



State of New Jersey

PHILIP D. MURPHY
Governor

SHEILA Y. OLIVER
Lt. Governor

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION
P.O. BOX 025
TRENTON, NJ 08625-0025
(609) 826-4700

KEVIN D. WALSH
Acting State Comptroller

JOSH LICHTBLAU
Director

July 17, 2023

BY ELECTRONIC MAIL

Dr. Jonathan Michael, DPM, Owner
Tri County Foot and Ankle Center, LLC
855 Broadway
Bayonne, NJ 07002

Re: Final Audit Report – Tri County Foot and Ankle Center

Dear Dr. Michael:

As part of its oversight of the Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of claims Tri County Foot and Ankle Center, LLC (Tri County) submitted under National Provider Identification Number [REDACTED] for the period from May 22, 2014 through May 21, 2019 (audit period). OSC hereby provides you with this Final Audit Report.

Executive Summary

Tri County specializes in podiatric medicine and provides Durable Medical Equipment (DME). Tri County, which was incorporated in 2007, maintains seven office locations in New Jersey: Bayonne; Clifton; Colts Neck; East Brunswick; Jersey City; Kearny; and Randolph. OSC reviewed Medicaid claims submitted by, and paid to, Tri County during the audit period to determine whether Tri County billed in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether Tri County correctly billed for office visits, custom orthotic inserts, and castings.

During the audit period, Tri County received \$2,798,129 in Medicaid payments from 33,145 claims. This audit focused on beneficiary dates of service (DOS) that included one or more of the following codes: Center for Medicare & Medicaid Services Healthcare Common Procedure Coding System (HCPCS) L3000 and American Medical Association Current Procedural Terminology (CPT) codes 99203, 99213, and S0395. OSC excluded claims that Managed Care Organizations (MCOs) previously reviewed. OSC's audit of the four procedures comprised approximately 58.7 percent of Tri County's total Medicaid billings (\$1.64 million of \$2.8 million).

OSC reviewed a statistically valid sample of 130 DOS, comprised of 291 Medicaid claims submitted by, and paid to, Tri County between May 22, 2014 and May 21, 2019, totaling \$40,427. OSC determined that Tri County failed to bill properly 130 of the 291 claims (76 of 130 DOS). OSC found monetary errors in 67 of the 291 claims (35 of 130 DOS), totaling \$5,824 out of \$40,427 in paid claims (14.4 percent). With respect to these 67 claims, Tri County violated N.J.A.C. 10:49-9.8 by not maintaining records that fully documented the services provided and by inaccurately billing HCPCS/CPT codes.

For purposes of ascertaining a final recovery amount, OSC extrapolated the error dollars for DOS that failed to comply with state regulations to the total dollars in the universe from which the sample of DOS was drawn, which in this case was 9,437 DOS, comprised of 14,895 claims with a total payment of \$1,644,179. By extrapolating the dollars in error over the entire audit universe, OSC calculated that Tri County improperly received an overpayment of at least \$168,878 that it must repay to the Medicaid program.¹

As part of the findings above, OSC found that in 127 sampled custom insert claims, Tri County billed Medicaid before providing the items to beneficiaries. OSC seeks a monetary recovery in 64 of the 127 claims because those claims were coded improperly or lacked a manufacturer invoice. OSC does not seek a monetary recovery in the remaining 63 instances because there is sufficient evidence in the record to show that beneficiaries received the items for which Tri County billed and was paid by Medicaid. Nonetheless, Tri County should discontinue this practice because it is improper to bill in advance of providing the service. Moreover, Tri County's practice of billing for services before the beneficiary received the item could have contributed to several of the findings identified in this report.

Background

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS) contracts with five MCOs to administer the provision of health care services to Medicaid beneficiaries in New Jersey. That contract requires MCOs and their network providers to adhere to applicable state and federal laws and regulations. Pursuant to Tri County's application to join the Medicaid program and as a provider in one or more MCO networks, Tri County agreed to comply not only with state and federal laws and regulations, including the provider certification and recordkeeping requirements set forth in N.J.A.C. 10:49-9.8, but also with the guidelines established by each MCO with whom it contracted. According to N.J.A.C. 10:49-9.8 providers must "keep such records as are necessary to disclose fully the extent of services provided."

