



State of New Jersey

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
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 4, 2018

BY ELECTRONIC AND CERTIFIED MAIL

Gloria Andrade, LCSW
C/O Michael A. Mark, Esq.
262 Lincoln Ave.,
Hawthorne, NJ 07506

RE: Final Report - Gloria Andrade, Licensed Clinical Social Worker

Dear Ms. Andrade:

As part of its oversight of the Medicaid and New Jersey FamilyCare program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted a review of claims billed under Healthcare Common Procedure Coding System (HCPCS) codes H0036 and H0018 paid to Gloria Andrade. The period of review was January 1, 2012 through December 31, 2015. OSC hereby provides you with this Final Report.

Executive Summary

OSC conducted a review of Medicaid claims paid to Gloria Andrade, a licensed clinical social worker (LCSW), to determine whether she appropriately billed for mental health rehabilitation services in accordance with applicable state and federal laws and regulations. Specifically, the review sought to determine whether Gloria Andrade correctly billed HCPCS code H0036 (Intensive in-community services, face-to-face, per 15 minutes) and H0018 (Behavioral health; non-hospital residential treatment program, without room and board, per diem), which are used to seek reimbursement for intensive in-community mental health rehabilitation services. Based on its review of 235 randomly selected claims for the relevant codes, OSC determined that 116 of the 235 claims for HCPCS codes H0036 and H0018, totaling \$23,362.75 in reimbursement to Gloria Andrade, failed to comply with state and federal regulations. The 116 failed claims had a total of 140 exceptions as some claims had multiple deficiencies. Specifically, OSC found: a) 55 exceptions for providing multiple services to different recipients, occurring on the same date of service, at the same or overlapping times; b) 37 exceptions for services occurring during times when she was working at other employment; c) 31 exceptions for billing unsubstantiated services; and, d) 17 exceptions for failing to document services.

For purposes of ascertaining a recovery amount, OSC extrapolated the error rate for claims that failed to comply with state and federal regulations to the total population of claims from which the sample claims were drawn, which in this case was 2,211 claims with a total amount of payment of \$572,843. By extrapolating the dollars in error over the entire universe, OSC has determined that the true overpayment of improper claims is no less than \$137,106. Given the egregious nature of the conduct that resulted in the documented exceptions – billing for services while physically in another job location and billing for services for more than one beneficiary at a time – OSC is adding a civil penalty. Specifically, OSC is seeking the overpayment of \$137,106 plus a civil penalty of \$137,106, for a total recovery of \$274,212.

Background

The Division of Medical Assistance and Health Services (DMAHS), within the 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. Under Medicaid, intensive in-community mental health rehabilitation services are designed to improve or stabilize children or 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 increased clinical risk or otherwise negatively affect a person's ability to function. The services are rendered within the context of an approved plan of care and are restorative or preventative in nature.

OSC conducted a review of Medicaid claims submitted by and paid to Gloria Andrade, an LCSW located in Teaneck, New Jersey. Gloria Andrade enrolled in the Medicaid program as an intensive in-community mental health rehabilitation services provider on January 1, 2005.

Objective

The objective of this review was to evaluate claims billed and paid to Gloria Andrade to determine whether she billed for mental health rehabilitation services in compliance with Medicaid requirements under state and federal laws and regulations.

Scope

The scope of this review includes a review of paid and adjusted claims under HCPCS codes H0036 and H0018 for the period January 1, 2012 through December 31, 2015. The review is being conducted under the authority of Office of the State Comptroller *N.J.S.A. 52:15C-23* and the Medicaid Program Integrity and Protection Act, *N.J.S.A. 30:4D-53 et seq.*

Methodology

OSC's methodology consisted of the following:

- Review a statistically valid sample of 70 service days representing 235 claims totaling \$62,206.50 selected from a population of 2,211 claims totaling \$572,843.50 billed under HCPCS codes H0036 and H0018.
- Review records to determine whether proper documentation exists to substantiate that: services were rendered; services were pre-authorized; services were documented in the progress notes; and, a parent/guardian attested to services having been performed on the Service Delivery Encounter Documentation (SDED) forms.

Findings

Billing for Multiple Services to Different Beneficiaries Occurring at the Same or Overlapping Times

The SDED form is a critical document used by behavioral health professionals in Medicaid to document the service provided and time spent providing such service, including the start and end time for each behavioral health session. This form, which must be signed and dated to demonstrate its authenticity, is designed to reflect every service encounter between a provider and beneficiary. Multiple regulations, including regulations issued by DHS for Medicaid beneficiaries receiving mental health rehabilitation services, require providers to prepare and maintain valid SDED forms for every Medicaid beneficiary encounter.

OSC reviewed records for 70 service dates representing 235 claims to determine whether Gloria Andrade completed the SDED form documenting that services were rendered. OSC compared the encounter date and time recorded on the SDED form to each service date to determine if an overlap of time existed between multiple services. OSC found that 55 of the 235 sample claims reflected overlapping service times. Based on this finding, Gloria Andrade billed for more hours of service than were rendered, as she billed for services for multiple beneficiaries on the same date of service occurring at the same or overlapping times. For example, one SDED form documented that she provided services on November 9, 2013 from 1:00 PM to 3:30 PM for a Medicaid beneficiary. A second SDED form for that same date documented that she provided services to a different Medicaid beneficiary from 1:30 PM to 3:30 PM, an overlap of two service hours (1:30 PM to 3:30 PM).

