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

KEVIN D. WALSH
Acting State Comptroller

JOSH LICHTBLAU
Director

March 8, 2021

BY ELECTRONIC MAIL

Ms. Devorah Schwartz, Owner
Surgical Sock Shop, Inc.
27 Orchard Street, Suite 207
Monsey, NY 10952

Re: Final Audit Report — Surgical Sock Shop, Inc.

Dear Ms. Schwartz:

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 (MFD) audited Surgical Sock Shop, Inc. (Surgical Sock) claims submitted under National Provider Identification Number [redacted] for the period from January 1, 2014 through December 31, 2018 (audit period). MFD hereby provides you with this Final Audit Report (FAR).

Executive Summary

Surgical Sock is a durable medical equipment (DME) and medical supplies provider operating in four locations: Monsey, New York (headquarters); Brooklyn, New York; Monroe, New York; and Lakewood, New Jersey. This audit reviewed certain claims and billings for Surgical Sock's Lakewood location.

MFD reviewed Medicaid claims paid to Surgical Sock during the audit period to determine whether Surgical Sock billed for DME and supplies in accordance with applicable state and federal laws and regulations and Managed Care Organization (MCO) policies. Specifically, the audit sought to determine whether Surgical Sock correctly billed for compression stockings and other items, such as breast pumps, walking boots, supportive devices, blood pressure monitors, enuresis (incontinence of urine) alarms, respiratory devices, and orthotics management and training.

During the audit period, Surgical Sock received $1,371,640 in Medicaid payments from 7,901 claims. From this universe, MFD statistically selected a sample of 135 claims totaling $27,136 paid to Surgical Sock. MFD determined that in 52 of the 135 sample claims, totaling $4,607 in reimbursement, Surgical Sock failed to comply with state and federal regulations or MCO policy. Specifically, MFD found that Surgical Sock violated *N.J.A.C.* 10:49-9.8 by failing to disclose fully the services provided, and/or by inaccurately billing Healthcare Common Procedure Coding System (HCPCS)/Current Procedural Terminology (CPT) codes. The identified overpayments include claims that were not supported adequately by prescribing practitioner (physician) orders or customer invoices, as well as claims that were upcoded and inappropriately billed.[1] These issues extended across every category of DME and related medical supplies reviewed.

For purposes of ascertaining a final recovery amount, MFD extrapolated the error rate for claims that failed to comply with state and federal regulations or MCO policy to the total population of claims from which the sample claims were drawn, which in this case was 7,901 claims with a total payment of $1,371,640. By extrapolating the dollars in error over the entire universe, MFD calculated that Surgical Sock improperly received an overpayment of $242,873 that it must repay to the Medicaid program.

Background

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) contracts with five MCOs to administer the provision of health care services to Medicaid recipients in New Jersey. That contract requires MCOs and their network providers to adhere to applicable state and federal laws and regulations. UnitedHealthcare (UHC) is one of five MCOs under contract with the state and the MCO through which Surgical Sock submitted the vast majority of its Medicaid claims for the audit period (97 percent). Surgical Sock, as a provider within the UHC MCO network, must comply with state and federal laws and regulations, including the provider certification and recordkeeping requirements set forth in *N.J.A.C.* 10:49-1.1 *et seq.* and 10:49-9.8, as well as guidelines established by any MCO with which it contracts (in this case UHC). According to *N.J.A.C.* 10:49-9.8, providers must "keep such records as are necessary to disclose fully the extent of services provided." DME providers, at a minimum, must maintain a legible, dated prescription for a DME item that is signed by the prescribing practitioner and references the item prescribed. *See N.J.A.C.* 10:59-1.5 and UHC Coverage Determination Guideline for durable medical equipment, orthotics, ostomy supplies, medical supplies and repairs/replacements (UHC Policy).

DME is defined by *N.J.A.C.* 10:59-1.2 as "an item or apparatus, other than hearing aids and certain prosthetic and orthotic devices . . . which . . . is primarily and customarily prescribed to serve a medical purpose and is medically necessary . . . is generally not useful to a beneficiary in the absence of a disease, illness, injury or disability and is capable of withstanding repeated use . . . ."

---

[1] "Upcoding" occurs when a healthcare provider improperly bills a higher code than the code that should have been billed for the good provided or procedure performed.

According to *N.J.A.C.* 10:59-1.5(a), DME requires a legible, dated prescription or a Certificate of Medical Necessity personally signed by the prescribing practitioner. Similarly, pursuant to UHC policy, DME and orthotics are deemed medically necessary when (i) ordered by a physician, (ii) the item meets UHC's medical necessity definition, (iii) the item is consistent with the state definition of DME or orthotics, and (iv) the item meets the criteria for DME Medicare Administrative Contracts established by the Centers for Medicare and Medicaid Services (CMS).

During the audit period, Surgical Sock received $1,371,640 in Medicaid payments from 7,901 claims. Surgical Sock's claims were broken down into two categories, compression stockings and other items/services such as breast pumps, walking boots, supportive devices, blood pressure monitors, enuresis alarms, respiratory devices, and orthotics management and training (collectively referred to as "Miscellaneous"). *See* Table I for a breakdown of Surgical Sock's claims by category description, dollar amount, number of claims, and percentage of dollars associated with each category of claims.

Table I
Total Billings and Claims Paid
for DME/Medical Supplies

Category Description	Dollar Amount	Number of claims	Percent of Total
Compression Stockings	711,251	3,910	52
Miscellaneous	660,389	3,991	48
Total	**$1,371,640**	**7,901**	**100%**

Prescription compression stockings are pressure gradient support stockings that help reduce edema and control vascular disorders. Compression stockings are available in different pressure gradients (18-30 mmHg, 30-40 mmHg, and 40-50 mmHg) and come in a variety of lengths, including knee-length, thigh-length, and waist-length. The HCPCS codes billed by Surgical Sock are dependent on the pressure gradient and length. For example, HCPCS codes A6539 and A6540 are both waist-length but have a pressure gradient of 18-30mmHg and 30-40mmHg, respectively. Exhibit A lists the HCPCS/CPT codes billed by Surgical Sock.