Podiatric medicine is defined as:

[T]he diagnosis or treatment of or the holding out of a right or ability to diagnose or treat any ailment of the human foot or ankle, including local manifestations of systemic diseases as they appear on the lower leg, foot or ankle . . . or the holding out of a right or

¹ MFD can reasonably assert, with 90% confidence, that the total overpayment in the universe is greater than \$168,878.24 (15.72% precision) with the error point estimate as \$200,389.30.

ability to treat the same by any one or more of the following means: local medical, mechanical, surgical, manipulative and physio-therapeutic, including the application of any of the aforementioned means to the lower leg and ankle for the treatment of a foot or ankle ailment.

[N.J.S.A. 45:5-7.]

DME is defined as:

[A]n item or apparatus, other than hearing aids and certain prosthetic and orthotic devices . . . which . . . is primarily and customarily prescribed to serve a medical purpose and is medically necessary . . . is not useful to a beneficiary in the absence of a disease, illness, injury or disability and is capable of withstanding repeated use.

[N.J.A.C. 10:59-1.2.]

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

During the audit period, Tri County submitted 33,145 Medicaid claims for which Tri County received payments totaling \$2,798,129. OSC selected the audit sample from DOS that included HCPCS code L3000 and/or CPT codes 99203, 99213, and S0395, which comprised approximately 58.7 percent of Tri County’s total Medicaid billings (\$1.64 million out of \$2.8 million). The audit universe consisted of office visits, custom orthotic inserts and castings. Table I provides a breakdown of the audit universe summarized by category of the item description, HCPCS/CPT codes, number of claims, and dollar amount.

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

Category Description	HCPCS/ CPT Codes	Number of Claims	Claim Amount
Custom Orthotic Inserts	L3000	4,529	\$950,167
Office Visits	99203, 99213	9,116	470,853
Casting	S0395	1,250	223,159
Total		14,895	\$1,644,179

According to the Center for Medicare and Medicaid Services, Medicare Benefit Policy Manual, Chapter 15, Section 140, orthotic shoe inserts are:

total contact, multiple density, removable inlays that are directly molded to the patient’s foot or a model of the patient’s foot or directly carved from a patient-specific, rectified electronic model

and that are made of a suitable material with regard to the patient's condition.

Tri County primarily billed custom orthotic inserts using HCPCS code L3000, which covers the supply of a removable foot insert custom fabricated from a model of the patient's foot.

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

Audit Objective

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

Audit Scope

The audit scope was May 22, 2014 through May 21, 2019. This audit was conducted pursuant to the authority of the Office of the State Comptroller as set forth in N.J.S.A. 52:15C-23 and the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 to -64.

Audit Methodology

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

- Selecting a statistical sample of 130 Medicaid beneficiaries' DOS that included 291 paid claims, totaling \$40,427. These 130 DOS included HCPCS code L3000 (custom orthotic inserts) along with CPT codes 99203 and/or 99213 (office visits), and/or S0395 (casting) and were selected from a total universe of 9,437 DOS, comprised of 14,895 paid claims, for which Medicaid paid Tri County a total of \$1,644,179.
- Reviewing records to determine whether Tri County maintained documentation that complied with the requirements of N.J.A.C. 10:49-1.1 to -24.5, including N.J.A.C. 10:49-9.8.

Audit Findings

OSC reviewed the patient records associated with the 291 Medicaid claims. The 291 claims covered custom orthotic inserts, castings, and office visits. OSC determined that Tri County failed to bill properly 130 of the 291 claims (76 of 130 DOS). OSC found monetary errors in 67 of the 291 claims (35 of 130 DOS), totaling \$5,824 out of \$40,427 paid claims (14.4 percent). OSC found that Tri County violated N.J.A.C. 10:49-9.8 by not maintaining records that fully documented the services provided and/or by inaccurately billing HCPCS/CPT codes. The errors included claims that Tri County (i) upcoded (billed at a higher paying code than permitted); (ii) failed to adequately

support with manufacturer invoices; (iii) double billed (billed for more items that its documentation supported); and (iv) underbilled (billed for a lower code that its documentation supported). In the remaining 63 deficient claims, OSC found that Tri County billed Medicaid prior to dispensing the item, which is not appropriate, but constitutes a non-monetary finding because OSC was able to obtain reasonable assurance that beneficiaries received these inserts as ordered and billed. See Table II for a breakdown of the identified exceptions (i.e., claims that failed to meet the state regulations) and Exhibit II for an individual sample claim breakdown by exception.

