State of New Jersey

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PHILIP JAMES DEGNAN
State Comptroller

JOSH LICHTBLAU
Director

September 25, 2017

By Certified and Electronic Mail

Dr. Sohaila Khan
11 Burlew Place
Parlin, NJ 08859

Re: Final Audit Report
Dr. Sohaila Khan
[redacted]

Dear Dr. Khan:

Enclosed is the Final Audit Report for your medical practice, New Jersey Medicaid Provider Number [redacted]. Island Peer Review Organization, in conjunction with SafeGuard Services, LLC, completed the audit on behalf of the Centers for Medicare & Medicaid Services and the State of New Jersey, Office of the State Comptroller, Medicaid Fraud Division. The Final Audit Report identified an overpayment for Medicaid claims paid to you in the amount of $42,785, for the period from January 1, 2011 through December 31, 2013.

Should you have questions about how to reimburse the Medicaid program for this overpayment, please contact Mr. Glenn Geib, Supervisor, Recovery and Exclusions, at (609) 789-5032 or by email at glenn.geib@osc.nj.gov. If you have questions regarding this Final Audit Report, you may contact Mr. Michael Morgese, Audit Supervisor at (609) 789-5067.

Dr. Sohaila Khan
[redacted]
September 25, 2017

Sincerely,

PHILIP JAMES DEGNAN
STATE COMPTROLLER

By:
Josh Lichtblau, Director
Medicaid Fraud Division

JL/mmm
Enc.
cc: Paul A. De Sarno, Esq.
Kay Ehrenkrantz, Deputy Director, OSC
Michael McCoy, Manager of Fiscal Integrity, OSC
Michael Morgese, Audit Supervisor, OSC
Glenn Geib, Supervisor Recovery and Exclusions, OSC
Meghan Davey, Director Division of Medical Assistance and Health Services
Elizabeth Lindner, Director Division of Field Operations – North, CMS

SafeGuard Services LLC

Revised Final Audit Report of
Sohaila Khan MD
NJ Medicaid Number: [redacted]

Audit Period January 1, 2011 to December 31, 2013

Date Issued: August 16, 2017

CMS Audit Number: 1-45809839

I. INTRODUCTION

Island Peer Review Organization (IPRO), the audit contractor acting on behalf of the Centers for Medicare & Medicaid Services (CMS) and the New Jersey Office of the State Comptroller, Medicaid Fraud Division (OSC), initiated an audit of Dr. Sohaila Khan (Provider) to determine whether the Medicaid services she provided from January 1, 2011 through December 31, 2013 complied with applicable federal and state laws, regulations, policies, and the Provider's Medicaid enrollment agreement.[1] Specifically, the audit focused on whether the services that the Provider billed for were, in fact, provided and whether the Provider's documentation for such services was consistent with the claims submitted for these services. From a universe of more than 22,907 claims with a total Medicaid payment of $759,308.61, the auditors randomly selected 250 claims for review. From that sample, the audit found recoupable errors in 67 claims. The vast majority of these errors related to lack of documentation to support the submitted claims. The remaining errors were attributable to a lack of documentation to support the level of Evaluation and Management (E&M) procedure code for the submitted claims. In the aggregate, the 67 errors resulted in overpayments totaling almost $466. When that error rate was extrapolated to the universe of claims, the overpayment total increased to more than $42,000.

As part of the audit process, the audit team met with the Provider, afforded the Provider opportunities to explain her claim submissions and, after issuing a Draft Audit Report, allowed the Provider to submit a formal response, which is attached. This Final Audit Report takes into account all of the information obtained through the audit process, including the Provider's written response to the Draft Audit Report.

