



# State of New Jersey

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*Director*

March 21, 2022

## **BY ELECTRONIC MAIL**

Dr. Fausto Ramos  
Ramos Foot and Ankle Center, LLC  
474 Amboy Ave  
Perth Amboy, NJ 08861

### **Re: Final Audit Report — Ramos Foot and Ankle Center, LLC**

Dear Dr. Ramos:

As part of its oversight of the Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims Ramos Foot and Ankle Center, LLC (RFAC) submitted under National Provider Identification Numbers [REDACTED] and [REDACTED] for the period from July 1, 2014 through June 30, 2019 (audit period). OSC hereby provides you with this Final Audit Report (FAR).

### **Executive Summary**

RFAC specializes in podiatric medicine and is an accredited Durable Medical Equipment, Prosthetics, Orthotics and Supplies (DMEPOS) supplier. RFAC, incorporated in 2008, is located in Perth Amboy, New Jersey. OSC's audit reviewed Medicaid claims submitted by and paid to RFAC during the audit period to determine whether RFAC billed in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether RFAC correctly billed for office visits, orthopedic shoes, inserts, and castings.

During the audit period, RFAC received \$3,629,305 in Medicaid payments from 46,747 claims. To avoid reviewing claims that Managed Care Organizations (MCOs) had previously reviewed, OSC excluded those MCO claims from its audit universe. OSC's audit focused on beneficiary dates of service that included one or more of the following codes: Centers for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) codes L3000, L3010, L3020, L3216, L3221, and S0395 and American Medical Association (AMA) Current Procedural Terminology (CPT) codes 99203 and 99213.

These codes collectively comprise approximately 52 percent of RFAC's total Medicaid billings (\$1.9 million out of \$3.6 million). *See* Exhibit I for a description of each code.

OSC reviewed a statistically valid sample of 130 Medicaid beneficiaries' dates of service (DOS), which was comprised of 324 Medicaid claims totaling \$36,350, submitted by and paid to RFAC with service dates between July 1, 2014 and June 30, 2020. OSC determined that for 27 of the 324 claims (14 of 130 DOS) sampled, totaling \$4,110 out of \$36,350 paid claims (11 percent), RFAC violated *N.J.A.C.* 10:49-9.8 by not maintaining documentation that fully documented the services provided.

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 was drawn, which in this case was 12,783 DOS, comprised of 21,449 claims, with a total payment of \$1,876,769. By extrapolating the net dollars in error over the entire audit universe, OSC calculated that RFAC improperly received an overpayment of \$128,719 that it must repay to the Medicaid program.

In addition to the findings above, OSC found that in 58 sampled claims for custom inserts and orthopedic shoes, RFAC billed Medicaid before it provided these items to the beneficiaries. OSC is not seeking a monetary recovery for these claims on that basis because there is sufficient evidence to show that the beneficiaries ultimately received these items and, when there was not sufficient evidence, OSC is seeking an overpayment based on the lack of proof of receipt. Although OSC is not seeking a recovery based on RFAC's billing before proof of receipt, it recommends that RFAC discontinue this practice because it is improper to bill in advance of providing a service and this practice likely contributed to several of the findings identified below, such as RFAC receiving payment for custom inserts when there was no evidence that the beneficiary received the inserts.

## **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 beneficiaries in New Jersey. Pursuant to RFAC's application to join the Medicaid program, and as a provider in one or more MCO networks, RFAC is required to adhere to applicable state and federal laws and regulations, including the provider certification and recordkeeping requirements set forth in *N.J.A.C.* 10:49-9.8. 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."

*N.J.S.A.* 45:5-7 defines podiatric medicine 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 . . . 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, RFAC submitted 46,747 Medicaid claims for which Medicaid paid RFAC a total of \$3,629,305. To avoid reviewing claims that MCOs had previously reviewed, OSC excluded those MCO claims from its audit universe. This audit sampled from beneficiary dates of service that included one or more of the following: HCPCS codes L3000, L3010, L3020, L3216, L3221, S0395 and/or CPT codes 99203 and 99213, which collectively comprised approximately 52 percent of RFAC’s total Medicaid billings (\$1.9 million out of \$3.6 million). The Audit universe consisted of office visits, custom inserts, orthopedic shoes and castings. Table I provides a breakdown of the Audit universe summarized by category of the item description, HCPCS/CPT codes, number of claims, and dollar amount.

**Table I**  
**Total Billings and Claims Paid based on the**  
**Audit Universe**

<b>Category Description</b>	<b>HCPCS/ CPT Codes</b>	<b>Number of Claims</b>	<b>Claim Amount</b>
Custom Inserts	L3000, L3010, L3020	7,869	\$1,110,720
Orthopedic Shoes	L3216, L3221	2517	238,034
Office Visits	99203, 99213	10,224	481,004
Casting	S0395	839	47,011
<b>Total</b>		<b>21,449</b>	<b>\$1,876,769</b>

Shoe inserts are total contact, multiple density, removable inlays that are directly molded to the patient’s foot or customized from a model of the patient’s foot to correct foot function and minimize stress. Ramos primarily billed shoe inserts using the following codes: L3000, L3010, and L3020. Codes L3000, L3010 and L3020 cover the supply of a removable foot insert custom fabricated from a model of the patient’s foot.

Orthopedic shoes prevent or correct foot deformities by providing arch support, holding the foot in an upright position, and permitting the addition of assistive devices. RFAC

primarily billed Medicaid two orthopedic shoe HCPCS codes: L3216 and L3221. HCPCS codes L3216 and L3221 represent non-custom shoes that provide extra depth and stability for female and male beneficiaries, respectively.

CPT codes 99203 and 99213 represent an office visit for new patients and established patients, respectively. Finally, HCPCS S0395 is billed when an impression casting of a foot is performed by a practitioner other than the manufacturer of the orthotic.

### **Objective**

The objective of the audit was to determine whether claims submitted by and paid to RFAC complied with Medicaid requirements under applicable state and federal laws and regulations.