Table II: Audit Exceptions

Exception Type	Number of Claims In Error	Claim Dollar Amount In Error	Percentage of Sample Dollars in Error to Total Dollars Sampled (\$40,427)
Upcoding	62	\$5,201	13%
No Manufacturer's Invoice	2	353	<1%
Double Billed	1	308	<1%
Underbilling	2	(38)	(<1%)
<i>Subtotal of monetary Exceptions</i>	67	\$5,824	14.4%
Non-monetary (Billed before delivery)	63	0	0%
Total	130	\$5,824	14.4%

OSC extrapolated the sample results to the audit universe. From this extrapolation, OSC calculated that Tri County received a total overpayment of at least \$168,878.² OSC's findings regarding each of the exception types are discussed further below.

A. Upcoding

For each sampled claim, OSC compared the information written in the beneficiary's medical record to the third party manufacturer invoices to determine whether the item provided to the beneficiary matched the HCPCS code description of an L3000 insert, which was the item that Tri County billed and received payment from the Medicaid program.³ OSC found that in 62 of 291 claims, totaling \$5,201 out of the \$40,427 sampled, Tri County did not maintain the documentation necessary to support billing for L3000 custom inserts. Specifically, Tri County failed to maintain insert order forms and manufacturer invoices to demonstrate that the manufacturer had provided Tri County with L3000 inserts. Consequently, OSC downcoded all 62 claims to the next lower paid code, L3010 (Foot, insert, removable, molded to patient model, longitudinal arch support, each).

² See footnote 1.

³ Per HCPCS official code description, L3000 should be billed for foot insert, removable, molded to patient model, "UCB" type, Berkeley Shell, each. The provider should report this code for the supply of each removable foot insert molded from a three-dimensional model of the patient's own foot. This code includes the supply of a rigid insert that may be made of plastic, leather, or other synthetic material.

The following is an example of an L3000 claim that OSC downcoded to L3010. According to Tri County's records, a Tri County podiatrist casted a beneficiary for a pair of "functional orthotics" and ordered orthotics on April 19, 2017. The third party manufacturer's invoice, dated May 2, 2017, stated that the manufacturer provided Tri County with custom orthotics and listed the beneficiary's name, order number, and price but no other product details or specification for what type of insert Tri County ordered and the manufacturer provided to Tri County. Tri County's medical record indicated that the beneficiary picked up the custom inserts on November 11, 2017, 206 days after Tri County placed the order with the third party manufacturer. The signed delivery form in Tri County's records stated that Tri County dispensed "orthotics" to the beneficiary. Since OSC could not reasonably determine whether the item the beneficiary received was the same as the item prescribed and for which Tri County billed and received payment, OSC downcoded the claim to a lower paid custom orthotic insert HCPCS code (procedure code L3010). See Exhibit III.

N.J.A.C. 10:49-9.8(b) requires providers to "keep such records as are necessary to disclose fully the extent of services provided." Tri County's records show that in these 62 instances, Tri County inappropriately billed HCPCS codes that resulted in higher reimbursement amounts than what Tri County's documentation could support. Therefore, the 62 claims are in violation of N.J.A.C. 10:49-9.8(b).

B. No Manufacturer Invoice

OSC found that Tri County failed to possess invoices to support 2 of the 291 claims reviewed, totaling \$353 of the \$40,427 sampled. For these two sampled claims, Tri County did not possess sufficient reliable documentation to demonstrate that it had obtained these items from a third-party manufacturer.

N.J.A.C. 10:49-9.8(b) requires providers to "keep such records as are necessary to disclose fully the extent of services provided." Since Tri County failed to maintain invoices to support the items billed, OSC finds these two claims totaling \$353 to be in violation of N.J.A.C. 10:49-9.8(b).

C. Duplicate Claims

OSC found that 1 of the 291 claims reviewed was duplicative. In this instance, Tri County billed four L3000 orthotic inserts through three separate claims for the same beneficiary, same date of service, and same HCPCS code (one claim with two units-left and right together, and two claims with one unit for the left and one for the right). Specifically, Tri County billed for four units of L3000 for service date January 30, 2017, but Tri County's records showed that Tri County had ordered from a third party manufacturer just two inserts for this beneficiary for this service date. As a result, Tri County received an overpayment of \$308, the amount paid for the two units for which Tri County lacked supporting documentation.

