LESSONS FOR AVOIDING MEDICAID FRAUD, WASTE AND ABUSE:

A PRESENTATION FOR NEW JERSEY ALLERGY AND IMMUNOLOGY PROVIDERS

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

February 25, 2026

Welcome to the presentation. We will begin momentarily.

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

LESSONS FOR AVOIDING MEDICAID FRAUD, WASTE AND ABUSE:

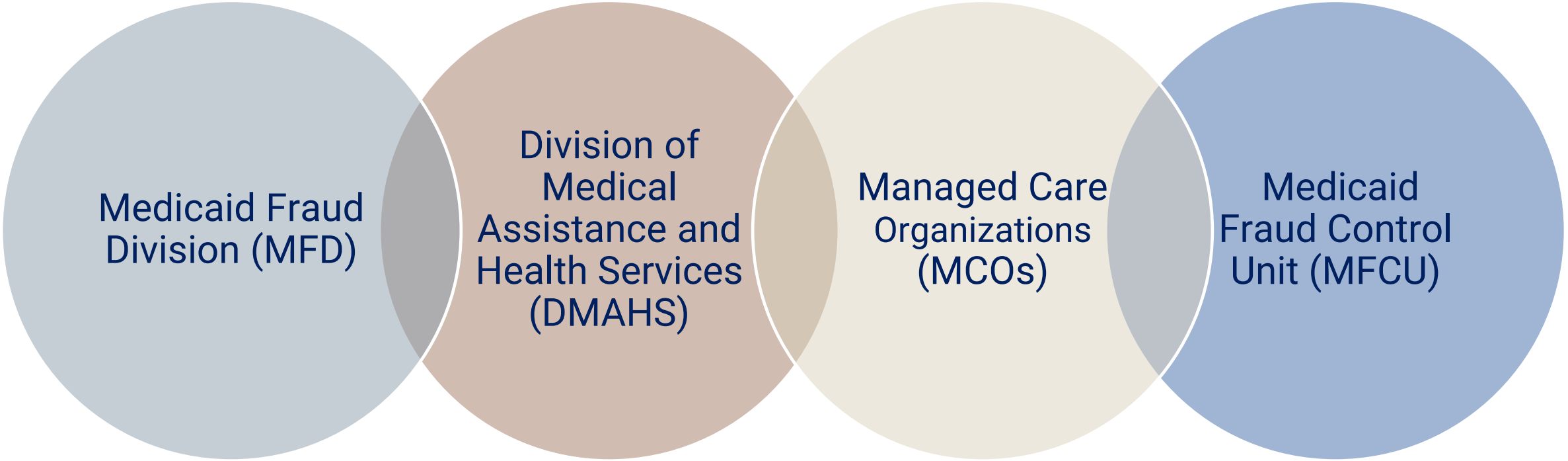
A PRESENTATION FOR NEW JERSEY ALLERGY AND IMMUNOLOGY PROVIDERS

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

February 25, 2026

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

PRESENTED IN PARTNERSHIP BY:



BEFORE WE BEGIN…

THANK YOU

for participating in the

NJ FamilyCare program!

DISCLAIMER

- This presentation is intended for general educational purposes only.
- It does not replace your responsibility to seek professional guidance, observe all laws and regulations that pertain to your practice as a Medicaid provider and exercise sound, independent, professional judgment.

GOALS FOR TODAY: TO HELP YOU BETTER UNDERSTAND

- The Medicaid program regulatory oversight structure and compliance requirements
- Medicaid documentation requirements for payment
- Fraud, waste, and abuse obligations of providers (prevention and reporting)
- Red flag areas and the consequences for non-compliance by providers

QUESTIONS?

Questions?

Enter them in the Q & A

WHAT IS MEDICAID?

- A joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals.
- Medicaid participation is voluntary.
- If you want to participate, you must know, accept and abide by the rules and regulations. Continued participation requires compliance with the regulatory requirements.

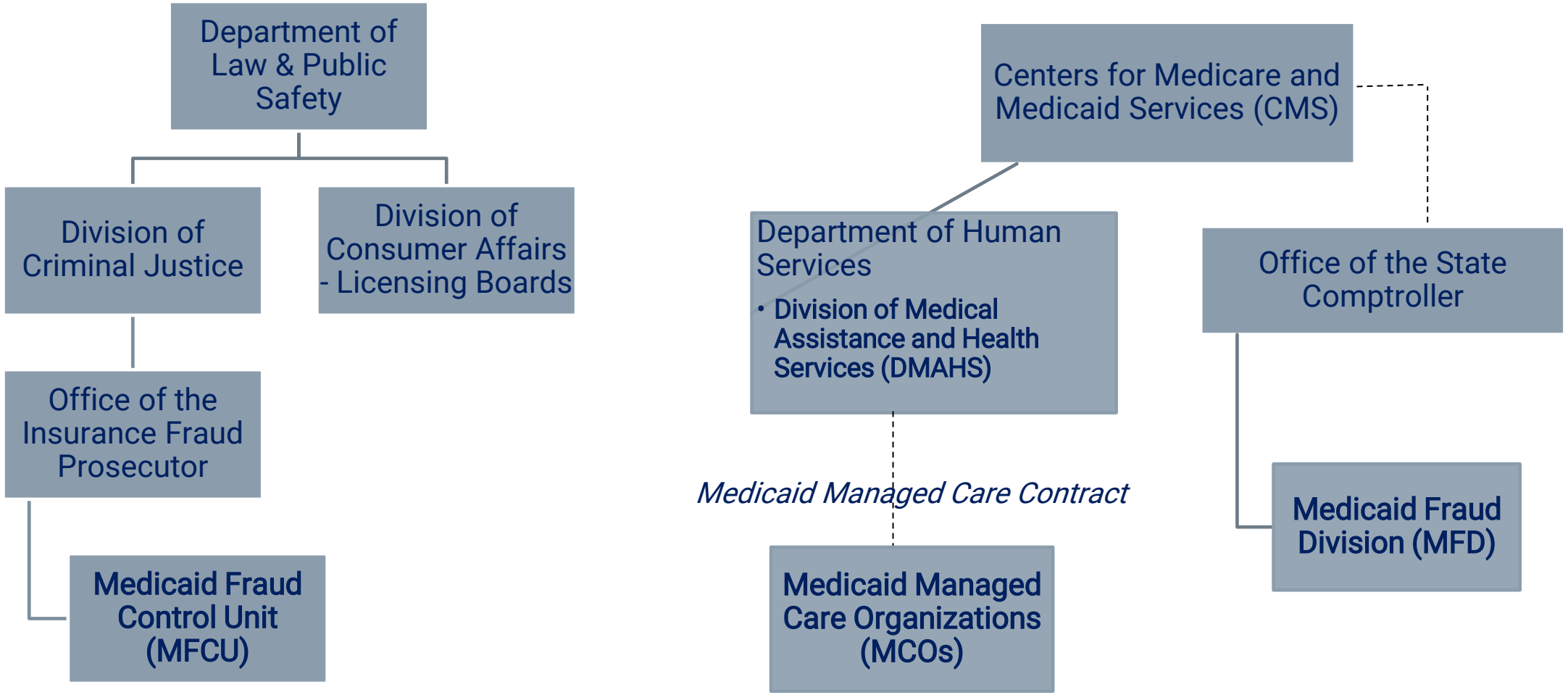
MEDICAID (NJ FAMILYCARE)

- Throughout this presentation the words Medicaid and NJ FamilyCare may be used interchangeably.
- NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion, with services provided through the State and the five Medicaid Managed Care Organizations (MCOs).

MEDICAID OVERSIGHT, GUIDING REGULATIONS, AND NEWSLETTERS

Presented by: Geralyn Molinari, Director, Managed Provider Relations,
Department of Human Services, Division of Medical Assistance and Health Services

MEDICAID OVERSIGHT – NEW JERSEY



REGULATORY FRAMEWORK & OVERSIGHT

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

- Establishes general Medicaid requirements.
- Oversees NJ Medicaid program.
- Approves Provider Networks and Capacities.

NJ Medicaid State Plan

NEW JERSEY HUMAN SERVICES
NJFAMILYCARE
Affordable health coverage. Quality care.

- Manages/administers NJ FamilyCare programs.
- Contracts with MCOs to provide services to members.
- Oversees MCO compliance with State Medicaid Contract.

NJ Medicaid MCO Contract

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

Managed Care Organizations *(MCOs)*

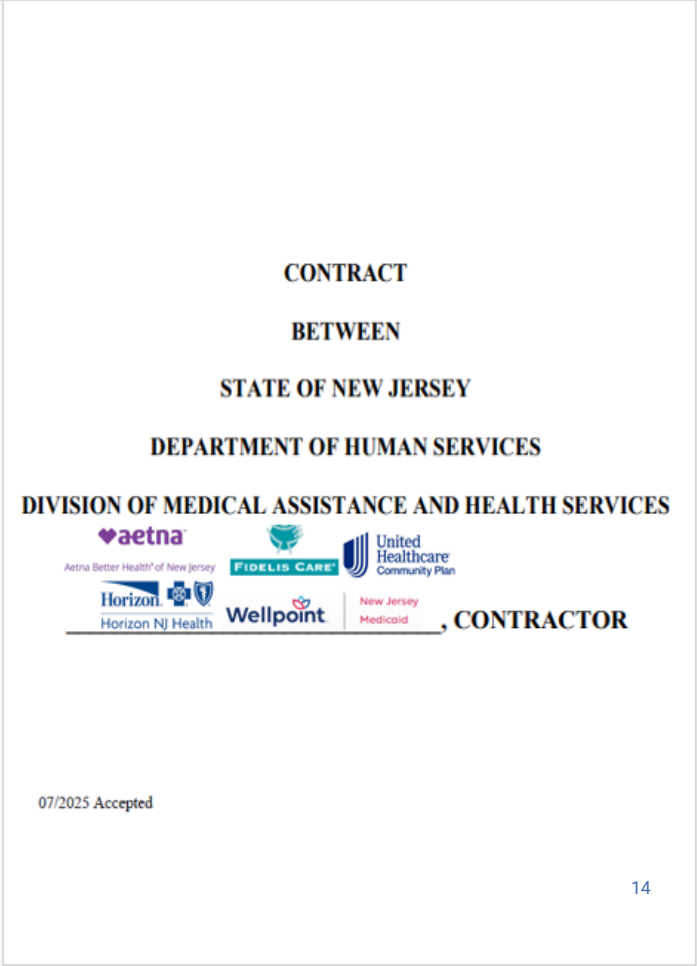
- Offers benefit packages/support to members.
- Provides provider network to members.
- Coordinates care.
- Responsible for ensuring providers comply with MCO contracts and program requirements.

MEDICAID MANAGED CARE CONTRACT

- DMAHS has a contract with the following Medicaid Managed Care Organizations (MCOs):
  - Aetna Better Health of New Jersey
  - Fidelis Care
  - Horizon NJ Health
  - UnitedHealthcare Community Plan
  - Wellpoint

FEDERAL REQUIREMENTS: 21ST CENTURY CURES ACT
42 U.S.C. 1396u-2(d)

- 21st Century Cures Act: a Federal Law requires healthcare providers participating in MCO network to enroll with NJ's Medicaid program.
- Effective January 1, 2018 - aims to ensure all providers are enrolled in state's Medicaid program, even if they do not receive fee-for-service (FFS) payments.
- NJ MCO Medicaid Contract upholds the Federal provision in contract section 4.8.1.A.3.
- **Impact to NJ Medicaid Providers:**
  - 21st Century Cures Act requires all FFS and MCO Enrolled providers to submit a completed 21st Century Cures Act application to Gainwell Technologies.


