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February 26, 2019

BY ELECTRONIC and CERTIFIED MAIL

Dr. Luis Mendoza
Passaic Vision Center, LLC
289 Monroe Street
Passaic, NJ 07055

RE: Final Audit Report: Dr. Luis Mendoza, MD and Passaic Vision Center, LLC

Dear Dr. Mendoza:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD) audited Medicaid claims submitted by Dr. Luis Mendoza and Passaic Vision Center, LLC (collectively referred to as Passaic). The period of review was January 1, 2012 through May 4, 2018. MFD hereby provides you with this Final Audit Report (FAR).

Executive Summary

MFD performed an audit to determine whether Passaic appropriately billed for ophthalmology services in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether Passaic separately billed and received payment for evaluation and management (E&M) service Current Procedural Terminology (CPT) codes (99201-99214) and general ophthalmological service CPT codes (92002-92014) for the same recipients on the same day. From a universe of 2,688 claims, MFD selected two stratified random samples of claims.[1] MFD selected each sample from a unique universe of claims, which means that no claims in

1 After initially reviewing these 2,688 claims, MFD identified a potential overlap with 432 claims ("Vision universe"), where it appeared that Passaic billed an E&M service and a different provider (other than Passaic) billed a general ophthalmological service, on the same day for the same recipient. To validate whether these claims overlapped, MFD selected a stratified random sample of 118 claims ("Vision sample") for testing. After reviewing these 118 claims and their associated medical records and payment information, MFD determined that there were no overlapping claims. From the remaining universe of 2,256 claims ("Mendoza universe"), MFD selected a stratified random sample of 212 claims ("Mendoza sample") for testing. Although these two universes of claims derive from Passaic claims, MFD treated them separately in order to ensure the integrity of the extrapolation results.

the first universe ("Mendoza universe") overlapped with any claims in the second universe ("Vision universe"). The sample selected from the Mendoza universe consisted of 212 claims ("Mendoza sample"); the sample selected from the Vision universe consisted of 118 claims ("Vision sample"). The total resulting sample consisted of 330 claims. All of the claims in both samples were paid to Passaic.

MFD found that 112 of 212 (52 percent) Mendoza sample claims, totaling $6,319.51, and 59 of 118 (50 percent) Vision sample claims, totaling $3,265.40, violated *N.J.A.C.* 10:49-9.8 for failing to adhere to the American Medical Association's (AMA) CPT guidelines, the AMA's Healthcare Common Procedure Coding System (HCPCS) guidelines, and the Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual for Medicaid Services (Medicaid NCCI).

Specifically, in the Mendoza sample, MFD found that Passaic improperly billed and was paid for: a) 95 claims where general ophthalmological services were billed separately from E&M services for the same recipients, on the same day; b) 5 claims where intermediate services were billed separately from comprehensive services for the same recipients, on the same day; c) 5 claims for unsubstantiated services; and, d) 7 claims for which Passaic failed to provide documentation. In the Vision sample, MFD found that Passaic improperly billed and was paid for 59 claims where general ophthalmological services were billed separately from E&M services for the same recipients, on the same day.

For purposes of ascertaining a final recovery amount, MFD extrapolated the error rate for claims that failed to each respective universe of claims from which the sample claims were drawn, as shown in Table I. The Mendoza universe consisted of 2,256 claims totaling $156,369.51, and its corresponding sample contained 212 claims totaling $14,141.26. The Vision universe consisted of 432 claims totaling $30,518.38, and its corresponding sample contained 118 claims totaling $8,091.05. Based on this extrapolation, MFD determined that the dollar amount of improper claims is $62,820.84 for the Mendoza sample and $11,969.28 for the Vision sample, for a total overpayment of $74,790.12.

