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January 10, 2020

BY ELECTRONIC and CERTIFIED MAIL

Matthew Sable, MA, NCC, LPC, LLC
6B Minneakoning Road
Flemington, NJ 08822

RE: Final Audit Report: Matthew Sable, MA, NCC, LPC, LLC

Dear Mr. Sable:

As part of its oversight of the New Jersey Medicaid program (Medicaid), the Office of the State Comptroller, Medicaid Fraud Division (MFD) conducted an audit of Medicaid claims submitted by and paid to Matthew Sable, MA, NCC, LPC, LLC (Sable) for the period from January 1, 2014 through December 31, 2018 (audit period). MFD hereby provides Sable with this Final Audit Report.

Executive Summary

MFD conducted an audit of Medicaid claims paid to Sable to determine whether Sable billed for intensive in-community mental-health rehabilitation services in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether Sable correctly billed Healthcare Common Procedure Coding System (HCPCS) codes H0036 (Intensive in-community services, face-to-face, per 15 minutes) and H0018 (Behavioral health; non-hospital residential treatment program, without room and board, per diem), which are used to seek reimbursement for intensive in-community mental-health rehabilitation services. From its audit of 528 statistically selected claims totaling $116,941.50 paid to Sable, MFD determined that 80 of the 528 claims, totaling $11,286.50 in reimbursement, failed to comply with state and federal regulations. The 80 failed claims contained a total of 93 exceptions as some claims had multiple deficiencies. Specifically, MFD found: a) 8 exceptions for providing multiple services to different recipients on the same date of service at the same or overlapping times; b) 25 exceptions for including travel time in the calculation of face-to-face contact with the beneficiary; c) 26 exceptions for billing unsubstantiated services; and, d) 34 exceptions for not documenting service with a progress note.

For purposes of ascertaining a final recovery amount, MFD extrapolated the error rate for claims that failed to comply with state and federal regulations to the total population of claims from which the sample claims were drawn, which in this case was 7,525 claims with a total payment amount of $1,666,422.75. By extrapolating the dollars in error over the entire universe, MFD determined that Sable improperly received an overpayment of $159,592.74 that he must repay to the Medicaid program.

Background

The Division of Medical Assistance and Health Services (DMAHS), within the Department of Human Services (DHS), administers New Jersey's Medicaid program. Medicaid is a program through which individuals with disabilities and/or low incomes receive medical assistance. The Medicaid program provides intensive in-community mental-health rehabilitation services, which are designed to improve or stabilize children's or young adults' level of functioning within the home and community. These services seek to prevent, decrease, or eliminate behaviors or conditions that may place the individual at an increased clinical risk or otherwise negatively affect a person's ability to function. These services are rendered within the context of an approved plan of care and are restorative or preventative in nature.

Sable, located in Flemington, New Jersey, has participated in the Medicaid program as an intensive in-community mental health rehabilitation services provider since January 1, 2004. Sable bills the Medicaid program for these services under HCPCS codes H0036 and H0018. During the audit period, Sable not only billed for services that he rendered, but also billed under his provider number for services provided by 10 other behavioral health professionals with whom he had contracted. For all billed services, whether performed by Sable or others under his provider number, Sable is responsible for ensuring compliance with state and federal regulations. Accordingly, references to "Sable" may include services performed by other behavioral health professionals for whom Sable billed under his provider number.

Objective

The objective of this audit was to evaluate claims billed by and paid to Sable to determine whether these claims were billed and paid in compliance with Medicaid requirements under state and federal laws and regulations.

Scope

The audit period was January 1, 2014 through December 31, 2018. The audit was conducted under the authority of the Office of the State Comptroller as set forth in *N.J.S.*A.52:15C-23 and the *Medicaid Program Integrity and Protection Act*, *N.J.S.A.*30:4D-53 *et seq*.

Audit Methodology

MFD's methodology consisted of the following:

- Selecting a statistically valid sample of 86 service days representing 528 claims, totaling $116,941.50, from a population of 7,525 paid claims totaling $1,666,422.75, billed under HCPCS codes H0036 and H0018.