CONTRACT

BETWEEN

STATE OF NEW JERSEY

DEPARTMENT OF HUMAN SERVICES

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

aetna Aetna Better Health of New Jersey | FIDELIS CARE | United Healthcare Community Plan | Horizon Horizon NJ Health | Wellpoint | New Jersey Medicaid

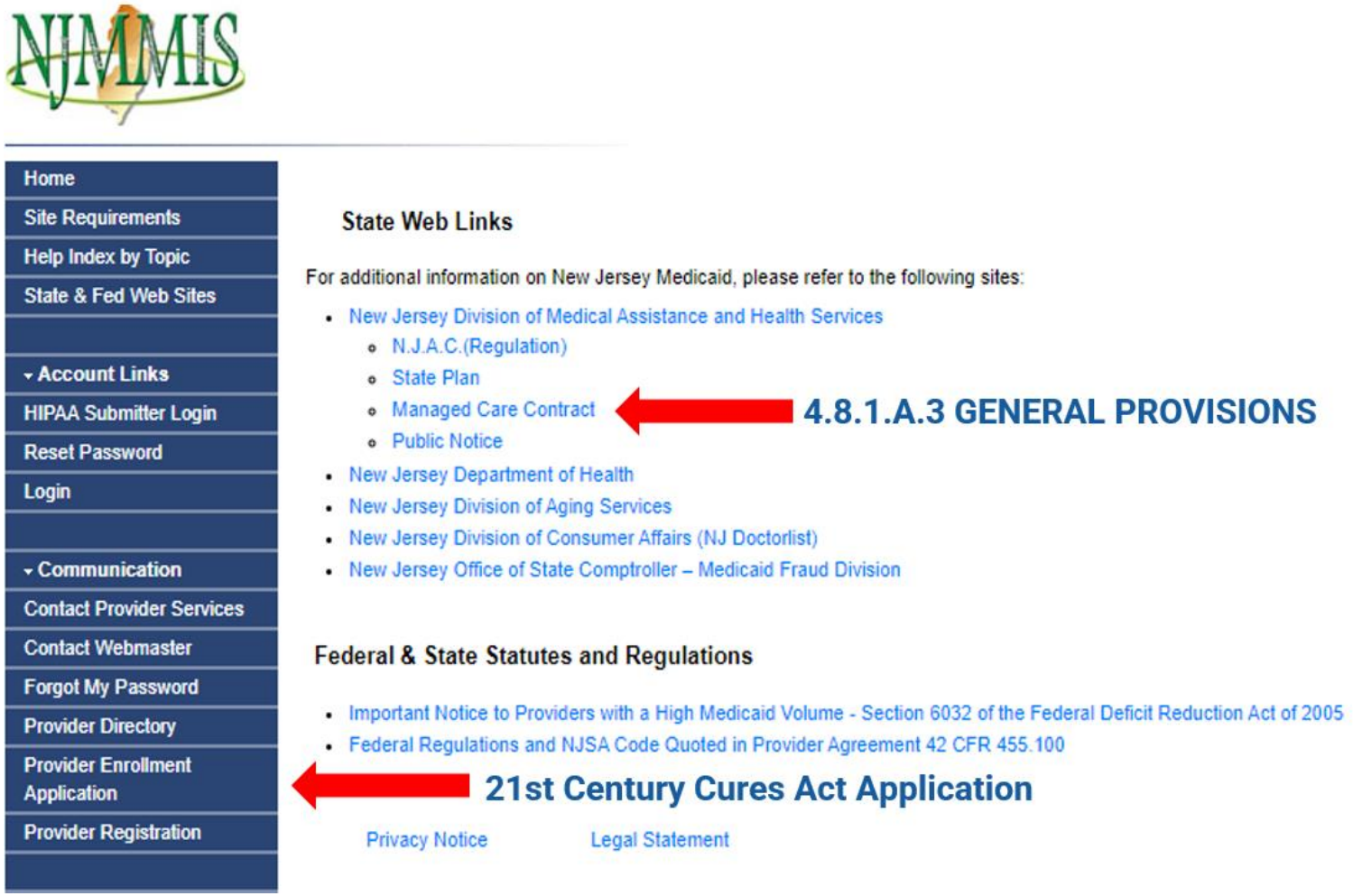
, CONTRACTOR

07/2025 Accepted

14

REGULATORY RESOURCES

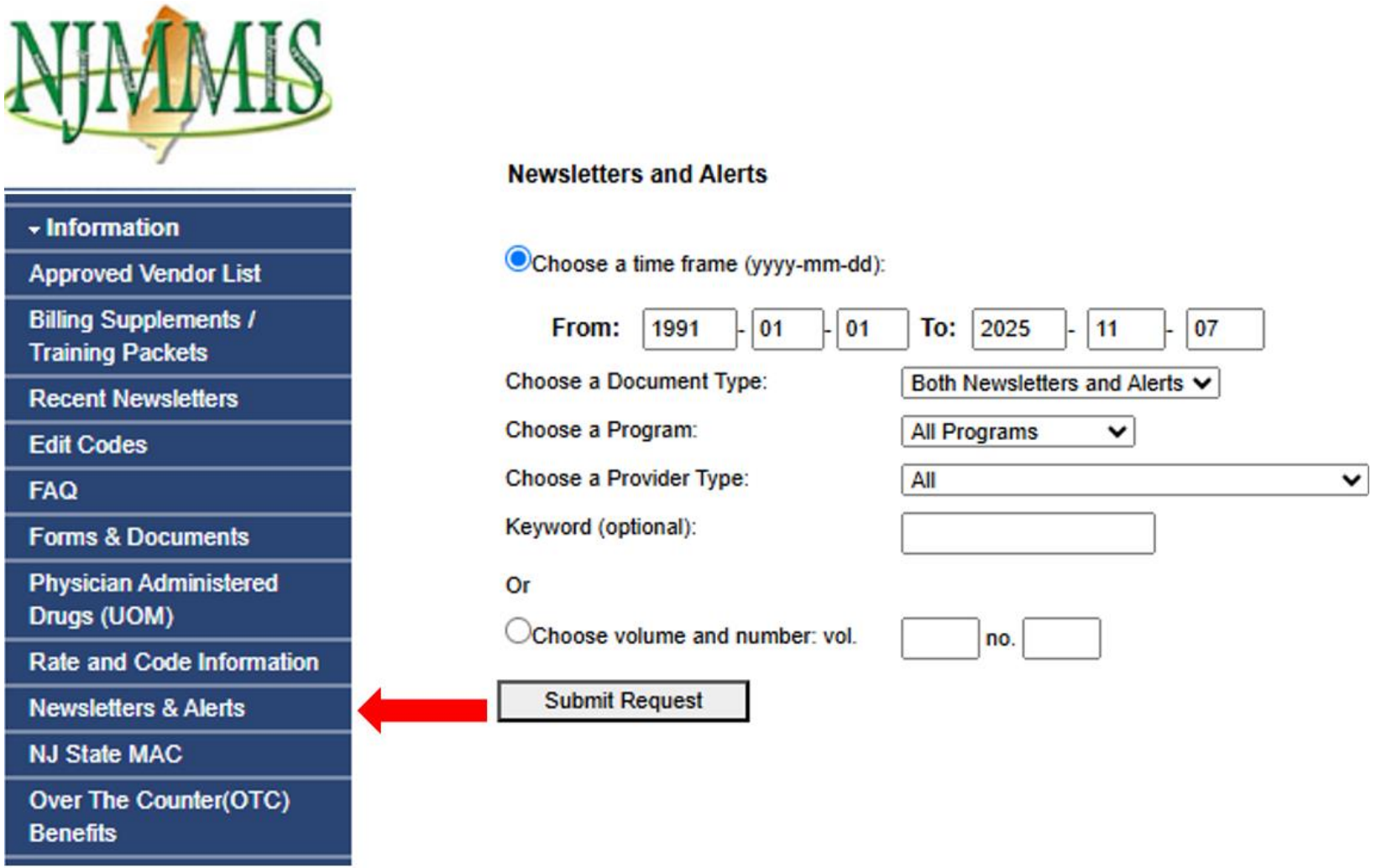
WWW.NJMMIS.COM



- Providers under contract with multiple MCOs - only required to submit a single 21st Century Cures Act application to Gainwell.

- Questions? Contact Gainwell Technologies Provider Enrollment Unit
  - 609-588-6036
  - NJMMISProviderenrollment@gainwelltechnologies.com.

REGULATORY RESOURCES: DMAHS NEWSLETTERS



- Medicaid Newsletters are used to introduce new programs or services, pending regulatory updates or general program guidance.
- Newsletters can be found on www.njmmis.com.
- Newsletters are searchable by provider type and subject.

MCO REQUIREMENTS FOR PARTICIPATION

Presented by: Danny Roman, Senior Manager Contracting & Network Development
Fidelis Care

MCO REQUIREMENTS FOR PARTICIPATION

- Participating with an MCO will allow your group to provide services to eligible NJ Medicaid members enrolled with that plan.
- Two main parts to this process:

Provider Credentialing

Provider Contracting

PROVIDER CREDENTIALING

- Credentialing - the way in which the MCO can verify the provider has all the required documentation to participate.
- It ensures quality, compliance, and accountability.

CREDENTIALING REQUIREMENTS

Credentialing Application

- Detailed application form to collect necessary information

Professional License

- Proof of valid and current New Jersey license

Professional Liability Insurance

- Evidence of liability insurance coverage

W9

- Federal Tax Identification Number and Mailing Address

NJ State Medicaid ID

- Enrolled in 21st Century Cures Act

PROVIDER CONTRACTS

- The contract makes you a participating provider with the MCO, allowing you to provide services to eligible MCO NJ Medicaid members.

Creation

- Contracts are prepared by the MCO and sent to the provider

Review & Signature

- Provider reviews the contract terms and signs

Return for Countersignature

- Contract is returned to the MCO for final countersignature

SUBMISSION OF CREDENTIALING PACKAGE

- Once the entire credentialing package (including signed contract) is complete, it is submitted to the MCO Credentialing Department for processing.

- The credentialing process takes approximately 60 to 90 days for completion; consult with the MCO for specific timelines.

MEDICAID REQUIREMENTS FOR PAYMENT
(DOCUMENTATION, BILLING GUIDELINES, AND RECORDS RETENTION)

Presented by: Blake Rogers, CFE
Manager, Program Integrity, Special Investigations Unit (Aetna)

DOCUMENTATION - REQUIRED ELEMENTS

Beneficiary's Info

- Name
- Address
- Medicaid/NJ FamilyCare eligibility identification number

Diagnosis and summary of the patient's physical condition:

- Examinations
- Progress notes
- Face-to-face evaluations
- Physician orders
- Treatment Plans

Prescriber's Info

- Name
- Credentials
- Signature
- Date

Supporting Documentation

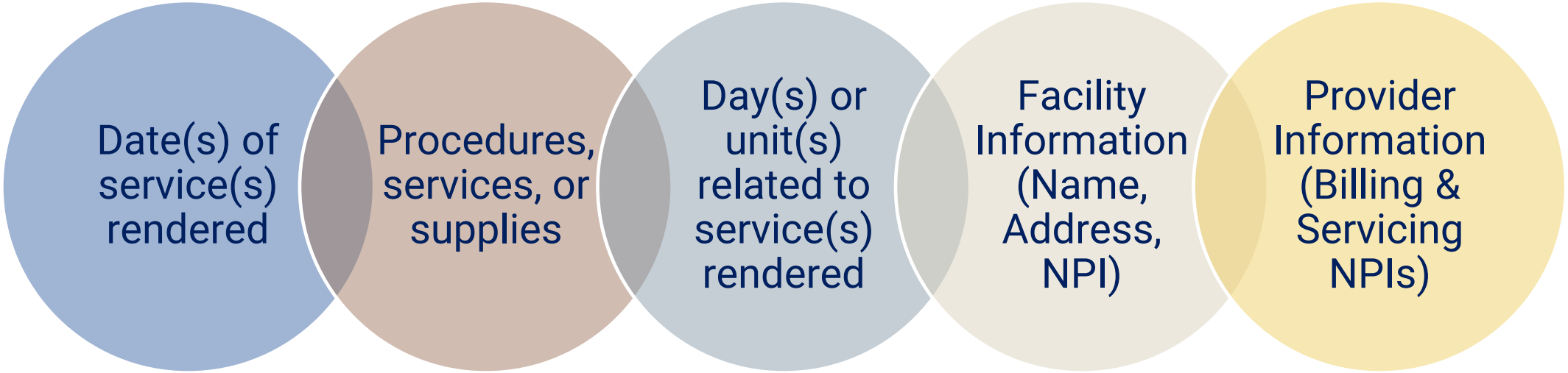
- Should support the procedure and modifier(s) used
- Be complete, dated, and timed.

