An Audit of Sokkyun Yi, An Intensive In-Community Mental Health Provider

MEDICAID FRAUD DIVISION REPORT

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Acting State Comptroller

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NEW JERSEY
OFFICE OF THE STATE
COMPTROLLER

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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 Sokkyun Yi (Yi), a licensed clinical social worker, for the period from September 21, 2016 through March 2, 2020 (audit period).

OSC's audit sought to determine whether Yi billed for intensive in-community mental health rehabilitation and behavioral assistance services in accordance with applicable state regulations. OSC randomly selected 37 service dates, representing 963 claims, and determined that 33 of the 37 sampled service dates, or 518 of the 963 claims (54 percent), failed to comply with state regulations. The 518 failed claims contained 704 total exceptions, as some claims failed for multiple reasons. OSC extrapolated the error dollars ($75,423) to the total population from which the sample was drawn, and calculated that Yi received an overpayment of at least $1,795,277.[1]

OSC's audit found numerous documentation deficiencies-- for example, forms that were missing pages, forms that contained inaccurate or conflicting information, and forms that were missing required signatures. In several instances, Yi billed for services that could not be substantiated, or "upcoded" claims-- billing for a higher-level, higher-cost service than what was actually provided. OSC also found several instances in which Yi improperly billed for travel time or billed for overlapping services (services performed by the same provider at the same time for different beneficiaries). OSC also found several instances in which Yi did not document services with a progress note. Lastly, OSC found that Yi failed to maintain documentation showing that he performed the necessary safety checks for those he employed. In several instances, he did not have documentation showing that the behavioral assistants (BA) he employed had required certifications, education, proof of age, criminal background checks and/or valid driver's licenses.

OSC seeks a total recovery from Yi of $1,795,277 and makes several recommendations to Yi for correcting the deficiencies identified in this report. Taken as a whole, OSC's findings present a troubling pattern of Yi failing to meet core regulatory requirements in a manner that not only led to him receiving overpayments, but also increased the risk that he employed unqualified providers which, in turn, increased the risk that his staff provided less than adequate quality of care.

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 children or young adults' level of functioning within the home and community. 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 otherwise negatively affect

[1] OSC can reasonably assert, with 90% confidence, that the total overpayment in the universe is at least $1,795,276.83 (7.14% precision) with the error point estimate as $1,933,234.65.

a person's ability to function. These services are provided within the context of an approved plan of care and are restorative or preventative in nature.

Yi, a licensed clinical social worker, located in Princeton, New Jersey, has participated in the Medicaid program as an intensive in-community mental health rehabilitation and behavioral assistance services provider since April 18, 2016. Yi billed the Medicaid program for such services under Healthcare Common Procedure Coding System (HCPCS) codes H0036 and H2014. For the sampled claims, Yi, using his Medicaid provider number, billed for services that he personally rendered as well as services rendered by other professionals with whom he contracted. Accordingly, references to Yi include services performed by Yi as well as those performed by other behavioral health professionals.[2]

III. Audit Objective, Scope, and Methodology

The objective of this audit was to evaluate claims billed by and paid to Yi to determine whether Yi billed these claims in accordance with applicable state regulations.

The scope of the audit was September 21, 2016 through March 2, 2020. 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 selected a probability sample of 37 service days representing 963 claims, totaling $200,776 paid to Yi, from a population of 1,164 service dates representing 25,350 claims totaling $5,192,149 paid to Yi under HCPCS codes H0036 and H2014.

OSC reviewed Yi's records related to 963 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), N.J.A.C. 10:49-9.8(b)(3), N.J.A.C. 10:49-9.8(b)(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), N.J.A.C. 10:77-4.9(g), N.J.A.C. 10:77-4.12(d)(3), -(5), N.J.A.C. 10:77-4.12(e)(6), N.J.A.C. 10:77-4.14(c)(1), N.J.A.C. 10:77-4.14(c)(2), N.J.A.C. 10:77-4.14(c)(4), N.J.A.C. 10:77-4.14(d)(1), N.J.A.C. 10:77-4.14(d)(2), N.J.A.C. 10:77-5.7(c), N.J.A.C. 10:77-5.7(d), N.J.A.C. 10:77-5.10(b), N.J.A.C. 10:77-5.12(d)(3), -(5), N.J.A.C. 10:77-5.12(e)(6), and N.J.A.C. 10:77-5.14(b).

IV. Discussion of Auditee Comments

The release of this Final Audit Report concludes a process during which OSC afforded Yi multiple opportunities to provide input regarding OSC's findings. Specifically, OSC provided Yi a Summary of Findings (SOF) and offered Yi an opportunity to discuss the findings at an exit conference. OSC and Yi, represented by counsel, held an exit conference during which the parties discussed OSC's findings in the SOF. After the exit conference, Yi provided OSC additional records. After considering Yi's submission, OSC provided Yi with a Draft Audit Report (DAR). Yi provided a formal response to the DAR, which is attached as Appendix M ("Yi's Response to Draft Audit Report").

[2] Yi's practice may be referred to hereafter as "Yi" or as "he/his."

In his response to the DAR, Yi provided a corrective action plan that referenced revised policies and procedures to address OSC's recommendations, but nonetheless objected to OSC's sampling and extrapolation methodology as well as the audit findings. Yi also failed to indicate whether he intended to repay the identified overpayment. OSC addresses each argument raised by Yi in Appendix N ("Yi's Comments and OSC's Responses").

V. Audit Findings

A. Yi Maintained Inaccurate and Incomplete Records

The Service Delivery Encounter Delivery (SDED) form is required by DCF to be completed by all intensive in-community and behavioral assistance services providers, and the form is available through the DCF website. DCF also provides detailed instructions to the providers on how to complete these necessary SDED forms. The purpose of the SDED form is to record and provide documentation for all encounters of intensive in-community and behavioral assistance services. The form is two pages. Page one 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. Page one also contains fields for service authorization information, as well as the name and license number of the clinical supervisor. Page two 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. This form must be accurately completed for every service encounter between a provider and beneficiary, and must be signed and dated by both the servicing provider who rendered the service and the beneficiary or their parent/legal guardian. In sum, the SDED form not only documents the services provided and frequency of such services, but also serves to ensure that appropriately credentialed providers rendered services.