- Reviewing records to determine whether proper documentation existed to substantiate that: services were rendered; services were pre-authorized; services were documented in the progress notes; and, a parent/guardian attested to services having been performed on the Service Delivery Encounter Documentation (SDED) forms.

- Reviewing records for compliance with the requirements in New Jersey Administrative Code (*N.J.A.C)* 10:49-9.8(a), *N.J.A.C.* 10:49-9.8(b) (1), *N.J.A.C.* 10:77-5.12(d)(3), (5), and *N.J.A.C.* 10:77-5.12(e)(6).

Audit Findings

Billing for Services Provided to Different Beneficiaries at the Same or Overlapping Times

State Medicaid regulations regarding intensive in-community mental-health services require providers to maintain records for each encounter that document the name and address of the beneficiary; the exact date, location and time of service; the type of service; and, the length of face-to-face contact. Most of this information is contained in the SDED form. This form, which must be signed and dated by the professional who rendered the service and the beneficiary or their parent/legal guardian, is supposed to be completed for every service encounter between a provider and beneficiary.

MFD reviewed records, including the SDED forms, to determine whether Sable sufficiently documented the services rendered. Specifically, MFD compared the encounter date and time recorded on the SDED forms to determine if an overlap of time existed between multiple claims. MFD found that for 8 of the 528 sample claims, totaling $932.25, Sable billed for services for a beneficiary that were provided at the same time as services billed for another beneficiary. In essence, Sable separately billed for services for multiple beneficiaries that took place at the same or overlapping times. For example, one SDED form documented that Sable himself provided services on August 25, 2015 from 2:00 PM to 5:00 PM. A second SDED form for that same date documented that Sable himself also provided services to a different Medicaid beneficiary from 3:00 PM to 4:45 PM, resulting in an overlap of one hour and forty-five minutes (3:00 PM to 4:45 PM). Therefore, in these instances, Sable violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 10:77-5.12(d)(3), (5), by improperly billing for overlapping services.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:77-5.12(d)(3), (5), providers shall maintain support of all intensive in-community mental-health rehabilitation services claims including "the exact date(s), location(s) and time(s) of service." In addition, this provision states that providers must maintain support for "the length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact."

Improperly Billed for Travel Time

MFD reviewed records to determine whether Sable improperly included travel time in the calculation for the length of face-to-face contact with beneficiaries when seeking reimbursement from the State. MFD found that for 25 of the 528 claims, totaling $960.50, Sable included travel time to and from the location of the beneficiary as part of his billing for face-to-face services. For example, one SDED form documented that Sable provided services to a beneficiary on December 8, 2015 from 2:30 PM to 4:30 PM. A second SDED form for that same date documented that Sable provided services to a different beneficiary from 4:30 PM to 6:15 PM. According to Google Maps, the locations of the two beneficiaries were 3.9 miles and approximately 14 minutes travel time apart. Notwithstanding that distance and the time needed to travel between these two locations, Sable billed for both services a total of three hours and forty-five minutes of face-to-face contact. As such, Sable did not account for the additional fourteen minutes that was needed for travel time and billed as if the two encounters took place continuously without any interruption for travel. Therefore, as set forth below, Sable violated *N.J.A.C.* 10:49-9.8(a) and *N.J.A.C.* 10:77-5.12(d)(3), (5) by improperly billing for travel time for the services provided.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Pursuant to *N.J.A.C.* 10:77-5.12(d)(3), (5), providers shall maintain support of all intensive in-community mental health rehabilitation services claims including "the exact date(s), location(s) and time(s) of service." In addition, this provision states that providers must maintain support for "the length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact."

Unsubstantiated Services Billed

MFD reviewed records to determine whether Sable maintained proper documentation for services he billed to Medicaid. MFD found that for 26 of the 528 sample claims, totaling $3,687.25, Sable billed for services that could not sufficiently be supported by documentation. Specifically, for some of these claims, Sable did not provide a SDED that would support the claims, and for the remaining claims, the hours of service in the SDED

conflicted with the hours billed and paid. Therefore, for these 26 claims, Sable violated *N.J.A.C.* 10:49-9.8(a) by failing to maintain appropriate records.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Failed to Document Services with a Progress Note

For intensive in-community mental health rehabilitation services, progress notes provide necessary information as to the treatment provided, the beneficiary's response to the treatment, significant events that may affect the beneficiary's condition or treatment, and other information pertinent to the beneficiary's clinical course.

