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December 6, 2019

BY CERTIFIED AND ELECTRONIC MAIL

Mr. Eli Schon
Owner Representative
New Essecare of NJ, LLC
20 Main Street
Orange, NJ 07050

RE: Final Audit Report –New Essecare of NJ, LLC

Dear Mr. Schon:

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) conducted an audit of claims submitted by New Essecare of NJ, LLC (New Essecare), National Provider Identification Number 1598992182 and Medicaid Provider Numbers 0193658 and 0501948, for the period January 1, 2015 through December 31, 2017 (audit period). MFD hereby provides you with this Final Audit Report (FAR).

Executive Summary

MFD conducted this audit to determine whether New Essecare billed for partial-care services in accordance with applicable state and federal laws, regulations and guidance. MFD statistically selected a sample of 212 partial-care claims from a universe of 94,989 claims billed under New Jersey local procedure code Z0170. MFD found that 96 of 212 claims (45.3 percent), totaling $2,900 in Medicaid funds paid to New Essecare, failed to comply with one or more of the following: *N.J.A.C.* 10:66-2.7, *N.J.A.C.* 10:49-9.8, and the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) Newsletter, Vol. 14 No. 42, June 2004. Specifically, MFD found that New Essecare's documentation for these 96 claims did not support the number of units (hours) billed for partial-care services. As a result, MFD adjusted these claims to reflect the appropriate dollar amount that should have been paid for partial-care services provided by New Essecare and is seeking a recovery from New Essecare for these adjusted claims.

To determine a final recovery amount, after accounting for 2 claims for which New Essecare mistakenly underbilled a total of $32, MFD extrapolated the dollars in error for the 96 claims that failed to comply with applicable regulations and guidance to the total population of claims from which the sample claims were drawn, which in this case was 94,989 claims with a total Medicaid reimbursement amount of $6,956,221. By extrapolating to this universe of claims/reimbursed amount, MFD determined that the amount of overpayment for partial-care services is $1,288,308.

Additionally, MFD found that New Essecare violated *N.J.A.C.* 10:66-1.4(c) by submitting claims for units of service that were greater than the pre-approved number of authorized units for such services. Specifically, New Essecare received $41,156 in Medicaid overpayments for 54 prior authorizations for which New Essecare submitted claims above the allowed number of the prior authorized units. Because MFD may already be seeking recovery of the funds attributable to these excess units based on the above-referenced lack of documentation, to avoid a potential duplicate recovery, MFD is not seeking repayment for these claims.

Background

New Essecare, located in Orange, NJ, has participated in the Medicaid program since May 2009. New Essecare provides partial-care services to over 100 beneficiaries on a daily basis. New Essecare primarily bills for services under New Jersey local procedure code Z0170 (Partial-Care Per Hour).

The Division of Mental Health and Addiction Services (DMHAS), within the New Jersey Department of Human Services, is responsible for administering the state's mental health and addiction programs. One of these programs, which is available to Medicaid beneficiaries, is "partial-care." This program provides individualized outpatient clinic services (*e.g.*, group and individual therapy, prevocational services, and medication management) to beneficiaries age 18 or older with a primary diagnosis of psychiatric disorder accompanied by an impaired ability to perform activities of daily living, learning, working, or social roles. In accordance with *N.J.A.C.* 10:66-2.7, partial-care service providers are required to: (1) provide mental health services by, or under the direction of, a psychiatrist; (2) perform a comprehensive intake evaluation; (3) develop and periodically review a written, individualized plan of care for each Medicaid beneficiary; (4) maintain written documentation to support each medical/remedial therapy service, activity, or session for which billing is made; (5) document individual services on a daily basis; and (6) write progress notes documenting the services provided at least once per week. To support partial-care services, the required daily documentation shall consist of the specific services rendered, date and time of each service, service duration, signature of the practitioner who rendered the service, the setting in which services were rendered, as well as notation of unusual occurrences or significant deviations from the treatment described in the plan of care. In addition, pursuant to *N.J.A.C.* 10:66-2.7(l) and DMAHS

Newsletter, Vol. 14 No. 42, partial-care providers must document on a daily basis the individual services provided to beneficiaries.

To receive partial-care services at a mental health clinic, the mental health clinic must first evaluate the Medicaid beneficiary and prepare a plan of care (*i.e.*, services to be provided). The clinic has 30 days from the initial visit to submit a prior authorization request to DMAHS seeking approval of partial-care services. This approval authorizes the clinic to provide services for up to six months and must be renewed every six months should services continue to be needed. A valid prior authorization request contains the authorized period of time that services are to be provided, the number of authorized units (hours), and a prior authorization number. The prior authorization number is required to be included on all claims billed to Medicaid for partial-care services.

Objective

The objective of this audit was to determine whether New Essecare appropriately billed for services in accordance with state and federal laws and regulations and state guidance, and whether New Essecare maintained adequate documentation to support the services it billed and for which it was paid.

Scope

The audit scope entailed a review of New Essecare's Medicaid claims for partial-care services from January 1, 2015 through December 31, 2017. This audit was conducted pursuant to OSC's authority as set forth in *N.J.S.A.* 52:15C-23 and the *Medicaid Program Integrity and Protection Act*, *N.J.S.A.* 30:4D-53 *et seq*.

Audit Methodology

MFD's methodology consists of the following:

- Selecting a statistically valid random sample of 212 claims (136 Medicaid beneficiaries associated with these claims) billed by New Essecare under code Z0170 totaling $14,056 paid to New Essecare.

- Reviewing New Essecare's records in support of the 212 claims to determine whether the documentation provided complied with the requirements of *N.J.A.C.* 10:49-9.8, *N.J.A.C.* 10:66-2.7, and DMAHS Newsletter, Vol. 14 No. 42, June 2004.

- Reviewing 260 prior authorizations from a universe of 1,408 prior authorizations to determine compliance with *N.J.A.C.* 10:66-1.4.

Audit Findings

A. Identified Deficiencies Regarding Partial-Care Code Z0170

MFD reviewed documentation provided by New Essecare for the statistically selected random sample of 212 Medicaid paid claims for partial-care code Z0170. MFD's review found that New Essecare billed incorrectly for 98 of 212 claims. For 96 out of the 98 sample claims, totaling $2,900 paid to New Essecare, New Essecare billed and was paid for a greater number of units than were supported by New Essecare's documentation. For the two remaining claims, MFD determined that New Essecare underbilled a total of $32. To accurately reflect this underpayment, MFD adjusted the $2,900 overpayment amount by the $32, resulting in a net overpayment amount of $2,868. (*See* Exhibit A). See Table I below for a recalculation of the number and dollar value of these claims.

Table I – Claims Billed in Error

Description	Number of Claims	Dollar Amount of Claims
Sampled Claims	212	$14,056
Reasons for Claims Billed in Error:		
- No Documentation	2	$127
- Documentation Did Not Support Minimum of Two Service Units	21	$1,069
- Documentation Did Not Support Service Units Billed	73	$1,704
Total Claims Overbilled	96	2,900
Total Claims Underbilled	2	($32)
Net Sample Overpayment Amount	**98**	**$2,868**

Overbilling of Units for Partial-Care Services

New Essecare requires beneficiaries to sign a Facility Sign In/Out Sheet upon entering and exiting its facility.[1] Based on the number of sessions listed in an individual's plan of care, New Essecare provides up to six different group sessions daily that a beneficiary may be scheduled to attend. To fulfill written documentation requirements set forth in *N.J.A.C.* 10:66-2.7(l), beneficiaries are required to sign a Group Sign In/Out Sheet upon entering each group session.[2] Accordingly, the daily documentation for each beneficiary

[1] A Facility Sign In/Out Sheet is a daily pre-printed attendance sheet that each beneficiary must sign and indicate the time upon entering and exiting the New Essecare facility.
[2] A Group Sign In/Out Sheet is a pre-printed class schedule of attendees that each beneficiary must sign as evidence of group session attendance. Each sheet also includes

should consist of a Facility Sign In/Out Sheet and up to six different Group Sign In/Out Sheets per day. MFD found that in 73 out of the 96 claims, New Essecare billed for more units than its documentation supported. In some of these instances, New Essecare's documentation showed that beneficiaries attended some but not all of the sessions for which New Essecare billed and was paid. Additionally, MFD found instances when beneficiaries were signed in during a group session, but the Facility Sign In/Out Sheet indicated that the beneficiary had arrived late to the group session, and/or left the facility prior to the end of the group session. Using the Facility Sign In/Out Sheets and the Group Sign In/Out Sheets, MFD calculated the amount of time each beneficiary was documented to have been present during group sessions. In those instances in which the number of units in active programming (group sessions) was fractional, as required by state guidance discussed below, MFD rounded down the units to the lower whole number in order to determine the proper number of units that New Essecare should have billed Medicaid. In total, after rounding down the number of units that should have been billed, MFD found that New Essecare overbilled 73 claims totaling $1,704.

In addition, MFD found that in 2 out of the 96 claims, New Essecare failed to provide documentation to MFD, and in another 21 claims, New Essecare provided documentation that supported fewer than the minimum of two service units permitted for billing purposes. MFD denied these 23 claims, totaling $1,196, in accordance with *N.J.A.C.* 10:66-2.7(d) and DMAHS Newsletter, Vol. 14 No. 42, June 2004, which do not allow a provider to submit a claim when services provided are less than two units.

According to *N.J.A.C.* 10:66-2.7(d), "[f]or purposes of partial care, full day means five or more hours of participation in active programing exclusive of meals, breaks and transportation; half day means at least three hours but less than five hours of participation in active programming exclusive of meals, breaks and transportation. The smallest unit of partial care that may be prior authorized by NJ Medicaid/FamilyCare is one hour, with a minimum of two hours per day and a maximum of five hours per day."

According to *N.J.A.C.* 10:66-2.7(l), "[t]he mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made.

1. This documentation, at a minimum, shall consist of
    i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself;
    ii. The date and time that services were rendered;
    iii. The duration of services provided;
    iv. The signature of the practitioner or provider who rendered the services."

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the specific group session name, date, class duration, practitioner's name and space for practitioner's signature.

Lastly, in accordance with DMAHS Newsletter, Vol. 14 No. 42, June 2004, "[u]nits of service of partial care services must be provided for a minimum of two hours and a maximum of five hours per day. If a claim is submitted for less than two hours or more than five hours, the claim will be denied by Error Code 374, 'Reported Service Units must be greater than 1 and less than 6'. In those instances in which the number of hours of services provided is fractional (for example, 2.5 hours), the provider must 'round-down' the units reported to the lower whole number (2 hours)."

Additional Non-Compliance Findings

MFD attempted to review all of the 1,272 Group Sign In/Out Sheets associated with the 212 sample claims (212 x 6 Sign In/Out Sheets = 1,272) to determine whether these forms contained the date, duration of the service and practitioner's signature. MFD identified the following exceptions relating to these documents:

- New Essecare did not provide to MFD 63 out of 1,272 (5.0 percent) Group Sign In/Out Sheets. Therefore, MFD could not confirm whether these documents existed and, if so, whether they contained the date, duration of the service, and practitioner's signature, which are required by *N.J.A.C.* 10:66-2.7(l). MFD is not seeking a recovery for these claims as they are included for recovery in the Overbilling of Units for Partial-Care Services section of this report; however, New Essecare should maintain this documentation in accordance with *N.J.A.C.* 10:49-9.8(b). (*See* Exhibit B).

- In 19 out of 1,272 (1.5 percent) Group Sign In/Out Sheets, there was no practitioner's signature, which is required by *N.J.A.C.* 10:66-2.7(l). MFD is not seeking a monetary recovery for these 19 exceptions because MFD was reasonably assured based on its review of other documentation that the partial-care services were provided by New Essecare. (*See* Exhibit C).

According to *N.J.A.C.* 10:66-2.7 (l), "[t]he mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial therapy service, activity, or session for which billing is made." This regulation sets forth that the documentation required to support these claims must contain, among other elements, the following:

i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself;
ii. The date and time that services were rendered;
iii. The duration of services provided;
iv. The signature of the practitioner or provider who rendered the services.

Pursuant to *N.J.A.C.* 10:49-9.8(b), among other requirements, "[p]roviders shall agree to the following:

1. To keep such records as necessary to disclose fully the extent of services provided, and, as required by *N.J.S.A.* 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary...."

B. Prior Authorization Overbilling

Partial-care prior authorization requests and approvals are required at least once every six months. According to *N.J.A.C.* 10:66-1.4(c), "mental health and substance use disorder outpatient rehabilitative services, including individual psychotherapy, group therapy, family consultation, and family therapy, provided to each Medicaid or NJ FamilyCare fee-for-service beneficiary require prior authorization when payment to an independent clinic exceeds $6,000 for that Medicaid or NJ FamilyCare fee-for-service beneficiary in any 12-month period, commencing with the beneficiary's initial visit.... The maximum period of authorization for partial care shall not exceed six months." *N.J.A.C.* 10:66-1.4(c)(6) also states that "[i]f the request for prior authorization is approved, the Division's fiscal agent shall notify the provider in writing regarding the Division's decision; authorized date or time frame; and activation of the prior authorization number." Further, pursuant to *N.J.A.C.*10.66-1.4(c), a provider is not permitted to submit claims for units in excess of the prior authorized number of units.

From a universe of 1,408 prior authorizations approved during the audit period, MFD identified 54 prior authorizations (3.8 percent) for which New Essecare submitted claims for partial care that exceeded the prior authorized number of units. Accordingly, by seeking and receiving payment for units in excess of the prior authorized number of units, New Essecare received an overpayment. MFD calculated the difference between the dollar value of the prior authorized number of units compared to the number of units that New Essecare submitted and was paid for and considered this differential as an overpayment. Based on this methodology, MFD determined that New Essecare received an overpayment of $41,156 for 54 prior authorizations. (*See* Exhibit D).

Due to the possible overlap between recoveries identified for non-compliant claims related to MFD's review of prior authorizations and New Essecare's lack of documentation to support partial-care code Z0170 discussed above, MFD is not seeking additional recoveries for the 54 identified deficiencies relating to prior authorization for partial-care claims.

Summary of Overpayments

Based on its review, MFD determined that New Essecare improperly billed and received payment for 96 out of 212 sample claims for partial-care code Z0170 for the period January 1, 2015 through December 31, 2017. New Essecare received a net overpayment of

$2,868 for these claims. For purposes of ascertaining a final recovery amount, MFD extrapolated the dollars in error for deficient claims to the total population from which the sample claims were drawn. In this case, the universe consisted of 94,989 claims with a total payment to New Essecare of $6,956,221. By extrapolating the sample of deficient claims to this universe of claims/reimbursed amount, MFD determined that the total amount of overpayment for partial-care services is $1,288,308.

Recommendations

New Essecare shall:

1. Reimburse the Medicaid Program the overpayment of $1,288,308.

2. Maintain documentation that fully supports the number of units billed for partial-care services under code Z0170. Specifically, New Essecare must maintain documentation to support claims for partial-care services that contains, among other elements, the specific services rendered, date and time the services were rendered, duration of services provided, and the signature of the practitioner who rendered the services.

3. Develop and institute procedures to ensure that the number of units billed for partial-care service do not exceed the prior authorized number of units.

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

New Essecare's Response to the Draft Audit Report and MFD's Comments

After being apprised of the findings above, New Essecare, through counsel, submitted a written response and Corrective Action Plan to MFD's Draft Audit Report (*See* Appendix A). In this response, New Essecare offers several specific objections to MFD's sampling and extrapolation methodology, and other arguments that it claims undercut MFD's findings. MFD's responses to New Essecare's sampling/extrapolation objections are attached as Appendix B, entitled "MFD's Response to New Essecare's Objections to Extrapolation." As more fully explained in that document, MFD disagrees with all of New Essecare's arguments. In addition, New Essecare raises five objections related to the audit findings, each of which is discussed in Appendix C, entitled "MFD's Response to New Essecare's Other Objections."

After carefully reviewing each of New Essecare's arguments and its supplemental documentation, MFD gave credit in those limited circumstances when New Essecare provided reliable support for its active programming claims. For the majority of the claims at issue, however, MFD did not modify its findings.

New Essecare provided a corrective action plan to address all of MFD's recommendations above and thereby correct the deficiencies cited in this report. Thus, the only issue that New Essecare must address is the overpayment. MFD finds that New Essecare received an overpayment of $1,288,308 that it must repay to the Medicaid program.

