

New Jersey Office of the State Comptroller Fiscal Year 2020 Annual Report

*Improving the efficiency, transparency, and fiscal accountability of
New Jersey government*

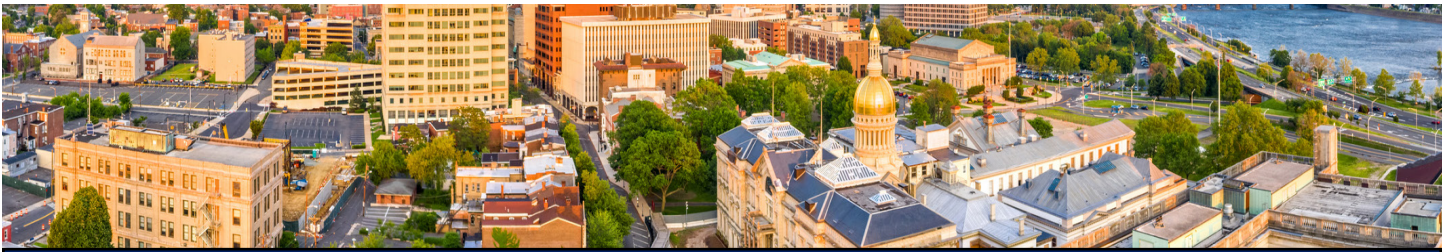
Kevin D. Walsh, Acting State Comptroller





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Letter from the Acting State Comptroller

Dear Governor Murphy, Members of the State Legislature, and the Residents of New Jersey,

Fiscal Year 2020 marked another year of the Office of the State Comptroller advancing transparency and accountability throughout New Jersey government. The year also proved to be a transitional one for the Office as I was nominated to serve as State Comptroller in January and began working in that role in an acting capacity.

The Office of the State Comptroller's mission is to advocate for New Jersey residents and ensure that their tax dollars are being spent efficiently and effectively. Our office works to detect and prevent waste, fraud and abuse of any kind in government, and we hold entities and officials accountable when it does occur.

We do that by reviewing public contracts above a certain dollar amount to make sure taxpayers are getting the best possible deal and benefiting from competition. Our procurement team has jurisdiction over 1,900 public entities in New Jersey, from public universities to school boards to independent authorities like the New Jersey Turnpike Authority.

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This fiscal year, our procurement team took corrective action in some 63 percent of all pre-screened contracts that were valued at more than \$10 million. Through their efforts, our team ensured that every contract reviewed complied with the state's various procurement laws which ultimately protects the taxpayers' bottom line.

We also advance transparency by auditing those same 1,900 public entities in New Jersey and releasing our findings publicly so that residents

can evaluate how effectively their government is working for them. While there are certainly challenges for one office to oversee nearly two thousand public entities, our audit team relies on a risk assessment process to determine which entities will be audited. A complete list of the audits released this fiscal year can be found [on our website](#).

Our audit team has sophisticated quality control systems in place to ensure that our audits are following best practices at every stage. Every three years, our audit team undergoes evaluation from the National State Auditors Association to determine whether the Office of the State Comptroller is conducting our audits appropriately. I am proud to report that our audit team passed its fourth peer review in June 2020.

Our Office's Medicaid Fraud Division, which was previously a separate entity known as the Office of Medicaid Inspector General, forms a crucial component of our mission to hold New Jersey government accountable and stretch every public dollar. Medicaid is the largest expenditure of state and federal funds in New Jersey's annual budget, making our scrutiny over the program especially important. This fiscal year, we recovered tens of millions of dollars in misspent Medicaid funds.

Through its data mining, audits, and third-party liability recovery efforts, the units within our Medicaid Fraud Division monitor claims and other data to detect waste, fraud and abuse. Collectively, they identified hundreds of unusual billing patterns and other anomalies. In one case, as a result of their work, an orthopedic footwear store called [Ortho-Step](#) was found to have improperly billed Medicaid for more than \$7.2 million.

All told, our Medicaid Fraud Division returned \$77.2 million in misspent Medicaid funds to taxpayers this fiscal year.

“ **All told, our Medicaid Fraud Division returned \$77.2 million in misspent Medicaid funds to taxpayers this fiscal year.** ”

The Investigations Division, which performs work previously performed by the State Inspector General, works to detect and uncover waste, fraud and misconduct in the management of public funds and the performance of public officials and employees. The Division operates a hotline that accepts tips from government employees and concerned residents who suspect government misconduct. This fiscal year, our investigations team fielded 147 tips or complaints, many of which led to further review or referrals to other appropriate state and federal agencies.

We also conducted our [sixth periodic report on the New Jersey State Police \(NJSP\)](#) to determine whether it is effectively preventing racial profiling and discrimination during motor vehicle stops by its State Troopers. This report is statutorily required by our Office, with the subject matter dating back to 1999 when the U.S. Department of Justice sued the State of New Jersey and NJSP for intentional racial discrimination in motor vehicle stops. New Jersey quickly settled that case and implemented a number of reforms – reforms that the Office of the State Comptroller is now tasked with monitoring. Our sixth report found overall compliance but identified areas where NJSP can guard more effectively against racial profiling. Our seventh report is

already underway and we are committed to our watchdog role to prevent racial discrimination and abuse of power of any kind in the NJSP.

Our investigations team received a tip on our hotline from a concerned citizen about a scheme that the Mayor of Wrightstown – who was also the Chairman of the Wrightstown Municipal Utilities Authority (WMUA) – entered into with Rodman Lucas, a WMUA supervisor who also operated a private waste disposal company. The scheme involved Mayor Harper allowing Lucas to dump over 565,000 gallons of waste from his private septage business into WMUA’s treatment facility. Our investigators referred [our findings](#) to the Office of the Attorney General; this year, both individuals accepted plea agreements and have been permanently banned from holding public office.

This is what occurs when people think nobody is watching, or when they think there will not be consequences for their actions. Our Office’s work to prevent such corruption – and hold people accountable when it does occur – is absolutely vital to instilling public trust in government and ensuring that government is able to effectively deliver services to New Jersey residents.

Public trust in government is more essential than ever now that the state is undertaking its recovery from the COVID-19 crisis and expending billions of federal dollars to help small businesses, public entities, and individuals get back on their feet. The Office of the State Comptroller is tasked with overseeing that recovery and protecting its integrity.

The Office continues to perform an educational function for other state agencies and authorities by producing additional resources and trainings concerning the expenditure of COVID-19 Relief Funds. Like we did with New Jersey’s recovery from Superstorm Sandy, we are reviewing public contracts and posting them on a dedicated [Transparency website](#) – a kind of itemized receipt for the public to see how New Jersey is spending its federal recovery dollars.

COVID-19 has impacted the work of every division at the Office of the State Comptroller and we are working hard to ensure that New Jersey’s recovery from the crisis is not disrupted by waste, fraud and abuse of any kind. We will be periodically updating [the Transparency website](#) as we receive more contracts, and I look forward to reporting on the status and findings of that work in our next annual report.

This annual report endeavors to detail the successes our four divisions have had this fiscal year and the issues within New Jersey government that our Office have helped to address.

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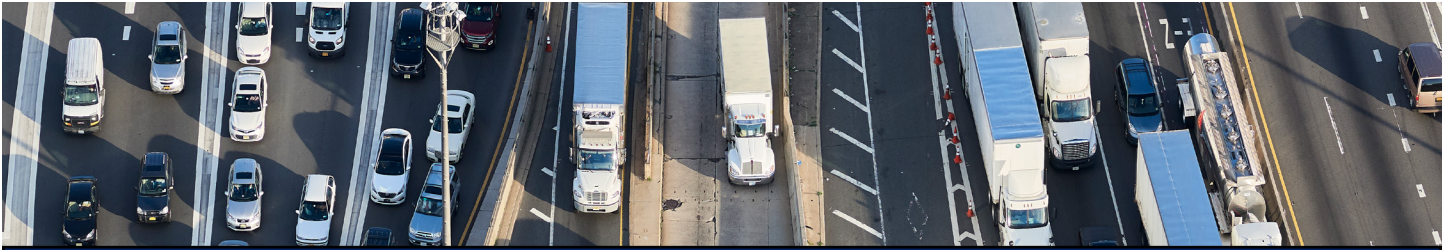
This is what occurs when people think no one is watching, or when they think there will not be consequences for their actions.