### **Audit Scope**

The scope of the audit was paid claims with dates of service from July 1, 2014 through June 30, 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 et seq.*

### **Audit Methodology**

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

- Selecting a statistically valid sample of 130 Medicaid beneficiaries' dates of service and the 324 paid claims associated with these dates of service for a total payment of \$36,350 from a total universe of 12,783 DOS, comprised of 21,449 paid claims, for which Medicaid paid RFAC a total of \$1,876,769.
- Reviewing records to determine whether RFAC possessed documentation that complied with the requirements of *N.J.A.C. 10:49-1.1 et seq.* and *N.J.A.C. 10:49-9.8.*

### **Audit Findings**

OSC reviewed 324 Medicaid claims submitted by and paid to RFAC with claim service dates during the audit period. The 324 claims covered orthopedic shoes, custom inserts, casting, and office visits. OSC determined that for 27 of the 324 claims sampled, totaling \$4,110 out of \$36,350 paid claims (11 percent), RFAC violated *N.J.A.C. 10:49-9.8* by not maintaining records that fully documented the services provided. *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**

<b>Exception Type</b>	<b>Number of Claims</b>	<b>Claim Dollar Amount</b>	<b>Percentage of Sample Dollars in Error to Total Dollars Sampled (\$36,350)</b>
No Proof of Delivery	22	\$3,226	9%
Duplicate Claims	3	684	1%
Returns	2	200	1%
<b>Total</b>	<b>27</b>	<b>\$4,110</b>	<b>11%</b>

OSC extrapolated the sample results to the Audit universe to calculate that RFAC received a total overpayment of \$128,719.

In addition to this monetary finding, OSC found that in 58 claims for inserts and shoes, RFAC billed Medicaid before beneficiaries received the inserts and shoes. OSC does not seek a monetary recovery for these billing deficiencies because they did not, standing alone, cause RFAC to receive an overpayment. RFAC should immediately discontinue this practice, however, because it violates the state regulation, may result in improper payments, and likely contributed to several of the findings herein. OSC’s findings regarding each of the four exception types are discussed further below.

**A. No Proof of Delivery**

OSC reviewed 324 claims with 243 of 324 claims consisting of orthopedic shoes and custom inserts. OSC found that for 22 of those 243 claims, RFAC lacked sufficient documentation to demonstrate that it provided the item to the beneficiary. These claims consisted of custom inserts billed under HCPCS codes L3000, L3010, L3020, and orthopedic shoes billed under L3216 and L3221. *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.” Accordingly, providers must maintain proof that each such item paid for with Medicaid funds was delivered to the beneficiary. RFAC did not require beneficiaries to sign for the items acknowledging receipt, and in these 22 claims, the medical records did not indicate that RFAC had provided the beneficiaries with the items. Of the 22 claims that lacked proof of delivery, 14 were for custom inserts and 8 were for orthopedic shoes. These exceptions total \$3,226 out of the universe of \$36,350 paid claims sampled.

For example, on April 21, 2016, a RFAC podiatrist ordered L3000 custom inserts for a beneficiary. Subsequently, RFAC billed Medicaid for the two custom inserts, listed April 21, 2016 as the claim service date, and was paid \$308 for the pair. According to the beneficiary’s medical records, however, the beneficiary did not return to RFAC until January 2017, and just a month later, in February 2017, RFAC initiated the process to

obtain another pair of inserts for the same beneficiary. In this example, RFAC did not provide any proof of delivery for the inserts ordered in April 2016. We further note that this beneficiary did not return to RFAC for an office visit until nine months later, January 2017, at which time RFAC initiated another order for an insert.

Proof of delivery is necessary because it establishes the date of service on the claim and documents that the provider actually performed the services billed. Just as with the deficient claim above, OSC found the remaining 21 claims to be in violation of *N.J.A.C. 10:49-9.8* because RFAC did not provide any proof of delivery.

### **B. Duplicate Claims**

OSC found that 3 of the 324 claims reviewed were duplicative. The three claims in question are composed of two L3000 custom inserts and one L3216 orthopedic shoe. Each claim shares the same beneficiary, date of service, and HCPCS code with three other similar claims billed by RFAC. For example, on August 8, 2016, RFAC provided a beneficiary with a pair of L3000 custom inserts. According to state Medicaid claims data, however, RFAC billed for four custom inserts — two more than it should have. Similarly, in another example, RFAC billed for three L3216 women's shoes, while providing the beneficiary with two. In total, RFAC received \$684 for these three deficient claims.

### **C. Returns**

OSC identified 2 out of the 324 claims in which RFAC billed and Medicaid paid for orthopedic shoes that beneficiaries subsequently returned, but RFAC failed to reverse the Medicaid claim payment. The evidence to support this is contained in RFAC's files, which included return forms showing that RFAC received refunds from the third party supplier from whom it had obtained the shoes. For example, on April 28, 2016, a RFAC podiatrist held an office visit with a beneficiary and subsequently ordered orthopedic shoes and custom inserts for the beneficiary. On the claim, RFAC listed the order date of the items as the claim service date and later received payment for these items. RFAC provided OSC with third party packing slips for the shoes and inserts. OSC's review of the beneficiary's file, however, revealed that RFAC only dispensed the inserts; there was a return authorization form for the shoes. According to the return authorization form, the beneficiary did not want the shoes. Notwithstanding that the beneficiary had returned the shoes, RFAC retained the Medicaid payment for the shoes. RFAC was paid \$200 for the two claims.

*N.J.A.C. 10:49-9.8* requires providers such as RFAC to "keep such records as are necessary to disclose fully the extent of services provided." As a result of the shoe returns, OSC finds that these two claims were in violation of *N.J.A.C. 10:49 9.8(b)*.

#### **D. Non-Monetary**

OSC found that for 58 out of the 324 claims reviewed, RFAC prematurely billed Medicaid for services. Specifically, RFAC billed Medicaid for 58 shoe and insert claims before RFAC provided the items to the beneficiaries, and in some cases, before RFAC had received the items from its third party suppliers. Pursuant 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.” Further, according to guidance provided by CMS, “The date that the beneficiary got the DMEPOS item should be the date of service on the claim.”

For a majority of the 58 claims, the medical records indicate that RFAC provided the services after having billed for them. Nevertheless, 10 of the 58 claims are cited above for other non-compliance issues, such as not having proof of delivery, or for billing for items that were returned to the third party suppliers. These findings were potentially avoidable as illustrated in two of the above examples in which the beneficiary never returned to pick up the prescribed inserts or the beneficiary did not like the shoes, which were subsequently returned to the third party. RFAC must discontinue billing for services before fully providing these services because it violates the state regulation, can result in an improper payment and likely contributed to several of the findings identified above.