A. BACKGROUND:

IPRO was contracted by CMS to audit Providers participating in the New Jersey Medicaid program. These audits were conducted in accordance with the procedures specified in federal and state laws and regulations and guidance, including the Code of

[1] IPRO conducted all stages of the work on this audit through approximately February 2017. IPRO was the vendor for the federal Medicaid Integrity Contract (MIC), through which CMS offered to states, including New Jersey, a supplemental audit team for Medicaid related audits. CMS replaced the MIC with a regional audit contract, the Northeast Unified Program Integrity Contract (NE UPIC), which CMS awarded to Safeguard Services (SGS) effective February 1, 2017. IPRO transitioned all of its work, including this audit, to SGS in or about February 1, 2017. Consequently, SGS completed the Final Audit Report for this audit.

Federal Regulations (*C.F.R.*), Titles 52 and 30 of New Jersey Statutes Annotated (*N.J.S.A.*), Titles 8 and 10 of the New Jersey Administrative Code (*N.J.A.C.*), and "*Government Auditing Standards*" as issued by the United States Government Accountability Office. Audits under this program also utilized guidelines established by CMS.

IPRO conducted this audit in accordance with the audit plan collaboratively prepared and approved by CMS and OSC.

B. PROGRAM OBJECTIVES:

IPRO provider audits have the following objectives:

- To determine if services for which a Provider submitted claims and was paid for such claims were, in fact, provided.
- To determine whether the Provider rendered, documented and submitted claims for services in compliance with federal and state Medicaid laws, regulations and guidance as well as the Provider's Medicaid enrollment agreement.
- To identify provider billing and/or payment irregularities within the State's Medicaid program.
- To determine appropriateness and necessity of care.

C. AUDIT PROCESS:

IPRO conducted this audit in the following manner:

Overview

IPRO and the Provider met at the Entrance Conference in July 2015 so that the audit team could obtain an understanding of the Provider's operations. The Provider also gave the audit team requested claims information at this meeting. This process allowed the audit team to understand, among other things, how the Provider billed for services. In addition, the audit team obtained Medical and related business records. The audit team used these records to determine whether claims were coded appropriately, services were rendered, and services were medically necessary.

Statistical Sampling

The auditors drew a stratified sample of 250 claims that met the requirements for this review. The sample was taken from the universe of Medicaid claims which included 22,907 fee-for-service (FFS) and encounter services during the period January 1, 2011 through December 31, 2013.

The audit team conducted its analysis using the stratified sample of claims. The audit findings from the sample were then extrapolated to the universe of claims from which the

sample was drawn. The findings are discussed in Section III of this report and the extrapolated results are outlined in Section IV.

Documentation Reviewed

For their on-site review, IPRO copied claims documents and the medical records that would support such claims. These documents included partial medical records, patient progress notes and patient sign-in sheets. IPRO did not remove original records from the premises and, for any records that were computer generated, the Provider made available the original, hard copy record for verification purposes. After the on-site review, IPRO asked for and the Provider supplied additional documents necessary to complete the audit.

As part of the on-site review, IPRO analyzed the documents to determine whether there were any billing irregularities or deviations from Medicaid laws, regulations, and guidance, or from the Provider's Medicaid enrollment agreement.

Discussion of Audit Results

After the on-site review, IPRO further analyzed copies of the Provider's documents and medical records to ascertain whether the Provider's Medicaid claims complied with applicable Medicaid laws, rules, guidelines and the Provider's Medicaid enrollment agreement. After IPRO concluded its internal analysis, it developed a summary of its findings, which it gave to the Provider. IPRO then held an exit conference on May 18, 2016 with representatives from the OSC and the Provider to discuss the summary of findings and any other issues involving the audit. At that exit conference, the Provider was given an opportunity to present its position regarding the summary of IPRO's findings. In addition, at the exit conference, IPRO and OSC representatives advised that the Provider could submit a written response to the summary of findings. The Provider submitted a response to the summary of findings in a document dated June 1, 2016. IPRO considered that response as part of its preparation of the Draft Audit Report. IPRO gave the Provider the Draft Audit Report for it to review and respond to. The Provider submitted a response to the Draft Audit Report in a document dated November 22, 2016 (which is attached as Appendix C). All of the work papers, the summary report, Draft Audit Report, and Provider responses have been considered in preparation of this report.

