State of New Jersey

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

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

PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

September 25, 2017

By Certified and Electronic Mail

Dr. Nagi Eltemsah
2775 Kennedy Blvd.
Jersey City, NJ 07306

Re: Final Audit Report
Dr. Nagi Eltemsah

Dear Dr. Eltemsah:

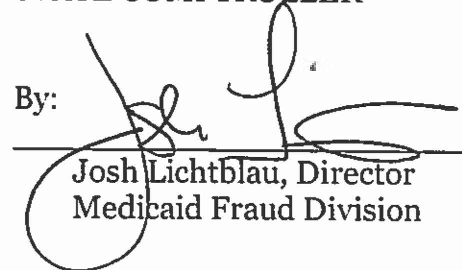
Enclosed is the Final Audit Report for your medical practice, New Jersey Medicaid Provider Number ______. Island Peer Review Organization, in conjunction with SafeGuard Services, LLC, completed the audit on behalf of the Centers for Medicare & Medicaid Services and the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division. The Final Audit Report identified an overpayment for Medicaid claims paid to you in the amount of $92,983, for the period from January 1, 2011 through December 31, 2013.

Should you have questions about how to reimburse the Medicaid program for this overpayment, please contact Mr. Glenn Geib, Supervisor, Recovery and Exclusions, at (609) 789-5032 or by email at glenn.geib@osc.nj.gov. If you have questions regarding this Final Audit Report, you may contact Mr. Michael Morgese, Audit Supervisor, at (609) 789-5067.

Dr. Nagi Eltemsah
[redacted]
September 25, 2017

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER



By:

Josh Lichtblau, Director
Medicaid Fraud Division

JL/mmm
Enc.
cc: David L. Adelson, Esq.
Kay Ehrenkrantz, Deputy Director, OSC
Michael McCoy, Manager of Fiscal Integrity, OSC
Michael Morgese, Audit Supervisor, OSC
Glenn Geib, Supervisor Recovery and Exclusions, OSC
Meghan Davey, Director Division of Medical Assistance and Health Services
Elizabeth Lindner, Director Division of Field Operations – North, CMS

Final Audit Report of
Nagi I Eltemsah, MD
NJ Medicaid Number: [redacted]

Audit Period January 1, 2011 to December 31, 2013

Date Issued: August 23, 2017

CMS Audit Number: 1-45810139

I. INTRODUCTION

Island Peer Review Organization (IPRO), the audit contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), initiated an audit of Dr. Nagi I Eltemsah (Provider) to determine whether the Medicaid services he provided from January 1, 2011 through December 31, 2013 complied with applicable federal and state laws, regulations, policies, and the Provider's Medicaid enrollment agreement.[1] Specifically, the audit focused on whether the services that the Provider billed for were, in fact, provided and whether the Provider's documentation for such services was consistent with the claims submitted for these services. From a universe of more than 33,000 claims with a total Medicaid payment of more than $1.5 million, the auditors randomly selected 250 claims for review. From that sample, the audit found recoupable errors in 43 claims. The vast majority of these errors related to inconsistencies between the medical records and the claims submissions. The remaining errors were attributable to a complete lack of documentation to support the submitted claims. In the aggregate, the 43 errors resulted in overpayments totaling almost $700. When that error rate was extrapolated to the universe of claims, the overpayment total increased to more than $92,000.

As part of the audit process, the audit team met with the Provider, afforded the Provider opportunities to explain his claim submissions and, after issuing a Draft Audit Report, allowed the Provider to submit a formal response, which is attached. This Final Audit Report takes into account all of the information obtained through the audit process, including the Provider's written response to the Draft Audit Report.

A. BACKGROUND:

IPRO was contracted by CMS to audit Providers participating in the New Jersey Medicaid program. These audits were conducted in accordance with the procedures specified in federal and state laws and regulations and guidance, including the Code of Federal Regulations (*C.F.R.*), Titles 52 and 30 of New Jersey Statutes Annotated (*N.J.S.A.*), Titles 8 and 10 of the New Jersey Administrative Code (*N.J.A.C.*), and

[1] IPRO conducted all stages of the work on this audit through approximately February 2017. IPRO was the vendor for the federal Medicaid Integrity Contract (MIC), through which CMS offered to states, including New Jersey, a supplemental audit team for Medicaid related audits. CMS replaced the MIC with a regional audit contract, the Northeast Unified Program Integrity Contractor (NE UPIC), which CMS awarded to Safeguard Services (SGS) effective February 1, 2017. IPRO transitioned all of its work, including this audit, to SGS in or about February 1, 2017. Consequently, SGS completed the Final Audit Report for this audit.

