



State of New Jersey

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February 21, 2023

BY ELECTRONIC MAIL

Attn: Esther Raymond, President and Owner
c/o Marsha Tipelin, Executive Director
Community Care Behavioral Health
3443 Route 9 North, Suite #11
Freehold, NJ 07728
Email: marshat@communitycare.us

Re: Final Audit Report – Community Care Behavioral Health ([REDACTED])

Dear Ms. Tipelin:

As part of its oversight of the New Jersey Medicaid and FamilyCare programs (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) audited claims submitted by Community Care Behavioral Health (Community Care), National Provider Identification (NPI) Numbers [REDACTED] and Medicaid Provider Numbers [REDACTED], for the period January 1, 2015 through September 30, 2019 (audit period).¹ OSC hereby provides you with this Final Audit Report (FAR).

Executive Summary

OSC conducted this audit to determine whether Community Care billed for partial care services in accordance with applicable state and federal laws, regulations, and guidance. OSC selected a probability sample of 292 partial care claims totaling \$24,765 from a universe of 154,879 claims totaling \$12,854,448 billed under New Jersey local procedure code Z0170 (Partial Care, Per Hour) and Healthcare Common Procedure Coding System (HCPCS) H0035 (Mental Health Partial Care). OSC found that 76 of the 292 claims (26 percent), totaling \$1,708 in Medicaid funds paid to Community Care, failed to comply with N.J.A.C. 10:66-2.7 and/or the Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) Newsletter, "Changes to Procedure Codes and Reporting Requirements for Service Units for Partial Care," Vol. 14, No. 42

¹ Community Care sold the Morris Plains facility (Medicaid Provider Number [REDACTED]) to an unaffiliated party on May 5, 2016. Accordingly, the review period for Morris Plains' claims is from January 1, 2015 through May 4, 2016.

(June 2004). Specifically, OSC found that Community Care's documentation for these 76 claims did not fully support the number of units (i.e., hours) billed for partial care services.

To ascertain the total amount that Community Care overbilled for partial care claims billed under New Jersey local procedure code Z0170 and HCPCS code H0035, OSC extrapolated \$1,708, the net adjusted dollars in error for the deficient claims, to the total population of claims from which the sample claims was drawn, which in this case was 154,879 claims with a total Medicaid reimbursement amount of \$12,854,448. OSC calculated that Community Care received an overpayment of at least \$816,280 that Community Care must repay the Medicaid program.²

Background

Community Care, located in Freehold, Piscataway and Morris Plains, New Jersey, is a psychiatric partial care program that provides an array of psychiatric rehabilitation treatments and services, including case management, counseling, group therapy, work skill groups, as well as therapeutic, recreational and social activities. Community Care provides specialized tracks for individuals, who in addition to having a mental illness also have substance abuse issues or developmental disabilities.

Partial care programs are administered primarily by the Division of Mental Health and Addiction Services, within the New Jersey Department of Human Services. These programs provide outpatient clinical services (e.g., group and individual therapy, prevocational services, and medication management) to participants ages five and older with a primary diagnosis of psychiatric disorder accompanied by an impaired ability to perform activities of daily living, learning, working, or social roles. Pursuant to regulation, among other requirements, partial care providers must: (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. N.J.A.C. 10:66-2.7.

To satisfy the documentation requirement, on a daily basis, a partial care provider must document the specific services rendered, date and time of each service, service duration, signature of the practitioner who rendered the service, the setting in which the provider rendered services, and any unusual occurrences or significant deviations from the treatment described in the plan of care. N.J.A.C. 10:66-2.7(l).

Audit Objective

The audit objective was to determine whether Community Care maintained adequate documentation to support the services it billed, and for which it was paid, and specifically whether Community Care appropriately billed for services under New Jersey local procedure

² Using the nonparametric Empirical Likelihood Approach (ELA) for extrapolation, OSC can reasonably assert, with 90% confidence, that the total overpayment in the universe is greater than \$816,280 (15% precision) with the error point estimate as \$957,814.

code Z0170 and HCPCS code H0035 in accordance with state and federal laws and regulations, and Medicaid guidance, which includes agency newsletters.

Audit Scope

The audit scope entailed a review of Community Care's Medicaid claims for partial care services from January 1, 2015 through September 30, 2019 for Medicaid Provider Numbers [REDACTED] and [REDACTED] (Freehold and Piscataway facilities), and from January 1, 2015 through May 4, 2016 for Medicaid Provider Number [REDACTED] (Morris Plains facility). This audit was conducted pursuant to OSC's authority as set forth in N.J.S.A. 52:15C-1 to -23 and the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 to -64.