There is plenty more work to be done in advancing the Office of the State Comptroller's mission to shine a bright light on every corner of government, which it has been doing with excellence since 2008. It is an honor to work alongside so many committed professionals who are dedicated to the work of making New Jersey government more transparent, more accountable, and more efficient on behalf of the residents of this state.

Sincerely,

Kevin D. Walsh
Acting State Comptroller





Overview

Since its creation in January 2008, the Office of the State Comptroller (OSC) has served as an advocate for taxpayers and a leader in bringing about government reform. OSC reports have focused on bringing greater efficiency, transparency and analysis to the operation of all levels of government in New Jersey.

OSC consists of four divisions – Audit, Investigations, Medicaid Fraud and Procurement. Each of the four divisions made significant contributions to OSC's accomplishments this past fiscal year.

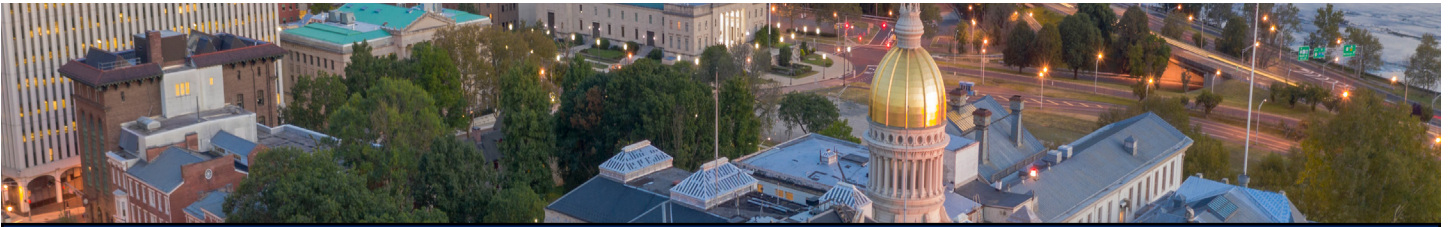
Our Audit Division concluded its work on a performance audit of the North Bergen School District and issued recommendations for the district to improve its fiscal and operating practices.

Our Investigations Division conducted the sixth in a series of OSC reviews of the New Jersey State Police and the Office of Law Enforcement Professional Standards. This review focused on motor vehicle stops and post-stop enforcement activity. Although no significant violations were found, OSC did identify areas for improvement. The division also completed a review concerning the improper disposal of private septage at the Wrightstown Municipal Utilities Authority. That review resulted in a criminal referral to the state Office of the Attorney General and the later acceptance of plea agreements by the Mayor of Wrightstown and an employee of the authority for their roles in the matter.

Our Medicaid Fraud Division's ongoing efforts to combat waste, fraud and abuse in the Medicaid Program resulted in the recovery of more than \$77 million of taxpayer dollars in FY 2020. Its anti-fraud efforts also resulted in the exclusion of 194 ineligible providers from the Medicaid program.

Our Procurement Division reviewed 655 contracts this past fiscal year, 192 of which were valued at \$10 million or more. Division attorneys also reviewed 414 contracts valued between \$2 million and \$10 million.

The sections of this report that follow briefly explain the role of each division while setting forth highlights of OSC accomplishments from the past fiscal year of July 1, 2019 to June 30, 2020.



Audit

OSC's Audit Division conducts audits and reviews the performance of New Jersey state government, public institutions of higher education, independent state authorities, local governments, and school districts.

The Audit Division is led by Director Yvonne Tierney who brings more than 30 years of experience as an auditor and investigator to the position. The Audit Division staff includes individuals who possess certifications or professional designations such as Certified Public Accountant, Certified Internal Auditor, and Certified Fraud Examiner.

Examples of our Audit Division's work in FY 2020 are set forth below. OSC audit reports can be viewed in their entirety on our website.

Audit

North Bergen School District — A Performance Audit of Selected Fiscal and Operating Procedures

OSC auditors examined the controls over selected fiscal and operating practices of the North Bergen School District. In doing so, OSC auditors identified various internal control weaknesses. Specifically, the audit found that the District: (1) lacked formal

policies and procedures and appropriate controls for its administration of employee leave benefits and payment processing for various employee benefits; (2) failed to properly monitor and oversee its legal services engagements and performed little to no review of the monthly invoices for such services resulting in duplicate payments and payment of improperly invoiced amounts; (3) violated multiple state laws and regulations in its procurement of certain services/vendors; and (4) obtained services from a public relations and communications consultant without a formal contract or agreement in place prior to the School Board's authorization for such services.

The District's lack of sufficient controls over fiscal and operating practices resulted in several examples of waste, overspending and mismanagement, including:

- The District failed to follow its own policies when it improperly paid an employee \$19,469 for unused vacation time that was not contemplated by that employee's collective bargaining agreement.
- OSC was not able to verify the accuracy of \$14,854 in District insurance opt-out payments made to a sample of five employees, because the District did not provide any supporting documentation for those payments.

- The District lacked appropriate monitoring and oversight of the legal services it contracted for and failed to properly review and approve legal invoices, resulting in overpayments.
- The District paid \$297,496 to three vendors for services performed without prior School Board authorization, as required by the Public School Contracts Law.

To improve fiscal and operational procedures, and improve the District’s compliance with the law, OSC’s report makes 15 recommendations that will enhance monitoring and oversight by the District. As required by law, OSC will conduct a follow-up review to determine whether the District has implemented the audit recommendations.

Policies and Procedures

Our efforts at OSC have included establishing policies and procedures that guide our audit process. The following are descriptions of some of the policies and procedures we have put into effect and have continued to refine over the past year.

Audit Manual

For professional audit organizations such as ours, it is essential that clearly defined policies be promulgated to provide audit guidance and to ensure the quality and consistency of the audit work performed. To that end, OSC developed an Audit Manual to serve as the authoritative compilation of the professional auditing practices, policies, standards, and requirements for OSC’s staff. Our Audit Manual is a constantly evolving document that is revised as standards are amended and other changes in the auditing profession occur.

Audit Process Brochure

Open communication concerning the audit process lets the auditee know up front what to expect. With that in mind, OSC developed a brochure outlining the critical components of the audit process, from initiation to completion. This brochure is provided to the auditee prior to the start of an audit and is also posted on our website.

Risk/Priority Evaluation

OSC’s enabling legislation requires us to “establish objective criteria for undertaking performance and other reviews authorized by this act.” Accordingly, OSC developed a risk/priority evaluation matrix that considers a number of risk factors including, among others, the entity’s past performance, size of budget, the frequency, scope and quality of prior audits, and other credible information which suggests the necessity of a review. OSC’s staff conducts research along these parameters and performs a risk assessment as an aid in determining audit priority.

Quality Control and Peer Review

Government auditing standards require audit organizations to establish an internal quality control system and to participate in an external quality control “peer review” program. The internal quality control system provides the organization with ongoing assurance that its policies, procedures and standards are adequate and are being followed. The external peer review, to be conducted once every three years, is a professional benchmark that provides independent verification that the internal quality control system is in place and operating effectively, and that the organization is conducting its work in accordance with appropriate standards.

In June 2020, OSC’s Audit Division successfully passed its fourth peer review conducted by the Na-

tional State Auditors Association. Audit organizations can receive a rating of “pass,” “pass with deficiencies,” or “fail.” OSC received a peer review rating of “pass.”

OSC had received “pass” ratings in its prior peer reviews conducted in 2011, 2014, and 2017. As in those reviews, the 2020 review concluded that OSC’s system for quality control has been “suitably designed” and complied with government auditing standards.

Audit Coordination

OSC’s enabling legislation requires the State Comptroller to establish a system of coordination with other state entities responsible for conducting audits, investigations and similar reviews. This system serves to avoid duplication and fragmentation of efforts while optimizing the use of resources, promoting effective working relationships and avoiding the unnecessary expenditure of public funds. We continue to work closely with both state and federal audit organizations and law enforcement officials in this regard.