Objective

The objective of the audit was to evaluate whether claims submitted by and paid to Surgical Sock complied with Medicaid requirements under applicable state and federal laws and regulations as well as MCO policies.

Audit Scope

The audit period was January 1, 2014 through December 31, 2018. MFD conducted this audit pursuant to the authority of the Office of the State Comptroller as set forth in *N.J.S.A.* 52:15C-23 and the *Medicaid Program Integrity and Protection Act*, *N.J.S.A.* 30:4D-53 *et seq*.

Audit Methodology

To achieve the audit objective, MFD's methodology consisted of the following:

- Selecting a statistically valid sample of 112 Medicaid recipients' dates of service and the 135 paid claims associated with these recipients' dates of service for a total payment of $27,136, out of a total population of 7,901 paid claims, for which Medicaid paid Surgical Sock a total of $1,371,640.

- Reviewing records to determine whether Surgical Sock possessed documentation that complied with the requirements of *N.J.A.C.* 10:49-1.1 *et seq., N.J.A.C.* 10:49-9.8 and *N.J.A.C.* 10:49-5.5. *See also N.J.A.C.* 10:59-1.2, -1.5 and UHC policies.

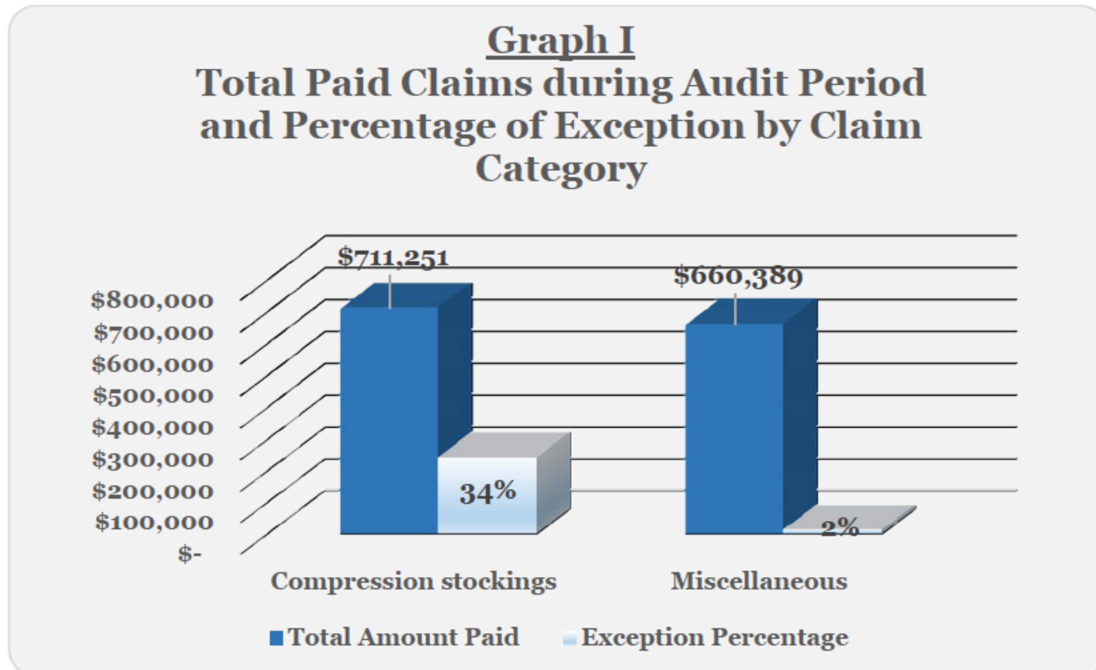
Audit Findings

MFD reviewed 135 Medicaid claims submitted by Surgical Sock between January 1, 2014 and December 31, 2018. The 135 paid claims covered DME and medical supplies, including compression stockings and other miscellaneous items and services, such as breast pumps, walking boots, supportive devices, blood pressure monitors, enuresis alarms, respiratory devices, and orthotics management and training. MFD determined that for 52 of the 135 paid claims, totaling $4,607 out of $27,136 paid claims sampled, Surgical Sock violated *N.J.A.C.* 10:49-9.8 by not fully disclosing the services provided, and/or by inaccurately billing HCPCS/CPT codes. *See* Table II for a breakdown of exceptions (claims that failed to meet the audit criteria) by claim category and Attachment I for an individual sample claim breakdown by exception.

Table II
Exceptions by Claim Category

Claim Category	Number of Sampled Claims	Sampled Claim Dollar Amount	Number of Claims with Exceptions	Claim Exception Dollar Amount
Compression Stockings	57	12,734	41	4,340
Miscellaneous	78	14,402	11	267
Total	**135**	**$27,136**	**52**	**$4,607**

See Graph I below for a representation of the sample error rate for each claim category and the total dollar amount of Medicaid program funds paid to Surgical Sock for each category.



A. Compression Stockings

MFD reviewed 57 claims for compression stockings. These claims include HCPCS codes A6530, A6531, A6537, A6539 and A6540. The different HCPCS codes denote various compression grades (or levels) and stocking lengths (*i.e.*, waist, thigh, or knee length). The vast majority (95 percent) of the claims in the sample were for A6539 and A6540, waist-length compression stockings. MFD found that 41 of 57 such claims reviewed violated *N.J.A.C.* 10:49-9.8, which requires that claims must be true, accurate, and complete and that the records supporting such claims must disclose fully the extent of services provided. These compression stockings exceptions total $4,340 out of $12,734 paid claims sampled, which is a 34 percent error rate in terms of the sample dollars paid. *See* Table III for a breakdown of compression stocking exceptions by reason, number of claims, and associated dollar values.

