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January 15, 2019

BY ELECTRONIC AND CERTIFIED MAIL

Dr. Daniel Stegman
Clifton Eye Care, LLC
1016 Main Avenue
Clifton, New Jersey 07011

RE: Final Audit Report: Dr. Daniel Stegman, MD; Clifton Eye Care, LLC; and Englewood Eye Center, LLC

Dear Dr. Stegman:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the New Jersey Office of the State Comptroller, Medicaid Fraud Division (MFD) completed its review of the selected universe of Medicaid claims submitted by Dr. Stegman, Clifton Eye Care, and Englewood Eye Center (collectively referred to as Clifton). The period of review was January 1, 2012 through May 4, 2018. MFD hereby provides you with this Final Audit Report (FAR).

Executive Summary

MFD performed an audit to determine whether Clifton appropriately billed for ophthalmology services in accordance with applicable state and federal laws and regulations. Specifically, the audit sought to determine whether Clifton properly billed intermediate service Current Procedural Terminology (CPT) codes (92002 and 92012) and comprehensive service CPT codes (92004 and 92014). MFD statistically selected 127 claims where Clifton separately billed and received payment for intermediate and comprehensive eye examination claims for the same recipient on the same day. MFD found that 70 of the 127 claims, totaling $4,281.94 billed by Clifton, violated *N.J.A.C.* 10:49-9.8 for failing to adhere to the American Medical Association's (AMA) CPT guidelines, the AMA's Healthcare Common Procedure Coding System (HCPCS) guidelines, and the Centers for Medicare & Medicaid Services National Correct Coding Initiative Policy Manual for Medicaid Services (Medicaid NCCI).

Specifically, MFD found that Clifton improperly billed and was paid for: a) 43 claims where claims for both intermediate services and comprehensive services were submitted for the same recipients, on the same day; b) 11 duplicate claims for the same service; c) 6 claims for unsubstantiated services; and, d) 10 claims for which it failed to provide documentation.

For purposes of ascertaining a final recovery amount, MFD extrapolated the error rate for claims that failed to comply with state and federal regulations to the total population of claims from which the sample claims were drawn. By extrapolating the dollars in error over the entire universe of comprehensive and intermediate eye service claims, MFD determined the total dollar amount of improper claims paid to Clifton that Clifton is required to repay is $26,912.10.

Background

The Medicaid NCCI guidelines designate service codes 92004 and 92014 for comprehensive services and 92002 and 92012 for intermediate services. According to the AMA's CPT code guidelines, the comprehensive service includes a patient "history, general medical observation, external and ophthalmoscopic examinations, gross visual field and basic sensorimotor examinations . . . [and] often includes, as indicated: biomicroscopy, examination with cycloplegia or mydriasis and tonometry . . . [and] always includes initiation of diagnostic and treatment programs." Further, the AMA's CPT code guidelines state that intermediate services (CPT codes 92002 and 92012) "describes an evaluation of a new or existing condition complicated with a new diagnostic or management problem not necessarily relating to the primary diagnosis, including history, general medical observation, external ocular and adnexal examination and other diagnostic procedures as indicated; may include the use of mydriasis for ophthalmoscopy."

According to the Medicaid NCCI, if a procedure is described as an "intermediate" procedure and another procedure performed for the same recipient on the same date of service is described as a "comprehensive" procedure, then, for billing purposes, the "intermediate" procedure is included in the "comprehensive" procedure and only the comprehensive procedure is billed. In other words, under these guidelines, when a provider seeks payment from the Medicaid program, these two services should be billed together in a bundled manner only as a comprehensive service when these services are provided to the same recipient on the same day.

As a condition of participation in the Medicaid program, Medicaid providers are required to adhere to all applicable state and federal laws. Similarly, the state contract between the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (DMAHS), and the Managed Care Organizations (MCO) requires MCOs and their providers to adhere to applicable New Jersey laws and regulations.

Objective

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

Scope

The audit period was January 1, 2012 through May 4, 2018. The audit was conducted under the authority of Office of the State Comptroller, *N.J.S.*A. 52:15C-23 and the Medicaid Program Integrity and Protection Act, *N.J.S.A*. 30:4D-53 *et seq*.

Audit Methodology

MFD's methodology consists of the following:

- Applying AMA CPT Code guidelines and the Medicaid NCCI Policy Manual to a statistically valid sample comprised of 127 claims for comprehensive and intermediate eye services performed on the same recipient on the same day totaling $8,860.96 selected from a population of 831 claims totaling $55,483.43; and,

- Reviewing Clifton records to determine whether proper documentation exists to substantiate paid claims and to ensure claims have been properly billed.

