unsubstantiated services; and g) 2 exceptions for ADV having failed to comply with the minimum age requirement for its BAs.

To better understand the significance of the exceptions noted above, it would be helpful to discuss the qualification requirements that apply to ADV and other intensive in-community mental-health rehabilitation and behavioral assistance service providers. First, these providers must ensure that their BAs successfully completed criminal background checks and maintain a record showing the successful completion of these checks. This ensures that BAs who are providing one-on-one care for Medicaid beneficiaries, in this case, children/youth/young adults, do not have a criminal history, which increases the assurance that the BA will not compromise the safety and security of beneficiaries. Similarly, pursuant to another regulatory provision, providers must ensure that each BA possesses, at a minimum, a high school diploma or equivalent, and is at least 21 years of age or older. These requirements provide a level of assurance that these hands-on caregivers possess the academic proficiency to have completed high school education or an equivalent thereto and that they are socially responsible enough to work in a one-on-one setting with the beneficiary population. Finally, a regulatory provision requires providers to maintain proof that each BA possesses a valid driver's license. This ensures that BAs, who often drive beneficiaries during the course of treatment, are duly licensed drivers. A provider that fails to meet one or more of these straightforward regulatory requirements may be retaining an unqualified BA and thereby potentially placing vulnerable beneficiaries into an unsafe position. Given the serious potential harm that can occur in these situations, any provider that violates any of these requirements must promptly and fully address, and fix the noted violation(s).

In summary, the total 47 failed claims contained 52 different exceptions, as some claims failed for multiple reasons. For purposes of ascertaining a final recovery amount, MFD extrapolated the dollar error rate for these 47 failed claims to the total population of claims from which the sample claims were drawn, which in this case was 12,556 claims with a total payment amount of $2,326,583.07. After extrapolating the sample dollars in error over the entire universe, MFD calculated that ADV received an overpayment of $76,663.68.[1]

[1] As more fully explained below, MFD will reduce this overpayment amount by $117 to account for two claims for which ADV repaid the Medicaid program as a result of one of the audit findings.

Background

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

ADV, located in Northfield, New Jersey, has participated in the Medicaid program as an intensive in-community mental health rehabilitation and behavioral assistance services provider since June 1, 2008. ADV bills the Medicaid program for services under HCPCS codes H0036, H2014, and H0018. During the audit period, Jaime (Kaplan) Epstein, as owner of ADV, not only billed for services that she personally rendered, but also billed under the ADV provider number for services provided by 52 other behavioral healthcare professionals with whom she had contracted. Accordingly, references to ADV may include services performed by Jaime (Kaplan) Epstein or the other behavioral health professionals for whose services Jaime (Kaplan) Epstein billed under ADV's provider number.

Objective

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

Scope

The audit period was March 1, 2014 through February 15, 2019. The audit was conducted under the authority of the Office of the State Comptroller as set forth in *N.J.S.A.*52:15C-23 and the *Medicaid Program Integrity and Protection Act*, *N.J.S.A.*30:4D-53 *et seq.*

Audit Methodology

MFD's methodology consisted of the following:

- Selecting a statistically valid sample of 70 service days representing 523 claims, totaling $95,061.09, from a population of 12,556 paid claims totaling $2,326,583.07, billed under HCPCS codes H0036, H2014, and H0018.

- Reviewing records to determine whether ADV possessed documentation to support that it: rendered the services billed; obtained prior authorization for services; maintained progress notes that contained required information; conducted criminal background checks on BAs before such BAs performed services for which ADV billed; ensured that services were performed by BAs who had a current and valid driver's license; ensured that BAs who performed services had the required level of education; and, obtained from a parent/guardian an attestation of services listed on the Service Delivery Encounter Documentation (SDED) forms.

- Reviewing records for compliance with the requirements in *N.J.A.C* 10:49-9.8 (a), *N.J.A.C.* 10:49-9.8(b)(1), *N.J.A.C.* 10:77-4.9(e), *N.J.A.C.* 10:77-4.9(f), *N.J.A.C.* 10:77-4.9(g), *N.J.A.C.* 10:77-4.12(e)(6), *N.J.A.C.* 10:77-4.14(c)(1), *N.J.A.C.* 10:77-4.14(d)(2), *N.J.A.C.* 10:77-4.12(d)(3), -(5), *N.J.A.C.* 10:77-4.14(d)(1), *N.J.A.C.* 10:77-5.12(d)(3), -(5), and *N.J.A.C.* 10:77-5.12(e)(6).

Audit Findings

A. ADV Failed to Obtain Criminal Background Checks for Behavioral Assistants Prior to Rendering Services to Beneficiaries

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

MFD requested documentation to determine whether ADV maintained evidence of successfully completed criminal background checks for each BA prior to each BA having provided services to beneficiaries. MFD found that ADV permitted three BAs to provide behavioral assistance services to beneficiaries without having first obtained a criminal background check before these BAs provided services. Specifically, MFD found that ADV billed for behavioral assistance services for 6 of the 523 claims, totaling $468.00, without having first obtained criminal background checks for three BAs. In one instance, accounting for 1 of the 523 claims totaling $78.00, ADV obtained a criminal background check subsequent to the BA providing services. ADV billed and was paid for 1 sample claim for a date of service of March 2, 2016, but did not obtain a successfully completed background check until June 11, 2016, more than three months after the date of service. For the remaining two BAs, who accounted for 5 of the 523 claims, totaling $390.00, ADV failed to provide supporting documentation that it ever obtained criminal background checks. By failing to obtain successful criminal background checks before its employees

provided services to Medicaid beneficiaries and, in other cases, for the entire audit period, ADV violated *N.J.A.C.* 10:77-4.9(g) and *N.J.A.C.* 10:77-4.14(d)(2).

