Greater New Jersey Creative Counseling, Inc.

An Intensive In-Community Mental Health and Behavioral Assistance Service Provider

MEDICAID FRAUD DIVISION REPORT

Kevin D. Walsh
Acting State Comptroller

Issued June 12, 2025

NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

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* Exhibits A, B and C were omitted to maintain confidentiality.

I. Executive Summary

As part of its oversight of the New Jersey Medicaid program (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC) conducted an audit of Medicaid claims submitted by and paid to Greater New Jersey Creative Counseling, Inc. (Greater New Jersey), for the period from August 1, 2017 through April 30, 2022 (audit period).

OSC's audit sought to determine whether Greater New Jersey billed for intensive in-community mental health rehabilitation and behavioral assistance services in accordance with applicable state regulations. OSC found that in over twenty three percent (23.4 percent) of the claims it reviewed, Greater New Jersey failed to meet Medicaid program requirements, including ones designed to protect the health and safety of Medicaid beneficiaries. Among the failures that OSC identified, OSC found that Greater New Jersey failed to maintain documentation showing that it performed required criminal background checks and other required screening for multiple employees. As a result, Medicaid beneficiaries received care from Greater New Jersey employees who were not properly vetted or trained prior to performing their job functions, and from individuals for whom Greater New Jersey failed to verify possession of a valid driver's license.

OSC also found that Greater New Jersey failed to accurately document the services it provided. Greater New Jersey billed for services without possessing the necessary supporting documentation. In some instances, the documentation was inaccurate, with issues like service dates that were not within the authorized period or service hours that did not match to the claims billed. In several instances, Greater New Jersey billed for services that were "upcoded," meaning it billed for a higher-level, higher-cost service than what its own documentation reflected that it had performed.

To arrive at its overpayment findings, OSC selected a statistical sample of 177 claims totaling $30,154 paid to Greater New Jersey. Of these sampled claims, OSC found that 39 claims failed at least one test criterion, resulting in an overpayment of $5,567. OSC extrapolated the error dollars for the sampled claims ($5,567) to the total population from which the sample was drawn and calculated that Greater New Jersey received an overpayment of at least $2,709,266.[1] In addition, OSC placed the 11 highest paid claims, totaling $6,362 in Medicaid payments, in a "take-all" stratum (i.e., a stratum for which OSC reviews 100% of the claims). Of these 11 claims, 5 failed at least one test criterion for an overpayment of $2,023. In total, Greater New Jersey received an overpayment of at least $2,711,289 (an extrapolated overpayment of $2,709,266 plus a direct recovery of $2,023).

OSC's review of Greater New Jersey highlights significant oversight failures by an organization serving a vulnerable population. Greater New Jersey did not consistently comply with regulations requiring providers to conduct qualifications and background checks, which caused unnecessary risk for Medicaid beneficiaries. While OSC did not identify any direct harm to Medicaid beneficiaries resulting from Greater New Jersey's failings, Greater New Jersey must address

[1] OSC can reasonably assert, with 90% confidence, that the total overpayment in the universe is at least $2,709,265.76 (19.75% precision) with the error point estimate as $3,376,216.58. Adding the error dollars from the TA stratum to the lower limit of S1, OSC calculates that the total overpayment amount is at least $2,711,288.71.

these shortcomings, and it must reimburse the Medicaid program for the above-referenced overpayments.

II. Background

The Division of Medical Assistance and Health Services, within the New Jersey Department of Human Services, 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 and behavioral assistance services to improve or stabilize the level of functioning of children and young adults within their homes and communities. These services, which are overseen by the Department of Children and Families (DCF) when provided to youth and children, seek to prevent, decrease, or eliminate behaviors or conditions that may place the individual at an increased clinical risk or may otherwise negatively affect a person's ability to function. These services are provided in accordance with an approved plan of care.

Greater New Jersey, which is located in Palmyra, New Jersey, has participated in the Medicaid program as an intensive in-community mental health rehabilitation and behavioral assistance services provider since November 23, 2015. Greater New Jersey billed the Medicaid program for intensive in-community mental health rehabilitation and behavioral assistance services under Healthcare Common Procedure Coding System (HCPCS) codes H0036 and H2014. During the Audit Period, for the audit sample, Greater New Jersey billed for services provided by 97 contracted behavioral healthcare professionals.

III. Audit Objective, Scope, and Methodology

The audit objective was to evaluate claims billed by and paid to Greater New Jersey to determine whether Greater New Jersey billed these claims in accordance with applicable state regulations.

The scope of the audit was August 1, 2017 through April 30, 2022. OSC conducted this audit pursuant to its authority set forth in N.J.S.A. 52:15C-1 to -23, and the Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 to -64.

OSC reviewed 188 claims, totaling $36,517 paid to Greater New Jersey, from a population of 107,365 claims, totaling $18,267,891 paid to Greater New Jersey under HCPCS codes H0036 and H2014.

OSC reviewed Greater New Jersey's records related to 188 claims to determine whether the documentation provided complied with the requirements of New Jersey Administrative Code N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:49-9.8(b)(1) to (4), N.J.A.C. 10:77-4.8(b), N.J.A.C. 10:77-4.9(e), N.J.A.C. 10:77-4.9(f) and (g), N.J.A.C. 10:77-4.12(d)(1)-(5), N.J.A.C. 10:77-4.12(e)(6), N.J.A.C. 10:77-4.14(c)(1), (2), and (4), N.J.A.C. 10:77-4.14(d)(1) and (2), N.J.A.C. 10:77-5.7(c), (d) and (e) N.J.A.C. 10:77-5.9(f), N.J.A.C. 10:77-5.10(b), N.J.A.C. 10:77-5.12(d)(1)-(5), N.J.A.C. 10:77-5.12(e)(6), N.J.A.C. 10:77-5.14(b) and (d)(1).

IV. Compliance Framework

Medicaid regulations for intensive in-community mental health rehabilitation and behavioral assistance services establish safeguards to ensure program integrity and prevent fraud, waste, and abuse. These rules establish requirements to ensure provision of high-quality medically necessary services and appropriate billing of these services as authorized by DCF. Understanding the broader framework provides essential context for these regulations.

The regulations governing intensive in-community mental health rehabilitation and behavioral assistance services in New Jersey emerged from broader efforts to reform the state's children's health system. In the early 2000s, New Jersey established the Children's System of Care (CSOC) to provide a comprehensive, community based approach to supporting youth with emotional and behavioral needs. This shift aimed to reduce reliance on institutional and out of home placements to in-community based services. The initiative was focused on delivering care in the least restrictive environment possible, emphasizing family involvement, individualized services, and community integration.

In support of these reforms, New Jersey adopted regulations to formalize service delivery standards and ensure program integrity. Specifically, N.J.A.C. 10:77-4 and -5, along with guidance issued by DCF, impose requirements on the intensive in-community and behavioral assistance providers relating to service authorization, provider qualifications, documentation, billing practices, etc. These rules are designed to ensure that youth receive appropriate and effective services and to protect the Medicaid program from fraud, waste and abuse. By establishing standards, the regulations promote accountability, transparency, and the responsible use of Medicaid funds.

V. Discussion of Auditee Comments

The release of this Final Audit Report concludes a process during which OSC afforded Greater New Jersey multiple opportunities to provide input regarding OSC's findings. Specifically, OSC provided Greater New Jersey with a Summary of Findings (SOF) and offered Greater New Jersey an opportunity to discuss the findings at an exit conference. OSC and Greater New Jersey, which was represented by counsel, held an exit conference during which the parties discussed OSC's findings in the SOF. After the exit conference, Greater New Jersey provided OSC written comments and additional records. After considering Greater New Jersey's submission, OSC provided Greater New Jersey with a Draft Audit Report (DAR) that contained recommendations and instructed Greater New Jersey to provide a Corrective Action Plan (CAP) as part of its formal response to the DAR. Greater New Jersey submitted a formal response to the DAR and a CAP, which is attached as Appendix A.

OSC addresses each argument raised by Greater New Jersey in more detail in Appendix B to this report. After reviewing Greater New Jersey's submission, OSC determined that there was no basis to revise any of its findings presented in this audit report.

VI. Audit Findings

A. Greater New Jersey Increased the Risk of Harm to Medicaid Beneficiaries

OSC found troubling lapses in regulatory compliance, revealing systemic shortcomings by Greater New Jersey that increased the risk of harm to the vulnerable Medicaid population it serves. These failings undermine the integrity of the program and highlight the need for immediate corrective action. The following sections outline specific failures identified during the audit.

1. Greater New Jersey Failed to Maintain Criminal Background Checks for Behavioral Assistants Prior to Rendering Services

State regulations mandate that providers of intensive in-community mental health rehabilitation and behavioral assistance services maintain evidence of successful criminal background checks for employees who interact with beneficiaries. The provider must obtain this evidence for all behavioral assistants (BAs) from a "recognized and reputable" entity.

OSC's audit revealed that Greater New Jersey failed to maintain the required proof of background checks. Although Greater New Jersey presented invoices indicating that it had made payments to a third party to perform these checks, it did not produce the actual background checks required by regulation. This lapse meant OSC could not confirm that Greater New Jersey had conducted adequate due diligence before allowing these BAs to serve Medicaid beneficiaries, thereby increasing the risk of exposing beneficiaries to individuals with potentially disqualifying criminal histories.

OSC found that Greater New Jersey did not have background checks for 5 of the 29 BAs sampled, who accounted for 11 out of 188 claims, totaling $2,014 in reimbursement. Instead, Greater New Jersey only had invoices indicating that background checks had been ordered, but no documentation confirming that Greater New Jersey had received such checks and whether these individuals had passed the checks.