Table III
Compression Stockings Exceptions

Exception	Number of Claims	Claim Dollar Amount
Upcoding	29	2,093
Deficient Physician Order	7	1,469
No Prescription	2	465
No Invoice	1	330
Underbilling	2	(17)
Total	**41**	**$4,340**

MFD identified 29 claims where Surgical Sock's documentation showed that Surgical Sock billed for A6531, A6539, and A6540 compression stockings without proper support. In 22 instances, Surgical Sock dispensed a stocking but there was no record of the length prescribed. In two instances, Surgical Sock dispensed a stocking but there was no record of the compression prescribed. In five other instances, Surgical Sock dispensed a stocking but there was no record of either the stocking length or compression grade prescribed. In instances in which the prescription lacked only the stocking length, MFD downcoded those A6539 and A6540 claims to a compression stocking with the lowest stocking length. For example, A6539 (gradient compression stockings, waist-length, 18-30 mmHg) was downcoded to A6530 (gradient compression stockings, below knee, 18-30 mmHg). In addition, MFD downcoded A6540 (gradient compression stockings, waist-length, 30-40 mmHg) to A6534 (gradient compression stocking, thigh-length, 30-40 mmHg). MFD downcoded A6540 to A6534 and not A6531 (gradient compression stockings, below knee, 30-40 mmHg) because in order for A6531 to be covered, it has to be for the treatment of an open venous stasis ulcer and there was no evidence of such condition in Surgical Sock's records. In instances in which the prescription lacked only the stocking compression grade, MFD downcoded those A6531 claims to the lowest compression stocking in the below the knee stocking category, A6530. If the prescription lacked both the compression grade and length, MFD downcoded the claim to the procedure code with the lowest length and compression grade (HCPCS code A6530). MFD used the fee schedule obtained from UHC to calculate the overpayment amount for those downcoded claims.

The following are examples of Surgical Sock's claims using A6539 and A6540 procedure codes that MFD downcoded. The first prescription, dated February 24, 2015, lacked both the grade and length of the stockings. Surgical Sock filled this prescription on March 10, 2015 (claim service date), submitted a claim for gradient compression stockings, waist-length, 18-30 mmHg (HCPCS code A6539) and received payment as billed. *See* Attachment II. Because Surgical Sock's documentation lacked the length and compression grade for the stockings, MFD downcoded that A6539 claim to the lower paid compression stocking, A6530. At the time of this claim, a unit of A6530 compression stockings paid at a rate of $26, and a unit of A6539 at $83, a $57 difference per unit.

The second prescription, dated March 24, 2015, called for 30-40 mmHg compression stockings but did not indicate the compression stocking length. Although the prescription

did not contain the stocking length, Surgical Sock submitted a claim and received payment for waist-length compression stockings. In addition to the lack of information in the prescription, Surgical Sock's other documentation further undercut this claim. The customer invoice stated that Surgical Sock billed for waist-length compression stockings with a grade of 30-40 mmHg, but the customer agreement/acknowledgment form stated that Surgical Sock dispensed knee-length compression stockings with a grade of 40-50 mmHg. Given that these two Surgical Sock documents contradict one another, MFD defaulted to the physician's prescription and downcoded this claim to a lower paid 30-40 mmHg procedure code, A6534. *See* Attachment III. At the time this claim was paid, the difference in the payment amount per unit between the two procedure codes was $54, with UHC paying $40 for the A6534 compression stockings and $94 for the A6540.

In addition, MFD found that Surgical Sock improperly billed seven claims because the ordering physician could not be identified or the prescriptions lacked a date, diagnosis, recipient name, physician signature, or a description of the item prescribed. At a minimum, these elements must be included to ensure that each physician's order is legitimate, meets the medical needs of the recipient, corresponds to the claim billed, and meets the record keeping requirement set forth in *N.J.A.C.* 10:49-9.8.

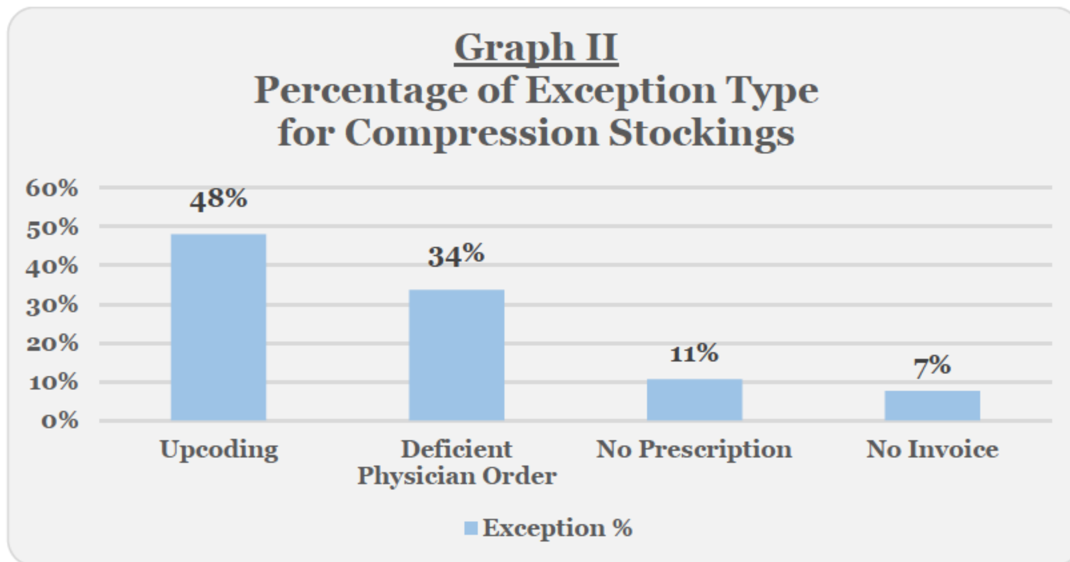
As an example of one of the seven invalid prescriptions, Surgical Sock provided a prescription to support billing procedure code A6539. The prescription, dated April 28, 2014, noted four compression stockings without a specified length or compression grade. While the prescription included a signature, MFD could not ascertain the identity of the individual who signed it because the prescription form did not include a physician's name, National Provider Identification number or license number, any of which could have been used to determine who prescribed the products. *See* Attachment IV. Because MFD could not ascertain who prescribed the stockings and whether the prescriber had authority to prescribe the stockings, MFD found this claim deficient.

Furthermore, MFD determined that two claims for compression stockings were deficient because Surgical Sock lacked any evidence of a physician order for the compression stockings. Pursuant to the relevant UHC policy, which mimics *N.J.A.C.* 10:59-1.5(a), DME, related supplies, and orthotics are eligible for reimbursement only when ordered by a prescribing practitioner.