Training

Audits conducted by OSC’s Audit Division comply with Generally Accepted Government Auditing Standards (GAGAS). Auditors performing work under GAGAS are required to maintain their professional competence through Continuing Professional Education (CPE). Specifically, every two years each auditor must complete at least 80 hours of CPE, 24 of which must directly relate to government auditing, the government environment, or the specific or unique environment in which the audited entity operates. OSC is recognized by the National Association of State Boards of Accountancy as a CPE sponsor. Annually, our staff receives formal training on topics such as governmental accounting, auditing and accounting, audit sampling, audit evidence, and internal controls. All staff members in the Audit Division have satisfied the biennial requirement of obtaining 80 CPE hours over the reporting period.

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For the fourth straight peer review, OSC received a ‘pass’ for its audit division, affirming that its system for quality control has been ‘suitably designed’ and complies with government auditing standards.



Investigations

OSC's Investigations Division works to detect and uncover fraud, waste and misconduct involving the management of public funds and the performance of government officers, employees, and programs.

Nicole Acchione is the Acting Director of the Investigations Division. Prior to joining OSC in 2015, Ms. Acchione worked as an attorney in the private sector representing clients in complex matters involving securities fraud, antitrust violations, contract disputes, and regulatory matters. The division consists of a staff of investigators and attorneys, including former federal and state law enforcement professionals from agencies such as the United States Postal Inspection Service and the New Jersey State Police. Staff members hold certifications such as Certified Financial Crimes Investigator and Certified Fraud Examiner.

OSC's investigators field and review all tips, referrals, and allegations submitted to the office. Those tips come from both the general public and from government employees, and are received through OSC's toll-free Hotline, OSC's website, via email, or through the U.S. mail. The Hotline is also used as the official statewide tipline for any tips regarding the waste or abuse of Superstorm Sandy funds.

Complaints and Referrals

In FY 2020, the Investigations Division fielded 147 complaints, 9 of which were referred to the Sandy Fraud Task Force. The division referred an additional four matters to criminal investigators at both the state and federal levels.

The Investigations Division also made 19 external referrals to other state, county, and federal agencies in FY 2020, among them, the state Department of Environmental Protection, the state Department of Community Affairs, the state Department of Banking and Insurance, and NJ Transit.

Other referrals were made in-house to OSC's Audit, Procurement, and Medicaid Fraud Divisions and are expected to result in future audits and/or investigations. The Investigations Division serves as a key resource to OSC's other divisions by helping to conduct witness interviews, and by using a variety of investigative tools to identify potential subjects for audits. Conversely, the Investigations Division also conducts inquiries based on incoming referrals from other state agencies. Our joint efforts with these other agencies continue to build a synergy that has led to increasingly robust investigative efforts across state government.

Public Reports

The Investigations Division produced the following public reports in FY 2020:

An Investigation into the Private Septage Deposits at the Wrightstown Municipal Utilities Authority

OSC's investigation uncovered an improper waste disposal arrangement entered into by Thomas Harper, the Mayor of Wrightstown and the Chairman of the Wrightstown Municipal Utilities Authority (WMUA), and Rodman Lucas, the Operations Manager of the WMUA. Without the knowledge of, or consent from, the WMUA Board Members, Lucas' private septage company, Aqua Clean Toilet Systems, LLC (Aqua Clean), dumped over 565,000 gallons of private septage at the WMUA for free.

OSC's investigation revealed that Lucas and Harper arranged for Aqua Clean to deposit private septage from residences and businesses at the WMUA without analyzing the environmental effects the deposits would create, informing the New Jersey Department of Environmental Protection (DEP) that the WMUA was accepting septage, or seeking approval from or even informing the WMUA Board. The deal cost the WMUA \$21,000 in fair-market septage acceptance fees.

OSC referred its findings to the state Office of the Attorney General for further criminal investigation. As a result, both Harper and Lucas accepted plea agreements for their role in this scheme, and have been permanently banned from holding public office or employment. OSC also referred this matter to DEP and the Local Finance Board within the Department of Community Affairs, Division of Local Government Services.

Sixth Periodic Report on Law Enforcement Professional Standards: Review of Motor Vehicle Stops and Post-Stop Enforcement Activities at the Division of New Jersey State Police and its monitoring by the Office of Law Enforcement Professional Standards

By statute, OSC is required to periodically review the performance of the New Jersey State Police (NJSP) with regard to its continuing efforts to prevent racial and other forms of discrimination in its policies, practices, and procedures and the state Office of Law Enforcement Professional Standards (OLEPS) oversight of those efforts.

For FY 2020, OSC completed its sixth periodic review of NJSP and OLEPS, and publicly issued its findings and recommendations. The review focused on the documentation and supervisory review of motor vehicle stops and post-stop enforcement activity by the NJSP. The report recognized that NJSP is complying with most of the requirements imposed upon it by law, but identified areas where the NJSP's practices should be changed to comport with the law and to guard more effectively against racial profiling. This report also evaluated the oversight function of OLEPS and recommended changes to that office's practices to improve its oversight of NJSP.

During this fiscal year, OSC also commenced its seventh periodic review, which will focus on internal affairs and disciplinary processes. OSC expects to release its findings in FY 2021.

Speaking Engagements and Outreach

In FY 2020, the Investigations Division continued outreach efforts to other government units across the state, including law enforcement agencies, as well as the public at large. The outreach efforts are intended to promote OSC's mission and encourage public employees and New Jersey residents to report instances of government fraud, waste, and abuse.

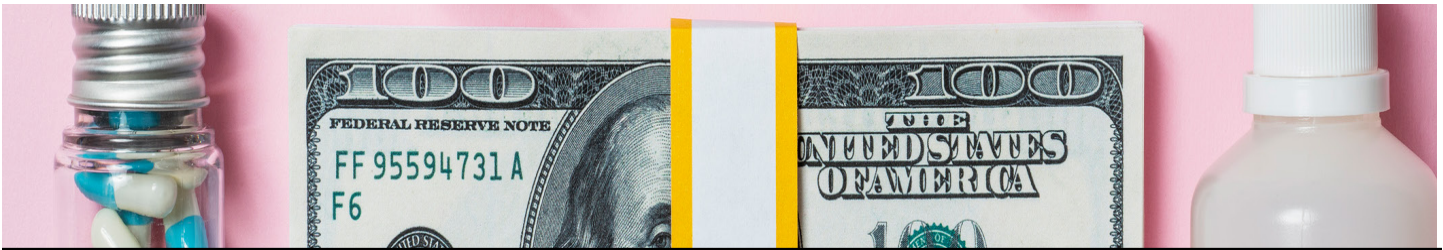
Members of the Division have also participated in a variety of speaking engagements to include continuing legal education seminars, fraud symposiums, and presentations aimed towards the general public.

GOVERNMENT WASTE AND MISMANAGEMENT HOTLINE

**Toll Free: 1-855-OSC-TIPS
(1-855-672-8477)**

Email: comptrollertips@osc.nj.gov

Website: www.nj.gov/comptroller



Medicaid Fraud

OSC's Medicaid Fraud Division (MFD) serves as the state's independent watchdog for New Jersey's Medicaid, FamilyCare, and Charity Care programs and works to ensure that the state's Medicaid dollars are being spent effectively and efficiently. MFD is comprised of trained auditors, investigators, analysts, attorneys, and other professionals and para-professionals.

Josh Lichtblau joined the OSC as Director of the MFD in July 2015 after more than two decades serving the interests of New Jersey citizens as a Deputy Attorney General, Assistant Attorney General and as Director of a major state regulatory agency.

Operating under the authority of the Medicaid Program Integrity and Protection Act, MFD provides oversight concerning the following programs:

- New Jersey's Medicaid program provides health insurance to qualifying parents and caretakers and their dependent children, along with pregnant women and individuals who are aged, blind or disabled. For example, the program pays for hospital services, doctor visits, prescriptions, nursing home care, and other health care needs.
- New Jersey FamilyCare is a Medicaid-type program for uninsured children whose family income is too high to qualify for traditional Medicaid but not high enough for the family to afford private health insur-

ance. Combined, the Medicaid and New Jersey Family-Care programs serve more than 1.7 million New Jersey residents.