By failing to obtain and review successful criminal background checks before Greater New Jersey's employees provided services to Medicaid beneficiaries, Greater New Jersey violated N.J.A.C. 10:77-4.9(g) and N.J.A.C. 10:77-4.14(d)(2).

Pursuant to N.J.A.C. 10:77-4.9(g), "[a]ll employees having direct contact with and/or rendering behavioral assistance services directly to the beneficiaries shall be required to successfully complete criminal background checks."

Pursuant to N.J.A.C. 10:77-4.14(d)(2), the provider must maintain "[v]erified written documentation of successful completion of a criminal background check conducted by a recognized and reputable search organization for all staff having direct contact with children."

2. Greater New Jersey Failed to Maintain Current and Valid Driver's Licenses for Servicing Providers

Behavioral assistance and intensive in-community services provided to beneficiaries, up to 21 years of age, may occur outside of their place of residence, in playgrounds and in other in-community settings. For such services, providers may drive beneficiaries to the service location. As such, state regulations require all servicing providers whose job functions include operating a vehicle used to transport children, youth or young adults, or their family or caregiver, to have a current and valid driver's license. State regulations further require providers to maintain a copy of each servicing provider's current and valid driver's license.

Greater New Jersey failed to verify that several of its BAs possessed current and valid driver's licenses. In the vast majority of these instances, Greater New Jersey maintained a copy of a driver's license that had expired before the date the BA provided services to a Medicaid beneficiary. Further, upon inquiry, Greater New Jersey confirmed that during the audit period, its policy was to obtain only a valid driver's license upon hire of a servicing provider, but not to update its records when licenses expired. Greater New Jersey advised that as of March 2023, which is after the audit period, it amended its policy to require servicing providers to inform Greater New Jersey of any changes in their driver's license status. Additionally, Greater New Jersey advised that as of October 2023, it began conducting regular checks on driver's license expiration dates. Greater New Jersey's failure to ensure that its BAs possessed current and valid driver's licenses increased the risk that BAs who were not competent to operate a vehicle cared for and transported Medicaid beneficiaries, which increased the risk of harm to these beneficiaries.

OSC requested documentation to determine whether Greater New Jersey maintained a copy of each servicing provider's current and valid driver's license. OSC found that for 14 of 97 servicing providers in the audit sample, which accounted for 17 of 188 claims, totaling $2,833 in reimbursement, Greater New Jersey failed to maintain a copy of the servicing provider's current and valid driver's license. Specifically, Greater New Jersey maintained driver's licenses for 12 servicing providers that were expired at the time services were provided, one driver's license copy was illegible, and for one servicing provider, Greater New Jersey did not maintain a copy of the driver's license.

By failing to maintain a copy of a current and valid driver's license, Greater New Jersey violated N.J.A.C. 10:77-4.9(f), N.J.A.C. 10:77-4.14(d)(1), N.J.A.C. 10:77-5.9(f), and N.J.A.C. 10:77-5.14(d)(1).

Pursuant to N.J.A.C. 10:77-4.9(f), "[a]ll employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children/youth or young adults. Transportation is not a covered behavioral assistance service."

Pursuant to N.J.A.C. 10:77-4.14(d)(1), "[a] copy of his or her current valid driver's license, if driving is required to fulfill the responsibilities of the job," is required to be maintained by the provider.

Pursuant to N.J.A.C. 10:77-5.9(f), "[a]ll employees shall have a valid driver's license if his or her job functions include the operation of a vehicle used in the transportation of the children, youth or young adults or their family or caregiver."

Pursuant to N.J.A.C. 10:77-5.14(d)(1), "[a] copy of his or her current valid driver's license, if job duties include transportation of children, youth or young adults or their families/caregivers" is required to be maintained by the provider.

3. Greater New Jersey Failed to Maintain Behavioral Assistance Training Certifications for Behavioral Assistants

Pursuant to state regulations, Greater New Jersey was required to maintain written documentation showing that BAs successfully completed the Behavioral Assistance Training Certifications required by DCF. As part of the Behavioral Assistance Training Certification process, every BA must attend live trainings, meet 13 core competencies, and successfully pass a 30-question multiple-choice review. BAs are required to obtain the certification within six months of the BA's hire date, and every BA must be recertified annually.[2]

OSC's audit found that Greater New Jersey failed to ensure that multiple BAs had received proper training. Specifically, it lacked proof of training certifications or re-certifications, submitted certifications obtained after services were rendered, or provided expired certifications. As a result, unverified BAs delivered services to Medicaid beneficiaries, increasing the risk that beneficiaries received inadequate care from BAs who lacked required training.

OSC requested that Greater New Jersey provide the Behavioral Assistance Training Certifications for BAs in OSC's sample claims to determine whether Greater New Jersey satisfied the requirement that it verified and maintained this documentation. OSC found that Greater New Jersey allowed 4 of the 29 BAs in the audit sample selection to provide behavioral assistance services to beneficiaries without obtaining the required certification within six months of their hire date and/or obtain re-certifications annually thereafter. Greater New Jersey allowed insufficiently trained BAs to provide behavioral assistance services and inappropriately billed for 7 of 188 claims, totaling $653 in reimbursement.

- For 1 of 4 BAs, which accounted for 1 of 7 claims, Greater New Jersey failed to provide documentation showing that the BA obtained their certification within the required six-month period. Additionally, the BA provided services to a new patient after the six-month certification period had passed, which violates DCF's guidance.

- For 2 of 4 BAs, which accounted for 5 of 7 claims, Greater New Jersey provided a BA training certification that it had obtained after the encounter date. For example, one BA

[2] N.J.A.C. 10:77-4.14(c) states that "[f]or the direct care staff employed by the agency, the following information shall be maintained" and lists five categories of documentation, including "[v]erified written documentation of the direct care staff person's successful completion of any Behavioral Health Assistance Rehabilitation Services training required by the Department of Children and Families." This regulation is supplemented by DCF's written policy that details how BA's should obtain their certification and recertification, including specific timelines for completion. DCF modified its policy through informal (oral) communication to providers allowing BAs who do not obtain their initial certification within the required six months, or fail to complete their annual recertification on time, to continue to provide services to established patients. Established patients are defined as those who are initially served within the six-month certification timeframe or before the BA's annual certification expired. However, in such cases, BAs are prohibited from providing services to new patients until they have obtained the required certification or recertification.

performed services on June 17, 2020, but Greater New Jersey did not obtain the BA Certification until March 14, 2022, almost two years after the service date. Additionally, these BAs continued providing services to new patients after the six-month certification period had passed, which violates DCF's guidance.

- For 1 of 4 BAs, which accounted for 1 of 7 claims, Greater New Jersey provided a copy of a BA training certification that had expired almost two years prior to the encounter date and provided no re-certification documentation. Additionally, this BA continued providing services to a new patient after the six-month certification period had passed, which violates DCF's guidance.

By failing to obtain such certificates within six months of hire date and re-certifications annually thereafter, Greater New Jersey violated N.J.A.C. 10:77-4.14(c)(4).

Pursuant to N.J.A.C. 10:77-4.14(c)(4), the provider must maintain "[v]erified written documentation of the direct care staff person's successful completion of any Behavioral Health Assistance Rehabilitation Services training required by the Department of Children and Families." DCF guidance requires BAs to obtain initial certification within six months of their hire date.

B. Greater New Jersey Failed to Follow Proper Billing Practices

OSC found significant discrepancies in billing practices and documentation oversight by Greater New Jersey. To perform this portion of the review, OSC focused on the Service Delivery Encounter Documentation (SDED) form, which DCF requires intensive in-community and behavioral health providers to complete. The SDED is a two-page document that records each service encounter and helps verify the services provided in support of a provider's billing. The first page of the SDED includes fields for the beneficiary's name, date of birth, address, the name and signature of the servicing provider, and an agency (provider) signatory certification. This page also contains fields for service authorization information, as well as the name and license number of the clinical supervisor. The second page includes fields for the service encounter date, time, and delivery location, and the name of the guardian or responsible party, their address, and signature, and the date of service. This form aligns with the state Medicaid regulations that require providers to maintain records for each encounter, including the name and address of the beneficiary; the exact date, location and time of service; the type of service; and, the length of time for the face-to-face encounter. In sum, the SDED form documents and verifies the services provided and frequency of such services, and also ensures that appropriately credentialed providers render services.

1. Greater New Jersey Billed Unsubstantiated Services and/or Maintained Inaccurate and Incomplete Records

OSC requested the two-page SDED forms to determine whether Greater New Jersey accurately completed and maintained required documentation for all intensive in-community and behavioral assistance provider encounters. OSC found that for 14 of 188 sample claims, totaling $2,866 in reimbursement, Greater New Jersey billed for services for which it failed to possess adequate documentation. Specifically, OSC found the following:

- For 6 of 14 claims, Greater New Jersey failed to provide SDED forms that would support the claims for which Greater New Jersey billed and was paid.

- For 5 of 14 claims, the hours of service on the SDED form conflicted with hours billed and paid.

- For 1 of 14 claims, Greater New Jersey failed to provide the first page of the SDED form.

- For 2 of 14 claims, Greater New Jersey submitted SDED forms on which the service delivery date noted on the second page was outside of the prior authorization date (start and end date) specified on the first page of the SDED form.