Prompt Documentation

- Timely entry of info into the medical record (completed at time of service or shortly after)

BILLING GUIDELINES – ACCURATE CLAIMS SUBMISSIONS

As a condition of reimbursement, allergy and immunology claims must contain the following:



DELEGATION OF TASKS
N.J.A.C. 13:35-6.4

- Established by the NJ State Board of Medical Examiners, N.J.A.C. 13:35-6.4 defines scope of services and medical tasks that certified medical assistants (CMAs) are permitted to render under the supervision of a physician. CMAs are:
  - Allowed to render injections when directed by a physician and venipuncture
  - **Prohibited** from administering any substance related to **allergenic testing or treatment**, local anesthetics, or controlled dangerous substances.
- Impact to Providers:
  - Defines the scope of practice for CMAs, documentation, physician responsibility for training and supervision, and billing.
  - Reimbursement is based on the physician's oversight and documentation of the service.

RECORDS RETENTION

- Records must be retained for the later of five (5) years from the date of service (N.J.S.A. 30:4D-12(d))

- Recommendation - If an audit, investigation, litigation, or other action involving the records is started before the end of the retention period, records shall be retained until all issues arising out of the action are resolved or until the end of the retention period, whichever is later.

RECORDS RETENTION

- For enrollees who are eligible through the Division of Child Protection and Permanency, records shall be kept in accordance with the provisions under N.J.S.A. 9:6- 8.10a and N.J.S.A. 9:6-8.40 and consistent with need to protect the enrollee's confidentiality.

COMPLIANCE AND THE MEDICAID FRAUD DIVISION

Presented by: Tracy Livingston, Assistant Director, Data and Fiscal
Office of the State Comptroller, Medicaid Fraud Division

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

- New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. 30:4D-53 et seq.
  - Established the Office of the Medicaid Inspector General to detect, prevent, and investigate Medicaid fraud and abuse, recover improperly expended Medicaid funds, enforce Medicaid rules and regulations, audit cost reports and claims, and review quality of care given to Medicaid recipients.
- These functions, powers and duties were later transferred to the Office of the State Comptroller (OSC), and are carried out by the Medicaid Fraud Division (MFD).

PROGRAM INTEGRITY (PI) OVERSIGHT

- Refers to the system of monitoring and auditing NJ Medicaid providers to ensure they are:
  - billing Medicaid accurately;
  - delivering appropriate services;
  - not engaging in fraudulent practices, abusive, or wasteful practices; and
  - properly documenting the goods/services billed.

MFD OVERSIGHT FUNCTIONS

Program Integrity Oversight

Enforce Medicaid rules and regulations	Audit and investigate potential fraud, waste and abuse by providers and recipients	Recover improperly expended Medicaid funds	Coordinate PI oversight efforts among State agencies that provide and administer Medicaid services and programs.	Exclude or terminate providers from the Medicaid program where necessary

WHY IS PI OVERSIGHT IMPORTANT?

Protecting Medicaid Funds

- ensures Medicaid dollars are used effectively

Maintaining Quality of Care

- ensures providers are delivering appropriate and necessary services to patients.

CONSEQUENCES

Non-compliance with Medicaid rules, standards and regulations regarding service may constitute acts of fraud, waste or abuse of Medicaid funds.

MEDICAID FRAUD DIVISION: ACTIONS, INELIGIBLE PROVIDERS, SELF-DISCLOSURES, AND THIRD PARTY LIABILITY

Presented by: Khia O'Neal, CPC, CPMA Assistant Division Director, Investigations,
Office of the State Comptroller, Medicaid Fraud Division

MFD RECOVERY ACTIONS

- If an investigation or audit leads to an identified overpayment, MFD initiates actions for recouping the improperly paid funds.

Send notice of Estimated Overpayment, Notice of Intent and, Notice of Claim

Add penalties, including false claim penalties between $14,308 and $28,619 per claim

File a Certificate of Debt on real estate owned by a provider/owner of business

Seek to withhold future Medicaid payments until overpayment is satisfied

INELIGIBLE PROVIDERS

- An ineligible provider - someone who is excluded from participation in Federal or State funded health care programs.
  - Debarred, disqualified, suspended, or excluded providers are considered ineligible providers.
- Any products or services that an ineligible provider directly or indirectly furnishes, orders or prescribes - not eligible for payment under those programs (N.J.A.C. 10:49-11.1(b)).
- It is incumbent upon providers to perform Ineligible Provider Checks, upon hire and monthly thereafter:
  - NJMMIS Newsletter Volume 33, Number 02

MEDICAID INELIGIBLE PROVIDER LIST REQUIREMENTS

1. State of New Jersey Ineligible Provider report (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
2. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
3. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
4. N.J. Division of Consumer Affairs licensure databases (mandatory): http://www.njconsumeraffairs.gov/Pages/verification.aspx
5. N.J. Department of Health licensure database (mandatory):http://www.state.nj.us/health/guide/find-select-provider/
6. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp
7. If the provider is out of state, you must also check that state's exclusion/debarment list

SELF-DISCLOSURE

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://nj.gov/comptroller/resources/#collapseSub30/

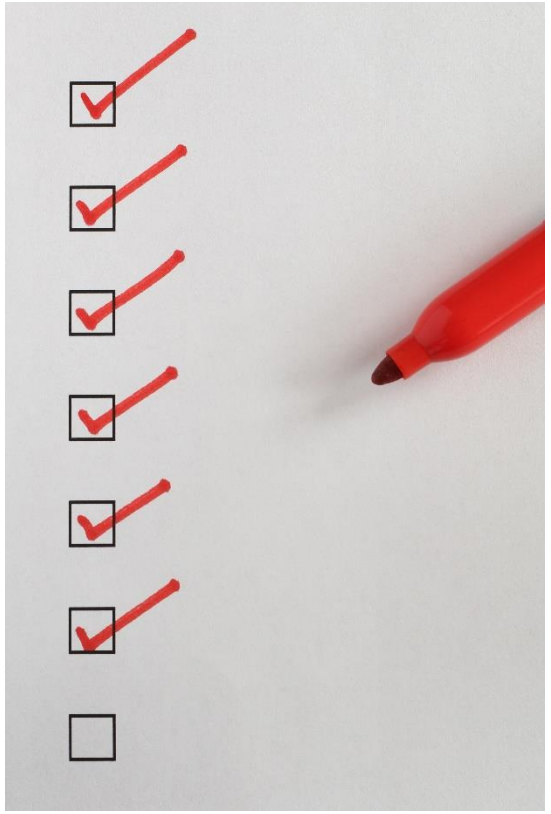
- Affordable Care Act §6402 and N.J.A.C. §10:49-1.5 (b)(1), (7)
  - require that any overpayments from Medicaid and/or Medicare must be returned within 60 days of identifying that they have been improperly received.

- Providers who follow the protocols for a proper self-disclosure can avoid imposition of penalties.

- MFD's Self Disclosure Form: https://www.nj.gov/comptroller/news/docs/MFD_Self_Disc_2025/SD%20Form.pdf

SELF-DISCLOSURES – MUST INCLUDE:

- A summary of the identified issue(s) including the underlying cause;
- The Medicaid program rules potentially implicated;
- The nature and extent of any investigation or audit conducted to identify and determine the amount of overpayment;
- All corrective action(s) taken;
- An Excel file including a detailed list of claims paid that comprise the overpayments;
- An attestation of accuracy and completeness; and
- The name and contact information of the individual making the report on behalf of the provider.



SELF-DISCLOSURE: STATISTICAL SAMPLING & EXTRAPOLATION

- If the self-disclosure involves statistical sampling and extrapolation:
  - Work must be performed by qualified personnel.
  - Provide an Excel file containing, at a minimum, the:
    - Sampling Plan;
    - Universe/ Sampling Frame;
    - Sample with the results of the Sample Review (i.e., for each claim indicate if it is in error, explain what the error is, and explain how much money should have been paid/how much money was overpaid);
    - Random Numbers (used to select random sample) / Seed Number (to replicate sample);
    - Extrapolation Methodology / Output; and
    - Explanation or description of all software used to perform the sample and extrapolation.

SELF-DISCLOSURE: SAMPLING & EXTRAPOLATION RESOURCES

OIG Self-Disclosure Protocol (discusses Sampling/ Extrapolation on pages 6-8)

- https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/

OIG Statistical Sampling and Extrapolation Software: RAT-STATS

- https://oig.hhs.gov/compliance/rat-stats/

Medicaid Fraud Control Unit (MFCU) Sampling Guidance

- https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/MFCU-Sampling-Guidance.pdf

CMS Medicare Program Integrity Manual (MPIM), Chapter 8 – Statistical Sampling for Overpayment Estimation

- https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c08.pdf

THIRD-PARTY LIABILITY (TPL)

- Third-Party Liability - when any entity or party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program.
  - Examples: Medicare, commercial health insurance, Tricare
- By law, Medicaid is the payer of last resort. All TPL shall, if available, be used first and to the fullest extent to pay claims before Medicaid/NJ FamilyCare pays for the care of the Medicaid recipient.
- It is a violation of Section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services (N.J.A.C. 10:49-7.3).

Name	Contact Information
TPL Hotline	(609) 826-4702
TPL Hotline en Español	(609) 777-2753

WHAT IS: FRAUD, WASTE, AND ABUSE (FWA)?

Presented by: Jessica Busse, Senior Investigator, SIU
UnitedHealthcare

WHAT IS FWA?

Fraud

- **N.J.S.A. 30:4D-55**
- An intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit.

Waste

- Considered a legal violation for civil purposes and can result in a recovery of an overpayment, debarment from the Medicaid program and penalties.
- Not *usually* considered a criminal act.

Abuse

- **N.J.S.A. 30:4D-55**
- Provider practices that are inconsistent with proper, sound fiscal, business, or professional or service delivery practices.
- Practices that result in:
  - unnecessary costs to or improper payment by Medicaid; or
  - reimbursement for services that are not necessary, not approved, not documented, that are outside those specifically authorized.