D. Underbilling

OSC found that 2 of the 291 claims reviewed were billed for a lower amount than Tri County's documentation supported. As a result, OSC adjusted these two claims to reflect the correct payment for HCPCS code L3010. The adjustment resulted in a \$38 credit that OSC accounted for in its extrapolated findings.

E. Non-Monetary Issue

OSC found that for 127 of the 291 claims reviewed, Tri County prematurely billed Medicaid for services. Specifically, Tri County billed Medicaid for 127 orthotic claims before Tri County had received the items from its third party suppliers and before Tri County had provided the items to the beneficiaries. Pursuant to N.J.A.C. 10:59-1.7(a), “[m]edical suppliers may request payment for medical supply services only after the supply/equipment has been delivered to the beneficiary.”

According to Tri County’s records, Tri County provided 127 inserts to beneficiaries an average of 40 days after Tri County had already billed Medicaid for these inserts. OSC identified two instances (Sample Numbers 188 and 189) in which Tri County billed Medicaid 206 days before it provided the goods for which it billed the Medicaid program and for which it was later paid.

OSC is only seeking a monetary recovery in 64 of the 127 instances based on one or more additional regulatory violations discussed above. In the remaining 63 claims, OSC is not seeking a monetary recovery because there is sufficient evidence in the record to show that beneficiaries received the items that Tri County billed. *See Exhibit II.*

Summary of Overpayments

OSC determined that for the audit period, Tri County improperly billed and received payment for 130 of 291 claims (76 of 130 DOS) sampled. Of the 130 claims, 63 had non-monetary errors. Therefore, 67 of 291 sampled claims (35 of 130 DOS) had monetary errors resulting in an overpayment of \$5,284. OSC extrapolated the error dollars to the audit universe of 9,437 DOS (14,895 claims) totaling \$1,644,179. By extrapolating the dollars in error over the entire audit universe, OSC calculated that Tri County received an overpayment of at least \$168,878 that Tri County must repay to the Medicaid program.⁴

Recommendations

1. Tri County shall reimburse the Medicaid program \$168,878.
2. Tri County must ensure that it adequately documents the Medicaid services and durable medical equipment and/or medical supplies provided in a comprehensive manner in a patient’s record in accordance with N.J.A.C. 10:49-9.8 and N.J.A.C. 10:49-5.5(a)13 before submitting a claim for payment.
3. Tri County shall maintain sufficient reliable documentation that fully discloses the extent of services provided, e.g., obtaining detailed third party manufacturer invoices that fully document the product details and specifications for custom inserts.
4. Tri County shall work with its third party manufacturers to ensure receipt of accurate, descriptive and patient-specific invoices containing product details for custom ordered inserts.

⁴ See footnote 1.

5. Tri County must discontinue billing Medicaid more than once for the same service to the same beneficiary on the same date of service.
6. Tri County must discontinue the practice of billing Medicaid before fully performing services.
7. Tri County shall provide training to its employees to address the deficiencies identified in this report.
8. Tri County must provide OSC with a Corrective Action Plan (CAP) indicating the steps it will take to implement procedures to correct the deficiencies identified in this report.

Tri County's Response to the Draft Audit Report and OSC's Comments

After receipt of OSC'S Draft Audit Report (DAR), Tri County, through counsel, submitted a written response (See Appendix A). In its response, Tri County disagreed with OSC's determination that it had received an overpayment. In support, Tri County maintained that it (i) provided all the relevant services and medical equipment; (ii) accurately billed the applicable services and equipment; (iii) provided the MFD with sufficient documentation to establish same; and (iv) did not submit any duplicate bills to Medicaid. Tri County did not provide a corrective action plan (CAP) to address the recommendations contained in OSC's DAR.

OSC addresses each argument raised by Tri County in Appendix B, entitled "Tri County's Comments to the Draft Audit Report and OSC's Responses." As explained more fully in that document, OSC found that Tri County failed to demonstrate that its documentation adequately supported its claims. Moreover, Tri County's failure to provide a CAP is cause for concern because, by failing to do so, Tri County has not provided assurance that it will correct its deficient practices. Accordingly, Tri County must reimburse the Medicaid program \$168,878, maintain sufficient documentation in the patient medical record that fully discloses the extent of services provided, and, discontinue the practice of billing Medicaid before fully performing service.