Audit Methodology

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

- Selecting of a probability sample of 292 claims (191 Medicaid participants associated with these claims) billed by Community Care under code Z0170 and HCPCS code H0035 totaling \$24,765 paid to Community Care.
- Reviewing of Community Care's records supporting the 292 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).

Audit Findings

A. Identified Deficiencies Regarding New Jersey Local Procedure Code Z0170 and HCPCS Code H0035 for Partial Care

OSC reviewed a probability sample of 292 claims for which Community Care billed and received Medicaid payments for New Jersey local procedure code Z0170 and HCPCS code H0035. OSC found that in 76 of 292 sample claims, Community Care improperly billed for more units than its documentation supported. (See Exhibit A1, Exhibit A2, and Exhibit A3.) See Table I for a breakdown by claim type exception and a calculation of the net adjusted dollars in error for these claims.

Table I: Community Care's Claims Billed In Error

Description	Number of Claims				Dollar Amount of Claims			
	Freehold	Piscataway	Morris Plains	Total	Freehold	Piscataway	Morris Plains	Total
Sampled Claims	136	137	19	292	\$11,714	\$11,669	\$1,382	\$24,765
Reasons for Claims Billed in Error:								
Claim Billed But Participant Was Absent	0	3	0	3	\$0	\$235	\$0	\$235
Documentation Did Not Support Service Units Billed	13	49	2	64	\$244	\$1,042	\$29	\$1,315
Non-Billable Meal Time	3	6	0	9	\$54	\$104	\$0	\$158
Total Claims Overbilled	16	58	2	76	\$298	\$1,381	\$29	\$1,708

Community Care requires program participants to sign their name and arrival time on a Facility Sign In/Out Sheet when they arrive at the facility and sign out with their departure time when they leave the facility.³ In addition, Community Care utilizes a weekly pre-printed Group Client Attendance Sheet ("Group Sheets") to document participants' active program attendance at the various group sessions offered by Community Care. The Group Sheets document various things about each session including, each participant's level of participation as assessed by Community Care's counselors, date, time, the name of the group session, as well as a short description of the topic discussed and the participant's engagement, and the counselor's signature. OSC reviewed both the Facility Sign In/Out Sheets and the Group Sheets to calculate the amount of time each participant was present during active programming. In order to calculate each participant's total active programming time, OSC added the total time recorded on the various Group Sheets submitted for each participant for the selected date of service.

OSC determined that in 67 of the 76 deficient claims, Community Care billed and was paid for more units than its documentation supported. In 64 of the 67 deficient claims, Community Care's documentation did not support attendance for all of the sessions for which Community Care billed and was paid by Medicaid. In the remaining three instances, Community's Care's documentation showed that the three participants associated with these claims were absent on the service date, yet Community Care billed and was paid for a full day (5 hours) of services for each of the three participants.

In instances in which the number of units in active programming was fractional, pursuant to DMAHS guidance, OSC rounded down the units to the lower whole number to determine the

³ A Facility Sign In/Out Sheet is a daily pre-printed attendance sheet indicating each participant's arrival and departure time from the facility.

proper number of units that Community Care should have billed Medicaid. DMAHS Newsletter, Vol. 14, No. 42 (June 2004). As a result, OSC adjusted 64 claims, totaling \$1,315 paid to Community Care, to reflect the proper number of units that Community Care should have billed.

In addition, OSC found that in 9 of the 76 claims, Community Care billed and was paid a total of \$158 for active programming time for which it was not entitled to be paid. Specifically, Community Care billed for active programming (group sessions) that included time participants spent eating meals, which is prohibited by N.J.A.C. 10:66-2.7(d). To address this, OSC excluded the meal times reflected in Community Care's documentation from the active programming. OSC then rounded down the number of units that Community Care should have billed, in conformity with the Medicaid Newsletter cited below.

According to N.J.A.C. 10:66-2.7(d):

For purposes of partial care, 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/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):

The 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. The description shall include, but is not limited to, a statement of patient progress noted, significant observations noted, 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.

Lastly, in accordance with DMAHS Newsletter, Vol. 14, No. 42 (June 2004):

Units 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, 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).