#### **Summary of Overpayments**

OSC determined that for the period of July 1, 2014 through June 30, 2019, RFAC improperly billed and received payment for 27 of the 324 claims (14 out of 130 DOS), totaling \$4,110. OSC extrapolated the error dollars to the audit universe of 12,783 DOS (21,449 claims) totaling \$1,876,769. By extrapolating the dollars in error over the entire audit universe, OSC calculated that RFAC received an overpayment of \$128,719 that it must repay to the Medicaid program.<sup>1</sup>

#### **Recommendations**

1. RFAC shall reimburse the Medicaid program \$128,719.
2. RFAC 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. RFAC shall maintain sufficient reliable documentation that fully discloses the extent of services provided, e.g., requiring beneficiaries to sign a receipt for custom inserts and orthopedic shoes documenting that the prescribed items were received.

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<sup>1</sup> OSC can reasonably assert, with 90% confidence that the total overpayment in the universe falls between \$65,700 and \$191,738 with the error point estimate as \$128,719.

4. RFAC must discontinue duplicate billing Medicaid for the same service to the same beneficiary on the same date of service.
5. RFAC shall reimburse the Medicaid program for those items returned to the manufacturer whereby no exchange was provided.
6. RFAC must discontinue the practice of billing Medicaid before fully performing service.
7. RFAC shall provide training to its employees to address the deficiencies identified in this report.
8. RFAC 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.

### **RFAC's Response to the Audit Report Findings and OSC's Comments**

After receipt of OSC's Draft Audit Report (DAR), RFAC, through counsel, submitted a written response and CAP (See Appendix A). In its response, RFAC disagreed with the audit findings, the amount owed, and took issue with OSC's sampling and extrapolation methodology. Despite that, in its CAP, RFAC agreed to implement a delivery ticket system that it asserted would "resolve any issue with how and where the encounter notes detail the delivery of the item..." and "any concern over when an item is exchanged or returned to a manufacturer." RFAC, however, did not address its practice of improperly billing for items prior to delivery. OSC addressed each argument raised by RFAC in a document entitled "RFAC Comments to the DAR and OSC's Response" (See Appendix B).

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:

- Exhibit I - AMA HCPCS Code Descriptions
- Exhibit II – Testing Results Summary
- Appendix A – RFAC's Full Response to the Draft Audit Report
- Appendix B – RFAC's Comments and OSC's Response

Dr. Fausto Ramos  
Ramos Foot and Ankle Center, LLC  
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Cc: Nicole Allocca, Esq.  
Michael Morgese, Chief Auditor (OSC – Medicaid Fraud Division)  
Don Catinello, Supervising Regulatory Officer (OSC – Medicaid Fraud Division)  
Glenn Geib, Recovery Supervisor (OSC – Medicaid Fraud Division)

**Exhibit I**

**HCPCS/CPT Code Descriptions**

<b>Code</b>	<b>Code Descriptor</b>
L3000	Foot, insert, removable, molded to patient model, 'UCB' type, Berkeley Shell, each
L3010	Foot, insert, removable, molded to patient model, longitudinal arch support, each
L3020	Foot, insert, removable, molded to patient model, longitudinal/ metatarsal support, each
L3216	Orthopedic footwear, ladies' shoe, depth inlay, each
L3221	Orthopedic footwear, men's shoe, depth inlay, each
S0395	Impression casting of a foot performed by a practitioner other than the manufacturer of the orthotic
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making

Ramos Billing Summary:										MFD Testing Results:			
Sample	Clm ICN Idn	Clm Rcp Idn	Rep Latest First Name	Rep Latest Last Name	Rep Birth Date	Clm Rep Birth Date	Clm Service Date	Clm Service Units Qty	Clm Payment Amount	Main Finding	Overpayment Code	Overpayment Amount	Additional Notes/Review of additional documentation provided by RFAC in response to SoF
15	201701370577644						11/22/2016	2	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
16	201812470729414						11/22/2016	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
22	201703870304493						1/5/2017	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
23	201703870304494						1/5/2017	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
127	201736370983890						4/28/2016	1	\$ 100.00	Item Returned to Manufacturer	L3221	\$ 100.00	
128	201736370983891						4/28/2016	1	\$ 100.00	Item Returned to Manufacturer	L3221	\$ 100.00	
131	201632370684647						9/30/2016	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
132	201632370684648						9/30/2016	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
159	201635171086191						9/30/2016	1	\$ 83.60	Delivery Not Documented	L3010	\$ 83.60	
160	201635171086192						9/30/2016	1	\$ 83.60	Delivery Not Documented	L3010	\$ 83.60	
196	201609170141731						3/16/2016	1	\$ 292.29	Delivery Not Documented	L3000	\$ 292.29	
197	201609170141732						3/16/2016	1	\$ 292.29	Delivery Not Documented	L3000	\$ 292.29	
205	201618270178665						11/14/2014	1	\$ 140.00	Delivery Not Documented	L3000	\$ 140.00	
206	201618270178666						11/14/2014	1	\$ 140.00	Delivery Not Documented	L3000	\$ 140.00	
210	201711570424385						3/30/2017	2	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
211	201731170040884						3/30/2017	1	\$ 100.00	Delivery Not Documented	L3216	\$ 100.00	
221	201616970173847						4/21/2016	1	\$ 154.00	Delivery Not Documented	L3000	\$ 154.00	
222	201616970173848						4/21/2016	1	\$ 154.00	Delivery Not Documented	L3000	\$ 154.00	
223	201829870756598						9/7/2018	1	\$ 96.80	Delivery Not Documented	L3020	\$ 96.80	
224	201829870756599						9/7/2018	1	\$ 96.80	Delivery Not Documented	L3020	\$ 96.80	
289	201633772004268						10/13/2016	1	\$ 154.00	Delivery Not Documented	L3000	\$ 154.00	
290	201633772004269						10/13/2016	1	\$ 154.00	Delivery Not Documented	L3000	\$ 154.00	
317	201628670440952						12/4/2015	1	\$ 100.00	Duplicate Billing	L3216	\$ 100.00	
319	201618870139170						6/20/2016	1	\$ 292.29	Delivery Not Documented	L3000	\$ 292.29	
320	201618870139171						6/20/2016	1	\$ 292.29	Delivery Not Documented	L3000	\$ 292.29	
323	201627270017557						8/8/2016	1	\$ 292.29	Duplicate Billing	L3000	\$ 292.29	
324	201627270017558						8/8/2016	1	\$ 292.29	Duplicate Billing	L3000	\$ 292.29	
<b>Grand Total</b>									<b>\$ 4,110.54</b>		<b>27</b>	<b>\$ 4,110.54</b>	



