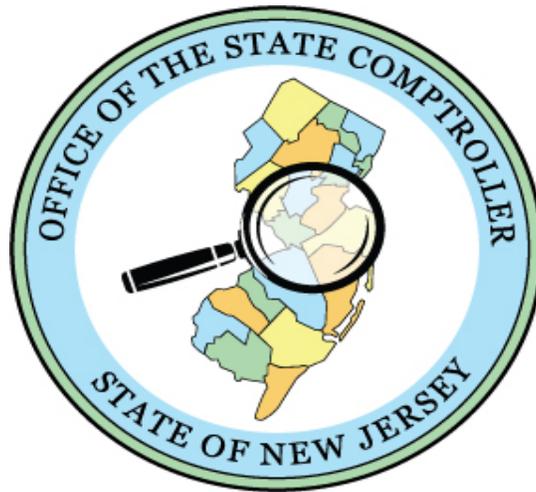


**STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION**

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



Reporting Period: July 1, 2018 to December 31, 2018

**Philip James Degnan
STATE COMPTROLLER**

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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 2019.

III. SUMMARIES OF AUDIT FINDINGS AND RECOMMENDATIONS

During the first and second quarters of Fiscal Year 2019, MFD auditors issued three audits of Medicaid health care providers located throughout the state. Collectively, these audits found that the audited providers received more than \$3.5 million dollars in improperly paid Medicaid funds. To date, MFD has recovered more than \$970,000 of these 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 for each of these audits are summarized below and copies of the official audit reports are included in the attached appendix.

Ocean County Internal Medical Associates

In this audit, MFD auditors found that Ocean County Internal Medical Associates (OCIMA) had improperly submitted 9,766 standalone claims to Medicaid using an “add-on” billing code for services provided outside normal business hours while evidence showed that the services actually were provided during OCIMA’s normal business hours. MFD recommended that OCIMA reimburse the Medicaid program \$232,241 to account for these claims.

Ammon Analytical Laboratory, LLC

Ammon is an independent clinical laboratory testing provider. In this audit, MFD auditors found that Ammon had improperly submitted more than \$3 million in claims related to various drug testing services. Ammon agreed with MFD’s findings and as part of a settlement agreed to reimburse Medicaid \$3,022,696. Ammon also agreed to implement a CAP to address the deficiencies found in this audit.

Gloria Andrade, Licensed Clinical Social Worker

In this audit, MFD auditors reviewed numerous claims submitted by Gloria Andrade, LCSW, to determine whether she had properly billed Medicaid for mental health rehabilitation services. MFD found multiple exceptions during the course of the audit including that Andrade had improperly billed Medicaid for services provided at one location while she was physically located at another facility and that she had improperly billed for services provided to more than one recipient at the same time. Given the egregious nature of her conduct, in addition to requiring Andrade to reimburse the Medicaid program for the identified overpayments, MFD assessed a civil

penalty. As a result of this audit, MFD concluded that Andrade should reimburse Medicaid more than \$274,000.

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 \$4.8 million to be paid back to the Medicaid program.¹ These settlements are listed below:

<u><i>Provider</i></u>	<u><i>Settlement Amount</i></u>
Nader Mishreki, M.D. (Bayonne, N.J.)	\$65,000
Edgar Mejia, M.D. (Paterson, N.J.)	\$86,121
Diego Morillo, O.D. (Newark, N.J.)	\$50,570
Comfort Care Medical, LLC (Jersey City, N.J.)	\$160,000
Senior Spirit of Jersey City (Jersey City, N.J.)	\$298,952
University Hospital (Newark, N.J.)	\$174,098
Muhammad Selevany, M.D. (Paterson, N.J.)	\$355,100
Ernesto Saravia, L.P.C. (Pompton Lakes, N.J.)	\$335,513

¹ Some of these settlements may have been separately reported during this time period.

<u><i>Provider</i></u>	<u><i>Settlement Amount</i></u>
Health Aid Drugs, Inc. (Jersey City, N.J.)	\$34,848
Bob's Pharmacy (Elizabeth, N.J.)	\$856,000
Irving Pharmacy (Paterson, N.J.)	\$11,493
Pediatric Cardiology (Brick, N.J.)	\$157,353
Sheefa Pharmacy (Paterson, N.J.)	\$85,000
Health Fair Pharmacy (Hoboken, N.J.)	\$107,100
Cherry Hill Women's Center, Inc. (Cherry Hill, N.J.)	\$500,000
Emes Pharmacy (Lakewood, N.J.)	\$1,270,000
My Friend's Pharmacy (Passaic, N.J.)	\$95,000
Vinod Lala, M.D. (Jersey City, N.J.)	\$125,320
John Fernandes, M.D. (West Orange, N.J.)	\$86,310

Ocean County Internal Medical Associates



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July 11, 2018

BY CERTIFIED AND ELECTRONIC MAIL

Dr. Jonathan Cohen
Ocean County Internal Medicine Associates, P.C.
1352 River Avenue
Lakewood, NJ 08701

**RE: Final Audit Report – Ocean County Internal Medicine Associates,
P.C.’s Use of American Medical Association’s CPT Code 99050**

Dear Dr. Cohen:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted an audit of Medicaid claims submitted by Ocean County Internal Medicine Associates, P.C. and its group members (OCIMA). The audit period covered July 1, 2011 through June 30, 2016. OSC hereby provides you with this Final Audit Report.

Executive Summary

OSC identified and reviewed OCIMA’s billing of American Medical Association’s (AMA) Current Procedural Terminology (CPT) code 99050, an add-on code used to receive additional reimbursement for “services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed [*e.g.*, evenings, weekends, and holidays]” (CPT Assistant: August 2010 – Volume 20: Issue 8). OSC found that OCIMA improperly billed this add-on payment code for services provided during regular office hours, which is not consistent with AMA’s CPT requirements for this code. Accordingly, OSC seeks a recovery for all noncompliant claims for which OCIMA billed and received payment.

After reviewing OCIMA’s records, representations, and formal response to OSC’s Draft Audit Report, OSC has determined that, during the audit period, OCIMA’s regularly scheduled office hours included early mornings, evenings, weekends, and holidays. Thus,

OCIMA should not have billed and received payment for CPT code 99050 during this period. In total, for the audit period, OCIMA submitted 9,766 claims for CPT code 99050 for which it was paid \$232,241. Accordingly, OSC seeks reimbursement of this amount.

Background

As a condition of participation in the Medicaid program, Medicaid providers are required to adhere to all applicable state and federal laws and regulations. Similarly, the state contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and the Managed Care Organizations (MCOs) requires the MCOs and their providers to adhere to applicable New Jersey laws and regulations. Among other requirements, providers must follow the AMA's standards relating to coding, reporting, and billing of medical procedures and services.

OSC conducted an audit of OCIMA's use of CPT code 99050, which is an after-hour add-on code that may be billed in addition to basic service codes but cannot be billed on its own. This after-hour code provides additional payments for claims associated with evaluation and management (E&M) services, which are basic services, provided to beneficiaries outside of a provider's established business hours. The additional payments are meant to compensate providers for the additional costs (*e.g.*, overtime, night differential) associated with providing services outside a medical practice's standard business hours.

The AMA publishes a monthly newsletter, titled "CPT Assistant," which provides information and clarification regarding proper CPT code usage. According to the CPT Assistant (August 2010 - Volume 20: Issue 8), prior to 2006, CPT code 99050 was used for "services requested after posted hours in addition to basic service." In 2006, CPT code 99050 was revised to cover "services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (*e.g.*, holidays, Saturday or Sunday), in addition to basic service." The CPT Assistant reference for CPT code 99050 explained that this code is used to provide supplemental reimbursement for "the additional time and effort involved with conducting the services outside of the office's standard business hours." As explained by the CPT Assistant, concurrently with the language change for CPT code 99050 in 2006, CPT code 99051 was added to bill for "[s]ervice(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service," to delineate practices that regularly provide services at times other than regular daytime business hours."

The CPT Assistant (August 2006 - Volume 16: Issue 8) included the following clinical example of when to bill using CPT code 99050: "A patient develops severe ear pain that is unresponsive to home treatment. Late Monday evening after the office is closed, the physician agrees by telephone to meet the patient in the office to provide treatment." In that example, according to the CPT Assistant, the provider would bill using CPT code 99050 in addition to the basic service code. Likewise, the CPT Assistant included a clinical example of when to bill using CPT code 99051: "A patient presents with a cough and fever on a weekend afternoon to an office with regularly scheduled weekend and evening

hours.” In that example, according to the CPT Assistant, the provider would bill using CPT code 99051 in addition to the basic service code.

According to the CPT Assistant, while the meaning of CPT code 99050 has remained essentially the same during the entire period discussed above (*i.e.*, to describe services provided outside of regularly scheduled hours and during unscheduled weekend and holiday hours), in 2006 the CPT code description of CPT code 99050 was revised to differentiate this code from the services described in CPT code 99051, which was added as a code in 2006.

Based on the claims reviewed by OSC, nearly all of OCIMA’s Medicaid beneficiaries are enrolled in UnitedHealthcare Community Plan of New Jersey (UHC). Accordingly, in order to determine OCIMA’s regularly scheduled office hours and whether they included evenings, weekends, and holidays, OSC also reviewed UHC’s “After Hours and Weekend Care Policy,” the hours of operation provided by OCIMA on UHC’s credentialing documents at the time of enrollment, OCIMA’s office hours inputted by OCIMA into UHC’s website, as well as guidance provided by UHC. Further, OSC considered that during the audit period UHC’s policy was not to reimburse provider claims for CPT code 99051 for services provided to beneficiaries in the office during regularly scheduled evening, weekend, or holiday office hours.

Audit Objective and Scope

The objective of this audit was to determine whether OCIMA billed claims using CPT code 99050 in compliance with state and federal laws and regulations, and AMA’s CPT code requirements. The audit period was July 1, 2011 through June 30, 2016. This audit was conducted pursuant to OSC’s authority 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 Finding: OCIMA Incorrectly Billed CPT Code 99050 during Regularly Scheduled Office Hours

In ascertaining whether OCIMA’s use of CPT code 99050 was appropriate, OSC first determined what OCIMA represented as its regularly scheduled office hours and then compared those with OCIMA claims to determine whether OCIMA frequently provided services at times other than its represented regularly scheduled office hours. OSC found that although OCIMA represented that its regular hours were Monday to Friday, varying from between 9:00 a.m. and 9:30 a.m. to 4:00 p.m. and 4:30 p.m., OCIMA’s regularly scheduled office hours were not limited to those hours. The following analyses led to the conclusion that OCIMA had regularly scheduled office hours on early mornings, evenings, weekends, and holidays, and it incorrectly billed and was paid for CPT code 99050 for office visits during these hours. Since OCIMA did not provide support that any CPT code 99050 claims met the AMA requirements of CPT code 99050, OSC seeks to recover all OCIMA claims for CPT code 99050 rendered during the audit period.

1. Office Hours Listed on UHC's Credentialing Documents

In order to determine OCIMA's regularly scheduled hours of operation, OSC examined the credentialing documents that OCIMA provided to UHC when OCIMA enrolled in UHC's managed care network. "Credentialing" is the process by which an MCO assesses and validates the applicable criteria and qualifications of licensed independent practitioners and facilities that seek to become or continue as participating practitioners and participating facilities within an MCO. According to this submission, OCIMA providers maintained regularly scheduled hours of operation that included early morning and late evening weekday hours and Sunday hours. Table I below summarizes OCIMA's office hours as reflected in UHC's credentialing documents.

Table I

Office Hours Listed on UHC's Credentialing Documents						
	J. Cohen, M.D.		B. Gordon, M.D.		T. Green, M.D.	
Sunday	11:00 AM	4:00 PM	None Provided		None Provided	
Monday	8:30 AM	1:00 PM	6:00 AM	7:00 PM	9:30 AM	4:30 PM
Tuesday	8:30 AM	11:00 PM	6:00 AM	6:00 PM	9:30 AM	4:30 PM
Wednesday	8:30 AM	11:00 PM	None Provided		9:30 AM	4:30 PM
Thursday	8:30 AM	11:00 PM	6:00 AM	7:00 PM	9:30 AM	4:30 PM
Friday	8:30 AM	5:00 PM	None Provided		9:30 AM	4:30 PM
Saturday	None Provided		None Provided		None Provided	
	A. Lempel, M.D.		D. Ogun, M.D.		N. Sokol, M.D.	
Sunday	None Provided		11:00 AM	4:00 PM	10:30 AM	4:00 PM
Monday	9:30 AM	4:30 PM	8:30 AM	11:00 PM	8:30 AM	10:00 PM
Tuesday	9:30 AM	4:30 PM	8:30 AM	11:00 PM	8:30 AM	10:00 PM
Wednesday	9:30 AM	4:30 PM	8:30 AM	11:00 PM	8:30 AM	10:00 PM
Thursday	9:30 AM	4:30 PM	8:30 AM	11:00 PM	8:30 AM	10:00 PM
Friday	9:30 AM	4:30 PM	8:30 AM	5:00 PM	8:30 AM	5:30 PM
Saturday	None Provided		None Provided		None Provided	

2. OCIMA's Office Hours Listed on UHC's Primary Care Physicians' Website

OCIMA is responsible for inputting and updating its office hours in UHC's online provider portal. This website portal provides Medicaid beneficiaries with a directory of locations and scheduled office hours for physicians, hospitals, laboratories, and other healthcare professionals that participate in a specific beneficiary's benefit plan.

Table II below summarizes the office hours that OCIMA self-disclosed on UHC's primary care physicians' (PCP) provider website. As shown in Table II, Dr. Lempel had regularly scheduled hours on Saturday and five of the six practicing physicians had regularly scheduled hours on Sunday.

Table II

Office Hours Listed on UHC's Primary Care Physicians' Website (as of 2/28/2017)						
	J. Cohen, M.D.		B. Gordon, M.D.		T. Green, M.D.	
Sunday	11:00 AM	3:30 PM	None Provided		11:00 AM	3:30 PM
Monday	9:00 AM	4:00 PM	None Provided		9:15 AM	4:15 PM
Tuesday	9:00 AM	4:00 PM	None Provided		9:15 AM	4:15 PM
Wednesday	9:00 AM	4:00 PM	None Provided		9:15 AM	4:15 PM
Thursday	9:00 AM	4:00 PM	None Provided		9:15 AM	4:15 PM
Friday	9:00 AM	4:00 PM	None Provided		8:30 AM	2:30 PM
Saturday	None Provided		None Provided		None Provided	
	A. Lempel, M.D.		D. Ogun, M.D.		N. Sokol, M.D.	
Sunday	11:00 AM	3:30 PM	11:00 AM	3:30 PM	11:00 AM	3:30 PM
Monday	9:15 AM	4:15 PM	9:15 AM	4:30 PM	9:15 AM	4:15 PM
Tuesday	9:15 AM	4:15 PM	9:15 AM	4:30 PM	9:15 AM	4:15 PM
Wednesday	9:15 AM	4:15 PM	9:15 AM	4:30 PM	9:15 AM	4:15 PM
Thursday	9:15 AM	4:15 PM	9:15 AM	4:30 PM	9:15 AM	4:15 PM
Friday	8:30 AM	2:30 PM	8:30 AM	2:30 PM	8:30 AM	2:30 PM
Saturday	8:30 AM	2:30 PM	None Provided		None Provided	

The credentialing documents OCIMA provided to UHC and the office hours included by OCIMA on UHC's PCP website together demonstrated that OCIMA's regularly scheduled hours included early mornings, late evenings, and weekends. Thus, based on OCIMA's self-reported information, OCIMA lacked a basis to bill CPT code 99050 during these periods.

The following sections provide further support for OSC's determination that OCIMA's regular office hours included holidays and weekends during the audit period.

3. OCIMA's Office Hours Included Holidays

CPT code 99050 describes services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed, such as holidays. If a provider's regularly scheduled office hours included holidays, that provider is not entitled to bill and receive payment for services under CPT code 99050. Accordingly, to determine the propriety of OCIMA's claims for services billed and paid under CPT code 99050 on holidays, OSC first ascertained whether OCIMA was regularly open and treated beneficiaries on holidays. To that end, OSC analyzed claims from seven holidays during the audit period: Fourth of July, Labor Day, Thanksgiving Day, Christmas Day, New Year's Day, Easter, and Memorial Day.

As explained in more detail below, from its analysis of OCIMA's schedule, OSC found that OCIMA billed and was paid for claims for services for add-on CPT code 99050 on the majority of the referenced holidays during the audit period. In most cases, more than one OCIMA physician billed under CPT code 99050 and OCIMA practitioners provided

services to multiple beneficiaries on these holidays. This indicated OCIMA held regularly scheduled office hours on these holidays, as opposed to a physician opening or returning to the office to provide service to a beneficiary outside of the office's regularly scheduled hours. Table III below summarizes the number of beneficiaries for whom OCIMA billed CPT code 99050 on seven holidays during the audit period.

Table III

Number of Beneficiaries Treated on Holidays During the Audit Period for CPT Code 99050 Claims				
DATE	HOLIDAY	DAY OF WEEK	NUMBER OF BENEFICIARIES	SERVICING PROVIDERS
July 4, 2011	Fourth of July	Monday	15	Cohen, Lempel, Ogun
July 4, 2012	Fourth of July	Wednesday	18	Cohen, Lempel, Ogun
July 4, 2013	Fourth of July	Thursday	20	Cohen, Gordon, Ogun
July 4, 2014	Fourth of July	Friday	35	Cohen, Gordon, Lempel, Ogun, Sokol
July 4, 2015	Fourth of July	Saturday	0	Note: Beneficiary was seen, but 99050 was not billed.
			<u>88</u>	
September 5, 2011	Labor Day	Monday	13	Cohen, Lempel, Ogun
September 3, 2012	Labor Day	Monday	11	Cohen, Ogun
September 2, 2013	Labor Day	Monday	2	Gordon
September 1, 2014	Labor Day	Monday	29	Cohen, Gordon, Lempel, Ogun
September 7, 2015	Labor Day	Monday	25	Lempel, Ogun
			<u>80</u>	
November 24, 2011	Thanksgiving Day	Thursday	15	Cohen, Lempel, Ogun
November 22, 2012	Thanksgiving Day	Thursday	0	Note: Beneficiaries were seen, but 99050 was not billed.
November 28, 2013	Thanksgiving Day	Thursday	0	Note: Beneficiaries were seen, but 99050 was not billed.
November 27, 2014	Thanksgiving Day	Thursday	17	Cohen, Lempel, Ogun
November 26, 2015	Thanksgiving Day	Thursday	0	Note: Beneficiaries were seen, but 99050 was not billed.
			<u>32</u>	
December 25, 2011	Christmas Day	Sunday	11	Ogun, Sokol
December 25, 2012	Christmas Day	Tuesday	12	Lempel, Ogun, Sokol
December 25, 2013	Christmas Day	Wednesday	27	Gordon, Lempel, Ogun, Sokol
December 25, 2014	Christmas Day	Thursday	15	Lempel, Ogun
December 25, 2015	Christmas Day	Friday	0	Note: Beneficiaries were seen, but 99050 was not billed.
			<u>65</u>	
January 1, 2012	New Year's Day	Sunday	18	Lempel, Sokol
January 1, 2013	New Year's Day	Tuesday	31	Cohen, Lempel, Ogun, Sokol
January 1, 2014	New Year's Day	Wednesday	28	Cohen, Gordon, Lempel, Ogun, Sokol
January 1, 2015	New Year's Day	Thursday	24	Cohen, Lempel
January 1, 2016	New Year's Day	Friday	28	Cohen, Lempel, Ogun
			<u>129</u>	
April 8, 2012	Easter	Sunday	0	Note: No beneficiaries were seen.
March 31, 2013	Easter	Sunday	10	Lempel, Ocean County Internal Medicine
April 20, 2014	Easter	Sunday	8	Ogun
April 5, 2015	Easter	Sunday	0	Note: No beneficiaries were seen.
March 27, 2016	Easter	Sunday	19	Cohen
			<u>37</u>	
May 28, 2012	Memorial Day	Monday	0	Note: No beneficiaries were seen.
May 27, 2013	Memorial Day	Monday	24	Cohen, Gordon, Ogun
May 26, 2014	Memorial Day	Monday	27	Cohen, Gordon, Lempel, Ogun
May 25, 2015	Memorial Day	Monday	0	Note: No beneficiaries were seen.
May 30, 2016	Memorial Day	Monday	7	Cohen, Ogun
			<u>58</u>	
	Total		489	

After analyzing OCIMA's activity on the seven holidays noted above, OSC concluded that OCIMA had regularly scheduled hours on these holidays during the audit period. Accordingly, OCIMA should not have billed and been paid for claims for services under CPT code 99050 during these regularly scheduled hours.

4. OCIMA's Regularly Scheduled Office Hours Included Weekends

To determine whether OCIMA's claims for services billed and paid under CPT code 99050 on Sundays were appropriate, OSC analyzed whether OCIMA was regularly open and treated beneficiaries on Sundays.

OSC's analysis of OCIMA's claims for services billed and paid under CPT code 99050 by day of the week found that OCIMA provided services to a significant number of beneficiaries on a regular basis on Sundays during the audit period. OCIMA billed 3,812 claims for services for CPT code 99050 on 242 of 261 Sundays during the audit period. In other words, OCIMA billed for services provided on approximately 93 percent of the Sundays in the five-year audit period. On average, OCIMA submitted claims for services to approximately 16 beneficiaries per day on the 242 Sundays under CPT code 99050.

Table IV below summarizes CPT code 99050 paid claims by day of the week during the audit period.

Table IV

CPT Code 99050 Paid Claims by Day of the Week					
	Number of Days in Audit Period	Number of Days with 99050 Claims	Number of 99050 Paid Claims	Average Beneficiaries Per Day for 99050 Claims	Total Amount Paid for 99050 Claims
Sunday	261	242	3,812	15.8	\$90,783
Monday	261	234	1,662	7.1	\$39,476
Tuesday	261	224	1,518	6.8	\$36,381
Wednesday	261	232	1,298	5.6	\$30,747
Thursday	261	215	983	4.6	\$22,936
Friday	261	12	84	7.0	\$2,090
Saturday	262	76	409	5.4	\$9,828
Total	1,828	1,235	9,766		\$232,241

After OSC combined the number of Sundays OCIMA submitted claims for services under CPT code 99050 (242 out of 261) with the average number of beneficiaries treated on Sundays and billed under CPT code 99050 (15.8), OSC inescapably concluded that OCIMA held regularly scheduled office hours on Sundays. Accordingly, OCIMA should not have billed and received payment for claims for services under CPT code 99050 on Sundays during the audit period.

In addition to analyzing OCIMA's CPT code 99050 submissions, OSC also evaluated a broader spectrum of OCIMA's claims submissions to more fully assess whether OCIMA held regular office hours on Sundays. Specifically, OSC analyzed the number of days that OCIMA had CPT code 99050 claims as well as the number of days it had evaluation and management claims (E&M) during this same period. From this analysis, OSC found that OCIMA had paid claims for services on 253 out of 261 Sundays in the audit period, which was similar to the number of days that OCIMA had paid claims for Mondays through Fridays. That statistic was consistent with the finding that OCIMA held regular office hours on Sundays. In addition, OCIMA had paid claims for services on approximately 38 percent of the 262 Saturdays in the audit period, which indicated that OCIMA had somewhat regular office hours on Saturdays as well.

Table V below summarizes the number of days with paid CPT code 99050 and E&M claims by day of the week.

Table V

Number of Days with Paid Claims					
	Number of Days with 99050 Claims	Number of Days with E&M Claims	Number of Days with One or More Claims	Number of Days in Audit Period	Number of Days Without Any Claims
Sunday	242	244	253	261	8
Monday	234	251	253	261	8
Tuesday	224	251	251	261	10
Wednesday	232	256	256	261	5
Thursday	215	247	249	261	12
Friday	12	248	251	261	10
Saturday	76	83	100	262	162
Total	1,235	1,580	1,613	1,828	215

OSC also evaluated the number of claims submitted by day of the week in order to compare Sundays with Mondays through Fridays. As shown in Table VI below, OSC found that OCIMA received payment for 14,930 claims for services provided on Sundays, which was more than the number it was paid for Fridays (14,511). Moreover, this analysis showed that of the total of 41,965 E&M claims, OCIMA billed and was paid for 9,766 claims under CPT code 99050, which amounted to 23 percent of the time. In other words, OCIMA received payment for an add-on code that is intended to be used outside of the regular course of business almost one out of every four times it provided E&M services to a Medicaid beneficiary.

Table VI below summarizes paid claims by day of the week.