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

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

B. ADV Failed to Maintain Proof of Education for Behavioral Assistants

To perform behavioral assistance services, a BA must have, at a minimum, a high school diploma or equivalent. ADV must maintain proof that each BA met this education requirement. MFD requested that ADV provide copies of high school diplomas or their equivalents for each BA to determine whether qualified individuals performed services and whether ADV maintained proper documentation showing that each BA satisfied this minimum education requirement. MFD found that ADV lacked the requisite documentation for one BA, who accounted for 1 of the 523 claims, totaling $68.25. For this claim, ADV violated *N.J.A.C.* 10:77-4.9(e) and *N.J.A.C.* 10:77-4.14(c)(1).

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

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

C. ADV Billed for Services Provided to Multiple Beneficiaries at the Same or Overlapping Times

State Medicaid regulations regarding intensive in-community mental-health and behavioral assistance services require providers to maintain records for each encounter documenting the name and address of the beneficiary; the exact date, location and time of service; the type of service; and, the length of face-to-face contact time. Most of this information is documented on the SDED. This form, which must be signed and dated by the servicing provider who rendered the service and the beneficiary or their parent/legal guardian, must be completed for every service encounter between a provider and beneficiary.

MFD reviewed ADV's records, including the SDED forms, to determine whether ADV sufficiently documented the services rendered. Specifically, MFD compared the encounter dates and times recorded on the SDED forms to determine if multiple claims overlapped in time. MFD found that for 9 of the 523 sample claims, totaling $883.00, ADV billed for services provided by the same servicing provider to multiple beneficiaries or by different servicing providers to the same beneficiary at the same or overlapping time(s). For example, one SDED form documented that an ADV servicing provider rendered services on October 27, 2017, from 3:30 PM to 8:30 PM. A second SDED form for that same date documented that the same ADV servicing provider provided services to a different Medicaid beneficiary from 4:00 PM to 9:30 PM, resulting in an overlap of four hours and thirty minutes (4:00 PM to 8:30 PM). For these claims, ADV violated *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:77-4.12(d)(3), -(5), and *N.J.A.C.* 10:77-5.12(d)(3), -(5) by improperly billing for overlapping services.

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

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

D. ADV Improperly Billed for Travel Time

MFD reviewed records to determine whether ADV improperly included travel time within the length of face-to-face time that the servicing provider interacted with the beneficiary. MFD found that for 8 of the 523 claims, totaling $152.00, ADV included travel time to and/or from the location of the beneficiary as part of its billing for face-to-face services. For example, one SDED form documented that an ADV servicing provider provided services to a beneficiary on May 21, 2015, from 6:25 PM to 8:25 PM. A second SDED form for that same date documented that the same ADV servicing provider provided services to a different beneficiary from 8:50 PM to 10:50 PM. According to Google Maps, the locations of the two beneficiaries were 31.2 miles apart, requiring approximately 37 minutes of travel time. In that instance, ADV improperly billed travel time as part of its face-to-face services as it did not account for an additional 12 minutes needed for travel. For these claims, ADV violated *N.J.A.C.* 10:49-9.8(a), *N.J.A.C.* 10:77-4.12(d)(3), -(5), and *N.J.A.C.* 10:77-5.12(d)(3), -(5) by improperly billing for travel time for the services provided.

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

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

E. ADV Failed to Document Services with Progress Notes

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

MFD reviewed ADV's records to determine whether it maintained progress notes that supported its billed services. MFD found that for 4 of the 523 claims, totaling $499.00, ADV failed to document services with a progress note. In addition, MFD found that for 3 claims, totaling $446.50, ADV provided 1 progress note that was an exact duplicate of progress note entered for another claim, 1 progress note that was similar, meaning that it closely resembled another progress note, and 1 progress note that referenced an incorrect beneficiary. For example, one progress note from June 6, 2014 mirrored a progress note for the same beneficiary from May 30, 2014. For these progress notes, the only information that differed were minor grammar modifications. The latter of the two notes did not contain any unique information regarding the services provided during the session, advancement toward goals outlined in the plan of care or other relevant information. When progress notes lack critical information and/or mirror one another, it raises questions as to whether the services were provided and, if so, what transpired during those sessions. For these claims, ADV violated *N.J.A.C.* 10:49-9.8(b)(1), *N.J.A.C.* 10:77-4.12(e)(6), and *N.J.A.C.* 10:77-5.12(e)(6) by failing to maintain appropriate records.

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

Pursuant to *N.J.A.C.* 10:77-4.12(e)(6), the provider shall maintain "weekly quantifiable progress notes toward defined goals as stipulated in the child/youth adult's BASP."

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

F. ADV Billed Unsubstantiated Services

MFD reviewed records to determine whether ADV maintained proper documentation for the services billed to Medicaid. MFD found that for 19 of the 523 sample claims, totaling $755.84, ADV billed for services that were not sufficiently supported by documentation. Specifically, for some of these claims, ADV did not provide an SDED form that would support the claims, and for the remaining claims, the hours of service in the SDED conflicted with the hours billed and paid. For these claims, ADV violated *N.J.A.C.* 10:49-9.8(a) by failing to maintain appropriate records.

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

G. ADV Failed to Ensure the Minimum Age Requirement for Behavioral Assistants

For the claims in its sample, MFD reviewed each BAs driver's license to determine whether the BA was at least 21 years of age prior to providing services for which ADV billed the Medicaid program. MFD found that for 2 of the 523 claims, totaling $117.00, one BA did not meet the minimum age requirement for performing services. For these claims, ADV violated *N.J.A.C.* 10:77-4.9(e) by allowing services to be provided by a BA under the age of 21 and by failing to maintain documentation to verify the BA's age.