Maintaining both pages of accurate and complete SDED forms is essential for ensuring that a beneficiary received appropriate services by a qualified professional for a sufficient duration and frequency. The prior authorization information on the first page of the document, when compared to the service delivery date on the second page, ensures that the provider who is attesting to the accuracy of the information contained in the form actually delivered services during the authorized service delivery period. When this information was inconsistent, OSC could not determine whether the information contained on the first page reflected the attestations on the second page and, thus, could not confirm that Greater New Jersey provided services as authorized. For example, in one instance, the first page of an SDED form contained a prior authorization date range of December 12, 2019 through February 5, 2020. The service date on page two, however, was January 18, 2021, more than eleven months after the specified date range. In this case, OSC found that the claim was deficient because it was outside of the authorized service period.

By failing to maintain and produce the appropriate records, Greater New Jersey violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:49-9.8(b)(1), N.J.A.C. 10:49-9.8(b)(2), and N.J.A.C. 10:49-9.8(b)(3).

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. 10:49-9.8(b)(1), providers are required "[t]o keep such records as are necessary to disclose fully the extent of services provided."

Pursuant to N.J.A.C. 10:49-9.8(b)(2), providers agree "[t]o furnish information for such services as the program may request."

Further, pursuant to N.J.A.C. 10:49-9.8(b)(3), providers who fail to maintain appropriate records that document the extent of services billed agree that "payment adjustments shall be necessary."

2. Greater New Jersey Upcoded Services Provided

State regulations require providers to assess and evaluate each Medicaid beneficiary receiving intensive in-community services to determine the appropriate level and type of medically necessary services. Intensive in-community services include three levels of service: supportive services, professional services, and clinical services. Providers must develop a service plan for those needing behavioral assistance services, based on an evaluation of the beneficiary's needs.

The provider must obtain prior authorization to bill specific services in accordance with the plan. Upcoding, or billing for services at a higher level than authorized, results in overbilling the Medicaid program and is considered wasteful and abusive.

OSC reviewed Greater New Jersey's records to determine whether it billed for services at the appropriate level using the proper billing procedure code. OSC found that for 3 of 188 claims, totaling $495 in reimbursement, Greater New Jersey billed for services using a higher reimbursed procedure code and/or modifier than appropriate, which resulted in Greater New Jersey receiving overpayments. For example, on October 25, 2019, a BA rendered service to a Medicaid beneficiary, however Greater New Jersey billed this encounter as a clinical level service. This billing resulted in Greater New Jersey receiving the highest reimbursement amount for the lowest reimbursable level of services actually provided.

By billing an inappropriate level of services and/or by upcoding for these claims, Greater New Jersey violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:49-9.8(b)(4), and N.J.A.C. 10:77-5.7(e).

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. 10:49-9.8(b)(4), providers agree "[t]hat 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."

Further, pursuant to N.J.A.C. 10:77-5.7(e), "Services may be provided at any level by professionals whose credentials exceed the minimum requirements for that service level; however, increased reimbursement shall not be provided."

3. Greater New Jersey Failed to Document Services with a Progress Note

For both intensive in-community mental health rehabilitation and behavioral assistance services, providers must document services through progress notes. These notes detail the treatment provided, the beneficiary's response, significant events affecting their condition, and other relevant information for their care plan. Progress notes are vital for continuity of care and evaluating service effectiveness. Inadequate notes can lead to incomplete documentation, impacting care quality and raising concerns about the legitimacy of the services for which the provider billed. Unlike the SDED form, which the parent or guardian signs to attest to the session's date, duration, and location, the servicing provider alone completes the progress note.

OSC reviewed Greater New Jersey's records to determine whether Greater New Jersey maintained progress notes that supported services billed. OSC found that for 1 of 188 claims, totaling $39 in reimbursement, Greater New Jersey failed to document services in a progress note. Moreover, for the sampled claim in question, Greater New Jersey failed to provide any other documentation substantiating the services, such as an SDED form.

By failing to maintain appropriate records for this claim, Greater New Jersey violated N.J.A.C. 10:49-9.8(b)(1), N.J.A.C. 10:77-4.12(e)(6), and N.J.A.C. 10:77-5.12(e)(6).

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

Pursuant to N.J.A.C. 10:77-4.12(e)(6), the provider shall maintain, "[w]eekly quantifiable progress notes toward defined goals as stipulated in the child/youth or young adult's BASP [Behavioral Assistance Service Plan]."

Pursuant to N.J.A.C. 10:77-5.12(e)(6), the provider shall maintain "[f]or 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."

VII. Summary Of Medicaid Overpayment

OSC determined that from its sample of 188 claims for the Audit Period that Greater New Jersey billed 44 claims that contained 53 exceptions for an overpayment of $7,589. To ascertain the total overpayment Greater New Jersey received, OSC extrapolated the error dollars from the sampled claims ($5,567) to the total population from which the sample was drawn, which in this case was 107,354 claims, with a total payment amount of $18,261,529. From this extrapolation, OSC calculated that Greater New Jersey received an overpayment of at least $2,709,266 that Greater New Jersey must repay to the Medicaid program.[3] OSC also determined that Greater New Jersey submitted five deficient claims for which it received an overpayment of $2,023, which means that Greater New Jersey received a total overpayment of at least $2,711,289 (an extrapolated overpayment of $2,709,266 plus a direct recovery of $2,023).

VIII. Recommendations

Greater New Jersey shall:

1. Reimburse the Medicaid program the overpayment amount of $2,711,289.

2. Adhere to state regulations and guidance for Medicaid services provided by Greater New Jersey and its health care professionals.

3. Obtain and maintain required documentation (i.e., successfully completed criminal background checks, valid driver's licenses) before assigning servicing providers case referrals, to ensure compliance with state regulations.

4. Ensure that all BAs successfully complete their initial behavioral assistance training certification within six months from the date of hire, complete recertification annually thereafter, and maintain proof of all such certifications as required by DCF.

5. Ensure that all professionals employed by Greater New Jersey receive training to foster compliance with applicable state regulations, and guidance.

[3] See Footnote 1.

6. Provide OSC with a Corrective Action Plan (CAP) indicating the steps Greater New Jersey will take to implement procedures to correct the deficiencies identified herein.

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April 4, 2025

VIA MAIL AND E-MAIL

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Re: Response to Draft Audit Report: Greater New Jersey Creative Counseling, Inc.

Dear Acting Comptroller Walsh:

We represent Greater New Jersey Creative Counselling ("GNJCC") with respect to this matter. Please accept the following in response to the Draft Audit Report ("DAR") dated March 13, 2025.

INTRODUCTION

We have reviewed the New Jersey Office of the State Comptroller's ("OSC") Draft Audit Report detailing the results of an audit of Medicaid claims submitted by and paid to GNJCC for the period from August 1, 2017 through April 30, 2022.

As an initial matter, we submit the following additional background information regarding improvements in GNJCC's compliance policies. GNJCC is an Intensive In-Community provider, offering counseling services to children and youth in their homes. GNJCC has always strived for excellence, and in keeping with that commitment, has implemented additional compliance-driven policies over the past two-and-a-half years. In September of 2022, GNJCC implemented a formal written corporate compliance plan. The plan focuses on ensuring adherence to all pertinent Medicaid regulations, training staff, improving billing policies, and eliminating any risk of fraud,

waste and abuse. More specifically, and pursuant to the compliance plan, GNJCC has improved its compliance by implementing the following improvements:

- Hiring a clinically licensed Compliance Director with years of experience with compliance-related issues, who conducts monthly audits of internal GNJCC paperwork and documents to ensure things are filed and completed correctly;
- Creating an electronic filing and backup system so that files and documents are easier to retrieve, reducing filing/retrieval errors;
- Requiring that a second employee audit and confirm dates, units, and/or level of service for all sessions billed before submission to Medicaid;
- Implementing a monthly internal audit to ensure that GNJCC has proper documentation for all sessions billed to Medicaid resulting in a zero error rate for the months September 2024 through January 2025;
- Revamping the driver's license policy to reflect the changes that Medicaid has implemented effective January 1, 2024 by requiring staff to submit updated drivers licenses, internally maintaining electronic backup of all staff licenses, and, for those staff members who do not have a driver's license, requiring them to sign an attestation indicating that they will not drive or transport children, youth, young adults, or their family or caregiver;
- Revamping the background check policy to reflect the changes that Medicaid has implemented effective March 1, 2025 requiring all staff to submit a request for State Bureau of Identification fingerprint-based background checks to CSOC, and internally requiring electronic backup of all staff background checks;
- In addition to hiring a Compliance Director, hiring an additional compliance officer to double-check all staff files to ensure that all required documentation is included and to audit the billings to make sure the correct dates and times are being billed and that all required documentation is included, including by making a quality call check to the claim recipient's parent or guardian prior to submitting the first billing; and
- Conducting an updated, annual compliance training with all staff to assist staff in understanding Medicaid regulations and rules, to help ensure proper and accurate documentation, to reinforce staff's understanding of GNJCC employee compliance expectations, and to educate staff about what constitutes fraud.[1]

Moreover, GNJCC has changed the way it submits billing and other documentation, requiring that they be double checked to ensure correct dates and other information prior to filing. GNJCC's paper filing system at times made it difficult to retrieve previously filed paper records. As a result, in July 2024, GNJCC implemented back-up electronic filing systems to ensure all

[1] GNJCC's most recent compliance training in October 2024 featured 100 percent staff participation, with attested certificates of attendance placed in all employee files.

records are appropriately filed and easy to retrieve.