Thank you for your attention to this matter.

Sincerely,

KEVIN D. WALSH
ACTING STATE COMPTROLLER

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

Enclosures (Omitted Unless Otherwise Noted):

Exhibit I - AMA HCPCS Code Descriptions

Exhibit II – Testing Results Summary

Exhibit III - Example of Upcoding

Appendix A – Tri County’s Response to the Draft Audit Report (Included)

Appendix B – Tri County Comments and OSC’s Response (Included)

Cc: Peter Sepulveda, Esq., Mandelbaum Barrett PC

Don Catinello, Deputy Director, Medicaid Fraud Division, OSC

Justin Berardo, Supervising Regulatory Officer, Medicaid Fraud Division, OSC

Mohamed H. Nabulsi, Esq.
mnabulsi@mblawfirm.com
d. 973-243-7933

3 Becker Farm Road, Suite 105
Roseland, New Jersey 07068
t. 973-736-4600 f. 973-325-7467
<http://www.mblawfirm.com>

February 27, 2023

[REDACTED]

[REDACTED]

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

**RE: Tri County Foot and Ankle Center, LLC
Response to Draft Audit Report (“DAR”)**

Dear [REDACTED]

As you are aware, we represent Tri County Foot and Ankle Center, LLC (“Tri County”). We are in receipt of the Medicaid Fraud Division’s Draft Audit Report (“DAR”) dated February 1, 2023. Please allow this letter to serve as Tri County’s response to same. As a threshold matter, please remove all references to Dr. Michael in the DAR and as a named addressee on all communications, as any alleged errors and billings were submitted on behalf of the business entity, Tri County, as such references are highly prejudicial to Dr. Michael and serve no legitimate purpose; rather, it would only sully his otherwise unblemished reputation.

At the outset, we would note that Tri County understands and appreciates the role of the Medicaid Fraud Division (“MFD”) in protecting the interests of the state and federal taxpayers and in protecting the integrity of the Medicaid program as vital to ensuring that medical care is delivered to those most in need. To that end, Tri County is dedicated to serving those who are less fortunate and takes great pride in serving New Jersey’s Medicaid population. As evidenced by the record in this case (specifically, Tri County’s ability to successfully rebut the MFD’s original contentions, which resulted in a 70% decrease in the MFD’s calculation of the alleged overpayment), Tri County is a legitimate and responsible Medicaid provider whose policies, practice and protocols are deliberately designed to comply with all applicable laws, regulations and guidance.

Despite the unduly burdensome and protracted nature of the MFD’s audit, Tri County was fully cooperative with the MFD with respect to the audit and complied with document requests that were intended to serve as “patch-work” for the contentions Tri County successfully rebutted. During the course of the audit, Tri County expended significant time and resources to substantiate the propriety of its billing, which could have been avoided had the MFD focused on whether the billed services were provided rather than seeking to apply regulations in an overly stringent manner to justify its initial impressions and pecuniary objective.

Appendix A

Tri County Response

To say that Tri County is disappointed in the DAR findings would be an enormous understatement. Tri County has never, and would never, bill for a service or item of medical equipment that was not provided. Tri County prides itself on its long-standing reputation for top-quality medical care and integrity. The DAR will needlessly and permanently damage the reputation of Tri County and associate Tri County with fraud where there is not a single finding that sounds in fraud or in services not rendered to Medicaid recipients served by Tri County.

A. Upcoding

The MFD's primary finding in the DAR is that custom orthotics provided by third party manufacturer Lab 2000 were insufficient to substantiate a billing for an L3000 claim and should be downcoded to coded L3010. This finding puts form over substance and removes common sense from the analysis. While conducting an audit must involve a certain amount of rigidity, it should not result in a finding that is illogical and is contradicted by the operative circumstances.

Through significant effort on the part of Tri County, Tri County obtained additional records from Lab 2000. These records are enclosed herewith and should be considered by MFD when reviewing the audit findings. When taken in conjunction with the records already provided by Tri County, these records clearly establish the appropriateness of Tri County's billings and the sufficiency of the records necessary to evaluate whether the service was provided.