FWA - EXAMPLES

Fraud

- billing for services not rendered
- billing for services while the member is inpatient
- transportation time used as time spent onsite

Waste

- overutilization
- misuse of resources
- overuse of supplies
- billing for services that are not medically necessary

Abuse

- services billed exceed the prior authorized approved amount

CIVIL MEDICAID FRAUD, WASTE AND ABUSE - CONSEQUENCES

- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Referral for criminal prosecution
- Restitution/Recovery of overpayments
- Additional penalties in addition to repaying Medicaid overpayments

RED FLAGS AND CASE EXAMPLES

Presented by: Stacey Houston, CPMA, CPC, Clinical Provider Auditor, Lead, Anthem Blue Cross and Blue Shield (Wellpoint); and
Jessica Busse, Senior Investigator, SIU, UnitedHealthcare

RED FLAG AREA #1 - ALLERGY PREP (CPT CODE 95165)

Missing:

- Mixing Form/Log
- Billing/supervising providers Signature on necessary forms
- Order or encounter note with intent to order

Excessive units billed (billed MORE than vials prepared)

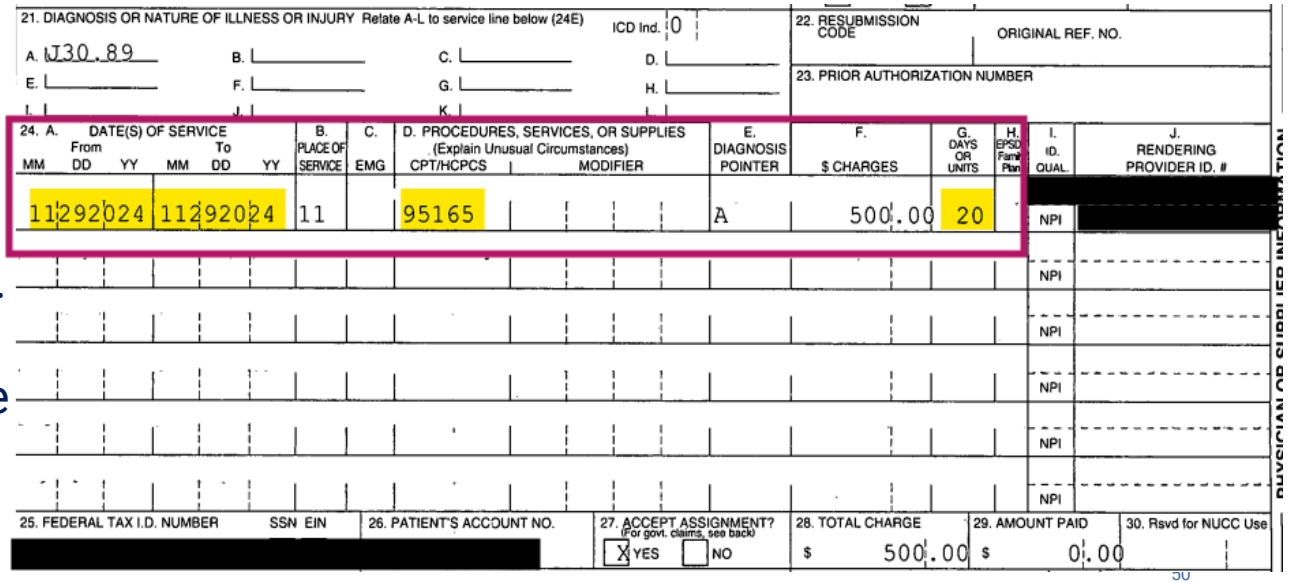
Billing on multiple days to circumvent MUE edit

EXAMPLE - ALLERGY PREP (CPT CODE 95165)

Example **supports** CPT code 95165 -
Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).

- Date of service is 11/29/24; provider is billing 20 units.

- Documentation, relevant to claim, was received:
  - Immunotherapy Prescription by referring provider dated prior to billed date of service.
  - Standing Order for Immunotherapy.
  - Immunotherapy Mixing Log for specific date of service, signed by supervising physician.
  - A Skin Test Panel report.



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. 0
A. J30.89 B. C. D.
E. F. G. H.
I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.
23. PRIOR AUTHORIZATION NUMBER

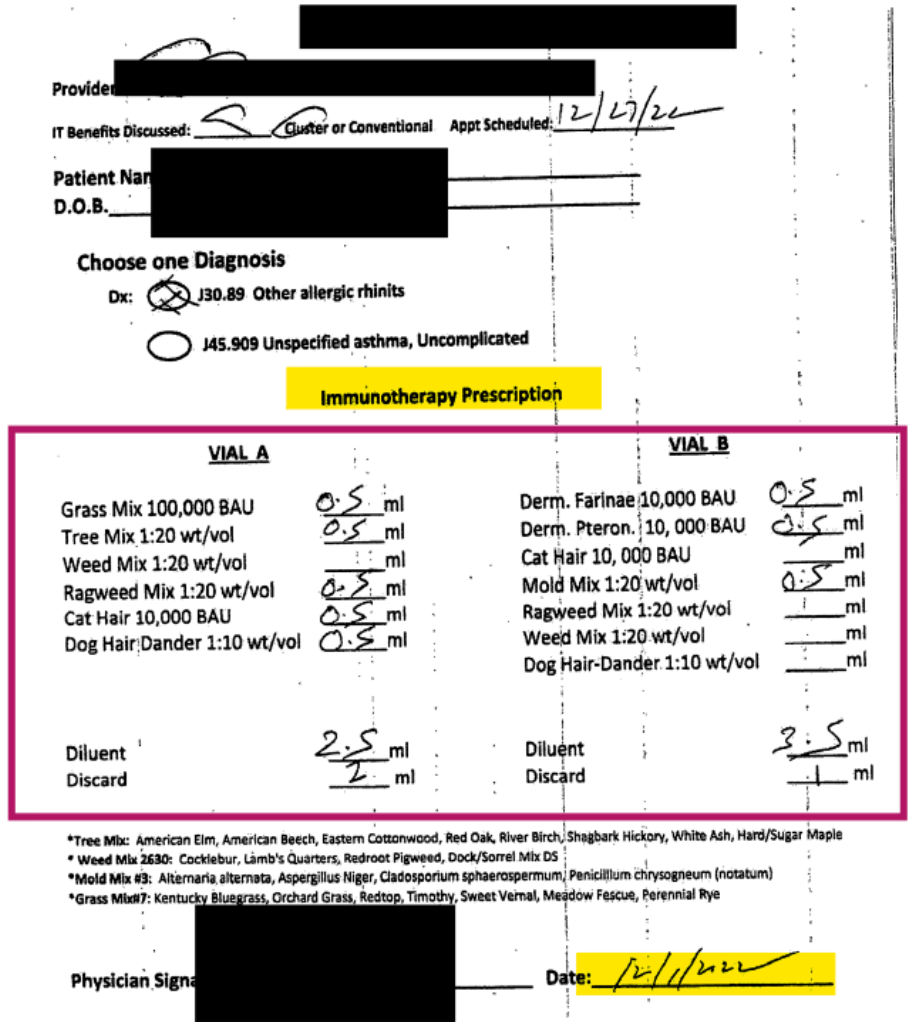
24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
11 29 24	11 29 24	11		95165		A	500.00	20			NPI [redacted]
											NPI
											NPI
											NPI
											NPI
											NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN [redacted] 26. PATIENT'S ACCOUNT NO. 27. ACCEPT ASSIGNMENT? (For govt. claims, see back) [X] YES [ ] NO 28. TOTAL CHARGE $ 500.00 29. AMOUNT PAID $ 0.00 30. Rsvd for NUCC Use

PHYSICIAN OR SUPPLIER INFORMATION

EXAMPLE - IMMUNOTHERAPY PRESCRIPTION

This example is signed by referring provider and dated before the billed date of service - shows intent for services.



[redacted]

Provider [redacted]

IT Benefits Discussed: S Cluster or Conventional Appt Scheduled: 12/27/22

Patient Name [redacted]

D.O.B.

Choose one Diagnosis

Dx: (X) J30.89 Other allergic rhinits

( ) J45.909 Unspecified asthma, Uncomplicated

Immunotherapy Prescription

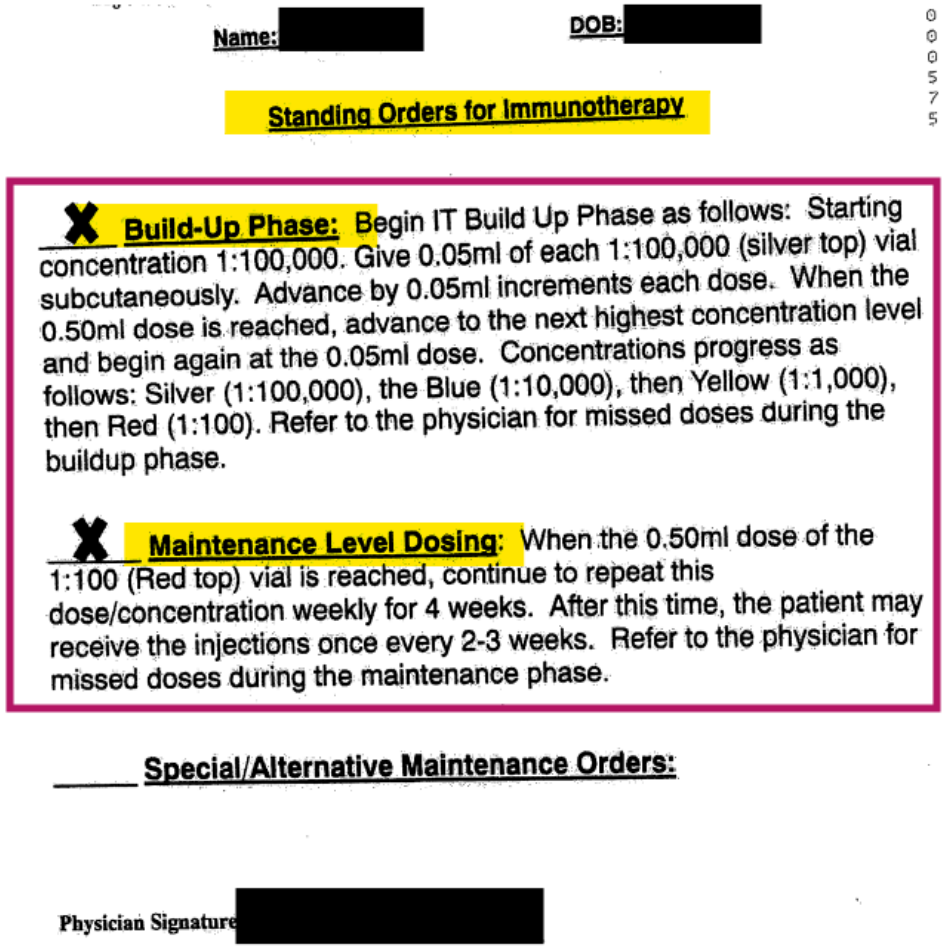
VIAL A		VIAL B	
Grass Mix 100,000 BAU	0.5 ml	Derm. Farinae 10,000 BAU	0.5 ml
Tree Mix 1:20 wt/vol	0.5 ml	Derm. Pteron. 10, 000 BAU	0.5 ml
Weed Mix 1:20 wt/vol	ml	Cat Hair 10, 000 BAU	ml
Ragweed Mix 1:20 wt/vol	0.5 ml	Mold Mix 1:20 wt/vol	0.5 ml
Cat Hair 10,000 BAU	0.5 ml	Ragweed Mix 1:20 wt/vol	ml
Dog Hair Dander 1:10 wt/vol	0.5 ml	Weed Mix 1:20 wt/vol	ml
		Dog Hair-Dander 1:10 wt/vol	ml
Diluent	2.5 ml	Diluent	3.5 ml
Discard	1 ml	Discard	1 ml

*Tree Mix: American Elm, American Beech, Eastern Cottonwood, Red Oak, River Birch, Shagbark Hickory, White Ash, Hard/Sugar Maple
* Weed Mix 2630: Cocklebur, Lamb's Quarters, Redroot Pigweed, Dock/Sorrel Mix DS
*Mold Mix #3: Alternaria alternata, Aspergillus Niger, Cladosporium sphaerospermum, Penicillium chrysogneum (notatum)
*Grass Mix#7: Kentucky Bluegrass, Orchard Grass, Redtop, Timothy, Sweet Vernal, Meadow Fescue, Perennial Rye

Physician Signature [redacted] Date: 12/27/2022

EXAMPLE - STANDING ORDER

This example details different dosing phases – build-up and maintenance. Also shows intent of services.