Against this additional background, we now turn to the specific deficiencies stated in the DAR. As stated initially in our August 20, 2024 response letter (the "August 2024 Letter") to OSC's Summary of Findings ("SOF") dated July 31, 2024, and as set forth more fully below, we submit that most of the claimed deficiencies in the DAR are erroneous. Each individual finding from the DAR will be addressed in turn.

RESPONSE

I. The DAR Fails to Address GNJCC's Objections to the Extrapolation of Alleged Overpayment Amounts.

GNJCC objects to the sampling method and proposed extrapolation stated in the DAR. The DAR states that OSC reviewed 188 claims from the total population of 107,365 claims between August 1, 2017 and April 30, 2022 and identified overpayments on 44 of these claims totaling $5,567. The DAR further states that OSC then extrapolated this overpayment to the total population of claims to arrive at an extrapolated overpayment totaling at least $2,709,266.

In its August 2024 Letter, GNJCC previously objected to a similar extrapolation methodology stated in the SOF. In particular, GNJCC objected that the SOF failed to adequately describe the sampling methodology and that the extrapolated amount was based upon erroneous overpayment amounts. Here, the DAR's extrapolation methodology suffers these same infirmities and entirely fails to address GNJCC's objections.

First, the DAR, like the SOF, does not explain the process used to determine the appropriate sample size, how the sample claims were selected, nor the steps taken to ensure that the sample was representative of the population as a whole. Without an explanation of those steps, it is impossible to determine the validity of the sample and whether it is appropriate for extrapolation. According to the DAR, the audit period covered a massive population of claims, totaling 107,365 individual claims, yet the audit sample was a miniscule 0.1751% (188 claims) of the population. Even in perfect circumstances, extrapolation based on these figures would be inappropriate.[2]

Second, the DAR does not account for GNJCC's identification of claims which were erroneously flagged as deficient. Where there are erroneous claims included in the overpayment amounts, the extrapolation is unfounded. Indeed, as set forth below, many of the claims included in the DAR were erroneously flagged and do not represent any errors or violations of any regulation by GNJCC. At a minimum, the OSC must revise the extrapolation to reflect the proper

[2] For large populations (populations over 10,000) the sample size should be a minimum of 10% of the population, "to ensure representativeness of the sample." *See* Sample Size – Institutional Effectiveness and Assessment, https://wp.stolaf.edu/iea/sample-size/, last accessed March 25, 2025.

number of claims and to exclude those claims which were erroneously identified.

Third, even with respect to the remaining claims, the extrapolation is unnecessarily punitive given the nature of the findings. Excluding the claims which were improperly identified, the remaining flagged claims in the DAR do not present a uniform trend of errors, but rather isolated and disparate instances of filing and other human error. As detailed above, both prior to and following the audit, GNJCC implemented more robust compliance programs and procedures, including, among other things, onboarding a Director of Compliance and establishing a protocol to maintain back-up files in an electronic format. Accordingly, all the claims here result from isolated instances of human error or lost paperwork and cannot form the basis for any extrapolated repayment amount.

II. Each of the DAR's Findings Includes Claims Which Were Erroneously Identified.

A. DAR Claim—Greater New Jersey Failed to Maintain Criminal Background Checks for Behavioral Assistants Prior to Rendering Services.

The DAR states that GNJCC failed to maintain required proof of background checks for 5 of the 29 Behavioral Assistants ("BAs") that OSC sampled, resulting in an overpayment on 11 of the claims sampled. However, as GNJCC stated in its August 2024 Letter, all of GNJCC's BAs (including the five identified in the DAR) have completed background checks, in keeping with the applicable state regulations.

The DAR wholly ignores the evidence GNJCC submitted to establish that the five BAs flagged in the DAR have all had background checks conducted. GNCJJ submitted documentation from [redacted], the company that conducted the background checks on behalf of GNJCC, establishing that the five BAs at issue completed background checks on the following dates:

- [redacted] – September 1, 2021
- [redacted] – June 16, 2021
- [redacted] – September 21, 2021
- [redacted] – September 25, 2019
- [redacted] – January 3, 2018

The DAR contends that the [redacted] documentation is insufficient because it establishes only that GNJCC ordered the background checks for these BAs, but not that they had passed the checks. However, this response ignores that OSC itself has conceded that the background check regulation at issue is ambiguous as to what documentation providers must maintain to ensure compliance. In connection with the August 2024 Letter, GNJCC submitted a letter from OSC dated November 16, 2021 stating that "[t]he criminal background check requirements for BAs are not

clear and thus difficult to apply." *See* Exhibit 1. The OSC's letter further recommends that that the background check requirements be revamped to alleviate confusion regarding how to comply—a recommendation which the State has since adopted effective March 1, 2025 in a comprehensive overhaul of the background check system. The OSC's letter and the subsequent overhaul establish that the prior system was unworkably vague and difficult to apply; thus, GNJCC was under no clear requirement to maintain the actual completed checks on the state system.

Accordingly, the DAR erroneously identified 5 BAs and the 11 claims they accounted for as deficient, and thus none represent any overpayment amount. GNJCC should face no repayment obligation with respect to any alleged violation of this regulation.

B. DAR Claim—Greater New Jersey Failed to Maintain a Current and Valid Driver's License for Servicing Providers.

The DAR states that GNJCC failed to maintain a copy of a current and valid driver's license for 14 of the 97 servicing providers that OSC sampled, resulting in an overpayment on 17 of the claims sampled. However, as the DAR concedes, the applicable regulation only applies to servicing providers "whose job functions include operating a vehicle used to transport children, youth or young adults or their family or caregiver." *See* DAR at 4 (emphasis added); (citing N.J.A.C. 10:77-4.9(f), 4.14(d)(1), 5.9(f), and 5.14(d)(1)). The DAR completely ignores that GNJCC has never required any of its servicing providers to drive clients, and no GNJCC employee's job function can be said to include such activity.

Furthermore, the DAR likewise ignores that this regulation, like the regulation surrounding background checks, has been met with uniform confusion. Per the attached Medicaid Newsletter, it is unclear whether the requirement must be satisfied prior to a provider providing services and whether the provider must update the checks on an annual basis. *See* Exhibit 1, at 2. Here, GNJCC maintained valid driver's licenses upon hiring, but did not regularly update its records when licenses expired. No regulation required this for employees who did not drive or transport children.

Accordingly, the DAR erroneously identified 14 servicing providers and the 17 claims they accounted for as deficient, and thus none represent any overpayment amount. GNJCC should face no repayment obligation with respect to this regulation.

C. DAR Claim—Greater New Jersey Failed to Maintain Behavioral Assistance Training Certifications for Behavioral Assistants.

The DAR states that 4 of the 29 BAs that OSC sampled were out of compliance with this requirement, resulting in an overpayment on 7 of the claims sampled. Here, as in the August 2024 Letter, GNJCC concedes that 2 BAs—[redacted] and [redacted]—were out of compliance with the certification requirements, resulting in an overpayment on 5 of the claims sampled. However, with respect to the remaining 2 BAs identified in the DAR [redacted] and [redacted] GNJCC disputes the DAR findings.

First, with respect to BA [redacted], GNJCC submitted documentation sufficient to show that [redacted] was within the six-month grace period during which to obtain the certification on the date of the claim at issue.[3] [redacted] first approached GNJCC about returning to work as a BA for GNJCC on October 9, 2019. *See* Exhibit 2. Thus, the earliest possible date by which [redacted] six-month grace period would expire was April 9, 2020. The claim at issue corresponds to a service date of February 8, 2020, well within the earliest possible grace period.

Second, [redacted] is not a BA, but a fully licensed therapist. Per the applicable regulations, she maintains an appropriate LAC license, which became active on June 26, 2020. Thus, the DAR erroneously identified [redacted] as being out of compliance with this requirement for BAs.

Accordingly, the DAR improperly identifies 2 of the 7 claims as non-compliant and which therefore should not be included in the overpayment calculation. For the remaining 5 claims, it is GNJCC's practice to maintain records for each BA's certification, but in these instances GNJCC was unable to locate them due to filing errors. Thus, only 5 claims included an actual instance of overpayment, as detailed below:

Behavioral Assistant Name	**Claimant Recipient Name**	**Claim Service Date**	**Overpayment Amount**
[redacted]	[redacted]	6/17/2020	$78.00
[redacted]	[redacted]	10/15/2020	$39.00
[redacted]	[redacted]	10/17/2020	$78.00
[redacted]	[redacted]	10/18/2020	$117.00
[redacted]	[redacted]	6/27/2021	$218.28
		Total	$530.28

D. DAR Claim—Greater New Jersey Billed Unsubstantiated Services and/or Maintained Inaccurate and Incomplete Records.

The DAR states that GNJCC failed to possess adequate documentation to support 14 of the 188 claims sampled, resulting in an overpayment on each of these 14 claims. Consistent with its August 2024 Letter, GNJCC again concedes that 12 of the SDED forms identified in the audit were filled out incorrectly or were not provided. These 12 deficiencies appear to be the result of

[3] *See* DAR at 5 ("BAs are required to obtain the certification within six months of the BA's hire date . . .").

human error causing paperwork to be misfiled in an incorrect location. GNJCC never bills for any services without proper documentation; instead, GNJCC's process is to enter sessions into its billing spreadsheet only after reviewing the appropriate forms, and with a second set of eyes (formerly a biller, and now, a compliance employee) reviewing the entries for accuracy. Here, then, the proper documentation for these claims exists and was available at the time of billing, but GNJCC now cannot retrieve them due as a result of human filing errors in its previous system. In recognition of these shortcomings, and as explained above, GNJCC has taken steps to improve its audit protocols and to avoid and minimize human error.