MFD is in possession of evidence that overwhelmingly establish that the underlying service was rendered, including the medical records, patient visit notes, prescriptions for durable medical equipment, invoices for custom orthotics, credit cards payments for the custom orthotics, patient signature logs for the custom orthotics, and the Medicaid billing records for each beneficiary. In each of the cases where Tri County billed the Medicaid program for code L3000, the patient record indicates that the device provided was fabricated from a three-dimensional model of the patient's own foot. In all such cases where L3000 was billed, the device ordered and the actual device delivered to the patient had a molded heel cup and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot.

Tri County ordered its custom orthotics from several laboratories during the time period relevant to this audit. The medical diagnoses and prescriptions were similar across the patient populations and the laboratory used. The only difference between the custom orthotics provided for patients where Tri County used another lab and those where Tri County used Lab 2000 was the documentation maintained by Lab 2000. These patients presented with the same or similar foot condition, were seen by the same doctor, received a similar written prescription, and a received similar custom orthotic fabricated after a foam mold was taken with a molded heel cup of substantial height. There is nothing in any record from which any reasonable person would draw an inference that one set of patients received a medical device that should have been billed as L3000 and another set of Tri County's patient population received a medical device that should have been billed as L3010. Many of these individuals were patients of Tri County for several years receiving orthotics from more than one lab. It is logical that the same patient who received an orthotic at level L3000 from one lab would have also received the same orthotic when receiving the orthotic custom made by Lab 2000.

MFD is fully aware of the orthotic that was ordered by Tri County and that which was delivered and used by the patient. To pretend, for purposes of justifying its audit, that the patients did not all receive a similar orthotic is to subscribe to a fiction simply because a third party manufacturer did not conform its paperwork to MFD's liking. While N.J.A.C. 10:49-9.8(b) requires providers to "keep such records as are necessary to disclose fully the extent of services provided," it does not require perfect

Appendix A

records (although our client certainly aspires for perfection in the operation of his practice). Based on the totality of the circumstances as well as the patient records, prescriptions, invoices, payments made and other information available to MFD, the extent of the services provided – a custom orthotic meeting the requirements of L3000 – has been clearly and convincingly established.

The DAR identified one particular example of an L3000 claim that MFD downcoded to L3010. One factor cited by MFD in this analysis was that the medical record indicated that the beneficiary picked up the inserts 206 days after Tri County placed the order with the third-party manufacturer. Given that this was the only example used by MFD to demonstrate that many of Tri County's claims for L3000 should be downcoded, it is worth noting what is notably absent from this example. Specifically, although the MFD has access to all of the medical records of the applicable recipient in the example, the MFD failed to mention that the recipient's underlying medical condition actually ***clinically indicated and required*** an orthotic that met the requirements of L3000. MFD would also know that the applicable recipient underwent foot surgery during the intervening time period, offering something of an explanation to the delay in picking up the orthotic. Additionally, MFD does not offer any explanation regarding as to whether the recipient was contacted or whether any efforts were made to determine what orthotic was received by the recipient. We submit that the materiality of these omitted facts underscores the arbitrary and capricious nature of the MFD's overpayment calculation and its disregard for the clinical interests of the actual recipients of our client's services.

B. No Manufacturer Invoice

We submit that the claims for which our client was not able to produce a manufacturer invoice were so negligible (i.e., 2 out of 291 claims is below a 1% error rate) such that the to render this discrepancy wholly immaterial to the propriety of the underlying claims. Given that Tri County possessed the invoices in 99.31% of all claims dating back several years, this should not result in any adverse audit finding. Such an error rate is of no significance especially where, as is the case here, there is no information to suggest that the medical device was not properly ordered, manufactured, and delivered to the Medicaid recipient.

C. Duplicate Claims

This finding is incorrect and should be removed from the DAR. We ask that MFD review the billings for this recipient, which would indicate that the L3000 was originally submitted on 2/1/17 on two separate line items with one unit per line with the RT and LT modifiers indicating right and left. This claim was denied with no payment paid to Tri County. The claim was rebilled as a corrected claim with L3000 – 2 units on a single line item. Payment on this claim was received in the amount of \$308.00.

This instance represented 1 of 291 claims reviewed for duplicate billing. Even if it was a double bill, it would represent a negligible error rate of .0034%. Since it is not in error, Tri County should be acknowledged to have a 0% error rate regarding duplicate claims, indicative of its reputation in the community for honesty and professionalism.