OSC requested SDED forms (both pages) to determine whether Yi accurately completed and maintained required documentation for all intensive in-community and behavioral assistance provider encounters. OSC found that for 265 of the 963 sample claims, totaling $52,459 in reimbursement, Yi billed for services for which he failed to possess adequate documentation. The 265 failed claims contained 273 total exceptions.

- For 113 of the 273 exceptions, Yi failed to provide page one and/or page two of the SDED form for the sampled dates of service.

- For 55 of the 273 exceptions, Yi provided SDED forms that were missing signatures of the servicing providers attesting that the services were rendered.

- For 105 of the 273 exceptions, Yi submitted SDED forms on which the service delivery date noted on page two was outside of the prior authorization date (start and end date) specified on page one of the SDED form.

Recording correct prior authorization information on page one is important because, when compared to the service delivery date on page two, it 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. Additionally, by affixing a signature, the servicing provider attests that the provider delivered the services. OSC determined that, taken together, Yi's SDED documentation was deficient because OSC could not determine whether the information contained on page one properly belonged to the document identified as the corresponding page two, and whether the attestations on page one properly related to the service delivery date captured on page two of the form. For example, page one of an SDED form noted that the prior authorization date range was February 15, 2019 (start date) through April 21, 2019 (end date). However, the service date noted on page two was July 29, 2019, which occurred more than three months after the specified date range, thus making the SDED form unreliable. In sum, based on these issues, OSC determined that for these 265 claims, Yi's SDED forms were not a reliable basis to support the claims.

By failing to maintain appropriate records, Yi violated N.J.A.C. 10:49-9.8(a) and N.J.A.C. 10:49-9.8(b)(1).

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 [.]"

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 [.]"

B. Yi Billed Unsubstantiated Services

OSC reviewed records to determine whether Yi maintained proper documentation for services billed to Medicaid. OSC found that for 311 of the 963 sample claims, totaling $28,468 in reimbursement, Yi billed for services for which he failed to possess accurate documentation. Specifically, the hours of service on the SDED form conflicted with hours billed and paid. For example, one SDED form documented that one servicing provider rendered services on May 1, 2019, from 5:00 PM to 6:00 PM (one hour), but Yi billed Medicaid for two hours and thirty minutes for the same service, a difference of one hour and thirty minutes.

By failing to maintain appropriate records, Yi violated N.J.A.C. 10:49-9.8(a) and N.J.A.C. 10:49-9.8(b)(1).

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."

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[.]"

C. Yi Upcoded Services Provided

For each Medicaid beneficiary receiving intensive in-community services, the provider must perform a needs assessment and clinical evaluation to determine the level and type of service that is medically necessary to address the identified issues. Intensive in-community services include three different levels of service: supportive services, professional services, and clinical services. Similarly, for those in need of behavioral assistance services, the provider must develop a service plan based on an evaluation of the beneficiary's needs. From that plan, the provider must obtain prior authorization to bill specific services.

OSC reviewed Yi's records to determine whether he billed for services at the appropriate level using the proper billing procedure code. OSC found that for 18 of the 963 claims, totaling $1,246 in reimbursement, Yi billed for services using a higher reimbursed procedure code and/or modifier than appropriate, which resulted in Yi receiving overpayments. For example, on October 18, 2018, a licensed social worker rendered service to a Medicaid beneficiary who was prior authorized to receive clinical services (clinical level), a higher level service than the service provided by the licensed social worker. Yi billed this encounter as a clinical level service even though the person who performed the service was a licensed social worker. Such billing resulted in Yi receiving the highest reimbursement amount for the lowest level of services actually provided.

By billing an inappropriate level of services and/or by upcoding, for these claims, Yi violated N.J.A.C. 10:49-9.8(a).

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."

Further, 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[.]"

D. Yi Billed for Services Provided to Different Beneficiaries at the Same or Overlapping Times

State Medicaid regulations regarding intensive in-community mental health and behavioral assistance services require providers to maintain true, accurate and complete records for each encounter documenting the name and address of the beneficiary; the exact date, location and time of service; the type of service; and the length of face-to-face contact time. This information is contained in the SDED form. As discussed above, this two-page form, which must be signed and dated both by the servicing provider who rendered the service, and the beneficiary or their parent/legal guardian, must be completed for every service encounter between a provider and beneficiary.

OSC reviewed Yi's records, including the SDED forms, to determine whether Yi sufficiently documented the services rendered. Specifically, OSC compared the encounter dates and times recorded on the SDED forms to determine if claims overlapped in time. OSC found that for 9 of the 963 sample claims, totaling $921 in reimbursement, Yi billed for services provided by the same servicing provider to several beneficiaries at the same or overlapping time(s). For example, one SDED form documented that one servicing provider rendered services on April 30, 2019 from 2:30 PM to 5:00 PM. A second SDED form for that same date documented that the same servicing provider provided services to a different Medicaid beneficiary from 2:30 PM to 5:00 PM, resulting in an overlap of the entire encounter for two hours and thirty minutes (2:30 PM to 5:00 PM).

By improperly billing for overlapping services, Yi violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:77-4.12(d)(3), -(5), and N.J.A.C. 10:77-5.12(d)(3), -(5).

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."

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[.]"

Pursuant to N.J.A.C. 10:77-4.12(d)(3), -(5) and N.J.A.C. 10:77-5.12(d)(3), -(5), providers shall maintain documentary support of all behavioral assistance services and intensive in-community mental health rehabilitation services claims including "[t]he exact date(s), location(s) and time(s) of service." In addition, these provisions state that providers must maintain documentary support for "[t]he length of face-to-face contact [time], excluding travel time to or from the location of the beneficiary contact."

E. Yi Improperly Billed for Travel Time

OSC reviewed records to determine whether Yi improperly billed for travel time that was included within the length of face-to-face time that the servicing provider interacted with the beneficiary. OSC found that for 24 of the 963 claims, totaling $707 in reimbursement, Yi improperly billed for travel time to and/or from the location of the beneficiary as part of his billing for face-to-face services. For example, one SDED form documented that one servicing provider rendered services to a beneficiary on August 22, 2018 from 9:00 AM to 11:00 AM. A second SDED form for that same date documented that the same servicing provider rendered services to a different beneficiary from 11:00 AM to 1:00 PM. According to Google Maps, the two service encounter locations were 40.6 miles apart, requiring approximately 40 minutes of travel time. In that instance, Yi improperly billed travel time as part of his face-to-face services and, as such, did not account for any time needed for travel.