- The New Jersey Hospital Care Payment Assistance Program, commonly known as Charity Care, provides free or reduced-charge services to patients who require care at New Jersey hospitals.

As part of its oversight role, MFD audits and investigates health care providers, managed care organizations (MCOs), and Medicaid beneficiaries to identify and recover improperly expended Medicaid funds; recommends MCO Contract changes designed to improve programmatic oversight; refers cases to other appropriate civil entities when the underlying conduct is outside of MFD's authority or more appropriately handled by such entities; refers cases of suspected criminal fraud to appropriate criminal prosecutors; and, investigates beneficiaries when there is a basis to suspect that they do not meet eligibility requirements, which helps ensure that only those who qualify are enrolled in Medicaid. In performing these functions, MFD considers the quality of care provided to Medicaid recipients and pursues civil and administrative enforcement actions against those who engage in fraud, waste, or abuse within the Medicaid program. MFD also excludes or terminates ineligible health care providers from the Medicaid program where necessary and conducts educational programs for Medicaid pro-

viders and contractors. Moreover, MFD oversees a contractor that identifies and collects payments from insurance carriers when Medicaid has paid for goods or services and there was third-party insurance coverage that should have paid for such claims.

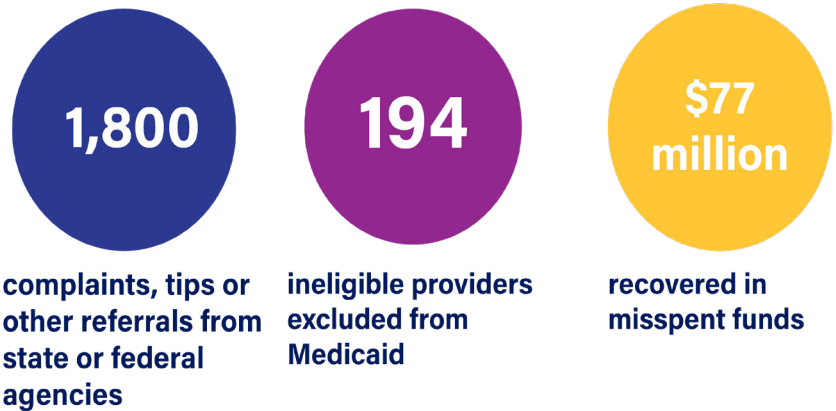
FY 2020 Statistics

In FY 2020, MFD recovered \$77.2 million in improperly paid Medicaid funds. Those funds were returned to both the state and federal budgets. MFD also excluded 194 ineligible providers from participating in the Medicaid program this past fiscal year.

The division received more than 1,800 complaints, tips, or other submissions (collectively “complaints”) from a variety of outlets, including the MFD Hotline, OSC website, referrals from other state and federal agencies, and correspondence from the public. All of the complaints received by OSC resulted in some type of action, up to and including opening an investigation. Pursuant to its internal processes, members of OSC’s Medicaid Fraud Division reviewed the substance of the complaints to determine whether additional steps were warranted. As a result of that review, OSC opened cases on 25 complaints and referred the majority of the remaining complaints to other more appropriate entities for handling, including the state Department of Human Services, Division of Medical Assistance and Health Services (DMAHS); professional licensing boards; county welfare agencies; and appropriate state vendors responsible for providing services related to the Medicaid program at issue.

The division also received and reviewed a total of 131 high-risk provider applications. In addition, the division referred 8 cases to the Medicaid Fraud Control Unit (MFCU) within the state Office of the Attorney General and an additional 15 matters to other civil and criminal enforcement entities, including county prosecutors’ offices, the state Division of Taxation,

Medicaid Fraud Division by the Numbers



and the federal Internal Revenue Service.

As part of its educational outreach program, MFD presents training programs to a wide variety of providers, including behavioral health, long-term care, medical day care, and sole providers/practitioners. MFD offered a training session in coordination with the MFCU, DMAHS, and the MCOs titled “Useful Tools for a Compliant Medicaid Provider” that was designed to help providers who participate in the New Jersey Medicaid market identify and protect against fraud, waste, and abuse within the Medicaid program. Speakers emphasized the importance of properly documenting medical and other records, submitting accurate Medicaid claims, disclosing improperly received payments, and proactively taking steps to train their employees in ways to identify, prevent, and properly address Medicaid fraud, waste, and abuse.

MFD’s oversight focuses on Medicaid health care providers, MCOs and Medicaid recipients, while coordinating oversight efforts among all state agencies that administer Medicaid program services.

What follows is an overview of the work performed by each unit in MFD in FY 2020. A more detailed listing of MFD’s individual settlements and audits is included as an Appendix to this report.

Fiscal Integrity Unit

The Fiscal Integrity Unit focuses on data mining, audits, and liability of third parties for expenses improperly paid by the Medicaid program.

Data Mining

MFD's data mining group monitors Medicaid claims and other data used to detect fraud, waste and abuse and, in collaboration with relevant Medicaid stakeholders, works to ensure that the data is sufficiently reliable for MFD to use in its audits and investigations. As such, the data mining group is involved in various stages of the process leading to the recovery of improperly paid Medicaid dollars. The unit employs numerous analytical techniques to detect anomalous or abnormal claims submitted by providers. In order to identify patterns of anomalous Medicaid reimbursements, MFD's data miners review Medicaid fraud reports and investigations from federal oversight bodies as well as reports from other states, and this unit also analyzes a range of additional resources to acquire pertinent data. The data mining group also monitors the Surveillance and Utilization Review System, a federally mandated exception reporting system, for indications of waste, fraud and abuse and to detect duplicate, inconsistent or excessive claim payments. This group also selects appropriate samples for audit/investigation purposes and, using statistically valid processes, extrapolates audit/investigative findings to determine the amount of overpayment (restitution) that should be pursued.

In total, MFD's data mining group referred 49 cases of anomalous claims behavior to the audit/investigation units and generated 369 reports for use by these units in FY 2020.

Audit

MFD conducts audits to ensure that Medicaid

providers comply with program requirements, to identify improper billings submitted by Medicaid providers and to deter fraud, waste, and abuse in the Medicaid program.

As part of MFD's fiscal integrity oversight, MFD launched audits in a number of areas, including durable medical equipment (DME), home care, hospitals, and speech and language providers. MFD completed audits in two areas that are particularly noteworthy.

First, MFD initiated audits of several DME providers. MFD issued its first DME audit on Ortho-Step, Inc. Through this audit, MFD found that 73 percent of the sample claims failed to comply with Medicaid program requirements. MFD found that Ortho-Step failed to maintain documentation from the prescribing practitioner (physician) orders or customer invoices to support the goods/services provided and/or by inaccurately billing the appropriate code. These deficiencies resulted in claims that were improperly submitted. By extrapolating these errors to the universe of claims/reimbursed amount, MFD determined that Ortho-Step improperly billed and was paid for more than \$7.2 million of Medicaid claims.

The MFD Audit Unit also completed an audit of a partial care provider, New Essecare of NJ, LLC. Through this audit, MFD found that in 45.3 percent of the sampled claims, New Essecare failed to document properly the number of units (hours) billed for partial-care services. As a result, MFD adjusted these claims to reflect the appropriate dollar amount that should have been billed and paid for partial-care services provided by New Essecare. As a result of this audit, MFD determined that New Essecare improperly billed and was paid for \$1.2 million of Medicaid claims.

In both the Ortho-Step and New Essecare audits, MFD recommended corrective steps that each provider must address regarding its billing deficien-

cies and notified each provider that it must repay the Medicaid program the amounts noted above (\$7.2 and \$1.2 million, respectively).

Third Party Liability

Under federal law, if a Medicaid recipient has other insurance coverage, Medicaid, as the payor of last resort, is responsible for paying the medical benefits only in cases where the other coverage has been exhausted or does not cover the service at issue. Thus, a significant amount of the state's Medicaid recoveries are the result of the efforts of MFD and its contracted vendor to obtain payments from third-party insurers responsible for services that were inappropriately paid with Medicaid funds. MFD's Third Party Liability (TPL) group, working with an outside vendor, seeks to determine whether Medicaid recipients have other insurance and recovers money from private insurers or providers in cases where Medicaid has paid claims for which the private insurer was responsible. In addition, the TPL group also manages a daily hotline for the public and providers to call and update third-party commercial insurance information for Medicaid recipients and ensure that Medicaid recipients receive their benefits when improperly denied.