Table I
Total Extrapolated Overpayment Amount

	Universe Claims	**Universe Dollars Paid**	**Sample Claims**	**Sample Dollars Paid**	**Extrapolated Overpayment**
Mendoza	2,256	$156,369.51	212	$14,141.26	$62,820.84
Vision	432	$ 30,518.38	118	$ 8,091.05	$11,969.28
Total	**2,688**	**$186,887.89**	**330**	**$22,232.31**	**$74,790.12**

Background

The Medicaid NCCI guidelines designate service codes 99201 through 99214 for E&M services and 92002 through 92014 for general ophthalmological services. E&M codes are for comprehensive services, which include patient history, examination, and medical decision making. General ophthalmological service codes are used for services such as examination and evaluation, the initiation of diagnostic services, and development of a treatment program. Under the CPT coding guidelines, when a provider seeks payment from the Medicaid program for these two types of services (E&M and general ophthalmological services) to the same recipient on the same day, the two services are to be billed together in a bundled manner only as an E&M service.

The Medicaid NCCI designates service codes 92004 and 92014 for comprehensive services and 92002 and 92012 for intermediate services. According to the Medicaid NCCI, if a procedure is described as an "intermediate" procedure and another procedure performed for the same recipient on the same date of service is described as a "comprehensive" procedure, then, for billing purposes, the "intermediate" procedure is included in the "comprehensive" procedure and only the comprehensive procedure is billed. In other words, under these guidelines (CPT coding and Medicaid NCCI), when a provider seeks payment from the Medicaid program, these two services should be billed together in a bundled manner only as a comprehensive service when these services are provided to the same recipient on the same day.

As a condition of participation in the Medicaid program, Medicaid providers are required to adhere to all applicable state and federal laws. Similarly, the state contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and the Managed Care Organizations (MCO), requires MCOs and their providers to adhere to applicable New Jersey laws and regulations.

Objective

The objective of this audit was to evaluate claims billed by and paid to Passaic to determine whether it billed claims in compliance with Medicaid requirements under state and federal laws and regulations.

Scope

The audit period was January 1, 2012 through May 4, 2018. The audit was conducted under the authority of the Office of the State Comptroller *N.J.S.*A. 52:15C-23 and the Medicaid Program Integrity and Protection Act*, N.J.S.A.*30:4D-53 *et seq*.

Audit Methodology

MFD's methodology consisted of the following:

- Applying AMA CPT Code guidelines and the Medicaid NCCI Policy Manual to a statistically valid sample comprised of 212 claims (Mendoza sample) for E&M and general ophthalmological services performed on the same day for the same recipients totaling $14,141.26, selected from a population of 2,256 claims totaling $156,369.51;

- Applying the AMA CPT Code guidelines and the Medicaid NCCI Policy Manual, to a statistically valid sample comprised of 118 claims (Vision sample) for E&M and general ophthalmological services performed for the same recipient on the same day totaling $8,091.05 selected from a population of 432 claims totaling $30,518.38; and

- Reviewing Passaic records to determine whether proper documentation exists to substantiate paid claims and to ensure claims have been properly billed.

Audit Findings

Unbundling of CPT Codes

MFD found that for 95 of 212 claims totaling $5,205.80 in the Mendoza sample, and 59 of 118 claims totaling $3,265.40 in the Vision sample, Passaic unbundled and billed general ophthalmological services, CPT codes 92002-92014, separate from E&M services, CPT codes 99201-99214, for the same recipients on the same day. Providers should not separately bill general ophthalmological services from E&M services when these services were performed for the same recipient on the same date.[2]

The NCCI Policy Manuals for Medicaid Services, Chapter 11, states:

> General ophthalmological services (CPT codes 92002-92014) describe components of the ophthalmologic examination. When evaluation and management (E&M) codes are reported, these general ophthalmological service codes (e.g., CPT codes 92002-92014) should not be reported separately. The E&M service includes the general ophthalmological services.