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

Further, prior to the completion of the audit, MFD noted that ADV started the process of reimbursing the Medicaid program for these two claims by submitting a refund request to the state's fiscal agent. MFD will still consider these claims as failed and will remain as part of the extrapolation for a final overpayment amount. MFD will then reduce the extrapolated amount by $117.00.

Summary of Overpayments

MFD determined that for the period from March 1, 2014 through February 15, 2019, ADV improperly billed and received payment for 47 of the 523 sample claims, totaling $3,042.59 (*See* Appendix A for Summary). These 47 failed claims contained a total of 52 exceptions, as some claims failed for multiple reasons. For purposes of ascertaining a recovery amount, MFD extrapolated the dollar error rate for 47 unique claims that failed to comply with applicable regulations to the total population of claims from which the sample claims were drawn, which in this case was 12,556 claims with a total amount of

payment of $2,326,583.07. By extrapolating the sample of deficient claims to this universe of claims/reimbursement amount, MFD calculated that ADV received an overpayment of $76,663.68 that it must repay to the Medicaid program.[2] Since ADV repaid the Medicaid program $117.00 for 2 of the sampled claims, the overpayment amount is decreased to $76,546.68 ($76,663.68 - $117.00 = $76,546.68).

Recommendations

ADV must:

1. Reimburse Medicaid the overpayment amount of $76,546.68.

2. Adhere to state and federal regulations for Medicaid services provided by ADV and its contracted health care professionals.

3. Before behavioral assistants are assigned case referrals, maintain documentation (i.e., successfully completed criminal background checks, valid driver's licenses, proof of education and proof of age) to ensure compliance with state regulations.

4. Ensure that ADV and its contracted health care professionals receive training to foster compliance with applicable state and federal regulations.

5. Provide MFD with a Corrective Action Plan (CAP) indicating the steps ADV will take to implement procedures to correct the deficiencies identified in this Draft Audit Report.

ADV's Response to the Draft Audit Report and MFD's Comments

After being apprised of the findings above, ADV, through counsel, submitted comments and a CAP in response to MFD's Draft Audit Report (*See* Appendix B). In this response, ADV offered several arguments against MFD's findings and its sampling and extrapolation methodology. MFD's responses to ADV's arguments are attached as Appendix C, entitled "ADV's Comments and MFD's Response." As more fully explained in that document, MFD disagrees with most of the ADV's arguments, but MFD gave credit in those circumstances when ADV provided sufficient and reliable documentation. For the majority of the claims at issue, however, MFD did not modify its findings.

Further, ADV provided a CAP to address all of MFD's recommendations above and thereby correct the deficiencies cited in this report. Thus, the only issue that ADV must

[2] MFD can reasonably assert, with 90% confidence, that the true overpayment falls between $47,764 and $105,563 with the most likely overpayment (i.e., error point estimate) being $76,663.68.

address is the overpayment. MFD calculated that ADV received an overpayment of $76,546.68 that it must repay to the Medicaid program.

Sincerely,

KEVIN D. WALSH
ACTING STATE COMPTROLLER

DATE: 02/1/2021

By: /s/Josh Lichtblau
Josh Lichtblau
Director
Medicaid Fraud Division

Cc: Kay Ehrenkrantz, Deputy Director, MFD
Don Catinello, Supervising Regulatory Officer, MFD
Glenn Geib, Recovery Supervisor, MFD
Thomas R. Calcagni; Attorney, Calcagni & Kanefsky LLP
Walter R. Krzastek; Attorney, Calcagni & Kanefsky LLP

Appendices:

Appendix A – Summary of Overpayments
Appendix B – ADV's response to Draft Audit Report
Appendix C –ADV's Comments and MFD's Response

Appendix A

ADV Counseling Services, LLC
Period: 03/01/2014 - 02/15/2019
Summary of Overpayments

Source: Shared Data Warehouse (SDW)								Source: Medicaid Fraud Division (MFD) Testing																
Claim ICN Identification	Claim Recipient Full Name	Claim Recipient First Name	Claim Recipient Last Name	Claim Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Payment Amount	Test A- Failed to Obtain Criminal Background Checks for BAs Prior to Initiating Services	Recoverable Claim Payment	Test B- Failed to Maintain Proof of Education for BAs	Recoverable Claim Payment	Test C- Billed for Services Provided to Beneficiaries at the Same or Overlapping Times	Overpayment	Test D- Improperly Billed for Travel Time	Overpayment	Test E- Failed to Document Services with a Progress Note	Overpayment	Test F- Billed Unsubstantiated Services	Recoverable Claim Payment	Test G- Failed Minimum Age Requirement for BAs	Recoverable Claim Payment	TOTAL Amount of Failed Claims	Total Number of Exceptions per Claim Dervice Date	Tickmarks
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/10/2018	H2014	$ 39.00	XX	39.00											XX	39.00	39.00	2	*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5/15/2018	H2014	$ 78.00	XX	78.00											XX	78.00	78.00	2	*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/6/2014	H2014	$ 58.50	XX	58.50													58.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/6/2014	H2014	$ 78.00	XX	78.00													78.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/17/2014	H2014	$ 136.50	XX	136.50													136.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/2/2016	H2014	$ 78.00	XX	78.00													78.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/9/2016	H2014	$ 68.25			XX	68.25											68.25	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/27/2015	H2014	$ 78.00					XX	19.50	XX	9.75							29.25	2	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/24/2017	H0036	$ 226.00					XX	226.00									226.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/10/2018	H0036	$ 226.00					XX	56.50									56.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7/17/2018	H0036	$ 169.50					XX	113.00									113.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/7/2016	H2014	$ 78.00					XX	19.50									19.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	11/16/2016	H2014	$ 78.00					XX	78.00									78.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/23/2017	H2014	$ 117.00					XX	117.00									117.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7/22/2017	H2014	$ 78.00					XX	78.00									78.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10/27/2017	H2014	$ 214.50					XX	175.50									175.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	4/1/2014	H0036	$ 226.00							XX	28.25							28.25	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/17/2014	H0036	$ 226.00							XX	28.25							28.25	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5/21/2015	H0036	$ 226.00							XX	28.25							28.25	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/26/2017	H0036	$ 226.00							XX	28.25							28.25	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	11/7/2015	H2014	$ 117.00							XX	9.75							9.75	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/8/2017	H2014	$ 117.00							XX	9.75							9.75	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/8/2017	H2014	$ 78.00							XX	9.75							9.75	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/20/2017	H0036	$ 113.00									XX	113.00	XX	113.00			113.00	2	*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/8/2017	H2014	$ 117.00									XX	117.00	XX	117.00			117.00	2	*
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/22/2018	H0036	$ 113.00									XX	113.00					113.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/9/2016	H2014	$ 156.00									XX	156.00					156.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5/7/2016	H2014	$ 156.00									XX - Progress Note References Different Beneficiary	156.00					156.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/6/2014	H0036	$ 212.50									XX - Duplicate	212.50					212.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2/8/2016	H2014	$ 78.00									XX - Duplicate	78.00					78.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/28/2015	H0036	$ 170.00											XX	(56.00)			(56.00)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2/12/2017	H0036	$ 310.75											XX	56.50			56.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/18/2017	H0036	$ 61.64											XX	(164.36)			(164.36)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	7/22/2017	H0036	$ 226.00											XX	226.00			226.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2/24/2018	H0036	$ 226.00											XX	226.00			226.00	1	