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February 7, 2022

**VIA ELECTRONIC MAIL ONLY**

[REDACTED]  
Medicaid Fraud Division  
Office of the State Comptroller  
20 West State Street, 4th Floor  
P.O. Box. 024  
Trenton, NJ 06625  
[REDACTED]

RE: Ramos Foot and Ankle Center, LLC  
NPI: [REDACTED]

Dear [REDACTED]:

As you know, our firm is legal counsel to Ramos Foot and Ankle Center, LLC (“the Practice”) in the claim audit currently being conducted by your office. We are in receipt of the Draft Audit Report (“DAR”) issued January 24, 2022. The DAR follows the Medicaid Fraud Division’s Summary of Findings (“SOF”) issued on October 18, 2021. An Exit Conference was then held on November 3, 2021, where the MFD further elaborated on the purported deficiencies contained in the SOF. On November 17, 2021, the Practice formally responded to the SOF, which included a supplemental production of documents and additional information that directed MFD to specific pages and references to support the claims billed.

The totality of MFD’s audit reviewed 324 claims with dates of service between July 1, 2014 and June 30, 2020, which totaled only \$36,350.00. MFD initially determined that for 41 of the 324 claims sampled, totaling \$5,874, the Practice’s documentation purportedly did not support the services billed. The overpayment contained in the SOF equaled \$205,072.00. After the Practice’s submission of supplemental documents and information, the DAR reduced the overpayment to \$128,719.00.

The DAR reduced the “deficiencies” from 41 to 27, which equaled only an 11% error rate for all claims reviewed. The claims deemed overpaid were broken into three categories: (i) no proof of delivery (22 claims); (ii) duplicate claims (3 claims); and (iii) returns (2 claims). These

claims totaled only \$4,110. However, MFD seeks a \$128,719.00 recovery based upon extrapolation. MFD justifies its extrapolation by initially stating that its “Error Dollars” was achieved using the “90% confidence, 5% precision level” from RAT-STATS output. However, the “Error Dollars” was adjusted because of the Practice’s submission of supplemental documentation. As such, the 5% precision level was not achieved. However, MFD concludes, without citation or justification, that “this modification, which transpired after MFD had selected the full sample size, does not affect MFD’s ability to extrapolate or to recommend a recovery.” Of course, MFD does not provide the new precision level based on the adjustment after the SOF was issued. As such, MFD’s extrapolation methodology is entirely suspect.

### **I. No Proof of Delivery.**

MFD’s final conclusions on the reasoning to deem twenty-two claims overpaid stems from three main findings: (i) the Practice incorrectly claims evidence of delivery is under the therapy section of the note; (ii) the note indicates that orthotics were dispensed instead of shoes, or vice versa; and (iii) the Practice did not provide documentation to refute findings.

As for the first “deficiency” noted in the DAR findings, the Practice directed MFD to specific pages and paragraphs to prove delivery. However, it appears as though MFD will only accept the word “dispensed” within the notes, even though it is obvious that specific shoes and orthotics were delivered as part of the patient visit. This cadence persists throughout the entirety of MFD’s review. A more in depth review is provided herein:

- Sample Nos. 15 and 16: The totality of the patient records demonstrate that shoes were ordered and dispensed to the patient. On 11/19/2016, the patient was seen at the Practice for foot care. RAMOS\_MFD\_005828-29. Four days later, the patient was seen again. RAMOS\_MFD\_005829. This note records the assessment of the stability of the ankles and difficulty in walking involving an ankle/foot joint. *Id.* As such, the “therapy” section of the note states, “orthopedic footwear – ladies shoe – depth inlay – each one right foot” and “orthopedic footwear – ladies shoe – depth inlay – each one left foot.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved footwear for the left and right foot. Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_005797. Here, the procedures section includes a column that states, “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 11/22/2016, “Orthoped Ladies Shoes Dpth I,” designated by CPT code L3216, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_005828-29. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthopedic shoes were given to the patients on November 22, 2016.
- Sample Nos. 22 and 23: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 1/5/17, the patient was seen

at the Practice for lateral ankle pain on the right ankle. RAMOS\_MFD\_004848-49. During this encounter, the note records the assessment of plantar fasciitis and tarsal tunnel syndrome of the left foot, localized primary osteoarthritis and sprain of the right ankle, as well as joint instability of the right ankle. *Id.* As such, the “therapy” section of the note states, “orthopedic footwear – ladies shoe – depth inlay – each one right foot” and “orthopedic footwear – ladies shoe – depth inlay – each one left foot.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved footwear for the left and right foot. Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_004728. Here, the procedures section includes a column that states, “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 1/5/17, “Orthoped Ladies Shoes Dpth I,” designated by CPT code L3216, was ordered and performed. RAMOS\_MFD\_004729. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_004848-49. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthopedic shoes were given to the patients on January 5, 2017.

- Sample Nos. 131 and 132: The MFD claims that there is no indication that shoes were dispensed on 9/30/16. Within the “therapy” section of the encounter note, it lists “orthopedic footwear – ladies shoe – depth inlay – each one right foot” and “orthopedic footwear – ladies shoe – depth inlay – each one left foot” as one of several therapies, including dispensing of orthotics. RAMOS\_MFD\_004878. Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_004868. Here, the procedures section includes a column that states “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 1/5/17, “Orthoped Ladies Shoes Dpth I,” designated by CPT code L3216, was ordered and performed. *Id.* This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_004878. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthopedic shoes were given to the patients on September 30, 2016.
- Sample Nos. 159 and 160: The MFD claims that there is no indication that inserts were dispensed on 9/30/16. MFD is correct that shoes were dispensed on this date, as shoes were the only items billed on this date. L3010 was not billed on the sampled date of service. *See* RAMOS\_MFD\_6928 (listing L3216 as the CPT code billed). As such, MFD cannot properly consider this claim as part of its sample, let alone as part of a refund request.
- Sample Nos. 210 and 211: The MFD claims that there is no indication that shoes were dispensed on 3/30/17. The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 3/30/17, the patient was seen at the Practice for pain on left foot. RAMOS\_MFD\_003914. The assessment

of the patient revealed onychomycosis, plantar fasciitis and tarsal tunnel syndrome of the left foot. As such, the “therapy” section of the note states, “orthopedic footwear – ladies shoe – depth inlay – each one right foot” and “orthopedic footwear – ladies shoe – depth inlay – each one left foot.” *Id.* It further states that orthotics were dispensed. In the same paragraph, the Practice further details that over-the-counter standard orthopedic Oxford shoes are considered medically necessary when the foot can reasonably be accommodated in this type of shoe. A standard orthopedic Oxford shoes are considered medically necessary when the foot can reasonably be accommodated in this type of shoe.”