Thank you for your attention to this matter.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: _____
Josh Lichtblau, Director
Medicaid Fraud Division

Attachments:

Appendix A – New Essecare's Response to Draft Audit Report
Appendix B – MFD's Response to New Essecare's Objections to Extrapolation
Appendix C – MFD's Response to New Essecare's Other Objections
Exhibit A - Overbilling of Units for Partial-Care Services
Exhibit B - Schedule of Missing Group Sign In/Out Sheets
Exhibit C - Schedule of Group Sign In/Out Sheets
Exhibit D - Schedule of Claims Paid in Excess of Prior Authorized Amount

cc: Cecilia Horner, Executive Director of New Essecare of NJ, LLC
Frank A. Mazzagatti, Esq., Attorney for New Essecare of NJ, LLC
Don Catinello, Medicaid Fraud Division Supervising Regulatory Officer
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August 28, 2019

Via email (Michael.morgese@osc.nj.gov) and Overnight Mail

State of New Jersey
Medicaid Fraud Division
20 W. State Street, 4th Floor
Trenton, New Jersey 08625
Attn: Michael M. Morgese, Audit Supervisor

REFERENCE: New Essecare of NJ, LLC
MFD-2018-00116

Dear Mr. Morgese:

Pursuant to the Recommendation set forth in the Draft Audit Report ("DAR") dated July 31, 2019 issued by the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division ("MFD"), attached please find New Essecare's Written Response to the DAR as well as a Corrective Action Plan.

Thank you again for your attention in this matter. We look forward to hearing from you after reviewing our responsive documents.

Very truly yours,

By: Frank A. Mazzagatti, Esq.

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August 28, 2019

Via Email (Michael.morgese@osc.nj.gov) and Priority Overnight Mail

State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, New Jersey 08625-0025
Attn: Michael M. Morgese, Audit Supervisor

REFERENCE: New Essecare of NJ, LLC
MFD-2018-00116

Dear Mr. Morgese:

As you are aware, we represent New Essecare of NJ, LLC ("New Essecare") in connection with the Office of the State Comptroller, Medicaid Fraud Division's ("MFD") Summary of Findings ("SOF") dated June 11, 2019 and Draft Audit Report ("DAR") dated July 31, 2019. Please accept this letter as New Essecare's written comments to the DAR and objections to the findings and conclusions set forth therein. You will also find enclosed a proposed Corrective Action Plan.

By way of procedural background, MFD issued its SOF to New Essecare on June 11, 2019, asserting that New Essecare improperly billed and received payment for 111 of the 212 claims sampled for the period January 1, 2015 through December 31, 2017, and that based upon extrapolation principles, it improperly billed Medicaid $1,495,407. In response to the SOF, New Essecare provided supplemental documentation concerning claims MFD alleged it did not have and was able to provide explanations as to the content and entries of the various Facility and Group Sign-In/Out sheets which New Essecare requires beneficiaries to use.

New Essecare then attended an Exit Conference with MFD representatives on June 25, 2019. During that meeting, Mr. Eli Schon, Owner and Cecilia Horner, MSW, LSW, Executive Director explained the Program, the beneficiaries, the staff, the processes used in the normal course of business and the documentation used to capture the partial-case services that were delivered

according to the requirements set forth in N.J.A.C 10:66-2.7. New Essecare produced and submitted supplemental information concerning the claims at issue and continued to provide certain documentation until the issuance of the DAR.

On July 31, 2019, New Essecare received the DAR. MFD found that of the 212 claims sampled against the universe of 94,989, 96 of the 212 claims or 45.3% totaling $2,900 failed to comply with one or more of the following: N.J.A.C. 10:66-2.7, N.J.A.C. 10:49-9.8 and the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) Newsletter, Vol. 14 No. 42, June 2004.

Specifically, MFD found that New Essecare's documentation for the 96 claims did not fully support the number of units (hours) billed for partial care services. As a result, MFD purportedly adjusted the 96 claims to reflect the dollar amount it deemed appropriate that should have been paid for such services.

MFD also found the existence of two claims for which New Essecare underbilled a total of $32. MFD extrapolated the dollars in error for the 96 claims that were determined to have failed to comply with the applicable Medicaid regulations and guidance to the total population of claims from which the sample claims were drawn (94,989) with a total Medicaid reimbursement amount of $6,956,221. By extrapolating to the universe of claims/reimbursed amount, MFD determined that the amount of the overpayment is $1,288,308.

GEBERAL INFORMATION

New Essecare provides Adult Partial Care to serve the mentally ill of New Jersey (the "Program"). The Program provides rehabilitative services, support, counseling, case management and psycho-social services (the "Services"). The Services are provided in a therapeutic environment with the goal of reducing and/or preventing hospitalization relapse and decompensation.

New Essecare employs 34 people of which 22 render clinical services to the attendees of the Facility's partial-care program.

ISSUES WITH DRAFT AUDIT FINDINGS

The scope of the audit is January 1, 2015 through December 31, 2017, making the earliest date in the audit sample almost five (5) years old. The audit reviews a sample of 212 partial-care claims from a universe of 94,989 claims billed under New Jersey local procedure code Z0170. Of the 212 claims reviewed, MFD asserts that two (2) claims presented without any documentation; twenty-one (21) claims did not support the minimum of two service units on any day; seventy-three (73) claims did not support the number of service units billed; and that two (2) claims were underbilled by New Essecare. In total, 98 claims were identified as those comprising the overpayment amount of $2,868 which, when extrapolated, results in an overpayment amount of $1,288,308.

New Essecare asserts its various objections, *infra,* with respect firstly to the statistical and extrapolation methodologies employed by MFD for the instant audit and secondly with respect to the administrative components set forth therein.

OBJECTIONS TO EXTRAPOLATION

New Essecare's counsel requested by letter dated August 6, 2019 (See Exhibit A) certain additional information from MFD in connection with MFD's statistical sampling analyses. On August 13, 2019, New Essecare's counsel received a letter with CD from [redacted], MFD's Regulatory Officer containing certain information including the sample selection, universe, strata, audit criteria, audit determinations, extrapolation and calculation of the overpayment. Based on a review of the data contained in the files provided to New Essecare from MFD, we have determined the following:

Insufficient Error Rate to Allow Extrapolation:

In its draft audit letter, MFD identified a Claim Error Rate (i.e. the percentage of claims with any measurable deficiency) to be 46%. More meaningfully, MFD also identified a Dollar Error Rate (i.e., the percentage of payment amounts found in error) to be 20%. Even if New Essecare's arguments disputing these error rates were ignored, MFD's calculated error rates are insufficient to allow extrapolation in similar matters. Despite the request from New Essecare's counsel in its August 6, 2019 letter (Exhibit A), the responses from MFD failed to set forth specific local reference standards concerning statistical sampling and extrapolation. In the absence of dispositive evidence of a standard which was applied by MFD in the instant audit, New Essecare was unable to evaluate the validity of the audit and findings or validate that the statistical tools employed by MFD were appropriate. As such, New Essecare proffers those relevant statistical and extrapolation standards used by CMS and recognized by facilities and providers throughout the United States. In the absence of any articulable statistical and extrapolation standard, New Essecare was denied its due process rights.

Specifically, the Centers for Medicare and Medicaid Services ("CMS") authorities have ruled that error rates must exceed 50% in order to permit extrapolation, and they have excluded such impermissible extrapolations stating that "the Provider error rate is below the threshold of 50% required to justify extrapolation."[1] In fact, CMS states in its Medicare Program Integrity Manual ("MPIM") guidance on statistical sampling that "For purposes of extrapolation, a sustained or high level of payment error shall be determined to exist through a variety of means, including, but not limited to: high error rate determinations by the contractor or by other medical reviews (i.e., greater than or equal to 50 percent from a previous pre- or post-payment review)."[2]

In this matter, MFD has presented no evidence that New Essecare's error rate was sustained over any period of time, and based upon similar CMS decisions, New Essecare's error rate is also

[1] QIC redetermination decision, dated June 1, 2017.
[2] Medicare Program Integrity Manual, 8.4.1.4.

not "high" as contemplated by CMS. Consequently, extrapolation should not be allowed for the purpose of estimating overpayments in this matter.

Lack of Scientific Rigor in Sample Size Determination:

Even if extrapolation were permissible in this matter, MFD's sample size of 212 claims was determined without scientific rigor and RAT-STATS, a statistical sampling software, was used improperly, leading to a non-representative sample selection and insufficient levels of statistical precision. In accordance with the CMS' MPIM, one of the "major" steps of statistical sampling involves "Performing the appropriate assessment(s) to determine whether the sample size is appropriate for the statistical analyses used."[3] Again, due to MFD's failure to provide specific local statistical and extrapolation standards, New Essecare proffers those relevant standards utilized by CMS.

Despite the well-known risk of selecting a sample size that is too small to achieve valid results, MFD adopted a sample size of only 212 claims to estimate overpayments for a population totaling 94,989 claims (i.e., a sample of less than 0.23%). Had they properly considered an appropriate sample size; they would have concluded that a much larger sample would be required to reach sufficiently precise conclusions in this matter.

MFD's stated reason for choosing a sample size of 212 was reliance on RAT-STATS and its *Stratified* sample size calculation module. However, RAT-STATS *Stratified* sample module was not applied properly in this matter. This is a common mistake since the *Stratified* module does not consider estimated error rates and/or probe sample findings. Instead, RAT-STATS *Unrestricted* sample module is more appropriate for evaluating the results of probe samples for each stratum when estimating overpayments. Had MFD properly considered the results of its probe samples and properly calculated sample size using RAT-STATS, it would have calculated a significantly higher minimum sample size.

Despite New Essecare's requests, MFD has not produced evidence of its sample size calculations, random number generation, or other documentation necessary to replicate their sample size calculations. Nonetheless, an appropriate sample size was re-calculated using RAT-STATS *Unrestricted* sample module based on the results of MFD's probe sample. Using MFD's own stated criteria for sample size (i.e., 95% confidence and 5% precision) a **properly calculated sample size would require a stratified random selection of over 10,500 claims** (i.e., over 10% of the total population).[4] Even when using the most aggressive values of confidence and precision available in RAT-STATS (i.e., 80% confidence and 15% precision) the calculated sample size for New Essecare's universe would be a **minimum sample size of 721 claims**.[5] Had MFD chosen an

[3] Medicare Program Integrity Manual, 8.4.1.3 (5).
[4] Essecare Re-Calculation of Sample Size with RAT-STATS.
[5] Essecare Re-Calculation of Sample Size with RAT-STATS.

adequately sized sample, many of the issues described in the following sections (i.e. representativeness, precision, etc.) would have likely been avoided.

Lack of Sample Representativeness

This dramatic difference in sample size is not merely a theoretical issue. In a universe with high variability (i.e. heterogeneity) small samples risk failing to adequately capture subsets or characteristics of the universe, thereby misrepresenting an extrapolated estimate. In fact, that is precisely what occurred in this case. Even if MFD's limited sample size was determined to be technically sound, which it is not, the sample of claims that was *actually* selected is not adequately representative of the universe from which it was chosen. Since characteristics of a sample will be used to infer characteristics of the broader population, a sample must be reasonably representative of the population to permit a valid extrapolation. If the sample chosen is not representative of the population, inferences about the population may be irreparably biased and invalid. Although selecting a sample randomly is anticipated to lead to a representative sample, it is not guaranteed, particularly when small samples are selected (such as this case).

Nonetheless, MFD provided no evidence that it adequately addressed the representativeness of its own sample in this matter. More importantly, a diligent review of MFD's chosen sample instead suggests it is not representative of the population of claims at issue, and therefore insufficient for the purposes of making inferences (i.e. extrapolation) about the distinctly heterogeneous population. For example, New Essecare treated patients with 54 distinct principal diagnoses during the audited timeframe. However, MFD's small sample captured less than 43% of those diagnoses.[6] In other words, 57% of the diagnoses treated by New Essecare were **not considered at all** as part of MFD's audit, yet each of those unexamined diagnoses was attributed an estimated overpayment, even without examining a single claim. Had MFD properly selected a larger sample, it likely would have selected and examined many more of these ignored claims leading to a more representative and reliable sample.

Poor Degree of Precision

Precision is an objective measure of a study's sampling error. This sampling error exists because only part of the universe has been measured, and the magnitude of this uncertainty can be influenced by the methodology, techniques, assumptions and calculations used to perform the analysis.[7]

MFD's extrapolation conclusions achieved an extremely poor degree of precision in each and every stratum. This is particularly problematic considering MFD's own minimum precision

[6] *New Essecare RSE-provider copy.xlsx*, Universe tab.
[7] Cochran, William G. *Sampling Techniques*. New York: Wiley, 1977, p 5.

threshold, which states "minimum of 95% confidence, 5% precision for each strata".[8] Note that lower precision percentages provide more precise estimates (i.e., lower precision is better). Instead of achieving its own goal, the actual precision of MFD's analysis in this case was dramatically higher than 5%, yielding markedly less-reliable conclusions. After evaluating MFD's findings, Figure 1 highlights the poor precision levels of MFD's analysis in every stratum of its audit. It is particularly concerning that MFD found these precision levels to be valid after stating their own threshold for acceptable precision level to be 5% in every stratum.

Figure 1. Actual Precision of MFD's Statistical Analysis[9]
Compare to MFD's stated precision threshold of 5%

Strata 1	Strata 2	Strata 3	Strata 4
75.6%	37.0%	39.8%	28.9%

In contrast to MFD's precision in this matter, most healthcare post-payment audits seek significantly lower (i.e., better) precision levels, and RAT-STATS software (which MFD purportedly used) pre-populates desired precision levels ranging from 1% to 15%. Even guidance for OIG Corporate Integrity Agreements prescribes a maximum precision level of 25%.[10] The poor degree of precision in this case reaffirms the lack of technical rigor applied by MFD and the high degree of variability in MFD's analysis. It also confirms the inadequacy of the sample size chosen by MFD in this matter, since increasing sample size is generally the most effective technique for improving precision.

Improper Use of Point Estimate

MFD relies on the Point Estimate in determining its overpayment demand. The Point Estimate is generally the midpoint of the statistical confidence interval and equally likely to be too high or too low. The Point Estimate is therefore anticipated to over-assess the disallowance almost half of the time. This distinction becomes more significant as the level of imprecision in a particular analysis grows, since the confidence interval grows wider with increased imprecision. For this reason, parties often agree that if a suitable level of precision is not achieved, which occurred in this case, the Lower Limit should be used as the appropriate estimate instead of the Point Estimate. For example, CMS generally prefers the use of the Lower Limit in post-payment audits since it "allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point-estimate."[11]

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[8] *New Essecare RSE-provider copy.xlsx*, Sampling Plan tab, cell A34.
[9] *RATSTATS Extrapolation.txt*, Re-extrapolation of MFD's sample findings using RAT-STATS variable appraisal module.
[10] HHS OIG: Corporate Integrity Agreement FAQs, CIA Claim Reviews. Available at https://bit.ly/2MertiD
[11] Medicare Program Integrity Manual, 8.4.5.1.

In light of the foregoing, the erroneous extrapolation methods employed by MFD should not be allowed. As such, the entire audit should be set aside.

NEW ESSCARE'S OBJECTIONS TO ALLEGATIONS THAT DOCUMENTATION DOES NOT SUPPORT MINIMUM OF TWO SERVICE UNITS (21 Claims)

Partial Care Billing Scheme

For purposes of partial care services, "full day" means five or more hours of participation in active programming exclusive of meals, breaks and transportation; "half day" means at least three hours but less than five hours of participation in active programming exclusive of meals, breaks and transportation. The smallest unit of partial care that may be prior authorized by NJ Medicaid/Family Care is one hour, with a minimum of two hours per day and a maximum of five hours per day. (N.J.A.C. 10:66-6).

For example, if a beneficiary actively participates in active programming for one hour and fifty-nine minutes in any single day, NJ Medicaid will round down to ZERO, essentially negating all active programming provided.

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

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

> **The case presents a classic example of the web of laws, rules, regulations and public assistance directives and requirements...which, by their volume and complexity, frustrate the very purpose for which the public assistance laws were enacted by our Congress and State Legislature...These, coupled with strict bureaucratic interpretations of the applicable statutes, rules and regulations and the forms**

required to be submitted for qualification and eligibility, constitute a challenge which the most literate of lay persons would fail to meet.

Id. At 423 (emphasis added) (quoting *Mount Sinai Hospital v. Brinn*, 73 Misc.2d 1 (Civ. Ct. 1973).

The court ultimately entered a judgment in favor of the nursing home for the full amount of the bill for services rendered. *Id.* at 424.

Partial Care Written Documentation Requirements

The mental health clinic shall develop and maintain legibly written documentation to support each medical/remedial service, activity or session for which billing is made. This documentation, at a minimum, shall consist of:

i. The specific services rendered, such as individual psychotherapy, group psychotherapy, family therapy, etc., and a description of the encounter itself. The description shall include, but not limited to, a statement of patient progress noted, significant observations, etc.;

ii. The date and time that services were rendered;

iii. The duration of services provided;

iv. The signature of the practitioner or provider who rendered the services;

v. The setting in which services were rendered; and

vi. A notation of unusual occurrences or significant deviations from the treatment described in the plan of care.

N.J.A.C. 10:66-2.7(l)(1)(i-vi).

The statute does not obligate the provider to use sign in/out sheets to satisfy the written documentation requirements set forth in the statute. New Essecare instead uses a Facility Sign In/Out Sheet to capture every beneficiary who enters the Facility every day. Additionally, New Essecare utilizes a Group Sign In/Out Sheet to evidence that beneficiaries have attended any of the six group sessions offered throughout the day.