Source: Shared Data Warehouse (SDW)								Source: Medicaid Fraud Division (MFD) Testing															
Claim ICN Identification	Claim Recipient Full Name	Claim Recipient First Name	Claim Recipient Last Name	Claim Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Payment Amount	Test A- Failed to Obtain Criminal Background Checks for BAs Prior to Initiating Services	Recoverable Claim Payment	Test B- Failed to Maintain Proof of Education for BAs	Recoverable Claim Payment	Test C- Billed for Services Provided to Beneficiaries at the Same or Overlapping Times	Overpayment	Test D- Improperly Billed for Travel Time	Overpayment	Test E- Failed to Document Services with a Progress Note	Overpayment	Test F- Billed Unsubstantiated Services	Recoverable Claim Payment	Test G- Failed Minimum Age Requirement for BAs	Recoverable Claim Payment	TOTAL Amount of Failed Claims	Total Number of Exceptions per Claim Dervice Date	Tickmarks
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	11/7/2018	H0036	$ 226.00											XX	(113.00)			(113.00)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10/18/2014	H0036	$ 254.20											XX	(0.05)			(0.05)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/24/2017	H0036	$ 197.50											XX	(0.25)			(0.25)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/17/2015	H2014	$ 234.00											XX	117.00			117.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	9/17/2015	H2014	$ 175.50											XX	58.50			58.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/7/2016	H2014	$ 97.50											XX	97.50			97.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/7/2016	H2014	$ 156.00											XX	(39.00)			(39.00)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/28/2016	H2014	$ 156.00											XX	(39.00)			(39.00)	1	**
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/28/2016	H2014	$ 58.50											XX	58.50			58.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/18/2017	H2014	$ 117.00											XX	117.00			117.00	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/10/2018	H2014	$ 78.00											XX	19.50			19.50	1	
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/6/2019	H2014	$ 78.00											XX	(39.00)			(39.00)	1	**
TOTAL Recovery:									**$ 468.00**		**$ 68.25**		**$ 883.00**		**$ 152.00**		**$ 945.50**		**$ 755.84**		**$ 117.00**	**$ 3,042.59**	
TOTAL Number of Claims:									**6**		**1**		**9**		**8**		**7**		**19**		**2**	**47**	
TOTAL Number of Exceptions:																							**52**

Tickmark Legend:
SDW - Shared Data Warehouse
MFD - Medicaid Fraud Division
BAs - Behavioral Assistants
XX - Finding
* No single recovery can exceed original payment amount
** Due to the underbilling by the provider, proper reimbursements were made

Appendix B

CALCAGNI KANEFSKY LLP

Walter R. Krzastek, Partner
862.208.1812 walterk@ck-litigation.com

October 28, 2020

Via Email [redacted]
[redacted] Supervising Auditor
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, NJ 08625-0025

Re: ADV Counseling Services, LLC

Dear Mr. [redacted]:

This law firm represents ADV Counseling Services, LLC (ADV), in connection with the Medicaid Fraud Division's ("MFD") Summary of Findings ("SOF") dated May 28, 2020, and its Draft Audit Report dated October 14, 2020 ("DAR"). Please accept this letter, and the additional documentation submitted herewith, as ADV's written comments to the DAR and objections to the findings and conclusions set forth therein. We have also attached a proposed Corrective Action Plan.

By way of background, ADV previously submitted comments, objections, and additional documentation in response to the SOF on July 12, 2020, July 27, 2020, August 27, 2020, and September 4, 2020 (the "Prior Submissions"). Rather than repeat those comments and objections, ADV hereby incorporates the Prior Submissions by reference.

Audit Finding A (Additional Criminal Background Checks Provided)

As a matter of practice, ADV requires background checks before Behavioral Assistants (BAs) may perform services. ADV also maintains copies of those background checks in the regular course of its business. Consistent with this practice, ADV, as part of this audit, produced copies of background checks for the vast majority of BAs (ADV produced at least 28 background checks for BAs) who performed services during the audited time period. The DAR alleges 16 exceptions for ADV having failed to obtain criminal background checks with respect to 4 BAs prior to those BAs providing service. ADV has since located additional background checks for 2 of the 4 BAs. With this submission, we have uploaded a March 4, 2016 background check for BA [redacted] along with a copy of the March 4, 2016 transmission email and a November 3, 2015 background check for BA [redacted]. ADV believes it maintained copies of background checks for the other two BAs and will continue to search its files.