With respect to the remaining 2 claims identified in the DAR, for which the service delivery date on page two differs from the prior authorization date on page one of the SDED form, GNJCC notes that the DAR ignores GNJCC's position that its clinician providers wrote the previous authorization number on page one of the encounter form, but that GNJCC always billed under the correct authorization number as a matter of practice. It is common for up-to-date authorization numbers to be unavailable at the time of the encounter, but to become available by the time GNJCC submits the claim. Indeed, the Medicaid billing system does not even allow GNJCC to enter a bill with an expired authorization number. Thus, these discrepancies on the SDED form are not material to payment, and GNCJJ should not be penalized for its staff using an expired number on an SDED form where no active authorization number is yet available, particularly since the claims were actually billed with the correct authorization numbers.

Accordingly, of the 14 claims identified in the DAR, only 12 were properly identified as erroneous and resulting in overpayments, as summarized below:

Claim Recipient	**Claim Service Date**	**Overpayment**
[redacted]	10/26/2017	$170.00
[redacted]	3/29/2018	$170.00
[redacted]	8/17/2017	$536.75
[redacted]	4/2/2022	$218.28
[redacted]	10/18/2017	$282.50
[redacted]	10/11/2018	$39.00
[redacted]	12/5/2018	$(42.50)
[redacted]	6/23/2020	$212.50
[redacted]	3/8/2022	$287.40

[redacted]	11/30/2021	$308.30
[redacted]	2/13/2018	$113.00
[redacted]	10/1/2021	$114.96
		$2,410.19

E. DAR Claim—Greater New Jersey Upcoded Services Provided.

The DAR states that for 3 of the 188 claims sampled GNJCC billed for services using a higher reimbursed procedure code and/or modifier than appropriate, resulting in overpayments. As in the August 2024 Letter, GNJCC concedes that of these 3 claims, two were the result of a mistakes and are legitimate instances of inaccurately coded services. Specifically, for BA [redacted], the biller made a mistake and billed [redacted] as a therapist rather than a BA.

Further, with respect to the claim involving [redacted], GNJCC concedes that [redacted] LAC license did not become active until June 26, 2020 and thus was not licensed as an LAC on the date of service of June 12, 2020. However, [redacted] had completed a master's degree, and thus GNJCC understood her to be a licensed LAC on the date of service.

With respect to the other remaining claim, involving services rendered by [redacted], GNJCC accurately billed for her services. [redacted] is independently licensed and has "U1" authorization. Accordingly, GNJCC appropriately billed her services using the "U1" code and the Medicaid billing system processed the claim, despite the authorization code in the system being a "U2". Historically, the billing system has included checks and balances to reject claims using a "U1" authorization where the system code noted "U2" authorization. Unbeknownst to GNJCC, however, there was a change in the Medicaid system removing those checks and balances, allowing this particular claim submission to go through. Per the ordinary process, GNJCC expected the system to reject the billing submission if there was a discrepancy between the code billed and the code authorized, yet this did not occur in this instance. Further, GNJCC did not "upcode" [redacted] services, but rather billed them accurately using the code "U1" reflective of her independent licensure status. The code billed thus accurately reflects the services rendered, and any error was on the part of Medicaid in accepting this claim, which was billed accurately.

Accordingly, only two of the claims identified in the DAR were properly identified as upcoded and was the result of an inadvertent human error. The overpayment associated with these two claims amount to a total of $507.75.

F. DAR Claim—Greater New Jersey Failed to Document Services with a Progress Note.

Finally, the DAR states that for 1 of the 188 claims sampled, GNJCC failed to document services in a progress note. However, the DAR wholly ignores the evidence presented in GNJCC's August 2024 Letter establishing that the State's online Cyber system is rife with errors and glitches, which frequently result in progress notes previously uploaded to the system disappearing or becoming inaccessible. GNJCC uploads and maintains all its progress notes on the State's cyber online system; however, for unknown reasons these progress notes frequently disappear in the system. By way of example, GNJCC has included screenshots indicating that progress notes GNJCC uploaded to the cyber site, and which were accessible on January 1, 2023 have since become inaccessible without explanation. *See* Exhibit 3. Despite possessing timestamped proof that these progress notes were in fact submitted on January 1, 2023, GNJCC has been unable to access these progress notes as recently March 17, 2025, with the cyber system giving the appearance that none were submitted. Accordingly, the mere fact that the progress note at issue is unavailable in the cyber system and that OSC was unable to locate it during the audit does not necessarily mean that GNJCC never submitted it. Thus, GNJCC should face no repayment obligation due to glitches in the States' own cyber system.

CONCLUSION

In sum, GNJCC disputes the DAR's findings and submits that the DAR erroneously identified 25 of the 188 claims sampled as deficient. After accounting for these erroneously identified claims, only 19 claims[4] in the sample remain deficient, resulting in a total overpayment amount of only $3,448.22.

What's more, given the miniscule sample size, relatively low rate of error when considering the appropriate number of deficient claims, and the inadvertent and disparate nature of the errors, GNJCC objects to the extrapolation of overpayment amounts to the entire population of claims submitted during the audit period. Contrary to the DAR's assertions, these inadvertent errors reveal neither "significant oversight failures" nor "systemic shortcomings" on the party of GNJCC, and there has been no showing that any of GNJCC's patients have been harmed or faced increased risk of harm as a result.

That being said, GNJCC does concede that the audit uncovered minor instances of human error. No organization is 100% compliant with applicable regulations, but, as set forth above, GNJCC has swiftly taken corrective actions and adopted compliance and audit procedures to minimize such errors in the future. GNJCC looks forward to your response and would like to continue discussions with the OSC to resolve any concerns and continue providing health care services to communities desperately in need of them.

Very truly yours,

[4] As detailed above, the 19 claims are comprised of: 5 claims regarding BA Certifications; 12 claims regarding unsubstantiated services; and 2 claims regarding the upcoded services.

s/ Nicholas C. Harbist

Nicholas C. Harbist, Esq.

NCH:
Attachments

cc: Kevin M. Moran
[redacted]

OSC Note: Exhibits attached to the provider's response have been omitted to maintain confidentiality.

Greater New Jersey's Comments and OSC's Responses

In response to the Draft Audit Report (DAR) issued by the Office of the State Comptroller, Medicaid Fraud Division (OSC), Greater New Jersey Creative Counseling, Inc. (Greater New Jersey), through counsel, submitted a response that takes issue with OSC's audit findings. In general, Greater New Jersey disagreed with OSC's findings; however, OSC stands by its conclusions based on the documentation and information it obtained during the audit.

Greater New Jersey also provided OSC with a Corrective Action Plan (CAP) indicating the steps Greater New Jersey will take or have taken to correct the deficiencies identified in the report, but did not address whether Greater New Jersey would repay the identified overpayment.

Set forth below are Greater New Jersey's specific objections to the audit findings and OSC's responses to each. After reviewing Greater New Jersey's submission, OSC determined that there was no basis to revise any of its audit results. Greater New Jersey's full response is attached to the Final Audit Report (FAR) as Appendix D.

1. Greater New Jersey's introduction and CAP

Greater New Jersey's Comments

We have reviewed the New Jersey Office of the State Comptroller's ("OSC") Draft Audit Report detailing the results of an audit of Medicaid claims submitted by and paid to GNJCC for the period from August 1, 2017 through April 30, 2022.

As an initial matter, we submit the following additional background information regarding improvements in GNJCC's compliance policies. GNJCC is an Intensive In-Community provider, offering counseling services to children and youth in their homes. GNJCC has always strived for excellence, and in keeping with that commitment, has implemented additional compliance-driven policies over the past two-and-a-half years. In September of 2022, GNJCC implemented a formal written corporate compliance plan. The plan focuses on ensuring adherence to all pertinent Medicaid regulations, training staff, improving billing policies, and eliminating any risk of fraud, waste and abuse. More specifically, and pursuant to the compliance plan, GNJCC has improved its compliance by implementing the following improvements:

• Hiring a clinically licensed Compliance Director with years of experience with compliance-related issues, who conducts monthly audits of internal GNJCC paperwork and documents to ensure things are filed and completed correctly;

• Creating an electronic filing and backup system so that files and documents are easier to retrieve, reducing filing/retrieval errors;

• Requiring that a second employee audit and confirm dates, units, and/or level of service for all sessions billed before submission to Medicaid;

• Implementing a monthly internal audit to ensure that GNJCC has proper documentation for all sessions billed to Medicaid resulting in a zero error rate for the months September 2024 through January 2025;

• Revamping the driver's license policy to reflect the changes that Medicaid has implemented effective January 1, 2024 by requiring staff to submit updated drivers licenses, internally maintaining electronic backup of all staff licenses, and, for those staff members who do not have a driver's license, requiring them to sign an attestation indicating that they will not drive or transport children, youth, young adults, or their family or caregiver;

• Revamping the background check policy to reflect the changes that Medicaid has implemented effective March 1, 2025 requiring all staff to submit a request for State Bureau of Identification fingerprint-based background checks to CSOC, and internally requiring electronic backup of all staff background checks;

• In addition to hiring a Compliance Director, hiring an additional compliance officer to double-check all staff files to ensure that all required documentation is included and to audit the billings to make sure the correct dates and times are being billed and that all required documentation is included, including by making a quality call check to the claim recipient's parent or guardian prior to submitting the first billing; and

• Conducting an updated, annual compliance training with all staff to assist staff in understanding Medicaid regulations and rules, to help ensure proper and accurate documentation, to reinforce staff's understanding of GNJCC employee compliance expectations, and to educate staff about what constitutes fraud.[1]

Moreover, GNJCC has changed the way it submits billing and other documentation, requiring that they be double checked to ensure correct dates and other information prior to filing. GNJCC's paper filing system at times made it difficult to retrieve previously filed paper records. As a result, in July 2024, GNJCC implemented back-up electronic filing systems to ensure all records are appropriately filed and easy to retrieve. Against this additional background, we now turn to the specific deficiencies stated in the DAR. As stated initially in our August 20, 2024 response letter (the "August 2024 Letter") to OSC's Summary of Findings ("SOF") dated July 31, 2024, and as set forth more fully below, we submit that most of the claimed deficiencies in the DAR are erroneous. Each individual finding from the DAR will be addressed in turn.