MFD also identified one instance in which a claim had a valid prescription, but Surgical Sock lacked a customer invoice indicating that the customer actually received the prescribed item. MFD found this claim deficient because MFD could not verify that the beneficiary received the product.

MFD identified two claims where Surgical Sock billed procedure code A6537 for four units of full-length/chap-style, 30-40 mmHg gradient compression stockings for which Surgical Sock was paid $150 for each claim. Despite submitting a claim for full-length/chap-style compression stockings, Surgical Sock dispensed 30-40 mmHg, thigh-high compression stockings for which it should have billed HCPCS code A6534 (Gradient compression stocking, thigh-length, 30-40 mmHg). MFD downcoded these two claims to

A6534. According to UHC's reimbursement per unit rate for procedure code A6534 at the time of the claim, Surgical Sock would have received a reimbursement of $158 for each claim, which would have resulted in an $8 underbilling for this item. Accordingly, MFD gave Surgical Sock a credit of $8 for each claim and included each credit in its extrapolation analysis. *See* Graph II below for the error rates for each exception type for the compression stockings category.



B. Miscellaneous Billings

In addition to the compression stocking category, MFD reviewed 78 claims for miscellaneous items and services, comprised of breast pumps, walking boots, supportive devices, blood pressure monitors, enuresis alarms, respiratory devices, and orthotics management and training. MFD found that 11 of these 78 sampled claims violated *N.J.A.C.* 10:49-9.8. These claims total $267 out of $14,402 in total sample claim dollars for these items. *See* Table IV for a breakdown by exception.

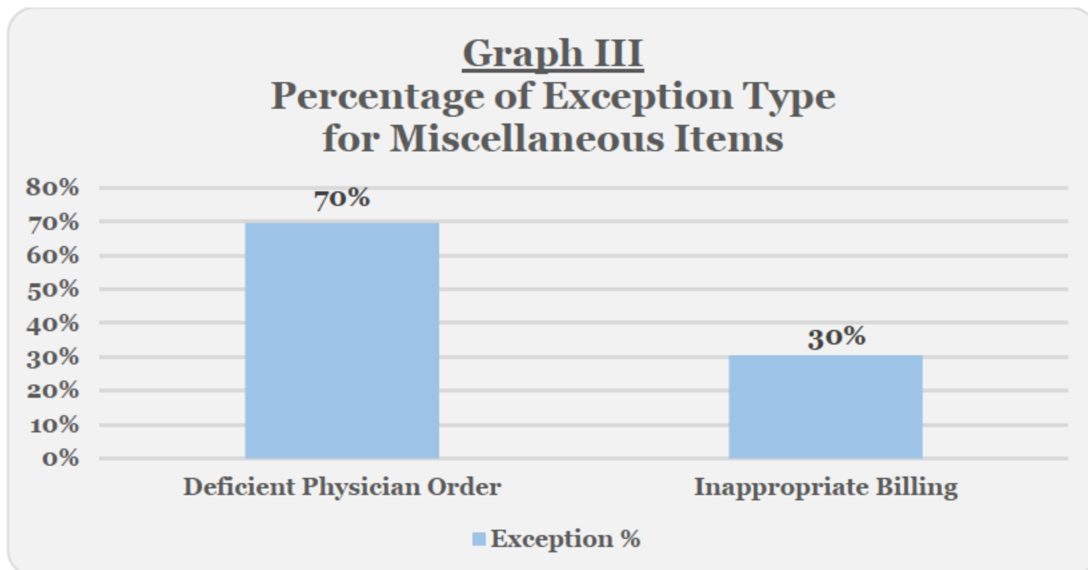
Table IV
Miscellaneous Items Exceptions

Exception	Number of Claims	Claim Dollar Amount
Deficient Physician Order	3	186
Inappropriate Billing of Orthotics Management and Training	8	81
Total	**11**	**$267**

In eight instances, Surgical Sock billed CPT code 97760 in conjunction with compression stocking procedure codes. CPT code 97760 is defined as "Orthotic(s) management and training (including assessment and fitting when not otherwise reported), upper

extremity(ies), lower extremity(ies) and/or trunk, initial orthotic(s) encounter, each 15 minutes." There was no documentation in Surgical Sock's records, however, to support that it provided such management and training. Moreover, Surgical Sock billed CPT code 97760 as a fitting fee for off–the-shelf compression stockings when procedure code 97760 can only be billed in specific circumstances for management and training related to orthotics, not fittings for compression stockings. *See* Attachment II. Therefore, Surgical Sock's submission of these claims under CPT code 97760 constituted an improper use of this procedure code.

Finally, for the remaining three exceptions, MFD determined that these claims lacked adequate prescriptions. *See* Graph III below for the error rates for each exception type for the miscellaneous category.



Summary of Overpayments

MFD determined that for the period January 1, 2014 through December 31, 2018, Surgical Sock improperly billed and received payment for 52 of the 135 sampled claims totaling $4,607. For purposes of ascertaining a recovery amount, MFD extrapolated the error rate for claims that failed to comply with state and federal regulations or MCO policy to the total population of claims from which the sample claims were drawn, which in this case was 7,901 claims with a total amount of payment of $1,371,640. By extrapolating the dollars in error over the entire universe, MFD calculated that Surgical Sock received an overpayment of $242,873 that it must repay to the Medicaid program.

Recommendations

1. Surgical Sock shall reimburse the Medicaid program $242,873.

2. Surgical Sock must ensure that it adequately documents the Medicaid services and durable medical equipment and/or medical supplies provided in a comprehensive

manner in a patient's record in accordance with *N.J.A.C.* 10:49-9.8 and *N.J.A.C.* 10:49-5.5(a)13 before submitting a claim for payment.