After Community Care received OSC's preliminary findings, it provided OSC with supplemental documentation to support some of the claims OSC found in error. In those instances where the documentation met the requirements of N.J.A.C. 10:66-2.7(l), OSC adjusted its findings accordingly. Most of Community Care's supplemental documentation, however, did not meet regulatory requirements. For example, Community Care's supplemental documentation included Weekly Progress Notes for 38 of the 64 sample claims that were missing Group Sheets. During the audit period, Community Care used two different formats for its Weekly Progress Notes. The first type of Weekly Progress Note, which Community Care provided for 3 out of 38 claims, did not include the date, time, duration of service, and the signature of the practitioner who rendered the service, all of which are required by N.J.A.C. 10:66-2.7(l), (ii), (iii), (iv). As such, OSC did not accept this supplemental documentation. The second type of Weekly Progress Note, which Community Care provided for the remaining 35 of the 38 claims, did not include the signature of the practitioner who rendered the service, as required by N.J.A.C. 10:66-2.7(l) (iv). As such, OSC did not accept this supplemental documentation.

B. Additional Non-Compliance Findings

OSC reviewed all of the Group Sheets associated with the 292 sample claims to determine whether these forms complied with Medicaid's documentation rules, including the requirements of N.J.A.C. 10:66-2.7(l). OSC identified the following exceptions relating to these documents:

- OSC's review of the Group Sheets revealed that for 24 of 292 claims, Community Care did not include the counselor's signature as required by N.J.A.C. 10:66-2.7(l)(iv). OSC is not seeking a monetary recovery for these 24 exceptions because OSC was reasonably assured based on its review of the other documentation that Community Care provided these partial care services. Community Care nonetheless should maintain this documentation in accordance with N.J.A.C. 10:66-2.7(l) and N.J.A.C. 10:49-9.8(b). (See Exhibit B.)
- OSC's review of the Group Sheets revealed that for 46 of 292 claims, Community Care did not include the group time as required by N.J.A.C. 10:66-2.7(l)(ii). OSC is not seeking a monetary recovery for these 46 exceptions because OSC was reasonably assured based on its review of the other documentation that Community Care provided these partial care services. Community Care nonetheless should maintain this documentation in accordance with N.J.A.C. 10:66-2.7(l) and N.J.A.C. 10:49-9.8(b). (See Exhibit C.)
- OSC's review of the Group Sheets revealed that for 40 of 292 claims, Community Care marked participants as having attended group sessions before their recorded arrival

time. In addition, for 11 of the 292 claims, Community Care marked participants as having attended group sessions after their recorded departure time. OSC is not seeking a recovery for these claims on these bases because they already are included in the overpayment shown in the "Identified Discrepancies Regarding New Jersey Local Procedure Code Z0170 and HCPCS Code H0035 for Partial Care, Per Hour" section of this report. Community Care nonetheless should maintain documentation in accordance with N.J.A.C. 10:66-2.7(l) and N.J.A.C. 10:49-9.8(b). (See Exhibit D.)

- OSC's review of Group Sheets revealed that 25 participants were signed into multiple group sessions offered during the same time. OSC made the appropriate adjustments within its analysis and, thus, is not seeking any additional recovery for these claims. Community Care should ensure that it is properly recording attendance at group sessions in accordance with N.J.A.C. 10:66-2.7(l) and N.J.A.C. 10:49-9.8(b). (See Exhibit E.)

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." As set forth fully above, this regulation requires providers to document, among other things, the type of service rendered, a description of the encounter, the date and time it rendered services, the duration of the services, and the signature of the practitioner or provider who rendered the services.

Additionally, providers are required to keep records in accordance with N.J.A.C. 10:49-9.8(b), which provides, in part:

(b) Providers shall agree to the following:

1. To keep such records as are 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.

Summary of Overpayments

OSC determined that for the period from January 1, 2015 through September 30, 2019, Community Care improperly billed and received payment for 76 of the 292 sample claims for New Jersey local procedure code Z0170 and HCPCS code H0035 and received a net overpayment of \$1,708 for these sampled claims. For purposes of ascertaining a final recovery amount, OSC extrapolated the dollars in error for deficient claims to the total population from which the sample claims was drawn. In this case, the universe consisted of 154,879 claims with a total payment to Community Care of \$12,854,448. OSC calculated that Community Care

received an overpayment of at least \$816,280 that Community Care must repay the Medicaid program.⁴

Recommendations

Community Care shall:

1. Reimburse the Medicaid Program the overpayment amount of \$816,280. Auditor Note: The overpayment amount was revised to reflect OSC's review and acceptance of additional documentation provided by Community Care subsequent to the October 19, 2022 Draft Audit Report.
2. Maintain documentation that fully supports the number of units billed for partial care services. Specifically, the documentation to support claims for partial care services must contain, among other elements, the specific services rendered, date and correct 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 meal time is not included in Community Care's calculation of billable hours for active programming.
4. Develop and institute procedures to ensure participants are not marked as attending group sessions prior to their recorded arrival time or after their recorded departure time.
5. Develop and institute procedures to ensure participants are not signed into multiple group sessions during the same time period.
6. Provide OSC with a Corrective Action Plan (CAP) indicating the steps Community Care will take to implement procedures to correct the deficiencies identified in this report.