By improperly billing for travel time for the services provided, Yi violated N.J.A.C. 10:49-9.8(a), N.J.A.C. 10:77-4.12(d)(3), -(5), and N.J.A.C. 10:77-5.12(d)(3), -(5).

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

Pursuant to N.J.A.C. 10:77-4.12(d)(3), -(5) and N.J.A.C. 10:77-5.12(d)(3), -(5), providers shall maintain support of all behavioral assistance services and intensive in-community mental health rehabilitation services claims including "[t]he exact date(s), location(s) and time(s) of service." In addition, these provisions state that providers must maintain support for "[t]he length of face-to-face contact, excluding travel time to or from the location of the beneficiary contact."

F. Yi Failed to Document Services with Progress Notes

For both intensive in-community mental health rehabilitation and behavioral assistance services, the servicing provider must document services provided through progress notes. These notes provide relevant information regarding the treatment provided, the beneficiary's response to the treatment, significant events that may affect the beneficiary's condition or treatment, and other information pertinent to the beneficiary's plan of care. The progress note differs from the SDED form in that the servicing provider completes the progress note, whereas the parent/guardian signs the SDED as an attestation as to the session's date, duration, and location.

OSC reviewed Yi's records to determine whether Yi maintained progress notes that supported his billed services. OSC found that for 37 of the 963 claims, totaling $7,697 in reimbursement, Yi failed to document services with a progress note.

By failing to maintain appropriate records for these claims, Yi 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."

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[.]"

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."

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."

G. Yi Failed to Maintain Behavioral Assistance Training Certification for Behavioral Assistants

Pursuant to state regulations, intensive in-community mental health rehabilitation and behavioral assistance service providers must maintain written documentation showing that their Behavioral Assistants (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. To be eligible to work as a BA, each BA must obtain the certification no

later than six months after the BA's hire date, and every BA must be recertified annually thereafter in order to continue providing BA services. Providers are responsible for verifying and maintaining evidence that their BAs obtained their certifications.

OSC requested that Yi provide the Behavioral Assistance Training Certifications for each BA in OSC's sample claim to determine whether Yi satisfied the requirement that he verified and maintained this documentation. OSC found that Yi allowed 4 of 15 BAs in the audit sample selection to provide behavioral assistance services to beneficiaries without having obtained the required certification within six months from their hire date. Specifically, OSC found that Yi allowed untrained BAs to provide behavioral assistance services and inappropriately billed for 10 of the 963 claims, totaling $1,024 in reimbursement. For example, for three BAs, who accounted for 8 of the 963 claims, totaling $790 in reimbursement, Yi failed to provide any supporting documentation that he ever obtained the required Behavioral Assistance Training Certifications. Further, for the remaining BA, who accounted for 2 claims, totaling $234 in reimbursement, Yi did not provide documentation demonstrating the BA was certified on the date of service.

By failing to obtain such certificates within six months of hire date and re-certifications annually thereafter, Yi 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."

H. Yi Failed to Maintain Proof of Education for Behavioral Assistants

According to state regulations, to perform behavioral assistance services, a BA must have, at a minimum, a high school diploma or equivalent. A Provider must verify and maintain proof that BAs satisfy this educational requirement.

OSC requested that Yi provide copies of high school diplomas or equivalents for each BA to determine whether qualified individuals performed services and to determine whether Yi possessed proof that these BAs had satisfied the minimum educational requirement. OSC found that Yi lacked the requisite documentation for 6 of the 15 BAs in the audit sample selection, which accounted for 19 of the 963 claims, totaling $1,940 in reimbursement.

By not obtaining and maintaining proof of education, Yi violated N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)(1).

Pursuant to N.J.A.C. 10:77-4.9(e), "[a]ll direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter."

Pursuant to N.J.A.C. 10:77-4.14(c)(1), the provider must maintain "[a] copy of the direct care staff person's high school diploma or equivalent."

I. Yi Failed to Maintain a Criminal Background Check for a Behavioral Assistant Prior to Rendering Services

Pursuant to state regulations, intensive in-community mental health rehabilitation and behavioral assistance service providers must ensure that successful background checks are performed on employees who have direct contact with or render behavioral assistance services to beneficiaries. State regulations further require providers to maintain evidence that a "recognized and reputable" entity successfully completed these criminal background checks.

OSC requested documentation to determine whether Yi maintained evidence of successfully completed criminal background checks for each BA prior to the BA providing services to beneficiaries. OSC found that Yi allowed one BA in the audit sample to provide behavioral assistance services to beneficiaries prior to obtaining a criminal background check for the BA. Specifically, OSC found that Yi billed for behavioral assistance services for 1 of the 963 claims, totaling $78 in reimbursement, without having first obtained a criminal background check.

By failing to obtain a successful criminal background check before his employee provided services to Medicaid beneficiaries, Yi 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."

J. Yi Failed to Maintain a Current and Valid Driver's License for a Behavioral Assistant

Behavioral assistance services provided to beneficiaries, up to 21 years of age, often occur outside of their place of residence, in playgrounds and in other in-community settings. For such services, BAs may drive beneficiaries to the service location. As such, state regulations require all BAs to have a current and valid driver's license and require providers to maintain a copy of each BA's valid driver's license.

OSC requested documentation to determine whether Yi maintained a copy of each BA's current and valid driver's license. OSC found that for 1 BA in the audit sample, which accounted for 1 of the 963 claims, totaling $78 in reimbursement, Yi failed to maintain a copy of a BA's current and valid driver's license.

By failing to maintain a copy of a current and valid driver's license, Yi violated N.J.A.C. 10:77-4.9(f) and N.J.A.C. 10:77-4.14(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.

K. Yi Failed to Maintain Proof of Minimum Age Documentation for a Behavioral Assistant

Pursuant to state regulations, a BA must be at least 21 years old to perform behavioral assistance services. OSC found that for 1 BA in the audit sample, which accounted for 1 of the 963 claims, totaling $78 in reimbursement, Yi failed to maintain proof of age for a BA performing services.

By failing to maintain the proof of age, Yi violated N.J.A.C. 10:77-4.9(e) and N.J.A.C. 10:77-4.14(c)(2).

Pursuant to N.J.A.C. 10:77-4.9(e), "[a]ll direct care staff shall, at a minimum, have a high school diploma or equivalent, be 21 years old and have a minimum of one year relevant experience in a comparable environment and shall be supervised by appropriate clinical staff in accordance with this subchapter."

