



# 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*

September 15, 2022

## BY ELECTRONIC MAIL

Edward Montoya, DPM  
300 Washington Avenue  
Elizabeth, NJ 07202

Re: **Final Audit Report – Edward Montoya, DPM** [REDACTED]

Dear Dr. Montoya:

As part of its oversight of the New Jersey Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims that Edward Montoya, DPM (Dr. Montoya) submitted under National Provider Identification Number [REDACTED] for the period from May 22, 2014 through May 21, 2019 (audit period). OSC hereby provides you with this Final Audit Report (FAR).

## Executive Summary

Dr. Montoya is a licensed podiatrist and surgeon who also is board certified by the American Board of Multiple Specialties in Podiatry. Dr. Montoya joined the Medicaid program on October 16, 2013 and maintains four office locations in New Jersey: Elizabeth, Passaic, Perth Amboy, and Avenel. OSC reviewed Medicaid claims paid to Dr. Montoya during the audit period to determine whether Dr. Montoya billed in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether Dr. Montoya correctly billed for office visits and custom inserts.

During the audit period, Dr. Montoya received \$2,385,299 in Medicaid payments from 32,346 paid claims. This audit focused on beneficiary dates of service (DOS) that included the following codes: Centers for Medicare & Medicaid Services (CMS) Healthcare Common Procedure Coding System (HCPCS) L3000 and American Medical Association (AMA) Current Procedural Terminology (CPT) codes 99203 and 99213. The audit universe included 2,870 DOS, or 6,722 claims, totaling \$1,067,557 in Medicaid payments. See Exhibit I for a description of each code.

From the audit universe, OSC reviewed a statistical sample of 73 DOS that included 180 Medicaid claims, totaling \$29,712 in Medicaid funds paid to Dr. Montoya. OSC determined that Dr. Montoya

failed to bill properly 114 of the 180 claims (57 of 73 DOS). OSC found monetary errors in 110 of the 180 claims (55 of 73 DOS) sampled, totaling \$10,606 out of \$29,712 paid claims (36 percent), where Dr. Montoya violated N.J.A.C. 10:49-9.8 by not maintaining documentation that fully documented the services provided, and/or by inaccurately billing HCPCS/CPT codes. The errors included claims that Dr. Montoya (i) upcoded (billed at a higher paying code than permitted), (ii) failed to adequately support with manufacturer invoices, and/or (iii) failed to provide proof of delivery. In the other four claims, as discussed further below, OSC found that Dr. Montoya billed Medicaid prior to having dispensed the item, which is not appropriate, but constitutes a non-monetary finding because OSC was able to obtain reasonable assurance that the beneficiary subsequently received the item as ordered and billed.

For purposes of ascertaining a final recovery amount, OSC extrapolated the net error dollars for DOS that failed to comply with state regulations to the total dollars in the universe from which the sample of DOS were drawn, which in this case was 2,870 DOS, comprised of 6,722 claims with a total payment of \$1,067,557. By extrapolating the net dollars in error over the entire audit universe, OSC calculated that Dr. Montoya improperly received an overpayment of at least \$333,408.21 that Dr. Montoya must repay to the Medicaid program.<sup>1</sup>

As part of the findings above, OSC found that in 42 sampled custom insert claims, Dr. Montoya billed Medicaid before providing the items to beneficiaries. OSC seeks a monetary recovery in 38 of those instances because those claims either failed because they lacked a manufacturer invoice or proof of delivery, or were coded improperly. OSC does not seek a monetary recovery in the remaining four instances because there was sufficient evidence in the record to show that the beneficiary received the item. Nonetheless, Dr. Montoya should discontinue this practice because it is improper to bill in advance of providing a service. Moreover, this practice may have contributed to several of the deficiencies identified in this report, such as Dr. Montoya receiving payment for custom inserts when there was no evidence that the beneficiaries received the inserts.

## **Background**

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) contracts with five Managed Care Organizations (MCOs) to administer the provision of health care services to Medicaid beneficiaries in New Jersey. That contract requires MCOs and their network providers to adhere to applicable state and federal laws and regulations. As part of Dr. Montoya's application to join the Medicaid program and become a provider in one or more MCO networks, Dr. Montoya agreed to comply not only with state and federal laws and regulations, including the provider certification and recordkeeping requirements set forth in N.J.A.C. 10:49-9.8, but also with the guidelines established by each MCO with whom he contracted. 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."

