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April 10, 2019

BY ELECTRONIC MAIL

Mr. Israel Stein
Mrs. Baila Stein
STS Therapy Services, LLC
1074 Times Square Blvd.
Lakewood, New Jersey 08701

Re: Final Audit Report – STS Therapy Services, LLC

Dear Mr. and Mrs. Stein:

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 an audit of claims submitted by STS Therapy Services, LLC (STS) for the period from January 1, 2013 through December 31, 2017. OSC hereby provides you with this Final Audit Report.

Executive Summary

OSC conducted this audit to determine whether STS's paid Medicaid claims complied with applicable state and federal laws and regulations and Managed Care Organization (MCO) policies. The audit results were based on two stratified random samples of episodes occurring between January 1, 2013 and December 31, 2017.[1] Each sample was selected from a unique universe of claims, which means that no claims in the first universe (Stein universe) overlapped with any claims in the second universe (STS universe).[2] The sample selected from the Stein universe consisted of 101 episodes (Stein sample); the

[1] For the purposes of this audit, an episode is defined as any date of service where a Medicaid provider billed procedure code 92507 in conjunction with codes 92526, 97532, or 97533. Each procedure code equates to an individual claim.

[2] OSC selected two unique stratified random samples because the initial data OSC obtained suggested that both STS and Baila Stein (Stein) had received payment for the services in question. MFD subsequently determined that, in fact, only STS received payment for these services. As a result, MFD consolidated its findings related to both the STS sample and the Stein sample into this report.

sample selected from the STS universe consisted of 100 episodes (STS sample). The total resulting sample consisted of 201 episodes. STS received payment for all of the claims in both samples.

OSC determined that STS failed to document adequately the services provided for all 201 episodes. Specifically, the documentation submitted to support the services lacked therapist signatures and license numbers and contained inadequate information regarding the patient's visit and the services provided. These deficiencies constitute violations of the New Jersey Administrative Code; specifically, *N.J.A.C.* 10:49-5.5(a)17, *N.J.A.C.* 13:44C-8.1 and *N.J.A.C.* 10:49-9.8. Further, 55 of the 101 episodes (54 percent) in the Stein sample and 59 of the 70 episodes (84 percent) in the STS sample that included timed codes did not include the duration of treatment.[3] STS's failure to document the duration of treatment is contrary to *N.J.A.C.* 10:49-5.5(a)13 and the American Medical Association's (AMA) Current Procedural Terminology (CPT) Manual guidelines.[4]

To calculate the final recovery amount, OSC extrapolated the results of each sample to its respective sample universe. The Stein universe consisted of 2,699 episodes totaling $204,298, and its corresponding sample contained 101 episodes totaling $7,640. The STS universe consisted of 5,357 episodes totaling $418,624, and its corresponding sample contained 100 episodes totaling $8,645. OSC found all $16,285 dollars reviewed to be in error. Using the difference method, OSC extrapolated the results of each sample back to its respective universe for a total of $622,181 ($203,812 for Stein, $418,369 for STS). Table I provides a breakdown of each of the universes, including dollars paid in each, the samples from each universe, the error rate, and extrapolated overpayment for each universe. The extrapolated amounts are slightly less than their respective universe dollars due to accounting for sampling risk (i.e. the risk that the auditor's conclusion based on a sample may be different from the conclusion if the entire population was subjected to the same audit procedure).

Table I
Total Extrapolated Overpayment Amount

	Universe Episodes	Universe Dollars Paid	Sample Episodes	Sample Dollars Paid	Dollar Error rate	Extrapolated Overpayment
Stein	2,699	$204,298	101	$7,640	100%	$203,812
STS	5,357	$418,624	100	$8,645	100%	$418,369
Total	**8,056**	**$622,922**	**201**	**$16,285**	**100%**	**$622,181**

In addition to inadequate documentation, OSC found that STS violated *N.J.A.C.* 10:49-9.8 by failing to adhere to UnitedHealthcare Community Plan's Reimbursement Policies

[3] The other 30 episodes in the STS sample of 100 episodes reflected a CPT code combination of 92507 and 92526, which are not timed codes.
[4] A "timed" code (e.g., 15 minutes) allows a provider to bill multiple units based on the amount of time spent delivering services.

(United Policies) and the Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual for Medicaid Services (Medicaid NCCI). Specifically, STS billed procedure code 92507 in conjunction with 97532 and/or 97533 for the same session for all 101 episodes reviewed in the Stein sample, and for 70 of the 100 episodes reviewed in the STS sample (See Exhibit A for a description of the relevant procedures codes). This practice is considered unbundling of services and violates United Policies and Medicaid NCCI, Chapter 11, Section H. For these claims, STS improperly used modifier 59, which bypassed the payer's (UnitedHealthcare) claim edit checks and thereby allowed STS to receive reimbursement for claims totaling $141,782 ($56,900 for the Stein sample and $84,882 for the STS sample) it would not otherwise have received. To avoid duplicative recovery and because OSC is seeking recovery of these funds for other reasons explained in this report, OSC does not seek repayment of the money paid for these unbundled claims.

Background

Speech therapy is used to treat disorders of speech, language, voice, communication and auditory processing. Treatment is provided by speech-language pathologists (SLPs) and is covered by Medicaid when a disorder results from injury, stroke, cancer, congenital anomaly, or autism spectrum disorders.