"*Government Auditing Standards*" as issued by the United States Government Accountability Office. Audits under this program also utilized guidelines established by CMS.

IPRO conducted this audit in accordance with the audit plan collaboratively prepared and approved by CMS and OSC.

B. PROGRAM OBJECTIVES:

IPRO provider audits have the following objectives:

- To determine if services for which a Provider submitted claims and was paid for such claims were, in fact, provided.
- To determine whether the Provider rendered, documented and submitted claims for services in compliance with federal and state Medicaid laws, regulations and guidance as well as the Provider's Medicaid enrollment agreement.
- To identify provider billing and/or payment irregularities within the State's Medicaid program.
- To determine appropriateness and necessity of care.

C. AUDIT PROCESS:

IPRO conducted this audit in the following manner:

Overview

IPRO, representatives from OSC, the Provider and members of the Provider's staff met at the Entrance Conference in July 2015 so that the audit team could obtain an understanding of the Provider's operations. The Provider also gave the audit team requested claims information at this meeting. This process allowed the audit team to understand, among other things, how the Provider billed for services. In addition, the audit team obtained Medical and related business records. The audit team used these records to determine whether claims were coded appropriately, services were rendered, and services were medically necessary.

Statistical Sampling

The auditors drew a stratified sample of 250 claims that met the requirements for this review. The sample was taken from the universe of Medicaid claims which included 33,407 fee-for-service (FFS) and encounter services during the period January 1, 2011 through December 31, 2013.

The audit team conducted its analysis using the stratified sample of claims. The audit findings from the sample were then extrapolated to the universe of claims from which the sample was drawn. The findings are discussed in Section III of this report and the extrapolated results are outlined in Section IV.

Documentation Reviewed

For their on-site review, IPRO copied claims documents and the medical records that would support such claims. These documents included partial medical records, patient progress notes and patient sign-in sheets. IPRO did not remove original records from the premises and, for any records that were computer generated, the Provider made available the original, hard copy record for verification purposes. After the on-site review, IPRO asked for and the Provider supplied additional documents necessary to complete the audit.

As part of the on-site review, IPRO analyzed the documents to determine whether there were any billing irregularities or deviations from Medicaid laws, regulations, and guidance, or from the Provider's Medicaid enrollment agreement.

Discussion of Audit Results

After the on-site review, IPRO further analyzed copies of the Provider's documents and medical records to ascertain whether the Provider's Medicaid claims complied with applicable Medicaid laws, rules, guidelines and the Provider's Medicaid enrollment agreement. After IPRO concluded its internal analysis, it developed a summary of its findings, which it gave to the Provider. IPRO then held an exit conference on August 11, 2016 with representatives from the OSC and the Provider to discuss the summary of findings and any other issues involving the audit. At that exit conference, the Provider was given an opportunity to present its position regarding the summary of IPRO's findings. In addition, at the exit conference, IPRO and OSC representatives advised that the Provider could submit a written response to the summary of findings. The Provider submitted a response to the summary of findings in a document dated September 19, 2016. IPRO considered that response as part of its preparation of the Draft Audit Report. IPRO gave the Provider the Draft Audit Report for it to review and respond to. The Provider submitted a response to the Draft Audit Report in a document dated March 7, 2017 (which is attached as Appendix C). All of the work papers, the summary report, Draft Audit Report, and Provider responses have been considered in preparation of this report.

II. AUDIT PROFILE

A. PROVIDER PROFILE:

Name:	Nagi I Eltemsah, MD
Address:	2775 Kennedy Blvd Jersey City, NJ 07306-5515
Provider Number:	[redacted]

Provider Type: Pediatrician

B. AUDIT SCOPE:

The scope of this audit was limited to determining compliance with federal and state Medicaid laws, regulations and guidance as well as adherence to the Medicaid program enrollment agreement.

The universe included 33,407 claims for services with a total Medicaid payment of $1,503,792.14. From this universe, auditors selected a stratified sample of 250 claims for services totaling $11,211.05 for review.