Summary of Position

Tri County disagrees with the MFD's determination that any refund is due to the Medicaid program. It maintains that it: (i) provided all the relevant services and medical equipment (ii) accurately billed the applicable services and equipment, (iii) provided the MFD with sufficient documentation to establish same, and (iv) did not submit any duplicate bills to Medicaid.

Appendix A

We would ask that, in your pursuit of fairness and in the interests of maintaining the integrity of the audit process and not undermining a long-standing Medicaid provider, you reevaluate your findings. Taking a step back yields an undeniable view of Tri County as a practice that did not bill for any services not provided, not a single time, a practice that fully complied with this audit and has dedicated itself to serve this underserved community.

Regards,

/s/ Mohamed Nabulsi
Mohamed H. Nabulsi, Esq.

Note: Attached patients' documentation omitted herein.

Tri County's Comments to the DAR and OSC's Responses

In its response to the Draft Audit Report (DAR), Tri County presented several arguments that it claimed rebutted OSC's findings and, as a result, Tri County maintained that it did not owe the Medicaid program any funds. Set forth below are Tri County's objections to the DAR and OSC's response to each.

Tri County Comments: Audit Finding - Upcoding

"The MFD's primary finding in the DAR is that custom orthotics provided by third party manufacturer Lab 2000 were insufficient to substantiate a billing for an L3000 claim and should be downcoded to code L3010. This finding puts form over substance and removes common sense from the analysis. While conducting an audit must involve a certain amount of rigidity, it should not result in a finding that is illogical and is contradicted by the operative circumstances.

"Through significant effort on the part of Tri County, Tri County obtained additional records from Lab 2000. These records are enclosed herewith and should be considered by MFD when reviewing the audit findings. When taken in conjunction with the records already provided by Tri County, these records clearly establish the appropriateness of Tri County's billings and the sufficiency of the records necessary to evaluate whether the service was provided.

"MFD is in possession of evidence that overwhelmingly establish that the underlying service was rendered, including the medical records, patient visit notes, prescriptions for durable medical equipment, invoices for custom orthotics, credit cards payments for the custom orthotics, patient signature logs for the custom orthotics, and the Medicaid billing records for each beneficiary. In each of the cases where Tri County billed the Medicaid program for code L3000, the patient record indicates that the device provided was fabricated from a three-dimensional model of the patient's own foot. In all such cases where L3000 was billed, the device ordered and the actual device delivered to the patient had a molded heel cup and trim lines with substantial height to provide both medial and lateral directive forces to control the hind and fore foot.

"Tri County ordered its custom orthotics from several laboratories during the time period relevant to this audit. The medical diagnoses and prescriptions were similar across the patient populations and the laboratory used. The only difference between the custom orthotics provided for patients where Tri County used another lab and those where Tri County used Lab 2000 was the documentation maintained by Lab 2000. These patients presented with the same or similar foot condition, were seen by the same doctor, received a similar written prescription, and a received similar custom orthotic fabricated after a foam mold was taken with a molded heel cup of substantial height. There is nothing in any record from which any reasonable person would draw an inference that one set of patients received a medical device that should have been billed as L3000 and another set of Tri County's patient population received a medical device that should have been billed as L3010. Many of these individuals were patients of Tri County for several years receiving orthotics from more than one lab. It is logical that the same patient who received an orthotic at level L3000 from one lab would have also received the same orthotic when receiving the orthotic custom made by Lab 2000.

“MFD is fully aware of the orthotic that was ordered by Tri County and that which was delivered and used by the patient. To pretend, for purposes of justifying its audit, that the patients did not all receive a similar orthotic is to subscribe to a fiction simply because a third party manufacturer did not conform its paperwork to MFD’s liking. While N.J.A.C. 10:49-9.8(b) requires providers to “keep such records as are necessary to disclose fully the extent of services provided,” it does not require perfect records (although our client certainly aspires for perfection in the operation of his practice). Based on the totality of the circumstances as well as the patient records, prescriptions, invoices, payments made and other information available to MFD, the extent of the services provided – a custom orthotic meeting the requirements of L3000 – has been clearly and convincingly established.