Pursuant to N.J.A.C. 10:77-4.14(c)(2), "[f]or the direct care staff employed by the agency, the following information shall be maintained: . . . 2. A copy of the direct care staff person's proof of age at the date of hiring."

L. Summary of Medicaid Overpayment

OSC determined that from its audit of 37 randomly selected service dates for the period from September 21, 2016 through March 2, 2020, Yi billed 33 service dates that contained errors. Yi improperly billed and received payment for 518 of the 963 sample claims, totaling $75,423 in reimbursement. These 518 failed claims contained 704 total exceptions, as some claims failed for multiple reasons. To ascertain the overpayment Yi received, OSC extrapolated the error dollars ($75,423) for the 33 service dates, or 518 unique claims that failed to comply with applicable regulations, to the total population from which the sample service dates were drawn, which in this case was 1,164 service dates, or 25,350 claims, with a total payment amount of $5,192,149. From this extrapolation, OSC calculated that Yi received an overpayment of at least $1,795,277 that he must repay to the Medicaid program.[3]

[3] See Footnote 1.

VI. Recommendations

Yi shall:

1. Reimburse Medicaid the overpayment amount of $1,795,277.

2. Adhere to state regulations for all Medicaid services provided by Yi and the health care professionals he employs.

3. Obtain and maintain required documentation for each behavioral assistant (i.e., successfully completed criminal background checks, valid driver's licenses, proof of education and proof of age) before behavioral assistants are assigned any case referrals, to ensure compliance with state regulations.

4. Ensure that all professionals employed by Yi receive training to foster compliance with applicable state regulations.

5. Provide OSC with a Corrective Action Plan indicating the steps Yi will take to implement procedures to correct the deficiencies identified herein.

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April 28, 2023

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Medicaid Fraud Division
P.O. Box 0025
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Re: Draft Audit Report: Sokkyun Yi, LCSW, Medicaid Provider Number [redacted].

Dear Mr. Morgese:

This office represents Sokkyun Yi with respect to this matter. Please accept the following in response to the Draft Audit Report provided by your office on March 31, 2023.

INTRODUCTION

Mr. Yi has provided behavioral services to clients for several years through his company, Family First Counseling Services. Throughout the years, Mr. Yi has provided these services through behavioral assistants who have contracted with Mr. Yi. During the entirety of his practice, Mr. Yi has not received any complaints from his clients and has served and improved the lives of numerous struggling children. Mr. Yi hopes to resolve the issues identified here and continue providing the high quality of service to his clients as he has for several years.

RESPONSE

I. MR. YI OBJECTS TO THE METHODS BY WHICH EXTRAPOLATION WAS APPLIED IN THE DRAFT AUDIT REPORT

Mr. Yi objects to the sampling method and proposed extrapolation. As a preliminary matter, the Draft Audit Report does not explain the process used to identify the appropriate size of the sample, how the sample days were selected, nor the steps taken to ensure that the sample was representative of the universe 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.

There are, however, several issues that raise concerns about the validity of the sampling and the legitimacy of the extrapolations made from the sample. In order for extrapolation to be valid, the sample size must be reasonably representative of the universe of claims. Here, there are issues that call into question the validity of the sampling and the conclusions drawn

therefrom. In the sample there are 37 service dates with 963 claims, or 26 claims per day. In the entire universe there are 25,350 claims over 1,164 service dates or approximately 21 claims per day. This means that the average day in the universe has 20% fewer claims than the days in the sample. The average sample day is erroneously not representative of the average universe day. Looking at a sample with more claims than average raises many issues, including whether the existence of the high level of claims in any given day has erroneously led to a greater number of exceptions.

There is also a large variance between the observed errors as a percentage of claims related to a legitimate percentage of dollars received. While the observed claims errors of 518, or 54% of the claims may seem high, the actual dollar amount of error was only 37.5 percent of the sample. This suggests that the error rate itself was not representative of the actual errors, but that perhaps the errors were more likely to occur with smaller claims. There was no showing that the variance in claim size in the sample was similar to the universe as a whole and this raises questions as to the appropriateness of extrapolation.

As will also be discussed below, it appears that the providers in this sample were not distributed evenly among the claims. Rather, nearly forty percent of the providers accounted for only two percent of the claims in the sample. This suggests that the remaining sixty percent of providers are exerting an outsized influence on the sample. The Draft Audit Report does not explain whether any analysis was undertaken to determine if the providers in the sample appeared in the same proportion in the universe of claims. Nor does it appear that any analysis was done to determine if any error rates correlate with any particular provider, which might invalidate the sample and any extrapolation. Because the inconsistencies in the sample raise questions about its representativeness extrapolation of the data appears inappropriate.

Further, the relatively low financial error rate suggests that extrapolation is inappropriate because it does not evidence a continuing and high rate of error. While the Medicare system has propagated rules that only permit extrapolation when an error rate is above 50%, the OSC has proffered no similar standard for when extrapolation is inappropriate. Here, the financial error rate was substantially below 50%. Accordingly, absent explanation from OSC, it appears that extrapolation under such circumstances is statistically unsupported and inappropriate.

II. MR. YI OBJECTS TO DETERMINATIONS THAT SPECIFIC ERRORS ARE REASONABLE TO INCLUDE IN ANY EXTRAPOLATION.

A. Mr. Yi Maintained Inaccurate and Incomplete Records

In the sample set OSC identified 265 instances in the 963 claims where it asserts that Mr. Yi failed to maintain accurate and complete records. This relates specifically to the maintenance of a two-page SDED form. Nearly half of those exceptions resulted from Mr. Yi's inability to locate both pages of the two-page form. The majority of others resulted from service dates on the forms which were outside of the prior authorization date. There is no allegation, however, that the claim is otherwise improper or that the service was not performed. Mr. Yi believes that the claims are valid, even if the SDED form could not be located at the time of the audit and that only authorized services were performed. These claims should not form the basis for any extrapolated repayment amount.

B. Mr. Yi Billed for Unsubstantiated Services

In the sample of 963 claims, OSC determined that slightly less than one-third of those claims included billing errors in which the time billed did not match the hours of service on the SDED form. These were coding errors due to the high volume of claims. Mr. Yi does not dispute the accuracy of the finding, but that does not render the extrapolation appropriate. The idiosyncratic nature of the errors, and the relatively low percentage of errors compared to the sample size, contribute to the illegitimacy of the conclusions drawn from the data.