3. All claims billed by Surgical Sock must adhere to the relevant AMA, CPT, and HCPCS guidelines.

4. Surgical Sock 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.

<u>Surgical Sock's Response to the Audit Report Findings and MFD's Comments</u>

After receipt of MFD's Draft Audit Report, Surgical Sock, through counsel, submitted a written response and Corrective Action Plan (*See* Appendix A). In this response, Surgical Sock objected to MFD's audit findings and stated that it reserved the right to challenge MFD's sampling and extrapolation methodologies. MFD addressed each argument raised by Surgical Sock in a document entitled "Surgical Sock's Comments and MFD's Response" (*See* Appendix B).

After carefully reviewing each of Surgical Sock's arguments and its supplemental documentation, MFD gave credit in those circumstances where Surgical Sock provided contemporaneous and reliable supporting documentation for deficient claims. For the majority of the claims at issue, however, MFD did not modify its findings. Surgical Sock's Corrective Action Plan addresses all of MFD's recommendations, other than MFD's recommendation that Surgical Sock reimburse the Medicaid program $242,873. Accordingly, Surgical Sock must reimburse the Medicaid program $242,873.

Thank you for your attention to this matter.

Sincerely,

KEVIN D. WALSH
ACTING STATE COMPTROLLER

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

Enclosures (Omitted Unless Otherwise Noted):
Exhibit A - AMA HCPCS and CPT Code Descriptions
Attachment I – Testing Results Summary
Attachment II – Compression Stockings – Example 1
Attachment III– Compression Stockings – Example 2
Attachment IV – Compression Stockings – Example 3
Appendix A – Surgical Sock's Response to the Draft Audit Report (Included)
Appendix B – Surgical Sock's Comments and MFD's Response (Included)

Cc: Karen Mandelbaum, Esq., Senior Counsel (Epstein Becker & Green, P.C.)
Jack Wenik, Esq, Member of the Firm (Epstein Becker & Green, P.C.)
Michael Morgese, Audit Supervisor (OSC – Medicaid Fraud Division)
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)

January 27, 2021

Attorneys at Law

Karen Mandelbaum
t 202.861.5322
f 202.296.2882
KMandelbaum@ebglaw.com

VIA ELECTRONIC AND CERTIFIED MAIL

State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
PO Box 025
Attn: Michael Morgese (Audit Supervisor)
Trenton, New Jersey 08625-0025

Re: Objections to and Submission in Connection with New Jersey Office of the State Comptroller, Medicaid Fraud Division's Confidential Draft Audit Report Dated January 12, 2021.

Dear Mr. Morgese:

As you know, Epstein Becker & Green, P.C. represents Surgical Sock Shop, Inc. ("Surgical Shop") in connection with the New Jersey Office of the State Comptroller, Medicaid Fraud Division's (the "OSC's") audit of claims for the period of January 1, 2014 through December 31, 2018 (the "Audit Period") (the "Audit")[1].

Surgical Shop denies any intentional fraudulent behavior during the Audit Period. In fact, it is undisputed that Surgical Shop provided the services in question and did so in a professional manner. Surgical Shop takes pride in the Medicaid services that it provides to its clients.

Surgical Shop disagrees with, and objects to, all of the OSC's proposed disallowances set forth in the Draft Audit Report, dated January 12, 2021. Below are Surgical Shop's specific objections to each category of disallowances, as well as its general objections to the Audit.

I. Missing Information

In the Draft Audit Report, the OSC asserted that the Medicaid Fraud Division ("MFD") identified one instance in which a claim had a valid prescription, but no customer invoice to indicate that the customer actually received the prescribed item. In addition, the MFD alleged that

[1] Epstein Becker & Green, P.C., on behalf of the Surgical Shop, the letter in response to the OSC's Summary of Findings on June 24, 2020. That letter along with the supplemental records supporting the Surgical Shop's objections to the preliminary findings and the Audit are hereby incorporated into the Surgical Shop's response to the Draft Audit Findings dated, January 12, 2021.

there were two instances where there was no evidence that compression stockings were ordered by a physician. In our response to the MFD's Summary of Findings, dated June 24, 2020, the Surgical Shop previously submitted a record from the patient whose invoice was missing that attests to the fact that the product was dispensed and received. In addition, copies of the two missing prescriptions were also submitted. Accordingly, we request that the OSC reconsiders and re-review all of the documentation previously submitted for this invoice and the prescriptions. For these reasons, Surgical Shop objects to the OSC's Draft Audit Report disallowances. At a minimum, both of these categories of the disallowances should not be extrapolated.

II. Deficient Physician Orders

In the Draft Audit Report, the OSC asserted that the Surgical Shop improperly billed seven (7) claims because the ordering physician could not be identified, or the prescriptions purportedly lacked a date, diagnosis, recipient name, physician signature, or a description of the item prescribed.

We strongly disagree. On June 24, 2020, the Surgical Shop previously submitted approximately 550 pages of documentation to the OSC including physician orders, contemporaneous medical records from the prescribing physicians and letters from the prescribing physicians to provide support for these orders.

In this regard, we would note generally that, contrary to the MFD's contention, full reimbursement by Medicaid is not contingent on a physician's prescription or an invoice alone containing all pertinent claim information. Rather, "**Any other evidence** of the performance of the services shall be admissible…" *N.J.A.C. §10:49-5.6(a)(13)(iii)* (emphasis added).

For the foregoing reasons, the Surgical Shop objects to this category of disallowances and respectfully requests that the OSC reconsider and re-review the documents submitted that contain the "missing" information identified by the MFD in response to the Summary of Findings for these instances.

For these reasons, Surgical Shop objects to the OSC's Draft Audit Report disallowances. Accordingly, we request that you reconsider and re-review the documentation previously submitted. At a minimum, the disallowances should not be extrapolated.

III. Up-coding

In the Draft Audit Report, the OSC asserts that the Surgical Shop billed for Healthcare Common Procedure Coding System ("HCPCS") codes A6531, A6539, and A6540 in 29 claims without proper support: i.e., that there was no record of the length of compression stockings prescribed (22 instances) or no record of the compression of the stockings prescribed (2 instances), or both (5 instances).

We strongly disagree. In this regard, we would note generally that, contrary to the MFD's contention, full reimbursement by Medicaid is not contingent on a physician's prescription or an invoice alone containing all pertinent claim information. Rather, "**Any other evidence** of the

performance of the services shall be admissible…" *N.J.A.C. §10:49-5.6(a)(13)(iii)* (emphasis added).