[1] GNJCC's most recent compliance training in October 2024 featured 100 percent staff participation, with attested certificates of attendance placed in all employee files.

OSC's Response

In its response, Greater New Jersey addressed most of OSC's recommendations from the DAR; however, the CAP did not address the recommendation to reimburse the Medicaid overpayment of $2,711,289.

2. Greater New Jersey's Objections to Extrapolation and Audit Findings

a. Greater New Jersey's Objection: Extrapolation of Alleged Overpayment Amounts

Greater New Jersey's Comments

GNJCC objects to the sampling method and proposed extrapolation stated in the DAR. The DAR states that OSC reviewed 188 claims from the total population of 107,365 claims between August 1, 2017 and April 30, 2022 and identified overpayments on 44 of these claims totaling $5,567. The DAR further states that OSC then extrapolated this overpayment to the total population of claims to arrive at an extrapolated overpayment totaling at least $2,709,266.

In its August 2024 Letter, GNJCC previously objected to a similar extrapolation methodology stated in the SOF. In particular, GNJCC objected that the SOF failed to adequately describe the sampling methodology and that the extrapolated amount was based upon erroneous overpayment amounts. Here, the DAR's extrapolation methodology suffers these same infirmities and entirely fails to address GNJCC's objections.

First, the DAR, like the SOF, does not explain the process used to determine the appropriate sample size, how the sample claims were selected, nor the steps taken to ensure that the sample was representative of the population as a whole. Without an explanation of those steps, it is impossible to determine the validity of the sample and whether it is appropriate for extrapolation. According to the DAR, the audit period covered a massive population of claims, totaling 107,365 individual claims, yet the audit sample was a miniscule 0.1751% (188 claims) of the population. Even in perfect circumstances, extrapolation based on these figures would be inappropriate[2].

Second, the DAR does not account for GNJCC's identification of claims which were erroneously flagged as deficient. Where there are erroneous claims included in the overpayment amounts, the extrapolation is unfounded. Indeed, as set forth below, many of the claims included in the DAR were erroneously flagged and do not represent any errors or

[2] For large populations (populations over 10,000) the sample size should be a minimum of 10% of the population, "to ensure representativeness of the sample." See Sample Size – Institutional Effectiveness and Assessment, https://wp.stolaf.edu/iea/sample-size/, last accessed March 25, 2025.

violations of any regulation by GNJCC. At a minimum, the OSC must revise the extrapolation to reflect the proper number of claims and to exclude those claims which were erroneously identified.

Third, even with respect to the remaining claims, the extrapolation is unnecessarily punitive given the nature of the findings. Excluding the claims which were improperly identified, the remaining flagged claims in the DAR do not present a uniform trend of errors, but rather isolated and disparate instances of filing and other human error. As detailed above, both prior to and following the audit, GNJCC implemented more robust compliance programs and procedures, including, among other things, onboarding a Director of Compliance and establishing a protocol to maintain back-up files in an electronic format. Accordingly, all the claims here result from isolated instances of human error or lost paperwork and cannot form the basis for any extrapolated repayment amount.

OSC's Response

OSC provided Greater New Jersey an excel file titled, GNJCC Full RS&E – Provider Copy, in July 2024. OSC provided a second excel file titled, GNJCC Full RS&E 1.8.25 – Provider Copy, in March 2025. Greater New Jersey received both of these files on the same dates that they were provided. The first tab, in each file, is the Sampling Plan, which outlines exactly how OSC defined the universe, the sampling method it used, the strata boundaries (in this case the distinction between the simple random sample and the take-all (TA) stratum), how OSC sorted the universe (in order to replicate the random selection process), how OSC determined the sample size (for both the Probe and Full Samples), and the seed number (to re-produce the random numbers that were generated in RAT-STATS). The Sampling Plan, in conjunction with the Universe tab that was provided, allows any qualified individual (i.e., a statistician or someone with significant sampling and extrapolation experience) to completely replicate OSC's sample from start to finish. This replication of the sample would answer all questions Greater New Jersey claims were left unanswered in its first challenge.

The second part of Greater New Jersey's first challenge is that the sample size was too small relative to the size of the universe. Sample size is determined by many different factors, both from statistical and business standpoints. The factors determining sample size from a statistics perspective are: desired confidence level; desired precision level; variance (or standard deviation) of the variable being estimated; mean (i.e., average) of the variable being estimated; and the universe size.

First, OSC will demonstrate how the sample size for the Full Sample was determined. Then, OSC will demonstrate why the size of the universe does not have a major impact in determining the size of the sample (except when the universe is very small).

From the probe sample of 52 claims, OSC was able to obtain estimates of the Error Mean and Error Standard Deviation, $55.30 and $86.01, respectively. The Universe is comprised of

107,354 claims. Entering this information into RAT-STATS (v1.9.0.0), "Stratified Variable Sample Size" package, sample sizes are calculated at varying levels of confidence and precision. OSC chose the 80% confidence, 15% precision level, which suggested 177 claims needed to be reviewed in Stratum 1 (S1).

To demonstrate how the size of the universe has a minimal impact on sample size calculations, OSC kept the Error Mean, Error Standard Deviation, Confidence Level, and Precision Level constant. The only variable that was changed, for each calculation, was the size of the universe. See the results below.

Constants in each test:

Error Mean	Error Standard Deviation	Confidence Level (Two-Sided)	Precision Level
$55.30	$86.01	80%	15%

Results:

Universe Size	RAT-STATS Sample Size	Sampling Percentage	Universe Size	RAT-STATS Sample Size	Sampling Percentage
250	104	41.60%	25,000	176	0.70%
500	131	26.20%	50,000	176	0.35%
1,000	151	15.10%	54,000	177	0.33%
1,500	158	10.53%	**107,354***	**177***	**0.16%***
2,000	163	8.15%	150,000	177	0.12%
5,000	171	3.42%	200,000	177	0.09%
10,000	174	1.74%	500,000	177	0.04%
15,000	175	1.17%	1,000,000	177	0.02%
***Actual Universe Size, Full Sample Size, and Sampling Percentage for this audit.**					

From the results, OSC observes that there is minimal change to the sample size once the sampling percentage drops below 10% (i.e., the Universe Size is greater than 2,000 claims). At 54,000 claims, the sample size stops increasing entirely. The fact that the Universe can differ by 950,000 claims (or more), and have the same sample size recommendation, proves that the size of the Universe is not the most important value in determining sample size. Therefore, any challenge from Greater New Jersey that the sample size is not sufficient for extrapolation because the Universe is large is misguided.

With that being said, increasing the sample size does have its merits. For instance, by increasing the sample size, the precision would improve, which would result in an increase in the lower limit. As such, if OSC used a larger sample size and had the same findings, Greater New Jersey would need to repay OSC an even larger amount than it currently does.

In Greater New Jersey's second challenge, it states that OSC included claims that were "erroneously flagged as deficient." This challenge is unfounded. OSC considers all

documentation submitted by the provider, and no new information was submitted that warranted a change of findings. As a result, the extrapolation did not need to be modified.

The third and final challenge made by Greater New Jersey was that the "extrapolation was unnecessarily punitive given the nature of the findings" and that the claims "do not present a uniform trend of errors." On both accounts, these statements are incorrect. The extrapolation is designed to only account for the errors identified, which means that by the very nature of its calculations, it cannot be overly punitive. In other words, each finding (or error) directly contributes to the overpayment amount whereas claims that were passed (i.e., not in error) have no contribution to the overpayment amount. Additionally, OSC utilizes the lower limit of a one-sided 90% confidence interval as its overpayment amount. This ensures the recovery amount is conservative, in the provider's favor, because there is a 90% chance that OSC is recovering less than the actual overpayment amount that exists in the universe. Finally, OSC is not projecting individual types of errors. It assesses each claim independently, and then projects all error dollars collectively back to the universe. Therefore, the type of error has no bearing on the overall calculation. Additionally, the overall frequency of errors (i.e., 39 of 177 in S1, 5 of 11 in TA) is what establishes a trend of errors for extrapolation, not the frequency of individual types of errors (e.g., 3 claims that were upcoded or 1 claim with Missing/Insufficient Progress Notes). Even if the frequency or trend of errors was lower than it currently is, the extrapolation would account for it with a larger precision amount, which would result in a lower overpayment demand.

b. Greater New Jersey's Objection: Failure to Maintain Criminal Background Checks for Behavioral Assistants Prior to Rendering Services

Greater New Jersey's Comments

The DAR states that GNJCC failed to maintain required proof of background checks for 5 of the 29 Behavioral Assistants ("BAs") that OSC sampled, resulting in an overpayment on 11 of the claims sampled. However, as GNJCC stated in its August 2024 Letter, all of GNJCC's BAs (including the five identified in the DAR) have completed background checks, in keeping with the applicable state regulations.