Name: [redacted] DOB: [redacted]

0 0 0 5 7 5

Standing Orders for Immunotherapy

X **Build-Up Phase:** Begin IT Build Up Phase as follows: Starting concentration 1:100,000. Give 0.05ml of each 1:100,000 (silver top) vial subcutaneously. Advance by 0.05ml increments each dose. When the 0.50ml dose is reached, advance to the next highest concentration level and begin again at the 0.05ml dose. Concentrations progress as follows: Silver (1:100,000), the Blue (1:10,000), then Yellow (1:1,000), then Red (1:100). Refer to the physician for missed doses during the buildup phase.

X **Maintenance Level Dosing**: When the 0.50ml dose of the 1:100 (Red top) vial is reached, continue to repeat this dose/concentration weekly for 4 weeks. After this time, the patient may receive the injections once every 2-3 weeks. Refer to the physician for missed doses during the maintenance phase.

____ **Special/Alternative Maintenance Orders:**

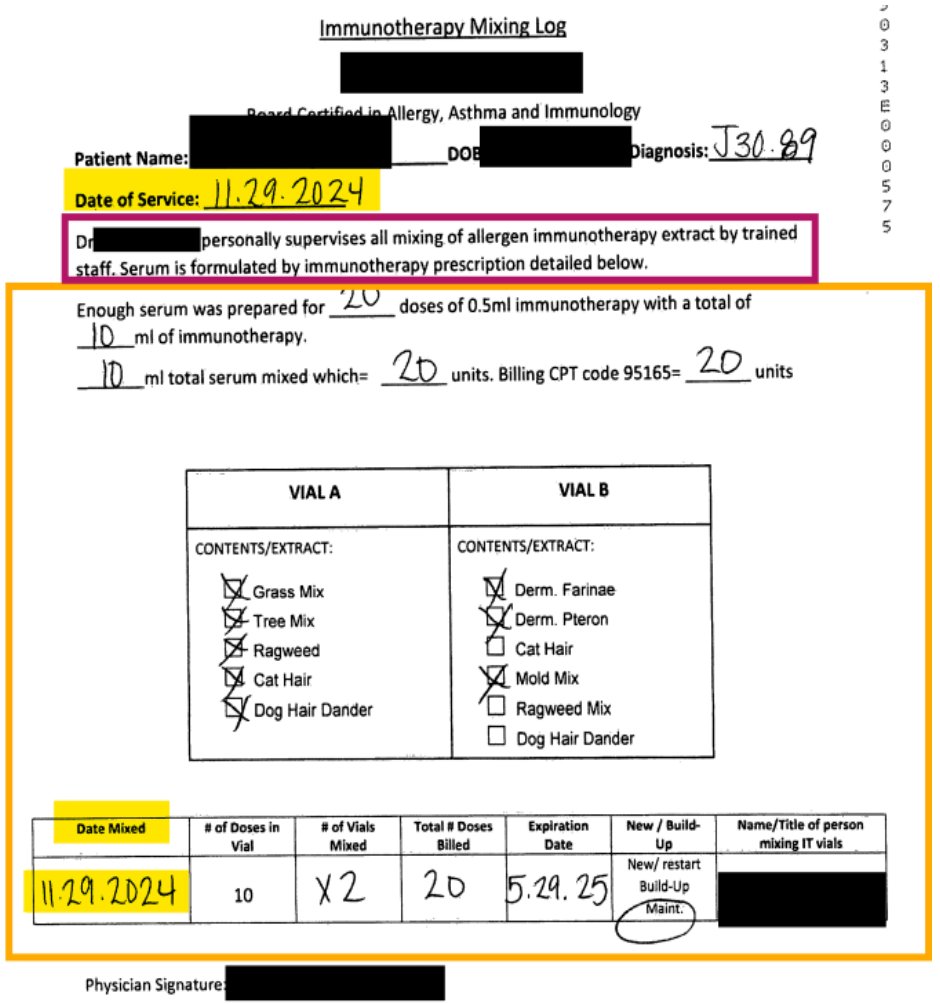
Physician Signature [redacted]

EXAMPLE - IMMUNOTHERAPY MIXING LOG

- Units on mixing form match number of units billed.
- Prescription form shows 11/29/24 as mixing date; provider is showing 2 vials were mixed.
- Each vial has 20 doses of serum at 0.5 ml per dose – equals 10 ml per vial (20x0.5=10). 2 vials = 20 doses.

Documentation supports the billed code:

- Billed date of service
- Name of billing/supervising provider
- Doses on mixing log match claim.



Immunotherapy Mixing Log

[redacted]

Board Certified in Allergy, Asthma and Immunology

Patient Name: [redacted] DOB [redacted] Diagnosis: J30.89

Date of Service: 11.29.2024

Dr [redacted] personally supervises all mixing of allergen immunotherapy extract by trained staff. Serum is formulated by immunotherapy prescription detailed below.

Enough serum was prepared for 20 doses of 0.5ml immunotherapy with a total of 10 ml of immunotherapy.

10 ml total serum mixed which= 20 units. Billing CPT code 95165= 20 units

VIAL A	VIAL B
CONTENTS/EXTRACT:	CONTENTS/EXTRACT:
☒ Grass Mix	☒ Derm. Farinae
☒ Tree Mix	☒ Derm. Pteron
☒ Ragweed	☐ Cat Hair
☒ Cat Hair	☒ Mold Mix
☒ Dog Hair Dander	☐ Ragweed Mix
	☐ Dog Hair Dander

Date Mixed	# of Doses in Vial	# of Vials Mixed	Total # Doses Billed	Expiration Date	New / Build-Up	Name/Title of person mixing IT vials
11.29.2024	10	X 2	20	5.29.25	New/ restart Build-Up Maint.	[redacted]

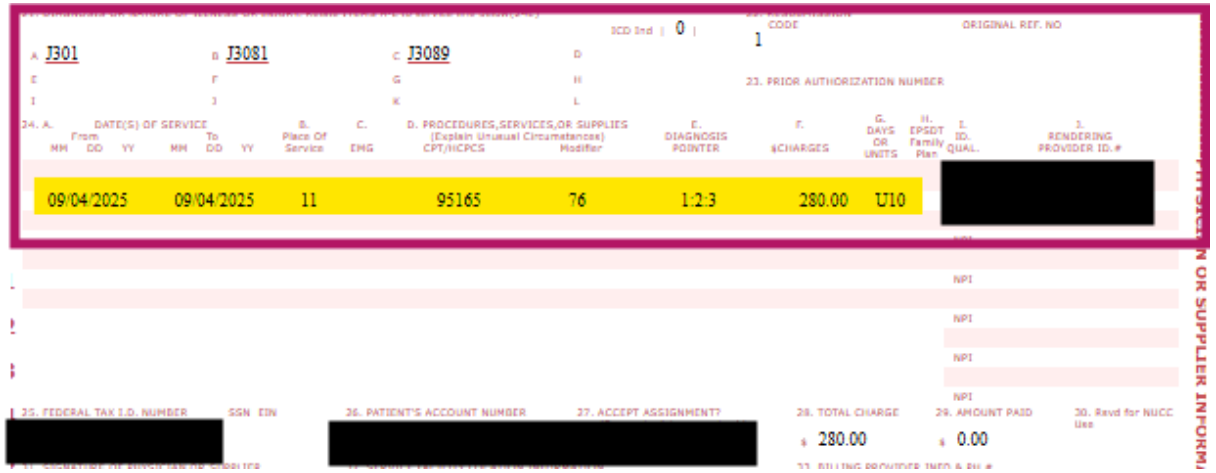
Physician Signature: [redacted]

EXAMPLE - ALLERGY PREP (CPT CODE 95165)

Example **does not support** CPT code 95165 -
Professional services for the supervision of preparation and provision of antigens for allergen immunotherapy; single or multiple antigens (specify number of doses).

- Date of service on claim is 9/4/25; provider is billing 10 units.

- Documentation, relevant to claim, was received:
  - Immunotherapy Mixing Log for specific date of service signed by the supervising physician.
  - Skin Test Panel report.
  - Provider note dated before the billed date of service showing intent for the therapy.



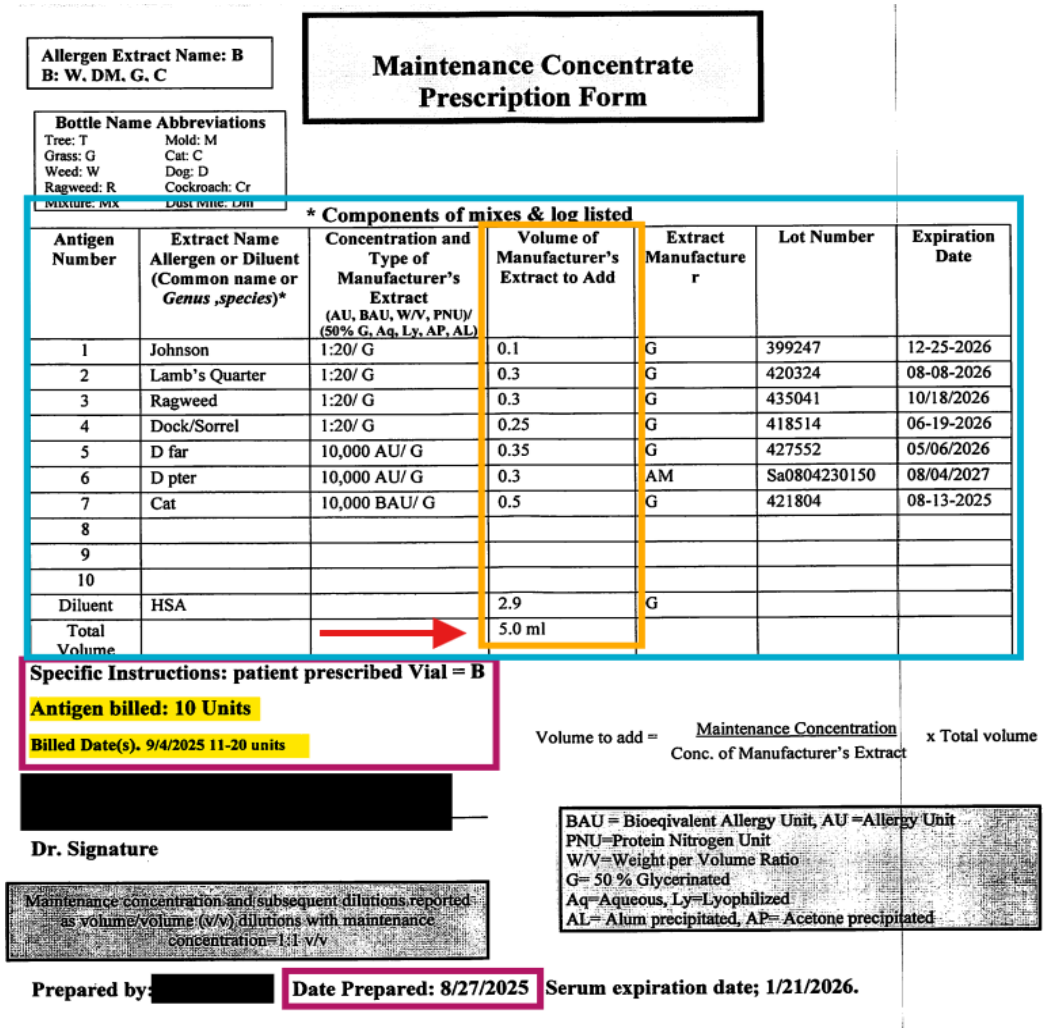
EXAMPLE - PRESCRIPTION FORM

- Received 3 separate prescription forms; not all were for the billed date of service.