New Essecare has complied with the written documentation requirements enumerated in the statute and should not be punished for including additional requirements not specifically required in the statute.

The Daily Community Meeting

New Essecare conducts a daily Community Meeting (the "Community Meeting") at 8:45 AM. Attendees, including beneficiaries and all staff gather in the general meeting room for fifteen minutes at which time various topics are discussed in a structured but less formal setting than for example, the group sessions. The Community Meeting is essentially a non-skilled group assembly where attendees are provided with an opportunity to engage in discussion on topics including, but not limited to, current events, importance of establishing and maintaining goals and to provide continued encouragement to participate in program services.

New Essecare typically "schedules" one to two staff counselors to facilitate and perform administrative functions at daily Community Meetings, however, all clinical staff members are present during that meeting.

MFD contends that the Community Meeting notes/agenda are neither signed with staff credentials nor supported with an acceptable staff-to-consumer ration of 1:15.

Attendance at the Community Meeting averages 50-60 beneficiaries. N.J.A.C 10:37F-2.5(a) states" the Provider Agency ("PA") shall provide, or arrange for, a range of services to effectively address the holistic needs of the consumer. Service provision shall be coordinated with other service providers. Services must not exceed a 1:15 staff-to-consumer ratio based upon the active daily census and direct care staff, except as indicated in 4(b) below." The reference to subsection 4(b) of the statute, *supra,* addresses skill development which is typically provided to beneficiaries either individually or in groups. New Essecare objects to this finding. Attached hereto (see Exhibit B) is an example Community Meeting Notes/Agenda as well as a schedule of Counselors (see Exhibit C) who were on-duty and scheduled for work on the dates New Essecare is seeking to be credited for Community Meeting participation for those beneficiaries whose Medicaid payments were deemed overpayments by MFD. The availability of New Essecare Counselors clearly demonstrates that the staff-to-consumer ratio of 1:15 for non-skilled groups was maintained.

The issue surrounding the application of the 1:15 staff-to-consumer ratio for non-skilled groups was posing difficulty and concern to many partial care providers who on one hand desired to capture all services provided and translate that into billing and on the other hand endeavored to remain compliant with all Federal and state Medicaid regulations. As such, on January 24, 2017, the [redacted] ("[redacted]") sent an e-mail (see Exhibit D) to [redacted], RN, MSN from the New Jersey Division of Medical Assistance and Health Services. That e-mail sought clarification concerning how many beneficiaries could attend non-skilled groups such as the Community Meeting.

On January 25, 2017, Mr. [redacted] replied in an e-mail to [redacted] (see Exhibit E) stating that: "The regulation is written to mean 4 staff can serve up to 60 attendees on any given day. There is no hard limit to the size of non-skilled groups such as current events, etc. I am working on this interpretation with my staff. Thanks, [redacted]."

Upon receiving that rather direct opinion from an agent of New Jersey Medicaid, [redacted] forwarded said response to New Essecare as a means to communicate what was now considered a settled matter, as the owner/operators of both facilities are officers of The Partial Care Association of New Jersey.

Attendance at the Community Meeting should be counted towards the two service units. There is no limit as to the size of the group, provided that the 1:15 staff-to-consumer ratio was complied with. New Essecare complied with such ratio. New Essecare should get credit for the twenty-one (21) base service units that MFD seeks to deny for failure to meet the minimum of two service units. (See Exhibit F).

Detrimental Reliance

In reading the e-mail from [redacted], non-skilled meetings such as the New Essecare Community Meeting were contemplated. The availability of staff Counselors as described, *supra,* and as outlined in Exhibit C, enabled New Essecare to adhere to the staff-to-consumer ratio of 1:15 as previously discussed. New Essecare relied on the content of that e-mail stating that a staff-to-consumer ratio of 1:15 is appropriate for non-skilled groups. As such, New Essecare considered the Community Meeting a non-skilled group and began billing for beneficiary participation in the Community Meeting.

Unjust Enrichment and Quantum Meruit

The doctrine of unjust enrichment essentially means "money had and received," as it was described by the United States District Court for the District of New Jersey in *Ramon v. Budget Rent-A-Car System, Inc.* (2007). The Court in *Ramon* adopted the standard that unjust enrichment occurs when a defendant has received a benefit from the plaintiff and that the retention of the benefit by the defendant is inequitable. *Wanaque Borough Sewerage Auth. V. West Milford,* 144 N.J. 564, 575 (1996).

As such, if equity and good conscience do not permit one party to be enriched at the expense of another, New Jersey courts will intervene to equitably redistribute the assets at issue.

In the instant case, New Essecare rendered services which it was dutybound to provide. New Essecare delivered the services in a professional, conscientious and thoughtful manner with the expectation that it would be entitled to the reimbursement under New Jersey local procedure code Z0170. Given the overwhelming success and financial advantages in providing certain services to beneficiaries in outpatient facilities such as New Essecare, MFD by seeking repayment of claims under the circumstances set forth in the DAR would cause MFD to be unjustly enriched at the expense of New Essecare.

The doctrine of quantum meruit ensures that, where there is a reasonable expectation of compensation for the performance of services, parties are compensated for the reasonable value of those services that are performed in good faith. In New Jersey, quantum meruit is established if a plaintiff can provide by a preponderance of the evidence: that plaintiff conferred a benefit on defendant; that plaintiff conferred such benefit with a reasonable expectation that defendant would

pay for it; and that the benefit was conferred under circumstances that should have put defendant on notice that plaintiff expected to be paid. *New York-Connecticut Dev. Corp. v. Blinds-To-Go (U.S.), Inc.*, 449 N.J. Super. 542 (App. Div. 2017); *Weichert Co. Realtors. Ryan*, 128 N.J. 427 (1991).

Here, MFD seeks to deprive New Essecare of any reimbursement whatsoever for claims in which it alleges certain documentation was either missing or insufficient to support the number of service units which were paid for partial care services. Recoupment by MFD for these claims would unjustly enrich the State of New Jersey and the Office of the State Comptroller, Medicaid Fraud Division would violate the equitable doctrine of quantum meruit by depriving New Essecare of reimbursements, which represent the reasonable value of the services that New Essecare was duty-bound to perform for its enrollees. Hence, the demand by MFD to be reimbursed for alleged overpayments is inequitable and must be rejected and overturned.

NEW ESSCARE'S OBJECTIONS TO ALLEGATIONS THAT DOCUMENTATION DOES NOT SUPPORT SERVICE UNITS BILLED (73 Claims)

MFD contends that documentation for 73 claims did not support the number of service units billed. Of this population, we focus on those beneficiaries who were "redirected." Redirection occurs when a beneficiary who is assigned to a particular group is experiencing difficulty and is instead sent to another group which is hopefully more clinically beneficial at that moment in time. It must be underscored that the beneficiaries who are participating in the partial care program are challenging and, because of their varying behavioral states, pose difficulties for facility staff members to ensure they are attending their scheduled group sessions. Equally, staff are often faced with having to locate and ensure that those beneficiaries who request or might benefit from another group session are redirected accordingly. When a beneficiary is redirected, the Group Sign In/Out sheet indicates an "R" next to that beneficiary's name.

In some instances, it was found that the Group Sign In/Out sheets for beneficiaries who were redirected did not adequately indicate the amount of time said beneficiary spent in that redirected group. As such, MFD determined that those bills constituted overpayments for which it seeks recovery.

New Essecare has presented documentary evidence to MFD of the Facility Sign In/Out sheets which every beneficiary who enters the building is required to sign. New Essecare contends that those beneficiaries (71 claims-see Exhibit G) who were redirected did in-fact receive services. These beneficiaries signed the Facility Sign In/Out sheets and even initially attended the groups for which they were originally assigned. Since no other evidence exists that any of the redirected beneficiaries were lingering around the building (which is not permitted by Security), or that they exited the building for which that activity would have captured on the separate Security Log, it is reasonable to conclude that these beneficiaries were on-site and availed themselves of the services which were available. Accordingly, New Essecare is entitled to reimbursement and the audit findings should be set aside.

CONCLUSION

For all of the foregoing reasons and the documentary evidence submitted, in concert with the additional documentation provided by New Essecare from the date of the issuance of the Statement of Findings, we respectfully request that the Draft Audit Report findings of overpayment be overturned and that the payments made to New Essecare in connection with these claims be upheld.

Both the Office of Administrative Law and the Appellate Division have consistently applied equitable doctrines to cases involving Medicaid regulations. In the instant matter, equity demands that the amount owed by New Essecare be adjusted consistent with the supplemental documents provided and the reasonable interpretation of the Medicaid NCCIs.

MFD's failure to follow an established set of standards concerning its statistical analyses and extrapolation methodologies renders the audit flawed, erroneous and invalid. As such, the entire audit should be set aside. Consequently, the findings set forth in the DAR should be nullified.

Finally, New Essecare maintains that the alleged violations of the Medicaid regulations are not a condition of payment under the Medicaid Program.

Thank you for your consideration of the foregoing. Should you have any questions or wish to further discuss this matter, kindly contact me at your convenience.

Very truly yours,

Frank A. Mazzagatti, Esq.

EXHIBIT A

ABRAMS FENSTERMAN
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Fax Not For Legal Service

FIRM OFFICES
Brooklyn
New York
Rochester

August 6, 2019

Via Email (Michael.morgese@osc.nj.gov) and Certified Mail Return Receipt Requested

State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, New Jersey 08625-0025
Attn: Michael M. Morgese, Audit Supervisor

REFERENCE: New Essecare of NJ, LLC
MFD-2018-00116

Dear Mr. Morgese:

As you are aware, we represent New Essecare of NJ, LLC in connection with the above referenced matter. Firstly, I would like the thank you for granting an extension of time to August 28, 2019 in which to respond to the Draft Audit Report.

In order for us to fully understand and evaluate the accuracy of the findings and conclusions of the audit, specifically how the alleged overpayment was calculated, we need additional information with regard to OSC's statistical sampling analysis. Among other things, a full and complete description of the methodology, data and calculation relied upon to complete the statistical sampling and extrapolation. In addition, we request the following information and documents which are necessary to fully understand and evaluate the statistical analysis utilized by OSC in this matter:

1. **Policy and Procedures.** Identify the policy and procedures, if any, adhered to in the planning, design and execution of the statistical sampling and extrapolation analysis in this matter. Provide written copies of these policies and procedures and identify all deviations or failures to adhere, if any, to the relevant procedure.

2. **Universe.** Identify the rationale and criteria used to develop the universe including, at a minimum, the following:

a. Identify the exceptions, exclusions, additions or any other manual adjustments to the universe; and
b. Provide a detailed listing of claims included in the universe, along with relevant claim characteristics (i.e. payment amount, payment date, coding, etc.).

3. **Sampling Frame.** Explain why the sampling frame differs, if at all, from the universe and identify any units excluded from the sampling frame along with rationale for their exclusion.

4. **Sample Design.** Describe the sampling methodology, identify the sample design and fully describe rationale for selecting the sample design. At a minimum:

    a. If a probe sample was selected, describe the rationale for selecting and reviewing the probe sample. Provide a detailed listing of claims sampled as part of the probe sample, along with any conclusions resulting from their audit analysis;
    b. Identify details and rationale for strata, clusters or multi-stage criteria, if used. For stratified sample designs, identify the specific definitions and composition of each strata of the universe/frame;
    c. Identify the rationale, anticipated error rate used, confidence level and/or precision level, if any, used to determine sample size; and
    d. Provide output of the sample size calculation (such as RAT-STATS, etc.) and identify the calculated sample size, including strata/cluster identifiers and allocations, if applicable.

5. **Sample Selection.** Identify the methodology utilized to select the sample from the sampling frame. At a minimum:

    a. Identify the source of random numbers (i.e. RAT-STATS, SQL, etc.);
    b. Identify the actual random numbers used to select the sample;
    c. Provide output of random number generation (such as RAT-STATS or equivalent program) and identify the seed value;
    d. Describe the method used to select the sample using the random numbers, including methodology for strata/cluster selections and the precise configuration of the sampling frame (i.e. how was it sorted or organized prior to random selection). Provide any applicable programs used for sample selection;
    e. Identify the methodology for oversampling or spares, if any;
    f. Identify any exceptions, exclusions, additions or any other manual adjustments to the sample selection; and
    g. Provide a detailed listing of the selected sample including strata/cluster identifiers, if applicable.

6. **Extrapolation Methodology.** Describe the estimation methodology including, at a minimum, the following:

    a. Describe the estimation methodology;

b. Provide data input file/spreadsheet supplied for statistical software (i.e. RAT-STATS Appraisal, etc.);
c. Provide output of statistical software calculations (i.e. RAT-STATS Appraisal, etc.) including all examined values, precision and confidence levels; and
d. Identify methodology for incorporating underpayments identified, if any.

7. **Statistical Expertise.** Identify the statistical expertise of personnel responsible for designing, performing and reviewing the analysis in this matter including, at a minimum, the following:

   a. Name and responsibilities for each individual involved in performing statistical analysis;
   b. Relevant education and experience related to probability sampling and estimation techniques for each individual involved in performing statistical analysis; and
   c. Statistics expert responsibility for reviewing the design and results of statistical analysis, if any.

Please provide the foregoing information as soon as possible as same is imperative to our ability to properly evaluate the audit and provide a comprehensive response to the audit, including additional documentation and arguments in objection to OSC's determination and proposed action on or before the August 28, 2019 deadline.

Thank you again for your attention in this matter. We look forward to working with you to resolve this instant matter.

Very truly yours,

Frank A. Mazzagatti, Esq.

FM/vs

EXHIBIT B

ESSECARE DAILY NOTES
THURSDAY, JANUARY 29, 2015

Essecare Daily Notes and Staff Responsibilities:`

OUR MISSION: To maximize the client's independence and community living skills in order to reduce unnecessary hospitalization.

SAFETY AND SECURITY ARE JOB #1!!! SECURITY—WE ARE COUNTING ON YOU!!!
MONITORS: Security and all drivers not on the road
MEDICATION ADMINISTRATION: (9:00, 12:00, 2:25): NURSE

COMMUNITY MEETING: (8:45-8:58)
ESSECARE IS A HANDS OFF AGENCY; PLEASE KEEP YOUR HANDS TO YOURSELF.

THERE IS NOT BORROWING, LENDING OR SELLING OF ANYTHING IN ESSECARE.

NO CLIENTS SHOULD BE IN THE BACK AREA BEFORE 8:30

THERE SHOULD BE NO CLIENTS BEHIND THE BUSES OR VANS. DESIGNATED SMOKING AREAS ARE LOCATED AT THE FAR ENDS OF THE PARKING LOT (BY TRAIN TRACKS AND FRONT GATE). IF YOU ARE CAUGHT BEHIND THE BUSES, WE WILL ASSUME THAT YOU ARE PERFORMING ACTS THAT ARE NOT ALLOWED ON THE PREMISES AND WE WILL ACT ACCORDINGLY.

IN ORDER TO ENSURE THE SAFETY OF CLIENTS AND STAFF, ALL BAGS ARE SUBJECT TO SEARCH.

WHO IS THE GUEST DJ?? MAKE SURE THAT YOU SIGN UP THE DJ CALENDAR IS IN THE APR UNDER THE PURPLE ARROW. YOU CAN ONLY SIGN UP ONCE/MONTH UNLESS WE NEED AN EXTRA DJ!

SERVICES FOR EVELYN F ARE BEING HELD AT PERRY'S FUNERAL HOME ON MONDAY, FEBRUARY 2ND. IF YOU ARE INTERESTED IN ATTENDING, PLEASE SPEAK WITH YOUR COUNSELOR.

TODAY IN HISTORY

1845 - EDGAR ALLAN POE'S "THE RAVEN" WAS PUBLISHED FOR THE FIRST TIME IN THE "NEW YORK EVENING MIRROR."
1949 - "THE NEWPORT NEWS" WAS COMMISSIONED AS THE FIRST AIR-CONDITIONED NAVAL SHIP IN VIRGINIA.
1963 - THE FIRST MEMBERS TO THE NFL'S HALL OF FAME WERE NAMED IN CANTON, OH.
1995 - THE SAN FRANCISCO 49ERS BECAME THE FIRST TEAM IN NATIONAL FOOTBALL LEAGUE (NFL)HISTORY TO WIN FIVE SUPER BOWL TITLES. THE 49ERS DEFEATED THE SAN DIEGO CHARGERS 49-26.

WHO SHARES YOUR BIRTHDAY

WILLIAM MCKINLEY (U.S.) 1843, W.C. FIELDS 1880, JOHN FORSYTHE 1918, TOM SELLECK 1945, OPRAH WINFREY 1954, EDWARD BURNS 1968, SARA GILBERT 1975

LUNCH: CHECK WITH THE KITCHEN, JUICE AND MILK.