Table VI

Paid Claims by Day of the Week				
	Number of 99050 Claims Paid	Number of E&M Claims Paid	Number of Other Claims Paid	Number of All Claims Paid
Sunday	3,812	4,164	6,954	14,930
Monday	1,662	8,738	10,374	20,774
Tuesday	1,518	8,332	10,860	20,710
Wednesday	1,298	7,397	9,749	18,444
Thursday	983	6,537	10,494	18,014
Friday	84	6,346	8,081	14,511
Saturday	409	451	4,484	5,344
Total	9,766	41,965	60,996	112,727

The high percentage of beneficiaries treated outside of OCIMA's purported office hours indicated that OCIMA's purported hours do not accurately represent its regularly scheduled office hours. Rather, based on the volume of claims, the services provided in the office during weekends occurred during what must be considered OCIMA's regularly scheduled office hours.

Conclusion

OCIMA submitted and was paid for 9,766 claims totaling \$232,241 for all services billed under CPT code 99050 during the audit period. CPT code 99050 should only be used for services provided outside of regular business hours. From the analyses set forth above, OSC determined that OCIMA's regularly scheduled office hours included early mornings, evenings, weekends, and holidays. Accordingly, OCIMA should not have sought payment for CPT code 99050 claims during these periods.

OSC found that OCIMA incorrectly billed and received payments totaling \$232,241 for 9,766 claims under CPT code 99050 in conjunction with E&M services. OSC seeks to recover the identified overpayment amount of \$232,241 and makes the following recommendations that are designed to ensure that OCIMA's CPT code 99050 billings comply with the AMA CPT requirements in the future.

Recommendations

1. OCIMA must reimburse Medicaid \$232,241 for all claims for services paid from July 1, 2011 through June 30, 2016 under CPT code 99050.
2. OCIMA must immediately discontinue the practice of billing CPT code 99050 during regularly scheduled office hours.

3. OCIMA must provide OSC with a Corrective Action Plan indicating the steps it will take to implement procedures that will ensure proper reporting of CPT code 99050, including the measures it will take to ensure that its staff understands proper billing practices for CPT code 99050.
4. OCIMA must accurately represent an up-to-date listing of its office hours to all interested parties, including but not limited to OSC and applicable MCOs.

OCIMA's Response to the Draft Audit Report and OSC's Comments

After being apprised of the findings above, OCIMA, through counsel, submitted a written response dated March 19, 2018. See Appendix A. OCIMA's objections can be broken into five general points, each of which is discussed below.

1. United Healthcare Community Plan Requested That OCIMA Use CPT Code 99050

OCIMA maintains that United Healthcare Community Plan (UHC) requested that OCIMA offer extended office hours to its Medicaid beneficiaries and bill for office visits during those periods using CPT Code 99050.¹ To support this position, OCIMA cites meetings, discussions, and written communications it had with representatives from UHC. Specifically, OCIMA points to a January 18, 2017 letter from a former UHC employee that OCIMA characterizes as evidence that UHC "directed" OCIMA to use CPT Code 99050 in cases when OCIMA treated beneficiaries outside of its normal, posted office hours. Appendix A, Exhibit D. OCIMA bolsters that claim by pointing to a UHC reimbursement policy that states that after-hour care is reimbursable when it is "required to provide services outside of regular posted office hours. . . ." Appendix A, Page 4. OCIMA notes that UHC "does not specify that the after-hours or weekend care must be occasional, or irregular." *Ibid*.

Notwithstanding OCIMA's claims regarding the guidance it received from UHC, OCIMA failed to demonstrate that any such directives were provided, and when guidance was provided, OCIMA failed to provide OSC with the full context for such guidance. OSC contacted UHC's Compliance Officer who stated that based upon the information available, "United has not been able to verify any guidance was provided to OCIMA regarding the use/inclusion of certain Current Procedural Terminology ("CPT") Codes for billing for covered services." UHC's Compliance Officer did refer to a meeting related to discussions around emergency room reduction and advised, "[a]t this meeting, a number of Codes were discussed; however at no time was there a hard directive on which Codes

¹ OCIMA also states that Amerigroup requested that OCIMA "make extended office hours available, and also indicated that code 99050 could be used for those visits." Appendix A, Page 4. OSC notes that OCIMA's purported office hours in correspondence with Amerigroup do not accurately reflect its regularly scheduled office hours. Nevertheless, the email correspondence from Amerigroup, see Appendix A, Exhibit F, was prospective advice and outside of OSC's audit period. Accordingly, that argument does not affect the findings in this audit.

to use and when to use them.” Appendix B. Similarly, OSC obtained additional relevant emails from UHC regarding its communications with OCIMA, which provided context for UHC’s guidance to OCIMA, that OCIMA neglected to include in its response letter. For example, in an email dated March 19, 2018, to OCIMA’s Quality Improvement Specialist, UHC’s Senior Provider Advocate stated the following:

I wanted to reiterate some scenarios that you may see in your office due to scheduling. In cases where you have visits that may be scheduled for the day that runs over through evening hours (technically after the posted office hours), **the visits would not be considered eligible for afterhours; as they were scheduled visits for your patients that ran over.** Also, if the practice does not close, if you continue seeing patients throughout your normal business day and after hours that would not be considered eligible as you never closed your practice, and just continued seeing patients. If you need further clarification we can discuss further if you like; but the After Hours scenario loans itself to meaning after the practice is technically closed and the provider returns back to the office to see an unscheduled patient in an acute/urgent visit. That is my interpretation. I just wanted to make sure we are on the same page.

[Appendix C.]

Additionally, in an email dated March 20, 2018, UHC’s Senior Provider Advocate advised OCIMA’s Quality Improvement Specialist of the following:

However, my e-mail was intended to provide additional information and reiterating what we discussed as there are so many scenarios that may apply to this policy. I conferred internally with my Director [Provider Relations] and he mentioned the scenario that I described below. I want to provide as much support as possible in helping you administer the coding correctly. That is our interpretation of the policy. There is an expectation that the After Hours Policy is being applied after the office is closed for its routine business; meaning services are being provided “after normal business hours” and it’s not an extension of normal business hours. These services are being rendered to members that have acute/urgent conditions, that would have otherwise been treated in an emergency room. I hope this is helpful.

[*Ibid.*]

The guidance offered by UHC above is consistent with the CPT guidelines as applied by OSC in this audit. OCIMA’s argument to the contrary is without merit because OCIMA is misrepresenting UHC’s position. Specifically, UHC’s explanation of how and when to use CPT code 99050 comports with the AMA CPT code description for CPT code 99050, the AMA CPT Assistant guidance provided for CPT code 99050 usage (August 2010 – Volume 20: Issue 8 and August 2006 – Volume 16: Issue 8), and the criteria OSC applied throughout this audit. OCIMA has also not provided any credible documentation to

support its position that UHC condoned OCIMA's use of CPT code 99050, much less directed OCIMA's billing of CPT code 99050.

OCIMA's argument that UHC's policy does not require after-hours to be "occasional, or irregular," *see* Appendix A, Page 4, defies logic. CPT code 99050 by definition is an add-on code; thus, the volume of billing for this code should reflect an exception-based code. Accordingly, based on the high volume and frequency of OCIMA's billing of CPT code 99050, OSC determined that these claims were improperly billed.

2. The Posted Office Hours OSC Uses in this Audit are Incorrect

OCIMA states that the office hours listed within the Draft Audit Report which reference the office hours listed on the UHC website are "completely inaccurate." Appendix A, Page 2. OCIMA further states that the UHC website "lists a completely different array of hours for physicians in the Practice than the hours which are listed on the office door of the Practice office, and which are in fact maintained by OCIMA as its regular office hours." *Id.*

According to UHC, when providers join its network, providers are initially responsible for submitting credentialing documents, including their office hours. OSC also has been advised by UHC that providers have the ability to update their demographic information, including office hours, in real time, through UHC's Provider Portal. Appendix B. OCIMA stated that it tried to revise the office hours listed on UHC's PCP website in March 2018 but was unable to make the changes. This issue does not affect the findings in OSC's audit because OCIMA's effort to change its office hours on UHC's PCP website occurred outside the audit period.

OCIMA is responsible for ensuring that its physicians' regularly scheduled office hours are properly reflected on UHC's PCP website. Medicaid beneficiaries rely on the information posted on each MCO's website when choosing a physician or practice, and the Medicaid program oversight staff rely on the information to determine whether each MCO is providing sufficient access to care. The fact that OCIMA only recently attempted to revise its practice's and physicians' regularly scheduled office hours does not change the fact that the information cited by OSC accurately reflected the hours listed during the audit period. In addition, contrary to OCIMA's representations, OSC is aware that the office hours reflected on OCIMA's entrance door, *see* Appendix A, Exhibit C, were revised after the audit period during the pendency of this audit. Appendix D. Because this change took place after the audit period, it does not affect the findings in OSC's audit.

3. OSC's Statistical Analysis of OCIMA's Use of CPT Code 99050 is Flawed

OCIMA questions the analysis provided in Table III ("Number of Beneficiaries Treated on Holidays During the Audit Period for CPT Code 99050 Claims"), noting that "in the case of each holiday, there were zero (or two) patients seen on certain of the dates listed," and "during calendar year 2015, code 99050 was only billed on two of the seven holidays reviewed." Appendix A, Page 5. OCIMA further states that if the office was open on a regular basis on holidays, OCIMA would have seen beneficiaries on every holiday.

OCIMA's assertions with respect to Table III are without merit. Table III simply identified the number of claims where OCIMA included the add-on CPT code 99050 when the claims for payment were submitted to Medicaid on each holiday listed, not the number of Medicaid beneficiaries seen. Of the 35 holidays listed in Table III, all holidays had billings for evaluation and management (E&M) claims or CPT code 99050 claims on all secular holidays except for four that coincided with religious holidays. That factual backdrop supports OSC's conclusion that these visits constituted "regularly scheduled" office visits.

OCIMA's claim that OSC's analysis in Table VI ("Paid Claims by Day of the Week") "undercuts the validity of the findings" is also misplaced. *Ibid.* In support, OCIMA points out that the number of CPT code 99050 claims represents "a very small percentage of the total number of all claims paid for patients seen in the offices of OCIMA for the period under review." *Ibid.* OCIMA's effort to compare CPT code 99050 claims to the total number of all claims paid does not affect the findings in OSC's audit. CPT code 99050 may be billed in addition to an E&M code, which is a basic service code, and cannot be billed alone. Accordingly, the appropriate comparison as explained in the Draft Audit Report indicates that of the 41,965 E&M claims, OCIMA billed and was paid for 9,766 claims under CPT code 99050, which amounts to 23 percent of the time or nearly one of every four office visits. The high percentage represents an anomaly. In other words, in 23 percent of its E&M claims, OCIMA billed and received payment for an add-on code that can only be used outside the regular course of business. That leads OSC to question how an after-hour add-on code can be found in almost a quarter of OCIMA's E&M claims. It should be further noted that OSC's analyses throughout this report represent only billings for Medicaid beneficiaries, which OCIMA claims are about 30 percent of its business. Therefore, one can safely conclude that there were many other non-Medicaid beneficiaries seen early mornings, evenings, weekends, and holidays during the audit period.

In sum, OSC stands by its conclusion that the high volume and frequency of CPT code 99050 billings for Medicaid beneficiaries treated outside of OCIMA's alleged regular office hours further demonstrates that these services were, in fact, provided during OCIMA's regular office hours.

4. OCIMA Claims That Disallowing All CPT Code 99050 Submissions is Unreasonable

OCIMA maintains that disallowing all of the CPT code 99050 claims submitted during the audit period is "arbitrary, capricious, and unreasonable." Appendix A, Page 6. In support, OCIMA states that OSC failed to review the nature of the beneficiary visits that formed the basis for these 99050 claims and, thus, failed to determine that these visits were of a "non-routine nature" for which "immediate care was needed." *Id.* According to OCIMA, because these visits were for emergent services and UHC had advised that OCIMA should use CPT code 99050 to provide this type of care in order to avoid emergency room visits, OSC is penalizing OCIMA for decreasing healthcare costs and following the dictates of an MCO. Additionally, OCIMA claims paying back Medicaid \$232,241 "would impose a serious financial hardship" and may force OCIMA "to lay off

staff, curtail its hours significantly, or end all after hours services and direct patients to the local emergency room." *Id.*

OSC did not review the underlying medical basis for OCIMA's use of CPT code 99050 because that is not relevant to the question of whether OCIMA's use of that code was proper. Rather, the operative question in deciding whether OCIMA's use of code 99050 was appropriate is whether the service was provided outside of OCIMA's regularly scheduled office hours. For all CPT code 99050 claims that are the subject of this audit, OSC offered OCIMA the opportunity to demonstrate that the services were provided outside of OCIMA's regularly scheduled office hours. OCIMA, however, declined to provide any such support. Without any support to show that a given CPT code 99050 claim was provided outside of OCIMA's regularly scheduled office hours (*e.g.*, records showing that a certain claim for a certain beneficiary was provided at 2 a.m. on a certain date), OSC is not in a position to remove any of the CPT code 99050 claims from its universe of improper claims for which OSC is seeking a recovery. With regard to OCIMA's claim that repaying Medicaid would impose a financial hardship, OSC notes the following. First, with the amount at issue, \$232,241, representing less than 10 percent of OCIMA's Medicaid claims paid during the audit period, \$3,545,930, see Appendix E, and given OCIMA's stated approximation that Medicaid constitutes just 30 percent of its business, the notion that such a small portion of OCIMA's total claims during this period would constitute a financial hardship is dubious. Second, OCIMA did not provide any evidence to support this claim.

5. OCIMA Claims that OSC's Position Conflicts with Federal Guidance

Finally, OCIMA states that "the position taken by the Medicaid Fraud Division conflicts with written policy guidance issued by the federal Medicare program (CMS), which allows physician practices to keep performance based incentive payments based on how the level of emergency room utilization for their beneficiaries compares to other practitioners." Appendix A, Page 2. OCIMA claims that UHC awarded OCIMA a \$100,000 bonus in recognition of the cost savings that OCIMA achieved by accepting beneficiaries outside of regularly posted office hours and thereby reducing emergency room visits. Appendix A, Pages 1-2. OSC finds that this bonus is not in any way connected to OCIMA billing CPT code 99050. The utilization of CPT code 99050 is not a performance-based incentive payment. Rather, it is an after-hour add-on code that provides additional payment for claims associated with E&M services provided to beneficiaries outside of a provider's regular hours of business. Therefore, the argument that OCIMA should be allowed to keep performance-based incentive payments is erroneously being applied to payment for CPT code 99050.

After carefully reviewing each of OCIMA's arguments, OSC finds no basis to alter OSC's audit finding or recommendations. OCIMA has discontinued the practice of billing CPT code 99050 during regularly scheduled office hours, but it has yet to comply with three of the four recommendations in this report. Accordingly, OCIMA must reimburse Medicaid \$232,241, provide OSC with a Corrective Action Plan, and accurately reflect its regularly scheduled office hours.

Thank you for your attention to this matter.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:



Josh Lichtblau, Director
Medicaid Fraud Division

cc: Elizabeth Christian, Esq. (Giordano, Halleran & Ciesla, P.C.)
Kay Ehrenkrantz, Deputy Director (OSC – Medicaid Fraud Division)
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March 19, 2018

Client/Matter No. 21182-0001

VIA EMAIL [REDACTED] & FEDERAL EXPRESS

[REDACTED]
Audit Supervisor, Medicaid Fraud Division
20W. State Street 4th Floor
Office of the State Comptroller
P.O. Box 024
Trenton, New Jersey 08625-0024

Re: Ocean County Internal Medicine Associates

Dear Mr. [REDACTED]:

I am writing in response to the draft audit report which you provided to Ocean County Internal Medicine Associates, P.C. ("OCIMA" or the "Practice") in connection with the use of CPT Code 99050 by OCIMA to bill for after-hours, weekend and holiday care. The draft audit report asserts that OCIMA utilized CPT Code 99050 during regular office hours, instead of limiting its use of the code to services rendered when the office is ordinarily closed during evenings, weekends and holidays. For the reasons set forth below, our client disputes the findings set forth in the audit report.

First of all, a little background is in order. The community of Lakewood, New Jersey, where the Practice offices are located, is a community with both a high number of Medicaid beneficiaries, and a high level of emergency room utilization at the hospital located in Lakewood (Monmouth Medical Center South, formerly Kimball Medical Center). As a provider participating in the Medicaid managed care plan known as United Healthcare Community Plan ("UHCP"), I have been advised that our client attended a number of meetings with representatives of that Medicaid managed care plan (including, but not limited to, meetings with a UHCP Medical Director). I have been advised by our client that UHCP representatives requested that OCIMA provide availability on an as-needed basis outside of their regular posted office hours in order to reduce the volume of emergency room visits for UHCP beneficiaries residing in Lakewood, since emergency department rates are substantially higher than the rates paid for services rendered by physicians in private medical practice. In fact, I have been advised that in calendar year 2016, UHCP awarded OCIMA a bonus of \$100,000 in recognition of the

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fact that OCIMA saved UHCP over \$600,000 by managing the entire cost of care for UHCP members, which includes helping to keep patients out of the emergency room. These cost savings inured to the benefit of both UHCP and the State Medicaid program. It would be inappropriate to penalize our client for the utilization of CPT code 99050 when our client agreed, at the direct request of UHCP, to accept patients outside of OCIMA's regularly posted office hours in order to reduce emergency room visits and Medicaid costs. Furthermore, the position taken by the Medicaid Fraud Division conflicts with written policy guidance issued by the federal Medicare program (CMS), which allows physician practices to keep performance based incentive payments based on how the level of emergency room utilization for their patients compares to other practitioners. An excerpt from the Medicare policy guidance is attached as Exhibit A.

I have been advised by our client that the office hours listed within the draft audit report, which references the office hours which are listed on the UHCP website, are completely inaccurate. First of all, Dr. [REDACTED] was a part-time physician who was close to retirement. Our client has advised me that he worked on a part-time, as-needed basis for approximately 6 hours per week, and has not practiced at OCIMA's office since the end of 2015. Notwithstanding this, UHCP still lists him as an OCIMA physician on its website, even though OCIMA has advised UHCP of Dr. [REDACTED]'s retirement. With regard to the other practitioners, I have attached a copy of the CAQH provider data summary which was prepared by our client and was accessible by UHCP to ascertain the hours worked by OCIMA physicians. The CAQH submissions which are updated by OCIMA are attached hereto as Exhibit B. As you can see, Dr. [REDACTED] had office hours Monday through Friday from 9:30 a.m. to 4:30 p.m. and did not have office hours on Saturday and Sunday. Drs. [REDACTED] and [REDACTED] had the same daytime office hours as Dr. [REDACTED], and also did not list any office hours for Saturday or Sunday. In addition, as can be seen by the photograph attached as Exhibit C, the hours posted on our client's office door clearly indicate that their regular office hours are Monday through Friday from 9:30 a.m. to 4:30 p.m. The office door clearly indicates that the office is closed Saturday, Sunday and holidays, but that urgent and emergent care is available. Our client's regularly posted office hours are the hours listed on its front door. The fact that the United Healthcare website is completely inaccurate can be seen by the fact that Dr. [REDACTED] is currently listed as a physician who provides services through the Practice, when in fact Dr. [REDACTED] has not provided physician services through our client's Practice since the end of December 2015. Furthermore, the UHCP website lists a completely different array of hours for physicians in the Practice than the hours which are listed on the office door of the Practice office, and which are in fact maintained by OCIMA as its regular office hours.

Our client has tried to revise the office hours listed for OCIMA physicians on the UHCP website, but has been unable to make those changes. I was advised that employees of our client have reached out to [REDACTED], their current UHCP representative, to ask how to effectuate a change in the posted hours on the UHCP website. Mr. [REDACTED] instructed our client to do so by email and to copy [REDACTED], Director of Provider Relations for UHCP. Mr. [REDACTED] indicated

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that Mr. [REDACTED] would probably want to be copied on the email, since "he was aware that the information does not usually end up being corrected."

It is my understanding that a field auditor who reviewed claims submitted by our client called our client's office and asked the person answering the telephone if the office was open. The individual in question indicated that the office was open as a result of the fact that at the time of the call on that particular date, the doctors had extended their workday to see patients who had requested to be seen after regularly scheduled office hours. If the auditor asking the question had requested information regarding the regular office hours maintained by the Practice, she would have been advised of OCIMA's regularly scheduled hours, and that patients are seen after hours if urgent care is needed. Our client maintains an on-call and back-up on-call list for after hours care. Physicians only extend their hours or come in on a day when they would not normally have office hours if there is a need to do so.

Attached as Exhibit D is a letter from [REDACTED], who formerly worked as the Manager of Network Operations for UHCP. Mr. [REDACTED] indicated that he was present at a number of meetings over the years with OCIMA staff members, including the physicians, [REDACTED] (as well as other OCIMA administrative staff), and Dr. [REDACTED], the Medical Director of United Healthcare. As Mr. [REDACTED] indicates, the Practice was asked by UHCP to assist in keeping UHCP patients out of the hospital by seeing more patients in the office. The Practice was directed by the Medical Director to use Code 99050 in cases when patients were seen outside of their normal posted office hours. Mr. [REDACTED] also indicates that over the years, the Practice requested verification from UHCP as to whether the usage of Code 99050 was correct, and also asked if OCIMA should continue utilizing the code. Mr. [REDACTED] indicated that he was present at meetings where the UHCP's Medical Director told the Practice representatives very clearly that they should continue seeing patients after hours and should use Code 99050 to bill for their services after hours, even if their addition of office hours outside of their posted office hours occurred on a consistent, ongoing basis. Mr. [REDACTED] also specified that UHCP's Medical Director agreed to a request by the Practice to be informed in writing if there were any changes to the policy.

It is my understanding that Mr. [REDACTED] is now retired and is no longer working for UHCP. However, his report of the substance of the meetings between our client and UHCP's Medical Director should be accepted by the Medicaid Fraud Division as evidence that OCIMA was repeatedly advised by UHCP of the propriety of using Code 99050 for after hours care, even if the office was opened on an ongoing basis to provide services to patients after OCIMA's regularly posted hours had ended. It is my understanding from speaking with our client that Mr. [REDACTED] did not put the letter on letterhead because he was not in the office when he was asked to provide the document to our client. I have attached a listing from the New Jersey Medical Society's website showing that Mr. [REDACTED] was in fact employed by UHCP as a provider relations specialist. The fact that our client repeatedly requested verification from UHCP regarding the

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appropriate use of code 99050 demonstrates that it has always been the intention of our client to bill appropriately and in compliance with all applicable requirements.

It appears that the Medicaid Fraud Division has ignored the published After Hours and Weekend Care reimbursement policy issued by UHCP, which I have attached as Exhibit E. The policy clearly states that "after hours or weekend care is reimbursable, within limitations, when an individual physician or other health care professional is required to provide services outside of regular posted office hours to treat a patient's urgent illness or condition. (emphasis supplied). Notably, the policy does not specify that the after-hours or weekend care must be occasional, or irregular. It also does not specify that the code may not be utilized if a physician extends their regular office hours during the day in order to see patients with urgent illnesses or emergency conditions. In addition, the policy does not state that a physician has to leave the office at the end of their work day, return home, and then return to the office later on in response to a patient request in order to bill code 99050. In addition, I have also attached as part of Exhibit E a recent e-mail sent to our client- [REDACTED] by [REDACTED] of UHCP. That e-mail also confirms that CPT Code 99050 may be used for "Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service". Since the payor of record in this case was UHCP, our client was entitled to rely on the posted written policy of UHCP, which does not contain any of the limitations regarding the use of CPT Code 99050 that are suggested in the draft audit report. The reference in the draft audit report to a 2006 version of "CPT Assistant" is misplaced, since the payor at issue here (UCHP) was entitled to set its own policy regarding the use of Code 99050, which our client was entitled to rely upon. While the Medicaid Fraud Division indicates that it relied in part upon UHCP "guidance," that guidance was not attached to the draft audit report (or any prior correspondence sent to our client). The Medicaid Fraud Division should not be entitled to rely on unpublished "guidance" in assessing an overpayment.

I have also attached as part of Exhibit B correction sheets submitted by our client to AmeriChoice in order to correct incorrect Practice hours of operation advertised by AmeriChoice.

It appears that our client is caught up in a difference of interpretation between the Medicaid Managed Care organizations, which provide one set of advice, with the Medicaid Fraud Division taking a different position than their contracted managed care payors. Our client should not be penalized for these differences in interpretation. If the Medicaid Fraud Division

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disagrees with the interpretation disseminated by its contracted Medicaid MCO providers regarding the issue of when Code 99050 should and should not be used, it should work with the Medicaid MCOs to disseminate consistent advice so that providers are on notice regarding the Medicaid program's position regarding use of this code.

Table III contained in the draft audit lists holidays for which OCIMA's office was open. However, please note that in the case of each holiday, there were zero (or two) patients seen on certain of the dates listed. In addition, during calendar year 2015, code 99050 was only billed on two of the seven holidays reviewed. This belies the assertion of the Medicaid Fraud Division that the office is open on a regular basis on holidays. If this were the case, then the Practice would have seen patients on every holiday.