MFD has taken the position that a valid prescription for compression stockings must include both a pressure gradient and a length. This assumption does not stand up to scrutiny. As a matter of industry practice, prescriptions often omit either or both the pressure gradient or length and leave it to the dispensing provider and a trained fitter to determine the appropriate level of compression and length of the stockings that fit each patient. The Surgical Shop has been in business for almost 30 years and has been subject to audits initiated by other payers, no other payer ever found that a prescription for compression stockings had to include a grade and length or if the prescription lacked one or the other and a different product was dispensed by the fitter that it constituted up-coding.

For the foregoing reasons, Surgical Shop objects to this entire category of disallowances and respectfully requests that the OSC reconsider and re-review the documents that were previously submitted that contains the "missing" information identified by the MFD in response to the Summary of Findings for these instances.

In addition, Surgical Shop reserves the right to submit additional information following its review of same. At a minimum, the proposed disallowances in these categories should not be extrapolated.

IV. Improper Use of CPT Code 97760

OSC also asserts in the Draft Audit Report that, in eight instances, the Surgical Shop billed CPT code 97760 in conjunction with compression procedure codes; but, that it did not have supporting documentation that it provided such management and training. OSC further asserts that Surgical Shop billed CPT code 97760 as a fitting fee for off-the-shelf compression stockings when procedure code 97760 can only be billed in specific circumstances for management and training related to orthotics, not fittings for compression stockings.

This allegation ignores the pertinent conduct by the State's Managed Care Organization, United Healthcare. In late 2010, UnitedHealthcare and the Surgical Shop negotiated a Facility Participation Agreement. As reflected in the final agreement, which was previously submitted to the OSC on June 24, 2020, the Surgical Shop negotiated for a fitting fee to be reflected via the use of CPT Code 97760, which was duly included in the fee schedule offered by UnitedHealthcare and accepted by the Surgical Shop. It was only used when Surgical Shop fitters had to spend a significantly longer time with certain patients because of the complexity of their care. The additional time spent was documented on the invoice when the fitter filled out an additional section marked "For Office Use Only". Furthermore, the Surgical Shop stopped using CPT code 97760 in January 2016, when UnitedHealthcare implemented a requirement for obtaining Prior Approval. While the Surgical Shop's position remains that this is a category of claims that should not have been included as a disallowance by the MFD because it was a negotiated and agreed upon per the terms in the contract between UnitedHealthcare and the Surgical Shop, at an absolute minimum, the proposed disallowance in this category should be excluded from the extrapolation as it was not even in use for the majority of the Audit Period.

V. General Objections to the OSC's Audit, Statistical Sampling and Extrapolation

In addition to the aforementioned objections, the appeals to the scope of the Audit and the Audit Period used. The Surgical Shop further objects to the use of the statistical sampling and extrapolation in the Audit, and expressly reserves the right to challenge the OSC's sampling and extrapolation methodologies, including, but not limited to: the sampling plan (including, but not limited to, the sampling frame, sample unit, sample design, sample size and population quantities to estimate); any and all documents describing any and all steps taken to create and verify the reliability of the sample frame; the random seed(s) used to generate the random numbers for the sample; the output(s) of the program used to generate the random number for the sample(s); the numbered frame used to pull the statistical sample(s); all file(s) with the overpayment amount for each sample item; all file(s) with the output from the valid statistical software program used to analyze any and all sample results; any and all communications with technical and/or subject matter experts about the sampling timeframe; all file(s) with overpayment calculations; all documents, information, and file(s) related to whether a "probe" or "pilot" sample was performed in connection with Audit, and if not, an explanation of why a probe or pilot sample was not performed; all other documents, information and files relating to the statistical sampling used in connection with the Audit (including, but not limited to, as to the statistical validity of the sample(s) and confidence level(s) used in the Audit); and the calculation of the overpayment demand based on the OSC's Draft Audit Report.

VI. Corrective Action Plan

While the Surgical Shop asserts its specific objections to categories of disallowances (as set forth above, and general objections to the Audit, the OSC's statistical sampling and extrapolation methodologies, Surgical Shop has implemented certain corrective actions as a result of the OSC's Audit. Specifically,

1. All billing staff have been re-trained on:
   a. the current and appropriate billing and documentation rules for AMA, CPT, and HCPCS codes included in the Audit; and,
   b. ensuring that the comprehensive documentation requirements of N.J.A.C. §10:49-9.8 and N.J.A.C. §10:49-5.5(a)(13) are met, to demonstrate that Medicaid services and durable medical equipment and/or medical supplies were provided in accordance with such laws before submitting claims for payment.
2. Surgical Shop reviews all prescriptions/physician orders carefully and remits any incomplete orders to the ordering practitioner, as appropriate. Surgical Shop staff have been trained to initial and date each order or prescription to indicate it was reviewed. These orders will be maintained for 10 years.
3. Surgical Shop will conduct periodic audits of appropriate use of AMA/CPT/HCPCS codes, billing and record keeping requirements of the same.

VII. Conclusion

For the foregoing reasons, Surgical Shop objects to the OSC's proposed disallowances and requests that the OSC revise its Draft Audit Report. Surgical Shop welcomes the opportunity to discuss the Audit and the additional documentation submitted herewith.

We also note that with the Corrective Action Plan, Surgical Shop will be able to ensure that all work provided meets applicable federal and state standards, and that proper documentation is maintained.

****

The referenced records are confidential and not subject to production under the New Jersey Open Public Records Act, N.J.S.A. §47:1A-1, et seq. Surgical Shop also asserts any other exemption to disclosure under the above law or any similar law, rule or regulation governing protected health information and the confidentiality of patient records.

Please note that this letter and all communications in this regard between and among parties and their counsel are all without prejudice to the rights and privileges of the parties. It is further understood that all parties preserve and retain, to the fullest extent provided by law, any and all privileges, claims of confidentiality and inadmissibility, which they may have relating to communications made and documents provided in connection with this process. To the extent that any document produced herein is protected by any such privilege, protection or immunity, its production shall be deemed inadvertent and shall not be deemed a waiver of the applicable privilege, protection or immunity, either as to the document or as to the subject matter of this document.