MFD reviewed records to determine whether Sable's progress notes supported his billed services. MFD found that for 34 of the 528 claims, totaling $6,893.00, Sable did not provide progress notes. Therefore, as set forth below, Sable violated *N.J.A.C.* 10:49-9.8(b)(1) and *N.J.A.C.* 10:77-5.12(e)(6) by failing to maintain appropriate records.

Pursuant to *N.J.A.C.* 10:49-9.8(b)(1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

Pursuant to *N.J.A.C.* 10:77-5.12(e)(6), the provider shall maintain "for each discrete contact with the child/family, progress notes which address the defined goals stipulated in the child/youth or young adult's plan of care must be completed."

Summary of Overpayments

MFD determined that for the period from January 1, 2014 through December 31, 2018, Sable improperly billed and received payment for 80 of the 528 sample claims, totaling $11,286.50. For purposes of ascertaining a recovery amount, MFD extrapolated the error rate for claims that failed to comply with state and federal regulations to the total population of claims from which the sample claims were drawn, which in this case was 7,525 claims with a total payment amount of $1,666,422.75. By extrapolating the dollars in error over the entire universe, MFD determined that the overpayment of improper claims is $159,592.74.

Recommendations

Sable must:

1. Reimburse Medicaid the overpayment amount of $159,592.74.

2. Adhere to state and federal regulations for Medicaid services provided by him and his contracted health care professionals.

3. Ensure that Medicaid services provided by him and his contracted health care professionals are adequately documented in the records in accordance with *N.J.A.C* 10:49-9.8(a), *N.J.A.C* 10:49-9.8(b)(1), *N.J.A.C* 10:77-5.12(d)(3), (5), and *N.J.A.C* 10:77-5.12(e)(6).

4. Ensure that he and his contracted health care professionals receive training to foster compliance with applicable state and federal regulations.

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

Sable Response

After being apprised of the findings above through MFD's Draft Audit Report (DAR), Sable, through counsel, submitted a written response and Corrective Action Plan. *See* Appendix A. In his response, Sable generally agrees with the findings but attributes the errors to human error and oversight. Further, in the response, Sable disagrees with three aspects of the audit. Sable states, "[w]hat is disagreeable in the State's DAR is the bending of statistically selected claims and the resulting anomaly of alleged overpayment." Additionally, Sable states, "[w]hile Mr. Sable realizes he is responsible for the work of his clinicians – and billing procedures – the faulty paperwork of just one these clinicians can indiscriminately skew a statistical analysis." Lastly, for failing to document services with a progress note, Sable responds that services were rendered but the progress note was not entered into the system. Sable states that "[u]nfortunately, this section represents the bulk of extrapolated overdue amounts and number of claims."

MFD Comments

Sable's disagreement with MFD's sampling methodology is without merit. Sable's response contains broad statements challenging MFD's use of statistical sampling/extrapolation, but it fails to provide any facts or basis to substantiate the argument that MFD's results were somehow "skewed." Sable acknowledges that it is Sable's responsibility to ensure that progress notes are maintained for each face-to-face session and Sable further concedes that "many, if not all of the errors, arose from a lack of attention to paperwork." Those acknowledged "paperwork" deficiencies form the basis for MFD's findings. Without proper documentation of services rendered there can be no assurance that services were provided and that the clinician providing the service was addressing the defined goals stipulated in the child/youth or young adult's plan of care. Simply put, Sable's lack of proper documentation and clinician oversight can lead to unsubstantiated services being provided, questionable claim billing, and lack of effective quality of care, each of which leaves the Medicaid program vulnerable to fraud, waste and abuse.