While the word “dispensed” does not appear verbatim when discussing the shoes, the “therapy” part of the visit clearly involved footwear for the left and right foot. Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_003865. Here, the procedures section includes a column that states “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 11/22/2016, “Orthoped Ladies Shoes Dpth I,” designated by CPT code L3216, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_003914. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthopedic shoes were given to the patient on March 30, 2017.

- Sample Nos. 223 and 224: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 9/7/2018, the patient was seen at the Practice for bilateral foot pain. RAMOS\_MFD\_007588-89. The assessment of the patient revealed bilateral plantar fasciitis of feet, hammer toe on the left and right fifth toes, tarsal tunnel syndrome on the left and right feet, and sciatic neuritis. As such, the “therapy” section of the note states, “orthopedic footwear – ladies shoe – depth inlay – each one right foot” and “orthopedic footwear – ladies shoe – depth inlay – each one left foot.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved footwear for the left and right foot. In the same paragraph, the Practice further details that over-the-counter standard orthopedic Oxford shoes are considered medically necessary when the foot can reasonably be accommodated in this type of shoe. A standard orthopedic Oxford shoes are considered medically necessary when the foot can reasonably be accommodated in this type of shoe.” *Id.* As such, the totality of the record shows that orthopedic shoes were given to the patient on September 7, 2018.
- Sample Nos. 289 and 290: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 10/13/16, the patient was seen at the Practice for a recurrent lesion under the ball of the left foot. RAMOS\_MFD\_002459-60. The assessment of the patient revealed thrombophlebitis of the left tibial vein, bilateral plantar fasciitis of feet, capsulitis of the fourth left metatarsophalangeal joint, joint instability of the left ankle,

hammer toe of the left foot, and lumbosacral radiculopathy. RAMOS\_MFD\_002459. As such, the “therapy” section of the note states, “foot insert – removable – molded to patient model – UCB Type – Berkley shell” for the left and right foot. It further states that impressions were obtained for fabrication of functional orthoses. I explained they may decrease pronation, decrease stretch on the plantar fascia, increase shock absorption and potentially prevent surgery.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved foot inserts, which are orthotics, for the left and right foot. Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_002342. Here, the procedures section includes a column that states, “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 10/13/16, “Orthotics UCB type, Berkley Shell,” designated by CPT code L3000, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_002459-60. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthopedic shoes were given to the patients on October 13, 2016.

- Sample Nos. 196 and 197: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 3/16/16, the patient was seen at the Practice for a flat feet and an orthotic check. RAMOS\_MFD\_003558. The assessment of the patient pes planus and hypermobility syndrome. *Id.* As such, the “therapy” section of the note states, “foot insert – removable – molded to patient model – UCB Type – Berkley shell” for the left and right foot. It further states that impressions were obtained for fabrication of functional orthoses. I explained they may decrease pronation, decrease stretch on the plantar fascia, increase shock absorption and potentially prevent surgery.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved foot inserts, which are orthotics, for the left and right foot. It also stated that the patient underwent gait evaluation and was scanned for custom orthosis. The old orthotics were no longer of an adequate size for the patient, thus the new orthotics order and delivery.

Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_003554. Here, the procedures section includes a column that states “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 10/13/16, “Orthotics UCB type, Berkley Shell,” designated by CPT code L3000, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_003558. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthotics were given to the patient on March 16, 2016.

- Sample Nos. 205 and 206: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 11/14/14, the patient was

seen at the Practice for foot pain. RAMOS\_MFD\_005944-45. The assessment of the patient revealed plantar fasciitis of the left foot. *Id.* As such, the “therapy” section of the note states, “foot insert – removable – molded to patient model – UCB Type – Berkley shell” for the left and right foot. It further states that impressions were obtained for fabrication of functional orthoses. I explained they may decrease pronation, decrease stretch on the plantar fascia, increase shock absorption and potentially prevent surgery.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved foot inserts, which are orthotics, for the left and right foot.

Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_005937. Here, the procedures include a column that states, “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 10/13/16, “Orthotics UCB type, Berkley Shell,” designated by CPT code L3000, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_005944-45. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthotics were given to the patient on November 14, 2014.

- Sample Nos. 221 and 222: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 4/21/16, the patient was seen at the Practice for bilateral heel pain. RAMOS\_MFD\_003252-53. The assessment of the patient revealed bilateral plantar fasciitis of feet. *Id.* As such, the “therapy” section of the note states, “foot insert – removable – molded to patient model – UCB Type – Berkley shell” for the left and right foot. It further states that impressions were obtained for fabrication of functional orthoses. I explained they may decrease pronation, decrease stretch on the plantar fascia, increase shock absorption and potentially prevent surgery.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved foot inserts, which are orthotics, for the left and right foot.

Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_003224. Here, the procedures include a column that states, “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 10/13/16, “Orthotics UCB type, Berkley Shell,” designated by CPT code L3000, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_003252-53. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthotics were given to the patient on April 21, 2016.

- Sample Nos. 319 and 320: The totality of the patient records demonstrate that orthotics were ordered and dispensed to the patient. On 6/20/16, the patient was

seen at the Practice for wart under right foot. RAMOS\_MFD\_004062-63. The assessment of the patient revealed chronic peripheral venous insufficiency, porokeratosis plantaris, bilateral plantar fasciitis of feet, benign skin neoplasm of the lower limb, including hip, and pain in the right foot. *Id.* As such, the “therapy” section of the note states, “foot insert – removable – molded to patient model – UCB Type – Berkley shell” for the left and right foot. It further states that impressions were obtained for fabrication of functional orthoses. I explained they may decrease pronation, decrease stretch on the plantar fascia, increase shock absorption and potentially prevent surgery.” *Id.* While the word “dispensed” does not appear verbatim, the “therapy” part of the visit clearly involved foot inserts, which are orthotics, for the left and right foot.