EXHIBIT C

Claim Service Date	Facility Attendees w/sign-in 8:45 or prior	Debra	Stephanie	David D	Luis	Margaret	Alex	Kathleen	Janet	SarahD	Kim	SarahM	Catherine	Kera	Sausha	Colleen	Jennifer	Monica	Gloria	Patrice	Elaine	Jaris	Kara
1/19/2015		x						x															
1/20/2015					x																	x	
1/29/2015																				X	X		
2/11/2015			x				x																
2/13/2015									X										X				
2/23/2015		X						X															
3/27/2015																							
4/17/2015									X										X				
4/29/2015	101	x					x																
5/22/2015									x										x				
6/26/2015																							
7/3/2015																							
7/7/2015					x																		x
7/17/2015									x														
8/11/2015	81				X																		X
8/25/2015	93				x																		x
9/4/2015																							
9/7/2015																							
9/7/2015																							
10/1/2015																							
10/27/2015																							
11/9/2015																							
12/1/2015					X	X																	
12/7/2015	75																						
12/9/2015							X	X															
12/20/2015																							

Blue	only one facilitator scheduled
Red	Schedule for day dated March 3/6/15 or 3/05
Yellow	three or more facilitators scheduled

Claim Service Date	Facility Attendees w/sign-in 8:45 or prior	Debra	Stephanie	David D	Luis	Margaret	Alex	Kathleen	Janet	SarahD	Kim	SarahM	Catherine	Kera	Sausha	Colleen	Jennifer	Monica	Gloria	Patrice	Elaine	Jaris	Kara
1/4/2016		X	X																				
1/8/2016			X						X														
2/2/2016																							
2/3/2016																							
2/26/2016									X	X	X												
3/3/2016			X									X											
3/8/2016					x	x																	
3/25/2016									X	X	X												
3/31/2016									x	x	x												
4/1/2016	81			x																			
4/4/2016	73				x	x																	
4/7/2016	91			x								x											
4/15/2016	86																						
5/16/2016		x	x																				
7/21/2016																							
7/28/2016				X																			
8/8/2016	94		X								X												
8/16/2016					X	X																	
8/24/2016	87						x	x															
8/30/2016	98				X	X																	
9/27/2016					X								X										
10/2/2016																							
10/21/2016									x	x													
11/30/2016	98				x								x										
12/1/2016																x							
12/6/2016					x								x										
12/19/2016	78													x	x								
12/20/2016	88				x								x										

Blue	only one facilitator scheduled
Red	Schedule for day dated March 3/6/15 or 3/05
Yellow	three or more facilitators scheduled

Claim Service Date	Facility Attendees w/sign-in 8:45 or prior	Debra	Stephanie	David D	Luis	Margaret	Alex	Kathleen	Janet	SarahD	Kim	SarahM	Catherine	Kera	Sausha	Colleen	Jennifer	Monica	Gloria	Patrice	Elaine	Jaris	Kara
1/16/2017	90																						
1/19/2017	101																						
1/20/2017	93																						
1/28/2017																							
2/3/2017	95							X		X													
2/6/2017	86													X	X								
2/8/2017	86						X	X															
2/15/2017	105							x															
2/16/2017	99															x	x						
2/27/2017	91													X	X								
2/28/2017	94					X							X										
3/7/2017													x										
3/21/2017						x							x										
4/4/2017						x							x										
4/13/2017	107															x	x						
5/1/2017	94																						
5/2/2017	53																						
5/5/2017	81																						
5/10/2017	74						x	x															
5/12/2017	84								x	x													
6/2/2017	55						X								X								
6/23/2017	82								x	x													
7/27/2017																x	x						
8/3/2017																x	x						
8/4/2017									X	X													
8/8/2017																							
8/14/2017																							
8/16/2017																							
9/5/2017																							
9/11/2017																							
9/20/2017																							
10/11/2017							x																
10/20/2017	96																						
10/25/2017	93						X	X															
11/15/2017	102						x	X															
11/16/2017	73																x	x					
11/20/2017	88														x								
11/28/2017	93																						
11/28/2017																							
12/7/2017	88																x	x					
12/8/2017	77								x	x													
12/13/2017	94						x	x															

Blue — only one facilitator scheduled
Red — Schedule for day dated March 3/6/15 or 3/05
Yellow — three or more facilitators scheduled

EXHIBIT D

From: [redacted]
Sent: Tuesday, January 24, 2017 3:47 PM
To: [redacted]
Cc: [redacted]
Subject: Partial Care Staff to Client Ratio

Good Afternoon [redacted],

I understand that [redacted] contacted you yesterday to discuss an issue regarding group size that several facilities are having with their local Medical review teams.

I know that skill groups in partial care may have no more than 12 participants.

I would like to confirm that the "15" in the same regulation pertains to the staff to consumer attendance on any given day, (e.g. that 4 clinical staff can only serve up to 60 program attendees on given day) and has nothing to due with the number of participants in any one group.

On Monday our local Medicaid team recently directed us that we may not bill for any groups with more than 15 participants as they would consider this Medicaid fraud.

If my understanding that the "15" has nothing to due with group size is correct, I would also like to confirm that we may bill for those non skill groups with 16+ participants.

I understand our obligation to ensure compliance with all regulations and will continue to work cooperatively with our local Medicaid team to ensure such.

I look forward to your response.

[redacted]

EXHIBIT E

Hi [redacted],

In response to your recent request for a plan of correction regarding group size, I just wanted to first present to you [redacted] email, where he informed [redacted] that there is "no hard limit" on attendees for regular unskilled groups. Please contact [redacted] regarding the request that you submitted to me regarding group size and the plan of correction that you requested from me. According to [redacted], I do not think we should have been written up. I am pasting the email from [redacted] below:

From: [redacted]
Date: January 25, 2017 at 6:59:23 AM EST
To: [redacted]
Cc: [redacted]
Subject: RE: Partial Care Staff to Client Ratio

The regulation is written to mean 4 staff can serve up to 60 attendees on any given day. There is no hard limit to the size of non-skill groups such as current events, etc. I am working on this interpretation with my staff. Thanks, [redacted]

EXHIBIT F

Recipient Last Name	Recipient First Name	Claim Service Date	Sign in Sheet Time In	Sign in Sheet Time Out	GHA AM ENTRY	Grassl pm entry	Total # Hrs in FAC	Claim Service Unit Quantity	Total in Group Hrs	Total Grp Hrs Rnd Dwn	GHA total min/hr	tot allowed units	units rnded dwn	ADD IN COMM MTG	addit units	Total units w/CM
[redacted]	[redacted]	11/9/2015	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	9/4/2015	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	3/21/2017	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	1/20/2015	8:45	12:30			3.75	3	1.75	1	105	0	1.75	2.00	2	2.00
[redacted]	[redacted]	1/19/2017	8:45	3:15		3:25 PM	6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	6/16/2017	8:15	3:15			7.00	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	7/28/2016	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	11/16/2017	8:45	3:15			6.50	5	1.75	1	105	0	1.75	2.00	2	2.00
[redacted]	[redacted]	8/16/2016	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	11/15/2017	8:00	1:00			5.00	3	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	8/4/2017	8:09	3:15			7.00	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	9/7/2015	8:15	3:15			7.00	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	5/1/2017	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	8/11/2015	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	4/4/2017	8:00	1:32			5.50	4	3.75	3	225	3	3.75	4.00	1	4.00
[redacted]	[redacted]	4/4/2016	8:00	3:13			7.25	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	9/7/2015	8:30	12:30			4.00	3	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	3/25/2016	8:45	3:15	10:07		6.50	4	1.25	1	75	0	1.25	1.50	0	0.00
[redacted]	[redacted]	3/3/2016	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	11/28/2017	8:22	3:15			7.00	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	8/3/2017	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	1/8/2016	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	7/7/2015	8:45	3:15			6.50	5	1.25	1	75	0	1.25	1.50	0	0.00
[redacted]	[redacted]	11/30/2016	8:45	3:15			6.50	5	2.25	2	135	2	2.25	2.50	0	2.00
[redacted]	[redacted]	12/13/2017	8:45	3:15			6.50	5	1.25	1	75	0	1.25	1.50	0	0.00
[redacted]	[redacted]	5/22/2015	8:45	12:30			4.75	3	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	1/20/2017	8:45	3:15			6.50	5	3.00	3	180	3	3.00	3.25	0	3.00
[redacted]	[redacted]	1/4/2016	8:45	12:30			3.75	3	0.75	0	45	0	0.75	1.00	0	0.00
[redacted]	[redacted]	4/13/2017	8:45	2:30			5.75	4	1.75	1	105	1	1.75	2.00	2	2.00
[redacted]	[redacted]	7/3/2015	8:45	3:15			6.50	5	2.25	2	135	2	2.25	2.50	0	2.00
[redacted]	[redacted]	1/16/2017	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	8/25/2015	8:45	3:15	not leg		6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	4/17/2015	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	4/1/2016	8:45	12:30			3.75	3	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	10/21/2016	8:30	12:30			4.00	3	1.00	1	60	0	1.00	1.25	0	0.00
[redacted]	[redacted]	10/20/2017	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	2/3/2016	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	10/11/2017	8:00	3:00			7.00	5	3.75	3	225	3	3.75	4.00	0	3.00
[redacted]	[redacted]	1/28/2017	8:33	3:15			6.75	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	12/20/2016	8:17	1:00			5.25	3	1.75	1	105	0	1.75	2.00	2	2.00
[redacted]	[redacted]	5/5/2017	8:45	3:15			5.75	5	4.95	4	297	4	4.95	5.20	1	5.00
[redacted]	[redacted]	6/23/2017	8:31	12:34			4.00	3	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	10/25/2017	8:45	2:03			5.25	4	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	2/11/2015	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	2/26/2016	8:45	3:15			6.50	5	2.25	2	135	2	2.25	2.50	0	2.00
[redacted]	[redacted]	2/27/2017	8:45	2:35			6.00	4	2.75	2	165	2	2.75	3.00	1	3.00
[redacted]	[redacted]	6/26/2015	8:45	3:15			6.50	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	12/7/2017	8:43	3:15			6.50	5	4.75	4	285	4	4.75	5.00	1	5.00
[redacted]	[redacted]	2/23/2015	8:45	1:45			5.00	4	3.75	3	225	3	3.75	4.00	1	4.00
[redacted]	[redacted]	6/2/2017	8:23	3:15			7.00	5	4.25	4	255	4	4.25	4.50	0	4.00
[redacted]	[redacted]	3/7/2017	8:45	2:30			5.75	4	3.53	3	212	3	3.53	3.78	0	3.00
[redacted]	[redacted]	11/28/2017	8:45	1:21			4.50	3	1.75	1	105	0	1.75	2.00	2	2.00
[redacted]	[redacted]	3/8/2016	7:50	3:15			7.50	5	3.25	3	195	3	3.25	3.50	0	3.00
[redacted]	[redacted]	10/27/2015	8:45	3:15			6.50	5	3.25	3	195	3	3.25	3.50	0	3.00
										149		141			21	161

EXHIBIT G

Redirected Clients

NEW ESSECARE OF NJ LLC
NPI: 1598992182

New Essecare of NJ, LLC
Overbilling of Units for Partial Care Services

Claim IGN Idn	Claim Recipient Current Idn	Recipient Last Name	Recipient First Name	Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Service Units Quantity	Claim Payment Amount	Source: Facility Sign In/Out Sheet					Source: Group Sign-In-Sheets						Claim Service Units Quantity	
									Sign In Sheet Time In	Time Out	Time In	Sign In Sheet Time Out	Total Number of Hours in the Facility	Group 9:02-10:02 (minutes/recip)	Group 10:04-11:04 (minutes/recip)	Group 11:15-12:06 (minutes/recip)	Group 12:32-1:32 (minutes/recip)	Group 1:43-2:43 (minutes/recip)	Group 2:45-3:15 (minutes/recip)		
					8/8/2017	ZD170	5	$ 89.60	8:48			3:15	6.50	60	R 0	45	R 0	R 0	30	5	$
					11/9/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	R 0	0	45	R 0	60	30	5	$
					4/29/2015	ZD170	2	$ 29.10	9:42			12:00	2.25	0	60	45	0	0	0	2	$
					9/4/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	0	30	5	$
					3/21/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	60	30	5	$
					1/20/2015	ZD170	3	$ 43.65	8:45			12:30	3.75	60	R 0	45	R 0	0	0	3	$
					1/19/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	60	60	45	R 0	60	30	5	$
					5/12/2017	ZD170	3	$ 53.76	9:14			1:35	3.75	48	60	45	0	0	0	3	$
					2/13/2015	ZD170	5	$ 72.75	9:07			3:15	6.00	55	R 0	45	0	60	30	5	$
					8/16/2017	ZD170	5	$ 89.60	8:15			3:15	7.00	60	60	45	0	0	30	5	$
					8/18/2016	ZD170	2	$ 35.84	12:25			3:15	3.00	0	0	0	60	0	30	2	$
					4/13/2017	ZD170	2	$ 35.84	11:53			3:15	3.25	0	0	0	0	60	30	2	$
					10/2/2016	ZD170	3	$ 53.76	10:30			2:45	4.25	0	0	45	0	0	0	3	$
					12/9/2015	ZD170	5	$ 72.75	9:15			3:15	6.00	0	0	0	60	0	0	5	$
					7/28/2016	ZD170	5	$ 89.60	8:45			3:15	6.50	60	R 0	45	60	0	30	5	$
					11/16/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	0	0	45	60	0	0	5	$
					8/16/2016	ZD170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	0	30	5	$
					4/8/2016	ZD170	4	$ 58.20	9:34			3:15	5.75	28	60	45	60	0	30	4	$
					11/15/2017	ZD170	3	$ 53.76	8:00			1:00	5.00	60	60	45	0	0	0	3	$
					8/27/2015	ZD170	4	$ 58.20	8:45			2:30	5.75	60	60	45	0	47	0	4	$
					8/4/2017	ZD170	5	$ 89.60	8:09			3:15	7.00	60	60	45	0	60	30	5	$
					8/31/2017	ZD170	5	$ 89.60	9:10			3:15	6.00	0	60	45	60	60	30	5	$
					2/2/2017	ZD170	4	$ 71.68	9:31			3:15	5.75	0	60	0	60	60	30	4	$
					9/7/2016	ZD170	5	$ 72.75	8:15			3:15	7.00	60	0	45	0	60	30	5	$
					5/1/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	60	60	45	0	60	30	5	$
					3/31/2016	ZD170	4	$ 58.20	9:05			2:04	5.00	57	60	45	60	0	0	4	$
					8/11/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	0	45	60	60	30	5	$
					4/4/2017	ZD170	4	$ 71.68	8:00			1:32	5.50	60	60	45	60	0	0	4	$
					5/2/2017	ZD170	5	$ 89.60	9:08			3:15	6.00	54	60	45	60	0	30	5	$
					4/4/2016	ZD170	5	$ 72.75	8:00			3:13	7.25	60	60	45	60	R 0	0	5	$
					2/16/2017	ZD170	5	$ 89.60	8:49			3:15	6.50	R 0	60	45	60	60	30	5	$
					4/4/2017	ZD170	5	$ 89.60	9:04			3:15	6.25	58	60	45	60	R 0	30	5	$
					9/7/2015	ZD170	3	$ 43.65	8:30			12:30	4.00	60	60	45	0	0	0	3	$
					3/25/2016	ZD170	4	$ 58.20	8:45			3:15	6.50	0	0	45	0	R 0	30	4	$
					3/3/2016	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	R 0	30	5	$
					11/28/2017	ZD170	5	$ 89.60	8:22			3:15	7.00	60	R 0	45	R 0	60	30	5	$
					8/3/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	R 0	60	45	60	0	30	5	$
					9/11/2017	ZD170	3	$ 53.76	10:58			3:15	4.25	0	0	45	60	0	0	3	$
					2/6/2017	ZD170	4	$ 71.68	9:53			3:15	5.50	0	60	45	R 0	60	0	4	$
					1/8/2016	ZD170	5	$ 72.75	8:45			3:15	6.50	R 0	60	45	60	0	30	5	$
					7/7/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	R 0	R 0	45	R 0	R 0	30	5	$
					11/30/2016	ZD170	5	$ 89.60	8:45			3:15	6.50	60	R 0	45	R 0	0	30	5	$
					12/13/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	R 0	R 0	45	0	R 0	30	5	$
					7/17/2017	ZD170	4	$ 71.68	9:40			3:15	5.50	0	60	45	60	60	0	4	$
					5/22/2015	ZD170	3	$ 43.65	8:45			12:30	4.75	60	60	45	0	0	0	3	$
					1/20/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	60	60	0	60	R 0	0	5	$
					1/4/2016	ZD170	3	$ 43.65	8:45			12:30	3.75	0	R 0	45	0	0	0	3	$
					4/13/2017	ZD170	4	$ 71.68	8:45			2:30	5.75	0	60	45	R 0	0	0	4	$