SLPs practicing in New Jersey are required to adhere to the Audiology and Speech-Language Pathology Advisory Committee regulations found in *N.J.A.C.* 13:44C-1.1 et seq. SLPs treating New Jersey Medicaid beneficiaries must comply with additional requirements. The State's contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) and the MCOs requires MCOs and their network providers to adhere to applicable New Jersey laws and regulations. STS is a provider within the UnitedHealthcare MCO network, and therefore must comply with the provider certification and recordkeeping requirements set forth in *N.J.A.C.* 10:49-1.1 et seq. In addition, STS must adhere to the guidelines established by any MCO with whom it contracts as a provider (in this case UnitedHealthcare).

STS is a specialty outpatient facility providing speech therapy services with an office in Lakewood, New Jersey. Baila Stein is a licensed SLP providing services at STS. She is also a principal and member of STS, along with her husband, Israel Stein. Between January 1, 2013 and December 31, 2017, STS received $776,545 in Medicaid payments (see Table II for a breakdown of STS's claims by procedure billed, including the number of claims for each procedure and the dollar amount of payment for such claims).

Table II
Total STS Billings and Amounts Paid
By Procedure Code

Claim Procedure Code	Claim Procedure Code Name	Number of Claims	Paid Amount
92507	Speech Language Therapy	10,146	$548,402
97532	Development of Cognitive Skills	7,618	$130,201
97533	Sensory Integrative Techniques	1,585	$17,968
92526	Swallowing Dysfunction	652	$48,001
Other	Various Procedures	302	$31,973
Total		**20,303**	**$776,545**

Objective

The objective of the audit was to evaluate claims for services that STS billed and was paid for by Medicaid or MCOs to determine whether STS complied with Medicaid requirements under applicable state and federal laws and regulations and MCO policies.

Audit Scope

The audit scope entailed a review of claims for services performed during the period of January 1, 2013 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

To achieve the audit objective, OSC reviewed two separate stratified random samples — the Stein sample (101 episodes) and the STS sample (100 episodes) — which included two or more procedure codes billed on the same day for the same recipient. Tables III and IV provide breakdowns of the two universes of claims from which the Stein and STS samples were selected.

Table III
Stein Universe of Claims

Claim Procedure Code Combination	Number of Claims	Number of Episodes	Paid Amount
92507; 97532	4,530	2,265	$171,416
92507; 97532; 97533	1,302	1,302	$32,882
Total	**5,832**	**2,699**	**$204,298**

Table IV
STS Universe of Claims

Claim Procedure Code Combination	Number of Claims	Number of Episodes	Paid Amount
92507; 97532	7,388	3,694	$264,010
92507; 97532; 97533	2,646	882	$ 68,207
92507; 92526	1,258	629	$ 76,478
92507; 97533	304	152	$ 9,929
Total	**11,596**	**5,357**	**$418,624**

OSC's audit methodology consisted of the following:

- Selection of 101 episodes from the Stein universe totaling $7,640 randomly selected from the population outlined in Table III.
- Selection of 100 episodes from the STS universe totaling $8,645 randomly selected from the population outlined in Table IV.
- Review of STS's records (Stein and STS samples combined) to determine whether the documentation complied with the requirements delineated in *N.J.A.C.* 10:49-5.5, *N.J.A.C.* 13:44C-8.1, *N.J.A.C.* 10:49-9.8, United Policies, and Medicaid NCCI.
- Review of STS's records (Stein and STS samples combined) to determine whether those episodes involving CPT codes 92507, 97532 and/or 97533 were performed by two different types of practitioners.

Audit Findings

A. Inadequate Documentation to Support Billed Claims

OSC reviewed the Stein sample (101 episodes) and the STS sample (100 episodes) which comprises CPT code 92507 being billed in conjunction with CPT codes 97532 and/or 97533 and/or 92526. OSC found that the records submitted by STS to support the sampled episodes (201 episodes in total) were materially deficient. The treatment notes (documentation submitted by STS to support the services on specific episode dates) referred to as progress notes by STS, contained stock information about the services provided which mimicked the patient's plan of care. In addition, the notes lacked signatures and license numbers of the therapists. These deficiencies constitute violations of *N.J.A.C.* 10:49-9.8 and *N.J.A.C.* 13:44C-8.1. Further, in the Stein sample, 55 of the 101 episodes (54 percent) that included time-based codes (97532 and 97533) did not include the duration of treatment. In the STS sample, 59 of 70 episodes (84 percent) lacked the duration of treatment. Failing to include the duration of treatment is contrary to *N.J.A.C.* 10:49-5.5(a)13 and the AMA CPT Manual.

N.J.A.C. 13:44C-8.1 requires SLPs to maintain written contemporaneous patient records. Pursuant to this regulation, written contemporaneous patient records must include,

among other requirements: a written plan of care indicating the goals of the treatment program; dated documentation of each treatment rendered that contains the licensee's full name and license number; and, dated and signed progress notes. OSC found that for all 201 episodes (100 percent) the notes, some of which were inputted weeks after the sessions took place, lacked signatures by the therapist. In addition, OSC determined that all 201 notes (100 percent) did not include a therapist's license number. These omissions are violations of the licensing regulation, *N.J.A.C.* 13:44C-8.1.

N.J.A.C. 10:49-9.8 requires providers to keep records as necessary to disclose fully the services provided. Specific information on the notes provided was limited to the following: prepopulated information (e.g. name, date of birth, etc....); the procedure code and its associated description; goals listed under a field titled "area of concern"; and a percentage of achievement towards each of those goals. However, the "area of concern" and goals listed on the notes are identical to and generated from the plan of care. The only information provided on the notes that was unique to the visit was a change in percentage towards a listed goal. Based on the documentation provided, it cannot be determined what transpired during the visit, the specific services STS provided the patient's response to treatment, or whether any treatment modifications would be necessary.