Community Care's Response to the Draft Audit Report and OSC's Comments

After receipt of OSC's Draft Audit Report, Community Care submitted a written response and Corrective Action Plan (See Appendix A). In this response, which generally agreed with the audit findings, Community Care provided some additional documentation related to the audit findings, objected to certain audit findings and the sampling/extrapolation methodology, and supplied a Corrective Action Plan that addressed all of OSC's recommendations above.

After carefully reviewing Community Care's comments and its supplemental documentation, OSC concludes that Community Care's Corrective Action Plan addressed all of the recommendations above and, based on the additional documentation, OSC gave credit in those circumstances in which Community Care provided reliable support for its active programming

⁴ See footnote 2.

claims, which reduced the amount that Community Care must reimburse the Medicaid program to \$816,280.

Thank you for your attention to this matter.

Sincerely,

KEVIN D. WALSH
ACTING STATE COMPTROLLER

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

Enclosures:

Exhibit A1 - Exhibit E were omitted to maintain confidentiality

Appendix A Community Care's Response to Draft Audit Report

Appendix B Community Care's Comments to the DAR and OSC's Response

- c. Marsha Tipelin, Executive Director, Community Care
Don Catinello, Deputy Director, Medicaid Fraud Division, OSC
Justin Berardo, Supervising Regulatory Officer, Medicaid Fraud Division, OSC



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October 27, 2022

Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, New Jersey 08625

Re: Corrective Action Plan/Audit Report ([REDACTED])

Dear Medicaid Fraud Division:

In receipt of and in response to the Draft Audit Report dated October 19, 2022, please accept the following comments/plan of correction addressing the MFB recommendations:

- 1) The overpayment amount is considered negotiable
- 2) Documentation will fully support the number of units billed for partial care services, with all elements including the specific service rendered, date and correct time of the services, duration and the signature of the practitioner who rendered them. In addition to the daily group notes, the updated /requisite weekly progress notes are now completed within the agency's electronic health record system, via a template containing each client's daily group topic listed to match their schedule, as well as a recording of day, time, duration and electronic staff signature necessary to complete/save the document; these weekly notes are monitored for timeliness and completeness by the office administrator every week, as are the daily group notes for all needed elements. However, in 35 cases, you did not accept the weekly notes in lieu of individual group notes because there was only one author summarizing the week, instead of a signature of the leader of each individual daily group, despite all other present elements (refer to #5 on page 2).
- 3) The staff have been trained to document group attendance only after meal time is completed by each consumer; we note that in all 9 cases wherein the meal time was cited as incorrectly billed, the client was late due to transportation, inclement weather, a medical appointment or other non-controllable factor, and did receive the benefit of the service provided by being allowed to eat their meal while attending the group that was underway (instead of denying food of course, or isolating them from the instruction).

- 4) Procedures have been developed and instituted to ensure participants are not marked as attending group sessions prior to their arrival or after their recorded departure times. The office managers or designees match the consumer daily sign in and out sheets to the group notes for that day.
- 5) Procedures also ensure that participants are not signed into multiple group sessions during the same time period- i.e. there are preprinted forms per group with the assigned clients listed. There are times where clients become re-assigned due to behaviors or other clinical reasons, in which case the staff assure the corrections of deleting from one and adding to another group attendance sheet.