Exhibit A

Redacted Clients

NEW ESSECARE OF NJ LLC
NPI: 1598992182

New Essecare of NJ, LLC
Overbilling of Units for Partial Care Services

Claim ICN #n	Claim Recipient Control #n	Recipient Last Name	Recipient First Name	Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Service Units Quantity	Claim Payment Amount	Source: Facility Sign In/Out Sheet					Source: Group Sign-in-Sheets						Claim Service Units Quantity	
									Sign In Sheet Time In	Time Out	Time In	Sign In Sheet Time Out	Total Number of Hours in the Facility	Group 9:02-10:02 (minutes/recip)	Group 10:04-11:04 (minutes/recip)	Group 11:15-12:00 (minutes/recip)	Group 12:32-1:32 (minutes/recip)	Group 1:43-2:43 (minutes/recip)	Group 2:45-3:15 (minutes/recip)		
					11/20/2017	ZD170	2	$ 35.84	10:04			1:30	3.50	0	R 0	45	R 0	0	0	2	$
					3/21/2017	ZD170	3	$ 53.76	9:53			2:30	4.50	R 0	R 0	R 0	R 0	0	0	3	$
					7/3/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	R 0	45	R 0	0	30	5	$
					9/27/2016	ZD170	3	$ 53.76	10:40			3:15	4.50	0	0	45	60	0	30	3	$
					11/22/2017	ZD170	5	$ 89.60	8:05			3:15	7.25	60	60	45	60	0	30	5	$
					7/21/2016	ZD170	2	$ 35.84	9:00			1:30	4.50	0	60	45	R 0	0	0	2	$
					8/14/2017	ZD170	4	$ 71.68	8:25			2:45	5.50	37	60	45	60	0	0	4	$
					12/8/2017	ZD170	4	$ 71.68	9:20			2:30	5.00	0	60	0	60	47	0	4	$
					4/22/2016	ZD170	4	$ 58.20	9:21			3:15	6.00	41	60	45	60	R 0	30	4	$
					5/16/2016	ZD170	4	$ 58.20	9:26			3:15	5.75	R 0	60	45	60	R 0	30	4	$
					12/7/2015	ZD170	5	$ 72.75	0:00			0	0.00	0	0	0	0	0	0	5	$
					1/16/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	60	60	45	60	0	30	5	$
					8/25/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	R 0	60	30	5	$
					4/17/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	R 0	30	5	$
					7/13/2015	ZD170	2	$ 29.10	10:15			1:50	3.50	R 0	49	45	R 0	0	0	2	$
					4/1/2016	ZD170	3	$ 43.65	8:45			12:30	3.75	60	60	45	0	0	0	3	$
					3/27/2015	ZD170	4	$ 58.20	8:38			3:15	5.50	0	60	45	R 0	0	30	4	$
					12/23/2016	ZD170	5	$ 89.60	8:25			3:15	6.75	60	60	45	0	60	30	5	$
					10/21/2016	ZD170	3	$ 53.76	8:30			12:30	4.00	60	R 0	R 0	0	0	0	3	$
					12/6/2016	ZD170	4	$ 71.68	9:31			3:15	5.75	31	0	45	60	R 0	30	4	$
					10/20/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	60	60	45	60	R 0	30	5	$
					2/3/2016	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	R 0	30	5	$
					8/24/2016	ZD170	4	$ 71.68	8:58			2:50	5.00	60	0	45	60	R 0	0	4	$
					12/29/2015	ZD170	3	$ 43.65	10:50			3:15	4.50	0	0	45	0	60	30	3	$
					12/1/2016	ZD170	4	$ 71.68	10:05			3:15	5.00	0	60	45	60	0	30	4	$
					2/2/2016	ZD170	4	$ 58.20	9:52			3:15	5.50	10	60	0	60	60	0	4	$
					2/15/2017	ZD170	2	$ 35.84	9:30			12:30	3.00	32	60	0	0	0	0	2	$
					10/11/2017	ZD170	5	$ 89.60	8:00			3:00	7.00	60	60	45	0	60	0	5	$
					1/26/2017	ZD170	5	$ 89.60	8:33			3:15	6.75	60	60	45	0	0	30	5	$
					2/28/2017	ZD170	2	$ 35.84	9:35			1:00	3.50	0	0	45	R 0	0	0	2	$
					12/1/2015	ZD170	3	$ 43.65	8:49			1:25	4.50	R 0	60	45	0	0	0	3	$
					10/1/2015	ZD170	5	$ 72.75	9:10			3:15	6.00	52	60	45	60	R 0	30	5	$
					12/29/2016	ZD170	3	$ 53.76	8:17			1:00	5.25	60	0	45	R 0	0	0	3	$
					11/22/2017	ZD170	5	$ 89.60	9:00			3:15	6.25	60	60	45	60	0	30	5	$
					5/5/2017	ZD170	5	$ 89.60	8:45	12:04	12:50	3:15	5.75	60	60	45	42	60	30	5	$
					2/3/2017	ZD170	2	$ 35.84	9:30			12:00	2.50	32	0	45	0	0	0	2	$
					9/20/2017	ZD170	4	$ 71.68	9:19			3:15	5.00	43	60	45	60	0	30	4	$
					6/23/2017	ZD170	3	$ 53.76	8:31			12:34	4.00	60	60	45	R 0	R 0	0	3	$
					8/8/2016	ZD170	4	$ 71.68	9:17			2:20	5.00	45	0	45	60	R 0	0	4	$
					10/25/2017	ZD170	4	$ 71.68	8:45			2:03	5.25	0	60	45	60	R 0	0	4	$
					2/11/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	60	60	45	R 0	60	30	5	$
					4/15/2016	ZD170	3	$ 43.65	11:05			3:15	4.00	0	0	45	0	60	30	3	$
					2/26/2016	ZD170	5	$ 72.75	8:45			3:15	6.50	0	60	45	0	0	30	5	$
					11/20/2017	ZD170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	60	30	5	$
					2/27/2017	ZD170	4	$ 71.68	8:45			2:36	6.00	60	60	45	R 0	R 0	0	4	$
					9/5/2017	ZD170	4	$ 71.68	9:57			3:15	5.25	0	60	45	60	0	30	4	$
					6/26/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	0	60	45	60	60	30	5	$
					12/11/2015	ZD170	5	$ 72.75	8:48			3:15	6.50	0	60	45	60	R 0	30	5	$

Exhibit A

Redirected Clients

NEW ESSECARE OF NJ LLC
NPI: 1598992182

New Essecare of NJ, LLC
Overbilling of Units for Partial Care Services

Claim ICN (ID	Claim Recipient Current Id	Recipient Last Name	Recipient First Name	Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Service Units Quantity	Claim Payment Amount	Source: Facility Sign In/Out Sheet					Source: Group Sign-In-Sheets						Claim Service Units Quantity	Claim Payment Amount
									Sign In Sheet Time In	Time Out	Time In	Sign In Sheet Time Out	Total Number of Hours in the Facility	Group 9:02-10:02 (minutes/recip)	Group 10:04-11:04 (minutes/recip)	Group 11:15-12:00 (minutes/recip)	Group 12:32-1:32 (minutes/recip)	Group 1:43-2:43 (minutes/recip)	Group 2:45-3:15 (minutes/recip)		
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	12/7/2017	ZD170	5	$ 89.80	8:43			3:15	6.50	60	60	45	60	60	0	5	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/19/2015	ZD170	4	$ 58.20	10:11			3:00	5.00	0	53	45	60	0	R 0	4	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	12/19/2016	ZD170	3	$ 53.76	10:30			3:10	4.75	0	0	45	60	R 0	25	3	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2/6/2017	ZD170	3	$ 53.76	11:11			3:15	4.00	0	0	45	0	60	30	3	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	2/13/2015	ZD170	4	$ 58.20	8:45			1:45	5.00	60	R 0	45	R 0	0	0	4	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	6/2/2017	ZD170	5	$ 89.60	8:23			3:15	7.00	60	R 0	0	60	60	0	5	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	5/10/2017	ZD170	2	$ 35.84	9:38			12:32	3.00	0	60	45	0	0	0	2	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	1/29/2015	ZD170	3	$ 43.65	8:48			12:30	3.50	R 0	60	45	0	0	0	3	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/7/2017	ZD170	4	$ 71.68	8:45			2:30	5.75	R 0	60	45	60	47	0	4	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	8/30/2016	ZD170	6	$ 89.60	11:00			3:15	4.25	0	0	45	60	60	30	5	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	11/28/2017	ZD170	3	$ 53.76	8:45			1:21	4.50	60	R 0	45	0	0	0	3	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	3/9/2016	ZD170	5	$ 72.75	7:50			3:15	7.50	60	60	45	R 0	R 0	30	5	$ [redacted]
[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	10/27/2015	ZD170	5	$ 72.75	8:45			3:15	6.50	R 0	60	45	R 0	60	30	5	$ [redacted]
																			Total of Non-Compliant Claims Amount		
																			Total of Claims Billed in Error		

xhibit A

CORRECTIVE ACTION PLAN
New Essecare of NJ, LLC
MFD-2018-00116

New Essecare of NJ, LLC ("Facility") submits this Corrective Action Plan in response to the Office of the State Comptroller, Medicaid Fraud Division's ("MFD") July 31, 2019 Draft Audit Report ("DAR"). The MFD report requires Facility to, among other things, provide MFD with a Corrective Action Plan indicating the steps it will take to implement procedures to correct the deficiencies identified in the DAR. To that end, Facility proposes the following plan to address the alleged deficiencies raised by MFD. **NOTHING CONTAINED HEREIN SHALL CONSTITUTE AN ADMISSION, CONCESSION OR FINDING OF LIABILITY AGAINST FACILITY.**

ISSUE #1: Documentation of 96 claims did not fully support the number of units (hours) billed for partial care services.

Corrective Action: Facility processes will be modified and documented in revised policies and procedures, with relevant staff retraining for the following corrective actions:

1. Counselors are scheduled to arrive before 8:45 AM and now monitor out/in and arrival/departure times to ensure correct units.
2. All beneficiaries who sign in upon entering the premises are required to attend the Community Meeting.
3. The Daily Note used for Community Meetings is signed by ALL staff present.
4. Breakfast is not served during the Community Meeting.
5. Billing shall be done based on documentation of participation, not scheduling.
6. Late entry/early departure will be allowed only within a specific time limitation:
    a. No entry to session or early departure disallowance; or
    b. Allow participation but no bill for session-new code for client participation of this type.
7. Facility check-in/out sheets and security check in/out sheets will be utilized to cross-check total units does not exceed total daily time in the facility.
8. New Essecare will be implementing scheduling a staff member assigned at every group time to engage and redirect any beneficiary experiencing difficulty reaching the group sessions. These staff members will document these types of encounters and escort beneficiaries to the groups to which the beneficiaries have been redirected.
9. New Essecare will place is list of beneficiaries (by first and last initials only) on the group room door indicating which beneficiaries are missing form that group. Security as well as designated clinical staff

will use these notes to attempt to locate beneficiaries are direct them to their respective groups.

10. All beneficiaries permitted into a group for which they have not been scheduled will have a note entered on the group sheet by the Counselor with a reason(s) that beneficiary was permitted into that particular group.
11. New client worksheets indicating sign in/out times will be developed for beneficiaries working in the prevocational activities.
12. A time in/out sheet will be used when any beneficiary visits with the Psychiatrist.
13. An Electronic Health Record ("EHR") system is being explored. If implemented, templates will be develo0ped for therapy sessions.
14. Any paper notes shall be scanned to patient chart for better record retention.
15. Upon implementation of the EHR system, billing will not be allowed/triggered unless countersigned (authorized) by a Supervisor.
16. Facility In/Out and breaks to be set-up in "Breakthrough." If yes, initiate and utilize for unit calculation.
17. Facility will explore whether the Breakthrough System is capable of calculating the minutes in the sessions. If yes, New Essecare will implement a plan to use said System for billing purposes.

ISSUE #2: Submission of claims for units of service that were greater than pre-approved number of authorized units for such services.

Corrective Action: Facility processes will be modified and documented in revised policies and procedures, with relevant staff retraining for the following corrective actions:

1. The billing system shall be configured to reconcile the number of units that are billable based on the schedule and prior authorization number.
2. Any units attended and in excess of prior authorization limits will not be billed.
3. On a monthly basis, or as frequently as New Essecare determines, there shall be a review of beneficiaries who exceeded their prior authorized amounts with resulting non-billable sessions to determine why it occurred and how it can be prevented in the future.

[Signature page to follow]

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

NEW ESSECARE OF NJ, LLC

By: Eli Schon, Owner Representative — Date: 8/28/19

ABRAMS, FENSTERMAN, FENSTERMAN, EISMAN, FORMATO, FERRARA, WOLF & CARONE
(Counsel for New Essecare of NJ, LLC)

By: Frank A. Mazzagatti, Esq. — Date: 8/28/2019

Office of the State Comptroller
Medicaid Fraud Division
New Essecare of NJ, LLC
December 6, 2019

Appendix B

MFD's Response to New Essecare's Objections to Extrapolation

New Essecare's Objection No.1
Insufficient Error Rate to Allow Extrapolation

"In its draft audit letter, MFD identified a Claim Error Rate (i.e. the percentage of claims with any measurable deficiency) to be 46%. More meaningfully, MFD also identified a Dollar Error Rate (i.e., the percentage of payment amounts found in error) to be 20%. Even if New Essecare's arguments disputing these error rates were ignored, MFD's calculated error rates are insufficient to allow extrapolation in similar matters. Despite the request from New Essecare's counsel in its August 6, 2019 letter (Exhibit A), the responses from MFD failed to set forth specific local reference standards concerning statistical sampling and extrapolation. In the absence of dispositive evidence of a standard which was applied by MFD in the instant audit, New Essecare was unable to evaluate the validity of the audit and findings or validate that the statistical tools employed by MFD were appropriate. As such, New Essecare proffers those relevant statistical and extrapolation standards used by CMS and recognized by facilities and providers throughout the United States. In the absence of any articulable statistical and extrapolation standard, New Essecare was denied its due process rights.

"Specifically, the Centers for Medicare and Medicaid Services ('CMS') authorities have ruled that error rates must exceed 50% in order to permit extrapolation, and they have excluded such impermissible extrapolations stating that 'the Provider error rate is below the threshold of 50% required to justify extrapolation.'[1] In fact, CMS states in its Medicare Program Integrity Manual ('MPIM') guidance on statistical sampling that 'For purposes of extrapolation, a sustained or high level of payment error shall be determined to exist through a variety of means, including, but not limited to: high error rate determinations by the contractor or by other medical reviews (i.e., greater than or equal to 50 percent from a previous pre- or post-payment review).'[2]

"In this matter, MFD has presented no evidence that New Essecare's error rate was sustained over any period of time, and based upon similar CMS decisions, New Essecare's error rate is also not 'high' as contemplated by CMS. Consequently, extrapolation should not be allowed for the purpose of estimating overpayments in this matter."

MFD's Response No. 1

MFD's sample and extrapolation methodology is guided by the industry standards set forth by the American Institute of Certified Public Accountants (AICPA). Audit Sampling

[1] QIC redetermination decision, dated June1, 2017.
[2] Medicare Program Integrity Manual, 8.4.1.4.

was previously addressed in the Statements on Auditing Standards (SAS) No. 39, Section AU-350. Currently, Audit Sampling is addressed in the Clarified Statements on Auditing Standards, SAS No.122, AU-C 530.

Per the AICPA's Audit Guide *Audit Sampling*, "there is no hard and fast rule about how many differences are necessary" but "a minimum of 20 or more differences is generally suggested" for extrapolation to take place (AAG-SAM 7.16, p119). MFD identified 98 total errors with at least 20 errors in each strata except for the first. According to audit industry standards, this far exceeds the minimums suggested for extrapolation.

The CMS MPIM (MPIM) applies to Medicare and is not an industry standard. Therefore, references to this manual are not applicable to this extrapolation performed by MFD as part of its oversight role in the New Jersey Medicaid program.

To claim the error rate is "not sustained over any period of time" is also erroneous. MFD determined that 46.23% of the sampled claims were in error during the three-year review period. In fact, the error rate actually trends upwards during this time.

Year	Sample Claims	Error Claims	Error Rate (Claims)	Sample Dollars	Error Dollars	Error Rate (Dollars)
2015	66	25	38%	$ 3,972.15	$ 698.40	18%
2016	68	28	41%	$ 4,260.31	$ 807.31	19%
2017	78	45	58%	$ 5,824.00	$ 1,361.92	23%
Total	**212**	**98**	**46%**	**$ 14,056.46**	**$ 2,867.63**	**20%**

New Essecare's Objection No. 2
Lack of Scientific Rigor in Sample Size Determination

"Even if extrapolation were permissible in this matter, MFD's sample size of 212 claims was determined without scientific rigor and RAT-STATS, a statistical sampling software, was used improperly, leading to a non-representative sample selection and insufficient levels of statistical precision. In accordance with the CMS' MPIM, one of the 'major' steps of statistical sampling involves 'Performing the appropriate assessment(s) to determine whether the sample size is appropriate for the statistical analyses used.'[3] Again, due to MFD'"s failure to provide specific local statistical and extrapolation standards, New Essecare proffers those relevant standards utilized by CMS.

[3] Medicare Program Integrity Manual, 8.4.1.3 (5).