Audit Finding B (Proof of Education for BAs)

Like background checks, as a matter of practice, ADV confirms that all BAs have a high school diploma or equivalent and maintains proof of education in its files. ADV, as part of this audit, produced proof of education for the vast majority of BAs (ADV produced proof of education for at least 25 BAs) who performed services during the audited time period. The DAR alleges 7 exceptions for ADV not maintaining proper documentation for 3 BAs. ADV previously produced proof of education for 2 of the 3 BAs identified in the DAR.

For [redacted], ADV produced a copy of her Stockton University diploma. Because the record (after printing and scanning) was blurry, ADV also submitted an email from [redacted] confirming that she presented the diploma to ADV at the start of her employment. With this submission, we have uploaded the file itself rather than a printed/scanned version. The file is much clearer and amply demonstrates that [redacted] earned a Bachelor of Arts from Stockton University. As can be seen, ADV required [redacted] to produce proof of education, [redacted] presented a copy of her college diploma to ADV, ADV verified that [redacted] met educational requirements, and ADV maintained a copy of the proof of education. As such, ADV requests that MFD adjust its findings with respect to [redacted].

For [redacted], ADV previously produced a copy of a transcript from Atlantic Cape Community College. This constitutes adequate proof of education and no exception should have been found. ADV also has a copy of [redacted] high school diploma in its files and we have uploaded that document as further proof of education.

ADV continues to review its files for proof of education for [redacted], who only worked for ADV for 12.25 hours over a two week period in September 2016.

Audit Finding C (Alleged Overlapping Times)

As stated in the Prior Submissions, ADV believes that 8 of the 9 exceptions relate to clerical errors. In each of those instances, the services were performed and documented, but the service provider likely made a mistake logging the date of service on the SDED form. ADV is entitled to compensation under these circumstances and objects to the finding of an alleged overpayment for services that were clearly provided.

Audit Finding D – (Travel Time)

MFD alleges that ADV improperly billed for travel time for 8 of the 523 claims reviewed. ADV continues to object to these findings and MFD's reliance on Google maps. As ADV explained in the Prior Submissions and exit conference, BAs are familiar with surrounding area and do not travel by one dimensional computerized maps such as Google maps. Google maps also does not account for traffic conditions that exist at the time the report was run and may not be an accurate representation of the day and time of travel – which is particularly relevant here where many of the alleged discrepancies are 10 minutes or less. And, even if this was a proper way to calculate travel time, we further object to the conclusion, based on these Google map readings,

that the provider cut the session time short and did not spend the full amount of face-to-face time with the client.

Moreover, as we have pointed out, 3 of the 8 alleged exceptions did not end in the claim recipient's home. The cyber notes for [redacted] (11/7/2015) and [redacted] (6/8/2017 and 9/26/2017) all indicate that those sessions ended in the community setting – not the home. For each of these instances, travel time to the next session cannot be started from the client's home as the session did not finish there. For example, the service provider advised that she took [redacted], on 9/26/2017, to East Faunce Landing Road in Absecon to look at the water in the back bay and then met the client's mother at Shop Rite on Route 30 in Absecon. Using Shop Rite as the starting point, rather than [redacted]'s home, the distance to the next session was 9.8 miles and 15 minutes away per MFD's Google maps methodology. We have uploaded a copy of the Google maps distance calculation and request that MFD adjust its findings.

Audit Finding E (Alleged Failure to Document Service with a Progress Note)

MFD alleges that ADV failed to maintain a progress note for 4 of 523 claims reviewed. As stated in the Prior Submissions, progress notes were properly input into cyber for 3 of the 4 claims ([redacted]). In each of these instances, the service was performed and documented in a progress note, but due to a clerical error the date of service was erroneously reflected in the bill. For example, [redacted] was seen on 6/7/2017 as reflected on the progress note. The claim mistakenly reflected 6/8/2017 as the service date. Medicaid was only billed one time as ADV did not submit a bill for 6/7/2017. The same occurred for [redacted] and [redacted]. ADV objects to the finding of an alleged overpayment under these circumstances.

As for the allegations related to [redacted], ADV notes that the provider in question worked only briefly (approximately April 28, 2014 to August 22, 2014) and this was her only case. As such, ADV objects to extrapolating this isolated case across five years of claims.

Audit Finding F (Alleged Billing for Unsubstantiated Services)

MFD alleges that ADV did not submit adequate documentation to support 19 of the 523 claims reviewed. One of these allegations ([redacted]-3/7/2016) appears to be a new exception that was not on the SOF or part of the spreadsheet attached to MFD's July 13, 2020 email about this appendix. ADV objects to the inclusion of a new exception and, at the very least, would appreciate more detail about this allegation to have a fair opportunity to respond.

Regarding the other findings, MFD alleged that SDED forms were missing for [redacted], [redacted], and [redacted]. *See* July 13, 2020 MFD email and spreadsheet. ADV produced the SDED forms as part of its July 27, 2020 production. Accordingly, these claims should not be listed as exceptions.

Like the progress note finding, several of the alleged exceptions involve clerical errors regarding the date of service reflected in the bill ([redacted], [redacted], [redacted] – 7/22/2017). These services were performed and properly documented in the SDED form, but the bill reflected the wrong date of service due to a clerical error. Medicaid was only billed one time for the services. As such, ADV objects to the finding of an alleged overpayment under these circumstances.

As stated in ADV's Prior Submissions, the remainder of the alleged over and underpayments were all likely due to inadvertent data entry errors.