In addition to the above, Community Care Behavioral Health disputes, explains or asserts the following objections:

- 1) In one case [REDACTED] you identified a client as being billed though absent. As we discussed, all the submitted group notes for that day are present with her participation and progress rated, the transportation log shows her as in attendance, the food check off list shows she received lunch. The sign in sheet, however, mistakenly documents her as being Out. It is understood that this is the document you chose to support the billing exclusion, but the majority of clinical documentation shows otherwise and hence our objection.
- 2) The rounding down of 66 claims to the lowest whole number of units resulted in numerous hours of actual, documented service provision negated and is thereby objectionable on its face.
- 3) Regarding duplicate times on one group sheet, as I explained some group topics run multiple times per week but at different times of each day, in which case they were documented manually on one sheet for efficiency. Also, sometimes a client would leave one group in preference for another, accounting for signatures in multiple group sessions offered during the same time (see #5 above).
- 4) In the Original Summary of Findings dated April 4, 2022, the total claims indicated as overbilled were 105, resulting in a quantified \$2,542 dollar amount asserted as owed before extrapolation to \$1,244,644. In the October 19, 2022 audit report, the Medicaid Fraud Division reconsidered information sent by the agency “to support some of the claims the Office of the State Comptroller found in error”, resulting in a correction to 78 claims, quantified to \$1,744 and extrapolated to the now demanded \$832,046. We assert that given unlimited time with this research as a sole focus, we could likely find additional corrections. For example, on October 26, 2022 the Freehold office sent three group notes ([REDACTED]) that were documented as “rejected” within the October 19th report, and were then told they weren’t previously received; during the follow up phone call with [REDACTED], Chief Auditor on October 27th, he indicated they “looked good” and I should indicate their pending status in this report.
- 5) Almost half of the claims exceptions pertain to denial of submitted weekly progress notes documenting client attendance in groups, participation and progress, but disallowed for missing some staff signatures. Clearly these clients were serviced, with all the associated costs to the agency, and we object to magnification of a clerical omission. In addition, the weekly notes were authored by the same staff person who rendered the majority of the daily services summarized therein, as the schedule is structured so that each practitioner facilitates groups containing the majority of the clients in their assigned caseload. It is argued that all clinical and accountability measures are evident in the weekly reports.

- 6) In conclusion, your methodology extrapolated a total exclusion of \$1,744.00 to a potential total universe of claims from January 1, 2015 through September 30, 2019 (57 months) to then total \$832,046. Although apparently a standard accounting practice, we dispute the legitimacy of this punitive action, and question if a 1.18% sample size is statistically valid.

We appreciate these comments being added to the Final Audit Report.

And acknowledge that [REDACTED] and his team have been professional in our interactions, receptive to answering all questions and obviously judicious in their audit functions.

Sincerely,

Marsha Tipelin, LCSW, LCADC

Executive Director

Community Care's Comments to the Draft Audit Report (DAR) and OSC's Response

Community Care's written response to OSC's audit findings challenges OSC's conclusions regarding reimbursement, acceptance of supplemental documentation, and sampling and extrapolation methodology. Community Care's comments and OSC's responses are set forth below.

Community Care's Comment #1

Credit Not Provided for Absent Beneficiary

Community Care disagrees with OSC's conclusion that it billed and was paid for active programming that improperly included one absent Medicaid beneficiary. Community Care argues that: "The sign in sheet, however, mistakenly documents her as being Out." but beneficiary was marked present on the Group Sheets, Meal Sheet and Transportation Log. Therefore, Community Care requests credit for that beneficiary.

OSC's Response

OSC has considered and is not persuaded by Community Care's argument related to the absent beneficiary. It is Community Care's common practice to use Facility Sign In/Out Sheet, which is considered a primary document followed by Group Sheets, to bill for partial care services. Facility Sign In/Out Sheet is the only document signed by a beneficiary upon their entrance to the facility as well as during their departure from the facility. Beneficiaries are required to record the exact time they enter/depart the facility and sign their name on this daily log. Moreover, there was a notation next to the client's name on the Facility Sign In/Out Sheet that the beneficiary was "OUT" (presumably written by a Community Care staff member). OSC is not persuaded by Community Care's argument related to the absent beneficiary.

Community Care's Comment #2

Rounding Down of Claims to the Lower Whole Number

Community Care argued that OSC's rounding down of 66 claims to the lowest whole number of units resulted in numerous hours of actual, documented service provision being negated and is thereby objectionable on its face.

OSC's Response

As a Medicaid provider, Community Care agreed to adhere to the laws, regulations, contractual and other obligations of the Medicaid program. 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. Since Community Care billed in violation of the DMAHS Newsletter, Vol. 14, No. 42 (June 2004), it is not entitled to receive reimbursement for

the full hour of claimed partial care services, whenever the full hour of service was not provided.