C. Mr. Yi Upcoded Services Provided

In the sample of 963 claims, OSC determined that in 18 instances, or 1.9% of claims services were upcoded to services with a higher reimbursement rate. These were inadvertent coding mistakes attributable to human error. Mr. Yi does not dispute their accuracy. However, Mr. Yi disputes that such a small error rate is suitable for extrapolation to the entire universe of claims.

D. Mr. Yi Billed for Services Provided to Different Beneficiaries at the Same or Overlapping Times

In the sample of 963 claims, OSC identified 9 instances where Mr. Yi billed for overlapping time for the work of the same servicing provider. These instances represent less that one percent of the claims in the sample. While the billed time overlaps with the information on the SDED forms, Mr. Yi disputes that any of the billed work was not provided. These errors almost certainly arose from incorrect dating on either the SDED form or on the claim itself. There is no suggestion that the billed services were not actually provided, and Mr. Yi maintains that they were in fact provided. Additionally, only nine instances is too few to support extrapolation to the entirety of claims.

E. Mr. Yi Improperly Billed for Travel Time

OSC identified 24 instances in the sample where it believes Mr. Yi billed for travel time for his providers. Mr. Yi disputes this determination. The OSC assumes travel time where a provider provided services to two different clients in two different locations, but in a time frame that does not permit for travel. This method is flawed. There are numerous typographic and practical issues that could result in an incorrect determination. As with Item D above, an incorrectly dated SDED form suggests the need for travel time that was not actually present if the encounters occurred on different days. Similarly, the encounter might have occurred in a public location where the provider might have met with clients one after the other without the need to travel, despite different locations inadvertently listed on the SDED form. Mr. Yi disputes that he billed for any travel time for his providers. Likewise, only 24 instances, less than 3% of the sample in insufficient to support an extrapolation.

F. Mr. Yi Failed to Document Services with Progress Notes

The OSC determined that for 37 claims out of the sample no progress note was recorded. Again, there is no suggestion that the services were not provided. Rather, Mr. Yi was unable to locate the progress notes for those instances. As previously discussed, the incorrect dating of such a note, or inadvertent mislabeling otherwise would render the note difficult to find and

identify, but the services in question still occurred. Mr. Yi disputes this purported error for that reason. Additionally, an error rate of 37 claims representing less than 4% of the sample is inappropriate for extrapolation.

G. Mr. Yi Failed to Maintain Behavioral Assistance Training Certification for Behavioral Assistants

The OSC identified 10 claims from four behavioral assistants where Mr. Yi failed to provide certifications of appropriate training for the assistants. This small number is not evidence of a trend, but an aberrant result. Despite identifying over one quarter of the providers in the sample as not having certification, these four providers only accounted for 1% of the claims in the sample. This shows that any improper provision of services by these providers was inadvertent and should not be the basis for any extrapolation to the greater set of claims. Additionally, there is no assertion or information that suggests that the assistants identified were insufficiently trained, nor that they provided any services that fell below the accepted standards for such assistants.

H. Mr. Yi Failed to Maintain Proof of Education for Behavioral Assistants

The OSC identified 19 claims from six behavioral assistants out of the sample where Mr. Yi failed provide proof of education. As with the objection to Item G, the small numbers here suggest an anomaly, not a trend. Here forty percent of the behavioral assistants in the sample account for only two percent of the claims. This again suggests a brief tenure and provides a reason that any such documentation may have been inadvertently lost. Further, the very low percentage in question suggests that extrapolation is not appropriate. In any event, Mr. Yi disputes that any of the assistants did not have the necessary education for the position, and that all assistants provided the appropriate levels of service to their clients.

I. Mr. Yi Failed to Maintain a Criminal Background Check for a Behavioral Assistant Prior to Rendering Services

J. Mr. Yi Failed to Maintain a Current and Valid Driver's License for a Behavioral Assistant

K. Mr. Yi Failed to Maintain Proof of Minimum Age Documentation for a Behavioral Assistants

Issues I, J, and K raised by the OSC all arise from one service provider accounting for one claim out of the entire sample. The behavioral assistant only briefly worked for Mr. Yi and left soon after. There is no indication that the behavioral assistant did not meet any of the standards required, and Mr. Yi contends that she did meet all necessary criteria. In any event, one instance is not a trend to extrapolate but an aberration. It is not likely that the one individual was anything but a one off occurrence with respect to a short lived employee. One such instance should not form the basis for extrapolation to a larger pool.

III. MR. YI'S CORRECTIVE ACTION PLAN

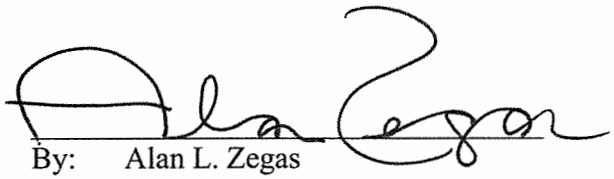
As the OSC has identified issues during the course of this audit, Mr. Yi has revised the policies and procedures for his business. These revised policies have been implemented to address the deficiencies identified by the Draft Audit Report. Mr. Yi's adoption of the revised policies in the corrective action plan are in no way an admission of wrong doing, or agreement

with the audit procedures or conclusions. The new policies adopted to address the concerns raised by the Draft Audit Report are attached hereto as Exhibit A.

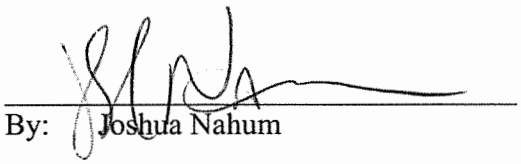
CONCLUSION

Mr. Yi disputes the findings in the Draft Audit Report. That said, Mr. Yi does recognize that errors in any busy organization do occur. Mr. Yi would like to continue discussions with the OSC to resolve its concerns and continue providing health care services to communities desperately in need of them.

Respectfully submitted,
LAW OFFICES OF ALAN L. ZEGAS



By: Alan L. Zegas



By: Joshua Nahum

OSC Note - Exhibit A was omitted to maintain confidentiality

Yi's Comments and OSC's Responses

Yi, through counsel, submitted a response to the Draft Audit Report (DAR) that took issue with OSC's sampling and extrapolation methodology as well as the audit findings. Yi also provided OSC with a corrective action plan, but did not address whether he would repay the identified overpayment. OSC summarizes each comment and provides a response to each below. Upon review of Yi's objections, OSC did not find any basis to revise its extrapolation or audit results.