In addition, an analysis of the percentage of patients seen pursuant to a review of Table VI contained in the draft audit report (entitled "Paid Claims by Days of the Week") shows that the number of 99050 claims are actually a very small percentage of the total number of all claims paid for patients seen in the offices of OCIMA for the period under review. On Monday through Friday, the number of 99050 claims paid as a percentage of all claims paid is less than 10% in all cases. Claims for visits on Saturdays are very low, with only 84 claims billed using code 99050 over a 5 year period. There is a higher percentage of 99050 claims paid on Sunday, a date when the office is not regularly open on a weekly basis.

In addition, I have been advised by our client that Lakewood has two federally qualified health centers, one of which did not have weekend hours during the time period of the audit, and whose patients called OCIMA to be seen outside of regularly posted hours.

The whole point of having Code 99050 available as an add-on code is to compensate a physician practice for the additional costs incurred by the Practice when the Practice keeps its office open later, or opens on weekends and holidays, and has to incur additional costs that would not otherwise be paid if the office were not opened. The Practice incurred additional utility, salary, supply and other costs by opening outside of its regular hours. Our client has advised me that they incurred additional office expenses estimated at approximately \$[REDACTED] for the period July 1, 2011 through June 1, 2016 by virtue of opening outside of normal business hours. This is a significant additional expense.

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The disallowance by the Medicaid Fraud Division of all of the 99050 claims submitted by our client is arbitrary, capricious, and unreasonable. It is apparent that the Medicaid Fraud Division did not take the time or trouble to review the nature of the patient visits that caused our client to have to extend its office hours and open on holidays and on weekends. Indeed, our client was advised by a UHCP representative that although hundreds of patient records were submitted by our client to UHCP for review at UHCP's request, UHCP has indicated that they were never reviewed by UHCP. In addition, our client was advised by the field auditor assigned to review this matter that she also did not review the patient records submitted by our client to UHCP. Instead, our client was asked to provide the first 60 names from a list of thousands of patient names, together with the dates that the 60 patients made appointments to be seen and the dates they were seen. I have been advised by our client that if the field auditor had reviewed the medical records, she would have seen that all of the visits in question were of a non-routine nature, and did not involve physicals, fitness for duty exams, surgical clearances or other routine appointments. I have been advised by our client that the Medicaid Fraud Division has not reviewed any medical records to determine whether or not the visits billed using code 99050 were for services for which immediate care was needed. This severely undercuts the validity of the audit findings. The draft audit report also completely ignores the underlying reason for the original request by UHCP that the office open for extended hours when needed: in order to alleviate emergency room volumes at the local hospital. There is a significant issue created here by the fact that UHCP provided our client with one set of directions, while the Medicaid Fraud Division is providing a completely different set of directions after care has already been provided. Our client should not be penalized for the inconsistency in interpretation between the State Medicaid agency and UHCP, particularly when the net result of our client's acceptance of after-hours patients was to decrease costs to UHCP and the State Medicaid program by keeping patients out of the emergency room and thereby avoiding the resultant higher costs of emergency room visits.

It is also not clear to our client why the Medicaid Fraud Division waited almost six years after July 1, 2011 to notify our client of a determination that our client should not use code 99050. Had the Medicaid Fraud Division's position been communicated to our client earlier, our client would undoubtedly be looking at a much smaller potential overpayment than the \$232,241.00 at issue now.

Requiring our client to pay back over \$200,000 would impose a serious financial hardship upon our client, and may force our client to lay off staff, curtail its hours significantly, or end all after hours services and direct patients to the local emergency room. Given the fact that our client extended its hours as an accommodation to UHCP, it would be a significant injustice to impose this huge overpayment repayment obligation upon our client. We would ask that the Medicaid Fraud Division reconsider its request for repayment of the overpayment. Any application of the Medicaid Fraud Division's current policy regarding the use of code 99050 should be prospective only.

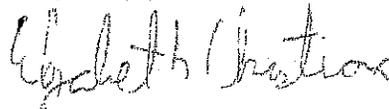
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Our client is willing to enter into a Corrective Action Plan in order to avoid any further misunderstandings between OCIMA, UHCP and the Medicaid Fraud Division regarding the usage of CPT Code 99050. In fact, our client voluntarily discontinued usage of Code 99050 as of August 15, 2016, and has directed all of its staff members not to utilize this code even for emergency and urgent after hours visits. Our client does not utilize an outside billing service. As its Corrective Action Plan, our client will voluntarily agree not to submit any claims utilizing Code 99050 unless our client obtains written authorization from the Medicaid managed care organization and submits that written authorization to the Medicaid Fraud Division for review and approval. In August 2016, all employees were notified that regardless of what may have been told to them during prior visits with a third party payor, and notwithstanding any written guidance in the UHCP manual, Code 99050 should not be used under any circumstance unless and until further clarification is received from the Medicaid managed care organization and the State of New Jersey regarding the appropriate use of that code. Please note that the Practice will continue to open after its regularly posted hours, as well as on weekends and holidays, if there is a need for patients to be seen for urgent or emergent medical needs.

Pursuant to the requirement set forth in the audit letter, the Practice posted its regular office hours, policy regarding the extension of its hours, and an explanation of the type of services which will not be provided after hours in its office. A copy of the notice posted in OCIMA's office is attached as Exhibit G. In addition, per the Medicaid Fraud Division's request, the OCIMA after hours policy is attached as Exhibit H. The policy clearly states that visits for routine services such as routine physicals, sports and school physicals, medical clearance for surgery, fitness for duty evaluations, and routine immunizations will not be seen outside of OCIMA's regular weekday office hours.

Very truly yours,



ELIZABETH CHRISTIAN

EC:nk

Enclosures

Docs #3103196-v4

A

EXHIBIT A HAS BEEN REDACTED

B

Tax Information:

Practice Name as it appears on the W-9:

Tax ID:



Type of Tax ID:

Group

Is this the primary Tax ID for this practice location?

Yes

Group Name:

OCEAN COUNTY INTERNAL
MEDICINE ASSO

Network Denial:

Have you closed your practice to any plans or programs?

Office Hours:

Monday

Start Time:

9:30 AM

End Time:

4:30 PM

Tuesday

Start Time:

9:30 AM

End Time:

4:30 PM

Wednesday

Start Time:

9:30 AM

End Time:

4:30 PM

Thursday

Start Time:

9:30 AM

End Time:

4:30 PM

Friday

Start Time:

9:30 AM

End Time:

4:30 PM

Saturday

Start Time:

End Time:

Sunday

Start Time:

None

End Time:

None

Patients:

Do you accept new patients into the practice?

Yes

Accept existing patients with change of payor?

Yes

Accept all new patients?

Yes

Accept new Medicare patients?

Yes

Accept new Medicaid patients?

Yes

Practice Name as it appear
the W-9 :

Tax ID :



Type of Tax ID :

Group

Is this the primary Tax ID for
this practice location?

Yes

Group Name :

OCEAN COUNTY INTERNAL
MEDICINE

Network Denial :

Have you closed your practice to any plans or programs ?

Office Hours :

Monday

Start Time :

9:30 AM

End Time :

4:30 PM

Tuesday

Start Time :

9:30 AM

End Time :

4:30 PM

Wednesday

Start Time :

9:30 AM

End Time :

4:30 PM

Thursday

Start Time :

9:30 AM

End Time :

4:30 PM

Friday

Start Time :

9:30 AM

End Time :

4:30 PM

Saturday

Start Time :

End Time :

Sunday

Start Time :

None

End Time :

None

Patients :

Do you accept new patients
into the practice?

Yes

Accept existing patients with
change of payor?

Yes

Accept all new patients?

Yes

Accept new Medicare patients?

Yes

Accept new Medicaid patients?

Yes

Accept new patients from
physician referral?

Yes

Street 2 Country United State
 City LAKE WOOD State N.
 County Province
 Zip Code : 8701-564 Email Address
 Can general correspondence be sent to this location? Yes Practice Location Website

Mailing Address :

Street1 : Street2
 City : State :
 County : Province :
 Country : Zip Code :

Type of Practice : Single Specialty Group

Do you have an organization (Type 2) NPI? Yes Organization (Type 2) NPI : 

Group Medicaid Number Group Medicare Number :

Phone Numbers :

Office Phone Number : 732-470-5100 Phone Extention :
 Fax Number : 732-401-0140
 Back Office Phone Number :

Phone Coverage :

Does this location provide 24hour/7day a week phone coverage? Yes
 Phone Coverage Type : Answering Service

Tax Information :

Practice Name as it appears on the W-9 : Ocean County Internal Medicine Associates
 Tax ID :  Type of Tax ID : Group
 Is this the primary Tax ID for this practice location? Yes
 Group Name : OCEAN COUNTY INTERNAL MEDICINE

Network Denial :

Have you closed your practice to any plans or programs ?

Office Hours :

Monday

Start Time : 9:30 AM End Time : 4:30 PM

Tuesday

Start Time : 9:30 AM End Time : 4:30 PM

Wednesday

Start Time : 9:30 AM End Time : 4:30 PM

Thursday

Start Time : 9:30 AM End Time : 4:30 PM

Friday

Start Time : 9:30 AM End Time : 4:30 PM

Saturday

Start Time : End Time :

Sunday

Start Time : None End Time : None

Patients :

Do you accept new patients into the practice? Yes

Accept existing patients with change of payor? Yes

Accept all new patients? Yes

Accept new Medicare patients? Yes

Accept new Medicaid patients? Yes

Accept new patients from physician referral? Yes

Under what circumstances do you accept referrals? (i.e., letter from another physician, etc.

What questions should we ask a patient, to help determine the appropriateness of the referral?

Does this information vary by health plan ? Yes

If Yes, please provide explanation below :

WE DO NOT ACCEPT MEDICARE OR MEDICAID ASSIGNMENT. Evening & Weekend urgent care available

Colleagues :

Do you have any Partners/Associate at this location ? Yes

Partners/Associates :

April 28, 2010

**PROVIDER DATA VERIFICATION
IMPORTANT RESPONSE REQUIRED**

in re: Provider ID: 91001650801



AmeriChoice of New Jersey is updating their files and requests your assistance in verifying information for the practitioner listed below. Please provide any missing information. If any of the information below is incorrect, please cross out and write in the corrected information. Please no longer work at your facility, please indicate and return as soon as possible. Once you have completed your review please return this fax to (toll free) 888-450-9617 within 5 days of receipt. Thank you in advance for your timely attention to our request. Please verify the following:

- Physician no longer at this location Can you provide a forwarding address:
- Physician does not participate with AmeriChoice Physician no longer with the practice

<p>OCEAN COUNTY INTERNAL MEDICINE 1352 RIVER AVE LAKEWOOD, NJ 08701 OCEAN</p> <p>Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does Practitioner have an additional office within OCEAN County? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, please provide address, phone & fax for additional location. Address: _____ Phone: _____ Fax: _____</p> <p>Phone Number: 7323705100 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fax Number: 329019240 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tax ID Number: [REDACTED] Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, if Tax ID is <u>NOT</u> correct, please fax corrected W9 to 866-946-0517</p> <p>Is the practitioner accepting new patients at this time? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specialty: <u>INTERNAL MEDICINE</u> Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Board Certified? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3 Primary languages spoken within the office other than English? <u>Arabic, Hindi, Spanish</u> <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Is your office handicap accessible? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can members easily access your office using public transportation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any special instructions for members, such as special days/times for blood draws, routine blood pressure checks, diabetic education, immunizations, etc.? <input checked="" type="checkbox"/> Yes-explain: _____ <input type="checkbox"/> No</p> <p>Do you perform lead screenings in your office? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No if yes, are you using the filter paper method (MedTox)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>April 2010</p>	<p>148</p> <p>Billing address: OCEAN CITY INT MEDICINE ASSOC 1352 RIVER AVE LAKEWOOD NJ 08701 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do providers in this office serve members with special needs: Developmental Disabilities? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Aged/Elderly? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hospital privileges: <u>KIMBALL MED CTR-ST BARNABAS HS</u> Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>National Provider Identification Number: [REDACTED] Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Number of additional practitioners within the office: <u>5</u></p> <p>Does your office have additional clinical support staff? <input type="checkbox"/> Yes <input type="checkbox"/> No if so, please indicate what type of support staff your office employs-</p> <p>Office Hours: <u>M8:30-10, T8:30-10, W8:30-10, Th8:30-10, F8:30-5.</u> Correct? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
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M-F-a

**PROVIDER DATA
IMPORTANT RESPONSE REQUIRED**

April 28, 2010

In re: Provider ID: 91002383700

AmeriChoice of New Jersey is updating their files and requests your assistance in verifying information. If any of the information below is incorrect, please cross out and write in the correct information. no longer works at your facility, please indicate and return as soon as possible. Once you have completed your revision, please fax to (toll free) 888-450-9617 within 5 days of receipt. Thank you in advance for your timely attention to our request. Please verify the following:

- Physician no longer at this location Can you provide a forwarding address?
- Physician does not participate with AmeriChoice Physician no longer with the practice

<p>OCEAN COUNTY INTERNAL MED 1352 RIVER AVE LAKEWOOD, NJ 08701 OCEAN</p> <p>Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Does Practitioner have an additional office within OCEAN County? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p> <p>If yes, please provide address, phone & fax for additional location. Address: _____ Phone: _____ Fax: _____</p> <p>Phone Number: 7323705100 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Fax Number: 7329019240 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Tax ID Number: [REDACTED] Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No, if Tax ID is NOT correct, please fax corrected W9 to 866-942-0517</p> <p>Is the practitioner accepting new patients at this time? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Specialty: INTERNAL MEDICINE Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Board Certified? <input type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>3 Primary languages spoken within the office other than English: <u>Spanish</u> Is your office handicap accessible? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Can members easily access your office using public transportation? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Are there any special instructions for members, such as special days/times for blood draws, routine blood pressure checks, diabetic education, immunizations, etc.? <input type="checkbox"/> Yes-explain: _____ <input type="checkbox"/> No</p> <p>Do you perform lead screenings in your office? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If yes, are you using the filter paper method (MedTox)? <input type="checkbox"/> Yes <input type="checkbox"/> No</p>	<p style="text-align: right;">56</p> <p>Billing address: OCEAN COUNTY INTERNAL MED 1352 RIVER AVE LAKEWOOD, NJ 08701 Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Do providers in this office serve members with special needs: Developmental Disabilities? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Aged/Elderly? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No HIV/AIDS? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Hospital privileges: KIMBALL MED CTR-ST BARNABAS HS Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> NA</p> <p>National Provider Identification Number: [REDACTED] Correct? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No</p> <p>Number of additional practitioners within the office: <u>3</u></p> <p>Does your office have additional clinical support staff? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No If so, please indicate what type of support staff your office employs:</p> <p>Office Hours: M9-8, T9-8, W9-8, Th9-8, F9-3, Su10-3, Correct? <input type="checkbox"/> Yes <input checked="" type="checkbox"/> No</p>
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April 2010

C

**OCEAN COUNTY
INTERNAL MEDICINE
ASSOCIATES, P.C.**

MD
MD
MD
MD

MONDAY - FRIDAY 9:30AM - 4:30PM

Closed Saturday,

Sunday and Legal Holidays

Urgent and Emergent Care Available

732.370.5100

D

RECEIVED 1/17/2017 11:11 AM 7328 374

01/17/2017 02:11:24 01000000

January 18, 2017

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

To Whom It May Concern,

I have worked together with Ocean County Internal Medicine Associates, PC for many years, originally in the capacity of Manager of Network Operations and more recently as Provider Data Consultant. I was present at numerous meetings over the years with OCIMA staff, including Dr. [REDACTED] Dr. [REDACTED] as well as other administrative staff, together with Dr. [REDACTED], the Medical Director of UnitedHealthcare.

OCIMA was asked by UnitedHealthcare to try to keep UnitedHealthcare patients out of the hospital by seeing more patients in the office. OCIMA was directed to use code 99050 in cases when patients were seen outside of their normal, posted office hours.

Over the years, OCIMA verified that their usage of the code 99050 was correct and asked if they should continue using the code. I was present at the meetings when the Medical Director told them very clearly that they should indeed continue to see patients in the office, after hours and use code 99050 even if they did so on a consistent and on-going basis. United Healthcare's Medical Director agreed to OCIMA's request to be informed in writing if there were any changes to this policy.

Sincerely,
[REDACTED]

[REDACTED]
[REDACTED] Provider Data Consultant

NEW JERSEY PROVIDER ADVOCATE - PHYSICIAN			
Physician Advocates (PAs)	Director	TERRITORY	TELEPHONE
	Manager - NJ MED		EMAIL ADDRESS
[REDACTED]	Monmouth, Cape May, Cumberland, & Salem, Advocate, Virtua, Cooper, NJSOM, EMA, Regional Women's	[REDACTED]	[REDACTED]
[REDACTED]	Essex, Sussex & Warren	[REDACTED]	[REDACTED]
[REDACTED]	Middlesex & Mercer, NJ Podiatry, ARC, St. Peters	[REDACTED]	[REDACTED]
[REDACTED]	Team Lead - Hunterdon, Summit Medical Group, Radnet St. Barnabas, Lifeline	[REDACTED]	[REDACTED]
[REDACTED]	Somerset, Union & Hudson	[REDACTED]	[REDACTED]
[REDACTED]	Morris & Passaic	[REDACTED]	[REDACTED]
[REDACTED]	Ocean, Atlantic, Burlington, Camden, & Gloucester	[REDACTED]	[REDACTED]
[REDACTED]	Bergen, Regional Cancer Care	[REDACTED]	[REDACTED]
[REDACTED]	Internal Advocate, St. Christophers	[REDACTED]	[REDACTED]
[REDACTED]	FQHC Advocate	[REDACTED]	[REDACTED]

E



REIMBURSEMENT POLICY
CMS-1500

After Hours and Weekend Care Policy					
Policy Number	2017R0044G	Annual Approval Date	3/8/2017	Approved By	Reimbursement Policy Oversight Committee

IMPORTANT NOTE ABOUT THIS REIMBURSEMENT POLICY

You are responsible for submission of accurate claims. This reimbursement policy is intended to ensure that you are reimbursed based on the code or codes that correctly describe the health care services provided. UnitedHealthcare Community Plan reimbursement policies uses Current Procedural Terminology (CPT[®]), Centers for Medicare and Medicaid Services (CMS) or other coding guidelines. References to CPT or other sources are for definitional purposes only and do not imply any right to reimbursement.

This reimbursement policy applies to all health care services billed on CMS 1500 forms and, when specified, to those billed on UB04 forms. Coding methodology, industry-standard reimbursement logic, regulatory requirements, benefits design and other factors are considered in developing reimbursement policy.

This information is intended to serve only as a general reference resource regarding UnitedHealthcare Community Plan's reimbursement policy for the services described and is not intended to address every aspect of a reimbursement situation. Accordingly, UnitedHealthcare Community Plan may use reasonable discretion in interpreting and applying this policy to health care services provided in a particular case. Further, the policy does not address all issues related to reimbursement for health care services provided to UnitedHealthcare Community Plan enrollees.

Other factors affecting reimbursement supplement, modify or, in some cases, supersede this policy. These factors include, but are not limited to: federal &/or state regulatory requirements, the physician or other provider contracts, the enrollee's benefit coverage documents, and/or other reimbursement, medical or drug policies.

Finally, this policy may not be implemented exactly the same way on the different electronic claims processing systems used by UnitedHealthcare Community Plan due to programming or other constraints; however, UnitedHealthcare Community Plan strives to minimize these variations.

UnitedHealthcare Community Plan may modify this reimbursement policy at any time by publishing a new version of the policy on this Website. However, the information presented in this policy is accurate and current as of the date of publication.

UnitedHealthcare Community Plan uses a customized version of the Optum Claims Editing System known as iCES Clearinghouse to process claims in accordance with UnitedHealthcare Community Plan reimbursement policies.

*CPT[®] is a registered trademark of the American Medical Association

Application

This reimbursement policy applies to UnitedHealthcare Community Plan Medicaid and Medicare products.

This reimbursement policy applies to services reported using the 1500 Health Insurance Claim Form (a/k/a CMS-1500) or its electronic equivalent or its successor form. This policy applies to all products and all network and non-network physicians and other qualified health care professionals, including, but not limited to, non-network authorized and percent of charge contract physicians and other qualified health care professionals.

Payment Policies for Medicare & Retirement, UnitedHealthcare Community Plan Medicare and Employer & Individual please use [this link](#).

Medicare & Retirement and UnitedHealthcare Community Plan Medicare Policies are listed under Medicare Advantage Reimbursement Policies.

Employer & Individual are listed under Reimbursement Policies-Commercial.



REIMBURSEMENT POLICY
CMS-1500

Policy

Overview

After hours or weekend care is reimbursable, within limitations, when an individual physician or other health care professional is required to provide services outside of regular posted office hours to treat a patient's urgent illness or condition.

Reimbursement Guidelines

The Centers for Medicare and Medicaid Services (CMS) considers reimbursement for Current Procedural Terminology (CPT®) codes 99050, 99051, 99053, 99056, 99058 and 99060 to be bundled into payment for other services not specified.

UnitedHealthcare Community Plan, however, will provide additional compensation to physicians for seeing patients in situations that would otherwise require more costly urgent care or emergency room settings by reimbursing CPT code 99050 in addition to basic services.

CPT Code 99050

UnitedHealthcare Community Plan will reimburse after hours CPT code 99050 when reported with basic services in one of the following CMS non-facility place of service (POS) designations only:

- School (CMS POS 03)
- Indian Health Service Free-standing Facility (CMS POS 5)
- Tribal 638 Free-Standing Facility (CMS POS 7)
- Office (CMS POS 11)
- Independent Clinic (CMS POS 49)
- Federally Qualified Health Center (CMS POS 50)
- State or Local Public Health Clinic (CMS POS 71)
- Rural Health Clinic (CMS POS 72)

CPT Codes 99051, 99053, 99056, 99058 or 99060

Consistent with CMS and with the intent of this policy, UnitedHealthcare Community Plan will not separately reimburse CPT codes 99051, 99053, 99056, 99058 or 99060.

State Exceptions

Kansas	CPT code 99058 is reimbursable. CPT code 99056 is reimbursable in POS 12, 19, 22, 23, or 65 ONLY.
Louisiana	CPT 99051 is reimbursable for all providers in the same non-facility POS as CPT code 99050 (see list above under Reimbursement Guidelines)
Maryland	CPT code 99058 is reimbursable in same non-facility POS 03, 05, 07, 11, 49, 50, 71, 72. CPT code 99050 is not reimbursable.
Michigan	CPT codes 99050, 99051, 99053, 99056, 99058 and 99060 are reimbursable in POS 11 and 50.
Missouri	CPT code 99050 is reimbursable in POS 03, 11, 49, 50, 71, and 72, except when billed within 30 days of a specified surgical procedure. (List of surgical procedures within the Attachments section).

CPT code 99051 is only reimbursable on Sundays and specified holidays in POS 03, 11,



**REIMBURSEMENT POLICY
CMS-1500**

49, 50, 71, and 72, except when billed within 30 days of a specified surgical procedure.
(List of surgical procedures within the Attachments section).

- Mississippi** Mississippi CAN: 99051 is reimbursable for all providers in the same non-facility POS as CPT code 99050 (see list above under Reimbursement Guidelines)
- Ohio** 99051 is reimbursable for all providers in same non-facility POS as CPT code 99050 (see list above under Reimbursement Guidelines) and in POS 19 and 22.
- Texas** Office based providers may use 99056 or 99060 for services outside of business hours.
- Virginia** VA Medicaid to allow 99056 for professional claims.

Questions and Answers

Q: Why doesn't UnitedHealthcare Community Plan provide reimbursement for CPT codes 99051, 99053, 99056, 99058 or 99060?

- 1 A:** The After Hours and Weekend Care policy is intended to reimburse physicians for services that are outside their normal office routines as an alternative to more costly emergency room or urgent care center services. Reimbursement for CPT codes 99051, 99053, 99056, 99058 or 99060 would not accomplish this purpose and are not reimbursed by CMS.

Attachments: Please right-click on the icon to open the file

UnitedHealthcare
Community Plan
Missouri Medicaid
Surgical Procedure List

Missouri surgical procedure code list.