Sable provided a corrective action plan to address all of MFD's recommendations above and thereby correct the deficiencies cited in the report. Thus, the only issue that Sable

must address is the overpayment. MFD finds that Sable received an overpayment of $159,592.74 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

Cc: Kay Ehrenkrantz, Deputy Director, MFD
Don Catinello, Supervising Regulatory Officer, MFD
Glen Geib, Recovery Supervisor, MFD
Michael Morgese, Audit Supervisor, MFD
Sean M. McDonough, Attorney

Attachment:
Appendix A – Sable's Response to Draft Audit Report

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* Reply to New Brunswick, NJ

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December 18, 2019

SENT THIS DATE BY ELECTRONIC (michael.morgese@osc.nj.gov) **and CERTIFIED MAIL**

State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, NJ 08625-0025

RE: State of New Jersey Medicaid Fraud Division v. Matthew Sable
Response to Draft Audit Report

Dear Sir/Madam,

Please be advised that this firm represents Matthew Sable in reference to the above noted matter. This correspondence is in response to the State's Draft Audit Report (DAR) dated December 4, 2019.

From 2004 to the present, Mr. Sable has acted as an Intensive In-community Provider (IIC) for the State. In that time Mr. Sable has been audited once (2014-2018), which is the basis of this inquiry. As an IIC, Mr. Sable has displayed diligence in his passion and care for his clients, exceeding professional industry standards. Mr. Sable denies intentional fraudulent

behavior with regard to the claims made in the DAR. In fact, it is undisputed that Mr. Sable, and the clinicians that worked for him, did provide the contracted services and did so at a high rate of dexterity.

It is Mr. Sable's position and the position of this response that the 80 claims (with 93 exemptions) are largely based on human error and oversight that resulted in unsatisfactory billing regarding these specific claims. Mr. Sable agrees completely the errors found can be attributed to one of the above. Within this response includes a Corrective Action Plan – many of the corrective actions have already been implemented – so that Mr. Sable may continue his business relationship with the state, providing Medicaid services to his clients.

What is disagreeable in the State's DAR is the bending of statistically selected claims and the resulting anomaly of alleged overpayment. Beginning in 2014, Mr. Sable had upwards of 10 clinicians working under his purview. The volume of work triggered the audit as Mr. Sable's business was listed as a single practice and not a group practice. While Mr. Sable realizes he is responsible for the work of his clinicians – and billing procedures – the faulty paperwork of just one these clinicians can indiscriminately skew a statistical analysis.

For thirty-four (34) of the claims falling under section *Failed to Document Services with a Progress Note* it is unrefuted that Mr. Sable or one of his clinicians did provide the required service, meaning therapy was given and received in person and on a noted day and time. However, a progress note as to the client's care plan and recovery goals were never entered into the system. This is human error and faulty paperwork. Unfortunately, this section represents the bulk of extrapolated overdue amounts and number of claims.

As represented above it is our contention that many, if not all of these errors, arose from a lack of attention to paperwork. As part of Mr. Sable's Corrective Action Plan, paperwork has been replaced with an electronic system of scheduling appointments and subsequent billing. With a streamlined and electronic, spreadsheet-based system Mr. Sable will be able to assure that his clinicians post progress notes with-in the 72-hour window. Additionally, with regard to progress notes, Mr. Sable will require a posted progress note before a clinician or he gets paid for work.

Mr. Sable's Corrective Action Plan also aims to eliminate Unsubstantiated Services Billed, as a large part of such is proper documentation. Of himself and clinicians, Mr. Sable will require proper documentation submitted electronically before any service is billed to the State.

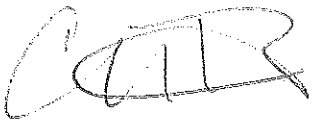
The implementation of spread sheet work schedules will make overlapping times of service calls and travel easily identifiable. In addition, travel time will be estimated before clinicians attend a service call and written into the work order. Mr. Sable will research and attend, along with his clinicians, appropriate training (s) that foster compliance with applicable state and federal statutes.

With this Corrective Action Plan, it is Mr. Sable's priority to ensure that all work provided by himself and his contracted clinicians meet all applicable state and federal standards.

This response is not intended to be a complete recitation of Mr. Sable's position.

cc: Matthew Sable (via email)

Very Truly Yours,



Christopher M. Brett, Esquire