- Verify number of units on claim match prescription
  - Volume of Manufacture's Extract + Amount of Diluent Used.
    - 0.1+0.3+0.3+0.25+0.35+0.3+0.5=2.1
  - 2.1 (antigens) + 2.9 (diluent) = 5.0 ml (or 5 units)

Documentation supports billed code:
- Billed date of service.
- Name of billing/supervising provider.

Documentation does not support billed code:
- Number of units
  - No documentation showing more than one vial prepared for date of service.
  - Billed units is 10 (10 ml) but only 5 ml documented.



Allergen Extract Name: B
B: W, DM, G, C

Maintenance Concentrate Prescription Form

Bottle Name Abbreviations

Tree: T	Mold: M
Grass: G	Cat: C
Weed: W	Dog: D
Ragweed: R	Cockroach: Cr
Mixture: Mx	Dust Mite: Dm

* Components of mixes & log listed

Antigen Number	Extract Name Allergen or Diluent (Common name or *Genus ,species*)*	Concentration and Type of Manufacturer's Extract (AU, BAU, W/V, PNU)/ (50% G, Aq, Ly, AP, AL)	Volume of Manufacturer's Extract to Add	Extract Manufacturer	Lot Number	Expiration Date
1	Johnson	1:20/ G	0.1	G	399247	12-25-2026
2	Lamb's Quarter	1:20/ G	0.3	G	420324	08-08-2026
3	Ragweed	1:20/ G	0.3	G	435041	10/18/2026
4	Dock/Sorrel	1:20/ G	0.25	G	418514	06-19-2026
5	D far	10,000 AU/ G	0.35	G	427552	05/06/2026
6	D pter	10,000 AU/ G	0.3	AM	Sa0804230150	08/04/2027
7	Cat	10,000 BAU/ G	0.5	G	421804	08-13-2025
8						
9						
10						
Diluent	HSA		2.9	G		
Total Volume			5.0 ml			

Specific Instructions: patient prescribed Vial = B

Antigen billed: 10 Units

Billed Date(s). 9/4/2025 11-20 units

Volume to add = Maintenance Concentration / Conc. of Manufacturer's Extract x Total volume

[redacted]

Dr. Signature

BAU = Bioeqivalent Allergy Unit, AU =Allergy Unit
PNU=Protein Nitrogen Unit
W/V=Weight per Volume Ratio
G= 50 % Glycerinated
Aq=Aqueous, Ly=Lyophilized
AL= Alum precipitated, AP= Acetone precipitated

Maintenance concentration and subsequent dilutions reported as volume/volume (v/v) dilutions with maintenance concentration=1:1 v/v

Prepared by: [redacted] **Date Prepared: 8/27/2025** **Serum expiration date; 1/21/2026.**

RED FLAG AREA #2 - PERCUTANEOUS (SCRATCH, PUNCTURE, PRICK) TESTS (CPT CODE 95004)

Missing:

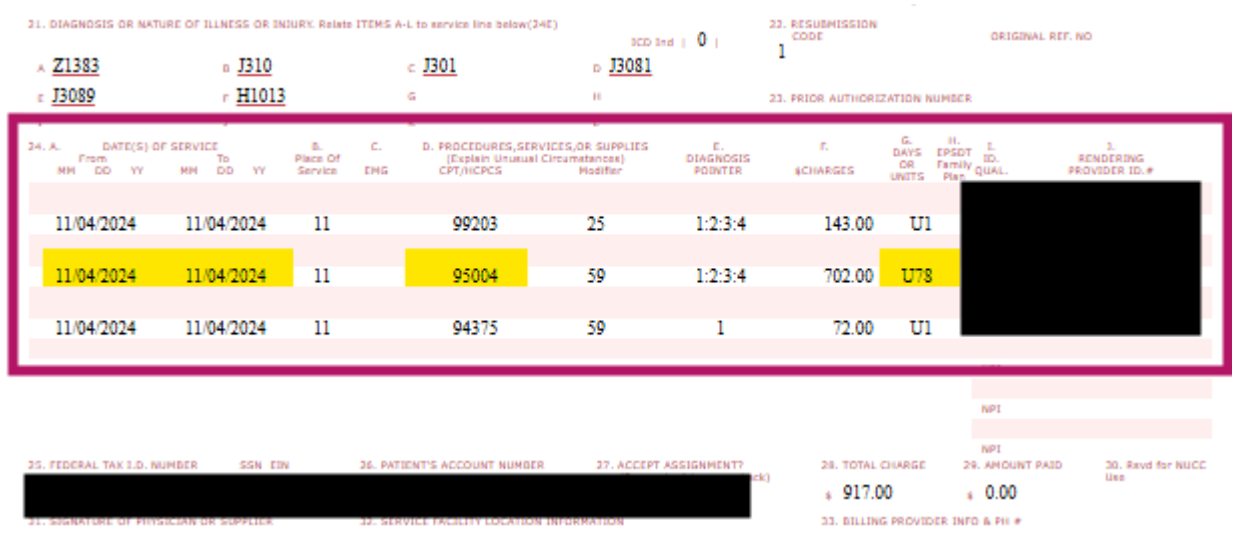
- Order or encounter note with intent to order
- Ordering physician's signature on order or encounter note with intent to order

Incorrect units billed (billing MORE than documented)

EXAMPLE – PERCUTANEOUS TESTING

Example **supports** CPT code 95004 –
Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests.

- Date of service on claim is 11/4/24 & provider is billing 78 units.
- Received the following documentation, from provider:
  - Provider note for billed date of service
  - Skin Prick Allergen Testing sheet



21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. Relate ITEMS A-L to service line below(24E) — ICD Ind | 0 |

A Z1383 B J310 C J301 D J3081
E J3089 F H1013 G H

22. RESUBMISSION CODE: 1 ORIGINAL REF. NO

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. Place Of Service	C. EMG	D. PROCEDURES,SERVICES,OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	Modifier	E. DIAGNOSIS POINTER	F. $CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID.#
11/04/2024	11/04/2024	11		99203	25	1:2:3:4	143.00	U1			[redacted]
11/04/2024	11/04/2024	11		95004	59	1:2:3:4	702.00	U78			
11/04/2024	11/04/2024	11		94375	59	1	72.00	U1			

NPI

NPI

25. FEDERAL TAX I.D. NUMBER SSN EIN — 26. PATIENT'S ACCOUNT NUMBER — 27. ACCEPT ASSIGNMENT? — 28. TOTAL CHARGE — 29. AMOUNT PAID — 30. Rsvd for NUCC Use

[redacted] — $ 917.00 — $ 0.00

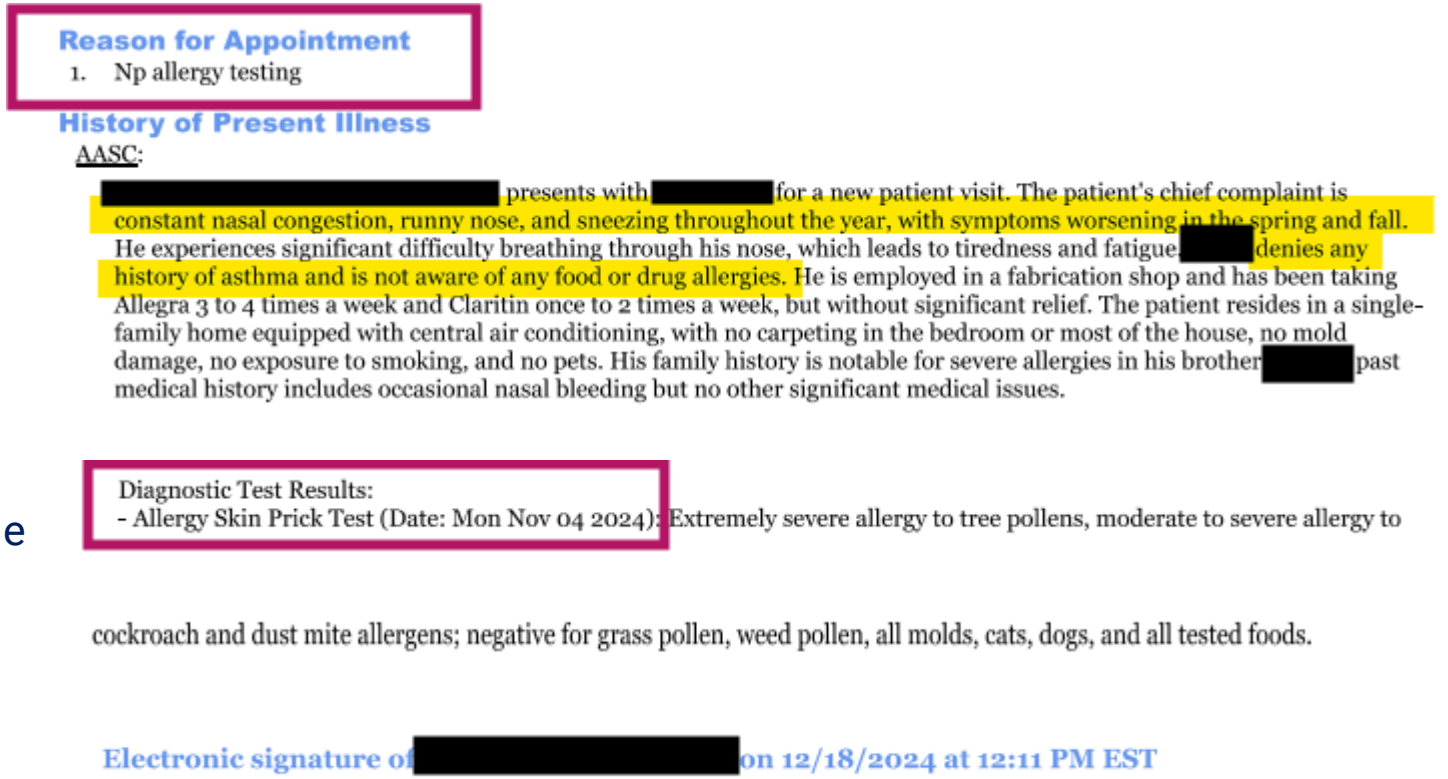
31. SIGNATURE OF PHYSICIAN OR SUPPLIER — 32. SERVICE FACILITY LOCATION INFORMATION — 33. BILLING PROVIDER INFO & PH #

EXAMPLE – PERCUTANEOUS TESTING

Documents received for date of service supports services:

1. Provider note on date of service
   - Reason for visit is allergy testing
   - Includes interpretation of diagnostic test results for skin testing
   - Signed by billing provider

2. Adult Skin Prick Allergen Testing Sheet (example of sheet is on next slide)
   - Lists controls used along with different allergens tested.
   - Each section is marked by tester



Reason for Appointment

1. Np allergy testing

History of Present Illness

AASC:

[redacted] presents with [redacted] for a new patient visit. The patient's chief complaint is constant nasal congestion, runny nose, and sneezing throughout the year, with symptoms worsening in the spring and fall. He experiences significant difficulty breathing through his nose, which leads to tiredness and fatigue [redacted] denies any history of asthma and is not aware of any food or drug allergies. He is employed in a fabrication shop and has been taking Allegra 3 to 4 times a week and Claritin once to 2 times a week, but without significant relief. The patient resides in a single-family home equipped with central air conditioning, with no carpeting in the bedroom or most of the house, no mold damage, no exposure to smoking, and no pets. His family history is notable for severe allergies in his brother [redacted] past medical history includes occasional nasal bleeding but no other significant medical issues.