Community Care's Comment #3

Duplicate Times on Group Sheet

Community Care provided the following explanation concerning duplicate group times recorded on the same Group Sheet: "Regarding duplicate times on one group sheet, as I explained some group topics run multiple times per week but at different times of each day, in which case they were documented manually on one sheet for efficiency. Also, sometimes a client would leave one group in preference for another, accounting for signatures in multiple group sessions offered during the same time. Procedures also ensure that participants are not signed into multiple group sessions during the same time period i.e. there are preprinted forms per group with the assigned clients listed. There are times where clients become re-assigned due to behaviors or other clinical reasons, in which case the staff assure the corrections of deleting from one and adding to another group attendance sheet."

OSC's Response

Included within its response, Community Care provided additional documentation. In some instances where Community Care's underlying documentation showed that participants attended multiple group sessions at the same time, OSC credited those claims where the documentation provided reasonable assurance that participants attended the requisite units of active programming billed to and paid by the Medicaid program. In those instances where Community Care did not provide additional documentation, OSC did not grant any credit.

Community Care's Comment #4

Additional Documentation Submitted

Community Care stated the following: "In the Original Summary of Findings dated April 4, 2022, the total claims indicated as overbilled were 105, resulting in a quantified \$2,542 dollar amount asserted as owed before extrapolation to \$1,244,644. In the October 19, 2022 audit report, the Medicaid Fraud Division reconsidered information sent by the agency "to support some of the claims the Office of the State Comptroller found in error", resulting in a correction to 78 claims, quantified to \$1,744 and extrapolated to the now demanded \$832,046. We assert that given unlimited time with this research as a sole focus, we could likely find additional corrections. For example, on October 26, 2022 the Freehold office sent three group notes [REDACTED] that were documented as "rejected" within the October 19th report, and were then told they weren't previously received; during the follow up phone call with [REDACTED], Chief Auditor on October

27th, he indicated they “looked good” and I should indicate their pending status in this report.”

OSC's Response

Throughout the audit process, OSC provided Community Care ample opportunity to provide additional documents/information to support its claims. OSC reviewed all of the submissions by Community Care and adjusted its findings accordingly for all partial care services that were supported by the additional documentation. At each stage of the audit process, including this FAR, OSC provided Community Care with a listing of all claims that OSC found deficient and the basis for such finding. In response to DAR, Community Care submitted additional documentation for deficient claims related to three beneficiaries, all of which was thoroughly reviewed and considered by OSC. Group Sheets submitted by Community Care for two of the claims satisfied documentation requirements and OSC adjusted the claims accordingly. The Group Sheets submitted for the third claim did not match the date of service for the deficient claim and, therefore, OSC denied this claim.

Community Care's Comment #5 Progress Notes Not Accepted

Community Care commented that almost half of the claim exceptions pertain to the denial of submitted weekly progress notes documenting beneficiary attendance but disallowed for missing staff signatures. Community Care emphasized that these beneficiaries were serviced, and characterized these omissions as “clerical omission”.

OSC's Response

Community Care's argument is without merit. As discussed in the report, Community Care provided OSC with Weekly Progress Notes as supplemental documentation to support some of the claims OSC found in error. During the audit period, Community Care used two different formats to document Weekly Progress Notes. In both formats, Community Care omitted certain key information, such as the date, time, duration of service, and the signature of the practitioner who rendered the service, all of which are required by N.J.A.C. 10:66-2.7(l), (ii), (iii), and (iv). As such, OSC did not accept Weekly Progress Notes as supplemental documentation for these errors.

Community Care's Comment #6 Sampling and Extrapolation Methodology

Community Care commented that “OSC's methodology extrapolated a total exclusion of \$1,744.00 to a potential total universe of claims from January 1, 2015 through September 30, 2019 (57 months) to then total \$832,046. Although apparently a standard accounting practice, we dispute the legitimacy of this punitive action, and question if a 1.18% sample size is statistically valid.”

OSC's Response

OSC used statistical sampling to select and then evaluate the Community Care claims. OSC then used a valid and appropriate extrapolation methodology to determine a fair and conservative overpayment amount. OSC also provided Community Care with all of the necessary information to validate the legitimacy of both its sample and extrapolation.

Community Care questioned the sample size used by OSC but did not raise any specific objection. First, the size of the sample has no bearing on the validity of the sample or extrapolation. Second, without more detail, Community Care has failed to raise a valid objection. Community Care also objected to OSC's use of sampling and extrapolation on the basis that it "dispute(s) the legitimacy of this punitive action." Again, Community Care questioned the "legitimacy" of OSC's methodology without stating any specific objections to OSC's sample or extrapolation.