To ascertain the type of record keeping that would be adequate in this field, it is instructive to look to professional standards for SLPs. The American Speech-Language-Hearing Association (ASHA) is the professional association for SLPs. ASHA provides guidance on how properly to document the services provided. According to ASHA, a note should contain objective data on progress toward functional goals with comparison to prior sessions, materials and strategies, analysis and assessment of patient performance including modification for the progression of treatment, and session length and/or start/stop time.[5] In contrast to the ASHA standards, the STS notes OSC reviewed did not include objective data, materials and strategies, an analysis and assessment of the patient performance, or in the majority of cases, session length. Accordingly, STS's notes did not meet the ASHA professionally recognized standards.

In sum, the documentation provided for all 201 episodes (100 percent) failed to comply with the above-mentioned regulations. Other than prepopulated fields, the notes lacked fundamental information such as the duration of the visit, a signature of the therapist who performed the service(s), and the license number of the therapist. Simply put, the notes lacked any information unique to the date of service except for the percentage of progress toward achieving a goal that was established in the plan of care. Proper documentation is critical for patient care, not only because it validates that the services were provided, but also because it can be used as a reference for a practitioner at a later date and can be used as a tool to share critical information with related or subsequent practitioners. At a minimum, the documentation reviewed does not conform to the requirements set forth in *N.J.A.C.* 13:44C-8.1 and does not fully disclose the services provided as required by *N.J.A.C.* 10:49-9.8.

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[5] ASHA guidelines can be found online at:
https://www.asha.org/PRPSpecificTopic.aspx?folderid=8589935365&section=Key_Issues

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. As previously stated, in the Stein sample, 55 of the 101 episodes (54 percent) reviewed did not include the number of units billed, duration and start/end times for timed codes. In the STS sample, 59 of the 70 episodes (84 percent) lacked this information. Specifically, the notes supporting these episodes failed to document that any units were provided and failed to document any number of minutes during which services were provided. According to the AMA CPT Manual, CPT Codes 97532 and 97533 are timed codes, with each unit representing 15 minutes that the provider spent with the patient. Failure to document the time and/or duration of the sessions violates *N.J.A.C.* 10:49-5.5(a)13 and the AMA CPT Manual.

After notification of the preliminary audit findings, STS provided OSC with a voluminous amount of documentation, including progress notes, plans of care, and evaluations, all of which OSC considered in preparing the draft version of this audit report. In response to the draft version of this report, STS provided several additional pieces of documentation, including signed statements from SLPs, attestations from caregivers, videos documenting some patient visits, and some audit logs (i.e. a system generated report that tracks when a patient's progress note was created). In general, STS's submissions, taken as a whole, provide some indication that, at least in some instances, a service took place. These submissions, however, do not rebut or otherwise challenge the finding that STS's documentation was wholly deficient.

As a result of the deficiencies described above and the 100 percent error rate, OSC finds that STS received an overpayment of $622,181, which STS must pay back to Medicaid.

B. Improper Unbundling of Codes

While STS's documentation failed to meet both Medicaid requirements and professional standards, the fact remains that the majority of these claims should have never been billed in the first place. United Policies and Medicaid NCCI Chapter 11, Section H state that a single practitioner is not permitted to bill CPT codes 92507 on the same date of service as CPT codes 97532 or 97533, unless the services are performed by two different types of practitioners. Notwithstanding that stated requirement, STS billed code 92507 in conjunction with 97532 and/or 97533 for the same session for all 101 episodes reviewed in the Stein sample, and for 70 of the 100 episodes reviewed in the STS sample. For all of these claims only one SLP therapist's name was included in the notes provided, eliminating the possibility that two separate types of therapists performed the services. This billing practice, which constitutes impermissible claim unbundling, violates United Policies and Medicaid NCCI policy.

Further, in the Stein sample, in 96 of the 101 (96 percent) sampled episodes (92507 billed in conjunction with 97532 and/or 97533), STS appended the claim with modifier 59. In the STS sample, STS appended the claim with modifier 59 in 68 of the 70 (97 percent) sampled episodes. Modifier 59 is used to identify procedures that are not normally reported together, but are appropriate under certain circumstances. By using modifier 59,

STS was able to bypass the payer's (UnitedHealthcare) claim edit checks, which resulted in improper payments. Modifier 59 should not be used to bypass an edit unless the proper criteria for use of the modifier are met. STS's improper use of Modifier 59 raises integrity concerns that STS will have to address.

To avoid overlapping or duplicative recoveries, OSC does not seek recovery totaling $141,782 for these unbundled claims because these claims and this recovery amount was incorporated in the previous finding regarding inadequate documentation.

Summary of Overpayments

Based on its review, OSC determined that STS improperly billed and received payment for all 201 sampled episodes for the period January 1, 2013 through December 31, 2017. STS received a total of $7,640 for the 101 episodes in the Stein sample, and a total of $8,645 for the 100 episodes in the STS sample. OSC used extrapolation to determine a final recovery amount for episodes that failed to comply with the aforementioned regulations (see Table I for details). OSC has determined that the total amount of improper payments is $622,181.

Recommendations

1. STS shall reimburse the Medicaid program $622,181.

2. STS must ensure that the Medicaid services provided are adequately documented in the medical records in accordance with *N.J.A.C.* 10:49-9.8, *N.J.A.C.* 13:44C- 8.1, *N.J.A.C.* 10:49-5.5(a)13 and the AMA CPT Manual before submitting a claim for payment.