I. Yi's Objections to the Extrapolation Methods Used in the DAR

Yi's Comment

"Mr. Yi objects to the sampling method and proposed extrapolation. As a preliminary matter, the Draft Audit Report does not explain the process used to identify the appropriate size of the sample, how the sample days were selected, nor the steps taken to ensure that the sample was representative of the universe 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."

OSC's Response

OSC's DAR, which OSC sent to Yi for review and formal response, included a Random Sampling and Extrapolation file (RS&E file) that contained all of the information Yi needed to review, reproduce, and validate OSC's statistical sample and extrapolation. Specifically, the RS&E file contained a Sampling Plan that referenced the software utilized for sample size calculations (RAT-STATS), the variables used to calculate the sample sizes at the probe and full sample stages, and the sample sizes that were selected. The Sampling Plan also explained how the sample days were selected. Furthermore, using the referenced software, RAT-STATS, and the seed numbers provided, Yi could have replicated the exact sample. Finally, using the information provided, Yi could have verified that the sample was representative of the universe. OSC ensures the sample is representative of the universe by using statistical sampling. The process of selecting a statistical sample, from choosing an appropriate sampling design and sample sizes to the random selection of sampling units, provides assurance that a representative sample is selected in terms of the characteristic of interest.

Here, the characteristic of interest is the paid amounts at the sampling stage, since the error dollars are not known until after the sample is selected and reviewed. OSC verifies that the paid amounts in the sample are comparable to the universe by using hypothesis testing (i.e., t-tests, f-tests, chi-square tests, etc.). OSC also extrapolates the paid amounts in the sample to confirm that the total universe dollars are captured in the confidence intervals. These tests and checks combine to provide further support that the sample is representative of the universe.

Yi's Comment

"In order for extrapolation to be valid, the sample size must be reasonably representative of the universe of claims."

OSC's Response

Sample size, by itself, is not what determines the validity of an extrapolation. The validity of an extrapolation is determined by numerous factors, most notably the extrapolation method utilized. Sample size, does however impact the precision of the extrapolation. Accordingly, OSC properly utilized the error dollars from the probe sample to determine the full sample size necessary to achieve a suitable precision level.

Yi's Comment

"In the sample there are 37 service dates with 963 claims, or 26 claims per day. In the entire universe there are 25,350 claims over 1,164 service dates or approximately 21 claims per day. This means that the average day in the universe has 20% fewer claims than the days in the sample. The average sample day is erroneously not representative of the average universe day. Looking at a sample with more claims than average raises many issues, including whether the existence of the high level of claims in any given day has erroneously led to a greater number of exceptions."

OSC's Response

Given the variance of the service dates in the universe, for both dollars and claims, OSC appropriately utilized a stratified cluster sampling design. The purpose of stratifying is to separate the service dates into homogenous groups, which subsequently reduces variance within each stratum. Using this approach, one can determine whether the average number of claims in a sample is representative of the average claims in the universe, by comparing the mean, or average, in each stratum to the universe.

Stratum	Universe Claim Average	Sample Claim Average	|Difference|
S1	5.11	5.44	0.33
S2	16.09	15.56	0.54
S3	31.03	31.20	0.17
S4	49.59	51.33	1.75
Total	**21.78**	**26.03**	**4.25**

From the above chart, one can visually confirm that the sample means in each stratum are comparable to the universe means. Using a t-test, OSC verified that there was no evidence that the means differed significantly in each stratum. Taking it one step further, OSC applied the t-test to the overall sample and universe averages that Yi argues is "erroneously not

representative." The conclusion of this test was the same – that there is no evidence that the means differ significantly.

With that being said, the average claims per service date was not a characteristic of interest in the sample and is not the variable that needs to be representative of the universe. However, by selecting a statistical sample, the average claims per day were still well represented.

Yi's Comment

"There is also a large variance between the observed errors as a percentage of claims related to a legitimate percentage of dollars received. While the observed claims errors of 518, or 54% of the claims may seem high, the actual dollar amount of error was only 37.5 percent of the sample. This suggests that the error rate itself was not representative of the actual errors, but that perhaps the errors were more likely to occur with smaller claims. There was no showing that the variance in claim size in the sample was similar to the universe as a whole and this raises questions as to the appropriateness of extrapolation."

OSC's Response

The difference between the claim error rate and the dollar error rate is due to partial credit being provided for claims where an incorrect number of units or an incorrect procedure code was billed. Accordingly, the difference between the two error rates has no impact on the validity of the sample or the results of the extrapolation.

Yi then suggests that "perhaps the errors were more likely to occur with smaller claims," which is also incorrect. As one can verify through the RS&E file that OSC provided to Yi along with the DAR, the recovery summary tab shows that the error rates increase in each stratum from one to four. Specifically, the first stratum (S1), which contains the service dates with the lowest dollars, only has an error rate of 16.96%, whereas the fourth stratum (S4), which contains the service dates with the highest dollars, has an error rate of 42.33%. This data demonstrates that Yi's assertion regarding the import of the variance between the error rates and dollars in error is incorrect.

Yi's Comment

"As will also be discussed below, it appears that the providers in this sample were not distributed evenly among the claims. Rather, nearly forty percent of the providers accounted for only two percent of the claims in the sample. This suggests that the remaining sixty percent of providers are exerting an outsized influence on the sample. The Draft Audit Report does not explain whether any analysis was undertaken to determine if the providers in the sample appeared in the same proportion in the universe of claims. Nor does it appear that any analysis was done to determine if any error rates correlate with any particular provider, which might invalidate the sample and any extrapolation. Because the inconsistencies in the sample raise questions about its representativeness extrapolation of the data appears inappropriate."

OSC's Response

No analysis was done to determine the "servicing providers in the sample" since that was not a relevant variable or characteristic of interest. Therefore, the natural proportion of servicing providers in the universe would be represented in the sample since that variable was not controlled. In other words, if a provider had a low number of claims in the universe for a particular stratum, then a low (or even zero) number of claims would be expected in the sample for that particular stratum. On the other hand, if a provider had a high number of claims in the universe for a particular stratum, then a large number of claims would be expected in the sample for that stratum.

Additionally, OSC does not have access to the "servicing providers in the sample" data until after the sample is drawn. That information, which is submitted by Yi as part of its billing, does not appear in the Servicing Provider fields in OSC's data. Yi is listed as the billing and the servicing provider for all claims.