Further, in 36 of the 55 claims, Gloria Andrade included travel time to and from the location of the beneficiary in the calculation of face-to-face contact with beneficiaries, despite a regulation that prohibits including travel time in a request for reimbursement of this type. For example, one SDED form documented that she provided services for a beneficiary on April 18, 2015 from 3:30 PM to 6:00 PM. A second SDED form for that same date recorded services rendered to a different beneficiary from 6:00 PM to 8:00 PM. According to Google Maps, the addresses for the two beneficiaries for whom Gloria Andrade provided services on April 18th were five miles and approximately 15 minutes

apart. Notwithstanding that distance and the time needed to travel between these two locations, Gloria Andrade billed for a full four and a half hours (4.5) hours of face-to-face contact and for travel between the locations.

Pursuant to New Jersey Administrative Code (*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.* 10:77-5.12(d)(3)(5), providers shall maintain support of all intensive in-community mental health rehabilitation services claims including "the exact date(s), location(s) and time(s) of service." Also, 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."

Billing for Services While Working a Secondary Job

OSC reviewed records for the 70 service dates representing 235 claims to determine whether the services Gloria Andrade billed to Medicaid were rendered. OSC subpoenaed employment attendance records from her secondary employer for the period and compared those records to Gloria Andrade's paid claims data. OSC found that 37 of the 235 sample claims reflected services that overlapped with timeframes when Gloria Andrade was working for a secondary employer. In other words, in these instances, she billed and was paid Medicaid funds for services provided to Medicaid beneficiaries during days and times when she was working at another job. OSC performed an analysis by service day and compared the SDED forms date and time to the paid claims date of service and employment attendance records and found instances where Gloria Andrade billed and received payment for Medicaid services while she was working at her secondary job. For example, according to the access card history report obtained from her secondary employer, on March 11, 2014, Gloria Andrade punched in at 7:24 am and punched out at 3:49 pm. But on the same day, she billed Medicaid for services from 1:00 pm to 3:30 pm, reflecting Medicaid services billed for by Gloria Andrade that occurred while Gloria Andrade was working at her secondary job.

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."

Unsubstantiated Services Billed

OSC reviewed records for 70 service dates representing 235 claims to determine whether the services that Gloria Andrade billed to Medicaid were rendered. OSC compared the service date and time recorded on the SDED form to the dates and time indicated on the Medicaid claims paid to Gloria Andrade. OSC found that for 31 of the 235 sample claims, Gloria Andrade billed for services that she could not provide documentation to support or submitted a SDED form with a different service date which did not correspond with the Medicaid paid claims data. Providers are required to bill and submit claims based on true, accurate and complete information.

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."

Undocumented Services

OSC reviewed records for 70 service dates representing 235 claims to determine whether services that Gloria Andrade provided were adequately documented in the medical record. OSC found that 17 of the 235 sample claims did not meet the appropriate documentation requirements. Specifically, for these 17 sample claims, there was no progress note maintained in the case files. Progress notes provide documentation that services were rendered to the recipient, and also provide necessary information as to the treatment provided, the beneficiary's response to the treatment, significant events impacting the beneficiary's condition or treatment, and any other information pertinent to the recipient's clinical course.

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. 10:77-5.12(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."

Summary of Overpayments

Based on its review, OSC determined that 116 of the 235 sample claims for Medicaid reimbursement failed to comply with state and federal requirements. The payments for these claims totaled \$23,362.75 in overpayments. For purposes of ascertaining a recovery amount, the error rate for claims that failed to comply with state and federal regulations was extrapolated to the total population of claims from which the sample claims were drawn, which in this case was 2,211 claims with a total amount of payment of \$572,843. By extrapolating the dollars in error over the entire universe, OSC has reasonably determined that the true overpayment of improper claims is no less than \$137,106. Given the egregious nature of the conduct resulting in the documented exceptions - billing for services while physically in another job location and billing for services for more than one beneficiary at a time - OSC is adding a civil penalty pursuant to *N.J.S.A. 30:4D-7(h)* and *N.J.S.A. 30:4D-17(e)*. For the reasons set forth above, OSC is seeking a recovery of \$274,212, which is comprised of an overpayment of \$137,106 and a civil penalty of \$137,106.

Pursuant to *N.J.S.A. 30:4D-7(h)*, MFD is authorized to "take all necessary action to recover any and all payments incorrectly made to or illegally received by a provider from such provider" and to "assess and collect such penalties as are provided for herein."

Pursuant to *N.J.S.A.* 30:4D-7(i), MFD is authorized to recover “the cost of benefits incorrectly provided to or illegally obtained” and is further authorized to “assess and collect” penalties.