3. All claims billed by STS should adhere to the AMA, NCCI, and other applicable guidelines.

4. STS must immediately discontinue its practice of separately billing for CPT code 92507 and 97532 or 97533 on the same date of service for the same Medicaid beneficiary. For services after January 1, 2018, STS should also not bill CPT code 92507 in conjunction with 97127 (effective January 1, 2018, CPT code 97127 replaced code 97532).

5. STS must provide OSC with a Corrective Action Plan (CAP) indicating the steps it will take to implement procedures to correct the deficiencies identified in this report.

Auditee Response and OSC Comments

STS's full response to the audit including its Corrective Action Plan can be found in Appendix A. After carefully reviewing each of STS's comments, OSC finds no basis to alter the audit findings or recommendations. In general, STS's response did not address the

sole basis for OSC's finding – that STS's documentation in support of its claims was wholly deficient. Rather, STS provided additional arguments and information that, at best, indicates that STS provided some services. Nothing in STS's response addressed OSC's audit finding that STS's documentation failed to meet the relevant requirements. A more complete discussion of STS's response, including OSC comments, can be found in Appendix B.

In sum, OSC finds that STS's documentation failed to provide adequate support for its claims and, thus, STS received an overpayment of $622,181 that it must repay to the Medicaid program.

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 – AMA CPT Code Descriptions
2. Appendix A – STS Response
3. Appendix B – Discussion of STS Response

Cc: Aidan O'Conner Esq. (Pashman Stein Walder Hayden P.C.)
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)
Michael Morgese, Audit Supervisor (OSC – Medicaid Fraud Division)

EXHIBIT A

AMA CPT Code Descriptions

Code	Code Descriptor
92507	Treatment of speech, language, voice, communication, and/or auditory processing disorder; individual
92532	Development of cognitive skills to improve attention, memory, problem solving (includes compensatory training), direct (one-on-one) patient contact, each 15 minutes
92533	Sensory integrative techniques to enhance sensory processing and promote adaptive responses to environmental demands, direct (one-on-one) patient contact, each 15 minutes
92526	Treatment of swallowing dysfunction and/or oral function for feeding

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March 7, 2019

VIA OVERNIGHT MAIL

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

Re: STS Therapy Services, LLC

Dear Mr. Morgese,

INTRODUCTION

This firm represents STS Therapy Services, Israel Stein and Baila Stein (collectively referred to as "STS") in connection with the Office of State Comptroller, Medicaid Fraud Division's ("MFD") Summary of Findings ("SOF") dated December 7, 2018 and Draft Audit Report ("DAR") dated February 20, 2018. Please accept this letter as STS' written comments to the DAR and you will also find enclosed a proposed Corrective Action Plan.

By way of procedural background, MFD issued its SOF to STS on December 7, 2018, asserting that STS improperly billed and received payment for 201 sampled episodes for the period January 1, 2013, through December 31, 2017 and that based upon extrapolation principles, it improperly billed Medicaid $622,181. In response to the SOF, STS provided two binders of extensive documentation along with videos of therapy sessions supporting STS' contention that it obtained pre-approval from United Healthcare to provide speech therapy services for each individual in MFD's sample and thereafter appropriately billed Medicaid for these speech therapy services. STS thereafter attended a meeting with MFD representatives on February 5, 2019. During the meeting, Ms. Stein explained the premise of her therapy treatment and how information concerning her treatment of each patient's sessions was entered into the "Goals" section of that patient's Progress Notes in the ClinicSource program, based on her understanding of the program. MFD cursorily reviewed the substantial information supplied by STS concerning patient treatment and billing for the audit period with the

clear intent to restate its conclusions from the SOF. And, it did so, as the DAR likewise concluded that STS improperly billed $622,181 to Medicaid. Based upon the documents and information previously supplied and for the reasons set forth herein, STS contends and urges that at worst, STS improperly and mistakenly billed Medicaid for $23,961.16.

GENERAL INFORMATION

STS provides outpatient speech language therapy services at their office in Lakewood, New Jersey. Baila Stein graduated from Adelphi University in 2005 with a Master's Degree in Speech Pathology, and in 2006 received her license in the State of New Jersey. Years later, in 2009, Israel and Baila Stein opened STS to help children improve their speech and communication deficits. Aside from Baila, STS also employs several other licensed and certified speech language pathologists. Each therapist met all state mandated prerequisites for licensure including the relevant educational and clinical internship requirements and were properly credentialed during every patient encounter.

STS has been a participating provider in the state Medicaid program for many years. In that regard, STS agreed to accept predetermined service rates for its patients that receive Medicaid benefits. As a participating Medicaid provider, STS took steps to ensure that it complied with all applicable state recordkeeping regulations. For example, STS purchased the ClinicSource computer program to track and document its patient encounters. While ClinicSource is certainly a useful tool, it is not a perfect one.

Given the fact that the ClinicSource documents were maintained electronically, the therapists did not believe that they needed to print out and physically sign every progress note. Additionally, since each therapist's name was reflected on the progress notes, they assumed that their license numbers were also automatically populated in the program. The therapists have certified that they believed they were complying with the applicable regulations and that the percentile evaluations were a standard method of tracking each patient's progress toward the treatment goals. Importantly, STS frequently videotaped its patient encounters as a secondary means of tracking patient progress and documenting the precise treatment provided at each encounter.[1]

As STS submitted Medicaid claims to United Healthcare (United), some were occasionally denied. United would then request that STS send its progress notes to

[1] STS advised MFD during the February 5, 2019, meeting that there were videos for most if not all of the therapy sessions but there were technical difficulties which prevented STS from supplying the videos. MFD did not express any interest in reviewing additional videos before issuing its DAR.

substantiate the claims. When STS did so, United approved the claims. As detailed below, STS reasonably relied on United's acceptance of its progress notes as confirmation that its documentation practices were proper.