Further, the patient notes include a “procedures” section that begins on RAMOS\_MFD\_004006. Here, the procedures include a column that states “date ordered,” “date performed,” “CPT code,” and “description.” For the sampled date of service, it states that on 10/13/16, “Orthotics UCB type, Berkley Shell,” designated by CPT code L3000, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_004062-63. As such, the word “performed” is replacing the word “dispensed.” Either way, the totality of the record shows that orthotics were given to the patient on June 20, 2016

Accordingly, MFD’s position that the word “dispensed” *must* appear within an encounter note to prove delivery is unjustified. The totality of the Practice’s care for the patient demonstrates that orthotics and shoes were ordered and delivered as necessary to treat various assessed ailments. Any conclusion otherwise fails to consider all evidence, which is fundamentally unfair.

## **II. Item Returned to Manufacturer.**

The MFD upholds one deficiency as it relates to its “finding” that two sampled claims were returned to a manufacturer, thus resulting in an overpayment. Despite the fact that *one* error is objectively statistically insignificant to extrapolate any overpayment, this deficiency is simply incorrect. The MFD states that for Sample Nos. 127 and 128, shoes billed on 4/28/16 were returned to the manufacturer. The DAR provides additional narration that the shoes were “dispensed on 7/25 but record state shoes were dispensed on 6/20. Shoes were not in [the Practice’s] possession on 6/20.” On 4/28/16, the patient encounter note states that orthopedic shoes were ordered to help address the foot deformity. RAMOS\_MFD\_003424. The first order of shoes was invoiced on 5/2/16, which is reflected in the production. RAMOS\_MFD\_003410 and -3415. These shoes were in fact returned. However, this return was actually an exchange, which is reflected on the 7/6/16 order forms. RAMOS\_MFD\_003407-09. These shoes were dispensed on 7/25/16. RAMOS\_MFD\_003421. The 6/20/16 note is inconsequential to this series of events.

### **III. Duplicate Billing.**

MFD did not adjust its findings as it related to the 3 of the 324 claims reviewed that it considered “duplicative.” The finding remains that “each claim shares the same beneficiary, date of service, and HCPCS code with three other similar claims billed.” When asked for supplemental information to support this finding, the MFD produced an “explanation” spreadsheet. This work sheet included expanded audit findings, but did not contain any supplemental documents to review. However, the expanded audit findings highlight discrepancies that are not deficiencies of the Practice.

The “duplications” seem to be either a billing company or payer error. Sample Nos. 315, 316, and 317 were for L3216, which is used for orthopedic footwear. However, the Practice routinely (and without deviation) bills for L3216 with a LT and RT designation. The expanded detail lists three codes with no such designations. Additionally, a true “duplication” would result in 4 claims, not 3. So, further review of the claim form is necessary to address this deficiency. Second, Sample Nos. 321, 322, 323, and 324 show purported duplicates of L3000, where two codes were “allowed” and two codes were considered overpayments as duplicates. However, the dates payment was issued and the payment amounts vary. Specifically, the “ok claims were paid at \$140 and paid on 8/17/16. The “duplicates” were paid at \$292.29 and paid on 9/24/16. So, again, more information is necessary to glean what the true error is, and the party with responsibility. MFD refused to provide any supplemental documentation that addressed these concerns.

As noted in prior conversations and correspondence, this “inconsistency” is not a documentation deficiency appropriate for extrapolation. The MFD has not identified any regulation violated by the Practice sufficient to apply its “finding” across the entire universe of claims. Rather, it is two isolated instances where the error may have been on the part of the insurance administrator or the billing company, not the Practice. As such, the Practice is obviously willing to repay any amounts paid to it as a result of such an error, but there is no other finding of a similar error that would warrant an “error rate.” Moreover, a simple claim report would plainly indicate whether other instances occurred without the need to resort to the imprecision of extrapolation.

So, again, this isolated instance is inappropriate to apply statistical extrapolation and should be removed from consideration in the FAR.

### **IV. Corrective Action Plan.**

As discussed at the Exit Conference, the Practice now utilizes delivery ticket and confirmations when it dispenses orthotics and shoes. So, patients are not given any DME without signing off on their receipt of same. This resolves any issue with how and where the encounter notes detail the delivery of the item, which is the primary concern within the audit findings. This new practice would also resolve any concern over when an item is exchanged or returned to a manufacturer. The Practice also maintains that it does not double bill for services it renders. Any



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evidence of same (which has not been provided to the Practice) is simply an administrative error and not corroboration of some larger deficiency. Nevertheless, the Practice will continue to monitor its coding and billing to make sure all future claim submissions are consistent with the services performed. However, MFD need not be concerned with any claim submissions for the future as the Practice is no longer a participating Medicaid provider.

\* \* \*

Thank you for your attention in this matter. We look forward to the updated findings within the Final Audit Report. Should you have any questions or concerns, please do not hesitate to contact me.

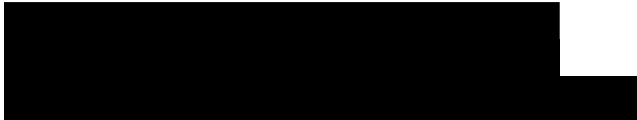
Respectfully yours,

BUTTACI LEARDI & WERNER LLC

Nicole P. Allocca  
A Member of the Firm

NPA/mn

cc:



### **RFAC's Comments to the DAR and OSC's Response**

RFAC, through counsel, submitted a response to the DAR and corrective action plan (CAP) that addressed the recommendations in OSC's DAR (Appendix A). RFAC's comments took issue with OSC's sampling and extrapolation methodology, as well as with OSC's audit findings and overpayment determination. RFAC did not address OSC's finding regarding its practice of improperly billing for items prior to delivery. Despite that omission, in its CAP, RFAC agreed to implement a delivery ticket system that it asserted would "resolve any issue with how and where the encounter notes detail the delivery of the item..." and "any concern over when an item is exchanged or returned to a manufacturer." Set forth below are RFAC's objections to the DAR and OSC's response to each objection. Upon review of RFAC's comments, OSC did not find any basis to revise its extrapolation or audit results.