[2] In 42 of the 95 Mendoza sampled claims and 14 of the 59 Vision sampled claims where MFD found that Passaic improperly unbundled and billed general ophthalmological services separate from E&M services for the same recipients on the same day, MFD found that Dr. Mendoza unbundled services performed by other Passaic physicians. In these cases, a Passaic physician performed E&M services, which included general ophthalmological services, and Passaic submitted a claim and was paid for the E&M services. Dr. Mendoza unbundled such claim for E&M services and submitted an additional claim, showing Dr. Mendoza as the servicing provider, for general ophthalmological services for that same recipient on the same date of service. The documentation, however, did not provide any support for Dr. Mendoza having provided general ophthalmological services on those dates for those recipients.

To avoid overlap, MFD does not seek recovery for these unbundled claims because they constitute a subset of claims for which MFD is seeking a recovery.

MFD found that for 5 of 212 Mendoza sample claims, totaling $278, Passaic submitted claims for intermediate eye examination services, CPT codes 92002 and 92012, which were unbundled and separately billed with comprehensive eye examination services, CPT codes 92004 and 92014, for the same recipients on the same day. Providers should not bill intermediate services separately from comprehensive services when performed for the same recipient, on the same date, but rather should bill only for the comprehensive service.

NCCI Policy Manuals for Medicaid Services, Chapter 1, states:

> If two procedures only differ in that one is described as an 'intermediate' procedure and the other as a 'comprehensive' procedure, the 'intermediate' procedure is included in the 'comprehensive' procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

Unsubstantiated Services Billed

MFD found that for 5 of 212 Mendoza sample claims, totaling $380.59, Passaic failed to possess documentation to support the sampled claims. Specifically, the medical records or billing information did not correspond with the Medicaid paid claims data. Providers are required to keep records that fully document the services provided and submit claims based on true, accurate and complete information.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete." Pursuant to *N.J.A.C.* 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

Undocumented Services

MFD found that for 7 of the 212 Mendoza sample claims, totaling $455.12, Passaic did not provide medical records for the sampled dates of service. Providers are required to maintain documentation showing that services were rendered to the recipient including necessary information as to the treatment provided, and any other information pertinent to the recipient's clinical course.

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

Summary of Overpayments

Based on its review, MFD determined that 112 of the 212 Mendoza sample claims, totaling $6,319.51, and 59 of the 118 Vision sample claims, totaling $3,265.40, failed to comply with state and federal requirements. For purposes of ascertaining a final recovery amount,

the dollars in error for claims that failed to comply with state and federal regulations were extrapolated to the total population of claims of the respective universe from which the sample claims were drawn, which in this case was 2,256 claims totaling $156,369.51 for the Mendoza universe and 432 claims totaling $30,518.38 for the Vision universe. By extrapolating to each universe of claims/reimbursed amounts, MFD determined that Passaic received an overpayment of $62,820.84 for the Mendoza sample and $11,969.28 for the Vision sample, totaling $74,790.12. For the reasons set forth above, MFD is seeking a recovery of $74,790.12.

Recommendations

Passaic must:

1. Reimburse Medicaid the overpayment amount of $74,790.12.

2. Provide training to staff to foster compliance with applicable state and federal laws and regulations.

3. Remain current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.

4. Provide MFD with a Corrective Action Plan indicating the steps it will take to implement procedures to correct the deficiencies identified in this FAR.

Auditee Response

In a written response, Passaic stated that it agreed with the audit findings and provided a Corrective Action Plan to address the recommendations above. Passaic also described the specific steps that it took or will take to implement the recommendations above. The full text of Passaic's response letter is included as an Appendix to this FAR.

MFD Comments

MFD notes that Passaic agrees with the audit's findings and recommendations. Accordingly, MFD requests that Passaic reimburse the Medicaid/NJFC program $74,790.12 and that Passaic initiate steps to correct the findings identified in the FAR. Given Passaic's agreement with the findings and recommendations and its stated corrective actions, MFD believes that no further action is necessary with respect to this audit.

Thank you for your attention to this matter.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: _____
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February 20, 2019

BY ELECTRONIC and CERTIFIED MAIL

Sanjeev Bassi
Auditor-In-Charge-MFD
Michael M. Morgese
Audit Supervisor
David J. Couture
Auditor-Office of the State Comptroller

RE: Medicaid Audit 2018

I read carefully your **Draft Audit Report** and I totally agree with your findings and conclusions.