"Despite the well-known risk of selecting a sample size that is too small to achieve valid results, MFD adopted a sample size of only 212 claims to estimate overpayments for a population totaling 94,989 claims (i.e., a sample of less than 0.23%). Had they properly considered an appropriate sample size; they would have concluded that a much larger sample would be required to reach sufficiently precise conclusions in this matter.

"MFD's stated reason for choosing a sample size of 212 was reliance on RAT-STATS and its *Stratified* sample size calculation module. However, RAT-STATS *Stratified* sample module was not applied properly in this matter. This is a common mistake since the *Stratified* module does not consider estimated error rates and/or probe sample findings. Instead, RAT-STATS *Unrestricted* sample module is more appropriate for evaluating the results of probe samples for each stratum when estimating overpayments. Had MFD properly considered the results of its probe samples and properly calculated sample size using RAT-STATS, it would have calculated a significantly higher minimum sample size.

"Despite New Essecare's requests, MFD has not produced evidence of its sample size calculations, random number generation, or other documentation necessary to replicate their sample size calculations. Nonetheless, an appropriate sample size was re-calculated using RAT- STATS *Unrestricted* sample module based on the results of MFD's probe sample. Using MFD's own stated criteria for sample size (i.e., 95% confidence and 5% precision) a **properly calculated sample size would require a stratified random selection of over 10,500 claims** (i.e., over 10% of the total population).[4] Even when using the most aggressive values of confidence and precision available in RAT-STATS (i.e., 80% confidence and 15% precision) the calculated sample size for New Essecare's universe would be a **minimum sample size of 721 claims.**[5] Had MFD chosen an adequately sized sample, many of the issues described in the following sections (i.e. representativeness, precision, etc.) would have likely been avoided."

MFD's Response No. 2

New Essecare states that the RAT-STATS *Stratified* sample module was not applied properly by MFD, and offers the RAT-STATS *Unrestricted* sample module as more appropriate for evaluating the results of probe samples for each stratum when estimating overpayments. While the RAT-STATS Unrestricted sample module may be an acceptable methodology in calculating a sample size, MFD's use of the RAT-STATS *Stratified* sample module for sample size selection is also a valid and reasonable methodology.

MFD supplied the provider with all the information needed to reproduce the sample and extrapolation. The Sampling Plan addresses how the universe of claims was determined,

[4] Essecare Re-Calculation of Sample Size with RAT-STATS.
[5] Essecare Re-Calculation of Sample Size with RAT-STATS.

the sample design used, the minimum requirements applied, and the seed numbers to generate the random numbers to select the sample. The Universe shows all 94,989 claims that were included and the dollars paid for each claim. The Sample & Review shows the 212 claims that were selected for the sample as well as how each claim was evaluated. Finally, the Recovery Summary showed the comparison of the universe and sample, as well as the results of the review.

In determining sample sizes, MFD uses a combination of OIG's statistical software, RAT-STATS, as well as minimum sample size criteria established through research and experience. These minimums are self-imposed to ensure that MFD reviews a sufficient number of records. There are no industry standards for minimum sample sizes. However, the AICPA's Audit Sampling guide suggests, as a rule of thumb, that the minimum sample size for the overall application should be between 50-75 sampling units with a minimum of 20-30 sample items per stratum (AAG-SAM 7.24, p122).

In the absence of a probe sample or previous audits, auditors generally use the descriptive parameters of the recorded values to determine a sufficient sample size to achieve its objectives (AAG-SAM 7.05, p116). In order to account for any differences between recorded and audited values, MFD selects sample sizes that will meet or exceed 95% confidence with 5% precision when extrapolating the true population recorded value (i.e. total dollars in the universe). MFD also requires a minimum of 100 claims for the full sample, with the goal of having at least 30 claims per strata. MFD achieved and surpassed all of these requirements.

MFD stratified the universe by service units since the number of service units billed is directly correlated with the dollars paid for each claim. Using RAT-STATS, the recommended sample size to achieve 95% confidence and 5% precision for the recorded values was only 20 claims. Since this was far below MFD's minimum requirements, MFD scaled each strata sample size up to achieve a total sample size of 212 claims. This sample size far exceeds industry standards as well as MFD's general requirements, as shown in the following table.

Total Sample Sizes						Probe	Full
						107	212
		Confidence Level					
		80%	90%	95%	99%		
Precision Level	1%	179	294	416	714		
	2%	47	75	105	181		
	5%	9 (*)	14 (*)	20 (*)	31		
	10%	5 (*)	6 (*)	7 (*)	9 (*)		
	15%	4 (*)	5 (*)	5 (*)	6 (*)		

Although MFD is not bound by the MPIM, it is important to note that the provider is directly contradicting Section 8.4.4.3 – Determining Sample Size. This section explicitly states that there are no minimum sample size requirements and that challenges related to sample sizes being too small are "without merit when presented in isolation from any reference to the actual sample methodology used, and when presented without a complete account of the actual sample methodology used."

New Essecare's Objection No. 3
Lack of Sample Representativeness

"This dramatic difference in sample size is not merely a theoretical issue. In a universe with high variability (i.e. heterogeneity) small samples risk failing to adequately capture subsets or characteristics of the universe, thereby misrepresenting an extrapolated estimate. In fact, that is precisely what occurred in this case. Even if MFD's limited sample size was determined to be technically sound, which it is not, the sample of claims that was *actually* selected is not adequately representative of the universe from which it was chosen. Since characteristics of a sample will be used to infer characteristics of the broader population, a sample must be reasonably representative of the population to permit a valid extrapolation. If the sample chosen is not representative of the population, inferences about the population may be irreparably biased and invalid. Although selecting a sample randomly is anticipated to lead to a representative sample, it is not guaranteed, particularly when small samples are selected (such as this case).

"Nonetheless, MFD provided no evidence that it adequately addressed the representativeness of its own sample in this matter. More importantly, a diligent review of MFD's chosen sample instead suggests it is not representative of the population of claims at issue, and therefore insufficient for the purposes of making inferences (i.e. extrapolation) about the distinctly heterogeneous population. For example, New Essecare treated patients with 54 distinct principal diagnoses during the audited timeframe. However, MFD's small sample captured less than 43% of those diagnoses.[6] In other words, 57% of the diagnoses treated by New Essecare were **not considered at all** as part of MFD's audit, yet each of those unexamined diagnoses was attributed an estimated overpayment, even without examining a single claim. Had MFD properly selected a larger sample, it likely would have selected and examined many more of these ignored claims leading to a more representative and reliable sample."

MFD's Response No. 3

MFD determines sample size using the only known quantities it has available, the recorded (book) values. MFD's goal is to select a sample of recorded values that is representative of the universe of recorded values. Per the RAT-STATS output below,

[6] *New Essecare RSE-provider copy.xlsx,* Universe tab.

MFD's sample estimated the universe dollars to be $7,017,368. Using the 95% Confidence Level, the achieved precision is 1.61%, which results in an estimated dollar universe between $6,904,060 and $7,130,675. Since MFD knows the exact dollar universe is $6,956,221, MFD can conclude that the sample accurately portrays the universe and is, in fact, representative because the actual dollar universe falls within the confidence interval. Due to the minimum sample sizes MFD requires, MFD actually far exceeded the goal of 5% precision, as shown in the following table.

OVERALL	POINT ESTIMATE / UNIVERSE	7,017,368	94,989
	STANDARD ERROR	57,811	
		CONFIDENCE LIMITS	
		80% CONFIDENCE LEVEL	
	LOWER LIMIT	6,943,280	
	UPPER LIMIT	7,091,456	
	PRECISION AMOUNT	74,088	
	PRECISION PERCENT	1.06%	
	Z-VALUE USED	1.281551565545	
		90% CONFIDENCE LEVEL	
	LOWER LIMIT	6,922,277	
	UPPER LIMIT	7,112,458	
	PRECISION AMOUNT	95,091	
	PRECISION PERCENT	1.36%	
	Z-VALUE USED	1.644853626951	
		95% CONFIDENCE LEVEL	
	LOWER LIMIT	6,904,060	
	UPPER LIMIT	7,130,675	
	PRECISION AMOUNT	113,307	
	PRECISION PERCENT	1.61%	
	Z-VALUE USED	1.959963984540	

Another simple way to check if the sample is representative of the universe is to evaluate the descriptive statistics. As shown in the table below, the sample means and standard deviations for each strata are similar to their universe counterparts.

Stratum	Boundary	Universe Mean	Universe SD	Universe Dollars	Universe Claims	Sample Mean	Sample SD	Sample Dollars	Sample Claims
S1	2 Units	$ 32.60	$ 3.37	$ 130,522.12	4,004	$ 32.02	$ 3.40	$ 960.62	30
S2	3 Units	$ 48.53	$ 5.05	$ 487,756.44	10,050	$ 49.14	$ 5.11	$ 1,719.84	35
S3	4 Units	$ 65.60	$ 6.71	$ 859,314.24	13,100	$ 66.63	$ 6.61	$ 2,665.00	40
S4	5 Units	$ 80.76	$ 8.42	$5,478,627.80	67,835	$ 81.41	$ 8.46	$ 8,711.00	107
				$6,956,220.60	**94,989**			**$14,056.46**	**212**

As discussed above, MFD's sample design stratified the universe by service units since there is a direct correlation between service units and dollars paid. The dollars paid is the variable of interest, not diagnosis, so it is not necessary to incorporate that variable into the sample design. Instead, MFD allowed the random selection of claims to demonstrate a proportionate representation of diagnoses based on their natural existence in the universe.

Moreover, MFD still analyzed the sample and universe diagnoses, which further disproves New Essecare's objection. The universe contains 54 unique diagnosis codes, and the sample contains 30 of those. New Essecare inaccurately states that MFD included less than 43% of the diagnoses, as 55.6% (30 of 54) of the diagnoses were in fact included. Of the 24 (44.4%) diagnoses not included, all of them had 0.69% or less claims in the universe. Therefore, by the laws of probability, the likelihood of the claims being randomly selected for the sample were extremely low. The 30 diagnoses that were included in the sample were those that had the highest probabilities of being randomly selected.

New Essecare's Objection No.4
Poor Degree of Precision

"Precision is an objective measure of a study's sampling error. This sampling error exists because only part of the universe has been measured, and the magnitude of this uncertainty can be influenced by the methodology, techniques, assumptions and calculations used to perform the analysis.[7]

"MFD's extrapolation conclusions achieved an extremely poor degree of precision in each and every stratum. This is particularly problematic considering MFD's own minimum precision threshold, which states 'minimum of 95% confidence, 5% precision for each strata'.[8] Note that lower precision percentages provide more precise estimates (i.e., lower precision is better). Instead of achieving its own goal, the actual precision of MFD's analysis in this case was dramatically higher than 5%, yielding markedly less-reliable conclusions. After evaluating MFD's findings, Figure 1 highlights the poor precision levels of MFD's analysis in every stratum of its audit. It is particularly concerning that MFD found these precision levels to be valid after stating their own threshold for acceptable precision level to be 5% in every stratum.

Figure 1. Actual Precision of MFD's Statistical Analysis[9]
Compare lo MFD's stated precision threshold of 5%

[7] Cochran, William G. *Sampling Techniques*. New York: Wiley, 1977, p 5.
[8] *New Essecare RSE-provider copy.xlsx,* Sampling Plan tab, cell A34.
[9] *RATSTATS Extrapolation.txt,* Re-extrapolation of MFD's sample findings using RAT - STATS variable appraisal module.

Strata 1	**Strata 2**	**Strata 3**	**Strata** 4
75.6%	37.0%	39.8%	28.9%

"In contrast to MFD's precision in this matter, most healthcare post-payment audits seek significantly lower (i.e., better) precision levels, and RAT-STATS software (which MFD purportedly used) pre-populates desired precision levels ranging from 1 % to 15%. Even guidance for OIG Corporate Integrity Agreements prescribes a maximum precision level of 25%.[10] The poor degree of precision in this case reaffirms the lack of technical rigor applied by MFD and the high degree of variability in MFD's analysis. It also confirms the inadequacy of the sample size chosen by MFD in this matter, since increasing sample size is generally the most effective technique for improving precision."

MFD's Response No. 4

New Essecare incorrectly assumes that MFD violated its own minimum precision level of 5% based on their interpretation of the wording in the Sampling Plan. As discussed above, the confidence and precision levels discussed in the Sampling Plan refer to the estimated confidence and precision that will be achieved when using the selected sample to project the true population recorded value. MFD has already proved that the precision achieved for the sample of recorded values was 1.61%, which is well below MFD's minimum requirement of 5%.

Secondly, New Essecare disregards that the precision level that should be evaluated is the overall precision level because the objective of the review is to make a statement about the total population, not the individual strata. The individual strata were only created to separate the universe into more homogenous groupings, which allows a more accurate estimate to be made on the universe as a whole. As a result of the stratification, the overall precision achieved is 20.94% at the 95% confidence level as shown in the following table. Although MFD is not bound by the rules of OIG Corporate Integrity Agreement, it should be noted that MFD is in fact below their recommended precision of 25%. In fact, if MFD used a lesser confidence level, such as 80% or 90%, the precision would drop well below this mark.

[10] HHS OIG: Corporate Integrity Agreement FAQs, CIA Claim Reviews. Available at https://bit.ly/2MertiD

OVERALL	POINT ESTIMATE / UNIVERSE	1,288,308	94,989
	STANDARD ERROR	137,626	
		CONFIDENCE LIMITS	
		80% CONFIDENCE LEVEL	
	LOWER LIMIT	1,111,933	
	UPPER LIMIT	1,464,683	
	PRECISION AMOUNT	176,375	
	PRECISION PERCENT	13.69%	
	Z-VALUE USED	1.281551565545	
		90% CONFIDENCE LEVEL	
	LOWER LIMIT	1,061,933	
	UPPER LIMIT	1,514,683	
	PRECISION AMOUNT	226,375	
	PRECISION PERCENT	17.57%	
	Z-VALUE USED	1.644853626951	
		95% CONFIDENCE LEVEL	
	LOWER LIMIT	1,018,566	
	UPPER LIMIT	1,558,050	
	PRECISION AMOUNT	269,742	
	PRECISION PERCENT	20.94%	
	Z-VALUE USED	1.959963984540	

New Essecare's Objection No.5
Improper Use of Point Estimate

"MFD relies on the Point Estimate in determining its overpayment demand. The Point Estimate is generally the midpoint of the statistical confidence interval and equally likely to be too high or too low. The Point Estimate is therefore anticipated to over-assess the disallowance almost half of the time. This distinction becomes more significant as the level of imprecision in a particular analysis grows, since the confidence interval grows wider with increased imprecision. For this reason, parties often agree that if a suitable level of precision is not achieved, which occurred in this case, the Lower Limit should be used as the appropriate estimate instead of the Point Estimate. For example, CMS generally prefers the use of the Lower Limit in post-payment audits since it 'allows a reasonable recovery without requiring the tight precision that might be needed to support a demand for the point-estimate.'[11]

[11] Medicare Program Integrity Manual, 8.4.5.1.

MFD's Response No. 5

MFD calculates a 95% Confidence Interval for the total projected overpayment for all extrapolations. However, MFD relies on the error point estimate, the midpoint of the 95% Confidence Interval, since it is the most likely amount of overpayment. As such, MFD's use of the point estimate is a valid and appropriate means to determine the amount of overpayment.

MFD's Response to New Essecare's Other Objections

1. New Essecare Argues that its Supplemental Documentation Provides Clear and Convincing Evidence that Services were Rendered and, Thus, it is Entitled to Payment for Such Services

New Essecare claims that it provided clear and convincing additional documentation, which corroborated and proved it rendered the services billed in accordance with *N.J.A.C.* 10:49-5.5(a)(13)(iii). Accordingly, New Essecare maintains that it should be paid in full for such services.

MFD disagrees with New Essecare's premise that its supplemental documentation provides clear and convincing evidence that New Essecare provided the services at issue. As explained in more detail below, the bulk of this documentation, including Progress Notes, Interim Psychiatric Evaluations, and Workshop Timesheets, did not demonstrate that it provided services related to active programming. Accordingly, MFD did not modify those findings. MFD did give New Essecare credit for units of service in the limited number of instances when New Essecare's supplemental documentation showed that it provided active programming to a given beneficiary.

The following examples illustrate why the vast majority of New Essecare's supplemental documents failed to meet the clear and convincing standard. In one case, New Essecare provided a beneficiary's Daily Progress Note, which included the beneficiary's goal of attending group sessions, to support its billing for a particular group session. The Group Sign In/Out Sheets, however, did not show the beneficiary as being present for the session at issue. The existence of a Daily Progress Note, even one showing that the beneficiary's goal was to attend group sessions, without some evidence that the person actually attended the session for which New Essecare sought to be given credit, does not equate to clear and convincing evidence that the beneficiary attended a particular session.