### **RFAC's Initial Comments Regarding OSC's Extrapolation**

"MFD justifies its extrapolation by initially stating that its 'Error Dollars' was achieved using the '90% confidence, 5% precision level' from RAT-STATS output. However, the 'Error Dollars' was adjusted because of the Practice's submission of supplemental documentation. As such, the 5% precision level was not achieved. However, MFD concludes, without citation or justification, that 'this modification, which transpired after MFD had selected the full sample size, does not affect MFD's ability to extrapolate or to recommend a recovery.' Of course, MFD does not provide the new precision level based on the adjustment after the SOF was issued. As such, MFD's extrapolation methodology is entirely suspect."

### ***OSC Response***

RFAC incorrectly states that OSC failed to provide the new precision level after it issued the SOF. Contrary to RFAC's statement, OSC did provide RFAC with OSC's Random Sample and Extrapolation (RS&E) methodology, which included the precision level on two occasions, both of which were after OSC issued the Summary of Findings (SOF). OSC first provided the RS&E report that contained this methodology on November 4, 2021, shortly after OSC provided RFAC the SOF. OSC provided RFAC with a revised RS&E report based on RFAC's supplemental documentation on January 24, 2022, when OSC transmitted the DAR to RFAC. The extrapolation files OSC provided to RFAC contained all of the relevant details regarding OSC's sampling and extrapolation methodology, including the precision.

Further, RFAC demonstrates in its response to the DAR that it received and reviewed all extrapolation files because it quotes several paragraphs found within the Recovery Summary tab. As this makes clear, OSC reported the precision with the confidence interval and the point estimate, all of which were included in the RS&E's reports.

Finally, OSC correctly stated that the change in the expected precision level did not alter its ability to extrapolate. There is no industry standard or relevant policy that requires a certain precision level in order to extrapolate, and RFAC fails to provide any evidence to the contrary.

### **RFAC's Comments: No Proof of Delivery**

“MFD’s final conclusions on the reasoning to deem twenty-two claims overpaid stems from three main findings: (i) the Practice incorrectly claims evidence of delivery is under the therapy section of the note; (ii) the note indicates that orthotics were dispensed instead of shoes, or vice versa; and (iii) the Practice did not provide documentation to refute findings.

“As for the first ‘deficiency’ noted in the DAR findings, the Practice directed MFD to specific pages and paragraphs to prove delivery. However, it appears as though MFD will only accept the word ‘dispensed’ within the notes, even though it is obvious that specific shoes and orthotics were delivered as part of the patient visit. This cadence persists throughout the entirety of MFD’s review. A more in depth review is provided herein:

- Sample Nos. 15 and 16: The totality of the patient records demonstrate that shoes were ordered and dispensed to the patient. On 11/19/2016, the patient was seen at the Practice for foot care. RAMOS\_MFD\_005828-29. Four days later, the patient was seen again. RAMOS\_MFD\_005829. This note records the assessment of the stability of the ankles and difficulty in walking involving an ankle/foot joint. *Id.* As such, the ‘therapy’ section of the note states, ‘orthopedic footwear – ladies shoe – depth inlay – each one right foot’ and ‘orthopedic footwear – ladies shoe – depth inlay – each one left foot.’ *Id.* While the word ‘dispensed’ does not appear verbatim, the ‘therapy’ part of the visit clearly involved footwear for the left and right foot. Further, the patient notes include a ‘procedures’ section that begins on RAMOS\_MFD\_005797. Here, the procedures section includes a column that states, ‘date ordered,’ ‘date performed,’ ‘CPT code,’ and ‘description.’ For the sampled date of service, it states that on 11/22/2016, ‘Orthoped Ladies Shoes Dpth I,’ designated by CPT code L3216, was ordered and performed. This obviously correlates to the encounter notes also provided at RAMOS\_MFD\_005828-29. As such, the word ‘performed’ is replacing the word ‘dispensed.’ Either way, the totality of the record shows that orthopedic shoes were given to the patients on November 22, 2016.
- Sample Nos. 159 and 160: The MFD claims that there is no indication that inserts were dispensed on 9/30/16. MFD is correct that shoes were dispensed on this date, as shoes were the only items billed on this date. L3010 was not

billed on the sampled date of service. *See* RAMOS\_MFD\_6928 (listing L3216 as the CPT code billed). As such, MFD cannot properly consider this claim as part of its sample, let alone as part of a refund request.”

“Accordingly, MFD’s position that the word ‘dispensed’ *must* appear within an encounter note to prove delivery is unjustified. The totality of the Practice’s care for the patient demonstrates that orthotics and shoes were ordered and delivered as necessary to treat various assessed ailments. Any conclusion otherwise fails to consider all evidence, which is fundamentally unfair.”

[With the exception of Sample numbers 159 and 160, RFAC provided virtually the same explanation for 20 of the 22 claim exceptions, RFAC’s comments for the deficient sampled claims can be viewed in RFAC’s response attached as Appendix A.]

### ***OSC Response***

In its response, RFAC individually addresses each of the 22 deficient claims cited in the DAR. RFAC’s main contention for all of these claims is similar - that OSC failed to take into account the totality of the information, and that the therapy and procedures sections of the medical notes offer proof that RFAC delivered the items. RFAC specifically states that the word “performed,” was included in the procedures section of the medical records when billing for shoes and inserts, and that this conveys the same meaning as the word “dispensed” which was not found elsewhere in the notes for the deficient claims.

RFAC’s assertion that OSC did not take into account the totality of the records is not accurate. In its review of the medical records for the vast majority of shoe and insert claims reviewed (nearly 90 percent), OSC found support for these claims through RFAC’s documented references to having provided such item to the beneficiary. For example, in the medical record associated with sample numbers 19 and 20, OSC gave credit for RFAC’s claims because the record stated that, “The patient was dispensed orthopedic shoes which will help address the foot deformity.” OSC did not give credit only in those instances where there was no proof of delivery. In essence, RFAC maintains that MFD should infer from the records that RFAC delivered the DME items in question despite the absence of any indication of delivery. This argument is not compelling because the vast majority of the records reviewed indicate delivery of the item, which shows that RFAC knew how to demonstrate delivery of DME through medical documentation, but it failed to do so in 22 of the instances reviewed. RFAC provides no reasonable explanation or justification for failing to document delivery in these 22 cases.