Regarding your **Recommendations:**

1. **Corrective Action Plan**

   Problem: "a) ...claims where general ophthalmological services were billed separately from E&M services for the same recipients, on the same day;"
   Solution: This will not happen anymore because we are to use mainly de ophthalmological codes and not the E&M codes.

   Problem: "...intermediate services were billed separately from comprehensive services for the same recipients, on the same day;"
   Solution: This will not happen again because we will follow the definitions of the codes 92002, 92004, 92012 and 92014 for each encounter and each patient.

   Problem: "5 claims for unsubstantiated services;"
   Solution: In these 5 claims the E&M codes were used improperly. These patients had a vision problem that only needed prescription of glasses. In these cases the ophthalmological codes should be used, and that is what we are going to do from now on.

Appendix

Problem: "7 claims for which Passaic failed to provide documentation."
Solution: Better care for the filing of Medical Records in the EMR system. These 7 claims were not found in the Electronic Medical Records of our office. The explanation is that we made a change in the EMR we were using for a better one and some records got lost, misplaced or vanished. Fortunately nothing serious happened to these patients as they are still our patients and doing well.

Problem: "...Passaic improperly billed and was paid for 59 claims where general ophthalmological services were billed separately from E&M services for same recipients, on the same day."
Solution: This has to do with the Refraction exam code 92015 or the prescription of eyeglasses for the correction of Myopia, Hyperopia, Astigmatism and Presbyopia. We will use only the Ophthalmological Codes for this exam at a separate visit at a different date from the medical exam.

Problem: Unbundling: Use of several CPT codes for a service when one inclusive code is available.
The practice of expanding into individual units a group of diagnostic or procedural test c odes—based on the 4th edition of
Current Procedural Terminology (CPT) coding promulgated by the American Medical Ass ociation
that might have beenpreviously included as a 'panel', to maximize Reimbursement from third party payers.
Solution: We will follow the rules regarding the use of the Ophthalmological codes, CPT 92002-92014 and the E&M services, CPT codes 99201-99214. These codes will be used only in the appropriate way in a manner that the will not be used for the same recipients on the same day.

Problem: "...MFD found that Dr. Mendoza unbundled services performed by other Passaic physicians.
Solution: The explanation of these unbundled services was that the other physician that saw these patient used the E&M codes for the initial medical visit and this physician was not register or in the panel for the prescription of eyeglasses as was Dr. Mendoza.

Superior Vision (Amerigroup), March Vision (United Healthcare), and Davis Vision (Horizon) these optical suppliers require to be registered with them in order to order the prescription of eyeglasses and contact lenses.
Steps to prevent this problem we already have taken. Dr. [redacted] already sent the applications to these three companies.

2. **Reimburse to Medicaid of overpayment of $74,790.12.**
   I agree in the reimbursement of this amount. I would like to set up a payment plan over a five year term, with monthly payments.

3. **Provide training to staff to foster compliance with applicable state and federal laws and regulations.**
   Dr. [redacted] and [redacted] (manager) have been to Chicago to attend the last Annual Meeting of the American Academy of Ophthalmology, in September 2018, regarding the latest in 2019 CPT and MIPS Update by [redacted], MD., MBA – Medical Director for Governmental Affairs.
   This coming March 27 [redacted] and [redacted] will be attending a Seminar on Ophthalmology Coding: by NJAO 2019 Coding Conference. Topics that will be covered: Billing Rules Affecting Diagnostic Teste Billing, Surgery Billing, Utilization Analysis.

4. **Remain current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.**
   The first step, that we will have the manuals on hand for the AMA and AAO.
   The second step, we will stay update with new regulations and laws through the internet and manuals, new letters and communications from all insurance companies.
   The third step, check with payer for specific coverage. This will be done mainly via email with Insurance representatives.

Sincerely,

Luis Mendoza, MD