Audit Findings

Improper Billing of CPT Codes

MFD found that for 43 of the 127 claims, totaling $2,776.01, Clifton submitted claims for intermediate eye examination services, CPT codes 92002 and 92012, which were unbundled and separately billed with comprehensive eye examination services, CPT codes 92004 and 92014, for the same recipients, on the same day.

The NCCI Policy Manuals Chapter 1 for Medicaid Services states:

> If two procedures only differ in that one is described as an intermediate procedure and the other as a comprehensive procedure, the intermediate procedure is included in the comprehensive procedure and is not separately reportable unless the two procedures are performed at separate patient encounters or at separate anatomic sites.

Duplicate Claims

MFD found that for 11 of the 127 claims, totaling $523.02, Clifton submitted duplicate claims as Clifton billed twice for the same service. Providers are required to bill and submit claims based on true, accurate and complete information.

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."

Unsubstantiated Claims

MFD found that for 6 of the 127 sample claims, totaling $340.26, Clifton failed to possess documentation to support the sampled claims. Specifically, the medical records provided failed to include an examination record documenting the services performed. Providers are required to bill and submit claims based on true, accurate and complete information.

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 "to keep such records as are necessary to disclose fully the extent of services provided."

Undocumented Services

MFD found that for 10 of the 127 sample claims, totaling $642.65, Clifton did not provide medical records for the sampled dates of service. Providers are required to maintain documentation showing that services were rendered to the recipient including necessary information as to the treatment provided, and any other information pertinent to the recipient's clinical course.

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

Summary of Overpayments

Based on its review, MFD determined that 70 of the 127 sample claims for Medicaid reimbursement failed to comply with state and federal requirements. Clifton improperly received a total of $4,281.94 in reimbursement for these 70 claims. For purposes of ascertaining a final recovery amount, the dollars in error for claims that failed to comply with state and federal regulations were extrapolated to the total population of comprehensive and intermediate eye service claims from which the sample claims were drawn, which in this case was 831 claims with a total payment amount of $55,483.43. By extrapolating to this universe of claims/reimbursed amount, MFD has determined that Clifton received an overpayment totaling $26,912.10. For the reasons set forth above, MFD is seeking a recovery of $26,912.10.

Recommendations

Clifton must:

1. Reimburse Medicaid the overpayment amount of $26,912.10.

2. Provide training to staff to foster compliance with applicable state and federal laws and regulations.

3. Remain current with coding and billing guidelines offered by the AMA and periodically check with payers for specific coverage guidance.

4. Provide MFD with a Corrective Action Plan indicating the steps it will take to implement procedures to correct the deficiencies identified in this FAR.

Auditee Response

In a written response, Clifton agreed with the audit findings and provided a Corrective Action Plan to address the recommendations above. Clifton also described the specific steps it has taken or will take to implement the recommendations made in this FAR. The full text of the response letter submitted by Clifton is included as an Appendix to this FAR.

MFD Comments

MFD notes that Clifton is in complete agreement with the audit's findings and recommendations. Accordingly, MFD requests that Clifton reimburse the Medicaid program $26,912.10 and based on the corrective actions taken, submit claims in accordance with applicable state and federal regulations. Given Clifton's agreement with the findings and recommendations, and its stated corrective actions, MFD believes that no further action is necessary with respect to this audit.

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By: _____
Josh Lichtblau, Director
Medicaid Fraud Division

Cc: Katrina James, Administrator, Clifton
Kay Ehrenkrantz, Deputy Director, MFD
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NJ EYE AND EAR

January 5, 2019

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

Dear Sir: **RE: Corrective Action Plan**

Based on your recommendations for Clifton Eye Care, here is my plan for corrective actions for the draft audit report.

Firstly, reimbursement for the calculated Medicaid overpayment amount of $26,912.10 will be paid to your recovery department.

We will continue to provide training to our staff, including the billing and authorization staff, in order to adhere to the AMA compliances and guidelines set forth by the state and federal laws and regulations. This will include but not limited to updates from payors via mail, conferences, and webinars. The administrator will continue to attend meetings and teaching seminars at the American Academy of Ophthalmology and other medical associations to stay abreast of any updates to the billing codes.

Since 2015, Clifton Eye Care implemented a new EMR system that totally interfaces with the practice management system to assure completeness of records and proper billing of CPT codes. This occurrence of the new billing system and new administration has provided a more sound, competent, and advanced system for billing and record/chart keeping. In addition, each one of our onboarding physicians are trained on the EMR before they see patients at our facility to assure proper use of the EMR. Billing will be eminently established with this new system. Each visit will be completely documented with this new system in place.

Sincerely,

Daniel Stegman, MD