RFAC’s argument is further weakened by its claim that proof of delivery can be found in the therapy and procedures sections of the medical notes (see RFAC narrative for sample numbers 15 and 16 above as an example). In 8 of the 22 claims cited for no proof of delivery, RFAC populated both the therapy and procedures sections before the prescribed

items were in RFAC's possession. From its analysis, OSC found that RFAC sometimes populated these fields weeks or months prior to RFAC actually delivering the items to the beneficiaries. In each such instance, RFAC billed the claim on the same date as it populated the records rather than when it delivered the item. Consequently, OSC cannot rely upon these sections of the medical records as evidence of delivery.

Finally, RFAC also asserts that it did not bill sample numbers 159 and 160 (inserts) on the sampled date of service. RFAC does not provide support for this assertion. OSC's findings are based on the beneficiary's medical records, which document that the inserts were ordered on August 31, 2016, the packing slip was dated September 16, 2016, the claim service date was listed as September 30, 2016, and RFAC was paid for the inserts on December 5, 2016. The beneficiary's medical records do not contain proof of delivery, for which RFAC is cited. As RFAC has provided no evidence that OSC's exception is incorrect, these claims will remain in the sample.

#### **RFAC's Comments: Item Returned to Manufacturer**

"The MFD upholds one deficiency as it relates to its 'finding' that two sampled claims were returned to a manufacturer, thus resulting in an overpayment. Despite the fact that *one* error is objectively statistically insignificant to extrapolate any overpayment, this deficiency is simply incorrect. The MFD states that for Sample Nos. 127 and 128, shoes billed on 4/28/16 were returned to the manufacturer. The DAR provides additional narration that the shoes were "dispensed on 7/25 but record state shoes were dispensed on 6/20. Shoes were not in [the Practice's] possession on 6/20." On 4/28/16, the patient encounter note states that orthopedic shoes were ordered to help address the foot deformity. RAMOS\_MFD\_003424. The first order of shoes was invoiced on 5/2/16, which is reflected in the production. RAMOS\_MFD\_003410 and -3415. These shoes were in fact returned. However, this return was actually an exchange, which is reflected on the 7/6/16 order forms. RAMOS\_MFD\_003407-09. These shoes were dispensed on 7/25/16. RAMOS\_MFD\_003421. The 6/20/16 note is inconsequential to this series of events."

#### **OSC Response**

RFAC asserts that OSC should have ignored a note dated June 20, 2016 stating that RFAC had dispensed the shoes on that date and instead determined that RFAC exchanged these shoes and dispensed them on July 25, 2016. OSC cannot "ignore" RFAC's medical record stating that RFAC dispensed the shoes on June 20, 2016 because the July 25, 2016 record exists and there is no dated documentation showing that RFAC returned these shoes.

In addition to not being able to "ignore" documentation, if OSC were to follow RFAC's argument, OSC's monetary finding still would not change. Applying RFAC's logic that it exchanged the shoes on July 6, 2016 and dispensed them on July 25, 2016, OSC still would fail this claim because RFAC did not possess any evidence that it had dispensed the shoes

on July 25, 2016. Accordingly, OSC would have shifted this deficiency from the returns to manufacturer category to the lack of proof of delivery category.

Further, RFAC's claim that this error is statistically "insignificant" is insupportable because OSC evaluates each claim independently and aggregates the errors found to calculate the dollar value of the overpayment. The reason for the overpayment has no bearing on the calculation of the total overpayment amount because OSC considers all overpayments simultaneously. Finally, this argument is without merit because it ignores the mathematical support for extrapolating individual findings regarding claims to a larger universe of like claims.

### **RFAC's Comments: Duplicate Billing**

"MFD did not adjust its findings as it related to the 3 of the 324 claims reviewed that it considered 'duplicative.' The finding remains that 'each claim shares the same beneficiary, date of service, and HCPCS code with three other similar claims billed.' When asked for supplemental information to support this finding, the MFD produced an 'explanation' spreadsheet. This work sheet included expanded audit findings, but did not contain any supplemental documents to review. However, the expanded audit findings highlight discrepancies that are not deficiencies of the Practice.

"The 'duplications' seem to be either a billing company or payer error. Sample Nos. 315, 316, and 317 were for L3216, which is used for orthopedic footwear. However, the Practice routinely (and without deviation) bills for L3216 with a LT and RT designation. The expanded detail lists three codes with no such designations. Additionally, a true 'duplication' would result in 4 claims, not 3. So, further review of the claim form is necessary to address this deficiency. Second, Sample Nos. 321, 322, 323, and 324 show purported duplicates of L3000, where two codes were 'allowed' and two codes were considered overpayments as duplicates. However, the dates payment was issued and the payment amounts vary. Specifically, the 'ok claims were paid at \$140 and paid on 8/17/16. The 'duplicates' were paid at \$292.29 and paid on 9/24/16. So, again, more information is necessary to glean what the true error is, and the party with responsibility. MFD refused to provide any supplemental documentation that addressed these concerns.

"As noted in prior conversations and correspondence, this 'inconsistency' is not a documentation deficiency appropriate for extrapolation. The MFD has not identified any regulation violated by the Practice sufficient to apply its 'finding' across the entire universe of claims. Rather, it is two isolated instances where the error may have been on the part of the insurance administrator or the billing company, not the Practice. As such, the Practice is obviously willing to repay any amounts paid to it as a result of such an error, but there is no other finding of a similar error that would warrant an 'error rate.' Moreover, a simple claim report would plainly indicate whether other instances occurred without the need to resort to the imprecision of extrapolation.

“So, again, this isolated instance is inappropriate to apply statistical extrapolation and should be removed from consideration in the FAR.”

***OSC Response***

More information is not required to determine that RFAC processed the same claim more than once. RFAC electronically submitted these claims, as it did all others that OSC reviewed. OSC provided RFAC with the claim details from the Medicaid database in October 2021, including the dates of submission and payment. If RFAC believed that it was not at fault, it had ample opportunity to provide documentation supporting its position. It did not provide any evidence that contradicted or called into question this finding. Instead, RFAC now attempts to shift responsibility to other parties, including its own billing agent.

In regard to extrapolation, as explained in OSC’s response above, the total overpayment in an extrapolation is determined through a compilation of all deficient claims; thus, each deficient claim is appropriately weighted and considered in this process.

In summary, RFAC has not put forth any viable arguments that invalidate or otherwise require OSC to modify its audit findings or sample/extrapolation methodology.