Yi's Comment

"Further, the relatively low financial error rate suggests that extrapolation is inappropriate because it does not evidence a continuing and high rate of error. While the Medicare system has propagated rules that only permit extrapolation when an error rate is above 50%, the OSC has proffered no similar standard for when extrapolation is inappropriate. Here, the financial error rate was substantially below 50%. Accordingly, absent explanation from OSC, it appears that extrapolation under such circumstances is statistically unsupported and inappropriate."

OSC's Response

This argument is not supportable for many reasons. First, more than half of the claims in the sample were found to be in error (518 of 963), which is, by any professional definition, "a continuing and high rate of error."

Second, Yi states, "the Medicare system has propagated rules that only permit extrapolation when an error rate is above 50%." Since Yi does not specifically state what the "propagated rules" are for the "Medicare system", MFD is assuming that Yi is referring to the Centers for Medicare and Medicaid Services (CMS) Medicare Program Integrity Manual (MPIM). Although the MPIM previously referenced a 50% suggested error rate threshold, the current MPIM does not contain such a suggested threshold (Rev. 11797, 01-19-23). Moreover, it is worth emphasizing that the prior versions only listed the 50% error rate as a possible threshold, not a firm rule.

Third, while OSC agrees with much of the current CMS MPIM, OSC does not follow, and is not bound by, the procedures outlined in the manual. The MPIM was created for CMS contractors and thus has no controlling authority over OSC's oversight of the New Jersey Medicaid program.

Last, and perhaps most importantly, there is no rule in statistics that establishes a threshold error rate that must be met to extrapolate. Therefore, any argument that OSC's extrapolation is "statistically unsupported and inappropriate" based on the error rate is unsupportable.

II. Yi's Objections to OSC Including Specific Errors In Its Extrapolation

OSC's Response

In Section II, A through K below, Yi repeatedly states that extrapolating a particular error is inappropriate because the identified error only occurs a small percentage of times in the sample. In essence, Yi highlights each of these errors as if it occurred in a vacuum, and that OSC is performing separate extrapolations for each. Yi's position is not supported by the principles underlying OSC's extrapolation approach.

Contrary to Yi's assertion, an extrapolation does not project the number of times a particular error reason could be found in the universe. Rather, the goal of an extrapolation is to determine the total overpayment for a given universe of claims, which is accomplished by determining the error dollars and projecting that figure to the universe. To perform this analysis, OSC must review the entire sample, determine the error dollars associated with each sampling unit, and then collectively extrapolate all error dollars identified in the sample back to the universe, which is exactly what OSC did in this case.

Yi's Comment Regarding Audit Finding A – Maintained Inaccurate and Incomplete Records

"In the sample set OSC identified 265 instances in the 963 claims where it asserts that Mr. Yi failed to maintain accurate and complete records. This relates specifically to the maintenance of a two-page SDED form. Nearly half of those exceptions resulted from Mr. Yi's inability to locate both pages of the two-page form. The majority of others resulted from service dates on the forms which were outside of the prior authorization date. There is no allegation, however, that the claim is otherwise improper or that the service was not performed. Mr. Yi believes that the claims are valid, even if the SDED form could not be located at the time of the audit and that only authorized services were performed. These claims should not form the basis for any extrapolated repayment amount."

OSC's Response

Yi's assertion that because the claims at issue are "valid" he has met the regulatory requirements is inaccurate. Yi provides no factual basis for his argument. OSC provided Yi multiple opportunities spanning the duration of this audit to produce required SDED forms, yet he could not and many of the SDED forms he did provide were incomplete and inaccurate. Based on these identified deficiencies, OSC found that Yi failed to maintain true, accurate, and complete records necessary to disclose the full extent of services provided. Yi's response herein does not provide any basis for OSC to modify these findings.

Yi's Comment Regarding Audit Finding B – Yi Billed for Unsubstantiated Services

"In the sample of 963 claims, OSC determined that slightly less than one-third of those claims included billing errors in which the time billed did not match the hours of service on the SDED form. These were coding errors due to high volume of claims. Mr. Yi does not dispute the accuracy of the finding, but that does not render the extrapolation appropriate. The idiosyncratic nature of the errors, and the relatively low percentage of errors compared to the sample size, contribute to the illegitimacy of the conclusions drawn from the data."

OSC's Response

Yi does not dispute OSC's finding that Yi billed for services that were not reflected in Yi's SDED forms for almost a third of the sampled claims, yet he attempts to minimize this finding by stating that it was "due to high volume of claims." That excuse is not valid because there is no exception in the Medicaid program, based on the volume of claims submitted or otherwise, that allows a provider to submit deficient claims. Yi then argues that OSC should discount this finding because his almost 33 percent error rate constitutes a "relatively low percentage of errors compared to the sample size…." This position is at odds with any objective understanding of an acceptable error rate for health care claims. Moreover, Yi's position fails to address the core Medicaid program requirement that applies to all providers – the requirement to submit and maintain true, accurate, and complete records for claims. Finally, as explained above, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding C – Yi Upcoded Services Provided

"In the sample of 963 claims, OSC determined that in 18 instances, or 1.9% of claims services were upcoded to services with a higher reimbursement rate. These were inadvertent coding mistakes attributable to human error. Mr. Yi does not dispute their accuracy. However, Mr. Yi disputes that such a small error rate is suitable for extrapolation to the entire universe of claims."

OSC's Response

Yi does not dispute that he inappropriately billed services using a higher reimbursement rate (upcoding), which resulted in Yi receiving overpayments. Rather, Yi attributes such mistakes to human error and disputes that this error rate is suitable for extrapolation. As explained above, Yi was required to maintain and submit true, accurate, and complete records for claims, but failed to do so. Moreover, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding D – Yi Billed for Services Provided to Different Beneficiaries at the Same or Overlapping Times

"In the sample of 963 claims, OSC identified 9 instances where Mr. Yi billed for overlapping time for the work of the same servicing provider. These instances represent less that one percent of the claims in the sample. While the billed time overlaps with the information on the SDED forms, Mr. Yi disputes that any of the billed work was not provided. These errors almost certainly arose from incorrect dating on either the SDED form or on the claim itself. There is no suggestion that the billed services were not actually provided, and Mr. Yi maintains that they were in fact provided. Additionally, only nine instances is too few to support extrapolation to the entirety of claims."