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<sup>1</sup> Using the "Difference Method" for extrapolation, OSC can reasonably assert, with 90% confidence, that the total overpayment in the universe is greater than \$333,408.21 (9.97% precision) with the error point estimate as \$370,346.10.

Pursuant to N.J.S.A. 45:5-7, podiatric medicine is defined as:

the diagnosis or treatment of or the holding out of a right or ability to diagnose or treat any ailment of the human foot or ankle, including local manifestations of systemic diseases as they appear on the lower leg, foot or ankle but not treatment of systemic diseases of any other part of the body, or the holding out of a right or ability to treat the same by any one or more of the following means: local medical, mechanical, surgical, manipulative and physio-therapeutic, including the application of any of the aforementioned means to the lower leg and ankle for the treatment of a foot or ankle ailment.

Durable Medical Equipment (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 not useful to a beneficiary in the absence of a disease, illness, injury or disability and is capable of withstanding repeated use . . . .

According to N.J.A.C. 10:55-1.2, an orthotic appliance is a device or a brace used to provide support, increased function, and to overcome physical impairment or defects.

During the audit period, Dr. Montoya submitted 32,346 Medicaid claims for which Dr. Montoya received payments totaling \$2,385,299. OSC selected the audit sample from DOS that included the following codes: HCPCS L3000 and CPT codes 99203 and 99213, which, Dr. Montoya collectively billed on 2,870 DOS, or 6,722 claims, totaling \$1,067,557 in Medicaid payments. The audit universe consisted of claims for only office visits and custom inserts. Table I provides a breakdown of the audit universe summarized by category of the item description, HCPCS/CPT codes, number of claims, and claim amount.

**Table I: Total Billings and Claims Paid Within the Audit Universe**

| Category Description | HCPCS/ CPT Codes | Number of Claims | Claim Amount       |
|----------------------|------------------|------------------|--------------------|
| Custom Inserts       | L3000            | 5,740            | \$1,017,875        |
| Office Visits        | 99203, 99213     | 982              | \$49,682           |
| <b>Total</b>         |                  | <b>6,722</b>     | <b>\$1,067,557</b> |

Shoe inserts are total contact, multiple density, removable inlays that are molded directly to a patient's foot or customized from a model of a patient's foot to correct foot function and minimize stress. Dr. Montoya primarily billed shoe inserts using HCPCS code L3000, which requires the supply of a removable foot insert custom fabricated from a model of the patient's foot. CPT codes 99203 and 99213 represent an office visit for new patients and established patients, respectively.

## Audit Objective

The objective of the audit was to determine whether claims for office visits and custom inserts submitted by and paid to Dr. Montoya complied with Medicaid requirements under applicable state and federal laws and regulations.

## Audit Scope

The audit scope was paid claims with dates of service from May 22, 2014 through May 21, 2019. This audit was conducted 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 to -64.

## Audit Methodology

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

- Selecting a statistical sample of 73 Medicaid beneficiaries' DOS that included 180 paid claims, totaling \$29,712. These 73 DOS included HCPCS code L3000 (custom inserts) and CPT codes 99203 and/or 99213 (office visit), and were selected from a total universe of 2,870 DOS, comprised of 6,722 paid claims, for which Medicaid paid Dr. Montoya a total of \$1,067,557.
- Reviewing records to determine whether Dr. Montoya maintained documentation that complied with the requirements of N.J.A.C. 10:49-1.1 to -24.5, including N.J.A.C. 10:49-9.8.

## Audit Findings

OSC reviewed the patient records associated with the 180 sampled Medicaid claims for custom inserts and office visits. OSC determined that 114 of the 180 claims (57 of 73 DOS) sampled were in error. OSC found monetary errors in 110 of the 180 claims (55 of 73 DOS) sampled, totaling \$10,606 out of \$29,712 paid claims (36 percent), where Dr. Montoya violated N.J.A.C. 10:49-9.8 by not maintaining documentation that fully documented the services provided, and/or by inaccurately billing HCPCS/CPT codes. The identified overpayments included claims that Dr. Montoya (i) upcoded (billed at a higher paying code than warranted), (ii) failed to adequately support with manufacturer invoices, and/or (iii) failed to provide proof of delivery. OSC found in the other four claims that Dr. Montoya billed Medicaid prior to having dispensed the item, which is not appropriate, but constitutes a non-monetary finding because OSC was able to obtain reasonable assurance that the beneficiary subsequently received the item as ordered and billed. See Table II for a breakdown of the identified exceptions (i.e., claims that failed to meet the state regulations) and Exhibit II for an individual sample claim breakdown by exception.