Objection to Extrapolation

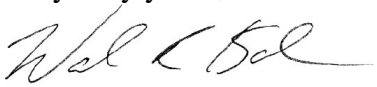
ADV objects to the extrapolation methodologies used by MFD in the audit. MFD audited 523 claims totaling $95,061.09 submitted between March 1, 2014 through February 15, 2019. MFD found purported issues with 57 claims, totaling $4,310.09 in reimbursement. This constitutes 10.8% of the claims reviewed and 4.5% of the total reimbursement. For the reasons above, ADV maintains that those percentages should be much lower.

Extrapolation is improper where, as here, there is no determination of a "high level of payment error." As CMS notes, the "Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that before using extrapolation (i.e., projection, extension, or expansion of known data) to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error." Medicare Program Integrity Manual (Rev. 10228, 07-27-20) at §8.4.1.2. A high level of payment error is further defined by CMS as "greater than or equal to 50 percent." *Id*. at §8.4.1.4. Here, the purported error rate comes nowhere near this level and, as such, MFD should not have resorted to extrapolation techniques.

Moreover, extrapolation techniques are particularly inappropriate here because the actual amount, if any, of the alleged overpayment is readily ascertainable for many of the audit categories. For example, for the missing background checks allegation, the value of sessions billed for the BAs in this category who each worked with ADV for only a few months – [redacted] and [redacted] – is easily calculable. Performing an extrapolation as a proxy for this identifiable amount grossly overstates the alleged overpayment. Similarly, for the proof of education allegation, the value of the sessions billed for the only BA in this category, [redacted] during her two weeks of employment, is also easily calculable. Again, the actual alleged overpayment – two weeks of claims – is far less than the extrapolated amount. Using extrapolation across five years of claims improperly inflates the alleged reimbursement for these two categories. As for the remainder of the findings, many of the other alleged errors relate to simple clerical errors where the services were performed and documented and payment is warranted. Extrapolation is simply not suitable in this case because there is no clear pattern of errors that might exist across the universe of claims.

Thank you for your consideration. Please contact us if you have any question or did not receive any of the documents referenced herein.

Very truly yours,



Walter R. Krzastek, Partner
Calcagni & Kanefsky LLP

CORRECTIVE ACTION PLAN

ADV Counseling Services, LLC (ADV) submits this Corrective Action Plan ("CAP") in response to the Office of State Comptroller, Medicaid Fraud Division's ("MFD") October 14, 2020 Draft Audit Report ("DAR"). The DAR requested a CAP "indicating the steps ADV will take to implement to correct the [alleged] deficiencies identified" in the report. Without waiving any defenses or objections to MFD's allegations, ADV proposes the following plan:

Findings A, B, and G
Corrective Actions: ADV will implement the following policies:

1. All Behavioral Assistant's must meet minimum age requirements and produce proof of age before performing services.
2. All Behavioral Assistant's must meet minimum education requirements and produce proof of education before performing services.
3. A criminal background check must be performed on every Behavioral Assistant before such BA may perform services.
4. ADV will maintain copies of all BA proof of age, proof of education, and criminal background checks in accordance with applicable laws and regulations.

Findings C, D, and E:
Corrective Actions:

1. Medicaid regulations will be reviewed with providers every 6 months to insure understanding of current guidelines.
2. Providers' paperwork will be checked upon submission and compared with documented electronic record.
3. Providers' documented sessions will be compared to prior sessions (to eliminate cut and pasted duplicate notes)
4. Paperwork will be cross referenced by therapist and BA and by date of service to insure accuracy.
5. Providers' sessions by date will be reviewed to insure time accuracy of sessions and travel time between sessions.
6. Random charts will be reviewed monthly to insure compliance.

Findings F:
Corrective Actions:

1. SDED forms will be compared with electronic record to insure accuracy.
2. Billed session will be compared to electronic record to insure accuracy.
3. Questionable handwriting will be double checked with provider to insure accuracy.
4. Remittances will be compared to sessions billed to insure accuracy.
5. Random billed sessions will be reviewed monthly to insure accuracy.

ADV's Comments and MFD's Response

ADV's Counsel provided a response to the Draft Audit Report stating that they have "previously submitted comments, objections, and additional documentation" in response to the preliminary findings. "Rather than repeat those comments and objections, ADV hereby incorporates the Prior Submissions by reference."

ADV's Comments to Audit Finding A - Criminal Background Checks for BAs

ADV contends that "[a]s a matter of practice, ADV requires background checks before Behavioral Assistants (BAs) may perform services. ADV also maintains copies of those background checks in the regular course of its business. Consistent with this practice, ADV, as part of the audit, produced copies of background checks for the vast majority of BAs. . . . ADV believes it maintained copies of background checks for the [remaining] two BAs and will continue to search its files."

MFD's Response

In its response, ADV averred that as a "general practice" the facility requires background checks and maintains the related documentation. Notwithstanding that statement, ADV does not provide any facts or arguments that challenge MFD's findings in this section. Specifically, ADV does not challenge that it failed to produce criminal background check documentation for two BAs providing services, resulting in MFD finding five failed claims. In addition, ADV does not challenge MFD's finding that ADV's documentation regarding a third BA revealed that the BA provided services prior to the completion of a criminal background check, resulting in MFD finding an additional failed claim.

ADV's Comments to Audit Finding B - Proof of Education for BAs

"Like background checks, as a matter of practice, ADV confirms that all BAs have a high school diploma or equivalent and maintains proof of education in its files. ADV, as part of this audit, produced proof of education for the vast majority of BAs."

MFD's Response

Similar to criminal background checks, ADV claims that it regularly confirms and documents proof of education for its BAs. Again, though, ADV did not provide any evidence that would challenge MFD's finding regarding the failed claim. ADV provided supplemental proof of education documentation regarding two BAs and six failed claims. MFD modified its findings to account for that documentation. ADV did not provide any documentation to cause MFD to modify its finding regarding the remaining failed claim.