Codes

CPT code section

- 99050 Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
- 99051 Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
- 99053 Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
- 99056 Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
- 99058 Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
- 99060 Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service



REIMBURSEMENT POLICY
CMS-1500

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

History

- 8/20/2017 Virginia state exceptions added.
- 5/20/2017 Application Section: Removed UnitedHealthcare Community Plan Medicare products as applying to this policy. Added location for UnitedHealthcare Community Plan Medicare reimbursement policies
- 3/23/2017 Missouri state exception updated.
- 3/8/2017 Policy Approval Date Change
- 2/26/2017 State Exception Section: Exception added for Missouri
- 2/12/2017 MO added to the policy.
- 1/1/2017 Annual Policy Version Change
History Section: Entries prior to 1/1/2015 archived
- 5/29/2016 State Exceptions Section: Exception revised for Louisiana
- 3/9/2016 Policy Approval Date Change
State Exceptions Section: Exception added for Pennsylvania and exception revised for Kansas
- 1/1/2016 Annual Policy Version Change
History Section: Entries prior to 1/1/2014 archived
State Exceptions Section: Exception updated for Kansas and Ohio to add POS 19
- 11/2/2015 State Exceptions Section: Added an exception for Michigan
- 3/11/2015 Annual Approval Date Change
Approved By Section: Replaced United HealthCare Community & State Payment Policy Committee with Payment Policy Oversight Committee
- 3/1/2015 Application Section: Removed reference to location of policy for MS Chip
State Exceptions: Changed verbiage for Mississippi to specify MS CAN.
- 2/15/2015 State Exceptions Section updated: Added Louisiana
- 1/1/2015 Annual Policy Version Change
History Section: Entries prior to 1/1/2013 archived.
- 3/15/2010 Policy implemented by UnitedHealthcare Community & State



REIMBURSEMENT POLICY
CMS-1500

Ohio	99051 is reimbursable for all providers in same non-facility POS as CPT code 99050 (see list above under Reimbursement Guidelines) and in POS 19 and 22.
Pennsylvania	99051 is reimbursable in non-facility POS 03, 05, 07, 11, 49, 50, 71, 72 for Reading Pediatrics Primary Care Group TIN 232104110.
Texas	Office based providers may use 99056 or 99060 for services outside of business hours.
Wisconsin	CPT code 99050 is not covered except for IPN providers who are allowed to bill due to contract requirements.

Questions and Answers

	Q: Why doesn't UnitedHealthcare Community Plan provide reimbursement for CPT codes 99051, 99053, 99056, 99058 or 99060?
1	A: The After Hours and Weekend Care policy is intended to reimburse physicians for services that are outside their normal office routines as an alternative to more costly emergency room or urgent care center services. Reimbursement for CPT codes 99051, 99053, 99056, 99058 or 99060 would not accomplish this purpose and are not reimbursed by CMS.

Codes

CPT code section	
99050	Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service
99051	Service(s) provided in the office during regularly scheduled evening, weekend, or holiday office hours, in addition to basic service
99053	Service(s) provided between 10:00 PM and 8:00 AM at 24-hour facility, in addition to basic service
99056	Service(s) typically provided in the office, provided out of the office at request of patient, in addition to basic service
99058	Service(s) provided on an emergency basis in the office, which disrupts other scheduled office services, in addition to basic service
99060	Service(s) provided on an emergency basis, out of the office, which disrupts other scheduled office services, in addition to basic service

Resources

Individual state Medicaid regulations, manuals & fee schedules

American Medical Association, *Current Procedural Terminology (CPT®)* and associated publications and services

Centers for Medicare and Medicaid Services, National Correct Coding Initiative (NCCI) publications

History

1/1/2016	Annual Policy Version Change
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From: "[REDACTED]"
Date: Mar 15, 2018 3:31 PM
Subject: RE: [REDACTED]
To: "[REDACTED]"
Cc:

Hi [REDACTED]

It was a please speaking with you and [REDACTED] today. I look forward to our continued partnership. As discussed today procedure code 99050 is an afterhours code created to allow physicians to treat members with urgent care needs outside of their normal business hours. We do have a policy that outlines the anticipated use of the code which I have attached. As discussed today the CPT code 99050 should only be used **outside of established normal business hours** that the practice has communicated; when treating a patients urgent illness or condition. I hope the information is helpful.

After hours or weekend care is reimbursable, **within limitations**, when an individual physician or other health care professional is required to provide services **outside of regular posted office hours to treat a patient's urgent illness or condition.**

UnitedHealthcare Community Plan, however, will provide additional compensation to physicians for seeing patients in situations that would otherwise **require more costly urgent care or emergency room settings by reimbursing CPT code 99050 in addition to basic services.**

99050:

Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

Thank you

[REDACTED]

From: [REDACTED] [mailto:[REDACTED]]
Sent: Thursday, March 15, 2018 2:16 PM
To: [REDACTED]
Subject: Ocean County Internal Medicine

Hi [REDACTED],

It was a pleasure speaking to you earlier today. We appreciate your time. As we discussed, can you please send us your interpretation of how we are meant to use the 99050 code? We have a meeting and we would like to address this with our staff.

We look forward to hearing from you.

Thank you,

--
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]
[REDACTED]

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F

From: [REDACTED]
Date: Wed, Mar 14, 2018 at 12:51 PM
Subject: Re: Payment for Code 99050 to Ocean County Internal Medicine (OCIM)
To: Nechan, Paulbert <[REDACTED]>

Sent from my iPhone

On Mar 14, 2018, at 12:18 PM, [REDACTED] wrote:

[REDACTED]
On Mon, Mar 12, 2018 at 2:18 PM,
<[REDACTED]> wrote:

~~Forwarded conversation~~

From: C

Date: Mon, Mar 12, 2018 at 2:18 PM

To:

Cc:

[REDACTED]

[REDACTED]

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[REDACTED]

To:
Cc:

Hi,

[REDACTED]
Ocean County Internal Medicine Associates
1352 River Avenue
Lakewood, NJ
732-370-3383

From: ([REDACTED]@[REDACTED].com)
Date: Tue, Mar 13, 2018 at 11:39 AM
To: [REDACTED]@[REDACTED].com
Cc: [REDACTED]@[REDACTED].com

Hi [REDACTED],

Sent from my iPhone

On Mar 13, 2018, at 10:58 AM, [REDACTED] wrote:

Hi,

[REDACTED]
Ocean County Internal Medicine Associates

G

Our regular office hours are

Monday through Friday 9:30 am-4:30 pm.

**Urgent and emergent care is available
after hours, weekends and legal holidays.**

**Please note that we do not perform routine physicals,
school or sports physicals, routine immunizations, fitness
for duty evaluations, or medical clearance evaluations
during evenings, weekends, or holidays.**

H



OCEAN COUNTY
INTERNAL MEDICINE ASSOCIATES, PC

Appendix A
Exhibit H
1532 River Avenue
Lakewood, NJ 08701
Phone: 732-370-5100
Fax: 732-901-9240

[REDACTED] MD [REDACTED] MD [REDACTED] MD [REDACTED] MD

Ocean County Internal Medicine Associates P.C. is open Monday through Friday from 9:30 am to 4:30 pm. We offer extended weekday hours as well as availability on weekends and legal holidays for urgent or emergent care only. These hours are determined on an as-needed basis, and patients must call to determine whether or not a physician or other practitioner will be available to see them outside of normal business hours. Please note that we do not perform routine physicals, school or sports physicals, routine immunizations, fitness for duty evaluations, or medical clearance evaluations during evenings, weekends, or holidays.



February 17, 2017

██████████, 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

Re: Response to Information Request -
Ocean County Internal Medicine Associates

Dear Ms. ██████████

I am writing, on behalf of UnitedHealthcare Community Plan of New Jersey, in response to your audit related requests for Ocean County Internal Medicine Associates ("OCIMA").

UnitedHealthcare Community Plan (UHC) offers this response based upon the information available. UHC is not aware of any direction provided to OCIMA by a former Medical Director, ██████████, of the Health Plan, or by other UnitedHealthcare Clinical Coverage Review Medical Directors on how to bill services that occur after normal business hours, on weekends or during holidays, but admittedly have limited information from the meeting discussed in ██████████ letter.

Notwithstanding the subject letter, United has not been able to verify any guidance was provided to OCIMA regarding the use/inclusion of certain Current Procedural Terminology ("CPT") Codes for billing for covered services. UHC believes the letter references back to Medical Director, ██████████'s, tenure with UHC Community Plan (██████████ ceased working for the plan in 2009) and related to discussions around "emergency room reduction". At this meeting, a number of Codes were discussed; however at no time was there a hard directive on which Codes to use and when to use them. Regarding the groups hours, UHC's has provided the CAQH applications, in which the providers reported their hours to us, when they came on board with our network. However, please be advised that the office hours in those documents only represent what was reported to us at the time of credentialing. I am advised that providers do have the ability to update their demographic information, including office hours, in close to real time via our Provider Portal, so that information can change over time.

If you have any questions or require additional information relating to this response, please contact my office directly at ██████████. Thank you.

Sincerely,

██████████

Compliance Officer

cc: ██████████ UHCCPNJ
██████████ UHCCPNJ

RECEIVED FEB 21 2017

[REDACTED]

From: [REDACTED] <[REDACTED]@uhc.com>
Sent: Thursday, March 29, 2018 12:04 PM
To: [REDACTED]
Subject: FW: Ocean County Internal Medicine

From: [REDACTED]
Sent: Tuesday, March 20, 2018 12:56 PM
To: [REDACTED]
Subject: RE: Ocean County Internal Medicine

Hi [REDACTED],

No there wasn't a policy change for UHCCP but there was one for Oxford. I have attached the link below. However, my e-mail was intended to provide additional information and reiterating what we discussed as there are so many scenarios that may apply to this policy. I conferred internally with my Director [REDACTED] and he mentioned the scenario that I described below. I want to provide as much support as possible in helping you administer the coding correctly. That is our interpretation of the policy. There is an expectation that the After Hours Policy is being applied after the office is closed for its routine business; meaning services are being provided "after normal business hours" and it's not an extension of normal business hours. These services are being rendered to members that have acute/urgent conditions, that would have otherwise been treated in an emergency room. I hope this is helpful.

Please the update to the Commercial Policy For Oxford. <https://www.uhcprovider.com/en/search-results.html?q=99050> which is effective 4-1-18.

Thank you
[REDACTED]

From: [REDACTED] [mailto:[REDACTED]@ocimed.com]
Sent: Monday, March 19, 2018 3:07 PM
To: [REDACTED]
Subject: Re: Ocean County Internal Medicine

Hi [REDACTED],

We already instructed our staff on Thursday with the information you provided as stated in the policy manual as well, that the 99050 code should only be used for patients seen after regular posted hours. Of course we understand and practice your first scenario that we cannot use the code for scheduled routine visits that run over our regular, posted hours.

Can you please tell me where it says in the UHC manual what you are stating regarding that the office must close etc.? I don't see this in the policy you sent me. We understand you are implying that there is a change in the manual as of 3/19/18. We do not see your new posted policy. We still see the same policy you sent us without changes.

Thank you,
[REDACTED]

On Mon, Mar 19, 2018 at 1:16 PM, [REDACTED] <[REDACTED]@uhc.com> wrote:

Hi [REDACTED],

I wanted to reiterate some scenarios that you may see in your office due to scheduling. In cases where you have visits that maybe scheduled for the day that runs over through evening hours(technically after the posted office hours), **the visits would not be considered eligible for afterhours; as they were scheduled visits for your patients that ran over.** Also, if the practice does not close, if you continue seeing patients throughout your normal business day and after hours that would not be considered eligible as you never closed your practice, and just continued seeing patients. If you need further clarification we can discuss further if you like; but the After Hours scenario loans itself to meaning after the practice is technically closed and the provider returns back to the office to see an unscheduled patient in an acute/urgent visit. That is my interpretation. I just wanted to make sure we are on the same page.

If you have any further questions; please give me a call and we can discuss further.

Have a wonderful day

Sign up for our News Bulletin:

<https://www.uhcprovider.com/en/resource-library/news.html>

[REDACTED]

From: [REDACTED] [mailto:[REDACTED]@ocimed.com]

Sent: Monday, March 19, 2018 12:45 PM

To: [REDACTED]

Subject: Re: Ocean County Internal Medicine

Hi [REDACTED],

Thank you so much for providing clarification. We look forward to working together.

Thank you,

[REDACTED]

On Thu, Mar 15, 2018 at 3:31 PM, [REDACTED] <[REDACTED]@uhc.com> wrote:

Hi [REDACTED],

It was a pleasure speaking with you and [REDACTED] today. I look forward to our continued partnership. As discussed today procedure code 99050 is an afterhours code created to allow physicians to treat members with urgent care needs outside of their normal business hours. We do have a policy that outlines the anticipated use of the code which I have attached. As discussed today the CPT code 99050 should only be used **outside of established normal business hours** that the practice has communicated; when treating a patient's urgent illness or condition. I hope the information is helpful.

After hours or weekend care is reimbursable, **within limitations**, when an individual physician or other health care professional is required to provide services **outside of regular posted office hours to treat a patient's urgent illness or condition**.

UnitedHealthcare Community Plan, however, will provide additional compensation to physicians for seeing patients in situations that would otherwise **require more costly urgent care or emergency room settings by reimbursing CPT code 99050 in addition to basic services**.

99050:

Services provided in the office at times other than regularly scheduled office hours, or days when the office is normally closed (eg, holidays, Saturday or Sunday), in addition to basic service

Thank you

[REDACTED]

From: [REDACTED] [mailto:[REDACTED]@ocimed.com]

Sent: Thursday, March 15, 2018 2:16 PM

To: [REDACTED]

Subject: Ocean County Internal Medicine

Hi [REDACTED],

It was a pleasure speaking to you earlier today. We appreciate your time. As we discussed, can you please send us your interpretation of how we are meant to use the 99050 code? We have a meeting and we would like to address this with our staff.

We look forward to hearing from you.

Thank you,

--

[REDACTED], MHA

Ocean County Internal Medicine Associates

1352 River Avenue

Lakewood, NJ

732-370-3383

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--

[REDACTED], MHA

Ocean County Internal Medicine Associates

1352 River Avenue

Lakewood, NJ

732-370-3383

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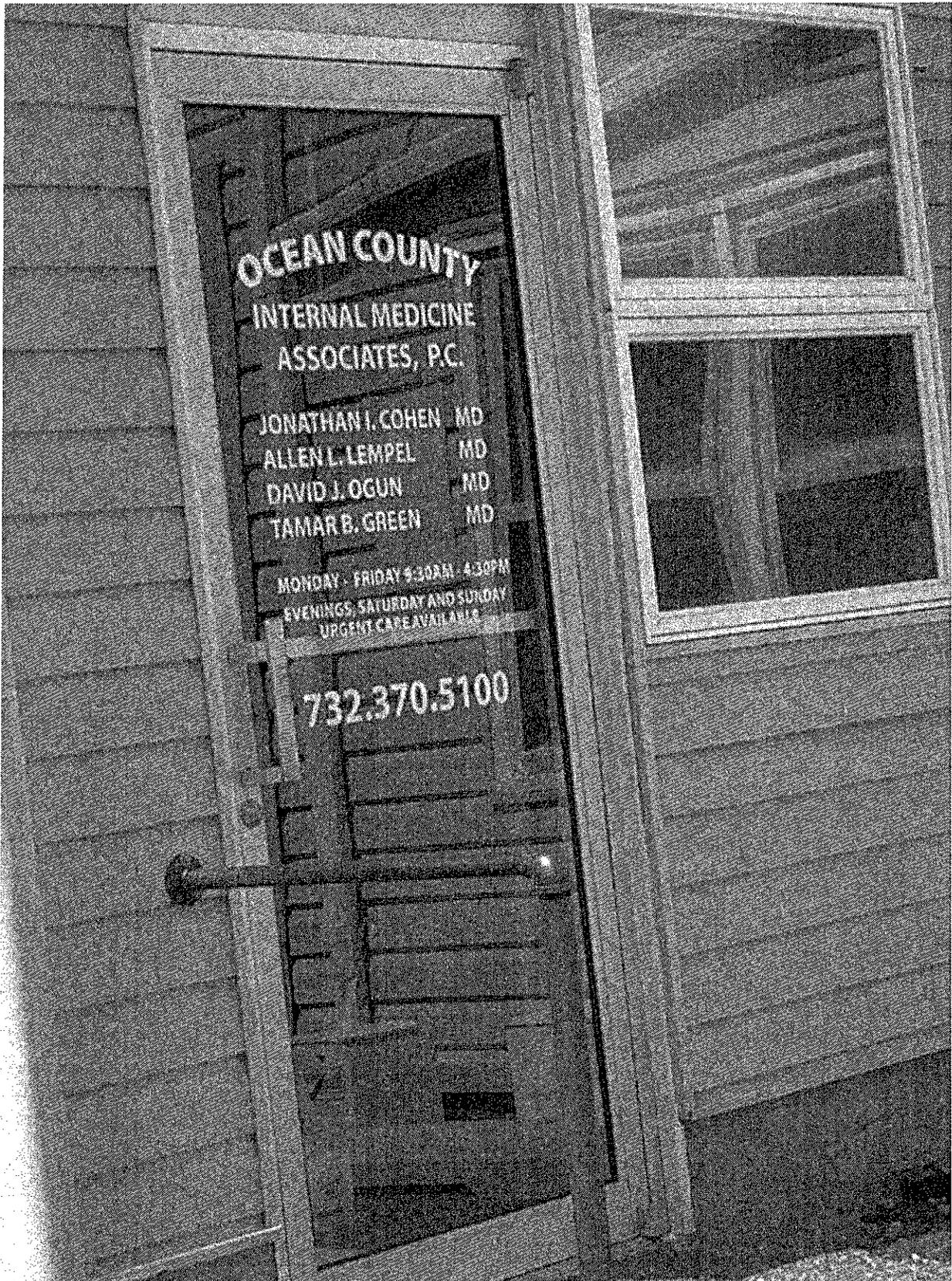
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--

 , MHA
Ocean County Internal Medicine Associates
1352 River Avenue
Lakewood, NJ
732-370-3383

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Picture of OCIMA's entrance door taken by OSC on August 25, 2016



Medicaid Paid Claims by Days of the Week								
	Number of 99050 Claims Paid	Total Amount Paid for 99050 Claims	Number of E&M Claims Paid	Total Amount Paid for E&M Claims	Number of Other Claims Paid	Total Amount Paid for Other Claims	Number of All Claims Paid	Total Amount Paid for All Claims*
Sunday	3,812	\$90,783	4,164	\$197,754	6,954	\$102,686	14,930	\$391,224
Monday	1,662	\$39,476	8,738	\$439,306	10,374	\$230,461	20,774	\$709,244
Tuesday	1,518	\$36,381	8,332	\$409,325	10,860	\$239,491	20,710	\$685,196
Wednesday	1,298	\$30,747	7,397	\$374,396	9,749	\$223,324	18,444	\$628,467
Thursday	983	\$22,936	6,537	\$332,258	10,494	\$221,365	18,014	\$576,558
Friday	84	\$2,090	6,346	\$310,829	8,081	\$152,811	14,511	\$465,730
Saturday	409	\$9,828	451	\$21,300	4,484	\$58,384	5,344	\$89,511
Total	9,766	\$232,241	41,965	\$2,085,168	60,996	\$1,228,522	112,727	\$3,545,930

*Difference due to rounding

Ammon Analytical Laboratory, LLC



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

November 20, 2018

BY CERTIFIED AND ELECTRONIC MAIL

Mr. Stephen Haupt
Chief Executive Officer
Ammon Analytical Laboratory, LLC
35 East Blancke Street
Linden, NJ 07036

RE: Final Audit Report – Ammon Analytical Laboratory, LLC

Dear Mr. Haupt:

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 (OSC) completed its review of a statistically selected universe of Medicaid claims submitted by Ammon Analytical Laboratory, LLC (Ammon), an independent clinical laboratory. For this audit, there were two operative periods of review. For OSC's analysis of presumptive and definitive drug testing, OSC utilized a review period of May 1, 2016 through September 30, 2017, and for specimen validity testing, a review period of January 1, 2015 through December 31, 2017. OSC hereby provides you with this Final Audit Report.

Executive Summary

OSC conducted an audit to determine whether Ammon appropriately billed for drug tests in accordance with applicable state and federal laws and regulations. OSC statistically selected 100 claims for presumptive and definitive drug testing codes billed on the same date of service for the same beneficiary. OSC found that 66 of the 100 sample claims failed to comply with the following regulations: *N.J.A.C. 10:49-9.8*, *N.J.A.C. 10:61-1.6*, and *N.J.A.C. 10:49-5.5*. The 66 of 100 sample claims had 76 exceptions, totaling \$4,127.03. Specifically, OSC found that Ammon: a) failed to maintain requisitions with a physician signature for 8 test requisitions; b) failed to ensure the beneficiary's gender was included on 11 test requisitions; c) billed for definitive drug tests which were not ordered by the physician or conducted by Ammon for 2 claims; d) failed to maintain

documentation to support the billing of definitive drug testing for 3 claims; and e) billed definitive drug tests for a greater level of service than ordered by the physician for 52 claims.

For purposes of ascertaining a final recovery amount for the presumptive and definitive drug tests, the dollars in error for claims that failed to comply with applicable state and federal regulations were extrapolated to the total population of claims from which the sample claims were drawn, which in this case was 69,629 claims with a total Medicaid reimbursement amount of \$10,254,387. By extrapolating to this universe of claims/reimbursed amount, OSC has determined that the total amount of improper claims for presumptive and definitive drug tests is \$2,270,754.

OSC also found that Ammon violated *N.J.A.C. 10:49-9.8* by failing to adhere to the American Medical Association's (AMA) Current Procedural Terminology (CPT) guidelines, the AMA's Healthcare Common Procedure Coding System (HCPCS) guidelines, and the Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual for Medicaid Services (Medicaid NCCI) by separately billing for (i.e., unbundling) specimen validity tests which were performed in conjunction with presumptive and/or definitive drug tests for the same beneficiary on the same date of service. As a result of Ammon's unbundling of 224,960 specimen validity tests, OSC seeks reimbursement of \$751,942 in improper Medicaid reimbursements that Ammon received for all of these validity test claims.

Overall, OSC seeks reimbursement of overpayments totaling \$3,022,696, which is comprised of \$2,270,754 relating to presumptive and definitive tests, and \$751,942 relating to validity tests.

Background

Ammon is located in Linden, New Jersey and was founded in 1998. Ammon has participated in the New Jersey Medicaid program since February 1999. According to its website, Ammon is an "industry-leading, College of American Pathologists accredited, full-service toxicology lab." Ammon provides services such as urine testing for drug and alcohol abuse, blood collection, oral fluid testing for drug abuse, and testing for specific metabolites (byproducts of a drug).

OSC identified Ammon as one of the highest paid Medicaid providers of independent clinical laboratory services. The top procedure codes that Ammon billed Medicaid included presumptive and definitive drug tests, as well as specimen validity tests. Presumptive procedures are used to identify the possible use or non-use of a drug or drug class, whereas definitive procedures specifically identify drugs or metabolites. Specimen validity tests are conducted to ensure that a specimen sample is unaltered and usable for testing.

Objective

The objective of this audit was to evaluate claims for services in which Ammon billed and was reimbursed to determine whether Ammon complied with Medicaid requirements under applicable state and federal laws and regulations.

Scope

The audit period of review for presumptive and definitive drug testing was May 1, 2016 through September 30, 2017, and the audit period of review for specimen validity testing was January 1, 2015 through December 31, 2017. This audit was conducted pursuant to OSC's authority 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

OSC's audit methodology consisted of the following:

- Reviewed Ammon's records to determine whether proper documentation existed to substantiate the claims and to ensure claims have been properly billed and reimbursed.
- Reviewed a statistically valid random sample comprised of 100 claims for presumptive and definitive drug tests performed on the same date of service for the same beneficiary totaling \$17,379. OSC selected these claims from a population of 69,629 claims totaling \$10,254,387 that Ammon billed under HCPCS codes G0479 to G0483 and CPT code 80307 for presumptive and definitive drug testing. (See Exhibit A for the HCPCS and CPT code descriptors).
- Reviewed claims for specimen validity tests performed in conjunction with a presumptive and/or definitive drug test for the same beneficiary on the same date of service that Ammon billed separately and received payment under CPT codes 83986, 84315, 82570, and 84311. (See Exhibit B for these CPT code descriptors).

Audit Findings

A. Billing Irregularities for Presumptive and Definitive Testing

OSC requested that Ammon provide test requisitions for the statistically selected random sample of 100 claims of presumptive and definitive drug testing codes billed on the same date of service for the same beneficiary. Based on OSC's review, Ammon improperly received a total Medicaid reimbursement of \$4,127.03 for 66 of the 100 sample claims. These 66 claims resulted in 76 exceptions, which are delineated in an attached spreadsheet. (See Exhibit C). A breakdown by type of exception is detailed below.

Insufficient Documentation

OSC's review found that test requisitions for 8 of the 100 sample claims failed to include the signature of the physician or other licensed practitioner who requested the services.

Pursuant to *N.J.A.C. 10:61-1.6(a)*, orders for clinical laboratory services shall be in the form of an explicit order personally signed by the physician or other licensed practitioner requesting the services.

OSC's review also found that test requisitions for 11 of the 100 sample claims did not indicate the gender of the beneficiary.