Pursuant to *N.J.S.A.* 30:4D-17(e), providers “shall be liable to civil penalties of payment of an amount not to exceed three-fold the amount of such excess benefits or payments;” and for “payment in the sum of not less than and not more than the civil penalty allowed under the federal False Claims Act.”

Gloria Andrade Response

In a written response dated October 30, 2018, Mr. Michael A. Mark, attorney for Gloria Andrade, disagreed with the audit findings and stated that, “Gloria Andrade denies making any intentional misrepresentations in connection with billing practices as a Licensed Clinical Social Worker. Ms. Andrade denies billing fraud.” Further, Ms. Andrade’s attorney stated, “At most, there may be confusion caused by inadvertent errors and improperly completed billing records. Ms. Andrade submits that billing was an overwhelming task. However, all services billed were in fact performed. Further, Ms. Andrade rejects the State’s contention that she was fabricating Medicaid billing records for times that she was at her full time job. The contention is not accurate. Ms. Andrade’s hours at her full time job were very flexible. This flexibility allowed Ms. Andrade to perform Medicaid services during the regular working day.” The full text of the Ms. Andrade’s response is included as an Appendix to this report

OSC Comments

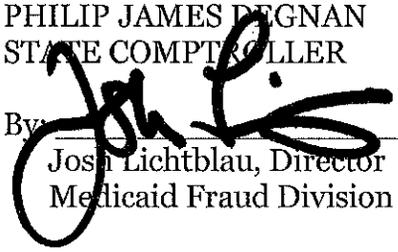
Ms. Andrade’s disagreement with the audit findings is without merit. This response contained broad refutations of the OSC findings, but it failed to provide any facts to substantiate Ms. Andrade’s claim that her billing was appropriate or information that would provide a basis for OSC to revise any of its findings. In contrast, OSC’s findings were based on careful analyses involving Ms. Andrade’s submission of required Medicaid documentation and her work attendance records, which OSC obtained from her full-time employer. In sum, notwithstanding Ms. Andrade’s disagreement with the audit findings, OSC finds no basis to alter the audit findings, including the imposition of a civil penalty. Consequently, OSC Ms. Andrade must reimburse the Medicaid program \$274,212.

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
Gloria Andrade, LCSW

Thank you for your attention in this matter.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: 

Josh Lichtblau, Director
Medicaid Fraud Division

Attachment (Auditee's response)

Cc: Kay Ehrenkrantz, Deputy Director
Michael Morgese, Audit Supervisor
Don Catinello, Supervising Regulatory Officer
Glenn Geib, Recovery Supervisor

Michael A. Mark

Attorney At Law

Certified By The Supreme Court Of New Jersey As A Civil Trial Attorney



October 30, 2018

Sent this date by email transmission only to Michael.morgese@osc.nj.gov

State of New Jersey
Office of State Comptroller
Medicaid Fraud Division
Box 025
Trenton, NJ 08625-0025

Re: Gloria Andrade v. Medicaid Fraud Division

Dear Sir/Madam:

Please note that this law firm represents Ms. Gloria Andrade in connection with the above referenced matter.

This letter is in response to the State's October 18, 2018 Draft Report letter.

Gloria Andrade denies making any intentional misrepresentations in connection with billing practices as a Licensed Clinical Social Worker. Ms. Andrade denies billing fraud. It was never the case that Ms. Andrade did not provide any services billed for. As a Spanish speaking therapist, Ms. Andrade was in heavy demand and consequently assigned a heavy case load. At most, there may be confusion caused by inadvertent errors and improperly completed billing records. Ms. Andrade submits that billing was an overwhelming task. However, all services billed for were in fact performed.

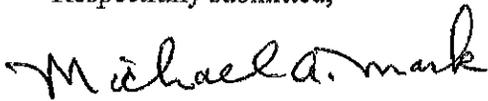
Further, Ms. Andrade rejects the State's contention that she was fabricating Medicaid billing records for times that she was at her full time job. This contention is not accurate. Ms. Andrade's hours at her full time job were very flexible. This flexibility allowed Ms. Andrade to perform Medicaid services during the regular working day. We note that the State fails to provide evidence that Ms. Andrade was physically at her full time job while it also alleges that she was at a patient's house. She was not required to be at her full time job from 9AM to 5PM. She was allowed to make up any lost time from her full time job on weekends. Some of Ms. Andrade's workdays began at 7AM and ended as late as 10PM. Working Saturdays and Sundays were commonplace.

This letter is not intended to be a complete recitation of Ms. Andrade's position.

State of New Jersey
Office of State Comptroller
Medicaid Fraud Division
Box 025
Trenton, NJ 08625-0025
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Thank you.

Respectfully submitted,



Michael A. Mark, Esq.

C: Justin Berardo, Esq. (by fax to (609) 826-4801
Peter Willis, Esq.
Gloria Andrade (via email transmission)
Deborah Pico, Esq. by fax (201) 947-3488

E MAIL: MICHAEL@MARKNJLAW.COM

262 Lincoln Avenue Phone (973) 423-9000 Fax (973) 423-0625 Hawthorne, NJ 07506