ADV's Comments to Audit Finding C - Overlapping Times

ADV claims that "8 of the 9 exceptions relate to clerical errors. In each of those instances, the services were performed and documented, but the service provider likely made a mistake logging the date of service on the SDED form. ADV is entitled to compensation

under these circumstances and objects to the finding of an alleged overpayment for services that were clearly provided."

MFD's Response

MFD's review of ADV's documentation indicates that ADV billed for services purportedly provided by the same servicing provider to multiple beneficiaries *at the same time*, or by different servicing providers to *the same beneficiary,* at the same or overlapping times. In short, ADV billed for services that could not have been rendered. ADV now attempts to explain eight of the nine failed claims as mere "clerical errors" that "likely" resulted from the servicing providers erroneously having documented the wrong date of service. Thus, by ADV's own admission, it cannot address MFD's findings with certainty. Providers are required to certify that the information furnished in a claim "is true, accurate, and complete." N.J.A.C. 10:49-9.8(a). ADV cannot assure MFD that services were provided. Simply put, the services for which ADV submitted claims to the Medicaid program and for which it was paid were not provided as ADV documented. Accordingly, ADV is not "entitled" to payment for services and MFD will not modify these findings.

ADV's Comments to Audit Finding D - Travel Time

ADV objects to MFD's reliance on Google Maps, claiming that the "BAs are familiar with surrounding area and do not travel by one dimensional computerized maps such as Google maps. Google maps also does not account for traffic conditions that exist at the time the report was run and may not be an accurate representation of the day and time of travel - which is particularly relevant here where many of the alleged discrepancies are 10 minutes or less. And, even if this was a proper way to calculate travel time, we further object to the conclusion, based on these Google map readings, that the provider cut the session time short and did not spend the full amount of face-to-face time with the client."

Further, ADV claims that "3 of the 8 alleged exceptions did not end in the claim recipient's home. The cyber notes for [redacted] (11/17/2015) and [redacted] (6/8/2017 and 9/26/2017) all indicate that those sessions ended in the community setting – not the home. . . . [A]nd request that MFD adjust its findings."

MFD's Response

MFD is not persuaded by either ADV's general or specific objections to MFD's findings based on travel time. MFD uses Google Maps as an independent tool to calculate distance and travel time from one beneficiary location to another. If BA familiarity with the area permitted quicker or shorter travel time, as ADV suggests, ADV had the opportunity to provide documentation of same to MFD, but it did not do so. In addition, although ADV opines that the time discrepancies identified by MFD are insignificant, MFD does not agree. MFD notes that the time discrepancies in this case, particularly when applied across a broader spectrum of claims, are significant for purposes of reimbursement. In short, MFD is not persuaded by ADV as they billed for services that could not have been

rendered by improperly including travel time within the length of face-to-face time that the servicing provider interacted with the beneficiary.

ADV's specific objections to three of the failed travel time claims is based on the representation that the sessions ended at locations other than the beneficiaries' homes. ADV is required to document "the exact date(s), location(s), and time(s) of service," *N.J.A.C.* 10:77-4.12, -5.12, and the information provided by ADV must be accurate and complete. *N.J.A.C.* 10:49-9.8. If there were alternate pick-up or drop-off locations for beneficiaries [redacted]. and [redacted] during the visits at issue, this information should have been recorded on their respective SDED forms, which provides for documentation of the service location address when it is not at a beneficiary's home. ADV's SDED forms did not support their claims, thus, MFD will not modify these findings.

ADV's Comments to Audit Finding E - Progress Notes

ADV claims that '[i]n each of these instances, the service was performed and documented in a progress note, but due to a clerical error the date of service was erroneously reflected in the bill. For example, [redacted] was seen on 6/7/2017 as reflected on the progress note. The claim mistakenly reflected 6/8/17 as the service date. Medicaid was only billed one time as ADV did not submit a bill for 6/7/2017. The same occurred for [redacted] and [redacted]. ADV objects to the finding of an alleged overpayment under these circumstances." ADV further states that "[a]s for the allegations related to [redacted], ADV notes that the provider in question worked only briefly (approximately April 28, 2014 to August 22, 2014) and this was her only case. As such, ADV objects to extrapolating this isolated case across five years of claims."

MFD's Response

MFD rejects ADV's proposed explanation for claims that are unsupported with a progress note. ADV again states that "clerical error" explains the undocumented claims. ADV states, inaccurately, that its servicing providers may have simply listed the incorrect date of service on a progress note and that "Medicaid was billed [only] one time" for this claim. This assertion is unsupported by the record. Contrary to ADV's representation, ADV billed twice for these claims for beneficiaries [redacted], [redacted] and [redacted] For example, ADV produced a progress note for [redacted] dated June 7, 2017. ADV billed for services for [redacted] on both June 7, 2017 and June 8, 2017. Similarly, ADV submitted unsupported billings for [redacted] and [redacted] As such, ADV billed for dates of service that were unsupported by progress notes. Accordingly, MFD will not adjust these findings.

ADV's objection to failed claims for beneficiary [redacted] due to the lack of a progress note is equally unavailing. ADV's position demonstrates a failure to understand fully the propriety of MFD's extrapolation process. Assuming, for the sake of ADV's argument, that the BA at issue was employed by ADV for only approximately four months, this fact does not render MFD's selection of a valid, representative sample and the resulting extrapolation inaccurate. Although ADV did not provide documentation supporting the BA's period of employment, even if it was relatively brief, any resulting errors are commensurately small, resulting in a smaller associated extrapolated overpayment

amount. ADV has not put forth a valid argument necessitating an adjustment of findings regarding [redacted]

ADV's Comments to Audit Finding F - Unsubstantiated Services

"MFD alleges that ADV did not submit adequate documentation to support 19 of the 523 claims reviewed. One of these allegations ([redacted]-3/7/2016) appears to be a new exception that was not on the SOF or part of the spreadsheet attached to MFD's July 13, 2020 email about this appendix. ADV objects to the inclusion of a new exception. . . .