The DAR wholly ignores the evidence GNJCC submitted to establish that the five BAs flagged in the DAR have all had background checks conducted. GNCJJ submitted documentation from [redacted], the company that conducted the background checks on behalf of GNJCC, establishing that the five BAs at issue completed background checks on the following dates:

- [redacted] – September 1, 2021
- [redacted] – June 16, 2021
- [redacted] – September 21, 2021
- [redacted] – September 25, 2019
- [redacted] – January 3, 2018

The DAR contends that the [redacted] documentation is insufficient because it establishes only that GNJCC ordered the background checks for these BAs, but not that they had passed the checks. However, this response ignores that OSC itself has conceded that the background check regulation at issue is ambiguous as to what documentation providers must maintain to ensure compliance. In connection with the August 2024 Letter, GNJCC submitted a letter from OSC dated November 16, 2021 stating that "[t]he criminal background check requirements for BAs are not clear and thus difficult to apply." See Exhibit 1. The OSC's letter further recommends that that the background check requirements be revamped to alleviate confusion regarding how to comply—a recommendation which the State has since adopted effective March 1, 2025 in a comprehensive overhaul of the background check system. The OSC's letter and the subsequent overhaul establish that the prior system was unworkably vague and difficult to apply; thus, GNJCC was under no clear requirement to maintain the actual completed checks on the state system.

Accordingly, the DAR erroneously identified 5 BAs and the 11 claims they accounted for as deficient, and thus none represent any overpayment amount. GNJCC should face no repayment obligation with respect to any alleged violation of this regulation.

OSC's Response

OSC found that Greater New Jersey did not maintain background checks for 5 of the 29 Behavioral Assistants (BAs) sampled, who accounted for 11 out of 188 claims, totaling $2,014 in reimbursement. In its response, Greater New Jersey asserted that background checks had been completed for the five BAs; however, OSC noted that the documentation provided by Greater New Jersey only showed that Greater New Jersey ordered and paid for background checks, not that it received, reviewed and acted on such checks. In short, Greater New Jersey failed to maintain documentation confirming that these BA's cleared background checks and were eligible to work with Medicaid beneficiaries.

Further, Greater New Jersey claimed that the regulation regarding background checks is unclear and cited a past communication from OSC to DMAHS requesting regulatory improvements. Although Greater New Jersey attributed its noncompliance to perceived ambiguity in the regulation, such ambiguity does not exempt providers of their responsibility to comply with its core requirements. The obligation to ensure that background checks are maintained and that BA's have cleared them remains unchanged; there is no ambiguity on this core requirement. As such, Greater New Jersey has provided no basis for OSC to modify its audit finding.

c. Greater New Jersey's Objection: Failure to Maintain a Current and Valid Driver's License for Servicing Providers

Greater New Jersey's Comments

The DAR states that GNJCC failed to maintain a copy of a current and valid driver's license for 14 of the 97 servicing providers that OSC sampled, resulting in an overpayment on 17 of the claims sampled. However, as the DAR concedes, the applicable regulation only applies to servicing providers "whose job functions include operating a vehicle used to transport children, youth or young adults or their family or caregiver." See DAR at 4 (emphasis added); (citing N.J.A.C. 10:77-4.9(f), 4.14(d)(1), 5.9(f), and 5.14(d)(1)). The DAR completely ignores that GNJCC has never required any of its servicing providers to drive clients, and no GNJCC employee's job function can be said to include such activity.

Furthermore, the DAR likewise ignores that this regulation, like the regulation surrounding background checks, has been met with uniform confusion. Per the attached Medicaid Newsletter, it is unclear whether the requirement must be satisfied prior to a provider providing services and whether the provider must update the checks on an annual basis. See Exhibit 1, at 2. Here, GNJCC maintained valid driver's licenses upon hiring, but did not regularly update its records when licenses expired. No regulation required this for employees who did not drive or transport children.

Accordingly, the DAR erroneously identified 14 servicing providers and the 17 claims they accounted for as deficient, and thus none represent any overpayment amount. GNJCC should face no repayment obligation with respect to this regulation.

OSC's Response

OSC found that for 14 of 97 servicing providers in the audit sample, which accounted for 17 of 188 claims, totaling $2,833 in reimbursement, Greater New Jersey failed to maintain a copy of the servicing provider's current and valid driver's license. In its response, Greater New Jersey asserted that it "has never required any of its servicing providers to drive clients, and no [Greater New Jersey] employee's job function can be said to include such activity [transporting beneficiaries]." However, this assertion is not supported by Greater New Jersey's documentation. Greater New Jersey's own progress notes in the CYBER system showed that at least 38 servicing providers documented transporting beneficiaries in vehicles. Of these 38 service providers, four were included in the audit sample. While three of the four documented driving beneficiaries on dates outside the sampled dates of service, one servicing provider documented transporting a beneficiary during the actual date of service included in the audit sample. Among the four servicing providers who documented having transported beneficiaries in vehicles, the progress notes explicitly referenced driving beneficiaries to various locations, such as McDonald's, gyms, nail salons, libraries, and even to beneficiaries' workplaces, on various service dates. Accordingly, contrary to Greater New Jersey's assertion, its employees

did transport beneficiaries as part of their delivery of service. Consequently, Greater New Jersey should have maintained these servicing providers current and valid driver's licenses.

Moreover, while the regulations refer to servicing providers "whose job functions include operating a vehicle used to transport" Medicaid beneficiaries, job function must be understood based on actual duties performed. When servicing providers are actively transporting beneficiaries, whether frequently or occasionally, transportation becomes part of their practical job function, thereby triggering the requirement for the provider, Greater New Jersey, to verify and maintain a valid driver's license on file.

Further, Greater New Jersey claimed that the regulation regarding driver's license is unclear and cited a past communication from OSC to DMAHS requesting regulatory improvements. As previously stated, although OSC continually works to improve Medicaid regulations and guidance, such efforts should not be misconstrued as justification or as an excuse for noncompliance. And the driver's license requirement is not ambiguous. As such, Greater New Jersey has provided no basis for OSC to modify its audit finding.

d. Greater New Jersey's Objection: Failure to Maintain Behavioral Assistance Training Certifications for BAs

Greater New Jersey's Comments

The DAR states that 4 of the 29 BAs that OSC sampled were out of compliance with this requirement, resulting in an overpayment on 7 of the claims sampled. Here, as in the August 2024 Letter, GNJCC concedes that 2 BAs—[redacted] and [redacted]—were out of compliance with the certification requirements, resulting in an overpayment on 5 of the claims sampled. However, with respect to the remaining 2 BAs identified in the DAR—[redacted] and [redacted]—GNJCC disputes the DAR findings.

First, with respect to BA [redacted], GNJCC submitted documentation sufficient to show that [redacted] was within the six-month grace period during which to obtain the certification on the date of the claim at issue[3]. [redacted] first approached GNJCC about returning to work as a BA for GNJCC on October 9, 2019. See Exhibit 2. Thus, the earliest possible date by which [redacted] six-month grace period would expire was April 9, 2020. The claim at issue corresponds to a service date of February 8, 2020, well within the earliest possible grace period.

Second, [redacted] is not a BA, but a fully licensed therapist. Per the applicable regulations, she maintains an appropriate LAC license, which became active on June 26, 2020. Thus, the

[3] See DAR at 5 ("BAs are required to obtain the certification within six months of the BA's hire date . . .").

DAR erroneously identified [redacted] as being out of compliance with this requirement for BAs.

Accordingly, the DAR improperly identifies 2 of the 7 claims as non-compliant and which therefore should not be included in the overpayment calculation. For the remaining 5 claims, it is GNJCC's practice to maintain records for each BA's certification, but in these instances GNJCC was unable to locate them due to filing errors. Thus, only 5 claims included an actual instance of overpayment, as detailed below:

Behavioral Assistant Name	Claimant Recipient Name	Claim Service Date	Overpayment Amount
[redacted]	[redacted]	6/17/2020	$78.00
		10/15/2020	$39.00
		10/17/2020	$78.00
		10/18/2020	$117.00
		6/27/2021	$218.28
		Total	$530.28

OSC's Response

OSC found that Greater New Jersey allowed 4 of the 29 BAs in the audit sample selection to provide behavioral assistance services to beneficiaries without obtaining the required certification and improperly billed for 7 of 188 claims, totaling $653 in reimbursement. In its response, Greater New Jersey conceded that 2 of the 4 BA's representing 5 of the 7 claims were non-compliant. However, Greater New Jersey disputed the findings for the remaining two BA's.

For one of the disputed BAs, Greater New Jersey asserted that the BA was within the six-month grace period, citing emails that allegedly show the BA was hired on October 9, 2019. According to Greater New Jersey, this would permit the BA to provide services on the February 8, 2020 date of service without yet obtaining a BA Training Certificate. OSC reviewed the submitted documentation and rejects Greater New Jersey's claim that October 9, 2019, was the actual hire date. Although Greater New Jersey provided emails from August and October 2019, none of these emails established a definitive hire or start date. Moreover, the only employment contract and some onboarding materials provided by Greater New Jersey were signed on April 3, 2017, nearly three years before the February 8, 2020 date of service. Greater New Jersey also provided additional onboarding documentation for this employee such as, the "BA/IIC Do's and Don'ts," "W4," "Earned Sick Leave Fact Sheet," and "Behavior Assistant Job Description," which were all signed on February 27, 2021, more than a year after the service date. Additionally, an "Employee Acknowledgement and Attestation" was later signed on March 17, 2023, over three years after the service date. In sum for this BA, the documents provided by Greater New Jersey span a wide timeframe and fail to establish a clear or

verifiable start date. As such, Greater New Jersey has not provided sufficient and reliable documentation for OSC to modify its audit finding.