The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean that such practices are acceptable. Because of the limited nature of this review, no inferences as to the overall level of provider performance should be drawn solely from this report.

Achieving the objectives of the audit did not require the review of the Provider's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

C. ANALYSIS OF FINDINGS:

Of the 250 sampled claims for services reviewed, there were 43 claims for services with recoupable monetary findings. Section III explains the monetary findings, along with support for such findings. Appendix A lists the findings and associated sample claim information.

III. AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

1. **Incorrect Procedure Code – Evaluation & Management (E&M) Code**

Auditors identified 38 instances in which the Provider billed an incorrect E&M procedure code for the service documented in the medical record. In other words, the Provider submitted claims for E&M codes that require a greater level of service than was documented in the medical records. For purposes of assessing an overpayment amount, the auditors downcoded these E&M codes to conform to the appropriate level of service documented and used the reimbursement for that lower level of service as the amount that should have been paid for such service. Appendix A lists the incorrect E&M code billed along with the correct E&M procedure code.

It is worth noting that for instances in which claim payments were made by Managed Care Organizations (MCO), the Provider provided the MCO payment rates for such services.

IPRO could not corroborate these rates independently and, thus, asked the OSC to verify these payment rates. OSC obtained the payment rates from all of the MCOs except for Healthfirst Health Plan of NJ, which as of July 1, 2014 no longer provided service to Medicaid beneficiaries in New Jersey. Using Medicaid paid claims data, IPRO was able to ascertain the highest rate paid by Healthfirst for the respective E&M code in the year of the disallowed sampled service. For Healthfirst claims, IPRO used that highest paid rate when computing the amount of the overpayment. As explained in Section IC above, the Provider was given ample opportunity to contest the rate used and did not do so.

The legal support for the finding above is as follows.

The applicable federal regulation states that the standard medical data code sets include:

> The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: (i) Physician services.

45 C.F.R. § 162.1002(a)(5) Medical data code sets

The applicable New Jersey regulation pertaining to a provider's use of procedure codes states:

> (b) General policies regarding the use of HCPCS for procedures and services are listed below:
>
> 2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in the CPT and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.
>
> 3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.

N.J.A.C. 10:54-9.1(b)(2) and (b)(3) Use of procedure codes

One of the state regulations regarding recordkeeping and the use of physician codes states:

> (a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

N.J.A.C. 10:54-2.6 (a) and (b) Recordkeeping; general

Another state regulation that pertains to recordkeeping states:

(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;

4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8 (b) Provider Certification and Recordkeeping

The authorizing statute for the regulatory requirements cited above mandates that the Medicaid program institute provider record maintenance requirements for providers in the Medicaid program. One requirement is that all such providers must properly maintain records that accurately reflect the services provided and billed to Medicaid. Specifically, the applicable statutory provision mandates that the Medicaid program:

(d) Require that any provider who renders health care services authorized under this act shall keep and maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered, and any additional information, as the department may require by regulation. Records herein required to be kept and maintained shall be retained by the provider for a period of at least 5 years from the date the service was rendered;

(e) Require that providers who render health care services authorized under this act shall not be entitled to reimbursement for the services rendered unless said services are documented pursuant to subsection (d) of this section. Any evidence other than the documentation required pursuant to subsection (d) of this section shall be inadmissible in any proceeding conducted pursuant to this act for the purpose of proving that said services were rendered; unless the evidence is found to be clear and convincing by the finder of fact;

N.J.S.A. 30:4D-12(d)&(e). Unnecessary Use of Care and Services; Methods and Procedures; Maintenance of Records Required for Reimbursement

2. No Documentation

Auditors identified four instances in which a medical record was not provided or a portion of the medical record was missing. Specifically, auditors determined the following:

2a. Missing Office Visit Note: In three instances there was missing documentation to support the E&M service billed.

2b. Missing Record: In one instance, there was no medical record for the associated claim.

The state regulation pertaining to recordkeeping provides in pertinent part:

(a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

(c) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

(d) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

(e) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid … program or its agents.