In FY 2020, the state Medicaid program, through its outside vendor, recovered a total of almost \$63.8 million from third parties.

MFD's TPL group, working with other MFD personnel, also reviews, oversees, and coordinates audit work performed by a state contractor. For example, the Affordable Care Act requires each state's Medicaid system to contract with a Recovery Audit Contractor to identify and recoup overpayments to Medicaid providers. The TPL group oversees the state's contract with this external auditor, coordinates the audits and reviews audit findings. In total, during FY 2020, MFD oversaw the recovery of almost \$1.26 million in overpayments that were identified by the state's Recovery Audit Contractor.

“**MFD determined that Ortho-Step improperly billed and was paid for more than \$7.2 million of Medicaid claims...MFD also determined that New Essecare improperly billed and was paid for \$1.2 million of Medicaid claims.**”

Investigations Unit

MFD's Investigations Unit investigates inappropriate conduct on the part of Medicaid, FamilyCare, and Charity Care providers and recipients. In FY 2020, the Investigations Unit opened 365 cases and made referrals to other agencies such as the MFCU, state licensing boards, county prosecutors' offices, and various county boards and social services entities. MFD investigators receive allegations of fraud, waste and abuse from many sources, including MFD's Hotline and website as well as from other state and federal agencies. In total, MFD received 1,863 telephone Hotline tips in FY 2020.

To ensure the integrity of Medicaid's enrollment process, the Investigations Unit also conducts background checks of high-risk providers applying to participate in the program. In FY 2020, the Investigations Unit received 131 such applications from high-risk providers — DME, prosthetics and orthotics, and home healthcare agencies, for which MFD performed 1,173 individual background checks using multiple verification sources. The unit also conducted 70 unannounced pre-enrollment site visits of prospective Medicaid providers and confirmed 28 site

visits on PECOS, a federal Medicare site. During the site visits, MFD investigators verify that the applying entity actually exists at the address listed, that it complies with state and federal requirements, and that the information supplied on the provider application is accurate.

When the Investigations Unit uncovers patterns of fraud, waste or abuse, in addition to addressing such actions by seeking to recover from the appropriate parties, it recommends programmatic fixes to improve systemic oversight and thereby prevent such activity from reoccurring. One example of this work in FY 2020 is the steps the Investigation Unit took with respect to provider billing and payments for a range of pharmacy products.

In FY 2020, the work of the Investigations Unit resulted in the recovery of \$11.2 million in misspent Medicaid funds, which includes recoveries resulting from MFD investigations of providers, provider self-disclosures of their overpayments, and civil recoveries from Medicaid beneficiaries who MFD determined received benefits when they were not eligible for such benefits.

Recovery & Exclusions Unit

The Recovery and Exclusions Unit (R&E) recovers overpayments that are identified by MFD's auditors and investigators and determines when to exclude a Medicaid provider from the Medicaid program. In cases of fraud, R&E may also assess additional penalties against a provider.

Once MFD identifies overpayments to be recovered, R&E sends out appropriate notices, recovers the money from providers and recipients on behalf of the state, and works with federal authorities to ensure that the federal government receives its share of any recovery. In instances where R&E cannot resolve an overpayment through a settlement, MFD will take administrative action against the provider or recipient.

Providers can be excluded from participating in the Medicaid program for numerous reasons including criminal convictions or exclusions by another state or the federal government. Adverse action taken by MFD against these individuals are part of an on-going OSC effort to ensure that only those medical providers who maintain the highest integrity may participate in the Medicaid program.

In FY 2020, MFD excluded 194 providers – including physicians, pharmacists, dentists, social workers, and home care nurse's aides – for failing to meet the standards for integrity in the Medicaid program.

Regulatory Unit

MFD's Regulatory Officers are licensed attorneys who handle MFD-initiated fraud, waste, and abuse cases from initiation of a Notice of Claim through the administrative law process, including settlement negotiations, the discovery process, and Office of Administrative Law Fair Hearings as State Agency Representatives. The Regulatory Officers provide regulatory guidance to the other units of the division, including advice regarding the legal sufficiency of an audit/investigation, and assessments regarding a provider's legal basis for objecting to an overpayment demand. MFD's Regulatory Officers also work with other state departments to propose new Medicaid program regulations and guidance designed to improve program integrity and strengthen the state's oversight of the Medicaid program.

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Contract

Procurement

OSC's Procurement Division, staffed by attorneys specializing in public contract law, fulfills the office's statutory mandate to review public agency procurements from more than 1,900 public entities. In FY 2020, the Procurement Division received notice of 655 contracts, including 192 contracts that were valued at more than \$10 million and pre-screened pursuant to OSC's statutory authority.

Barbara Geary, Director of the Procurement Division, has more than 20 years of contracting experience in both the public and private sectors. She became Director in June 2015 after joining the OSC as an attorney in 2011.

In addition to reviewing contracts, the attorneys of the Procurement division work with OSC's audit teams

and provide guidance concerning the many legal issues that arise during the course of an audit. Division attorneys also assist in investigations and other projects.

As prescribed by statute, the Procurement Division pre-screens the legality of the proposed vendor selection process for all government contracts exceeding \$10 million and has post-award oversight responsibilities for contracts exceeding \$2 million. OSC's procurement reviews cover contracts awarded by municipalities, school districts, state colleges, and state authorities and departments, as well as other public boards and commissions with contracting authority. Regulations promulgated by OSC assist public entities in determining whether OSC review is required for a particular contract and provide guidance as to how OSC reviews are conducted.

Procurements subject to OSC review cover a wide range of contracts, including land sales, leases, and purchases of goods or services.

For contracts exceeding \$10 million, the Procurement Division works closely with government entities as they formulate specifications, intervening when necessary to achieve procurements that comply with all applicable laws, regulations and rules. Errors are corrected before the contract advertisement takes place.

The review of contracts valued at more than \$10 million begins with judging the appropriateness of the

Procurement Division by the Numbers



vendor selection process proposed by the contracting unit. The reviewing attorney assesses, for example, whether the procurement requires sealed bids or whether other contracting procedures are appropriate. The reviewer further determines whether the government unit has followed all other statutes, rules and regulations applicable to the procurement. Additional questions asked include: Has the governing body, department or authority approved the procurement? Are the specifications designed to ensure a competitive process? Is the method of advertisement appropriate?

For contracts exceeding \$10 million, the contracting unit must submit notification to OSC 30 days before advertisement or otherwise entering into a contract. On occasion, contracting units request flexibility in that time period. Accordingly, OSC has set forth a procedure through which government entities can seek a waiver of the 30-day time period. OSC works closely with contracting units needing such a waiver to ensure that contract solicitations can be made in a timely manner.

Contracts exceeding \$2 million, including \$10 million contracts previously submitted for pre-approval, are examined post-award. The focus post-award remains on compliance with laws and regulations. In addition, a determination is made as to whether the award followed the guidelines set forth in the solicitation. For example: Did the lowest bidder get the award in a sealed bid determination that appropriately considered alternates? Did the governing body approve and certify funding for the contract? Are the records submitted sufficient to justify the governing body's action? Is there any evidence of collusion or bid rigging?

To ensure that OSC's contract reviews result in a better contracting process in both the short and long terms, the Procurement Division consults directly with contracting units during and following reviews.

Depending upon the nature of the review and any deficiency noted, the Procurement Division might hold an exit interview, prepare a written determination or simply provide oral guidance to the contracting unit. In cases involving serious deficiencies, OSC may refer contracts for audit review or further civil or administrative action, such as actions to recover monies expended. Criminal activity is referred to appropriate law enforcement authorities.

Among the most frequent errors OSC encountered were the misstatement of the Business Registration Certificate requirement as set forth in *N.J.S.A. 52:32-44*, vague or confusing evaluation criteria and inadequate descriptions of services in the scope of work.