ISSUES WITH DRAFT AUDIT FINDINGS

The scope of the audit is January 1, 2013, through December 31, 2017. The earliest date in the audit sample was November 28, 2013, which is five and a half years ago. The audit reviews a sample of 201 sessions and using the difference method extrapolates the results of each sample back to the respective universe. Thus, the MFD report concludes that almost 100% of the universe of claims were overpayments, even though there is no dispute the services were provided on each occasion by qualified licensed therapists. (Total universe $622,922, Overpayment $622,181, which equals 99.88%). For the reasons below, STS submits that requiring it repay $622,181 is wholly inequitable given the facts of this case and contrary to applicable regulation.[2]

A. Reliance on United Healthcare Audits

Before STS rendered treatment to Medicaid patients, it was required to preauthorize the proposed treatments with United. In that regard, STS would often provide its initial evaluation of a patient to United, and United would opine on whether speech language services were medically necessary. If speech language therapy was deemed medically necessary, United would authorize STS to provide those services.

On occasion, United would deny STS payment due to documentation issues with certain claim submissions. In response, STS would submit the progress notes that supported the denied claim. Importantly, an actual employee at United reviewed the progress notes provided by STS and compared the notes to the claims submitted. Those progress notes, which MFD now criticizes as legally insufficient to support the billings, were accepted by United for many years. Upon its review of the STS progress notes, United consistently approved and paid the challenged claims. In addition, United sometimes notified STS that it was not permitted to utilize Modifier 59 to append codes without submitting the corresponding progress notes. In response, STS would submit the requested documents and the claim, using Modifier 59, would be paid. United never advised STS that it was "improperly unbundling" codes during any of its audits.

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[2] N.J.A.C. 10:49-5.5(a)(13)(iv) provides that the Medicaid Agent may only recoup the **difference** between the amount paid to the provider based on the claim submitted and the Medicaid Agent's value of the procedure, which is the agreed upon service rate for the services actually provided.

STS reasonably relied on these claim audits performed by actual employees of United with regard to the use of modifier 59 and the detail of its progress notes. As a result of the United audits, STS was led to believe that the way in which it documented and submitted its claims was appropriate. STS was unaware that its billing submissions were incorrect. Indeed, based upon the feedback from United – the company hired by the state to facilitate the Medicaid program – any reasonable Medicaid provider would have concluded that his or her claim submission practices conformed with the applicable regulations.

B. The Supplemental Documents and Certifications Provided by STS Clearly and Convincingly Support the Billed Claims.

The Medicaid regulations are designed to ensure that services for which a provider is compensated were actually provided. To that end, the Legislature authorized the Department of Medical Assistance and Health Services (DMAHS) to promulgate regulations for New Jersey's Medicaid program. N.J.S.A. 30:4D-12(d), (e). Applicable here is N.J.A.C. 10:49-5.5(a) which enumerates the services for which DMAHS will not remit payment to a provider. The relevant portion of the regulation states that payment will not be made for services billed by a Medicaid provider for which the corresponding records do not support the procedure described. N.J.A.C. 10:49-5.5(a)(13). That section, however, expressly permits providers to submit supplemental corroborating documents and other "clear and convincing evidence" to prove that the services billed were actually rendered. N.J.A.C. 10:49-5.5(a)(13)(iii). Thus, although the regulation requires certain recordkeeping practices, it also recognizes that providers are entitled to payment when they can establish that the billed services actually occurred.

In In re Alina Drug Store, OAL Docket No. HMA 11656-07 (June 11, 2008), an Administrative Law Judge (ALJ) reviewed whether DMAHS was entitled to recoup Medicaid payments based upon a pharmacy's failure to provide original records to support the prescriptions it filled. DMAHS initially demanded that the pharmacy repay $55,981.72 for the alleged payments that lacked proper documentation. Thereafter, however, DMAHS accepted certain of the pharmacy's secondary proofs and decreased the amount owed to $18,837.46. The pharmacy challenged the amount owed, arguing that the secondary documents it provided were sufficient to support the extent of services billed. In concluding that the pharmacy was permitted to submit secondary documents in electronic form (since the originals were lost) the ALJ noted that there was no indication of fraud, and that "[t]he purpose of the statutory and regulatory requirements here is to prevent the issuance of Medicaid reimbursements that lack a bona fide basis." Id. at *4-5 (emphasis in original). In that regard, the ALJ concluded that the supplemental documents provided by the pharmacy were sufficient to establish the bona fide basis for its services, and that the amount owed should be reduced commensurate with the documents provided. Id. at *5-6. Ultimately, the Director of

DMAHS adopted the ALJ's conclusions of law, finding that "due to the unique factual circumstances presented here as well as the absence of any allegations of fraud that DMAHS accept hard copies of Alina's electronic records (together with the patient signature logs) as proof that the prescription service was in fact provided and reduce the demand for repayment accordingly."