N.J.A.C. 10:54-2.6 (a)-(e) Recordkeeping; general

For established patients, which is the case here, there are more specific recordkeeping requirements. Specifically, the applicable regulation provides:

(a) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

1. In an office or Residential Health Care Facility:

i. The purpose of the visit;

ii. The pertinent physical, family and social history obtained;

iii. A record of pertinent physical findings, including pertinent negative findings based upon i and ii above;

iv. Procedures performed, if any, with results;

v. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

vi. Prognosis and diagnosis."

N.J.A.C. 10:54-2.8(a)(1)(i-vi) Minimum documentation; established patient

In addition to the regulations set forth immediately above (*N.J.A.C.* 10:54-2.8), there are additional regulations that require Medicaid providers to properly document the services they render and put providers on notice that when there is no such documentation or inadequate documentation, their claims may be adjusted accordingly. The specific regulations state the following:

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.
i. The following signature types are unacceptable:

(1) Initials instead of signature;
(2) Stamped signature; and
(3) Automated (machine-generated) signature.

(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;

4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8(a) & (b) Provider Certification and Recordkeeping

As set forth in Section III 1 above, the New Jersey law that underpins the regulations cited in this report requires providers to properly maintain records that accurately reflect the services provided and billed to Medicaid. *N.J.S.A.* 30:4D-12(d) & (e).

3. <u>Two E&M Claims Billed on the Same Date of Service</u>

In one instance, the Provider billed for two E&M claims on the same date of service, but the medical record documentation supported only one E&M claim for the service.

As set forth in Section III 1 above, the applicable federal rule sets forth the standard medical data code sets that Medicaid providers must use. *45 C.F.R. § 162.1002(a)(5) Medical data code sets*

Also, as stated above in Section III 1, the applicable regulations in New Jersey provide that the HCPCS procedure codes, including modifiers and qualifiers, "must be used in accordance with the narratives and descriptions" set forth in the New Jersey regulations. *N.J.A.C. 10:54-9.1(b)(2)*. Moreover, for services performed in the office, the regulations require providers to maintain a "progress note in the clinical record for each visit, which supports the procedure code(s) claimed." *N.J.A.C. 10:54-2.6(b).* The final set of regulations that applies here are the provisions in *N.J.A.C. 10:49-9.8(a) and (b)*. As explained in Section III 1 above, these regulations, in part, require providers to keep "such records as are

necessary to disclose fully the extent of services provided" and put providers on notice that "where such records do not document the extent of services billed, payment adjustments shall be necessary."

The applicable law likewise, in pertinent part, requires providers to "maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered" and any other required information. *N.J.S.A. 30:4D-12(d).*

IV. SUMMARY OF OVERPAYMENTS

Of the 250 claims tested, the auditors found that 43 claims failed to meet the statutory and regulatory requirements outlined above. Consequently, the auditors found that these claims constituted overpayments. Applying the principles discussed above regarding the determination of the overpayment, the auditors determined that the identified overpayments for the 43 discrepant sampled claims for services totaled $696.63. When extrapolated to the universe of claims from which the sample was drawn, the point estimate overpayment amount totals $92,983.00. The calculation of this amount is illustrated in Appendices A and B. Accordingly, the total amount of the overpayment that must be returned to New Jersey is $92,983.00.

After being apprised of the findings above, the Provider, through counsel, submitted a response dated March 7, 2017 (attached as Appendix C). In that response, the Provider took issue with the underlying use of an extrapolation methodology, stating, in part, the following:

> We note that any extrapolation conducted relative to the documents reviewed should only concern errors and/or omissions that transpired on more than one occasion. In the spirit of extrapolating for repeated errors and/or omissions (e.g., insufficient documentation), a random isolated event should not be part of an extrapolation as said event occurs once during the review period. Hence by definition, you cannot extrapolate for a one time random occurrence.

The Provider's response that extrapolations cannot be used for a one time occurrence is not a supportable argument. This claim, in essence, rejects the validity of properly performed random sampling processes. By definition, a Statistically Valid Random Sample treats all errors that are a source of improper payments the same way. Whether it is a one-time occurrence or a repetitive occurrence, a sample that is randomly selected from the frame of payments does not have any way of telling what kind of errors will be encountered during the medical review. Each sampled unit is then measured against the same requirements (federal and state laws, regulations and guidance). Since the Provider's response did not

include any sufficient reliable documentation to support his position, no adjustments will be made to the audit analysis or the extrapolation. Therefore, we stand by the original extrapolated amount. The Provider must reimburse the Medicaid program $92,983.