II. AUDIT PROFILE

A. PROVIDER PROFILE:

Name:	Sohaila Khan MD
Address:	11 Burlew Place Parlin, NJ 08859
Provider Number:	[redacted]

Provider Type: Pediatrician

B. AUDIT SCOPE:

The scope of this audit was limited to determining compliance with federal and state Medicaid laws, regulations and guidance as well as adherence to the Medicaid program enrollment agreement.

The universe included 22,907 claims for services with a total Medicaid payment of $759,308.61. From this universe, auditors selected a stratified sample of 250 claims for services totaling $8,079.23 for review.

The audit was not intended to discover all possible errors in billing or record keeping. Any omission of other errors from this report does not mean that such practices are acceptable. Because of the limited nature of this review, no inferences as to the overall level of provider performance should be drawn solely from this report.

Achieving the objectives of the audit did not require the review of the Provider's overall internal control structure. Accordingly, the auditors limited the internal control review to the controls related to any overpayments.

C. ANALYSIS OF FINDINGS:

Of the 250 sampled claims for services reviewed, there were 67 claims for services with recoupable monetary findings. Section III explains the monetary findings, along with support for such findings. Appendix A lists the findings and associated sample claim information.

III. AUDIT FINDINGS

The following detailed findings reflect the results of the audit:

1. No Documentation

Auditors identified 53 instances in which the medical record provided was missing thermography test results.

The state regulation pertaining to recordkeeping provides in pertinent part:

> (a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

(c) The progress note shall be placed in the clinical record and retained in the appropriate setting for the service performed.

(d) Records of Residential Health Care Facility patients shall be maintained in the physician's office.

(e) The required medical records including progress notes, shall be made available, upon their request, to the New Jersey Medicaid … program or its agents.

N.J.A.C. 10:54-2.6 (a)-(e) Recordkeeping; general

For established patients, which is the case here, there are more specific recordkeeping requirements. Specifically, the applicable regulation provides:

(a) The following minimum documentation shall be entered in the progress notes of the medical record for the service designated by the procedure codes for ESTABLISHED PATIENT:

1. In an office or Residential Health Care Facility:

i. The purpose of the visit;

ii. The pertinent physical, family and social history obtained;

iii. A record of pertinent physical findings, including pertinent negative findings based upon i and ii above;

iv. Procedures performed, if any, with results;

v. Laboratory, X-Ray, electrocardiogram (ECG), or any other diagnostic tests ordered, with the results of the tests; and

vi. Prognosis and diagnosis."

N.J.A.C. 10:54-2.8(a)(1)(i-vi) Minimum documentation; established patient

In addition to the regulations set forth immediately above (*N.J.A.C.* 10:54-2.8), there are additional regulations that require Medicaid providers to properly document the services they render and put providers on notice that when there is no such documentation or inadequate documentation, their claims may be adjusted accordingly. The specific regulations state the following:

(a) All program providers, except institutional, pharmaceutical, and transportation providers, shall be required to certify that the services billed on any claim were rendered by or under his or her supervision (as defined and permitted by program

regulations); and all providers shall certify that the information furnished on the claim is true, accurate, and complete.

1. All claims for covered services must be personally signed by the provider or by an authorized representative of the provider (for example, hospital, home health agency, independent clinic) unless the provider is approved for electronic media claims (EMC) submission by the Fiscal Agent. The provider must apply to the Fiscal Agent for EMC approval and sign an electronic billing certificate.
i. The following signature types are unacceptable:

(1) Initials instead of signature;
(2) Stamped signature; and
(3) Automated (machine-generated) signature.

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;

2. To furnish information for such services as the program may request;

3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;

4. That 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;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8(a) & (b) Provider Certification and Recordkeeping

As set forth in Section III 1 above, the New Jersey law that underpins the regulations cited in this report requires providers to properly maintain records that accurately reflect the services provided and billed to Medicaid. *N.J.S.A.* 30:4D-12(d) & (e).