**Table II: Audit Exceptions**

| Exception Type                                | Number of Claims In Error | Claim Dollar Amount In Error | Percentage of Sample Dollars in Error to Total Dollars Sampled (\$29,712) |
|---|---------------------------|------------------------------|---|
| Upcoding                                      | 100                       | \$8,378                      | 28%   |
| No Proof of Delivery                          | 6                         | 1,060                        | 4%  |
| No Manufacturer Invoice                       | 4                         | 1,168                        | 4%  |
| <b><i>Subtotal of monetary exceptions</i></b> | <b>110</b>                | <b>\$10,606</b>              | <b>36%</b>  |
| Non-monetary (Billed before delivery)         | 4                         | 0                            | 0%  |
| <b>Grand Total</b>                            | <b>114</b>                | <b>\$10,606</b>              | <b>36%</b>  |

OSC extrapolated the sample results to the Audit universe and determined that Dr. Montoya received a total overpayment of at least \$333,408.21. OSC’s findings regarding each of the exception types are discussed below.

In addition to the monetary findings above, OSC found that in 42 of the sampled claims, Dr. Montoya improperly billed the Medicaid program prior to dispensing the item billed. OSC seeks a recovery in 38 of these instances where OSC found one or more regulatory violation for each. In the remaining four claims, OSC is not seeking a monetary recovery because there is sufficient evidence in the record to show that the beneficiary received the item Dr. Montoya billed.

### **A. Upcoding**

For each sample claim, OSC compared the information written in the beneficiary’s medical record to the insert order forms sent to the manufacturer and the third party invoices received from the manufacturer to determine whether the item provided to the beneficiary matched the HCPCS code description of an L3000 insert.<sup>2</sup>

OSC found that in 100 out of 180 claims, totaling \$8,378 out of the \$29,712 sampled, Dr. Montoya did not maintain the documentation necessary to support billing for L3000 custom inserts. Specifically, Dr. Montoya failed to maintain complete insert order forms, and the manufacturer invoices failed to demonstrate that the manufacturer had provided Dr. Montoya with L3000 inserts. Based on a review of the documentation provided, OSC could not determine whether Dr. Montoya had dispensed L3000 inserts. Consequently, OSC downcoded 92 of the 100 claims to L3010 (Foot, insert, removable, molded to patient model, ‘UCB’ type, Berkeley shell, each) and the remaining eight claims to L3002 or L3030.

<sup>2</sup> Per HCPCS official code description, L3000 should be billed for foot insert, removable, molded to patient model, “UCB” type, Berkeley Shell, each. The provider should report this code for the supply of each removable foot insert molded from a three-dimensional model of the patient’s own foot. This code includes the supply of a rigid insert that may be made of plastic, leather, or other synthetic material.

The following is an example of an L3000 claim that OSC downcoded to L3010. According to Dr. Montoya's records, on August 12, 2017, Dr. Montoya casted a beneficiary for a pair of "prescription orthotics." In the pre-populated insert order form that Dr. Montoya sent to the third-party manufacturer, Dr. Montoya checked off the boxes marked "cork device" and "extension full foot" for the beneficiary. Dr. Montoya failed to complete several other boxes on the insert order form such as heel depth or posting instructions. The third-party manufacturer's invoice stated that the manufacturer had provided Dr. Montoya with "semi rigid cork devices." Since OSC could not reasonably determine whether the item the beneficiary received was the item prescribed, OSC downcoded the claim to a lower paid insert HCPCS code (procedure code L3010). *See Attachment I.*

N.J.A.C. 10:49-9.8 requires providers to "keep such records as are necessary to disclose fully the extent of services provided." Dr. Montoya's records show that in these 100 instances Dr. Montoya inappropriately billed HCPCS codes that resulted in higher reimbursement amounts than what Dr. Montoya's documentation could support.

### **B. No Proof of Delivery**

OSC found that in 6 out of the 180 claims, totaling \$1,060 out of the \$29,712 sampled, Dr. Montoya lacked sufficient documentation to demonstrate that he dispensed inserts to beneficiaries. For these six claims, Dr. Montoya failed to provide documentation showing that he had dispensed the prescribed items. For example, on October 20, 2015, Dr. Montoya ordered custom inserts for a beneficiary and, on this same date, billed HCPCS code L3000, for which he was later paid \$280. According to the beneficiary's medical record, however, there was no indication that Dr. Montoya dispensed the inserts to the beneficiary. *See Attachment II.*

Proof of delivery is required because it demonstrates that the Medicaid beneficiary received the item for which the Medicaid provider billed and received payment. In the example above and in the five remaining sample claims, there was no proof of delivery within the beneficiaries' medical records showing that these six beneficiaries received the items for which Dr. Montoya billed and received payment. Accordingly, OSC found that these claims were in violation of N.J.A.C. 10:49-9.8(b).