Similarly, in In re King James Nursing Home, 138 N.J. Super. 417 (App. Div. 1976), the nursing home appealed the final decision of DMAHS, rejecting a Medicaid claim for services rendered to a patient, on the grounds that the claim was not submitted within the requisite timeframe and lacked certain supporting documentation. The appellate panel reversed the final decision of DMAHS, reasoning that the hyper technical application of the regulations to the nursing home "**was an abuse of the discretionary power of the Division, whether tested by its own rules or the principles of equity applied by the court.**" Id. at 424 (emphasis added). In so holding, the panel cited an analogous case in New York, in which the court remarked:

> **The case presents a classic example of the web of laws, rules, regulations and public assistance directives and requirements . . . which, by their volume and complexity, frustrate the very purpose for which the public assistance laws were enacted by our Congress and State Legislature. . . . These, coupled with strict bureaucratic interpretations of the applicable statutes, rules and regulations and the forms required to be submitted for qualification and eligibility, constitute a challenge which the most literate of lay persons would fail to meet.**
>
> [Id. at 423 (emphasis added) (quoting Mount Sinai Hospital v. Brinn, 73 Misc.2d 1, (Civ. Ct. 1973)).]

Ultimately, the court entered judgment "in favor of King James Nursing Home for the full amount of the bill for services rendered" to the patient. Id. at 424.

Here, STS has provided MFD with extensive documentation to establish a *bona fide* basis that the billed services were in fact provided.[3] That supplemental documentation includes affidavits from several STS therapists confirming that the services were provided, certifications from parents of STS patients confirming that their children received treatment at STS on the dates in question, office calendars, fax

[3] MFD recognized in the DAR that STS provided services when it noted, "STS' submissions, taken as a whole, provide some assurance that a service took place." See DAR at Page 7.

confirmations, prescriptions, and videos documenting treatment sessions with STS patients. Those documents clearly and convincingly establish that the services for which STS submitted claims actually occurred. Moreover, although the exact time of each treatment session was not reflected on the patient progress notes, the session videos demonstrate that STS complied with all time requirements under the applicable regulations.

The common thread in the above cited cases is that the state Medicaid regulations are subject to the principles of equity and fundamental fairness. Here, like in Alina and King James there is no indication that STS acted fraudulently, and the supplemental documentation provided by STS clearly and convincingly establishes that the challenged services were in fact provided. Requiring full repayment based on minor record keeping flaws in STS's documentation procedures, despite proof that the services were actually rendered, is surely inequitable. Moreover, the denial of any downward adjustment of the amount owed by STS fails to consider the extensive supplemental documentation and videos provided, as expressly permitted under N.J.A.C. 10:49-5.5(a)(13)(iii) and is contrary to N.J.A.C. 10:49-5-5(a)(14) which only allows for recoupment of the "difference between the amount paid to the provider based on the claim submitted and the Medicaid Agent's value of the procedure". Accordingly, STS submits that it is entitled to credit for the services actually rendered, which was clearly and convincingly established through its supplemental document submissions.

C. STS Reasonably Misinterpreted the Conflicting NCCI Policies on Unbundling Codes and Use of Modifier 59.

At the outset, it is important to recognize that Modifier 59 is properly used to append two timed codes. Specifically, Medicaid NCCI, Chapter 1, Section E, Subsection (d)(3) (Rev. 2015) provided:

> There are several exceptions to this general principle about misuse of modifier 59 that apply to some code pair edits for procedures performed at the same patient encounter.
>
> (3) There is an appropriate use for modifier 59 that is applicable only to codes for which the unit of service is a measure of time (e.g., per 15 minutes, per hour). If two timed services are provided in time periods that are separate and distinct and not interspersed with each other (i.e., one service is completed before the subsequent service begins), modifier 59 may be used to identify the services.

The above language appears in the very first chapter of the Medicaid NCCI manual, and clearly states that Medicaid providers may use Modifier 59 when they perform two

separate timed services. As detailed above, STS was audited by United on numerous occasions without any indication that its use of Modifier 59 was improper. Relying on United – the state's own Medicaid Agent – STS continued its use of Modifier 59 when appending timed codes.

STS reasonably believed it was complying with the Medicaid NCCI by using Modifier 59 when two timed codes were entered – which occurred in the vast majority of entries on Attachments 1.1 and 2.1. As can be seen on MFD Attachments 1.1 and 2.1, STS often used Modifier 59 to append codes 97532 and 97533 – both of which are indisputably timed codes.

Indeed, in the "Stein Sample" only 3 out of 101 entries (approximately 3%) used modifier 59 without two timed codes. See MFD Attachment 1.1. In the "STS Sample" 31 of the 100 entries (31%) used modifier 59 without two timed codes. See MFD Attachment 2.1. In total, just 34 of the 201 episodes (16.9%) in the combined Stein and STS Samples used Modifier 59 without two timed codes. Thus, out of the $141,782 that MFD claims is owed to DMAHS due to alleged "improper unbundling of codes" STS should only be responsible to pay 16.9% of that sum or $23,961.16.

Later provisions of the Medicaid NCCI conflict with the above language regarding the proper use of Modifier 59. Specifically, Medicaid NCCI, Chapter 11, Section H, Subsection 3 (Rev. 2015) provides in pertinent part:

> A single practitioner should not report CPT codes 92507 (treatment of speech, language, voice...; individual) . . . on the same date of service as CPT codes 97532 (development of cognitive skills to improve...) or 97533 (sensory integrative techniques to enhance...). However, if the two types of services are performed by different types of practitioners on the same date of service, they may be reported separately by a single billing entity.

Here, STS provided certain services that did not strictly comply with the above section of the Medicaid NCCI. This was done by mistake and without an intent to bypass any of United claim edit checks. Indeed, STS, as noted above, believed based on past practice, that it was complying with United's requirements. Despite the conflicting provisions of the NCCI, STS agrees to cease submitting claims for CPT codes 92507

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A Professional Corporation

and 97532 or 97533 on the same date of service for the same Medicaid beneficiary when there is only one service provider.[4]

STS submits that it is entitled to the agreed upon payments for services provided based upon its good faith belief that it properly used Modifier 59 and its reliance on United's prior audit decisions. Given the conflicting provisions within the NCCI itself and United's acquiescence, any ambiguity or misinterpretation of the NCCI provisions should be resolved in favor of STS.