The Procurement Division also has added oversight responsibilities with regard to contracts connected to Superstorm Sandy. Under Executive Order (EO) 125, the division is required to review any and all state procurements that involve the expenditure of federal re-

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Notable state contracts include \$56.6 million to develop a state-based health insurance exchange, and a \$78 million contract for Newark to replace lead service water lines for its drinking water.

construction resources connected to Sandy recovery. The division then posts Sandy-related contracts on OSC's Sandy Transparency website. As a result, in FY 2020, the Procurement Division reviewed a variety of purchasing practices that otherwise would have been below OSC's

statutory monetary threshold for review.

The division reviews proposed procurements subject to EO 125 on an immediate basis, providing guidance and feedback to agencies to ensure compliance with public contracting laws without sacrificing expediency in the state's recovery process. In FY 2020, the division reviewed 49 contracts and purchase orders pursuant to EO 125 in furtherance of our state's rebuilding and recovery effort.

In all, the Procurement Division received notice of 655 contracts for review in FY 2020. Of those contracts, 192 of them were valued at more than \$10 million and were pre-screened pursuant to OSC's regular statutory authority. OSC attorneys took corrective action in 121 (63 percent) of those pre-screened contracts to ensure the legality of the

procurement process.

Some notable contracts reviewed include: a \$56.6 million contract for the development of a state-based health insurance exchange platform; a \$78 million contract for the City of Newark to replace lead service water lines for its drinking water; and a \$180 million federally-funded contract for the state Department of Transportation to construct new highway ramps connecting Route 42 and Interstate 295.

The Procurement Division also reviewed 414 contracts valued between \$2 million and \$10 million. In these contracts, the Procurement Division found a 60 percent error rate. In each case, the division gave guidance to the contracting entity to ensure that the errors are not repeated.





Appendix - MFD Settlements & Audits

FY 2020 Settlements

- **Ultra Care Pharmacy Settlement Agreement** – MFD resolved an investigation of Ultra Care Pharmacy, located in Jersey City, New Jersey, with Ultra Care agreeing to repay the Medicaid program \$25,409. Through this investigation, MFD determined that, for the period from July 1, 2013 through April 30, 2018, Ultra Care’s inventory for selected medications was not sufficient to account for the quantity of these medications that Ultra Care dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.
- **Trimax Pharmacy Settlement Agreement** – MFD resolved an investigation of Trimax Pharmacy, located in Newark, New Jersey, with Trimax agreeing to repay the Medicaid program \$243,517.86. Through this investigation, MFD determined that, for the period from December 1, 2013 through September 30, 2018, Trimax’s inventory for selected medications was not sufficient to account for the quantity of these medications that Trimax dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.
- **C-Line Community Outreach Services Settlement Agreement** – MFD resolved an investigation of C-Line Community Outreach Services (C-Line), located in Jersey City, New Jersey, with C-Line agreeing to repay the Medicaid Program \$354,283.73. Through this investigation, MFD determined that, for the period from November 1, 2013 through November 19, 2018, C-Line billed Medicaid for claims in which its medical documentation failed to support the claims billed. MFD found that C-Line received overpayments totaling \$334,229.95 and, because C-Line sought to repay this amount over an extended time period, the parties agreed that C-Line would pay an additional 6% interest, which brought the total settlement amount to \$354,283.73.
- **Fayrouz Pediatrics Settlement Agreement** – MFD resolved a desk audit of Fayrouz Pediatrics, located in Clifton, New Jersey, with Fayrouz Pediatrics agreeing to repay the Medicaid program \$73,872.61. Through this desk audit, MFD determined that, for the period between January 1, 2015 through August 31, 2019, Fayrouz improperly unbundled claims submitted to the Medicaid program that were supposed to have been billed under a single code.
- **Town Drugs Settlement Agreement** – MFD resolved an investigation of Town Drugs, located in Perth Amboy, New Jersey, with Town Drugs agreeing

to repay the Medicaid program \$20,580.76. Through this investigation, MFD determined that, for the period from June 26, 2013 through March 1, 2018, Town Drugs' inventory for selected medications was not sufficient to account for the quantity of these medications that Town Drugs dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Mabel's Pharmacy Settlement Agreement** – MFD resolved an investigation of Mabel's Pharmacy, located Elizabeth, New Jersey, with Mabel's agreeing to repay the Medicaid program \$505,000. Through this investigation, MFD determined that, for the period from March 1, 2011 through March 31, 2016, Mabel's inventory for selected medications was not sufficient to account for the quantity of these medications that Mabel's dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Wellcare Pharmacy Settlement Agreement** – MFD resolved an investigation of Wellcare Pharmacy, located in Patterson, New Jersey, with Wellcare agreeing to repay the Medicaid program \$177,000. Through this investigation, MFD determined that, for the period from April 1, 2012 through April 1, 2017, Wellcare's inventory for selected medications was not sufficient to account for the quantity of these medications that Wellcare dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Star Pediatric Home Care Agency Settlement Agreement** – MFD resolved an investigation of Star Pediatric Home Care Agency, a home health provider, located in Lakewood, New Jersey, with Star Pediatric Home Health agreeing to repay the Medicaid program \$7,705.35. Through this investigation, MFD

determined that, for the period from January 1, 2013 through July 31, 2018, Star Pediatrics Home Health improperly billed Medicaid for providing personal care home services on days when the Medicaid recipient was either in the hospital or outside of the home.

- **West Essex Dental Settlement Agreement** - MFD resolved an investigation of Cyrus Dekhan, D.D.S. and West Essex Dental Practice, P.A. (West Essex), with locations in Caldwell and Pemberton, New Jersey, with West Essex agreeing to repay the Medicaid program \$70,000. Through this investigation, MFD determined that, for the period from January 1, 2013 through December 2, 2017, West Essex improperly billed Medicaid for dental services for which it lacked sufficient documentation substantiating that the dental services had been performed.

- **Divine Health Care Services Settlement Agreement** – MFD resolved an investigation of Divine Health Care Services (Divine), located in East Orange, New Jersey, with Divine agreeing to repay the Medicaid program \$21,566.98. Through this investigation, MFD determined that, during the period from January 1, 2015 through May 31, 2019, Divine improperly billed Medicaid for providing personal care services on days when the Medicaid beneficiary was in a hospital as an in-patient, contrary to Medicaid regulations.

- **Mo's Pharmacy Settlement Agreement** – MFD resolved an investigation of Mo's Pharmacy, located in New Brunswick, New Jersey, with Mo's agreeing to repay the Medicaid program \$135,000. Through this investigation, MFD determined that Mo's Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that Mo's Pharmacy dispensed during the period from November 1, 2014 through December 15, 2017. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Liss Pharmacy Settlement Agreement** – MFD resolved an investigation of Liss Pharmacy, located in Newark, New Jersey, with Liss agreeing to repay the Medicaid program \$149,703.47. Through this investigation, MFD determined that, for the period from January 1, 2015 through October 31, 2018, Liss’s inventory for selected medications was not sufficient to account for the quantity of these medications that Liss dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications. This settlement was comprised of two portions, an underlying overpayment and a penalty. MFD found a principal overpayment of \$109,741,36. In addition, because this was a second finding for this type of overpayment for a portion of the period covered by these claims, MFD assessed a civil penalty of \$39,962.11. As a result, the parties agreed that Liss would repay a total overpayment amount of \$149,703.47.

- **Lifeline Rx, LLC Pharmacy Settlement Agreement** – MFD resolved an investigation of Lifeline Pharmacy, located in West New York, New Jersey, with Lifeline agreeing to repay the Medicaid program \$10,755.00. Through this investigation, MFD determined that, for the period from July 1, 2017 through November 30, 2018, Lifeline’s inventory for selected medications was not sufficient to account for the quantity of these medications that Lifeline dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **We Care Health Services Settlement Agreement** – MFD resolved an audit of We Care Health Services (We Care), located in Trenton, New Jersey, with We Care agreeing to repay the Medicaid Program \$23,886.79. Through this audit, MFD determined that We Care billed the Division of Medical Assistance and/or Managed Care Organizations which

were not supported by the required documentation for claims billed for the period from January 1, 2015 through May 2019.