Pursuant to *N.J.A.C. 10:61-1.6(d)*:

The laboratory must ensure that all orders . . . contain the following information:

1. The name and address or other suitable identifiers of the authorized person requesting the test and, if appropriate, the individual responsible for using the test results, or the name and address of the laboratory submitting the specimen, including, as applicable, a contact person to enable the reporting of imminently life-threatening laboratory results or panic or alert values;
2. The patient's name or unique patient identifier;
3. The sex and the age (or date of birth) of the patient (emphasis added);
4. The test(s) to be performed;
5. The source of the specimen, when appropriate; and
6. The date and, if appropriate, time of specimen collection.

OSC's review found that test requisitions for 2 of the 100 sample claims did not indicate that a definitive drug test was ordered by a physician. In addition, a review of the test results confirmed that the definitive drug tests had not been conducted. Nevertheless, Ammon billed and was reimbursed by Medicaid for these tests.

Pursuant to *N.J.A.C. 10:49-9.8(a)*, providers must certify that the "information furnished on the claim is true, accurate, and complete." In addition, pursuant to *N.J.A.C. 10:49-9.8(b)*, providers shall keep such records as are necessary to disclose fully the extent of services provided for a minimum period of five years from the date the service was rendered.

OSC's review also found that for 3 of the 100 sample claims Ammon failed to maintain documentation to support the billing of a definitive drug test. These requisitions did not specify that a physician ordered a definitive test. In two of the three cases, the requisitions listed a profile code instead of the actual tests ordered. According to Ammon, each client was assigned a unique profile code(s) which represented the tests

ordered by the physician. Ammon was unable, however, to provide documentation that the ordering physician approved the tests that comprised the unique profile code. In the remaining case, the manual requisition listed the drug classes to be tested. However, the requisition did not indicate that definitive testing was ordered.

Pursuant to *N.J.A.C. 10:61-1.6(d)4*, laboratories must ensure that all orders contain the tests to be performed. Moreover, pursuant to *N.J.A.C. 10:49-9.8(a)*, providers must certify that the "information furnished on the claim is true, accurate, and complete." Similarly, pursuant to *N.J.A.C. 10:49-9.8(b)*, providers are required 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 the service was rendered. Finally, under *N.J.A.C. 10:61-1.6(a)*, all orders for clinical laboratory services shall be in the form of an explicit order and written orders shall contain the specific clinical laboratory tests requested.

Improper Definitive Procedure Code Billing

OSC found that for 52 of the 100 sample claims, Ammon billed and was paid for a greater level of service for definitive drug testing than ordered by the physician. The definitive codes specifically identify which drugs or metabolites should be tested within different drug classes. These classes are grouped into four levels for claim and payment purposes, with lower levels resulting in lower payment reimbursements than higher levels. The lowest level of definitive testing covers 1 to 7 drug classes; the next level tests for 8 to 14 drug classes; the next level tests for 15 to 21 drug classes; and, the final level tests for 22 or more drug classes. OSC found that Ammon billed and was reimbursed for higher level tests than were actually ordered by the physician. In calculating the amount of overpayment attributed to this deficiency, OSC down coded these claims to conform to the level of definitive drug testing that was actually ordered. OSC then used the corresponding Medicaid reimbursement rate for the down coded level of testing to determine the amount that Ammon should have been paid by Medicaid.

Pursuant to *N.J.A.C. 10:49-5.5(a)13*, Medicaid will not cover services billed for which the corresponding records do not adequately and legibly reflect the requirements of the procedure code utilized by the billing provider. In accordance with *N.J.A.C. 10:49-5.5(a)13(i)*, final payment shall be made in accordance with a review of those services actually documented in the provider's health care record.

B. Improper Billing of Specimen Validity Testing

A validity test performed in conjunction with a presumptive/definitive test cannot be billed separately. OSC found that Ammon improperly submitted claims for specimen validity testing separately from claims submitted for presumptive and definitive drug tests for the same beneficiary on the same date of service. This practice, referred to as "unbundling claims," is improper. In total, Ammon unbundled 224,960 specimen validity claims for which it was paid \$751,942. Therefore, OSC seeks reimbursement of \$751,942 from Ammon for the claims that failed to comply with AMA and Medicaid NCCI guidelines. See Table I below for a breakdown by year.

Table I

	Number of Claims Paid	Total Dollars Paid
2015	106,058	\$ 342,600
2016	113,451	\$ 389,752
2017	5,451	\$ 19,590
Total	224,960	\$ 751,942

Pursuant to the 2016 and 2017 HCPCS and CPT guidelines, presumptive and definitive drug tests include sample validation or specimen validity testing. Additionally, the Medicaid NCCI, which promotes correct coding methodologies and reduces improper coding that may result in inappropriate payments of Medicaid claims, further states that specimen validity testing is not separately billable from urine drug tests. The 2015, 2016, and 2017 NCCI Policy Manual Chapter X(e) for Medicaid Services states:

Providers performing validity testing on urine specimens utilized for drug testing should not separately bill the validity testing. For example, if a laboratory performs a urinary pH, specific gravity, creatinine, nitrates, oxidants, or other tests to confirm that a urine specimen is not adulterated, this testing is not separately billed.

C. Use of Profile Codes on Requisitions May Not Support Services Provided

During its audit, OSC made several observations related to Ammon's use of profile codes for the purposes of ordering drug tests. Ammon advised OSC that the profile codes are determined and assigned when services for a new client provider begin. According to Ammon, a new provider completes a test panel and/or account set-up form and/or service agreement, jointly with Ammon, in which they indicate specific drug classes that will be requested for testing. It is these documents, as described by Ammon, which are used to create a unique profile code for the provider. These codes, according to Ammon, are used by the ordering physician on the test requisition in place of a list of specific drug tests. The codes are populated by Ammon's web portal onto the electronic requisitions used by the provider to order drug tests.

Despite the above-mentioned process, as conveyed by Ammon, OSC found that in some cases, test panels/account set-up forms or service agreements between Ammon and its providers either did not provide an effective date and were otherwise undated, or were not fully executed in that one or both parties had not signed the documents. The documentation does not indicate the providers' agreement of specific drugs to be tested, changes that may occur in the types of drug tests ordered, or the effective date to begin testing for those specific drugs. Furthermore, in the cases where such documents did exist, the tests selected by the physician did not always match the tests being performed by Ammon pursuant to the profile code. It is evident from OSC's review that in some cases the profile code represented different tests to Ammon and its providers. Ultimately,

Ammon is responsible for maintaining documentation to support its claims for drug testing. *N.J.A.C.* 10:49-9.8. In the excepted cases, Ammon failed to produce any documentation that its providers had explicitly ordered definitive tests, contrary to *N.J.A.C.* 10:61-1.6. It is also worth noting that, given the individualized needs of each beneficiary, it is difficult to understand why all tests ordered by an entity would be identical, "one-size-fits-all." OSC's review showed that the tests performed by Ammon pursuant to the profile code included the same tests for each provider's patients with little, if any, variance. Standing orders must be patient specific and not blanket requests from the physician. *N.J.A.C.* 10:61-1.6.

During OSC's audit, it also found one instance of Ammon unilaterally adding drug classes to a provider's profile code. Ammon's action would undoubtedly lead to additional tests. OSC is also aware that Ammon advised this provider that the tests would be added as a courtesy, at no additional cost to the provider. OSC notes, however, while there may be no additional cost to providers, the Medicaid program may incur additional costs for these drug tests.

Although OSC's audit is not seeking a monetary recovery based on Ammon's use of profile codes alone, but rather because of Ammon's failure to adhere to applicable regulations, OSC raises these issues in order to point out that this practice does not appear to promote the most effective use of Medicaid funds. In doing so, OSC recognizes that it is the physician or other licensed practitioner, not Ammon, who is charged with ordering tests. Ammon's duty is to perform those tests ordered by the physician. *N.J.A.C.* 10:61-1.6. As the party that performs these tests, however, Ammon does bear some degree of responsibility for this practice. Indeed, the regulations provide that "the medical necessity for the services must be apparent and the quality of care must be acceptable as determined upon review by an appropriate and qualified health professional consultant." *N.J.A.C.* 10:49-5.5(a)(13)(i).

The use of profile codes in the manner described above may contribute to inappropriate and/or unnecessary testing which could increase costs to the Medicaid program. Ammon should review its practices to determine if the continued use of profile codes in the manner described above is appropriate.

Summary of Overpayments

Based on its review, OSC determined that Ammon improperly billed and received payment for 66 of 100 sample claims for presumptive and definitive drug tests during the period May 1, 2016 through September 30, 2017. Ammon received a total of \$4,127.03 in Medicaid reimbursement for these 66 sample claims. For purposes of ascertaining a final recovery amount for presumptive and definitive drug tests, the dollars in error for claims that failed to comply with state and federal regulations were extrapolated to the total population from which the sample claims were drawn, which in this case was 69,629 claims with a total payment of \$10,254,387. By extrapolating to this universe of claims/reimbursed amount, OSC has determined that the total amount of improper claims for presumptive and definitive drug tests is \$2,270,754.

Additionally, OSC identified 224,960 Medicaid claims submitted by Ammon totaling \$751,942 for specimen validity testing under CPT codes 83986, 84315, 82570, and 84311 that were unbundled and billed separately from January 1, 2015 to December 31, 2017. Ammon improperly unbundled specimen validity codes from presumptive and definitive drug tests that should have been bundled together. As a result, Ammon improperly submitted claims for services and was overpaid a total of \$751,942, for which OSC seeks reimbursement.

Overall, OSC seeks reimbursement of \$3,022,696, which is comprised of \$2,270,754 relating to presumptive and definitive tests, and \$751,942 relating to validity tests.

Recommendations

1. Ammon shall reimburse the Medicaid program \$3,022,696.
2. Ammon must ensure that all orders for clinical laboratory services and all records and documentation maintained by Ammon comply with applicable statutes and regulations, including the regulations cited above.
3. Ammon must maintain the necessary documentation to ensure that profile codes assigned to providers include the requested drug tests and only those drug tests ordered by the physician or other licensed practitioner requesting the services, and the effective date of drug tests ordered. Any and all changes to the tests included within a profile code must be contemporaneously documented.
4. All test orders including tests listed under profile codes must clearly indicate the specific drugs or class of drugs as defined by the AMA.
5. All claims for drug tests should adhere to the AMA or other applicable guidelines.
6. Ammon must immediately discontinue its practice of separately submitting claims for specimen validity testing to confirm that a urine specimen is unadulterated from claims submitted for presumptive and definitive drug tests.
7. Ammon must provide training to its staff to foster compliance with Medicaid requirements under applicable state and federal laws and regulations.
8. Ammon must provide OSC with a Corrective Action Plan indicating the steps it will take to implement procedures to correct the deficiencies identified in this report.

Auditee Response

In a written response, Mr. Michael Plick, Ammon's Senior Vice President of Payer Relations and Chief Compliance Officer, agreed with the audit findings and provided a Corrective Action Plan to address the recommendations above. Mr. Plick also described the specific steps Ammon has taken or will take to implement the recommendations made

in this audit report. The full text of the Corrective Action Plan submitted by Mr. Plick is included as an Appendix to this report.

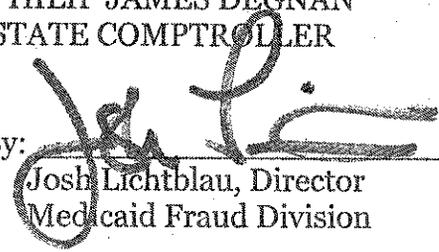
OSC Comments

OSC notes that Ammon is in complete agreement with the audit's findings and recommendations. Accordingly, OSC requests that Ammon reimburse the Medicaid program \$3,022,696 and that it implement the necessary measures to correct the findings identified in the audit. Given Ammon's agreement with the findings in this audit and its stated intention to implement corrective actions, OSC believes that no further action is necessary with respect to this audit.

Thank you for your attention to this matter.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: 
Josh Lichtblau, Director
Medicaid Fraud Division

Attachments:

1. Exhibit A – HCPCS and CPT Code Descriptors for Presumptive and Definitive Drug Testing
2. Exhibit B – CPT Code Descriptors for Specimen Validity Testing
3. Exhibit C – Summary of Noncompliant Presumptive and Definitive Testing
4. Appendix – Ammon's Corrective Action Plan

cc: Michael Plick, SVP of Payer Relations & Chief Compliance Officer
Kay Ehrenkrantz, Deputy Director (OSC – Medicaid Fraud Division)
Don Catinello, Supervising Regulatory Officer (OSC – Medicaid Fraud Division)
Glenn Geib, Recovery Supervisor (OSC – Medicaid Fraud Division)

AMA HCPCS Code Descriptions - Presumptive

Code	Code Descriptor
G0479	Drug test(s), presumptive, any number of drug classes; any number of devices or procedures by instrumented chemistry analyzers utilizing immunoassay, enzyme assay, TOF, MALDI, LDTD, DESI, DART, GHPC, GC mass spectrometry), includes sample validation when performed, per date of service

AMA CPT Code Descriptions - Presumptive

Code	Code Descriptor
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers (eg, utilizing immunoassay [eg, EIA, ELISA, EMIT, FPIA, IA, KIMS, RIA]), chromatography (eg, GC, HPLC), and mass spectrometry either with or without chromatography, (eg, DART, DESI, GC-MS, GC-MS/MS, LC-MS, LC-MS/MS, LDTD, MALDI, TOF) includes sample validation when performed, per date of service

AMA HCPCS Code Descriptions - Definitive

Code	Code Descriptor
G0480	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers (but not necessarily stereoisomers), including, but not limited to GC/MS (any type, single or tandem) and LC/MS (any type, single or tandem and excluding immunoassays (e.g., IA, EIA, ELISA, EMIT, FPIA) and enzymatic methods (e.g., alcohol dehydrogenase)); qualitative or quantitative, all source(s), includes specimen validity testing, per day, 22 or more drug class(es), including metabolite(s) if performed

AMA CPT Code Descriptions

Code	Code Descriptor
83986	pH; body fluid, not otherwise specified
84315	Specific gravity (except urine)
82570	Creatinine; other source
84311	Spectrophotometry, analyte not elsewhere specified

Ammon Analytical Laboratory, LLC
Final Audit Report

Sample Number	Claim Service Date				Audit Findings				*Insufficient Documentation			
	Claim Service Date	Presumptive Procedure Code Billed	Presumptive Claim Payment Amount	Definitive Procedure Code Billed	Definitive Claim Payment Amount	Total Presumptive and Definitive Claim Payment Amount	1. Insufficient Documentation *	2. Incorrect Definitive Procedure Code Billed **	1a. Missing Physician Signature on Manual Requisition	1b. Gender Not Listed on Requisition	1c. Lack of Documentation to Support Definitive Test Performed by Laboratory	1d. Lack of Document to Support Definitive Order Physic
1	8/3/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X		X			
7	7/25/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X		X			
8	8/18/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X					
9	11/7/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X					X
25	8/2/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X		X			X
26	7/22/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X					
28	6/27/2016	G0479	\$ 63.40	G0480	\$ 63.95	\$ 127.35	X		X			X
34	7/25/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
35	8/15/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
36	7/15/2017	80307	\$ 86.28	G0481	\$ 98.39	\$ 184.67		X				
37	8/11/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
38	9/15/2016	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				
39	8/9/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
40	6/23/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79	X					
41	7/21/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
42	8/30/2016	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				
43	8/17/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
46	6/19/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				
47	5/25/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22		X				
48	7/24/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
50	1/20/2017	G0479	\$ 63.40	G0480	\$ 94.12	\$ 157.52	X					
51	8/28/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
52	9/12/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07	X					
53	8/30/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
54	9/11/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
56	6/29/2017	G0479	\$ 63.40	G0483	\$ 172.18	\$ 235.58		X				
57	5/1/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				
60	8/27/2016	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				
61	8/11/2017	80307	\$ 86.28	G0483	\$ 203.10	\$ 289.38		X				
62	8/14/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
63	7/13/2017	80307	\$ 86.28	G0481	\$ 98.39	\$ 184.67		X				
65	9/5/2017	80307	\$ 86.28	G0480	\$ 94.12	\$ 180.40	X					
66	4/27/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22		X				
67	6/16/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07		X				
68	7/13/2017	80307	\$ 86.28	G0481	\$ 98.39	\$ 184.67		X				
69	8/11/2017	80307	\$ 86.28	G0483	\$ 203.10	\$ 289.38		X				
70	7/12/2017	80307	\$ 86.28	G0480	\$ 63.95	\$ 150.23	X					
71	8/17/2017	80307	\$ 86.28	G0482	\$ 163.47	\$ 249.75		X				
72	10/8/2016	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X				

Sample Number	Claim Service Date						Audit Findings			*Insufficient Documentation			
	Claim Service Date	Presumptive Procedure Code Billed	Presumptive Claim Payment Amount	Definitive Procedure Code Billed	Definitive Claim Payment Amount	Total Presumptive and Definitive Claim Payment Amount	1. Insufficient Documentation *	2. Incorrect Definitive Procedure Code Billed **	1a. Missing Physician Signature on Manual Requisition	1b. Gender Not Listed on Requisition	1c. Lack of Documentation to Support Definitive Test Performed by Laboratory	1d. Lack of Documentation to Support Definitive Orders	Physic
74	5/1/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X					
75	2/16/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79	X			X			
76	10/20/2016	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79		X					
77	8/23/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
78	7/28/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07	X			X			
79	7/17/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
80	5/27/2016	G0479	\$ 50.00	G0481	\$ 98.39	\$ 148.39	X			X			
81	7/12/2017	80307	\$ 86.28	G0483	\$ 172.18	\$ 258.46							
82	6/13/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
83	4/30/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
84	8/30/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
85	4/28/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
86	7/13/2017	80307	\$ 86.28	G0481	\$ 98.39	\$ 184.67							
87	4/13/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22							
88	6/22/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
89	7/14/2017	80307	\$ 86.28	G0481	\$ 98.39	\$ 184.67							
90	7/6/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
91	4/13/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22							
92	7/7/2017	G0479	\$ 63.40	G0481	\$ 98.39	\$ 161.79							
93	7/27/2017	80307	\$ 86.28	G0480	\$ 94.12	\$ 180.40	X			X			
94	9/9/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
95	4/27/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22							
96	8/14/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
97	5/15/2017	G0479	\$ 63.40	G0482	\$ 132.82	\$ 196.22							
98	8/28/2017	80307	\$ 86.28	G0483	\$ 203.10	\$ 289.38							
99	7/12/2017	80307	\$ 86.28	G0480	\$ 63.95	\$ 150.23	X			X			
100	7/31/2017	80307	\$ 86.28	G0481	\$ 128.79	\$ 215.07							
							17	52	8	11	2	3	

Universe Dollars	Universe Claims	Sample Dollars	Sample Claims
\$ 10,254,387.15	69,629	\$ 17,379.03	100

Ammon Analytical Laboratories LLC Corrective Action Plan

Scope

For over 20 years, Ammon Analytical Laboratories LLC has been driven by a continual focus on adhering to the highest standards of compliance in every test we provide on behalf of our healthcare partners and addiction treatment providers. Our longevity and focus on providing accurate and reliable testing services has enabled us to service some of the state's largest behavioral treatment facilities and directly support the communities being ravaged by the opioid crisis.

Unfortunately, we were recently made aware of deficiencies in our documentation and billing processes that resulted in an overpayment by the State of New Jersey's Medicaid Office. We appreciate the findings of this report as they will ensure that moving forward, we are able to adhere to our long-held commitment to compliance in every aspect of our business.

Prior to and since learning of the audit findings, Ammon Analytical Laboratories LLC has taken steps to improve our processes and policies, correct deficiencies in staff training, and reimburse the state for every dollar that was overpaid to our company. Ammon Analytical Laboratories LLC hired a Chief Compliance Officer and new Billing Director in July of 2017, as well as an independent consultant to review ordering and billing processes. Ammon Analytical Laboratories LLC also continues to add resources and staff trainings to our Compliance and Billing Departments to reflect the company's ongoing compliance needs. Moving forward, we have instituted ongoing measures to ensure that we are able to meet continually evolving state and federal regulations and rules to deliver accurate, compliant and reliable testing services to each of our clients.

Corrective Action Plan

Recommendation	Finding	Name of Person Responsible for Corrective Action	Corrective Action	Timeframe for Implementation	Follow Up and Monitoring Ongoing Compliance
Ammon must pay Medicaid \$3,022,696	Ammon received an overpayment of \$3,022,696	Evan Haupt, President	Ammon will repay the state Medicaid office \$3,022,696.	Payment terms will be finalized upon completion of audit process.	Currently, Ammon has hired an outside billing consultant to review and audit our existing billing practices. In addition, Ammon will implement internal audits as

<p>Ammon must ensure all orders for Clinical Laboratory services and all records and documentation maintained by Ammon comply with applicable statutes and regulations, including the regulations cited above.</p>	<p>Ammon failed to verify all information on requisitions required by Medicaid Guidelines (i.e. DOB, Sex)</p>	<p>Alejandro Amador, COO/ Alice Taipina</p>	<p>Ammon has implemented a new missing information procedure. In the event of missing information accounts are notified the day of by the Key Account Manager. If a response is not received, the Key Account Managers follow up at the account with a form to get all missing information. If missing information is still unable to be secured, Ammon will not conduct any testing for that client until the information has been secured.</p>	<p>Implemented 09/03/18 Standard Laboratory Missing Information Procedure</p>	<p>part of the ongoing compliance program. If Ammon is made aware of an overpayment scenario, Ammon will self-report.</p>	<p>Records are constantly checked by customer service coordinators. Customer service coordinators will also undergo ongoing training in line with applicable statutes and regulations.</p>
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<p>Ammon must maintain the necessary documentation to ensure that profile codes assigned to providers include the requested drugs tests and only those drug tests ordered by the physicians or other licensed practitioner requesting the services, and the effective date of drug test ordered. Any of all changes to the tests included within a profile code must be contemporaneously documented.</p>	<p>Due to deficiencies in the account management process, Ammon failed to update requisition panel description and failed to provide documentation of panel change request after the account requested a change.</p>	<p>Alejandro Amador, COO/Michael Plick, CCO</p>	<p>Ammon has overhauled our client management system and policies. We have created new contracts, new account set up forms and trained staff in compliant account management. Ammon is updating all contracts with existing accounts, verifying panels and components, and verifying provider information for all existing accounts.</p>	<p>Implemented 08/09/18 New Contract 08/24/18 New Account Set Up Form 08/21/18 Trained Sales Staff on New Forms and Requirements 01/31/2019 New paperwork in place for all legacy accounts</p>	<p>All new account panels are immediately reviewed by our internal laboratory team and client onboarding specialists. All new account panels are reviewed internally immediately. Existing requisitions are reviewed on a monthly basis by customer service coordinators and client onboarding specialists. Ammon will also regularly train all customer service coordinators and client onboarding specialists on updated regulations and procedures.</p>
<p>All test orders including tests listed under profile codes must clearly indicate the specific drugs or class of drugs as defined by the AMA</p>	<p>Ammon failed to accurately align drug class definitions with AMA guidelines.</p>	<p>Alejandro Amador, COO/ Alice Taipina</p>	<p>New panel descriptions will accompany requisitions to accurately reflect all AMA drug classes included in the test request.</p>	<p>Implemented on 8/15/18. Requisitions being updated as print request are processed.</p>	<p>New panel requests are verified by laboratory, customer service, and account managers. All laboratory, customer service</p>

<p>All claims for drug tests should adhere to the AMA or other applicable guidelines.</p>	<p>Ammon failed to accurately describe the testing methodology on the requisition forms.</p>	<p>Alejandro Amador, COO/ Alice Taipina</p>	<p>Ammon has updated the language in requisitions, contract and communications to better explain the testing methodology and components utilized in each test requested by our clients.</p>	<p>Implemented on 8/15/18. Requisitions being updated as print request are processed.</p>	<p>and account managers are also undergoing regular training on updated drug classes and AMA regulations. As testing continues to evolve and processes change, Ammon will update all forms and contracts to ensure compliance. All new panel requests will be created by the laboratory team and QA will be performed by customer service, and the sales rep or key account manager will verify the panel.</p>
<p>Ammon must immediately discontinue its practice of separately submitting claims for Specimen Validity Testing</p>	<p>Changes in the Medicaid reimbursement guidelines meant that SVT became unbillable in 2015. However, the Medicaid fee schedule had a fee listed for the</p>	<p>Alexis Jones, AVP of Clinical Billing</p>	<p>Ammon stopped billing SVT in November 2017 and updated all software and billing procedures to reflect new procedure.</p>	<p>Implemented November, 2017</p>	<p>Ammon's expanded compliance department will enable the company to biannually conduct a complete regulations</p>

	<p>SVT codes through 2107. Ammon failed to immediately update billing processes accordingly and inadvertently continued to bill for SVT.</p>				<p>compliance overview and more quickly respond to changes in state and federal Medicaid regulations and processes.</p>
<p>Ammon must provide training to its staff to foster compliance with Medicaid requirements under applicable state and federal laws and regulations.</p>	<p>A substantially increased workload prompted by the opioid crisis, caused Ammon to fail to adequately train personnel on updated Medicaid Requirements.</p>	<p>Alice Taipina/Penelope Jordan/Alejandro Amador, COO</p>	<p>Ammon will train all front facing staff on Medicaid requirements. Ammon will train analytical staff on Medicaid requirements. Ammon is working on updating the collection manual to include Medicaid regulations and requirements.</p>	<p>08/21/18 Trained Sales Staff on New Forms and Requirements 08/22/18 Analytical Staff trained on information requirements for Medicaid (Added MSEX, MDOB to test lists to track missing information) 01/31/2019 Updated Collection Manual and Collection staff trained.</p>	<p>As Medicaid requirements continue to evolve to reflect best practices, Ammon will require all staff to attend Medicaid trainings in line with their job responsibilities. Ammon will also institute monthly internal staff trainings on new or revised Medicaid billing procedures.</p>

The Corrective Action Plan presented by Ammon Analytical Laboratories represents our company's renewed focus on adhering to the highest compliance standards in every test that we perform. As we move forward with the implementation of our Corrective Action Plan, we will continue to look for additional opportunities to better align our procedures and processes with any updates or changes to the State of New Jersey's Medicaid regulations and rules to ensure compliance and better serve the addiction treatment community and our partners.