V. RECOMMENDATIONS

Based on the findings cited in this audit report, the Provider is directed to repay the Medicaid program $92,983, and to take corrective action to ensure adherence with all federal and state laws and regulations and billing instructions provided under the Medicaid program. Pursuant to *N.J.A.C.* 10:49-11.1, continued violation(s) may result in the termination or suspension of the Provider's eligibility to provide services in the Medicaid program.

VI. SGS COMMENTS

In his response, the Provider did not state whether he agreed or disagreed with the Audit findings, recommendations, or assessment. Rather, he appears to have taken issue with the application of an extrapolation method to the sample of claims. Specifically, he states that "any extrapolation … should only concern errors and/or omissions that transpired on more than one occasion." He goes on to state that "a random isolated event should not be part of an extrapolation as said event occurs once during the review period." That position amounts to a repudiation of the essence of using an extrapolation within a data set. Given that the auditors utilized a proper sampling methodology and otherwise performed the extrapolation in an appropriate manner, the Provider has not given any supportable reason to discount or modify the audit findings. Accordingly, the Provider is directed to repay to the Medicaid program the full amount identified, $92,983, and implement specific policies and procedures to address the Audit's Recommendations.

Dr. Nagi I Eltemsah
Appendix A
Audit Findings Claim Detail

Sample #	Recipient ID	Recipient Name	Claim Service Date	Claim Pay(FFS)/ Processing (ENC) Date	Claim HMO Payment Date	Claim Source Code	Clm Submitting Prov Name	Procedure Code Billed	Amount Paid	Correct Procedure Code	Amount Per Audit	Overpayment	Federal Fiscal Year	Federal Share %	Federal Share Amount	Audit Findings: 1. Incorrect Procedure Code	Audit Findings: 2. No Documentation*	Audit Findings: 3. Two Evaluation & Management Charges Billed on the Same Date of Service	*No Documentation: 2a. Missing Office Visit Note	*No Documentation: 2b. Missing Record
12			02/06/12	09/05/12	03/07/12	ENC	HORIZON NJ HEALTH - VSM	99213										X		
21			02/15/13	05/01/13	03/19/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99212		99211						X				
32			11/11/11	12/14/11	12/01/11	ENC	HORIZON NJ HEALTH - VSM	99213		99212						X				
38			04/12/12	06/27/12	05/10/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99212		99211						X				
44			05/22/13	06/26/13	05/29/13	ENC	HORIZON NJ HEALTH - VSM	99212									X		X	
56			09/18/12	11/28/12	10/17/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99212		99211						X				
59			05/17/12	06/20/12	05/28/12	ENC	HORIZON NJ HEALTH - VSM	99392									X		X	
72			12/09/12	01/23/13	01/02/13	ENC	HORIZON NJ HEALTH - VSM	99212		99211						X				
82			12/03/12	01/30/13	12/31/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99212		99211						X				
86			03/07/13	05/22/13	04/24/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213									X		X	
102			03/13/13	06/19/13	05/15/13	ENC	HEALTHFIRST HEALTH PLAN OF NJ	99212		99211						X				
111			12/08/11	02/29/12	01/24/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213									X			X
121			03/01/12	06/06/12	04/17/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213		99212						X				
132			07/22/13	11/06/13	08/14/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213		99212						X				
136			02/21/12	06/06/12	03/26/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213		99212						X				
157			10/09/13	12/04/13	11/06/13	ENC	HEALTHFIRST HEALTH PLAN OF NJ	99214		99213						X				
159			03/31/12	06/27/12	05/08/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
165			01/21/13	03/20/13	02/27/13	ENC	HORIZON NJ HEALTH - VSM	99213		99212						X				
166			09/27/13	10/23/13	10/07/13	ENC	HORIZON NJ HEALTH - VSM	99204		99202						X				
169			12/26/11	03/14/12	02/06/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
170			09/08/13	10/23/13	10/07/13	ENC	HORIZON NJ HEALTH - VSM	99213		99212						X				
172			12/05/12	01/23/13	01/02/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
177			01/08/13	02/20/13	01/30/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
178			12/20/12	01/23/13	01/09/13	ENC	HORIZON NJ HEALTH - VSM	99213		99212						X				
181			01/20/13	11/06/13	02/25/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
187			11/23/13	01/01/14	12/16/13	ENC	HORIZON NJ HEALTH - VSM	99214		99212						X				
190			10/23/12	12/19/12	11/21/12	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
192			10/20/11	12/28/11	11/14/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
197			07/13/12	09/26/12	08/06/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
199			08/27/13	10/16/13	09/09/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
201			09/09/13	10/16/13	09/25/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
204			10/12/11	11/30/11	11/01/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99203		99202						X				
206			08/30/13	10/16/13	09/16/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
208			11/07/11	12/14/11	12/01/11	ENC	HORIZON NJ HEALTH - VSM	99203		99202						X				
209			03/03/12	06/06/12	04/17/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
210			01/03/12	03/14/12	02/21/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
215			10/25/11	12/28/11	11/14/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
216			02/07/13	04/10/13	03/06/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
221			10/12/12	11/28/12	11/07/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
228			06/16/12	08/15/12	07/09/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213						X				
235			10/02/13	10/30/13	10/14/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
246			01/24/13	04/03/13	03/06/13	ENC	HEALTHFIRST HEALTH PLAN OF NJ	99214		99213						X				
249			08/31/13	10/16/13	09/16/13	ENC	HORIZON NJ HEALTH - VSM	99214		99213						X				
												$ 696.63				38	4	1	3	1