- **New Hope Behavioral Center Settlement Agreement** – MFD resolved an investigation of New Hope Behavioral Center (New Hope), located in Irvington, New Jersey, with New Hope agreeing to repay the Medicaid Program \$51,380.00. Through this investigation, MFD determined New Hope billed Medicaid for claims in which its medical documentation failed to support the claims billed for the period from January 6, 2017 through February 15, 2019.

- **ICare Pharmacy Settlement Agreement** – MFD resolved an investigation of ICare, located in Bloomfield, New Jersey, with ICare agreeing to repay the Medicaid program \$10,493.87. Through this investigation, MFD determined that, for the period from January 1, 2014 through March 31, 2018, ICare’s inventory for selected medications was not sufficient to account for the quantity of these medications that ICare dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Billstra Pharmacy Settlement Agreement** – MFD resolved an investigation of Billstra Pharmacy, located in Paterson, New Jersey, with Billstra agreeing to pay the Medicaid program \$130,000. Through this investigation, MFD determined that, for the period from December 27, 2013 through November 27, 2018, Billstra’s inventory for selected medications was not sufficient to account for the quantity of these medications that Billstra dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Girgis Family Medicine Settlement Agreement** – MFD resolved an investigation of Girgis Family Med-

icine, located in South River, New Jersey, with Girgis agreeing to pay the Medicaid program \$7,513.57. Through this investigation, MFD determined that, for the period from July 1, 2014 through October 1, 2018, Girgis had billed the Medicaid program for vaccines it received from the Vaccines for Children (VFC) program, in violation of federal regulations. Additionally, Girgis did not maintain proper documentation regarding the vaccine lot number and manufacturer in some instances, but nevertheless billed the Medicaid program.

- **Diligent Medical Care, PC Settlement Agreement** – MFD resolved an investigation of Diligent Medical Care, PC, located in Union City, New Jersey, with Diligent agreeing to pay the Medicaid program \$16,191.81. Through this investigation, MFD determined that, for the period from July 1, 2014 through December 6, 2018, Diligent billed Medicaid for services that were not supported by medical records for the level of service billed.

- **Rainbow Pediatrics, PC Settlement Agreement** – MFD resolved an investigation of Rainbow Pediatrics, PC, located in Cape May Court House, New Jersey, with Rainbow agreeing to pay the Medicaid program \$350,000. Through this investigation, MFD determined that, for the period from January 1, 2015 through March 30, 2019, Rainbow billed for various services, including developmental screenings, that were not supported by sufficient documentation.

- **OncoMed Pharmaceutical Services of Jersey City, New Jersey, LLC Settlement Agreement** – MFD resolved an investigation of OncoMed, located in Jersey City and South Plainfield, New Jersey, with OncoMed agreeing to pay the Medicaid program \$250,000. Through this investigation, MFD determined that, for the period from December 1, 2011 through November 1, 2015, OncoMed billed the Medicaid program for services that could not be supported by documentation.

- **Roses Home Care Services Settlement Agreement** – MFD resolved an investigation of Roses Home Care Services, located in East Orange, New

Jersey, with Roses agreeing to pay the Medicaid program \$250,000. Through this investigation, MFD determined that, for the period from January 1, 2012 through August 3, 2017, Roses billed the Medicaid program for services that were not supported by documentation or were for patients receiving inpatient care at a hospital or other facility when Roses billed and was paid for home healthcare services. These billings therefore resulted in a Medicaid overpayment.

- **STS Speech Therapy, LLC Settlement Agreement** – MFD resolved a desk audit of STS Speech Therapy, LLC, located in Lakewood, New Jersey, with STS agreeing to repay the Medicaid program \$190,000. Through this desk audit, MFD determined that, for the period from January 1, 2013 through December 31, 2017, STS billed Medicaid for claims in which its medical documentation failed to supported the claims billed and improperly unbundled claims submitted to the Medicaid program that were supposed to have been billed under a single code.

- **Mia Capozella Seiger Settlement Agreement** – MFD resolved an investigation of Mia Capozella Seiger, DMD, located in West Orange, New Jersey, with Seiger agreeing to repay the Medicaid Program \$80,470.25. Through this investigation, MFD determined that, for the period from January 1, 2012 through March 12, 2018, Seiger billed Medicaid for claims in which the relevant medical documentation failed to support the claims billed.

- **Friendly Pharmacy Settlement Agreement** – MFD resolved an investigation of Friendly Pharmacy, located in Jersey City, New Jersey, with Friendly Pharmacy agreeing to repay the Medicaid Program \$360,000. Through this investigation, MFD determined that, for the period from February 1, 2012 through February 28, 2017, Friendly Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Accu Reference Medical Lab, LLC Settlement Agreement** – MFD resolved an investigation of Accu Reference Medical Lab, LLC, located in Linden, New Jersey, with Accu Reference Lab agreeing to repay the Medicaid Program \$142,235.98. Through this investigation, MFD determined that, for the period from January 1, 2015 through November 30 2018, Accu Reference Lab billed Medicaid for improperly unbundled claims that were supposed to have been billed under a single code.

- **AR-EX Pharmacy Settlement Agreement** – MFD resolved an investigation of AR-EX Pharmacy, Inc., located in Fords, New Jersey, with AR-EX Pharmacy agreeing to repay the Medicaid Program \$12,000. Through this investigation, MFD determined that, for the period from September 1, 2013 through August 31, 2018, AR-EX Pharmacy’s inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Farmacia San Antonio Settlement Agreement** – MFD resolved an investigation of Farmacia San Antonio, located in Camden, New Jersey, with Farmacia San Antonio agreeing to repay the Medicaid Program \$160,000. Through this investigation, MFD determined that, for the period from March 1, 2013 through December 31, 2015, Farmacia San Antonio’s inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Paterson Pharmacy Settlement Agreement** - MFD resolved an investigation of Paterson Pharmacy, located in Paterson, New Jersey, with Paterson Pharmacy agreeing to repay the Medicaid Program \$41,750. Through this investigation, MFD determined that, for the period from February 1, 2012 through February 10, 2017, Paterson Pharmacy’s inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **CarePoint Health Settlement Agreement** - MFD resolved a self-disclosure submitted by CarePoint Health (CarePoint), located in Hoboken, New Jersey, with CarePoint agreeing to repay the Medicaid program \$501,690. Through this self-disclosure and MFD’s subsequent investigation of the claims at issue, MFD determined that, for the period from October 1, 2015 through November 10, 2017, CarePoint billed Medicaid for hospital observation claims exceeding 24 hours at three of its hospitals that that were not supported by sufficient documentation.

- **Tony’s Pharmacy Settlement Agreement** - MFD resolved an investigation of Tony’s Pharmacy, located in Passaic, New Jersey, with Tony’s Pharmacy agreeing to repay the Medicaid Program \$449,170.68. Through this investigation, MFD determined that, for the period from February 1, 2012 through February 10, 2017, Tony’s Pharmacy’s inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory “shortage” constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications. This settlement was comprised of two portions, an underlying overpayment and a penalty. MFD found a principal overpayment of \$224,585.34. In addition, because this was a second finding against Tony’s Pharmacy for this type of overpayment, MFD assessed a civil penalty of an additional \$224,585.34, which brought the total settlement amount to \$449,170.68.

- **RMC Pharmacy Settlement Agreement** - MFD resolved an investigation of RMC Pharmacy, located in Newark, New Jersey, with RMC Pharmacy agreeing to repay the Medicaid Program \$60,000. Through this investigation, MFD determined that, for the period from October 1, 2013 through May 1, 2018, RMC Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Abilities of Northwest Jersey, Inc. Settlement Agreement** – MFD resolved a self-disclosure submitted by Abilities of Northwest Jersey, Inc. (Abilities), located in Washington, New Jersey, with Abilities agreeing to repay the Medicaid program \$81,620.72. Through this self-disclosure and MFD's subsequent investigation of the claims at issue, MFD determined that, for the period from April 11, 2016 through April 17, 2019, Abilities billed Medicaid for services rendered by two employees who failed to possess the requisite education background to have performed the services billed.

- **Preferred Ultrasound Center Settlement Agreement** – MFD resolved an investigation of Preferred Ultrasound Center (Preferred), located in Linden, New Jersey, with Preferred agreeing to repay the Medicaid program \$168,480. Through this investigation, MFD determined that, for the period from March 1, 2013 through April 17, 2018, Preferred billed Medicaid for claims in which the relevant medical documentation failed to support the claims billed.