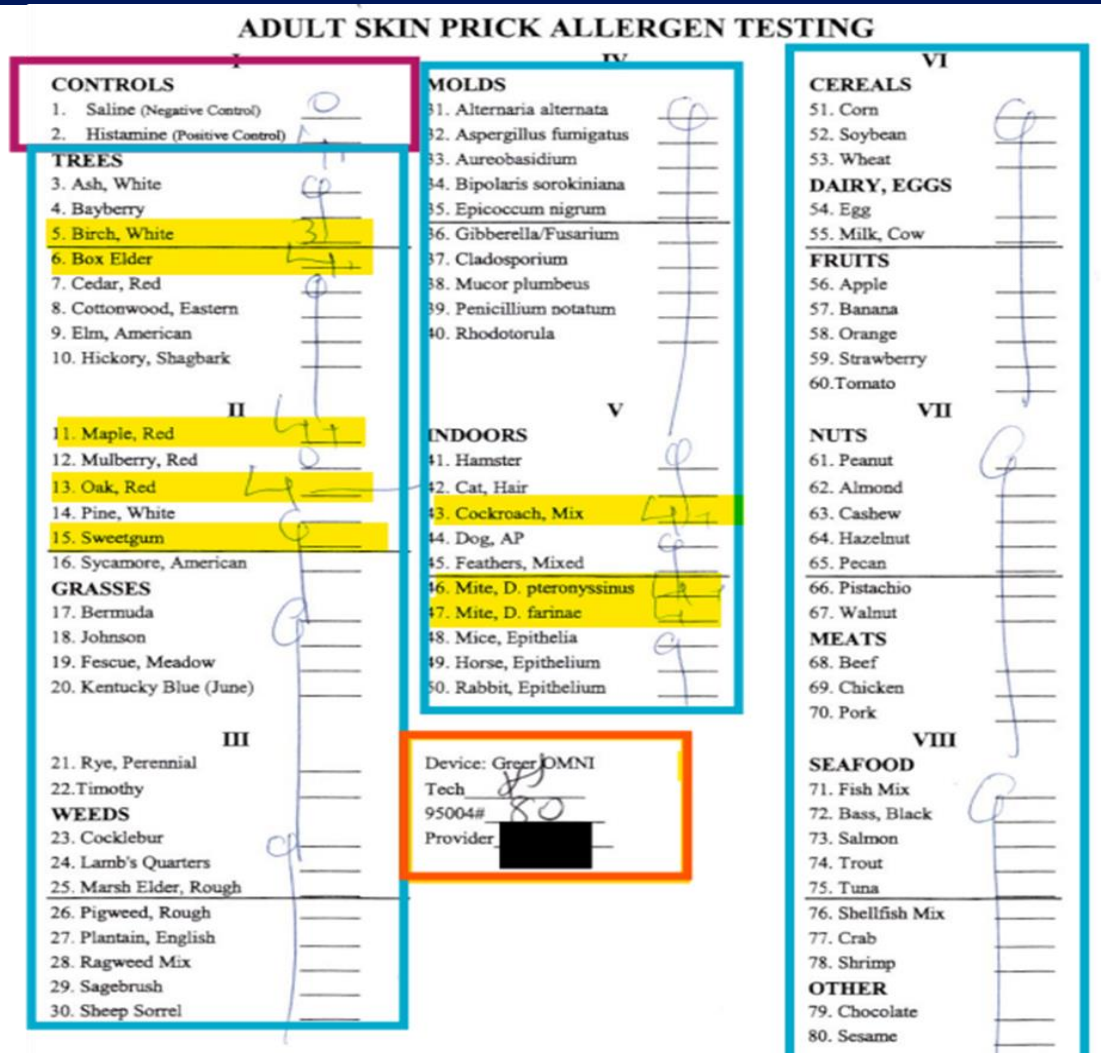
Diagnostic Test Results:
- Allergy Skin Prick Test (Date: Mon Nov 04 2024): Extremely severe allergy to tree pollens, moderate to severe allergy to cockroach and dust mite allergens; negative for grass pollen, weed pollen, all molds, cats, dogs, and all tested foods.

Electronic signature of [redacted] on 12/18/2024 at 12:11 PM EST

EXAMPLE – PERCUTANEOUS TESTING CONT.

Documentation supports code billed:

- Report
- Interpretation
  - Extremely severe allergy to tree pollens, moderate to severe allergy to cockroach, and dust mite allergens
  - Lists negatives
- Units supported
  - Orange box totals number of tests given – total of 80 – but provider only billed for 78.
  - Provider has not billed for controls used in testing. Some areas/states/policies require you to subtract controls from total number of tests billed.
- Provider signed visit note



ADULT SKIN PRICK ALLERGEN TESTING

I
CONTROLS
1. Saline (Negative Control)
2. Histamine (Positive Control)
TREES
3. Ash, White
4. Bayberry
5. Birch, White
6. Box Elder
7. Cedar, Red
8. Cottonwood, Eastern
9. Elm, American
10. Hickory, Shagbark

II
11. Maple, Red
12. Mulberry, Red
13. Oak, Red
14. Pine, White
15. Sweetgum
16. Sycamore, American
GRASSES
17. Bermuda
18. Johnson
19. Fescue, Meadow
20. Kentucky Blue (June)

III
21. Rye, Perennial
22. Timothy
WEEDS
23. Cocklebur
24. Lamb's Quarters
25. Marsh Elder, Rough
26. Pigweed, Rough
27. Plantain, English
28. Ragweed Mix
29. Sagebrush
30. Sheep Sorrel

IV
MOLDS
31. Alternaria alternata
32. Aspergillus fumigatus
33. Aureobasidium
34. Bipolaris sorokiniana
35. Epicoccum nigrum
36. Gibberella/Fusarium
37. Cladosporium
38. Mucor plumbeus
39. Penicillium notatum
40. Rhodotorula

V
INDOORS
41. Hamster
42. Cat, Hair
43. Cockroach, Mix
44. Dog, AP
45. Feathers, Mixed
46. Mite, D. pteronyssinus
47. Mite, D. farinae
48. Mice, Epithelia
49. Horse, Epithelium
50. Rabbit, Epithelium

Device: Greer OMNI
Tech
95004#
Provider

VI
CEREALS
51. Corn
52. Soybean
53. Wheat
DAIRY, EGGS
54. Egg
55. Milk, Cow
FRUITS
56. Apple
57. Banana
58. Orange
59. Strawberry
60. Tomato

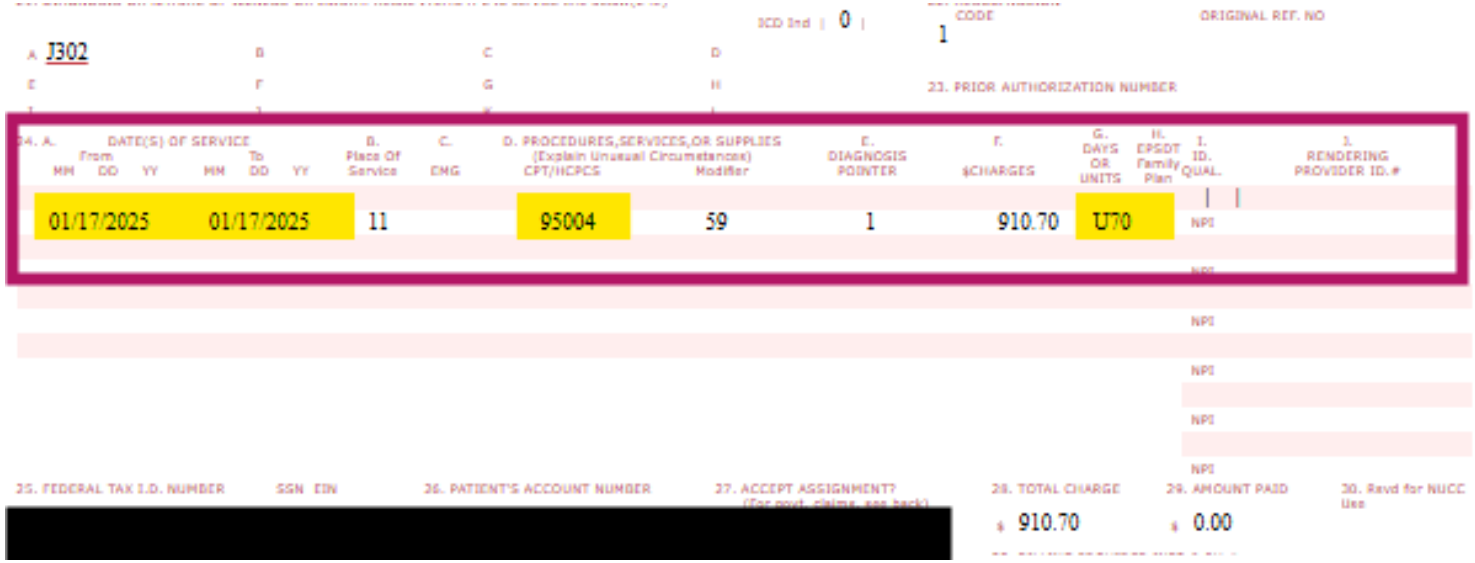
VII
NUTS
61. Peanut
62. Almond
63. Cashew
64. Hazelnut
65. Pecan
66. Pistachio
67. Walnut
MEATS
68. Beef
69. Chicken
70. Pork

VIII
SEAFOOD
71. Fish Mix
72. Bass, Black
73. Salmon
74. Trout
75. Tuna
76. Shellfish Mix
77. Crab
78. Shrimp
OTHER
79. Chocolate
80. Sesame

EXAMPLE - PERCUTANEOUS TESTS (CPT CODE 95004)

Example **does not support** CPT code 95004 –
Percutaneous tests (scratch, puncture, prick) with allergenic extracts, immediate type reaction, including test interpretation and report, specify number of tests.

- Date of service on claim is 1/17/25; provider is billing 70 units.
- Documentation, relevant to our claim, was received:
  - Provider note for billed date of service.