Nagi I Eltemsah, MD
Appendix B
Extrapolation of Sample Findings

Number of Claims in Universe	33,407
Number of Claims in Sample	250
Total Amount Paid for Claims in Universe	$1,503,792.14
Total Amount Paid for Claims in Sample	$11,211.05
Number of Claims Disallowed in Sample	43
Stratified Point Estimate	$92,983

KERN AUGUSTINE, P.C.
Attorneys to Health Professionals

David L. Adelson
NJ & NY Bars
(800) 445-0954 • DrLaw.com • DAdelson@DrLaw.com

New York • New Jersey

Reply to: 1120 Route 22 East | Bridgewater, NJ 08807 | Tel: (908) 704-8585 Fax: (908) 704-8899

March 7, 2017

Via E-Mail & Regular Mail
Matt.Kochanski@hpe.com

Matt Kochanski, Program Director
SafeGuard Services LLC
1250 Camp Hill Bypass, Suite 2000
Camp Hill, PA 17011

Re: Nagi Eltemsah, M.D.
NJ Medicaid Provider No.: [redacted]
CMS Audit No.: 1-45810139
Our File No: 61000-00031

Dear Mr. Kochanski:

As you know our firm represents Dr. Eltemsah in connection with the IPRO audit. On behalf of Dr. Eltemsah we would like for IPRO to note the following relative to the Draft Audit Report's findings and any proposed overpayment demand.

We note that any extrapolation conducted relative to the documents reviewed should only concern errors and/or omissions that transpired on more than one occasion. In the spirit of extrapolating for repeated errors and/or omissions (e.g., insufficient documentation), a random isolated event should not be part of an extrapolation as said event occurs once during the review period. Hence by definition, you cannot extrapolate for a one time random occurrence. For those such instances where the event is isolated, we would propose merely a straight dollar-for-dollar repayment.

Specifically, IPRO's audit revealed a few isolated instances that should not be part of this extrapolation:

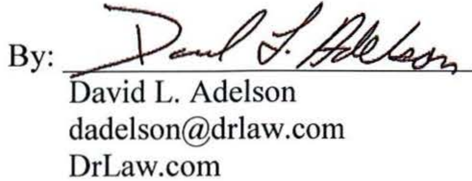
- Where one patient was seen twice in the same day;
- Where siblings were both seen the same day but bills were submitted mistakenly for one of the brothers twice; and
- Where one patient was later discovered to not be Medicaid eligible.

Dr. Eltemsah of course reserves his rights to respond to any overpayment demand and to submit additional responses to same.

In the interim, should you have any questions or would like to discuss any aspect of this matter further, please do not hesitate to contact us. Thank you.

Very truly yours,

KERN AUGUSTINE, P.C.

By: 

David L. Adelson
dadelson@drlaw.com
DrLaw.com

cc: Nagi Eltemsah, M.D. (Via Certified Mail)