“The DAR identified one particular example of an L3000 claim that MFD downcoded to L3010. One factor cited by MFD in this analysis was that the medical record indicated that the beneficiary picked up the inserts 206 days after Tri County placed the order with the third-party manufacturer. Given that this was the only example used by MFD to demonstrate that many of Tri County’s claims for L3000 should be downcoded, it is worth noting what is notably absent from this example. Specifically, although [t]he MFD has access to all of the medical records of the applicable recipient in the example, the MFD failed to mention that the recipient’s underlying medical condition actually *clinically indicated* and *required* an orthotic that met the requirements of L3000. MFD would also know that the applicable recipient underwent foot surgery during the intervening time period, offering something of an explanation to the delay in picking up the orthotic. Additionally, MFD does not offer any explanation regarding as to whether the recipient was contacted or whether any efforts were made to determine what orthotic was received by the recipient. We submit that the materiality of these omitted facts underscores the arbitrary and capricious nature of the MFD’s overpayment calculation and its disregard for the clinical interests of the actual recipients of our client’s services.”

OSC Response

OSC found that in approximately 50 percent of sampled HCPCS L3000 claims, Tri County did not provide documentation of the specifications or instructions it provided to the manufacturer or that it received back from the manufacturer to support the L3000 claim. In short, Tri County did not possess any record that the insert it ordered was made to L3000 standards. Tri County’s attempt to gloss over that failing demonstrates that, for these deficient claims, it could not document what specifications it provided to the third party manufacturer and what orthotic it received back from the manufacturer. Although OSC could determine from Tri County’s medical record that the prescription/medical order existed for a custom insert and Tri County provided the beneficiaries an insert, OSC could not determine whether Tri County provided L3000 inserts or another less expensive insert to these beneficiaries. Accordingly, OSC down-coded these claims from the L3000, which is the most expensive insert, to the less expensive (approximately 45 percent lower cost) custom orthotic insert HCPCS L3010. In short, because Tri County did not provide OSC documentation to support these claims, Tri County did not provide any basis for OSC to modify this finding.

Tri County Comments: Audit Finding - No Manufacturer Invoice

“We submit that the claims for which our client was not able to produce a manufacturer invoice were so negligible (i.e., 2 out of 291 claims is below a 1% error rate) such that to render this

discrepancy wholly immaterial to the propriety of the underlying claims. Given that Tri County possessed the invoices in 99.31% of all claims dating back several years, this should not result in any adverse audit finding. Such an error rate is of no significance especially where, as is the case here, there is no information to suggest that the medical device was not properly ordered, manufactured, and delivered to the Medicaid recipient.”

OSC Response

OSC rejects Tri County’s unsupportable assertion that these errors are somehow “immaterial” and “of no significance.” To the contrary, just as with other findings from a sample, the identified exceptions are reportable and are projected to the testing universe. For the claims noted, Tri County’s statement that “there is no information to suggest that the medical device was not properly ordered, manufactured, and delivered,” is simply off base. Tri County’s records do not contain insert order forms, proof of customization, manufacturer invoices, or proof of delivery. As such, Tri County did not provide any basis for OSC to modify this finding.

Tri County Comments: Audit Finding - Duplicate Claims

“This finding is incorrect and should be removed from the DAR. We ask that MFD review the billings for this recipient, which would indicate that the L3000 was originally submitted on 2/1/17 on two separate line items with one unit per line with the RT and LT modifiers indicating right and left. This claim was denied with no payment paid to Tri County. The claim was rebilled as a corrected claim with L3000 – 2 units on a single line item. Payment on this claim was received in the amount of \$308.00.

“This instance represented 1 of 291 claims reviewed for duplicate billing. Even if it was a double bill, it would represent a negligible error rate of .0034%. Since it is not in error, Tri County should be acknowledged to have a 0% error rate regarding duplicate claims, indicative of its reputation in the community for honesty and professionalism.”

OSC Response

Tri County originally submitted the L3000 claim at issue on two separate line items, with one unit per line with modifiers indicating right and left. These claims were denied and, as a result, no payment was made to Tri County for these claims. Tri County then re-billed these claims for the same patient with the same date of service on two additional occasions. First, as a claim with L3000 – two units on a single line item, for which Tri County was paid on March 1, 2017; and, second as a claim with L3000 - one unit per line (right and left on each line), for which it was paid on June 28, 2017.

As discussed above, under OSC’s comments to Tri County’s argument to the Audit Finding - No Manufacturer Invoice, each exception found in a sample is reportable and, for extrapolation purposes, properly projected to the testing universe. Accordingly, Tri County did not provide any basis for OSC to modify this finding.