"Regarding the other findings, MFD alleged that SDED forms were missing for [redacted], [redacted], and [redacted]. . . . ADV produced the SDED forms as part of its July 27, 2020 production. Accordingly, these claims should not be listed as exceptions."

"Like the progress note finding, several of the alleged exceptions involve clerical errors regarding the date of service reflected in the bill ([redacted], [redacted], [redacted] – 7/22/2017). These services were performed and properly documented in the SDED form, but the bill reflected the wrong date of service due to a clerical error. Medicaid was only billed one time for the services. As such, ADV objects to the finding of an alleged overpayment under these circumstances."

MFD's Response

MFD does not agree with ADV's objections to the finding of 19 failed claims due to ADV's failure to submit a SDED form or the submission of SDED forms containing inconsistent information. First, ADV claims that the failed claim related to beneficiary [redacted] is a "new exception," to which ADV did not have the opportunity to respond. This is inaccurate. The failed claim regarding [redacted] was included initially in Audit Finding C as an overlapping service. Upon submission of documentation from ADV, this failed claim was reclassified as an error in Audit Finding F, based on ADV's having billed for services allegedly provided prior to the billing date.

Next, ADV addresses three failed claims for beneficiaries [redacted], [redacted], and [redacted], maintaining that ADV provided SDED forms to MFD and, therefore, should be given credit for these claims. MFD reviewed the SDED forms provided and found they contained significant inconsistent information. For example, the SDED form for [redacted] was dated February 27, 2018, but ADV billed for services allegedly provided on February 24, 2018. Similarly, the SDED forms for [redacted] and [redacted] contained similarly inconsistent information. Again, ADV argues that these errors should be credited because they were merely "clerical errors" that did not result in multiple billings to Medicaid. This argument fails to address those instances where SDED forms were not submitted. Moreover, as explained previously, ADV is required to submit true, accurate and complete claims information, but failed to do so. As such, MFD will not modify these findings.

ADV's Comments to Extrapolation

"ADV objects to the extrapolation methodologies used by MFD in the audit. . . . Extrapolation is improper where, as here, there is no determination of a 'high level of payment error'. As CMS notes, the 'Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that before using extrapolation (i.e., projection, extension, or expansion of known data) to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error.' Medicare Program Integrity Manual (Rev. 10228, 07-27-20) at §8.4.1.2. A high level of payment error is further defined by CMS as 'greater than or equal to 50 percent'. . . . Here the purported error rate comes nowhere near this level and, as such, MFD should not have resorted to extrapolation techniques."

"Moreover, extrapolation techniques are particularly inappropriate here because the actual amount, if any, of the alleged overpayment is readily ascertainable for many of the audit categories. For example, for the missing background checks allegation, the value of sessions billed for the BAs in this category who each worked with ADV for only a few months . . . is easily calculable. Performing an extrapolation as a proxy for this identifiable amount grossly overstates the alleged overpayment. Similarly, for the proof of education allegation, the value of the sessions billed for the only BA in this category . . . is also easily calculable. . . . Using extrapolation across five years of claims improperly inflates the alleged reimbursement for these two categories. As for the remainder of the findings, many of the other alleged errors relate to simple clerical errors where the services were performed and documented and payment is warranted. Extrapolation is simply not suitable in this case because there is no clear pattern of errors that might exist across the universe of claims."

MFD's Response

ADV's reliance on CMS' Medicare Program Integrity Manual (MPIM) is misplaced. The MPIM was created for use by contractors performing audits on behalf of Medicare. See MPIM section 8.4.1.1. Even if the MPIM were binding on Medicaid, which it is not, ADV misconstrues the section cited. The purpose of the section cited by ADV is to limit Medicare contractor use of extrapolation without permission from CMS, not to define all instances in which extrapolation is appropriate. The MPIM states that for extrapolation purposes, a high level of payment error is determined through a variety of means, not just a high-error rate. See MPIM section 8.4.1.1. The MPIM also states that "[f]ailure by a contractor to follow one or more of the requirements contained herein does not necessarily affect the validity of the statistical sampling that was conducted or the projection of the overpayment." Low error rates can still achieve reasonable precision at high confidence levels. The MPIM acknowledges too that there are other circumstances not identified in the MPIM in which extrapolation may be appropriate and establishes a process for contractors to seek approval to use extrapolation. Simply put, the MPIM is not binding on MFD's audit of a New Jersey Medicaid provider, but even if it were, it does not support ADV's flawed position.

MFD has already addressed ADV's objection to the inclusion of claims associated with employees working for a brief period of time in the extrapolation process. Excluding such claims from the sample, as ADV advocates, would invalidate the extrapolation results of the statistically valid, random sample.

Finally, ADV's claim that the use of extrapolation was inappropriate because the "actual amount . . . of the alleged overpayment is readily ascertainable" is misguided. First, the claim-by-claim analysis ADV advocates for through a direct recovery is not "readily accessible" because it would require ADV to produce all of the necessary documentation regarding every BA who worked for ADV and to link every claim in the universe, of which there are 12,556, to a specific BA. Then, MFD would have to review each such claim and perform the same analysis that it performed on 523 claims, on 12,033 more claims. The amount of time and effort that both ADV and MFD would have to expend to complete such a process would be overwhelming to both parties. These practical considerations are why it is well established that MFD and other government oversight bodies use random sampling and extrapolations processes to identify overpayments in Medicaid and other government programs. In short, MFD is not persuaded by ADV's arguments regarding MFD's use of extrapolation in this matter.