CONCLUSION

STS submits that the supplemental documentation provided to MFD establishes that speech therapy services were in fact provided to the identified patients. Requiring STS to repay $622,181 due to minor record deficiencies is wrong and inequitable. The majority of the challenged claims in the STS and Stein Samples are supported by the clear and convincing supplemental documents provided to MFD. In addition, STS should only be required to repay 16.9% or $23,961.16 of the claims that MFD contends were improperly unbundled, because STS reasonably relied on the conflicting Medicaid NCCIs and United's long-term approval of its use of Modifier 59.

Both the Office of Administrative Law and our Appellate Division have consistently applied equitable doctrines to cases involving Medicaid regulations. Here, equity demands that the amount owed by STS be adjusted consistent with the supplemental documents provided and the reasonable misinterpretation of the Medicaid NCCIs.

If you have any questions or wish to further discuss this matter, please contact me at (201) 270-4940 or aoconnor@pashmanstein.com.

Yours truly,

Aidan P. O'Connor

AIDAN P. O'CONNOR

cc: STS Therapy Services, LLC

[4] It should be noted that use of the word "should" instead of "must" or "shall" in Medicaid NCCI, Chapter 11, Section H, Subsection 3 is misleading inasmuch as the word "should" indicates the section is permissive or at least subject to exceptions.

CORRECTIVE ACTION PLAN

STS THERAPY SERVICES, LLC

STS Therapy Services, LLC (STS) submits this Corrective Action Plan in response to the Office of the State Comptroller, Medicaid Fraud Division's (MFD) February 20, 2019, Draft Audit Report. The MFD report requires STS to indicate "the steps it will take to implement procedures to correct the deficiencies identified . . . ." To that end, STS proposes the following plan to address the alleged issues raised by MFD. Nothing contained herein shall constitute an admission, concession, or finding of liability against STS.

ISSUE 1: MFD contends that STS' patient records and documentation were inadequate and failed to support the Medicaid claims in question.

Corrective Action: STS agrees to take the following action to ensure its patient records comply with all applicable guidelines and regulations including the AMA, NCCI, and United Healthcare billing policies:

1. All Progress Notes will be entered into ClinicSource within two days of session;
2. All Progress Notes will include a narrative of the steps taken during a session (*e.g.*, therapy interventions, showing what did and did not work);
3. All Progress Notes will be printed and signed at the time of completion (or electronically signed and stored);
4. All Progress Notes will include the license information for the treating therapists;
5. All Progress Notes will include the duration of treatment for timed codes.

ISSUE 2: MFD contends that STS improperly unbundled services and misused Modifier 59 to append codes 92507 with codes 97532 and 97533.

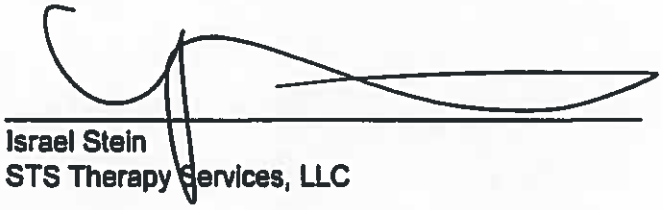
Corrective Action: STS agrees to take the following action to ensure that its claim submissions adhere to all applicable guidelines and regulations including the AMA, NCCI, and United Healthcare billing policies:

1. STS will no longer separately bill CPT codes 92507 and 97532 or 97533 on the same date of service for the same Medicaid beneficiary, unless more than 1 type of practitioner performs those services in accordance with then applicable regulations.

2. STS will cease using Modifier 59 to append two or more CPT codes unless the services rendered are measured by "timed codes" and the "timed codes" are not billed separately with CPT code 92507 in accordance with then applicable regulations;

3. STS will also cease submitting claims under CPT code 97127 (which replaced CPT code 97532 as of January 1, 2018) on the same date that it bills for CPT code 92507 in accordance with then applicable regulations.

The form and content of this Corrective Action Plan are hereby agreed to and accepted by:



Israel Stein
STS Therapy Services, LLC

Dated: 3/7/19

Baila Stein
STS Therapy Services, LLC

Dated: 3/7/19

Aidan O'Connor

Aidan P. O'Connor, Esq.
Counsel for STS Therapy Services, LLC

Dated: 3-11-19

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

After being apprised of the findings above, STS, through counsel, submitted a written response along with a Corrective Action Plan (CAP) dated March 7, 2019 (See Appendix A). STS's CAP, if implemented, addresses the deficiencies identified by this audit. STS's objections can be broken into three general points, each of which is discussed below.

1. STS relied on United Healthcare Audits

STS Response:

"On occasion, United would deny STS payment due to documentation issues with certain claim submissions. In response, STS would submit the progress notes that supported the denied claim. Importantly, an actual employee at United reviewed the progress notes provided by STS and compared the notes to the claims submitted. Those progress notes, which MFD now criticizes as legally insufficient to support the billings, were accepted by United for many years. Upon its review of the STS progress notes, United consistently approved and paid the challenged claims. In addition, United sometimes notified STS that it was not permitted to utilize Modifier 59 to append codes without submitting the corresponding progress notes. In response, STS would submit the requested documents and the claim, using Modifier 59, would be paid. United never advised STS that it was "improperly unbundling" codes during any of its audits.