- **City Rx Pharmacy Settlement Agreement** – MFD resolved an investigation of CityRx Pharmacy, located in Paterson, New Jersey, with City Rx Pharmacy

agreeing to repay the Medicaid Program \$130,000. Through this investigation, MFD determined that, for the period from March 1, 2012 through December 31, 2016, City Rx Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Hoboken Family Pharmacy Settlement Agreement** – MFD resolved an investigation of Hoboken Family Pharmacy (Hoboken Pharmacy), located in Hoboken, New Jersey, with Hoboken Pharmacy agreeing to repay the Medicaid Program \$85,888.80. Through this investigation, MFD determined that, for the period from February 1, 2012 through February 12, 2017, Hoboken Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Kennedy Pharmacy Settlement Agreement** - MFD resolved an investigation of Kennedy Pharmacy, located in Stratford, New Jersey, with Kennedy Pharmacy agreeing to repay the Medicaid program \$110,000. Through this investigation, MFD determined that, for the period from January 15, 2013 through December 15, 2017, Kennedy Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

- **Ideal Pharmacy Settlement Agreement** - MFD resolved an investigation of Ideal Pharmacy, located in

Union, New Jersey, with Ideal Pharmacy agreeing to repay the Medicaid Program \$48,900. Through this investigation, MFD determined that, for the period from September 1, 2011 through September 1, 2015, Ideal Pharmacy's inventory for selected medications was not sufficient to account for the quantity of these medications that were dispensed. This inventory "shortage" constituted a Medicaid overpayment because the pharmacy could not provide documentation to support the claims it submitted for these medications.

MFD Audits, Closing Reports, and Overpayment Letters

- **Community Psychiatric Institute (Closing Report)** – MFD audited Community Psychiatric Institute, Inc. (CPI), a mental health and substance abuse provider located in East Orange, New Jersey. CPI offers partial-care services, which are individualized outpatient clinical services (e.g., group and individual therapy, prevocational services, and medication management) to beneficiaries age 18 or older with a primary diagnosis of psychiatric disorder accompanied by an impaired ability to perform activities of daily living, learning, working, or social roles. MFD audited CPI's partial-care claims and supporting documentation for the period from July 1, 2014 through March 31, 2019 to determine whether CPI billed for these services in accordance with applicable federal and state laws, regulations and guidance. Based on its review of a probe, or initial, sample, MFD determined with reasonable certainty that CPI's claims comported with the relevant requirements. Accordingly, MFD closed the audit without any adverse findings.

- **CareFinders (Notice of Overpayment)** – MFD's Audit Unit reviewed claims submitted by Secura Home Health, LLC, and CareFinders, Inc. (CareFinders), a home health care provider located in

Hackensack, New Jersey, for the period from January 1, 2015 through May 31, 2019. Specifically, MFD reviewed CareFinders' claims for Personal Care Services (PCS). MFD found that CareFinders submitted claims for services provided to beneficiaries while these beneficiaries had in-patient status in a hospital setting. Pursuant to Medicaid regulations, a beneficiary cannot receive PCS, Private Duty Nursing or In-Home-Nursing services, while Medicaid is paying a hospital for room and board services for the same beneficiary. MFD determined that CareFinders improperly billed and received payments totaling \$24,178.86 for these PCS services. CareFinders paid the full amount identified in MFD's review.

- **Full Circle Health Services, LLC (Notice of Overpayment)** - MFD's Audit Unit reviewed claims submitted by Full Circle Health Services, LLC (Full Circle), a home health care provider located in Union, New Jersey, for the period from January 1, 2015 through May 31, 2019. Specifically, MFD reviewed Full Circle's claims for Personal Care Services (PCS). MFD found that Full Circle submitted claims for services provided to beneficiaries while these beneficiaries had in-patient status in a hospital setting. Pursuant to Medicaid regulations, a beneficiary cannot receive PCS, Private Duty Nursing or In-Home-Nursing services, while Medicaid is paying a hospital for room and board services for the same beneficiary. MFD determined that Full Circle improperly billed and received payments totaling \$24,991.42 for these PCS services. Full Circle paid the full amount identified in MFD's review.

- **Taylor Care Adult Behavioral Health (Overpayment Letter)** – MFD's Audit Unit reviewed claims submitted by Taylor Care Adult Behavioral Health (Taylor), a mental health and substance abuse provider located in Galloway, New Jersey. Taylor offers partial-care services, which are individualized outpatient clinical services (e.g., group and individual therapy, prevocational services, and medication

management) to beneficiaries age 18 or older with a primary diagnosis of psychiatric disorder accompanied by an impaired ability to perform activities of daily living, learning, working, or social roles. MFD reviewed Taylor's partial-care claims and supporting documentation for the period from January 1, 2015 through September 30, 2019 to determine whether Taylor billed for these services in accordance with applicable federal and state laws, regulations and guidance. MFD determined that Taylor billed and received payment for units of services in excess of the pre-approved authorized number of units, in violation of the applicable regulatory requirement. As such, MFD found that Taylor received an overpayment of \$17,265.76 that it had to repay to the Medicaid program. Taylor paid the full amount identified in MFD's review.

- **[Matthew Sable, MA, NCC, LPC, LLC \(Final Audit Report\)](#)** - MFD audited Matthew Sable, a mental health rehabilitation services provider located in Flemington, New Jersey. MFD audited Sable's intensive in-community mental health rehabilitation services claims and supporting documentation for the period from January 1, 2014 through December 31, 2018 to determine whether Sable billed for these services in accordance with applicable federal and state laws, regulations and guidance. MFD found that 80 of 528 sampled claims failed to comply with applicable requirements. After extrapolating this finding to the universe of claims from which the sample was drawn, MFD calculated that Sable received an overpayment of \$159,265.76 that had to be repaid to the Medicaid program.

- **[Ortho-Step, Inc. \(Final Audit Report\)](#)** - MFD audited claims submitted by Ortho-Step, Inc., an orthopedic shoe and durable medical equipment (DME) provider located in Lakewood, New Jersey. MFD audited Ortho-Step's claims for the period from January 1, 2013 through December 31, 2017 to determine whether these claims complied with applicable laws, regulations and policies. To perform this audit, MFD

statistically selected 914 claims from a universe of more than 91,000 claims totaling payments of almost \$13.5 million for the period at issue. From this sample, MFD determined that 673 of these claims lacked sufficient supporting documentation and, thus, were paid in error. MFD found that Ortho-Step lacked sufficient documentation to support its claims in every category of DME audited, including compression stockings, shoe inserts, orthopedic shoes, and breast pumps. The errors ranged from a lack of any order for the DME billed; to an inadequate prescription for the DME, such as ones that did not include the name of an ordering physician; to a lack of any evidence that a beneficiary received the item in question. MFD extrapolated this error rate to the universe from which the audit sample was drawn. From that process, MFD calculated that Ortho-Step received an overpayment of \$7,265,776 that had to be repaid to the Medicaid program.

- **[New Essecare of NJ, LLC \(Final Audit Report\)](#)** - MFD audited claims submitted by New Essecare of NJ, LLC (New Essecare), a mental health and substance abuse provider located in Orange, New Jersey. New Essecare offers partial-care services, which are individualized outpatient clinical services (e.g., group and individual therapy, prevocational services, and medication management) to beneficiaries age 18 or older with a primary diagnosis of psychiatric disorder accompanied by an impaired ability to perform activities of daily living, learning, working, or social roles. MFD audited New Essecare's partial-care claims and supporting documentation for the period from January 1, 2015 through December 31, 2017 to determine whether New Essecare billed for these services in accordance with applicable federal and state laws, regulations and guidance. MFD found that 96 of the 212 claims it reviewed (45.3%) failed to comply with one or more of the applicable requirements. In the majority of these cases, MFD determined that the supporting documentation failed to support the number of units billed. After extrapolating this finding to the universe of claims from which the sample was drawn,

MFD calculated that New Essecare received an over-payment of \$1,288,308 that had to be repaid to the Medicaid program.

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