OSC's Response

OSC's review of Yi's records, including the SDED forms, identified nine instances where Yi billed for services provided by the same servicing provider to several beneficiaries at the same or overlapping time(s). In short, Yi's own documentation showed that these claims were insupportable. Yi now attempts to explain the nine failed claims as errors that "almost certainly arose from incorrect dating on either the SDED form or on the claim itself." Yi offered no evidence that would dispute OSC's determination. In fact, Yi acknowledges that the "billed time overlaps with information on the SDED forms," which is what OSC found. Finally, as stated above, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding E – Yi Improperly Billed for Travel Time

"OSC identified 24 instances in the sample where it believes Mr. Yi billed for travel time for his providers. Mr. Yi disputes this determination. The OSC assumes travel time where a provider provided services to two different clients in two different locations, but in a time frame that does not permit for travel. This method is flawed. There are numerous typographic and practical issues that could result in an incorrect determination. As with Item D above, an incorrectly dated SDED form suggests the need for travel time that was not actually present if the encounters occurred on different days. Similarly, the encounter might have occurred in a public location where the provider might have met with clients one after the other without the need to travel, despite different locations inadvertently listed on the SDED form. Mr. Yi disputes that he billed for any travel time for his providers. Likewise, only 24 instances, less than 3% of the sample in insufficient to support an extrapolation."

OSC's Response

In essence, Yi is arguing that notwithstanding that his own records contain "typographical" errors, including "incorrectly dated" information, OSC should remove these travel time deficiencies from its findings because the underlying SDED information may have been incorrect. OSC audited Yi's claims using his own documentation and cannot ignore instances when it found discrepancies that constitute regulatory violations, which is what happened in

these 24 instances. As with the findings noted above, OSC afforded Yi ample opportunity to provide documentation to support these claims, but he failed to do so. He now raises possible reasons for these deficiencies, but offers no evidence in support of such position. Finally, his effort to call the extrapolation into question ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding F – Yi Failed to Document Services with Progress Notes

"The OSC determined that for 37 claims out of the sample no progress note was recorded. Again, there is no suggestion that the services were not provided. Rather, Mr. Yi was unable to locate the progress notes for those instances. As previously discussed, the incorrect dating of such a note, or inadvertent mislabeling otherwise would render the note difficult to find and identify, but the services in question still occurred. Mr. Yi disputes this purported error for that reason. Additionally, an error rate of 37 claims representing less than 4% of the sample is inappropriate for extrapolation."

OSC's Response

OSC rejects Yi's explanation for claims unsupported by a progress note. Yi states that "incorrect dating" or "inadvertent mislabeling" explains the undocumented progress notes for claims, but he fails to provide any documentation supporting such assertion. As explained above, Yi's position also ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding G – Yi Failed to Maintain Behavioral Assistance Training Certification for Behavioral Assistants

"The OSC identified 10 claims from four behavioral assistants where Mr. Yi failed to provide certifications of appropriate training for the assistants. This small number is not evidence of a trend, but an aberrant result. Despite identifying over one quarter of the providers in the sample as not having certification, these four providers only accounted for 1 % of the claims in the sample. This shows that any improper provision of services by these providers was inadvertent and should not be the basis for any extrapolation to the greater set of claims. Additionally, there is no assertion or information that suggests that the assistants identified were insufficiently trained, nor that they provided any services that fell below the accepted standards for such assistants."

OSC's Response

OSC identified 10 claims from four BAs where Yi was unable to provide training certifications. The lack of certifications in itself demonstrates that these four BAs were providing services without being properly trained, which constitutes a regulatory violation. Regardless of whether these BAs provided services in an appropriate or inappropriate manner, there is no dispute that Yi failed to maintain proof of certification, which is what OSC found here. Finally, Yi's claim that "this small number is not evidence of a trend, but an aberrant result" and "these four providers

only accounted for 1% of the claims in the sample" is misguided. Once again, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding H – Yi Failed to Maintain Proof of Education for Behavioral Assistants

"The OSC identified 19 claims from six behavioral assistants out of the sample where Mr. Yi failed provide proof of education. As with the objection to Item G, the small numbers here suggest an anomaly, not a trend. Here forty percent of the behavioral assistants in the sample account for only two percent of the claims. This again suggests a brief tenure and provides a reason that any such documentation may have been inadvertently lost. Further, the very low percentage in question suggests that extrapolation is not appropriate. In any event, Mr. Yi disputes that any of the assistants did not have the necessary education for the position, and that all assistants provided the appropriate levels of service to their clients."

OSC's Response

Yi does not dispute OSC's finding that Yi lacked proof of education for 6 of the 15 BAs in the audit sample selection. By regulation, BAs must possess a high school diploma, or equivalent, to perform behavioral assistant services and Yi is required to maintain proof of same, which he did not do in these instances. Finally, as explained above, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.

Yi's Comment Regarding Audit Finding I - Yi Failed to Maintain a Criminal Background Check for a Behavioral Assistant Prior to Rendering Services

Yi's Comment Regarding Audit Finding J - Yi Failed to Maintain a Current and Valid Driver's License for a Behavioral Assistant

Yi's Comment Regarding Audit Finding K - Yi Failed to Maintain Proof of Minimum Age Documentation for a Behavioral Assistant

"Issues I, J, and K raised by the OSC all arise from one service provider accounting for one claim out of the entire sample. The behavioral assistant only briefly worked for Mr. Yi and left soon after. There is no indication that the behavioral assistant did not meet any of the standards required, and Mr. Yi contends that she did meet all necessary criteria. In any event, one instance is not a trend to extrapolate but an aberration. It is not likely that the one individual was anything but a one off occurrence with respect to a short-lived employee. One such instance should not form the basis for extrapolation to a larger pool."

OSC's Response

Although Yi contends that the BA met "all necessary criteria," the documentation does not support that position. Despite having ample opportunity to do so through the course of this audit, Yi failed to provide a background check, a current and valid driver's license, and proof of age for this BA. Finally, Yi characterizes these exceptions as a "one off occurrence" as a means to excuse his failure to have satisfied the regulatory requirement that he maintain documentation showing a successful background check, current and valid driver's license, and proof of age. The fact that OSC found this set of deficiencies with regard to one BA does not excuse Yi's failure to satisfy the regulatory requirements. Finally, Yi's position ignores the principles underlying OSC's extrapolation approach. As such, OSC will not modify these findings.