"STS reasonably relied on these claim audits performed by actual employees of United with regard to the use of modifier 59 and the detail of its progress notes. As a result of the United audits, STS was led to believe that the way in which it documented and submitted its claims was appropriate. STS was unaware that its billing submissions were incorrect. Indeed, based upon the feedback from United - the company hired by the state to facilitate the Medicaid program - any reasonable Medicaid provider would have concluded that his or her claim submission practices conformed with the applicable regulations."

OSC Comment:

STS's claim that it relied on United's audit results is not persuasive for a number of reasons. First, at the outset of the audit, OSC learned that United had audited the claims of two of STS's speech therapists. To avoid duplication, OSC excluded those claims from the universe of claims it reviewed. Thus, the claims OSC reviewed did not include any of the claims that United reviewed.

Second, despite the fact that OSC excluded any affected claims, STS still maintains that it reasonably relied on the results of the United audits and feedback from United to conclude that its documentation and claim submissions were appropriate. This argument does not hold up under scrutiny because STS only learned of the results of the United audits in October 2017 and, thus, could not have relied upon these results in submitting claims during the vast majority of the audit period of January 2013 through December 2017.

Finally, the fact that an MCO may not have identified deficiencies to a provider as part of an audit does not grant the STS a waiver to deviate from well-established regulatory requirements. In other words, OSC cannot speak to the scope, objective, methodology or findings of any audit United may have performed on STS claims. OSC, however, did find through its own review that STS failed to document adequately the services provided for all episodes that OSC analyzed.

2. Supplemental Documents and Certifications Provided by STS Clearly and Convincingly Support the Billed Claims

STS Response:

STS stated that the *N.J.A.C.* "expressly permits providers to submit supplemental corroborating documents and other 'clear and convincing evidence' to prove that the services billed were actually rendered. N.J.A.C. 10:49-5.5(a)(13)(iii). Thus, although the regulation requires certain recordkeeping practices, it also recognizes that providers are entitled to payment when they can establish that the billed services actually occurred." Further, STS stated, "STS has provided MFD with extensive documentation to establish a *bona fide* basis that the billed services were in fact provided.[ ] That supplemental documentation includes affidavits from several STS therapists confirming that the services were provided, certifications from parents of STS patients confirming that their children received treatment at STS on the dates in question, office calendars, fax confirmations, prescriptions, and videos documenting treatment sessions with STS patients. Those documents clearly and convincingly establish that the services for which STS submitted claims actually occurred. Moreover, although the exact time of each treatment session was not reflected on the patient progress notes, the session videos demonstrate that STS complied with all time requirements under the applicable regulations."

OSC Comment:

The supplemental documentation provided by STS (session videos, audit logs, SLPs attestations and some parental attestations) does not change the findings and conclusions of the audit, which are based on STS's failure to document properly for services rendered. While *N.J.A.C.* 10:49-5.5(a)(13)(iii) does permit a provider to submit certain "clear and convincing" documentation "for the purpose of proving that services were rendered," this audit has not alleged that the services were not rendered. Rather, this audit concluded that STS did not adequately document the services provided, as is required by applicable statutes, regulations, policies and guidelines.

3. STS Reasonably Misinterpreted the Conflicting NCCI Policies on Unbundling Codes and Use of Modifier 59

STS Response:

Citing Medicaid NCCI Chapter 1, Section E, STS stated that "[a]t the outset, it is important to recognize that Modifier 59 is properly used to append two timed codes.... Medicaid providers may use Modifier 59 when they perform two separate timed services. As detailed above, STS was audited by United on numerous occasions without any indication that its use of Modifier 59 was improper. Relying on United - the state's own Medicaid Agent - STS continued its use of Modifier 59 when appending timed codes.

"STS reasonably believed it was complying with the Medicaid NCCI by using Modifier 59 when two timed codes were entered - which occurred in the vast majority of entries on Attachments 1.1 and 2.1. As can be seen on MFD Attachments 1.1 and 2.1, STS often used Modifier 59 to append codes 97532 and 97533 - both of which are indisputably timed codes....

"In total, just 34 of the 201 episodes (16.9%) in the combined Stein and STS Samples used Modifier 59 without two timed codes. Thus, out of the $141,782 that MFD claims is owed to DMAHS due to alleged 'improper unbundling of codes' STS should only be responsible to pay 16.9% of that sum or $23,961.16."

Finally, STS stated that Medicaid NCCI Chapter 11, Section H (the unbundling provision cited in the report), is conflicting with the previously cited NCCI Chapter 1, Section E, which allows the use of Modifier 59 when two separate timed services performed. Specifically, STS stated it "provided certain services that did not strictly comply with the above section of the Medicaid NCCI. This was done by mistake and without an intent to bypass any of United claim edit checks. Indeed, STS, as noted above, believed based on past practice, that it was complying with United's requirements. Despite the conflicting provisions of the NCCI, STS agrees to cease submitting claims for CPT codes 92507 and 97532 or 97533 on the same date of service for the same Medicaid beneficiary when there is only one service provider."

OSC Comment:

Medicaid NCCI, Chapter 1 and the use of Modifier 59 does not conflict with Medicaid NCCI Chapter 11, Section H. Chapter 1 provides general coding principles and policies and points to specific chapters for further reference. The policies specific to STS's billing practices are stated in Medicaid NCCI Chapter 11, Section H, which expressly prohibits a single practitioner from reporting CPT codes 92507 and 97532/97533 on the same date of service for the same recipient. While OSC acknowledges STS's argument that its improper billings may have been inadvertent, nevertheless these unbundled claims and the payments received for such claims were improper and must be repaid.