In another case, New Essecare provided a beneficiary's Interim Psychiatric Evaluation to support three group sessions (three hours) for which New Essecare submitted claims and received payment. This documentation fails to support the active programming hours for two reasons. First, it only provides evidence that the beneficiary was in active programing for at most 20 minutes. The Interim Psychiatric Evaluation indicated the start time as 2:30 p.m. and end time as 2:50 p.m. Second, this documentation conflicts with a Group Sign In/Sign Out Sheet that New Essecare previously provided, which listed the beneficiary as being signed into another class that coincided with the time indicated on the Interim Psychiatric Evaluation. MFD already gave credit for that other class based on the Group Sign In/Out Sheet. Accordingly, there is no basis to give New Essecare credit for the three group sessions (three hours) at issue.

A third example again highlights the inconsistency of New Essecare's documentation. In this case, to justify and receive credit for a beneficiary's absence from a group session that ran from 1:43 p.m. to 2:43 p.m., New Essecare provided a Workshop Timesheet showing

that the beneficiary worked from 12:30 p.m. to 2:00 p.m. New Essecare's Group Sign In/Out Sheets, however, showed that the beneficiary had signed into a separate group session from 12:32 p.m. to 1:32 p.m. Thus, taken as a whole, New Essecare's documentation placed this beneficiary in attendance at a group session and in a Workshop at the same time and neither accounted for the beneficiary's absence from the group session that occurred from 1:43 p.m. to 2:43 p.m. A beneficiary cannot be in two places at the same time and the provider cannot bill and receive payment based on conflicting records.

In the relatively few cases when New Essecare's supplemental documentation provided adequate evidence that a beneficiary attended active programming, MFD gave credit for such active programming. For the vast majority of the cases, however, New Essecare's supplemental documentation conflicted with Group Sign In/Out Sheets or failed to provide any reasonable assurance that the beneficiary attended active programming for which New Essecare sought credit. Accordingly, MFD did not modify those findings.

2. New Essecare Argues It Is Not Required to Use Sign In/Out Sheets to Satisfy the Written Documentation Requirements set forth in N.J.A.C. 10:66-2.7(l) when Billing for Partial-Care Services

New Essecare asserts that *N.J.A.C.* 10:66-2.7(l) does not require the provider to use sign in/out sheets to satisfy the written documentation requirements set forth in the regulation. New Essecare maintains that it complied with the written documentation requirements enumerated in *N.J.A.C.* 10:66-2.7(l) by choosing to use Facility and Group Sign In/Out Sheets and it is being "punished for including additional requirements not specifically required by statute."

New Essecare's argument is without merit. MFD does not question the manner in which New Essecare documented its active programming. Rather, MFD found that in the 96 excepted claims, New Essecare's documentation failed to meet the regulatory requirements. *N.J.A.C.* 10:66-2.7(l) requires the provider to document, at a minimum, the specific services rendered, the date and time the provider rendered such services, the duration of the services, the signature of the practitioner or provider who rendered the services, setting in which services were rendered, and a notation of unusual occurrences or deviations from the treatment described in the plan of care. New Essecare tracks its active programming time billed to Medicaid through Facility Sign In/Out Sheets and Group Sign In/Out Sheets. MFD reviewed these documents and based its findings on that review. The Facility Sign In/Out Sheets alone (i.e., without taking into consideration the relevant Group Sign In/Out Sheets), only provide support as to whether the beneficiary entered or left the facility, and the times of such entry/departure. Therefore, the Facility Sign In/Out Sheets alone do not meet the requirements of this regulation because these documents do not contain any information about the specific services rendered, the time services were rendered, the duration of the services, the signature of the practitioner or provider who rendered the services, or a notation of unusual occurrences or deviations from the treatment described in the plan of care. According to the Executive Director,

New Essecare maintains Group Sign In/Out Sheets to support active programming. New Essecare's own documentation, which included both the Facility and Group Sign In/Out Sheets, failed to support the services billed for 96 claims.

3. New Essecare Argues that Attendance at the Daily Community Meeting Should Be Counted Toward the Minimum Two Service Units Required for Billing

New Essecare contends that the 15 minute daily Community Meeting that runs from 8:45 a.m. until 8:58 a.m., is a non-skilled group assembly that should be counted towards the two service units required for billing partial-care services. In support of receiving credit for this programming, New Essecare submitted three copies of the "Essecare Daily Notes" (the flyer/agenda for this Community Meeting) to account for claims spanning the three-year audit period.

Just as with the deficiencies noted above, New Essecare's supplemental documentation concerning the Community Meeting time does not provide sufficient documentation that the beneficiaries associated with the claims at issue attended this meeting. The Essecare Daily Notes do not provide the names of the beneficiaries who attended the Community Meeting. Moreover, New Essecare's argument is inconsistent with its Facility Sign In/Out Sheets. According to New Essecare's Facility Sign In/Out Sheet, 9 out of the 21 beneficiaries who New Essecare claims attended the Community Meeting arrived at the facility after 9 a.m., which is after the Community Meeting would have ended. Thus, these beneficiaries could not possibly have attended the Community Meeting. In addition, New Essecare did not provide any evidence of the signatures of the practitioner or provider who facilitated the Community Meeting, which is required under N.J.A.C. 10:66-2.7(l)(iv).

Although New Essecare claims the Community Meeting is for fifteen minutes, this is belied by New Essecare's own documentation, the Essecare Daily Notes, which states the Community Meeting runs from 8:45 a.m. to 8:58 a.m., which is 13 minutes. Thus, even if New Essecare could overcome the deficiencies noted above and the Community Meeting time were included in active programming, the addition of this 13 minute period (8:45-8:58) would not increase the total active programming time for any of the 21 claims at issue.

4. New Essecare Argues That the State Would be Unjustly Enriched by Recouping Funds for Services New Essecare Provided to Beneficiaries and That New Essecare Should be Compensated for its Services based on the Theory of Quantum Meruit

New Essecare maintains that the Medicaid program would be unjustly enriched if it were to recover funds connected to New Essecare's partial care claims and that New Essecare is entitled to retain these funds under the equitable doctrine of quantum meruit.

The doctrines of unjust enrichment and quantum meruit are wholly inapplicable here. As a Medicaid provider, New Essecare agreed to adhere to the laws, regulations, contractual and other obligations of the Medicaid program. As explained above, these include a host of documentation requirements that are designed to ensure that the Medicaid program only pays for services that are properly provided and for which the provider retains sufficient documentation to support the services provided. As repeatedly demonstrated above, New Essecare failed to provide adequate support for the claims at issue. Consequently, these claims constitute an overpayment for which New Essecare must reimburse the Medicaid program. MFD is authorized to seek recovery when a provider is found to have received a Medicaid overpayment, which is the case here. *See N.J.S.A.* 30:4D-7(h); *N.J.A.C.* 10:49-9.8(b)(3).

5. New Essecare Argues That its Documentation Supports Service Units Billed for Redirected Beneficiaries

New Essecare contends that its documentation shows that it provided services in 71 of 73 claims where the beneficiaries were "redirected" from one active programming group to another. According to New Essecare, a beneficiary may be redirected from one group session to another when the beneficiary is experiencing difficulty in one setting and another setting may be more clinically beneficial. When a beneficiary is redirected, the Group Sign In/Out Sheet for the original group is marked with an "R" next to the beneficiary's name to indicate that the beneficiary was redirected to another group session. The beneficiary then is supposed to sign the Group Sign In/Out sheet for the group to which the beneficiary was redirected.

MFD reviewed the signatures on all Group Sign In/Out Sheets for redirected beneficiary claims and gave full credit when the documentation showed a continuation of services from one group session to another. In cases where MFD could not confirm the beneficiary's presence based on any of the provided Group Sign In/Out Sheets, MFD requested that New Essecare provide supplemental documentation to show that the beneficiary was in active programming after being redirected. MFD reviewed all supplemental documentation provided by New Essecare and gave credit in those instances where the documentation demonstrated that the beneficiary was in active programming at the time or times in question. Much of New Essecare's supplemental documentation, however, proved to be conflicting or unreliable and, in those cases, MFD did not give credit for the claims at issue. For example, as support for a beneficiary who was redirected from a group session, New Essecare provided a progress note stating that the redirected beneficiary went to a one-on-one meeting with a counselor. Upon review, however, MFD determined that other New Essecare documentation placed this same counselor in a group session during the time in question. MFD did not give credit in this and other similar cases when New Essecare's documentation was conflicting or not sufficiently reliable.

NEW ESSECARE OF NJ, LLC
Overbilling of Units for Partial Care Services
1/1/2015-12/31/2017

Claim ICN Idn	Claim Recipient Current Idn	Recipient Last Name	Recipient First Name	Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Service Units Quantity	Claim Payment Amount	Source Facility Sign In/Out Sheet					Source Group Sign-In-Sheets						Claim Service Units Quantity	Claim Payment Amount	Total In Group Hrs	Total In Group Hrs Rounded Down to Nearest Whole Hour	Hourly Rate	Calculated Payment Amount per Audit	Recovery Amount
									Sign In Sheet Time In	Time Out	Time In	Sign In Sheet Time Out	Total Number of Hours in the Facility	Group 9 02-10 02 (minutes/recip)	Group 10 04-11 04 (minutes/recip)	Group 11 15-12 00 (minutes/recip)	Group 12 32-1 32 (minutes/recip)	Group 1 43-2 43 (minutes/recip)	Group 2 45-3 15 (minutes/recip)							
					8/8/2017	Z0170	5	$ 89.60	8:48			3:15	6.50	60	60	45	0	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					11/9/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	0	60	45	0	60	30	5	$ 72.75	3 25	3	$14.55	$43 65	$29.10
					7/27/2017	Z0170	4	$ 71.68	7:40			3:15	7.00	60	60	45	60	60	30	4	$ 71.68	5 25	5	$17.92	$89 60	-$17.92
					4/29/2015	Z0170	2	$ 29.10	9:42			12:00	2.25	0	60	45	0	0	0	2	$ 29.10	1.75	0	$14.55	$0 00	$29.10
					9/4/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					3/21/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					1/20/2015	Z0170	3	$ 43.65	8:45			12:30	3.75	60	0	45	0	0	0	3	$ 43.65	1.75	0	$14.55	$0 00	$43.65
					1/19/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	60	60	45	0	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					5/12/2017	Z0170	3	$ 53.76	9:14			1:35	3.75	48	60	45	0	0	0	3	$ 53.76	2 55	2	$17.92	$35 84	$17.92
					2/13/2015	Z0170	5	$ 72.75	9 07			3:15	6.00	55	0	45	0	60	30	5	$ 72.75	3.17	3	$14.55	$43 65	$29.10
					6/16/2017	Z0170	5	$ 89.60	8:15			3:15	7.00	60	60	45	0	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					4/7/2016	Z0170	2	$ 29.10	9:17			12:55	3.75	45	60	45	37	0	0	2	$ 29.10	3.12	3	$14.55	$43 65	-$14.55
					10/2/2016	Z0170	3	$ 53.76	10 30			2:45	4.25	0	0	45	0	0	0	3	$ 53.76	0.75	0	$17.92	$0 00	$53.76
					12/9/2015	Z0170	5	$ 72.75	9:15			3:15	6.00	0	60	45	60	60	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					7/28/2016	Z0170	5	$ 89.60	8:45			3:15	6.50	60	0	45	60	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					11/16/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	0	0	45	60	0	0	5	$ 89.60	1.75	0	$17.92	$0 00	$89.60
					8/16/2016	Z0170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					11/15/2017	Z0170	3	$ 53.76	8 00			1:00	5.00	60	60	45	0	0	0	3	$ 53.76	2.75	2	$17.92	$35 84	$17.92
					8/4/2017	Z0170	5	$ 89.60	8 09			3:15	7.00	60	60	45	0	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					9/7/2015	Z0170	5	$ 72.75	8:15			3:15	7.00	60	0	45	0	60	30	5	$ 72.75	3 25	3	$14.55	$43 65	$29.10
					5/1/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	60	60	45	0	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					3/31/2016	Z0170	4	$ 58.20	9 05			2:04	5.00	57	60	45	60	0	0	4	$ 58.20	3.70	3	$14.55	$43 65	$14.55
					8/11/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	0	45	60	60	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					4/4/2017	Z0170	4	$ 71.68	8 00			1:32	5.50	60	60	45	60	0	0	4	$ 71.68	3.75	3	$17.92	$53.76	$17.92
					5/2/2017	Z0170	5	$ 89.60	9 08			3:15	6.00	54	60	45	60	0	30	5	$ 89.60	4.15	4	$17.92	$71 68	$17.92
					4/4/2016	Z0170	5	$ 72.75	8 00			3:13	7.25	60	60	45	60	0	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					2/16/2017	Z0170	5	$ 89.60	8:49			3:15	6.50	0	60	45	60	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					4/4/2017	Z0170	5	$ 89.60	9 04			3:15	6.25	58	60	45	60	0	30	5	$ 89.60	4 22	4	$17.92	$71 68	$17.92
					9/7/2015	Z0170	3	$ 43.65	8 30			12:30	4.00	60	60	45	0	0	0	3	$ 43.65	2.75	2	$14.55	$29.10	$14.55
					3/25/2016	Z0170	4	$ 58.20	8:45			3:15	6.50	0	0	45	0	0	30	4	$ 58.20	1 25	0	$14.55	$0 00	$58.20
					3/3/2016	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					11/28/2017	Z0170	5	$ 89.60	8 22			3:15	7.00	60	0	45	0	60	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					8/3/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	0	60	45	60	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					9/11/2017	Z0170	3	$ 53.76	10 58			3:15	4.25	0	0	45	60	0	0	3	$ 53.76	1.75	0	$17.92	$0 00	$53.76
					2/6/2017	Z0170	4	$ 71.68	9 53			3:15	5.50	0	60	45	0	60	0	4	$ 71.68	2.75	2	$17.92	$35 84	$35.84
					1/8/2016	Z0170	5	$ 72.75	8:45			3:15	6.50	0	60	45	60	0	30	5	$ 72.75	3 25	3	$14.55	$43 65	$29.10
					7/7/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	0	0	45	0	0	30	5	$ 72.75	1 25	0	$14.55	$0 00	$72.75
					11/30/2016	Z0170	5	$ 89.60	8:45			3:15	6.50	60	0	45	0	0	30	5	$ 89.60	2 25	2	$17.92	$35 84	$53.76
					12/13/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	0	0	45	0	0	30	5	$ 89.60	1 25	0	$17.92	$0 00	$89.60
					7/17/2017	Z0170	4	$ 71.68	9:40			3:15	5.50	0	60	45	60	60	0	4	$ 71.68	3.75	3	$17.92	$53.76	$17.92
					5/22/2015	Z0170	3	$ 43.65	8:45			12:30	4.75	60	60	45	0	0	0	3	$ 43.65	2.75	2	$14.55	$29.10	$14.55
					1/20/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	60	60	0	60	0	0	5	$ 89.60	3 00	3	$17.92	$53.76	$35.84
					1/4/2016	Z0170	3	$ 43.65	8:45			12:30	3.75	0	0	45	0	0	0	3	$ 43.65	0.75	0	$14.55	$0 00	$43.65
					4/13/2017	Z0170	4	$ 71.68	8:45			2:30	5.75	0	60	45	0	0	0	4	$ 71.68	1.75	0	$17.92	$0 00	$71.68
					11/20/2017	Z0170	2	$ 35.84	10 04			1:30	3.50	0	0	45	0	0	0	2	$ 35.84	0.75	0	$17.92	$0 00	$35.84
					3/21/2017	Z0170	3	$ 53.76	9 53			2:30	4.50	0	0	0	0	0	0	3	$ 53.76	0 00	0	$17.92	$0 00	$53.76
					7/3/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	0	45	0	0	30	5	$ 72.75	2 25	2	$14.55	$29.10	$43.65
					9/27/2016	Z0170	3	$ 53.76	10:40			3:15	4.50	0	0	45	60	0	30	3	$ 53.76	2 25	2	$17.92	$35 84	$17.92
					7/21/2016	Z0170	2	$ 35.84	9 00			1:30	4.50	0	60	45	0	0	0	2	$ 35.84	1.75	0	$17.92	$0 00	$35.84
					8/14/2017	Z0170	4	$ 71.68	9 25			2:45	5.50	37	60	45	60	0	0	4	$ 71.68	3 37	3	$17.92	$53.76	$17.92
					12/8/2017	Z0170	4	$ 71.68	9 20			2:30	5.00	0	60	0	60	47	0	4	$ 71.68	2.78	2	$17.92	$35 84	$35.84
					5/16/2016	Z0170	4	$ 58.20	9 26			3:15	5.75	0	60	45	60	0	30	4	$ 58.20	3 25	3	$14.55	$43 65	$14.55
					12/7/2015	Z0170	5	$ 72.75	0 00			0	0.00	0	0	0	0	0	0	5	$ 72.75	0 00	0	$14.55	$0 00	$72.75
					1/16/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					8/25/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	0	60	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					4/17/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					4/1/2016	Z0170	3	$ 43.65	8:45			12:30	3.75	60	60	45	0	0	0	3	$ 43.65	2.75	2	$14.55	$29.10	$14.55
					3/27/2015	Z0170	4	$ 58.20	9 38			3:15	5.50	0	60	45	0	0	30	4	$ 58.20	2 25	2	$14.55	$29.10	$29.10
					10/21/2016	Z0170	3	$ 53.76	8 30			12:30	4.00	60	0	0	0	0	0	3	$ 53.76	1 00	0	$17.92	$0 00	$53.76