Surgical Shop expressly reserves all rights, privileges, defenses and protections it has in connection with this matter and that it does not waive any of the foregoing, either in whole or in part. Surgical Shop is not, at this time, submitting detailed legal arguments. However, Surgical Shop reserves the right to, among other things: (1) contest the scope of the audit and lookback period; (2) argue that the MFD/State of New Jersey is bound by the statements of UnitedHealthcare; (3) argue that the MFD has misconstrued both the scope and time period of Medicaid's record retention requirements; (4) contest the audit sampling and extrapolation methods MFD employed in its Audit; and, (5) such further legal arguments as are relevant and appropriate. Further, while the Surgical Shop has consulted with clinicians, coding and statistical experts, we are not submitting any expert reports from these professionals at this time. However, Surgical Shop reserves the right to do so at the appropriate time if a resolution of this matter cannot be reached.

Regards,

Karen Mandelbaum

Karen Mandelbaum
Elizabeth Scarola
Jack Wenik

 Appendix B

Surgical Sock's Comments and MFD's Response

In a letter dated January 27, 2021, Surgical Sock, through counsel, responded to the Draft Audit Report (Appendix A). Surgical Sock's comments and MFD's responses are set forth below.

Surgical Sock's Objection #1
Missing Information

"In the Draft Audit Report, the OSC asserted that the Medicaid Fraud Division ('MFD') identified one instance in which a claim had a valid prescription, but no customer invoice to indicate the customer actually received the prescribed item. In addition, MFD alleged that there were two instances where there was no evidence that compression stockings were ordered by a physician. In our response to MFD's Summary of Findings, dated June 24, 2020, Surgical Sock previously submitted a record from the patient whose invoice was missing that attests to the fact that the product was dispensed and received. In addition, copies of the two missing prescriptions were also submitted."

MFD's Response No. 1

MFD reviewed the documentation that Surgical Sock supplied, which included one prescription in support of two separate claims and one recipient attestation in support of a beneficiary's receipt of the DME. MFD did not modify its position on these three claims. MFD denied two claims from May and June 2015 because the prescription provided was dated June 9, 2018, which was approximately three years after these two claims that it purportedly supported. For a prescription to support a claim, it must be dated *prior* to the date of service. That was not the case here. Accordingly, MFD found these two claims deficient. MFD denied the remaining claim with a date of service in December 2016 because the recipient's attestation was signed on June 19, 2020, which was approximately three and one-half-years after the date of service. Given the relatively long lapse in time and the nature of the underlying deficiency, MFD found that this documentation lacked sufficient indicia of reliability to overcome the noted deficiency.

Surgical Sock's Objection #2
Deficient Physician Orders

"In the Draft Audit Report, the OSC asserted that the Surgical Shop improperly billed seven (7) claims because the ordering physician could not be identified, or the prescriptions purportedly lacked a date, diagnosis, recipient name, physician signature, or a description of the item prescribed.

"We strongly disagree. On June 24, 2020, the Surgical Shop previously submitted approximately 550 pages of documentation to the OSC including physician orders, contemporaneous medical records from the prescribing physicians and letters from the prescribing physicians to provide support for these orders.

"In this regard, we would note generally that, contrary to the MFD's contention, full reimbursement by Medicaid is not contingent on a physician's prescription or an invoice alone containing all pertinent claim information. Rather, '**Any other evidence** of the performance of the services shall be admissible…' *N.J.A.C. §10:49-5.6(a)(13)(iii)* (emphasis added)."

MFD's Response No. 2

MFD had found that Surgical Sock improperly billed 10 claims (seven compression stocking and three miscellaneous claims) because either the ordering physician could not be identified, or the prescriptions lacked a date, diagnosis, recipient name, physician signature, or a description of the item prescribed. In its comments, Surgical Sock failed to account for three claims that were included as exceptions in the Miscellaneous Billings section of the report.

MFD did not modify its findings on the 10 claims at issue because Surgical Sock did not provide sufficient evidence to do so. In response to the SOF, Surgical Sock submitted four different prescriptions with service dates unrelated to the service dates listed on four of MFD's sampled claims. Given that inconsistency, MFD did not modify its results for those four claims.

Additionally, Surgical Sock submitted two signed prescriptions related to two claims that had been denied for lack of a physician's signature. MFD rejected these signed prescriptions because they conflicted with the prior unsigned prescriptions. For the remaining four claims, MFD also found that the supplemental documentation Surgical Sock provided remained deficient. In two of these four claims, Surgical Sock provided patient medical records that did not clarify or cure the deficient prescriptions. In one medical record, there was no diagnosis or notation that indicated the recipient needed compression stockings. In the other patient's medical record, the name of the physician that Surgical Sock notated on the invoice for the claim service date was not listed anywhere in the patient's file. Similarly, for two remaining claims, the prescriptions provided with the supplemental documentation did not include the prescriber's signature. For the remaining claim, the provided prescription lacked a diagnosis.

Finally, Surgical Sock mistakenly cited *N.J.A.C.* §10:49-5.6(a)(13)(iii). This regulation is not applicable to the claims at issue. MFD believes Surgical Sock intended to reference *N.J.A.C.* §10:49-5.5(a)(13)(iii). MFD agrees that reimbursement is not contingent solely on a prescription and an invoice, however, these documents do not support the necessity of the item prescribed and dispensed to the patient. For billing purposes, these documents must be viewed in relation to *N.J.A.C.* 10:49-9.8, which requires providers to "keep such records as are necessary to disclose fully the extent of services provided." Although *N.J.A.C.* §10:49-5.5(a)(13)(iii) does allow for other evidence supporting the performance of services, this evidence must be clear and convincing. As Surgical Sock did not provide

MFD with clear and convincing supplemental documentation that would persuade MFD to change its audit findings, MFD denied these 10 claims due to deficient physician orders.