### **C. No Manufacturer Invoice**

OSC found that Dr. Montoya failed to possess invoices to support 4 of the 180 claims reviewed, totaling \$1,168 out of the \$29,712 sampled. For these four sampled claims, Dr. Montoya did not possess sufficient reliable documentation to demonstrate that Dr. Montoya had obtained these items from a third-party manufacturer.

N.J.A.C. 10:49 9.8(b) requires providers to "keep such records as are necessary to disclose fully the extent of services provided." Since Dr. Montoya failed to maintain invoices to support items billed, OSC finds these four claims totaling \$1,168 to be in violation of N.J.A.C. 10:49 9.8(b).

## D. Non-Monetary Issue

OSC found that for 42 out of the 180 claims reviewed, Dr. Montoya prematurely billed Medicaid for services. Specifically, Dr. Montoya billed Medicaid for 42 custom insert claims before Dr. Montoya provided the items to the beneficiaries. According to N.J.A.C. 10:59-1.7(a), "Medical suppliers may request payment for medical supply services only after the supply/equipment has been delivered to the beneficiary."

OSC is seeking a recovery in 38 of these 42 instances based on one or more additional regulatory violations discussed above. In the remaining four claims, OSC is not seeking a monetary recovery because there is sufficient evidence in the record to show that the beneficiary received the item Dr. Montoya billed. (See Exhibit II.)

## Summary of Overpayments

OSC determined that for the period of May 22, 2014 through May 21, 2019, Dr. Montoya improperly billed and received payment for 114 of the 180 claims (57 of 73 DOS) sampled. Of the 114 claims, four had non-monetary errors. OSC found monetary errors in 110 of the 180 sampled claims (55 out of 73 DOS), totaling \$10,606. OSC extrapolated the dollars in error to the audit universe of 2,870 DOS (6,722 claims) totaling \$1,067,557. By extrapolating the dollars in error over the entire audit universe, OSC calculated that Dr. Montoya received an overpayment of at least \$333,408.21 that Dr. Montoya must repay to the Medicaid program.

## Recommendations

1. Dr. Montoya shall reimburse the Medicaid program \$333,408.21.
2. Dr. Montoya must ensure that each Medicaid beneficiary's medical record contains sufficient information of the services and DME and/or medical supplies provided 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 Dr. Montoya must adhere to state and federal law and regulation and other related guidance, including CMS' HCPCS guidelines and AMA's CPT codes.
4. Dr. Montoya shall maintain sufficient documentation that fully discloses the extent of services provided, DME and medical supplies ordered and delivered to the patient (e.g., require beneficiaries to sign a receipt for DME and medical supplies documenting that the patient received the prescribed item).
5. Dr. Montoya must discontinue billing Medicaid before fully performing the billed service (i.e., billing before delivering the DME or medical supply to the patient.)
6. Dr. Montoya must provide OSC with a Corrective Action Plan (CAP) indicating the steps taken or to be taken to implement procedures and the expected timeline to correct the deficiencies identified in this report.

## Dr. Montoya's Response to the Audit Report Findings and OSC's Comments

After receipt of OSC's Draft Audit Report, Dr. Montoya, through counsel, submitted a written response that included the corrective actions that he had taken to address the report's findings and recommendations (See Appendix A). Specifically, Dr. Montoya agreed with OSC's audit findings and advised that he had implemented processes to address OSC's recommendations regarding his documentation deficiencies and had hired experts, including a registered nurse/certified coder and healthcare attorney/board certified podiatrist, to assist him in improving his documentation. With respect to the \$333,408.21 overpayment, Dr. Montoya stated that while he agreed with OSC's findings, this amount was "excessive" and "not in line with the treatment" he provided to Medicaid beneficiaries.

OSC accepts Dr. Montoya's corrective action plan, but notes that he still must repay the identified overpayment. Dr. Montoya did not offer any evidence to support his assertion that the overpayment demand was "excessive" or how his treatment of Medicaid beneficiaries was relevant to OSC's calculation of the overpayment. OSC notes that it calculated the overpayment from its findings based on statistically valid methods and Dr. Montoya did not challenge OSC's findings or extrapolation methods. Dr. Montoya fails to address the core Medicaid program requirement that applies to all providers – the requirement to submit true, accurate and complete claims, and maintain records as are necessary to disclose fully the extent of services provided. Accordingly, OSC finds no basis to modify the amount due. Consequently, Dr. Montoya must reimburse the Medicaid program the full overpayment of \$333,408.21.