NEW ESSECARE OF NJ, LLC
Overbilling of Units for Partial Care Services
1/1/2015-12/31/2017

Claim ICN Idn	Claim Recipient Current Idn	Recipient Last Name	Recipient First Name	Recipient Birth Date	Claim Service Date	Claim Procedure Code	Claim Service Units Quantity	Claim Payment Amount	Source Facility Sign In/Out Sheet					Source Group Sign-In-Sheets						Claim Service Units Quantity	Claim Payment Amount	Total In Group Hrs	Total In Group Hrs Rounded Down to Nearest Whole Hour	Hourly Rate	Calculated Payment Amount per Audit	Recovery Amount
									Sign In Sheet Time In	Time Out	Time In	Sign In Sheet Time Out	Total Number of Hours in the Facility	Group 9 02-10 02 (minutes/recip)	Group 10 04-11 04 (minutes/recip)	Group 11 15-12 00 (minutes/recip)	Group 12 32-1 32 (minutes/recip)	Group 1 43-2 43 (minutes/recip)	Group 2 45-3 15 (minutes/recip)							
					12/6/2016	Z0170	4	$ 71.68	9 31			3:15	5.75	31	0	45	60	0	30	4	$ 71.68	2.77	2	$17.92	$35 84	$35.84
					10/20/2017	Z0170	5	$ 89.60	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					2/3/2016	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	60	0	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					8/24/2016	Z0170	4	$ 71.68	8 56			2:50	6.00	60	0	45	60	0	0	4	$ 71.68	2.75	2	$17.92	$35 84	$35.84
					12/20/2015	Z0170	3	$ 43.65	10 50			3:15	4.50	0	0	45	0	60	30	3	$ 43.65	2 25	2	$14.55	$29.10	$14.55
					12/1/2016	Z0170	4	$ 71.68	10 05			3:15	5.00	0	60	45	60	0	30	4	$ 71.68	3 25	3	$17.92	$53.76	$17.92
					2/2/2016	Z0170	4	$ 58.20	9 52			3:15	5.50	10	60	0	60	60	0	4	$ 58.20	3.17	3	$14.55	$43 65	$14.55
					2/15/2017	Z0170	2	$ 35.84	9 30			12:30	3.00	32	60	0	0	0	0	2	$ 35.84	1 53	0	$17.92	$0 00	$35.84
					10/11/2017	Z0170	5	$ 89.60	8 00			3:00	7.00	60	60	45	0	60	0	5	$ 89.60	3.75	3	$17.92	$53.76	$35.84
					1/26/2017	Z0170	5	$ 89.60	8 33			3:15	6.75	60	60	45	0	0	30	5	$ 89.60	3 25	3	$17.92	$53.76	$35.84
					2/28/2017	Z0170	2	$ 35.84	9 35			1:00	3.50	0	0	45	0	0	0	2	$ 35.84	0.75	0	$17.92	$0 00	$35.84
					12/1/2015	Z0170	3	$ 43.65	8:49			1:25	4.50	0	60	45	0	0	0	3	$ 43.65	1.75	0	$14.55	$0 00	$43.65
					10/1/2015	Z0170	5	$ 72.75	9:10			3:15	6.00	52	60	45	60	0	30	5	$ 72.75	4.12	4	$14.55	$58 20	$14.55
					12/20/2016	Z0170	3	$ 53.76	8:17			1:00	5.25	60	0	45	0	0	0	3	$ 53.76	1.75	0	$17.92	$0 00	$53.76
					5/5/2017	Z0170	5	$ 89.60	8:45	12:04	12 50	3:15	5.75	60	60	45	42	60	30	5	$ 89.60	4 95	4	$17.92	$71 68	$17.92
					2/3/2017	Z0170	2	$ 35.84	9 30			12:00	2.50	32	0	45	0	0	0	2	$ 35.84	1 28	0	$17.92	$0 00	$35.84
					9/20/2017	Z0170	4	$ 71.68	9:19			3:15	6.00	43	60	45	60	0	30	4	$ 71.68	3 97	3	$17.92	$53.76	$17.92
					6/23/2017	Z0170	3	$ 53.76	8 31			12:34	4.00	60	60	45	0	0	0	3	$ 53.76	2.75	2	$17.92	$35 84	$17.92
					8/8/2016	Z0170	4	$ 71.68	9:17			2:20	5.00	45	60	45	60	0	0	4	$ 71.68	3 50	3	$17.92	$53.76	$17.92
					10/25/2017	Z0170	4	$ 71.68	8:45			2:03	5.25	0	60	45	60	0	0	4	$ 71.68	2.75	2	$17.92	$35 84	$35.84
					2/11/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	60	60	45	0	60	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					4/15/2016	Z0170	3	$ 43.65	11 05			3:15	4.00	0	0	45	0	60	30	3	$ 43.65	2 25	2	$14.55	$29.10	$14.55
					2/26/2016	Z0170	5	$ 72.75	8:45			3:15	6.50	0	60	45	0	0	30	5	$ 72.75	2 25	2	$14.55	$29.10	$43.65
					2/27/2017	Z0170	4	$ 71.68	8:45			2:35	6.00	60	60	45	0	0	0	4	$ 71.68	2.75	2	$17.92	$35 84	$35.84
					9/5/2017	Z0170	4	$ 71.68	9 57			3:15	5.25	0	60	45	60	0	30	4	$ 71.68	3 25	3	$17.92	$53.76	$17.92
					6/26/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	0	60	45	60	60	30	5	$ 72.75	4 25	4	$14.55	$58 20	$14.55
					12/7/2017	Z0170	5	$ 89.60	8:43			3:15	6.50	60	60	45	60	60	0	5	$ 89.60	4.75	4	$17.92	$71 68	$17.92
					1/19/2015	Z0170	4	$ 58.20	10:11			3:00	5.00	0	53	45	60	0	0	4	$ 58.20	2 63	2	$14.55	$29.10	$29.10
					12/19/2016	Z0170	3	$ 53.76	10 30			3:10	4.75	0	0	45	60	0	25	3	$ 53.76	2.17	2	$17.92	$35 84	$17.92
					2/6/2017	Z0170	3	$ 53.76	11:11			3:15	4.00	0	0	45	0	60	30	3	$ 53.76	2 25	2	$17.92	$35 84	$17.92
					2/23/2015	Z0170	4	$ 58.20	8:45			1:45	5.00	60	60	45	60	0	0	4	$ 58.20	3.75	3	$14.55	$43 65	$14.55
					6/2/2017	Z0170	5	$ 89.60	8 23			3:15	7.00	60	0	45	60	60	30	5	$ 89.60	4 25	4	$17.92	$71 68	$17.92
					5/10/2017	Z0170	2	$ 35.84	9 38			12:32	3.00	0	60	45	0	0	0	2	$ 35.84	1.75	0	$17.92	$0 00	$35.84
					1/29/2015	Z0170	3	$ 43.65	8:48			12:30	3.50	0	60	45	0	0	0	3	$ 43.65	1.75	0	$14.55	$0 00	$43.65
					3/7/2017	Z0170	4	$ 71.68	8:45			2:30	5.75	0	60	45	60	47	0	4	$ 71.68	3 53	3	$17.92	$53.76	$17.92
					8/30/2016	Z0170	5	$ 89.60	11 00			3:15	4.25	0	4	45	60	60	30	5	$ 89.60	3 32	3	$17.92	$53.76	$35.84
					11/28/2017	Z0170	3	$ 53.76	8:45			1:21	4.50	60	0	45	0	0	0	3	$ 53.76	1.75	0	$17.92	$0 00	$53.76
					3/8/2016	Z0170	5	$ 72.75	7 50			3:15	7.50	60	60	45	0	0	30	5	$ 72.75	3 25	3	$14.55	$43 65	$29.10
					10/27/2015	Z0170	5	$ 72.75	8:45			3:15	6.50	0	60	45	0	60	30	5	$ 72.75	3 25	3	$14.55	$43 65	$29.10

No Documentation Provided (Number of Claims/Amount)	2	$127
Documentation Did Not Support Minimum of Two Service Units (Number of Claims/Amount)	21	$1,069
Documentation Did Not Support Service Units Billed (Number of Claims/Amount)	73	$1,704
Total Claims Overbilled (Number of Claims/Amount)	**96**	**$2,900**
Total Claims Underbilled (Number of Claims/Amount)	**2**	**-$32**
Net Sample Overpayment Amount (Number of Claims/Amount)	**98**	**$2,868**

Exhibit B

NEW ESSECARE OF NJ, LLC
Schedule of Missing Group Sign In/Out Sheets
1/1/2015-12/31/2017

Rcp #	Clm ICN Idn	Clm Rcp Curr Idn	Rcp Latest Last Name	Rcp Latest First Name	Clm Service Date	Is date, start and end time listed on the Group Sign In/Out Sheet? (Yes/No)						
						Group 9:02-10:02	Group 10:04-11:04	Group 11:15-12:00	Group 12:32-1:32	Group 1:43-2:43	Group 2:45-3:15	Exception
7	[redacted]				9/4/2015					N/P		
8					1/20/2015		N/P			N/P		
9					5/12/2017					N/P	N/P	
11					6/16/2017				N/P	N/P		
14					8/18/2016		N/P					
14					10/2/2016	N/P	N/P		N/P	N/P	N/P	
18					11/16/2017		N/P					
32					9/7/2015				N/P			
37					5/13/2016					N/P		
38					4/4/2017					N/P		
41					9/7/2015				N/P			
48					8/3/2017	N/P				N/P		
50					9/11/2017	N/P	N/P			N/P	N/P	
51					10/27/2016						N/P	
55					1/8/2016					N/P		
59					6/30/2015	N/P						
59					8/24/2016	N/P						
60					1/20/2015					N/P		
62					1/20/2017			N/P			N/P	
67					4/3/2017						N/P	
70					7/3/2015					N/P		
74					12/8/2017	N/P		N/P				
89					8/24/2016						N/P	
90					12/20/2015	N/P	N/P		N/P			
90					2/2/2016			N/P			N/P	
91					2/15/2017						N/P	
92					10/11/2017						N/P	
94					1/26/2017				N/P	N/P		
95					3/15/2016				N/P			
95					12/1/2015				N/P			
96					5/25/2017				N/P	N/P	N/P	
98					12/20/2016		N/P					
103					3/17/2015				N/P	N/P		
103					7/22/2015					N/P		
103					2/3/2017				N/P			
104					9/20/2017					N/P		
112					2/11/2015				N/P			
117					2/26/2016	N/P			N/P	N/P		
126					12/22/2016				N/P			
127					12/11/2015					N/P		
128					12/7/2017						N/P	
					Total of Documents Not Provided (N/P)	8	7	3	14	19	12	63
					Total of Tested Documents	212	212	212	212	212	212	1272
					Percentage of Non-Compliant Documents							5.0%

NEW ESSECARE OF NJ, LLC
Schedule of Group Sign In/Out Sheets
Without Practitioner's Signature
1/1/2015-12/31/2017

Rcp #	Clm ICN Idn	Clm Rcp Curr Idn	Rcp Latest Last Name	Rcp Latest First Name	Clm Service Date	Is signature present of the practitioner who rendered the service? (Yes/No)						
						Group 9:02-10:02	Group 10:04-11:04	Group 11:15-12:00	Group 12:32-1:32	Group 1:43-2:43	Group 2:45-3:15	Exceptions
6	[redacted]	[redacted]	[redacted]	[redacted]	4/15/2015			No				
8					10/7/2016				No			
17					2/21/2017	No	No					
24					1/20/2015						No	
25					11/15/2017					No		
45					12/13/2017						No	
46					8/17/2015						No	
57					7/5/2017				No			
58					5/22/2015		No					
62					1/20/2017		No					
63					5/13/2015	No						
67					4/3/2017		No					
68					11/29/2017		No				No	
81					4/1/2016				No			
126					12/22/2016	No						
136					10/27/2015					No	No	
Total of Documents with Missing Practitioner's Signature (No)						3	5	1	3	2	5	19
Total of Tested Documents						212	212	212	212	212	212	1272
Percentage of Non-Compliant Documents												1.5%

NEW ESSECARE OF NJ, LLC
Schedule of Claims Paid in Excess of Prior Authorized Amount
1/1/2015-12/31/2017

Claim Prior Authorization Number	Claim Recipient Current Idn	Recipient Last Name	Recipient First Name	Prior Authorization From Date	Prior Authorization To Date	Prior Authorization Units Quantity	MFD Calculated Amount of Units Billed	Difference Between Authorized Units and Units Billed	Hourly Rate	Overpayment Amount
[redacted]	[redacted]	[redacted]	[redacted]	4/25/15	10/24/15	520	535	15	$14 55	$218 25
				2/2/16	8/1/16	520	525	5	$17 92	$89 60
				8/2/16	2/1/17	520	615	95	$17 92	$1,702.40
				11/13/16	5/12/17	520	535	15	$17 92	$268 80
				5/1/17	9/13/17	220	328	108	$17 92	$1,935 36
				9/24/15	3/23/16	520	530	10	$14 55	$145 50
				3/24/16	9/23/16	520	621	101	$17 92	$1,809 92
				8/24/15	2/23/16	520	574	54	$14 55	$785.70
				8/2/15	2/1/16	520	529	9	$14 55	$130 95
				3/24/16	9/23/16	520	531	11	$17 92	$197.12
				1/5/17	7/4/17	520	525	5	$17 92	$89 60
				10/3/15	4/2/16	520	593	73	$14 55	$1,062.15
				10/8/15	4/7/16	520	618	98	$14 55	$1,425 90
				5/1/17	12/10/17	520	614	94	$17 92	$1,684.48
				7/2/15	1/1/16	520	539	19	$14 55	$276.45
				1/2/16	7/1/16	520	605	85	$14 55	$1,236.75
				1/1/15	6/30/15	520	623	103	$14 55	$1,498 65
				10/6/16	4/5/17	520	525	5	$17 92	$89 60
				7/19/15	1/18/16	520	570	50	$14 55	$727 50
				5/7/16	11/6/16	520	563	43	$17 92	$770 56
				12/23/15	6/22/16	520	535	15	$14 55	$218 25
				6/23/16	12/22/16	520	611	91	$17 92	$1,630.72
				5/1/15	10/31/15	520	575	55	$14 55	$800 25
				11/1/15	4/30/16	520	525	5	$14 55	$72.75
				5/1/16	10/31/16	520	618	98	$17 92	$1,756.16
				5/1/17	10/14/17	480	545	65	$17 92	$1,164 80
				2/12/16	8/11/16	0	101	101	$17 92	$1,809 92
				8/3/15	2/2/16	520	632	112	$14 55	$1,629 60
				7/1/17	11/25/17	310	351	41	$17 92	$734.72
				8/5/17	1/3/18	260	299	39	$17 92	$698 88
				8/9/15	2/8/16	520	533	13	$14 55	$189.15
				8/9/16	2/8/17	520	594	74	$17 92	$1,326 08
				1/2/16	7/1/16	520	524	4	$14 55	$58 20
				7/27/17	10/24/17	260	265	5	$17 92	$89 60
				8/24/17	11/25/17	260	271	11	$17 92	$197.12
				12/9/15	6/8/16	520	525	5	$14 55	$72.75
				6/1/15	11/30/15	520	599	79	$14 55	$1,149.45
				6/1/16	11/30/16	520	573	53	$17 92	$949.76
				12/25/15	6/24/16	520	605	85	$14 55	$1,236.75
				12/25/14	6/24/15	520	590	70	$14 55	$1,018 50
				4/1/15	9/30/15	520	525	5	$14 55	$72.75
				10/1/15	3/31/16	520	562	42	$14 55	$611.10
				4/1/16	9/30/16	520	524	4	$17 92	$71 68
				10/1/16	3/31/17	520	562	42	$17 92	$752 64
				5/1/16	10/31/16	520	525	5	$17 92	$89 60
				11/1/16	4/30/17	520	572	52	$17 92	$931 84
				5/1/16	10/31/16	520	525	5	$17 92	$89 60
				11/1/16	4/30/17	520	600	80	$17 92	$1,433 60
				3/12/15	9/11/15	520	525	5	$14 55	$72.75
				9/12/15	3/11/16	520	581	61	$14 55	$887 55
				3/12/16	9/11/16	520	525	5	$17 92	$89 60
				9/12/16	3/11/17	520	592	72	$17 92	$1,290 24
				6/26/15	12/25/15	520	540	20	$14 55	$291 00
				6/26/16	12/25/16	520	605	85	$17 92	$1,523 20
						Total Overpayment - # of Units/Amount		3040		$41,155.80

Over Billed Prior Authorizations	54
Prior Authorization Universe	1,408
Percentage of Over Billed Prior Authorizations	3.8%