For the second BA, Greater New Jersey asserted that the individual was a "fully licensed therapist," with the license becoming effective on June 26, 2020. However, the service date at issue is June 12, 2020, two weeks before the license became active. At the time of service, the individual had not yet obtained professional licensure and, consequently, was functioning as a BA. As such, the individual was required to meet all applicable BA training and certification requirements. Since Greater New Jersey failed to meet the requirements for this individual, OSC will not modify its audit findings.

e. Greater New Jersey's Objection: Billing for Unsubstantiated Services and/or Maintaining Inaccurate and Incomplete Records

Greater New Jersey's Comments

The DAR states that GNJCC failed to possess adequate documentation to support 14 of the 188 claims sampled, resulting in an overpayment on each of these 14 claims. Consistent with its August 2024 Letter, GNJCC again concedes that 12 of the SDED forms identified in the audit were filled out incorrectly or were not provided. These 12 deficiencies appear to be the result of human error causing paperwork to be misfiled in an incorrect location. GNJCC never bills for any services without proper documentation; instead, GNJCC's process is to enter sessions into its billing spreadsheet only after reviewing the appropriate forms, and with a second set of eyes (formerly a biller, and now, a compliance employee) reviewing the entries for accuracy. Here, then, the proper documentation for these claims exists and was available at the time of billing, but GNJCC now cannot retrieve them due as a result of human filing errors in its previous system. In recognition of these shortcomings, and as explained above, GNJCC has taken steps to improve its audit protocols and to avoid and minimize human error.

With respect to the remaining 2 claims identified in the DAR, for which the service delivery date on page two differs from the prior authorization date on page one of the SDED form, GNJCC notes that the DAR ignores GNJCC's position that its clinician providers wrote the previous authorization number on page one of the encounter form, but that GNJCC always billed under the correct authorization number as a matter of practice. It is common for up-to-date authorization numbers to be unavailable at the time of the encounter, but to become available by the time GNJCC submits the claim. Indeed, the Medicaid billing system does not even allow GNJCC to enter a bill with an expired authorization number. Thus, these discrepancies on the SDED form are not material to payment, and GNCJJ should not be penalized for its staff using an expired number on an SDED form where no active authorization number is yet available, particularly since the claims were actually billed with the correct authorization numbers.

Accordingly, of the 14 claims identified in the DAR, only 12 were properly identified as erroneous and resulting in overpayments, as summarized below:

Claim Recipient	Claim Service Date	Overpayment
[redacted]	10/26/2017	$170.00
[redacted]	3/29/2018	$170.00
[redacted]	8/17/2017	$536.75
[redacted]	4/2/2022	$218.28
[redacted]	10/18/2017	$282.50
[redacted]	10/11/2018	$39.00
[redacted]	12/5/2018	$(42.50)
[redacted]	6/23/2020	$212.50
[redacted]	3/8/2022	$287.40
[redacted]	11/30/2021	$308.30
[redacted]	2/13/2018	$113.00
[redacted]	10/1/2021	$114.96
		$2,410.19

OSC's Response

OSC found that Greater New Jersey failed to possess adequate documentation to support 14 of 188 claims sampled, totaling $2,866 in reimbursement. Greater New Jersey acknowledged that 12 Service Delivery Encounter Documentation (SDED) forms were either completed incorrectly or could not be located, resulting in improper billing.

Greater New Jersey disputed the remaining two claims, asserting that although the prior authorization number listed on the first page of the SDED form was outdated, the claims were billed under the correct authorization number. Greater New Jersey asserted that these discrepancies were immaterial. That is not correct. The prior authorization information on the first page of the SDED must align with the service delivery dates on the second page for the SDED to fulfill its intended purpose. This alignment ensures that the provider attesting to the form's accuracy delivered services within the approved authorization period. In both disputed cases, internal discrepancies prevented OSC from verifying that the services were rendered as authorized. Furthermore, OSC's review of the authorization report confirms that the correct prior authorization was approved and available at the time of service, leaving no reason for Greater New Jersey servicing providers to document incorrect authorization information. As such, OSC will not modify its audit findings.

f. Greater New Jersey's Objection: Upcoding Services

Greater New Jersey's Comments

The DAR states that for 3 of the 188 claims sampled GNJCC billed for services using a higher reimbursed procedure code and/or modifier than appropriate, resulting in overpayments. As in the August 2024 Letter, GNJCC concedes that of these 3 claims, two were the result of a mistakes and are legitimate instances of inaccurately coded services. Specifically, for BA [redacted], the biller made a mistake and billed [redacted] as a therapist rather than a BA.

Further, with respect to the claim involving [redacted], GNJCC concedes that [redacted] LAC license did not become active until June 26, 2020 and thus was not licensed as an LAC on the date of service of June 12, 2020. However, [redacted] had completed a master's degree, and thus GNJCC understood her to be a licensed LAC on the date of service.

With respect to the other remaining claim, involving services rendered by [redacted], GNJCC accurately billed for her services. [redacted] is independently licensed and has "U1" authorization. Accordingly, GNJCC appropriately billed her services using the "U1" code and the Medicaid billing system processed the claim, despite the authorization code in the system being a "U2." Historically, the billing system has included checks and balances to reject claims using a "U1" authorization where the system code noted "U2" authorization. Unbeknownst to GNJCC, however, there was a change in the Medicaid system removing those checks and balances, allowing this particular claim submission to go through. Per the ordinary process, GNJCC expected the system to reject the billing submission if there was a discrepancy between the code billed and the code authorized, yet this did not occur in this instance. Further, GNJCC did not "upcode" [redacted] services, but rather billed them accurately using the code "U1" reflective of her independent licensure status. The code billed thus accurately reflects the services rendered, and any error was on the part of Medicaid in accepting this claim, which was billed accurately.

Accordingly, only two of the claims identified in the DAR were properly identified as upcoded and was the result of an inadvertent human error. The overpayment associated with these two claims amount to a total of $507.75.

OSC's Response

OSC found that for 3 of 188 claims, totaling $495 in reimbursement, Greater New Jersey billed for services using a higher reimbursed procedure code and/or modifier than appropriate, which resulted in Greater New Jersey receiving overpayments. Greater New Jersey conceded that two of the three claims were submitted in error, which inadvertently led to higher overpayments.

For the third claim, Greater New Jersey contended that it did not upcode but appropriately billed using the "U1" modifier to reflect the clinician's independent licensure. OSC rejects this justification. As set forth in N.J.A.C. 10:77-5.11(h) "[i]ntensive in-community services that are within the scope of a direct care staff person shall not be reimbursed at an increased rate, if delivered by a clinical staff person." In other words, although independently licensed professionals may deliver these services, they must still be billed at the lower rate applicable to the service level rendered. Additionally, Greater New Jersey contended that "[h]istorically, the billing system has included checks and balances to reject claims using a "U1" authorization where the system code noted "U2" authorization." In other words, Medicaid's billing system previously included checks to reject mismatched authorized claims, such as billing "U1" services when the authorization was for "U2", and that it relied on these system checks to catch discrepancies. However, reliance on Medicaid system edits does not absolve providers of responsibility for ensuring claims accuracy, and in this case, Greater New Jersey billed the service inaccurately but anticipated the billing system to reject the claim. Medicaid regulations require providers to certify that each claim submitted is true, accurate, and complete. In this case, Greater New Jersey submitted a claim that did not match the authorized service level. As such, OSC will not modify its audit findings.

g. Greater New Jersey's Objection: Failure to Document Services with a Progress Note

Greater New Jersey's Comments

Finally, the DAR states that for 1 of the 188 claims sampled, GNJCC failed to document services in a progress note. However, the DAR wholly ignores the evidence presented in GNJCC's August 2024 Letter establishing that the State's online Cyber system is rife with errors and glitches, which frequently result in progress notes previously uploaded to the system disappearing or becoming inaccessible. GNJCC uploads and maintains all its progress notes on the State's cyber online system; however, for unknown reasons these progress notes frequently disappear in the system. By way of example, GNJCC has included screenshots indicating that progress notes GNJCC uploaded to the cyber site, and which were accessible on January 1, 2023 have since become inaccessible without explanation. See Exhibit 3. Despite possessing timestamped proof that these progress notes were in fact submitted on January 1, 2023, GNJCC has been unable to access these progress notes as recently March 17, 2025, with the cyber system giving the appearance that none were submitted. Accordingly, the mere fact that the progress note at issue is unavailable in the cyber system and that OSC was unable to locate it during the audit does not necessarily mean that GNJCC never submitted it. Thus, GNJCC should face no repayment obligation due to glitches in the States' own cyber system.

OSC's Response

OSC found that for 1 of 188 claims, totaling $39 in reimbursement, Greater New Jersey failed to document services with a required progress note. Greater New Jersey attributed the

missing progress note to errors in the State's Cyber system and provided screenshots referencing an unrelated beneficiary's service date. However, these screenshots do not pertain to the claim at issue and do not demonstrate that a progress note ever existed for the service date in question. Additionally, Greater New Jersey failed to provide any other documentation, including an SDED form, to substantiate that the service was rendered. In the absence of any supporting documentation, OSC cannot validate the claim. As such, OSC will not modify its audit finding.