Surgical Sock's Objection #3
Upcoding

"In the Draft Audit Report, the OSC asserts that the Surgical Shop billed for Healthcare Common Procedure Coding System ('HCPCS') codes A6531, A6539, and A6540 in 29 claims without proper support: i.e., that there was no record of the length of compression stockings prescribed (22 instances) or no record of the compression of the stockings prescribed (2 instances), or both (5 instances).

"We strongly disagree. In this regard, we would note generally that, contrary to the MFD's contention, full reimbursement by Medicaid is not contingent on a physician's prescription or an invoice alone containing all pertinent claim information. Rather, '**Any other evidence** of the performance of the services shall be admissible…' *N.J.A.C. §10:49-5.6(a)(13)(iii)* (emphasis added).

"MFD has taken the position that a valid prescription for compression stockings must include both a pressure gradient and a length. This assumption does not stand up to scrutiny. As a matter of industry practice, prescriptions often omit either or both the pressure gradient or length and leave it to the dispensing provider and a trained fitter to determine the appropriate level of compression and length of the stockings that fit each patient. The Surgical Shop has been in business for almost 30 years and has been subject to audits initiated by other payers, no other payer ever found that a prescription for compression stockings had to include a grade and length or if the prescription lacked one or the other and a different product was dispensed by the fitter that it constituted up-coding."

MFD's Response No. 3

MFD disagrees with Surgical Sock's objection based on two regulations, *N.J.A.C.* 10:59-1.5(a)2, which states that a prescription shall contain "a description of the specific supplies and/or equipment prescribed" and *N.J.A.C.* 10:49-9.8, which states that providers must "keep such records as are necessary to disclose fully the extent of services provided." Both the compression gradient and length are critical parts of the description needed for compression stockings and both must be included on the prescription and maintained by the provider in order for the provider's claim to be valid and payable.

In addition, Surgical Sock again mistakenly cited *N.J.A.C.* §10:49-5.6(a)(13)(iii) when it likely meant to cite *N.J.A.C.* §10:49-5.5(a)(13)(iii). As discussed above, a properly completed prescription and an invoice are needed to support the necessity of the item prescribed and dispensed to the patient. To state that it is industry practice for medical professionals to submit prescriptions to a DME provider without any indication of the pressure gradient or length needed and for the DME provider to apply its judgment to determine the appropriate level of compression and length for a patient is speculative and

unsupported. Surgical Sock did not provide MFD with clear and convincing documentation that would persuade MFD to change its audit findings. Therefore, MFD denied these 29 claims due to upcoding.

Surgical Sock's Objection #4
Improper Use of CPT Code 97760

"OSC also asserts in the Draft Audit Report that, in eight instances, the Surgical Shop billed CPT code 97760 in conjunction with compression procedure codes; but, that it did not have supporting documentation that it provided such management and training. OSC further asserts that Surgical Shop billed CPT code 97760 as a fitting fee for off-the-shelf compression stockings when procedure code 97760 can only be billed in specific circumstances for management and training related to orthotics, not fittings for compression stockings.

"This allegation ignores the pertinent conduct by the State's Managed Care Organization, United Healthcare. In late 2010, UnitedHealthcare and the Surgical Shop negotiated a Facility Participation Agreement. As reflected in the final agreement, which was previously submitted to the OSC on June 24, 2020, the Surgical Shop negotiated for a fitting fee to be reflected via the use of CPT code 97760, which was duly included in the fee schedule offered by UnitedHealthcare and accepted by the Surgical Shop. It was only used when Surgical Shop fitters had to spend a significantly longer time with certain patients because of the complexity of their care. The additional time spent was documented on the invoice when the fitter filled out an additional section marked 'For Office Use Only'. Furthermore, the Surgical Shop stopped using CPT code 97760 in January 2016, when UnitedHealthcare implemented a requirement for obtaining Prior Approval."

MFD's Response No. 4

MFD did not modify its findings regarding these eight claims. These claims were for CPT code 97760, which is defined as orthotic(s) management and training. Surgical Sock sought credit for these claims despite the fact that these claims were for compression stocking fittings, not orthotics fittings. In support, Surgical Sock pointed to a Participation Agreement (Agreement) it entered with UHC. The plain language of that Agreement, however, does not support Surgical Sock's position.

Pursuant to the Agreement, the relevant code, CPT code 97760, is an *orthotic(s)* management and training code. There is no provision in the Agreement that would allow Surgical Sock to use this code to bill a fitting fee for compression stockings. MFD conferred with UHC regarding this code. UHC advised MFD that CPT code 97760 should be used only for *orthotics* management and training, not for fitting or other services related to compression stockings.

Surgical Sock's Objection #5
General Objections to Statistical Sampling and Extrapolations

"The Surgical Shop further objects to the use of the statistical sampling and extrapolation in the Audit, and expressly reserves the right to challenge the OSC's sampling and extrapolation methodologies, including, but not limited to: the sampling plan (including, but not limited to, the sampling frame, sample unit, sample design, sample size and population quantities to estimate); any and all documents describing any and all steps taken to create and verify the reliability of the sample frame; the random seed(s) used to generate the random numbers for the sample; the output(s) of the program used to generate the random number for the sample(s); the numbered frame used to pull the statistical sample(s); all file(s) with the overpayment amount for each sample item; all file(s) with the output from the valid statistical software program used to analyze any and all sample results; any and all communications with technical and/or subject matter experts about the sampling timeframe; all file(s) with overpayment calculations; all documents, information, and file(s) related to whether a 'probe' or 'pilot' sample was performed in connection with Audit, and if not, an explanation of why a probe or pilot sample was not performed; all other documents, information and files relating to the statistical sampling used in connection with the Audit (including, but not limited to, as to the statistical validity of the sample(s) and confidence level(s) used in the Audit); and the calculation of the overpayment demand based on the OSC's Draft Audit Report."

MFD's Response No. 5

MFD provided Surgical Sock with the random sample and extrapolation data, which included the sampling plan, the universe, and a recovery summary that could be used to reproduce MFD's sample and extrapolation results. Although Surgical Sock stated that it objected to MFD's use of the statistical sampling and extrapolation, it did not offer any substantive argument in support of its objection. MFD stands behind its sampling and extrapolation process and the results of that process.