Thank you for your attention to this matter.

Sincerely,

KEVIN D. WALSH  
ACTING STATE COMPTROLLER

By: Josh Lichtblau  
Josh Lichtblau  
Director, Medicaid Fraud Division

Enclosures (Omitted Unless Otherwise Noted):

- Exhibit I – AMA HCPCS Code Descriptions
- Exhibit II – Testing Results Summary
- Attachment I – Example of Upcoding
- Attachment II – Example of No Proof of Delivery
- Appendix A – Dr. Montoya's Response to the Draft Audit Report (Included)

Cc:

Mr. Guillermo J. Beades, Esq. Frier Levitt, LLC  
Don Catinello, Deputy Director, Medicaid Fraud Division, OSC  
Nina Galletto, Supervising Regulatory Officer, Medicaid Fraud Division, OSC

Guillermo J. Beades, Esq.  
direct: 973.852.8354  
gbeades@frierlevitt.com

August 12, 2022

[Via Email \(michael.morgese@osc.nj.gov\)](mailto:michael.morgese@osc.nj.gov)

Michael Morgese, Chief Auditor  
Medicaid Fraud Division  
PO Box 025  
Trenton, NJ 08625-0025

**Re: Edward Montoya, DPM  
Medicaid Fraud Division Audit Response**

Dear Mr. Morgese:

As you are aware this office represents Edward Montoya, DPM (“Dr. Montoya” or “Practice”) in connection with the above-referenced matter.

Please allow the following to serve as our response to the Medicaid Fraud Division’s (“MFD”) critiques concerning Edward Montoya, DPM. As noted during Dr. Montoya’s exit interview, none of the MFD’s concerns involve allegations of fraud, waste, or abuse. The issues raised by the MFD’s auditors involve the sufficiency and/or level of documentation regarding the prescribing and dispensing of pedal orthoses, namely L3000 services. They also involve a minor technical or administrative issue that did not rise to the level of asking for any money to be returned to Medicaid.

We would like to highlight that throughout this process, Dr. Montoya has taken all the MFD’s critiques seriously and has addressed them in a fashion designed to allay any future worries in this regard. As a corrective action, Dr. Montoya is now saving all orthotic lab invoices as well as orthotic order forms. His documentation involving dispensing of the orthoses is more detailed. Dr. Montoya is also working with the lab to make sure that the orthoses being dispensed meet all criteria required by Medicaid guidelines and the AMA’s CPT Manual. Please note that Dr. Montoya is ensuring that patients sign a document stating the date that they received their pedal orthoses as well. Additionally, if a patient fails to pick up their orthoses, Dr. Montoya will mail it to them with a proof of delivery option. Although Dr. Montoya believed he billed every claim correctly that was audited, he understands that his documentation can improve. Towards that end, Dr. Montoya has taken this audit as an opportunity to better educate himself of podiatric coding, with an emphasis on foot orthosis documentation, and we are confident that his documentation going forward will reflect the correct level of orthoses dispensed.

Additionally, please note that our expert, [REDACTED], RN, CPC continues to work with Dr. Montoya to improve his level of documentation. [REDACTED] is a registered nurse, certified in healthcare compliance, a certified professional coder, certified medical professional auditor, certified surgical foot and ankle coder, and a senior consultant with Medical Compliance Associates, Inc. In this matter, [REDACTED] is working with [REDACTED] DPM, JD. [REDACTED] is both a healthcare attorney and a board-

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certified podiatrist by ABQAURP, the American Board of Quality Assurance and Utilization Review Physicians. They will continue to advise Dr. Montoya in increasing his level of documentation and in avoiding any technical or administrative issues in the podiatry arena.

While we understand the MFD's comments concerning Dr. Montoya's coding and documentation, we believe the stated overpayment demand is excessive and not in line with the treatment provided by Dr. Montoya Medicaid beneficiaries.

Should you have any questions or would like to discuss any aspect of this matter further, please do not hesitate to contact me or [REDACTED], DPM, JD, who is assisting me in this matter.

Thank you.

Very truly yours,

**FRIER LEVITT, LLC**

*/s/ Guillermo J. Beades*

Guillermo J. Beades

GJB/lfk