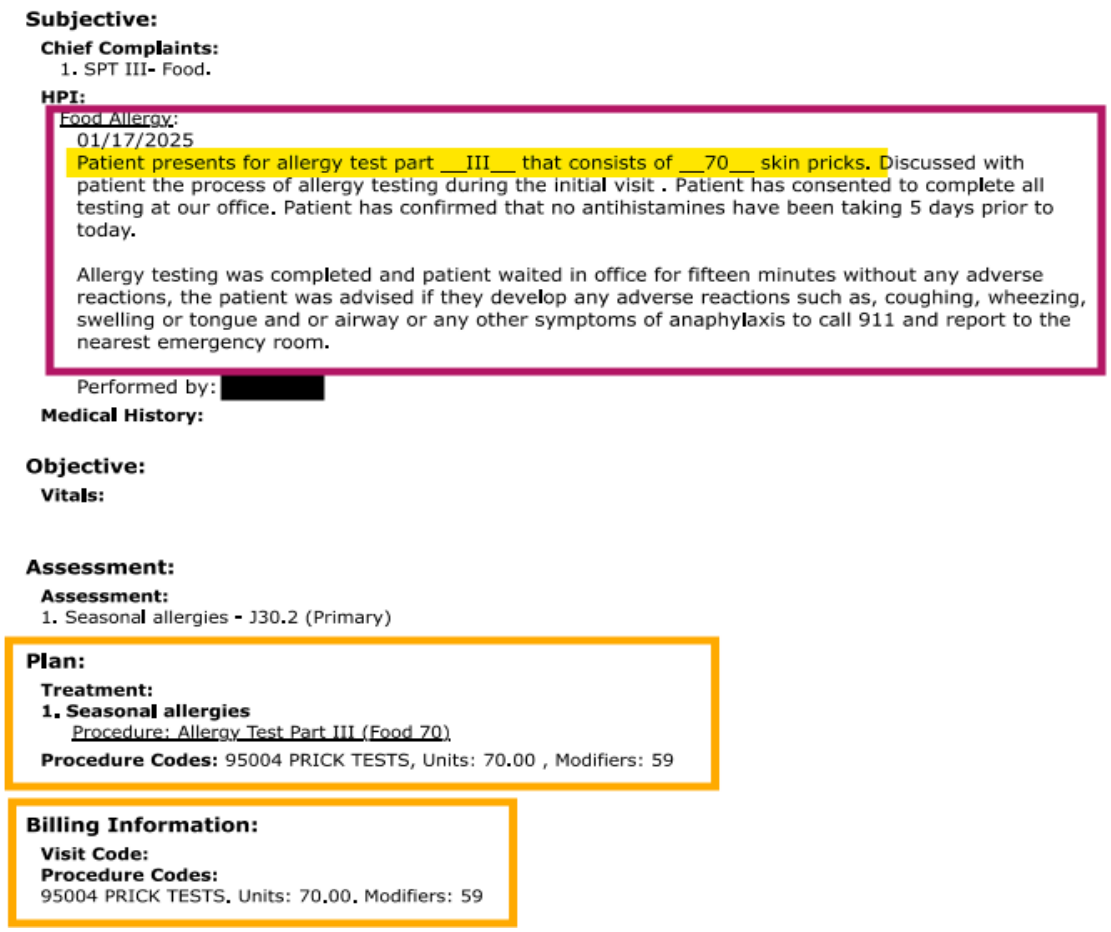
EXAMPLE – PROVIDER NOTE

Documentation supports the billed code:

- Provider note for billed date of service - demonstrates intent for test.

Documentation does not support the code billed:

- Missing test report
  - What allergens were tested?
  - Was there a reaction?
- Missing provider test interpretation
  - Note only reflects 70 skin pricks and waited in the office without adverse reactions – this is not an interpretation of the actual test.
- Signature of billing provider
- Only a printed name at the bottom with the date. Per CMS, valid electronic signatures should also have a time stamp.



Subjective:

Chief Complaints:
1. SPT III- Food.

HPI:

Food Allergy:
01/17/2025
Patient presents for allergy test part __III__ that consists of __70__ skin pricks. Discussed with patient the process of allergy testing during the initial visit . Patient has consented to complete all testing at our office. Patient has confirmed that no antihistamines have been taking 5 days prior to today.

Allergy testing was completed and patient waited in office for fifteen minutes without any adverse reactions, the patient was advised if they develop any adverse reactions such as, coughing, wheezing, swelling or tongue and or airway or any other symptoms of anaphylaxis to call 911 and report to the nearest emergency room.

Performed by: [redacted]

Medical History:

Objective:

Vitals:

Assessment:

Assessment:
1. Seasonal allergies - J30.2 (Primary)

Plan:

Treatment:
1. Seasonal allergies
Procedure: Allergy Test Part III (Food 70)
Procedure Codes: 95004 PRICK TESTS, Units: 70.00 , Modifiers: 59

Billing Information:

Visit Code:
Procedure Codes:
95004 PRICK TESTS. Units: 70.00. Modifiers: 59

RED FLAG AREA #3 – MISUSE OF MODIFIER 25

- Billing providers are responsible for knowing what codes have an E/M bundled
- NCCI guidelines are online: https://www.cms.gov/medicare-medicaid-coordination/national-correct-coding-initiative-ncci/ncci-medicaid/medicaid-ncci-edit-files
- Notes - be very clear about what is separate and distinct from the allergies being treated

RED FLAG AREA #4 - ALLERGY INJECTIONS (CPT CODE(S) 95115-95117, 95120, 95125, 95130-95134)

Missing:

- Order or encounter note with intent to order
- Ordering physician's signature on order or encounter note with intent to order

Incorrect units billed (billing MORE than documented)

Billing E&M service on same date as allergy immunotherapy injection

EXAMPLE – ALLERGY INJECTIONS

- Billing for E&M on same date as AIT - typically not permitted.
  - Injection administered, and patient monitored, after which appointment is complete
  - This scenario does not qualify as an E&M visit.

- Provider previously received education on unbundling:
  - E&M is submitted with allergen immunotherapy code (CPT codes 95115-95117) for same patient and date of service unless documentation supports that E&M service is unrelated to the work required for injection service.

- Records for 78 claims were reviewed where CPT code 99213 or 99214 were billed.
  - 74 claims were unsupported due to unbundling.
  - Code was included in another code billed on same day and was not separately reimbursable.
  - Documentation showed patients seen for allergy injection procedures only - no new issues/complaints.

RED FLAG AREA #5 – EXCESSIVE BILLING / BILLING ON MULTIPLE DAYS

- An investigation was initiated based on data analytics designed to identify outliers and unusual billing activities.
- CMS placed a medically unlikely edit (MUE) at 30 units per day for AIT serum preparation (CPT code 95165).
  - Providers may try to circumvent this by billing 30 units on multiple days in a month.

RED FLAG AREA #5 CONT. – EXCESSIVE BILLING / BILLING ON MULTIPLE DAYS

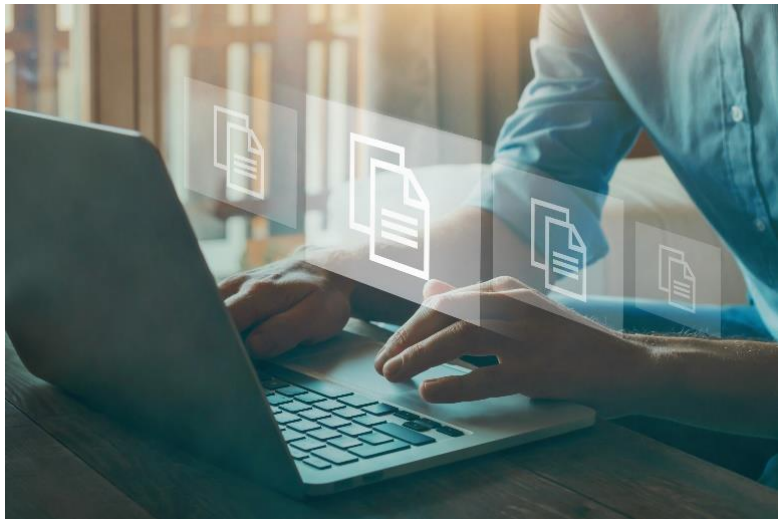
- Data analytic identified instances where provider prepared 46+ injections for one 30-day rolling window - may be suspicious

- Potential excessive billing scenario accounted for 29% of provider's billing of CPT code 95165
  - Instances of 50 units to 240 units billed within a 30-day rolling window for same member.

- Review of medical records and provider discussions confirmed all units of extract for an individual are created at the same time
  - Provider inappropriately billed CPT code 95165 in 30 unit increments or less over multiple days to avoid the MUE.

CONSULT THE PAYER

- MCO policies may change over time.
- Consult the payer to obtain correct billing information!



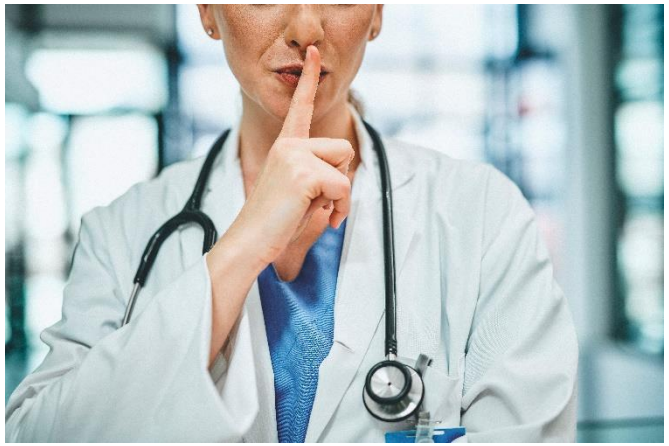
MEDICAID FRAUD CONTROL UNIT (MFCU)

Presented by: Sergeant Michael Rosati
Medicaid Fraud Control Unit

MEDICAID FRAUD CONTROL UNIT (MFCU)

Medicaid Fraud is a serious crime.

- The MFCU, within the Office of the Insurance Fraud (OIFP) is the criminal oversight entity.



- MFCU investigates and prosecutes Medicaid Fraud.

- The MFCU utilizes attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

MEDICAID FRAUD CONTROL UNIT (MFCU)

- The MFCU investigates and prosecutes alleged criminal actions:
  - Allegations of physical abuse to beneficiaries.
  - Fraudulent activities by providers against the Medicaid program.
  - Fraud in the administration of the program.
  - Fraud against other federally or state funded health care programs where there is a Medicaid nexus.

CRIMINAL HEALTH CARE CLAIMS FRAUD

N.J.S.A. 2C:21-4.3

- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims.
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license

FALSE CLAIMS

Did you know…

- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.

MEDICAID FRAUD

Bottom line:

Ignorance of the law excuses no one.

It is the provider’s responsibility to know the laws.

WRAP UP

FRAUD, WASTE, AND ABUSE REPORTING

Name	Contact Number	FWA Reporting Website
Aetna Better Health of New Jersey	(855) 282-8272	Aetna FWA Reporting
Fidelis Care	(866) 685-8664	Fidelis Care FWA Reporting
Horizon NJ Health	(855) 372-8320	HNJH FWA Reporting
UnitedHealthcare Community Plan	(844) 359-7736	UHC FWA Reporting
Wellpoint	(866) 847-8247	Wellpoint FWA Reporting
NJ Office of the State Comptroller, Medicaid Fraud Division	(888) 937-2835	MFD FWA Reporting
NJ Medicaid Fraud Control Unit	(609) 292-1272	NJMFCU@njdcj.org

QUESTIONS? PLEASE CONTACT US!

- Division of Medical Assistance and Health Services (DMAHS)
  - Email: mahs.provider-inquiries@dhs.nj.gov
  - Website: https://www.nj.gov/humanservices/dmahs/info/
- Medicaid Fraud Division (MFD)
  - Email: provider-education@osc.nj.gov
  - Website: https://nj.gov/comptroller/about/work/medicaid/
- Medicaid Fraud Control Unit (MFCU)
  - Email: NJMFCU@njdcj.org
  - Website: https://www.njoag.gov/about/divisions-and-offices/office-of-the-insurance-fraud-prosecutor-home/medicaid-fraud-control-unit/

QUESTIONS?

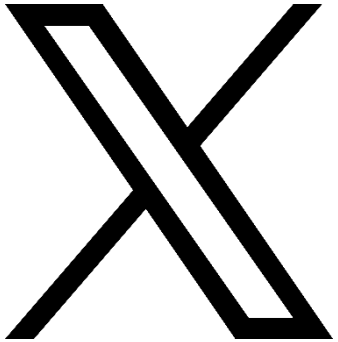
Any questions we are unable to answer today, please submit in writing to:

provider-education@osc.nj.gov

HOW DID WE DO?

Please respond to a brief poll to help us know how we did!

KEEP IN TOUCH



@NJComptroller

New Jersey
Office of the
State Comptroller

New Jersey
Office of the
State Comptroller

@NewJerseyComptroller

@NJComptroller

provider-education@osc.nj.gov