Gloria Andrade,
Licensed Clinical Social Worker



State of New Jersey

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
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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

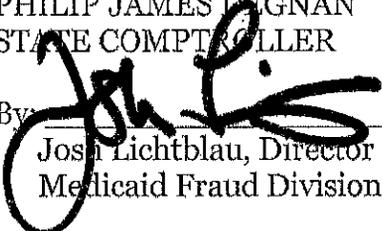
Ms. Andrade’s disagreement with the audit findings is without merit. This response contained broad refutations of the OSC findings, but it failed to provide any facts to substantiate Ms. Andrade’s claim that her billing was appropriate or information that would provide a basis for OSC to revise any of 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.

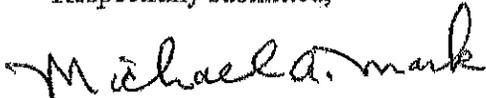
Further, Ms. Andrade rejects the State's contention that she was fabricating Medicaid billing records for times that she was at her full time job. This contention is not accurate. Ms. Andrade's hours at her full time job were very flexible. This flexibility allowed Ms. Andrade to perform Medicaid services 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
Page 2

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

Settlements

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 18th day of July, 2018 ("Effective Date") by and between NADER MISHREKI, MD ("DR. MISHREKI") (██████████); and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Mishreki and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an investigation and found that between January 1, 2013 and October 30, 2017, Dr. Mishreki improperly billed the Division of Medical Assistance and Health Services ("DMAHS"), and/or its fiscal agent, and/or the Medicaid Managed Care Organizations ("MCOs") for services that were not adequately supported by clinical documentation for American Medical Association (AMA) Current Procedural Terminology (CPT) Evaluation and Management codes for new and established patient office visits, 99204, 99211, 99213, and 99214, in violation of N.J.S.A. 30:4D-12 and N.J.A.C. 10:49-9.8 (the "Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Dr. Mishreki received overpayments from the Medicaid program; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

WHEREAS, Dr. Mishreki requested an installment plan, MFD assessed six percent (6%) interest on the principal balance of \$65,000, in the amount of Three Thousand Nine Hundred Dollars (\$3,900) for a total recovery of Sixty-Eight Thousand Nine Hundred Dollars (\$68,900) as set forth further below; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Dr. Mishreki agrees to pay to MFD the total sum of Sixty-Eight Thousand Nine Hundred Dollars (\$68,900) in the following manner:

- a. Thirty Thousand Dollars (\$30,000) shall be paid by August 30, 2018;
- b. Two Thousand Two Hundred Eighty-Eight Dollars and Twenty-Five Cents (\$2,288.25) shall be paid on or before the thirtieth (30th) day of each of the next sixteen (16) months thereafter (i.e. September 30, 2018 through December 30, 2019);
- c. Two Thousand Two Hundred Eighty-Eight Dollars (\$2,288) shall be paid in the following month by January 30, 2020;

(2) All payments outlined above shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered to:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Dr. Mishreki must include "Dr. Mishreki: [REDACTED]" in the memo line of the checks so that the payments are properly credited.

(3) If any payment provided for in this Settlement Agreement is more than ten (10) days late as set forth above, Dr. Mishreki will be in default of this Settlement Agreement

and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) The Parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct at issue in this matter, and is intended by each Party to release the other Party and its representatives from liability arising out of the Covered Conduct at issue in this matter, unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Dr. Mishreki or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed, Dr. Mishreki and MFD agree to the following Release: in consideration of the provision hereof including this release, each Party agrees to release the other Party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(7) Nothing herein shall constitute an admission, concession or finding of liability by any Party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in Counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the Parties hereto.

(11) This Settlement Agreement sets forth the entire agreement between and among the Parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the Parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the Parties hereto have executed the foregoing Settlement Agreement:

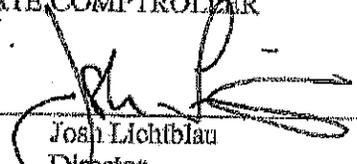
FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 7/19/18

By: 
Nador Mishrekt, MD

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 7/20/18

By: 
Josh Lichtblau
Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

7/20/18

By:

Don Catinello

Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

AMENDMENT TO NADER MISHREKI, MD SETTLEMENT AGREEMENT

This Amendment to the Settlement Agreement ("Amendment") is entered into this 30th day of August, 2018 ("Effective Date") by and between NADER MISHREKI, MD ("DR. MISHREKI") (Provider Idn 8025703); and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Mishreki and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, Dr. Mishreki originally agreed to pay \$68,900, which includes interest, over six (6) months;

WHEREAS, Dr. Mishreki has stated that he is now able to pay the full principal amount owed upon execution of the settlement agreement;

NOW THEREFORE, the original Settlement Agreement is amended as follows:

(1) Dr. Mishreki agrees to pay to MFD the total sum of Sixty-Five Thousand Dollars (\$65,000) in the following manner: as a one-time payment upon execution of this Amendment.

(2) The payment outlined above shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered to:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Dr. Mishreki must include "Dr. Mishreki: [REDACTED]" in the memo line of the checks so that the payments are properly credited.

(3) If Dr. Mishreki does not pay the full amount of \$65,000 by September 15, 2018, the original agreement will be in effect.

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:
9/4/18

By: 
Nader Mishreki, MD

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 9/6/2018

By: 
Josh Lichtblau
Director
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 18th day of July, 2018 ("Effective Date") by and between the medical practice of Edgar Mejia, M.D., its owners, officers, directors, successors, and assigns (hereinafter collectively referred to as "Dr. Mejia") and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Dr. Mejia and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an investigation and found that between January 1, 2013 and November 14, 2017, Dr. Mejia was reimbursed by the Division of Medical Assistance and Health Services ("DMAHS") and/or its fiscal agent and/or the Managed Care Organizations for claims for CPT code codes 49250, 92583, 95930 and 99401 that were not supported by the necessary supporting documentation in violation of N.J.A.C. 10:49-9.8(b) and N.J.S.A. 30:4D-12(d) ("Covered Conduct"); and

WHEREAS, Dr. Mejia supplied documentation supporting some of the discrepant claims thereby reducing the overpayment amount;

WHEREAS, the parties have agreed that Dr. Mejia should be given credit in the amount of \$153,866.57, which reduced the overpayment to \$81,246.43;

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them; and

WHEREAS, Dr. Mejia requested an installment plan, MFD assessed six percent (6%) interest on the principal balance of \$81,246.43, in the amount of Four Thousand Eight Hundred Seventy Four Dollars and Seventy Nine Cents (\$4,874.79) for a total recovery of Eighty Six Thousand One Hundred Twenty One Dollars and Twenty Two Cents (\$86,121.22) as set forth further below; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Dr. Mejia agrees to pay to MFD the sum of Eighty Six Thousand One Hundred Twenty One Dollars and Twenty Two Cents (\$86,121.22) by way of twelve (12) consecutive monthly payments of Seven Thousand One Hundred Seventy Six Dollars and Seventy Seven Cents (\$7,176.77) on or before the 1st of each month starting September 1, 2018 through August 1, 2019.

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Dr. Mejia" and "[REDACTED]" must be included in the memo line so that payment is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than thirty (30) days late, Dr. Mejia will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is

mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Urban Medical Center or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed, Urban Medical Center and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(7) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(11) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto
have executed the foregoing Settlement Agreement:

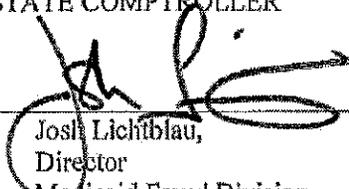
FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 7/18/18

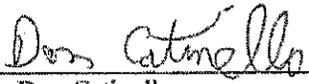
By: 
Edgar Mejia, M.D.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 7/20/18

By: 
Josh Lichtblau,
Director
Medicaid Fraud Division

DATE: 7/20/18

By: 
Don Catinello,
Supervising Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 18th day of July, 2018 ("Effective Date") by and between DIEGO MORILLO, OD ("MORILLO") (██████████); and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Morillo and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an investigation and found that between January 1, 2012 and December 12, 2016, Morillo improperly billed the Division of Medical Assistance and Health Services ("DMAHS"), and/or its fiscal agent, and/or the Medicaid Managed Care Organizations ("MCOs") for services that were not adequately supported by clinical documentation for American Medical Association (AMA) Current Procedural Terminology (CPT) code 92225, Ophthalmoscopy extended with retinal drawing, in violation of N.J.S.A. 30:4D-12 and N.J.A.C. 10:49-9.8 (the "Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Morillo received overpayments from the Medicaid program; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Morillo agrees to pay to MFD the total sum of Fifty Thousand Five Hundred Seventy Dollars (\$50,570) in the following manner:

a. Twenty Thousand Five Hundred Seventy Dollars (\$20,570) shall be paid by August 30, 2018;

b. Six Thousand Dollars (\$6,000) shall be paid on or before the thirtieth (30th) day of each of the next five (5) months thereafter (i.e. September 30th, 2018 through January 30th, 2019).

(2) All payments outlined above shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered to:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Morillo must include "Morillo: [REDACTED]" in the memo line of the checks so that the payments are properly credited.

(3) If any payment provided for in this Settlement Agreement is more than ten (10) days late as set forth above, Morillo will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) The Parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct at issue in this matter, and is intended by each Party to release the other Party and its representatives from liability arising out of the Covered Conduct at issue in this matter, unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Morillo or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed, Morillo and MFD agree to the following Release: in consideration of the provision hereof including this release, each Party agrees to release the other Party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(7) Nothing herein shall constitute an admission, concession or finding of liability by any Party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in Counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the Parties hereto.

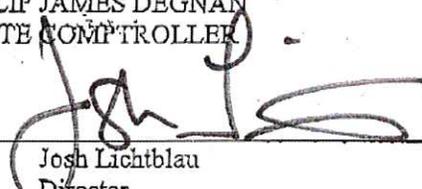
(11) This Settlement Agreement sets forth the entire agreement between and among the Parties hereto with respect to the claims described herein and supersedes any other

written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the Parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the Parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 7.20.18 By: 
Diego Morillo, OD

DATE: 7/20/18 By: 
PHILIP JAMES DEGNAN
STATE COMPTROLLER
Josh Lichtblau
Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: 7/20/18 By: 
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 18th day of July 2018 ("Effective Date") by and between SVETLANA DIMITROVICH, the owner of COMFORT CARE MEDICAL, LLC (hereinafter collectively referred to as "Comfort Care"), represented by Riza I. Dagli, Esq. at the law firm of Brach Eichler, LLC, and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Comfort Care and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an incontinence supply inventory analysis of Comfort Care and found that between February 1, 2011 and December 31, 2013, Comfort Care was reimbursed by the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or the Managed Care Organizations that contract with DMAHS, for incontinence supply claims that failed to have necessary supporting documentation in violation of N.J.A.C. 10:49-9.8, and N.J.S.A. 30:4D-12(d) ("Covered Conduct"); and

WHEREAS, MFD seeks a recovery for payments on claims in excess of amounts payable under the Medicaid program in the amount of \$347,921.85; and

WHEREAS, Comfort Care has ceased doing business in the State of New Jersey; and

WHEREAS, Comfort Care provided additional information and documentation to MFD; and

WHEREAS, Comfort Care disputed MFD's determination and denied any civil wrongdoing in connection with the recovery sought; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the recovery and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby

acknowledged, the parties agree to settle their dispute on the following terms:

(1) Comfort Care agrees to pay to MFD the sum of \$160,000 in twelve monthly payments of \$13,333.33 on or before the first of every month starting August 1, 2018.

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Comfort Care – [REDACTED]" must be included in the memo line so that payment is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Comfort Care will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or

other action for alleged conduct concerning Comfort Care or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed, Comfort Care and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the covered conduct.

(7) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in Counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(11) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 7/18/18

By: S. Dimitrova
Svetlana Dimitrovich
Comfort Care Medical, LLC

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 7/20/18

By: Josh Lichtblau
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: 7/20/18

By: Don Catinello
Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this ____ day of July, 2018 ("Effective Date") by and between Family Senior Health, LLC, d/b/a SENIOR SPIRIT OF JERSEY CITY, and its owners, officers, directors, successors, and assigns (hereinafter collectively referred to as "Senior Spirit") and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Senior Spirit and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an investigation and found that between July 1, 2011 and June 30, 2014, Senior Spirit was reimbursed by the Division of Medical Assistance and Health Services ("DMAHS") and/or its fiscal agent and/or the Managed Care Organizations for claims in excess of the maximum daily limit of 200 Medicaid beneficiaries per day, contrary to the 2010 to 2014 Appropriations Acts, N.J.S.A. 30:4D-7, and N.J.A.C. 10:49-5.5(a)(17) ("Covered Conduct"); and

WHEREAS, Senior Spirit disputes MFD's determination and denies any civil wrongdoing in connection with the Covered Conduct; and

WHEREAS, MFD determined that, based on the Covered Conduct, Senior Spirit received overpayments from the Medicaid program totaling \$298,952.79; and

WHEREAS, the parties desire to amicably resolve any and all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them; and

WHEREAS, in 2018, MFD instituted a partial withholding of Medicaid reimbursement against Senior Spirit, to be held in a pend file (the "withheld funds");

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Senior Spirit agrees to pay to MFD the sum of Two Hundred Ninety Eight Thousand Nine Hundred Fifty-Two Dollars and Seventy Nine Cents (\$298,952.79) within six months of the execution of this Settlement Agreement (the "Total Payment Amount"). The payments are to be made by way of twelve (12) bi-monthly payments over a period of six (6) months, in the amount of \$24,912.73, on or before the 1st and 15th business day of each month, starting August 1, 2018, as follows:

- i. August 1, 2018;
- ii. August 15, 2018;
- iii. September 1, 2018;
- iv. September 17, 2018;
- v. October 1, 2018;
- vi. October 15, 2018;
- vii. November 1, 2018;
- viii. November 15, 2018;
- ix. December 3, 2018;
- x. December 17, 2018;
- xi. January 2, 2019; and
- xii. January 15, 2019.

Upon execution of this Settlement Agreement, MFD shall notify each Medicaid Managed Care Organization ("MCO") to take the necessary steps to lift the withhold of funds within seven (7) business days.

(2) Senior Spirit agrees to allow MFD to obtain the withheld funds as part of the settlement of this matter and MFD agrees that the withheld funds will be applied toward the Total Payment Amount as soon as such funds are determined by MFD. Payments by Senior Spirit shall continue as set forth in paragraph (1). Once the withheld funds have been adjudicated, MFD agrees to provide Senior Spirit with an amended payment schedule that will reflect adjustments made to the last one or more payments that result from the application of the adjudicated withheld funds.

(3) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Senior Spirit" and "[REDACTED]" must be included in the memo line so that payment is properly credited.

(4) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Senior Spirit will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(5) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(6) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Senior Spirit or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(7) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-6 above, by the signatures set forth below, the authorization of which is hereby affirmed, Senior Spirit and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(8) Upon verification of payment of the full amount, \$298,952.79, MFD shall file a warrant to satisfy judgment removing the Certificate of Debt against Family Senior Health, LLC, d/b/a Senior Spirit of Jersey City, Frank Cretella and Ilya Nabutovsky with the Superior Court of New Jersey within seven (7) business days.

(9) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in counterparts.

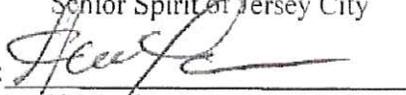
(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

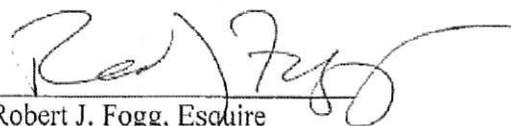
(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

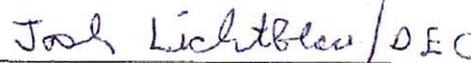
FORM AND CONTENT ACCEPTED AND AGREED TO BY:

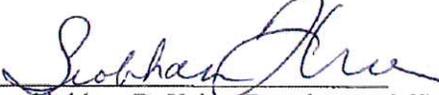
DATE: 7/23/18 By: 
Frank Cretella
Senior Spirit of Jersey City

DATE: 7/30/18 By: 
Ilya Nabutovsky
Senior Spirit of Jersey City

DATE: 7/31/18 By: 
Robert J. Fogg, Esquire
Archer & Greiner, P.C.
Counsel for Senior Spirit of Jersey City

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 7/31/18 By:  DEC
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: 7/31/18 By: 
Siobhan B. Krier, Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 1st day of August, 2018 ("Effective Date") by and between UNIVERSITY HOSPITAL, its owners, officers, directors, successors, and assigns (hereinafter collectively referred to as "UH"); and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). UH and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, the University Hospital (UH) conducted a review of its patient accounts for potential credit balances owed to third parties; and

WHEREAS, UH identified 530 accounts with credit balances owed to the New Jersey Medicaid and NJFamily Care programs; and

WHEREAS, UH determined that it was reimbursed by the Division of Medical Assistance and Health Services ("DMAHS"), and/or its fiscal agent, and/or the Medicaid Managed Care Organizations ("MCOs") payments in excess of the amount payable under the New Jersey Medical Assistance and Health Services (NJ Medicaid) program in the amount of \$174,098.83 which led to the aforementioned credit balances during the period of January of 1990 through June of 2014, in violation of N.J.A.C. 10:49-7.3 and N.J.A.C. 10:49-9.8 (the "Covered Conduct"); and

WHEREAS, UH self-disclosed the Covered Conduct to MFD and is seeking to repay the amount of \$174,098.83 to MFD; and

WHEREAS, MFD independently determined that based on the Covered Conduct, UH received payments from the Medicaid program and/or its fiscal agents and/or the Managed Care Organizations; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) UH agrees to pay to MFD the total sum of One Hundred Seventy-Four Thousand Ninety-Eight Dollars and Eighty-Three Cents (\$174,098.83) by August 30, 2018.

(2) All payments outlined above shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered to:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

UH must include "University Hospital: [REDACTED]" in the memo line of the checks so that the payments are properly credited.

(3) If any payment provided for in this Settlement Agreement is more than ten (10) days late as set forth above, UH will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) The Parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct at issue in this matter, and is intended

by each Party to release the other Party and its representatives from liability arising out of the Covered Conduct at issue in this matter, unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning UH or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed, UH and MFD agree to the following Release: in consideration of the provision hereof including this release, each Party agrees to release the other Party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(7) Nothing herein shall constitute an admission, concession or finding of liability by any Party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in Counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the Parties hereto.

(11) This Settlement Agreement sets forth the entire agreement between and among the Parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the Parties with respect to any other matter.

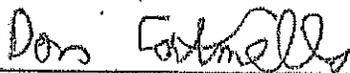
IN WITNESS WHEREOF, and intending to be legally bound, the Parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: _____
By: 
Thomas M. Daly
Chief Financial Officer
University Hospital

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: _____
By: 
Josh Lichtblau
Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: _____
By: 
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 31st day of August, 2018 ("Effective Date") by and between Dr. Muhammad T. Selevany (hereinafter referred to as "Dr. Selevany"), represented by Ronen B. Yair, Esq. of Mandelbaum Salsburg, P.C. and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Dr. Selevany and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD investigated Dr. Selevany and based upon a review of the medical records determined that between April 1, 2010 and March 31, 2015, Dr. Selevany submitted claims to the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or Managed Care Organizations which were not supported by the medical records in violation of N.J.A.C. 10:49-9.8, N.J.A.C. 10:54-9.1, and N.J.S.A. 30:4D-12(d) ("Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Dr. Selevany received overpayments from the Medicaid Program; and

WHEREAS, Dr. Selevany denied any wrongdoing, fraud or guilt in this matter; and

WHEREAS, on April 16, 2018, MFD issued a Notice of Claim and Certificate of Debt against Dr. Selevany; and

WHEREAS, in May 2018, MFD instituted a partial withholding of Medicaid reimbursement against Dr. Selevany, to be held in a pend file (the "withheld funds");

WHEREAS, Dr. Selevany requested a pre-hearing conference on the Covered Conduct in advance of any proceeding before the State of New Jersey, Office of Administrative Law; and

WHEREAS, Dr. Selevany asserted to MFD that he did not possess sufficient resources to pay back the overpayments within six (6) months; and

WHEREAS, Dr. Selevany submitted to MFD detailed financial disclosures to support his contention that he was not able to make payment within six (6) months; and

WHEREAS, MFD carefully analyzed the completed financial disclosures submitted by Dr. Selevany and, as warranted, verified information provided to ensure its accuracy; and

WHEREAS, based on its analysis of the financial condition of Dr. Selevany, MFD is agreeing to permit Dr. Selevany to pay back the Medicaid overpayment in a period greater than six (6) months, the terms of which are set forth below; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Dr. Selevany agrees to pay to MFD the sum of Three Hundred Fifty-Five Thousand One Hundred Dollars [Medicaid Overpayment = \$335,000 plus a 6% simple interest assessment of \$20,100 for a total amount of \$355,100] (the "Total Payment Amount") as follows:

- a. 9/1/2018 \$10,000.00
- b. 10/1/2018 \$10,000.00

c.	11/1/2018	\$10,000.00
d.	12/1/2018	\$10,000.00
e.	1/1/2019	\$10,000.00
f.	2/1/2019	\$10,000.00
g.	3/1/2019	\$10,000.00
h.	4/1/2019	\$10,000.00
i.	5/1/2019	\$10,000.00
j.	6/1/2019	\$10,000.00
k.	7/1/2019	\$10,000.00
l.	8/1/2019	\$10,000.00
m.	9/1/2019	\$10,000.00
n.	10/1/2019	\$10,000.00
o.	11/1/2019	\$10,000.00
p.	12/1/2019	\$10,000.00
q.	1/1/2020	\$10,000.00
r.	2/1/2020	\$10,000.00
s.	3/1/2020	\$10,000.00
t.	4/1/2020	\$10,000.00
u.	5/1/2020	\$10,000.00
v.	6/1/2020	\$10,000.00
w.	7/1/2020	\$10,000.00
x.	8/1/2020	\$10,000.00

y.	9/1/2020	\$10,000.00
z.	10/1/2020	\$10,000.00
aa.	11/1/2020	\$10,000.00
bb.	12/1/2020	\$10,000.00
cc.	1/1/2021	\$10,000.00
dd.	2/1/2021	\$10,000.00
ee.	3/1/2021	\$10,000.00
ff.	4/1/2021	\$10,000.00
gg.	5/1/2021	\$10,000.00
hh.	6/1/2021	\$10,000.00
ii.	7/1/2021	\$10,000.00
jj.	8/1/2021	\$5,100.00

Upon execution of this Settlement Agreement, MFD shall notify DMAHS and each Medicaid Managed Care Organization (“MCO”) to take the necessary steps to lift the withhold of funds within seven (7) business days.

(2) Dr. Selevany agrees to allow MFD to obtain the withheld funds as part of the settlement of this matter and MFD agrees that the withheld funds will be applied toward the Total Payment Amount as soon as such funds are determined by MFD. Payments by Dr. Selevany shall continue as set forth in paragraph (1). Once the withheld funds have been adjudicated, MFD agrees to provide Dr. Selevany with an amended payment schedule that will reflect adjustments made to the last one or more payments that result from the application of the adjudicated withheld funds.

(3) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Dr. Muhammad T. Selevany – OSC/MFD" must be included in the memo line so that payment is

properly credited.

(4) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Dr. Selevany will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(5) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(6) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Dr. Selevany from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or

investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(7) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-6 above, by the signatures set forth below, the authorization of which is hereby affirmed, Dr. Selevany and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(8) Upon verification of payment of the full amount, \$355,100, MFD shall file a warrant to satisfy judgment removing the Certificate of Debt against Dr. Muhammad T. Selevany with the Superior Court of New Jersey within seven (7) business days.

(9) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in Counterparts.

(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(12) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto

have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 8.30.18

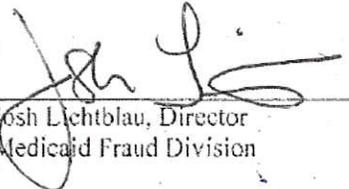
By: 
Muhammad T. Selevany, M.D.

DATE: 8.31.18

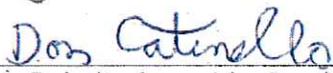
By: 
Ronen B. Yair, Esq.
Mandelbaum Salsburg, P.C.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

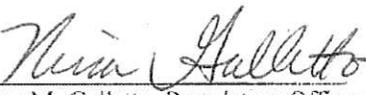
DATE: 8/31/18

By: 
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: 8/31/18

By: 
Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

DATE: 8/31/18

By: 
Nina M. Galletto, Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 6th day of September, 2018 ("Effective Date") by and between ERNESTO SARAVIA ("SARAVIA") and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Saravia and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD audited Saravia and determined that between January 1, 2012, and December 31, 2015, Saravia was paid for Medicaid claims for services provided by him and his professional staff to different recipients on the same date of service, at the same or overlapping times, and for services that were not documented in service delivery encounter forms signed by clients' legal guardians, in violation of N.J.S.A. 30:4D-12(d); N.J.A.C. 10:49-9.8; N.J.A.C. 13:34-18.1; and N.J.A.C. 10:49-5.5(a)(17)("the Covered Conduct"), resulting in Saravia receiving overpayments from the Medicaid Program; and

WHEREAS, Saravia asserted and provided attestations to the effect that all services for which Saravia submitted claims to be paid by Medicaid program funds were performed and properly supported by documentation; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them; and

WHEREAS, Saravia provided financial documentation to MFD to support his claim that he was not able to pay the full amount owed at one time and to support his request to pay over an extended period; and

WHEREAS MFD reviewed the Financial documentation provided by Saravia and independently determined that an extended payment plan would be appropriate; and

WHEREAS given that Saravia has requested and MFD has agreed to an extended payment plan, MFD assessed Six percent (6%) interest on the principal balance of Three Hundred Sixteen Thousand Five Hundred and Twenty Two Dollars (\$316,522), which is Eighteen Thousand Nine Hundred Ninety One Dollars and Thirty Two Cents (\$18,991.32), for a total recovery of Three Hundred Thirty Five Thousand Five Hundred Thirteen Dollars and Thirty Two Cents (\$335,513.32) as set forth below; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Saravia agrees to pay restitution to the Medicaid program in the sum of Three Hundred Thirty Five Thousand Five Hundred Thirteen Dollars and Thirty Two Cents (\$335,513.32), in the following manner:

a. An initial payment of Thirty Thousand Dollars (\$30,000.00) shall be remitted no later than the close of business on the 24th day of October, 2018;

b. For each of the following twenty-one (21) months, beginning November 20, 2018, Saravia shall make a payment of Fifteen Thousand Dollars (\$15,000.00) by no later than the close of business on the first day of the month as follows:

- i. November 20, 2018 \$15,000.00;
- ii. December 20, 2018 \$15,000.00;
- iii. January 20, 2019 \$15,000.00;

iv.	February 20, 2019	\$15,000.00;
v.	March 20, 2019	\$15,000.00;
vi.	April 20, 2019	\$15,000.00;
vii.	May 20, 2019	\$15,000.00;
viii.	June 20, 2019	\$15,000.00;
ix.	July 20, 2019	\$15,000.00;
x.	August 20, 2019	\$15,000.00;
xi.	September 20, 2019	\$15,000.00;
xii.	October 20, 2019	\$15,000.00;
xiii.	November 20, 2019	\$15,000.00;
xiv.	December 20, 2019	\$15,000.00;
xv.	January 20, 2020	\$15,000.00;
xvi.	February 20, 2020	\$15,000.00;
xvii.	March 20, 2020	\$15,000.00;
xviii.	April 20, 2020	\$15,000.00;
xix.	May 20, 2020	\$15,000.00;
xx.	June 20, 2020	\$15,000.00;
xi.	July 20, 2020	\$5,513.32;

Upon execution of this Settlement Agreement, MFD shall notify each Medicaid Managed Care Organization (“MCO”) to take the necessary steps to lift the withhold of funds within seven (7) business days.

(2) Saravia agrees to allow MFD to obtain the withheld funds as part of the settlement of this matter and MFD agrees that the withheld funds will be applied toward the Total Payment Amount as soon as such funds are determined by MFD. Payments by Saravia shall continue as set forth in paragraph (1). Once the withheld funds have been fully adjudicated, MFD agrees to provide Saravia with an accounting and amended payment schedule. This schedule will reflect adjustments that will be made to the last one or more payments (i.e., beginning at payment xxi and proceeding to xx, xix, etc.) that result from the application of the adjudicated withheld funds.

(3) Concurrent with the Parties' execution of this Settlement Agreement, MFD will submit a revised Certificate of Debt against Saravia in the amount of \$335,513.32 to the Superior Court of New Jersey for filing as a judgment in this matter. Within seven business days of receipt of the final payment from Saravia, MFD shall file a Warrant to Discharge with the Clerk of the Superior Court of New Jersey indicating that the Certificate of Debt filed against Saravia is satisfied and should be removed from the Court's docketed list of judgments.

(4) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Saravia will include "Saravia – OSC-MFD" and "██████████" in the memo line so that it is properly credited.

(5) If the payment arrangement as provided for in this Settlement Agreement

is more than ten (10) days late, Saravia will be in default of this Settlement Agreement and the outstanding and unpaid balance, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(6) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct, referenced above, and is intended by each party to release the other party and its representatives from any and all liability arising out of the Covered Conduct, unless MFD is mandated to act by federal or state law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(7) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Saravia or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct. Nothing in this Settlement Agreement waives any defenses that Saravia, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(8) Saravia agrees to comport his professional practice in full compliance with all applicable state and federal rules and regulations, including but not limited to the following:

a. Saravia shall only submit claims that accurately and completely reflect the services provided by him and his professional staff;

b. Saravia shall not employ or utilize any additional professional staff for the purpose of providing services to beneficiaries where such services are billed under Saravia's Medicaid Provider Number without having submitted all necessary documentation and information to the Department of Human Services, Division of Medical Assistance and Health Services;

c. Saravia shall not bill for multiple services to different recipients that occur on the same date of service, at the same or overlapping times;

d. Saravia shall not include travel time to and from the location of the beneficiary contact in the calculation of face-to-face contact with beneficiaries;

e. Saravia shall accurately record all data required by the recordkeeping regulations and take sufficient measures to maintain said records for a minimum of five (5) years or longer, as required by professional practice or other regulation.

(9) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-8 above, by the signatures set forth below, the authorization of which is hereby affirmed, Saravia and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from any and all liability, obligations and damages arising out of the Covered Conduct, referenced above.

(10) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(11) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(12) This Settlement Agreement may be executed in Counterparts.

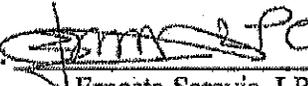
(13) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(14) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 9-5-2018

By: 
Ernesto Saravia, LPC

DATE: 9-6-18

By: 
Joann Pietro, R.N., Esq.
Counsel to Ernesto Saravia, LPC

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

By: _____
Josh Lichtblau
Director
Medicaid Fraud Division

DATE:

By: _____
Siobhan B. Krier
Regulatory Officer
Medicaid Fraud Division

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: _____
Ernesto Saravia, LPC

DATE:

By: _____
Joann Pietro, R.N., Esq.
Counsel to Ernesto Saravia, LPC

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

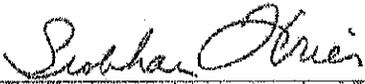
9/6/18

By: _____

Josh Lichtblau
Director
Medicaid Fraud Division

DATE:

9/6/18

By: _____

Siobhan B. Krier
Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 25th day of September, 2018 ("Effective Date") by and between Health Aid Drugs Inc. (Medicaid ID [REDACTED]) its owners, officers, directors, employees, successors, and assigns ("Health Aid") and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Health Aid and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis ("Inventory Analysis") and alleged that during the period of review between February 1, 2012 and March 31, 2017, Health Aid submitted a total of 385 claims for pharmaceutical products provided to Medicaid patients that could not be supported by wholesaler invoices for an overpayment amount of \$48,216.11 (this scope and period is hereafter referred to as the "covered conduct");

WHEREAS, Health Aid supplied documentation to support some of the discrepant claims thereby reducing the overpayment amount;

WHEREAS, the parties have agreed that Health Aid should be given credit in the amount of \$13,368.05 which reduced the overpayment amount to \$34,848.06;

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the alleged overpayment and have reached a mutually acceptable resolution of the outstanding issues.

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Health Aid agrees to pay to MFD the sum of thirty four thousand, eight hundred and forty eight dollars and six cents (\$34,848.06) in six consecutive monthly payments of \$5,808.01. The first payment is due on or before October 15, 2018. Payments thereafter will be made on or before the 15th of each month.

(2) Payments shall be by certified check, bank check, or attorney trusts check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Avenue, Building 20
Lockbox 656
Trenton, New Jersey 08646
Attention: Processing Bureau

Health Aid will include "Health Aid Drugs [REDACTED]" in the memo line so that the payment is properly credited.

(3) Health Aid agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided by Health Aid's professional staff.

(4) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues in connection with the claims at issue in this matter, and is intended by each party to release the other party and its representatives from liability arising out of the claims at issue in this matter, unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(5) Nothing in this Settlement Agreement waives the rights of any other State or Federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Health Aid or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(6) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-5 above, by the signatures set forth below, the authorization of which is hereby affirmed Health Aid and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and

directors from liability, obligations and damages arising out of the submission by, and payments to, Health Aid of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the covered conduct.

(7) Nothing herein shall constitute an admission, concession or finding of wrongdoing by any party.

(8) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(9) This Settlement Agreement may be executed in Counterparts.

(10) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

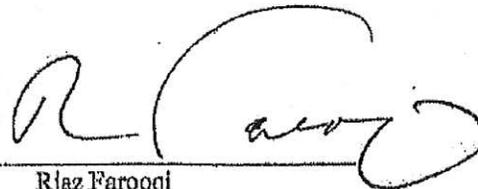
(11) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 9.25.10

By:



Riaz Farooqi
Owner
Health Aid Drugs

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 10/1/18

By: Don Catinello
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE: 10/1/2018

By: Josh Lichtblau
Josh Lichtblau
Director
Office of the State Comptroller
Medicaid Fraud Division

**SETTLEMENT AGREEMENT AND
AGREEMENT TO PARTIAL DEFAULT JUDGMENT**

THIS PARTIAL SETTLEMENT AGREEMENT is entered into this ____ day of August, 2018 (“Effective Date”) by and between by and between SMZX, Inc., d/b/a Bob’s Pharmacy, Sandra Marguez, and Daniel Zaretsky, respectively (hereinafter collectively referred to as “Bob’s Pharmacy”), represented by Angelo J. Cifaldi, Esq. of Wilentz, Goldman and Spitzer, PA and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION (“MFD”). Bob’s Pharmacy and MFD are hereinafter collectively referred to as the “Parties” and each individually as a “Party.”

WHEREAS, MFD conducted a pharmacy inventory analysis and found that during the period of review between March 1, 2012, and March 31, 2016, Bob’s Pharmacy submitted a total of 4,359 claims totaling \$856,045.37 for pharmaceutical products provided to Medicaid patients that could not be supported by wholesaler invoices (the “Covered Conduct”); and

WHEREAS, MFD determined that, based on the Covered Conduct, Bob’s Pharmacy had received overpayments from the Medicaid Program in the amount of \$856,045.37; and

WHEREAS, the parties desire to amicably resolve the dispute between them giving rise to the Covered Conduct and have reached a mutually acceptable partial resolution of the controversies that exist between them; and

WHEREAS, Bob’s Pharmacy has asserted that it is not able to pay the full amount owed at one time or by a payment plan; and

WHEREAS, MFD has given Bob’s Pharmacy the opportunity to provide MFD with documentation supporting its claim that it cannot pay the full overpayment amount either at one time or by a payment plan; and

WHEREAS Bob's Pharmacy has declined to submit any documentation to MFD in support of its claim that it cannot pay the full overpayment amount either at one time or by a payment plan; and

WHEREAS, Bob's Pharmacy has Five Hundred Fifty Thousand Dollars (\$550,000) held in escrow with Wilentz, Goldman & Spitzer, PA; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to partially settle their dispute on the following terms:

(1) Bob's Pharmacy agrees to pay restitution to the Medicaid program in the sum of Five Hundred Fifty Thousand Dollars (\$550,000.00) within thirty (30) days of the execution of this Partial Settlement Agreement;

(2) Concurrent with the Parties' execution of this Partial Settlement Agreement, MFD will reduce the amount of overpayment owed by \$550,000 and reflect that by submitting a revised Certificate of Debt against Bob's Pharmacy in the amount of \$306,045.37 to the Superior Court of New Jersey for filing as a judgment in this matter. MFD will issue an Amended Notice of Claim in this matter amending the alleged outstanding overpayment amount to Three Hundred Six Thousand Forty Five Dollars and Thirty Seven Cents (\$306,045.37);

(3) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Bob's Pharmacy will include "Bob's Pharmacy – OSC-MFD" and "[REDACTED]" in the memo line so that it is properly credited.

(4) If the payment arrangement as provided for in this Partial Settlement Agreement is more than ten (10) days late, Bob's Pharmacy will be in default of this Partial Settlement Agreement and the total unpaid balance, \$856,045.37, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(5) The parties agree that this Partial Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against Bob's Pharmacy, and is without prejudice to any defenses that Bob's Pharmacy, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Partial Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Bob's Pharmacy or from taking any action for such conduct. Nothing in this Partial Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Partial Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Partial Settlement Agreement as provided for in paragraphs 1-7 above, by the signatures set forth below, the authorization of which is hereby affirmed, Bob's Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations or damages arising out of the Covered Conduct limited to Five Hundred and Fifty Thousand Dollars (\$550,000.00) and agrees that the parties are not released from liability, obligations or damages arising out of the Covered Conduct in the amount of Three Hundred Six Thousand Forty Five Dollars and Thirty Seven Cents (\$306,045.37).

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Partial Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Partial Settlement Agreement may be executed in Counterparts.

(12) This Partial Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Partial Settlement Agreement sets forth the preliminary agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings, and does not extinguish MFD's claim against Bob's Pharmacy for the remainder of the alleged remaining overpayment. This Partial Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

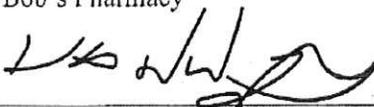
IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Partial Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: 
Sandra Marquez, Owner
Bob's Pharmacy

DATE:

By: 
Daniel Zaretsky, Owner
Bob's Pharmacy

DATE:

By: 
Angelo J. Cifaldi, Esq.
Attorney for Bergenline Drugs

DATE:

8/28/2018

By: 
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

8/28/2018

By: 
Siobhan B. Krier, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 11th day of October, 2018 ("Effective Date") by and between ULI Drugs Inc. D/B/A Irving Pharmacy (hereinafter referred to as "Irving Pharmacy"), represented by Angelo Cifaldi, R.Ph., Esq. and Satish Poondi, R.Ph., Esq. of Wilentz, Goldman & Spitzer, P.A., and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Irving Pharmacy and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis and found that between October 1, 2011 and September 30, 2016, Irving Pharmacy was reimbursed by the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or the Managed Care Organizations for prescription claims which failed to have necessary supporting documentation, in violation of N.J.A.C. 10:49-9.8(b) and N.J.S.A. 30:4D-12(d) ("Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Irving Pharmacy received overpayments totaling \$15,311.54 from the Medicaid program; and

WHEREAS, Irving Pharmacy supplied documentation to support some of the discrepant claims thereby reducing the overpayment amount;

WHEREAS, the parties have agreed that Irving Pharmacy should be given credit in the amount of \$3,818.10, which reduced the overpayment amount to \$11,493.44; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Irving Pharmacy agrees to pay to MFD the sum of Eleven Thousand Four Hundred Ninety-Three Dollars and Forty-Four Cents (\$11,493.44) as follows:

- a. 10/30/2018 \$1,918.44
- b. 11/30/2018 \$1,915.00
- c. 12/30/2018 \$1,915.00
- d. 1/30/2019 \$1,915.00
- e. 2/28/2019 \$1,915.00
- f. 3/30/2019 \$1,915.00

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"ULI Drugs Inc. D/B/A Irving Pharmacy – OSC/MFD" must be included in the memo line so that payment is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Irving Pharmacy will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) Irving Pharmacy agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided and medications dispensed by Irving Pharmacy. To that end, Irving Pharmacy agrees that it will only submit claims for services provided and medications dispensed for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed and thereby not repeated.

(5) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(6) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Irving Pharmacy from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(7) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-6 above, by the signatures set forth below, the authorization of which is hereby

affirmed, Irving Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(8) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(9) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(10) This Settlement Agreement may be executed in Counterparts.

(11) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(12) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 10/11/18

By: 
George Ullas
Owner, Irving Pharmacy

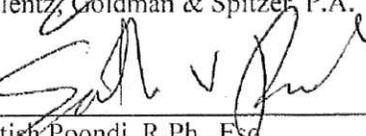
DATE: 10/11/18

By: 
Thannickal Ullas
Owner, Irving Pharmacy

DATE:

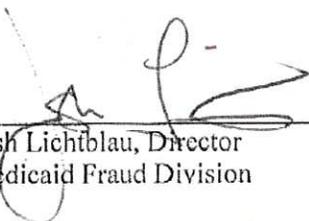
By: 
Angelo Cifaldi, R.Ph., Esq.
Wilentz, Goldman & Spitzer, P.A.

DATE: 10/15/18

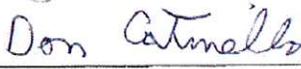
By: 
Satish Poondi, R.Ph., Esq.
Wilentz, Goldman & Spitzer, P.A.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 10/31/2018

By: 
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: 10/31/18

By: 
Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

DATE: 10/31/18

By: 
Nina M. Galletto, Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 1st day of November, 2018 ("Effective Date") by and between Alpert, Zales and Castro Pediatric Cardiology, P.A. (hereinafter referred to as "Pediatric Cardiology"), represented by Grace D. Mack, Esq. of Wilentz, Goldman & Spitzer, P.A., and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Pediatric Cardiology and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD investigated Pediatric Cardiology and based upon a review of the medical records determined that between February 17, 2012 through February 17, 2017, Pediatric Cardiology submitted claims to the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or Managed Care Organizations which were not supported by the medical records in violation of N.J.A.C. 10:49-5.5(a)13, N.J.A.C. 10:49-9.8, and N.J.S.A. 30:4D-12(d) ("Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Pediatric Cardiology received overpayments totaling \$157,353.00 from the Medicaid program; and

WHEREAS, Pediatric Cardiology asserts that it was their understanding that their billing for the Covered Conduct was in conformance with payor policies; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Pediatric Cardiology agrees to pay to MFD the sum of One Hundred Fifty-Seven Thousand Three Hundred Fifty-Three Dollars (\$157,353.00) as follows:

- a. 11/15/2018 \$26,225.50
- b. 12/15/18 \$26,225.50

- c. 1/15/2019 \$26,225.50
- d. 2/15/2019 \$26,225.50
- e. 3/15/2019 \$26,225.50
- f. 4/15/2019 \$26,225.50

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Alpert, Zales and Castro Pediatric Cardiology, P.A. – OSC/MFD" must be included in the memo line so that payment is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Pediatric Cardiology will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) Pediatric Cardiology agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided by Pediatric Cardiology. To that end, Pediatric Cardiology agrees that it will only submit claims for services provided for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed and thereby not repeated.

(5) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(6) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Pediatric Cardiology from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(7) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-6 above, by the signatures set forth below, the authorization of which is hereby affirmed, Pediatric Cardiology and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(8) Nothing herein shall constitute an admission, concession or finding of liability by any party.

(9) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(10) This Settlement Agreement may be executed in Counterparts.

(11) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(12) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

10/31/18

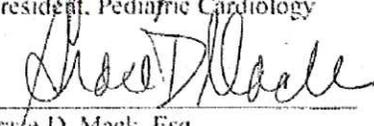
By:


Mitchell Alpert, M.D.
President, Pediatric Cardiology

DATE:

10/31/18

By:

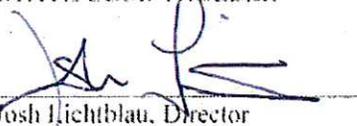

Grace D. Maek, Esq.
Wientz, Goldman & Spitzer, P.A.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

11/1/18

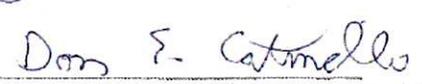
By:


Josh Lichtblau, Director
Medicaid Fraud Division

DATE:

11/1/18

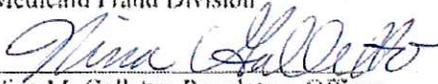
By:


Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

DATE:

11/1/18

By:


Nina M. Galletto, Regulatory Officer
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this 19th day of November, 2018 ("Effective Date") by and between AJI INC. d/b/a/ SHEEFA PHARMACY and AMJAD ABUKWAIK (hereinafter collectively referred to as "Sheefa Pharmacy"), represented by ANGELO J. CIFALDI, ESQ. of WILENTZ, GOLDMAN AND SPITZER, PA and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Sheefa Pharmacy and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis and found that between July 1, 2011, and April 30, 2016, Sheefa Pharmacy was reimbursed by the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or the Managed Care Organizations for prescription claims which failed to have the necessary supporting documentation, in violation of N.J.S.A. 30:4D-12(d) and N.J.A.C. 10:49-9.8 (this scope and period is hereafter referred to as "Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Sheefa Pharmacy received overpayments from the Medicaid program; and

WHEREAS, the parties desire to amicably resolve the dispute between them giving rise to the alleged overpayments and have reached a mutually acceptable resolution of the controversies that exist between them; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Sheefa Pharmacy agrees to pay restitution to the Medicaid program in the sum of Eighty-Five Thousand Dollars (\$85,000) principal in the following manner:

(a) Fourteen thousand, one hundred seventy-five dollars (\$14,175) shall be due by November 20, 2018.

(b) Fourteen thousand, one hundred sixty-five dollars (\$14,165) shall be due by December 15, 2018.

(c) Fourteen thousand, one hundred sixty-five dollars (\$14,165) shall be due by January 15, 2019.

(d) Fourteen thousand, one hundred sixty-five dollars (\$14,165) shall be due by February 15, 2019.

(e) Fourteen thousand, one hundred sixty-five dollars (\$14,165) shall be due by March 15, 2019.

(f) Fourteen thousand, one hundred sixty-five dollars (\$14,165) shall be due by April 15, 2019.

(2) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Sheefa Pharmacy will include "Sheefa Pharmacy – OSC-MFD [REDACTED]" in the memo line to ensure it is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Sheefa Pharmacy will be in default of this Settlement Agreement and the

total unpaid balance, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(4) Sheefa Pharmacy agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided and medications dispensed by Sheefa Pharmacy. To that end, Sheefa Pharmacy agrees that it will only submit claims for services provided and medications dispensed for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed.

(5) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against Sheefa Pharmacy, and is without prejudice to any defenses that Sheefa Pharmacy, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Sheefa Pharmacy or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-7 above, by the signatures set forth below, the authorization of which is hereby affirmed, Sheefa Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the submission by, and payments to, Sheefa Pharmacy of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in counterparts.

(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

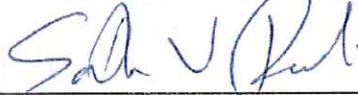
IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 11/14/2018

By: 
Amjad Abukwaik, Owner
AJI Inc. d/b/a Sheefa Pharmacy

DATE: 11/14/2018

By: 
Angelo J. Cifaldi, Esq. SATISH V. POONDE, ESQ.
Attorney for AJI Inc. d/b/a Sheefa
Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

By: _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Jillian Holmes, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: _____
Amjad Abukwaik, Owner
AJI Inc. d/b/a Sheefa Pharmacy

DATE:

By: _____
Angelo J. Cifaldi, Esq.
Attorney for AJI Inc. d/b/a Sheefa
Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

11/19/18

By: _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

11/19/18

By: _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE:

11/19/18

By: _____
Jillian Holmes, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this 20th day of November, 2018 ("Effective Date") by and between Health Fair Pharmacy and Venkata Raju, respectively (hereinafter collectively referred to as "Health Fair Pharmacy"), represented by Angelo J. Cifaldi, Esq. of Wilentz, Goldman and Spitzer, PA and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Health Fair Pharmacy and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis ("Inventory Analysis") and alleged that during the period of review between December 1, 2012 through June 3, 2016, Health Fair Pharmacy submitted a total of 632 claims for pharmaceutical products provided to Medicaid patients that could not be supported by wholesaler invoices for an overpayment amount of \$131,333.99 (this scope and period is hereafter referred to as "Covered Conduct"); and

WHEREAS, Health Fair Pharmacy supplied documentation to support some of the discrepant claims thereby reducing the overpayment amount;

WHEREAS, the parties have agreed that Health Fair Pharmacy should be given credit in the amount of \$24,233.56, which reduced the overpayment amount to \$107,100.43; and

WHEREAS, a temporary suspension of Medicaid payments to Health Fair Pharmacy was imposed, pursuant to 42 CFR 455.23, resulting in an accrual of Medicaid payment funds by Molina and Managed Care Organizations; and

WHEREAS, the parties desire to amicably resolve the dispute between them giving rise to the alleged overpayment and have reached a mutually acceptable resolution of the controversies that exist between them; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Health Fair Pharmacy agrees to pay restitution to the Medicaid program in the sum of One Hundred Seven Thousand One Hundred Dollars and Forty-Three Cents (\$107,100.43);

(2) Health Fair Pharmacy agrees to allow MFD to apply withheld funds as part of the settlement of this matter and MFD agrees that the withheld funds will be applied toward the settlement amount set forth in paragraph (1). Once the withheld funds have been adjudicated, MFD agrees to provide Health Fair Pharmacy with an amended payment schedule that will reflect adjustments made to the adjudicated withheld funds. Any withheld funds in excess of the settlement amount set forth in paragraph (1) will be released to Health Fair Pharmacy.

(3) Health Fair Pharmacy agrees to pay any remaining portion of the settlement amount set forth in paragraph (1) should the withheld funds not be sufficient. Payment of this balance will be made within ten (10) days of notification by MFD that the withheld funds are insufficient. Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Health Fair Pharmacy will include "Health Fair Pharmacy – OSC-MFD" and "MFD-

██████████" in the memo line so that it is properly credited.

(4) Health Fair Pharmacy agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided and medications dispensed by Health Fair Pharmacy. To that end, Health Fair Pharmacy agrees that it will only submit claims for services provided and medications dispensed for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed.

(5) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against Health Fair Pharmacy, and is without prejudice to any defenses that Health Fair Pharmacy, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Health Fair Pharmacy or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-7 above, by the signatures set forth below, the authorization of which is hereby affirmed, Health Fair Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the submission by, and payments to, Health Fair Pharmacy of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in Counterparts.

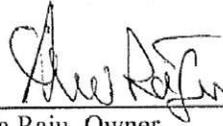
(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

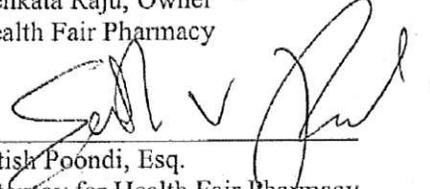
IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 10/31/18

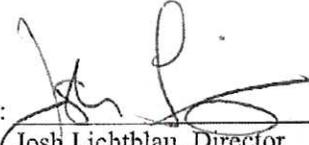
By: 
Venkata Raju, Owner
Health Fair Pharmacy

DATE: 11/5/2018

By: 
Satish Poondi, Esq.
Attorney for Health Fair Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

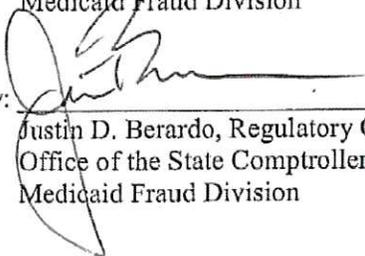
DATE: 11/20/18

By: 
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: 11/20/18

By: 
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE: 11/20/18

By: 
Justin D. Berardo, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this ___ day of December, 2018 ("Effective Date") by and between CHERRY HILL WOMEN'S CENTER, INC., (hereinafter referred to as "CHWC"), represented by Gregory R. Smith, Esq., and Andrew Blustein, Esq, of Garfunkel Wild, P.C. and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). CHWC and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD investigated CHWC and determined that between April 1, 2011 through April 30, 2015, CHWC submitted for reimbursement claims that were not supported by required clinical documentation, including claims for psychotherapy services for which time was not documented, as required by the CPT code, and claims for abortion services where the CPT code billed did not describe the procedure performed, in violation of N.J.S.A. 30:4D-12, N.J.A.C. 10:49-9.8, N.J.A.C. 10:54-9.1 (hereafter, the time period and conduct is referred to as the "Covered Conduct"), resulting in CHWC receiving overpayments from the Medicaid Program; and

WHEREAS, on January 26, 2018, MFD issued a Notice of Intent against CHWC seeking recovery for overpayments from the Medicaid Program for the Covered Conduct referenced above; and

WHEREAS, CHWC has asserted that all services for which CHWC submitted claims to be paid by Medicaid program funds were performed and properly supported by documentation; and

WHEREAS, MFD took into consideration the documentation, facts and information that CHWC supplied; and

WHEREAS, the parties desire to amicably resolve all disputes between them giving rise to the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) CHWC agrees to pay restitution to the Medicaid program in the sum of Five Hundred Thousand Dollars (\$500,000), on or before December 16, 2018, which funds constitute a repayment and not a penalty or fine.

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

CHWC will include "Cherry Hill Women's Center – OSC-MFD" in the memo line so that it is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, CHWC will be in default of this Settlement Agreement and the outstanding and unpaid balance plus interest will immediately become due and collected through any means available to MFD as provided by law.

(4) CHWC agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and

completely reflect the services provided. To that end, CHWC agrees that it will only submit claims for services provided for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed.

(5) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against CHWC, and is without prejudice to any defenses that CHWC, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning CHWC or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-7 above, by the signatures set forth below, the authorization of which is hereby affirmed, CHWC and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the

submission by, and payments to, CHWC of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in Counterparts.

(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: 12/3/2018

By: Elizabeth Barnes
Elizabeth Barnes, President
Cherry Hill Women's Center

DATE: 12/5/2018

By: Andrew Blustein
Andrew Blustein, Esq.
Attorney for
Cherry Hill Women's Center

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 12/11/18

By: Josh Lichtblau
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: 12/11/18

By: Don Catinello
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE: 12/10/18

By: Justin D. Berardo
Justin D. Berardo, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this day 19th day of December, 2018 ("Effective Date") by and between Mr. Shamindra Dhanantwari, Moshe Vizel and Emes Pharmacy LLC respectively (hereinafter collectively referred to as "Emes Pharmacy"), represented by Angelo J. Cifaldi, Esquire of Wilentz, Goldman and Spitzer, PA and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Emes Pharmacy and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis ("Inventory Analysis") and alleged that during the review period, between October 1, 2011 and October 1, 2016, Emes Pharmacy submitted a total of 8,972 claims for pharmaceutical products provided to Medicaid patients that could not be supported by wholesaler invoices for an overpayment amount of \$1,556,603.72 (hereinafter referred to as the "Covered Conduct"); and

WHEREAS, Emes Pharmacy supplied documentation to support some of the discrepant claims along with facts and information that it maintained would reduce the overpayment amount; and

WHEREAS, MFD took into consideration the additional documentation, facts and information that Emes supplied; and

WHEREAS, the parties desire to amicably resolve the dispute between them giving rise to the alleged overpayment and have reached a mutually acceptable resolution of the controversies that exist between them; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Emes Pharmacy agrees to pay restitution to the Medicaid program in the sum of One Million Two Hundred Seventy Thousand Dollars (\$1,270,000.00) within six months of the execution of this Settlement Agreement (the "Total Payment Amount"). The payments are to be made by way of six (6) monthly payments in the amount of \$211,666.67, on or before the 15th business day of each month, starting December 15, 2018, as follows:

- i. December 15, 2018;
- ii. January 15, 2019;
- iii. February 15, 2019;
- iv. March 15, 2019;
- v. April 15, 2019;
- vi. May 15, 2019;

(2) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Emes Pharmacy will include "Emes Pharmacy – OSC-MFD" and "[REDACTED]" in the memo line so that it is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Emes Pharmacy will be in default of this Settlement Agreement and the total unpaid balance, \$1,270,000.00, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(4) Emes Pharmacy agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided and medications dispensed by Emes Pharmacy. To that end, Emes Pharmacy agrees that it will only submit claims for services provided and medications dispensed for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed and thereby not repeated.

(5) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against Emes Pharmacy, and is without prejudice to any defenses that Emes Pharmacy, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning Emes Pharmacy or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-9 above, by the signatures set forth below, the authorization of which is hereby affirmed, Emes Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the submission by, and payments to, Emes Pharmacy of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in Counterparts.

(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

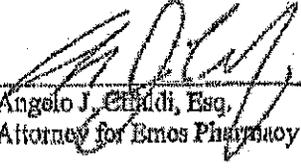
IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: 
Emos Pharmacy

DATE:

By: 
Angelo J. Ghidli, Esq.
Attorney for Emos Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

By: _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

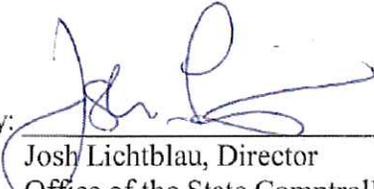
By: _____
Shamindra Dhanantwari, Owner
Emes Pharmacy

DATE:

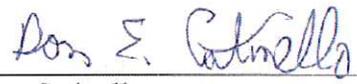
By: _____
Angelo J. Cifaldi, Esq.
Attorney for Emes Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 12/19/2018

By:  _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: 12/19/2018

By:  _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this 19th day of December, 2018 ("Effective Date") by and between Mr. Nimish I. Patel and Bella Vista Pharmacy, d/b/a My Friend's Pharmacy, respectively (hereinafter collectively referred to as "My Friend's Pharmacy"), represented by Angelo J. Cifaldi, Esquire of Wilentz, Goldman and Spitzer, PA and STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). My Friend's Pharmacy and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted a pharmacy inventory analysis ("Inventory Analysis") and alleged that during the period of review between March 1, 2012 through December 31, 2016, My Friend's Pharmacy submitted a total of 2,791 claims for pharmaceutical products provided to Medicaid patients that could not be supported by wholesaler invoices for an overpayment amount of \$115,543.21 (herein after referred to as the "Covered Conduct"); and

WHEREAS, MFD issued a Notice of Claim, Notice of Withhold and Certificate of Debt in the amount of \$115,543.21 in the matter on September 6, 2017; and

WHEREAS, My Friend's Pharmacy supplied documentation to support some of the discrepant claims along with facts and information that it maintained would reduce the overpayment amount; and

WHEREAS, MFD took into consideration the additional documentation, facts and information that My Friend's supplied; and

WHEREAS, the parties desire to amicably resolve the dispute regarding the alleged overpayment and have reached a mutually acceptable resolution of the controversies that exist between them; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) My Friend's Pharmacy agrees to pay restitution to the Medicaid program in the amount of Ninety Five Thousand Dollars (\$95,000.00) within six months of the execution of this Settlement Agreement (the "Total Payment Amount"). The payments are to be made by way of six (6) monthly payments on or before the 15th business day of each month, starting January 15, 2018, as follows:

- i. December 15, 2018 \$15,833.33
- ii. January 15, 2019 \$15,833.33;
- iii. February 15, 2019 \$15,833.33;
- iv. March 15, 2019 \$15,833.33;
- v. April 15, 2019 \$15,833.33; and
- vi. May 15, 2019 \$15,833.33.

Within five (5) days of execution of this Settlement Agreement, MFD shall notify DMAHS and each Medicaid Managed Care Organization ("MCO") to immediately take the necessary steps to terminate withholding of otherwise payable funds.

(2) "Withheld Funds" refers to the monies withheld by DMAHS or the MCOs of otherwise payable claims to My Friend's Pharmacy during the period of withholding. The parties understand that the Withheld Funds cannot be determined until MFD has completed an accounting of such funds. MFD shall make all reasonable efforts to provide to My Friend's

Pharmacy an accounting of Withheld Funds no later than sixty (60) days after the effective date of this Settlement Agreement.

(3) The Withheld Funds shall be released to My Friend's Pharmacy upon satisfaction of the Total Payment Amount.

(4) Nothing in this Settlement Agreement precludes My Friend's Pharmacy from disputing the amount of the Withheld Funds by any means permitted by law.

(5) Concurrent with the Parties' execution of this Settlement Agreement, MFD will submit a revised Certificate of Debt against My Friend's Pharmacy in the amount of \$95,000.00 to the Superior Court of New Jersey for filing as a judgment in this matter. Within seven business days of receipt of the final payment from My Friend's Pharmacy, MFD shall file a Warrant to Discharge with the Clerk of the Superior Court of New Jersey indicating that the Certificate of Debt filed against My Friend's Pharmacy is satisfied and should be removed from the Court's docketed list of judgments.

(6) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

My Friend's Pharmacy will include "My Friend's Pharmacy – OSC-MFD" and "MFD-

██████████" in the memo line so that it is properly credited.

(7) If payment as provided for in this Settlement Agreement is more than ten (10) days late, My Friend's Pharmacy will be in default of this Settlement Agreement and the total

unpaid balance, \$95,000, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(8) My Friend's Pharmacy agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided and medications dispensed by My Friend's Pharmacy. To that end, My Friend's Pharmacy agrees that it will only submit claims for services provided and medications dispensed for which it possesses sufficient documentation to support such claims and that it will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed and thereby not repeated.

(9) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against My Friend's Pharmacy, and is without prejudice to any defenses that My Friend's Pharmacy, its officers, directors, successors or assigns may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(10) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for alleged conduct concerning My Friend's Pharmacy or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not

specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(11) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(12) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-11 above, by the signatures set forth below, the authorization of which is hereby affirmed, My Friend's Pharmacy and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the submission by, and payments to, My Friend's Pharmacy of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(13) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(14) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(15) This Settlement Agreement may be executed in Counterparts.

(16) This Settlement Agreement is effective upon the Effective Date reflected on the first page of the Settlement Agreement.

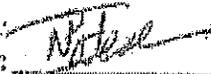
(17) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral

understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: 
Nimish I. Patel, Owner
My Friend's Pharmacy

DATE:

By: 
Angelo J. Ghaldi, Esq.
Attorney for My Friend's Pharmacy

PHILIP JAMES DEONAN
STATE COMPTROLLER

DATE:

By: _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Slobhan B. Krier, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

By: _____
Nimish I. Patel, Owner
My Friend's Pharmacy

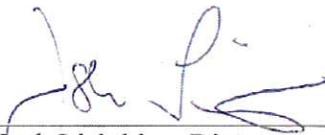
DATE:

By: _____
Angelo J. Cifaldi, Esq.
Attorney for My Friend's Pharmacy

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

12/19/18

By:  _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

12/19/18

By:  _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE:

12/19/18

By:  _____
Siobhan B. Krier, Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

SETTLEMENT AGREEMENT

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE is entered into this 20th day of December, 2018 ("Effective Date") by and between Dr. Vinod Lala ("Dr. Lala") and the STATE OF NEW JERSEY, OFFICE OF THE STATE COMPTROLLER, MEDICAID FRAUD DIVISION ("MFD"). Dr. Lala and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD investigated Dr. Lala and, based upon its review of the medical records, has determined that between January 1, 2011 and July 31, 2014, Dr. Lala submitted claims for reimbursement for CPT codes 99214, 99215 and 99401 that were not supported by required documentation, in violation of N.J.S.A. 30:4D-7, N.J.A.C. 10:49-9.8, N.J.A.C. 10:54-9.1, resulting in an overpayment of Medicaid funds in the amount of \$125,320.91 (hereinafter referred to as "the Covered Conduct"); and

WHEREAS, the parties desire to amicably resolve the dispute between them giving rise to the alleged overpayment and have reached a mutually acceptable resolution of the controversies that exist between them; and

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Dr. Lala agrees to pay restitution to the Medicaid program in the sum of One Hundred Twenty Five Thousand Three Hundred Twenty Dollars and Ninety One Cents (\$125,320.91). The payment is to be made on or before December 15, 2018, as follows:

(2) Payment to MFD shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

Dr. Lala will include "Dr. Vinod Lala – OSC-MFD" and "[REDACTED]" in the memo line so that it is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Dr. Lala will be in default of this Settlement Agreement and the total unpaid balance, \$125,320.91, plus interest, will immediately become due and collected through any means available to MFD as provided by law.

(4) Dr. Lala agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided by Dr. Lala. To that end, Dr. Lala agrees that he will only submit claims for services provided for which he possesses sufficient documentation to support such claims and that he will ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed and thereby not repeated.

(5) The parties agree that this Settlement Agreement is intended to be without prejudice to all remaining claims, rights and remedies against Dr. Lala, and is without prejudice to any defenses that Dr. Lala may raise with respect to claims of any nature that may be raised by MFD or any other state or federal agency.

(6) Nothing in this Settlement Agreement waives the rights of any other state or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil or criminal investigation or other action for

alleged conduct concerning Dr. Lala or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this agreement, and to take any action civilly or criminally for such conduct.

(7) The terms of this Settlement Agreement may be modified only by a subsequent written agreement signed by all Parties.

(8) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-7 above, by the signatures set forth below, the authorization of which is hereby affirmed, Dr. Lala and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its employees, representatives, officers and directors from liability, obligations and damages arising out of the submission by, and payments to, Dr. Lala of any and all claims for reimbursement by Medicaid or the Medicaid Managed Care Program for the Covered Conduct, referenced above.

(9) Nothing herein shall constitute an admission, concession or finding of wrongdoing or liability by any party.

(10) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(11) This Settlement Agreement may be executed in Counterparts.

(12) This Settlement Agreement is effective upon the last date it is executed by the parties hereto.

(13) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other written or oral

understanding. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto on the following page have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: Dec. 8
2018

By: 
Dr. Vinod Lala

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE:

By: _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE:

By: _____
Nicole Acchione
Regulatory Officer
Office of the State Comptroller

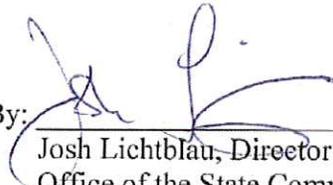
FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

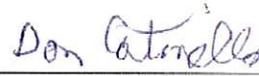
By: _____
Dr. Vinod Lala

PHILIP JAMES DEGNAN
STATE COMPTROLLER

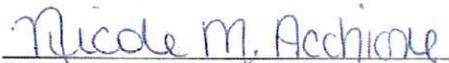
DATE: 12/20/2018

By:  _____
Josh Lichtblau, Director
Office of the State Comptroller
Medicaid Fraud Division

DATE: 12/20/18

By:  _____
Don Catinello
Supervising Regulatory Officer
Office of the State Comptroller
Medicaid Fraud Division

DATE: 12/20/18

By:  _____
Nicole Acchione
Regulatory Officer
Office of the State Comptroller

SETTLEMENT AGREEMENT AND MUTUAL RELEASE

THIS SETTLEMENT AGREEMENT AND MUTUAL RELEASE ("Settlement Agreement") is entered into this 20th day of December, 2018 ("Effective Date") by and between the medical practice of John Fernandes, M.D., its owners, officers, directors, successors and assigns (hereinafter collectively, "Dr. Fernandes") and the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division ("MFD"). Dr. Fernandes and MFD are hereinafter collectively referred to as the "Parties" and each individually as a "Party."

WHEREAS, MFD conducted an investigation of Dr. Fernandes and based upon a review of medical records found that between July 1, 2013 and July 1, 2018, Dr. Fernandes was reimbursed by the Division of Medical Assistance and Health Services (DMAHS) and/or its fiscal agent and/or the Managed Care Organizations for claims that were not supported by the medical records, in violation of N.J.S.A. 30:4D-12(d), N.J.A.C. 10:49-9.8 and N.J.A.C. 10:49-5.5(a)13 ("Covered Conduct"); and

WHEREAS, MFD determined that, based on the Covered Conduct, Dr. Fernandes received overpayments totaling \$86,310.00 from the Medicaid program; and

WHEREAS, the parties desire to amicably resolve all disputes regarding the Covered Conduct and have reached a mutually acceptable resolution of the controversies that exist between them;

NOW THEREFORE, in consideration of the mutual promises contained herein, as well as for other good and valuable consideration, the receipt and sufficiency of which is hereby acknowledged, the parties agree to settle their dispute on the following terms:

(1) Dr. Fernandes agrees to pay to MFD the total amount of Eighty-Six Thousand Three Hundred and Ten Dollars (\$86,310.00) in two equal installments of \$43,155.00. The first payment is due on or before January 1, 2019. The second payment is due on or before April 1, 2019.

(2) Payment shall be by certified check, bank check, or attorney trust check made payable to "Treasurer, State of New Jersey," and shall be mailed or delivered as follows:

Attention: Processing Bureau
Treasurer, State of New Jersey
Division of Revenue
200 Woolverton Street, Building 20
Lockbox 656
Trenton, New Jersey 08646

"Dr. Fernandes- MFD- [REDACTED]" must be included in the memo line so that payment is properly credited.

(3) If the payment arrangement as provided for in this Settlement Agreement is more than ten (10) days late, Dr. Fernandes will be in default of this Settlement Agreement and the outstanding and unpaid balance will immediately become due and collected through any means available to MFD as provided by law.

(4) Dr. Fernandes agrees to act in full compliance with all applicable state and federal rules and regulations, including but not limited to submitting only claims that accurately and completely reflect the services provided by Dr. Fernandes. To that end, Dr. Fernandes agrees that he will only submit claims for services provided for which he possesses sufficient documentation to support such claims and will implement policies to ensure that the underlying issues that caused or contributed to the Covered Conduct will be appropriately addressed.

(5) The parties agree that this Settlement Agreement is intended to be a final resolution of all issues arising out of the Covered Conduct and is intended by each party to release the other party and its representatives from liability arising out of the Covered Conduct

unless MFD is mandated to act by federal or State law; or mandated by order or judgment of a court or administrative agency (other than MFD).

(6) Nothing in this Settlement Agreement waives the rights of any other State or federal agency, including, among others, the New Jersey Division of Criminal Justice, from continuing with a pending or beginning a future civil, administrative or criminal investigation or other action for alleged conduct concerning Dr. Fernandes or from taking any action for such conduct. Nothing in this Settlement Agreement waives the rights of MFD to conduct an audit or investigation of prior or future years for the improper submission of any claims or conduct not specifically covered by this Settlement Agreement, and to take any action civilly or criminally for such conduct.

(7) Subject to the express terms of this Settlement Agreement as provided for in paragraphs 1-6 above, by the signatures set forth below, the authorization of which is hereby affirmed, Dr. Fernandes and MFD agree to the following Release: in consideration of the provision hereof including this release, each party agrees to release the other party and its representatives from liability, obligations and damages arising out of the Covered Conduct.

(8) Nothing herein shall constitute an admission, concession or finding of wrongdoing by any party.

(9) This Settlement Agreement shall be construed, enforced and governed by the laws of the State of New Jersey.

(10) This Settlement Agreement may be executed in Counterparts.

(11) This Settlement Agreement sets forth the entire agreement between and among the parties hereto with respect to the claims described herein and supersedes any other

written or oral understandings. This Settlement Agreement does not reflect any other terms or conditions or agreements between or among the parties with respect to any other matter.

IN WITNESS WHEREOF, and intending to be legally bound, the parties hereto have executed the foregoing Settlement Agreement:

FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE: Dec 20 2018 By: John Fernandes M.D.
John Fernandes, M.D.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: _____ By: _____
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: _____ By: _____
Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

DATE: _____ By: _____
Jillian Holmes, Regulatory Officer
Medicaid Fraud Division

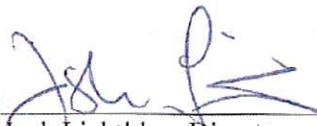
FORM AND CONTENT ACCEPTED AND AGREED TO BY:

DATE:

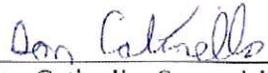
By: _____
John Fernandes, M.D.

PHILIP JAMES DEGNAN
STATE COMPTROLLER

DATE: 12/20/18

By:  _____
Josh Lichtblau, Director
Medicaid Fraud Division

DATE: 12/20/18

By:  _____
Don Catinello, Supervising Regulatory Officer
Medicaid Fraud Division

DATE: 12/20/18

By:  _____
Jillian Holmes, Regulatory Officer
Medicaid Fraud Division