2. **<u>Incorrect Procedure Code – Evaluation & Management (E&M) Code</u>**

Auditors identified 14 instances in which the Provider billed an incorrect E&M procedure code for the service documented in the medical record. In other words, the Provider submitted claims for E&M codes that require a greater level of service than was

documented in the medical records. For purposes of assessing an overpayment amount, the auditors downcoded these E&M codes to conform to the appropriate level of service documented and used the reimbursement for that lower level of service as the amount that should have been paid for such service. Appendix A lists the incorrect E&M code billed along with the correct E&M procedure code.

It is worth noting that for instances in which claim payments were made by Managed Care Organizations (MCO), the Provider failed to provide the MCO payment rates for such services. IPRO could not corroborate these rates independently and, thus, asked the OSC to verify these payment rates when necessary. OSC obtained the payment rates from all of the MCOs. As explained in Section IC above, the Provider was given ample opportunity to contest the rate used and did not do so.

The legal support for the finding above is as follows.

The applicable federal regulation states that the standard medical data code sets include:

> The combination of *Health Care Financing Administration Common Procedure Coding System (HCPCS)*, as maintained and distributed by HHS, and *Current Procedural Terminology, Fourth Edition (CPT-4)*, as maintained and distributed by the American Medical Association, for physician services and other health care services. These services include, but are not limited to, the following: (i) Physician services.
>
> *45 C.F.R. § 162.1002(a)(5) Medical data code sets*

The applicable New Jersey regulation pertaining to a provider's use of procedure codes states:

> (b) General policies regarding the use of HCPCS for procedures and services are listed below:
>
> 2. When filing a claim, the HCPCS procedure codes, including modifiers and qualifiers, must be used in accordance with the narratives in the CPT and the narratives and descriptions listed in this Subchapter 9, whichever is applicable.
>
> 3. The use of a procedure code, which describes the service, will be interpreted by the New Jersey Medicaid program, as evidence that the physician or practitioner personally furnished, as a minimum, the stated service. He or she will sign the claim as the servicing provider with the Medicaid Servicing Provider Number (MSPN) as evidence of the validity of the use of the procedure code reflecting the service provided.
>
> *N.J.A.C. 10:54-9.1(b)(2) and (b)(3) Use of procedure codes*

> One of the state regulations regarding recordkeeping and the use of physician codes states:

(a) All physicians shall keep such legible individual records as are necessary to fully disclose the kind and extent of services provided, as well as the medical necessity for those services.

(b) The minimum recordkeeping requirements for services performed in the office . . . shall include a progress note in the clinical record for each visit, which supports the procedure code(s) claimed.

N.J.A.C. 10:54-2.6 (a) and (b) Recordkeeping; general

Another state regulation that pertains to recordkeeping states:

(b) Providers shall agree to the following:

1. To keep such records as are necessary to disclose fully the extent of services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five years from the date the service was rendered;

2. To furnish information for such services as the program may request;

3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;

4. That 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;

5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and

6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

N.J.A.C. 10:49-9.8 (b) Provider Certification and Recordkeeping

The authorizing statute for the regulatory requirements cited above mandates that the Medicaid program institute provider record maintenance requirements for providers in the Medicaid program. One requirement is that all such providers must properly maintain records that accurately reflect the services provided and billed to Medicaid. Specifically, the applicable statutory provision mandates that the Medicaid program:

(d) Require that any provider who renders health care services authorized under this act shall keep and maintain such individual records as are necessary to fully disclose the name of the recipient to whom the service was rendered, the date of the service rendered, the nature and extent of each such service rendered, and any additional

information, as the department may require by regulation. Records herein required to be kept and maintained shall be retained by the provider for a period of at least 5 years from the date the service was rendered;

(e) Require that providers who render health care services authorized under this act shall not be entitled to reimbursement for the services rendered unless said services are documented pursuant to subsection (d) of this section. Any evidence other than the documentation required pursuant to subsection (d) of this section shall be inadmissible in any proceeding conducted pursuant to this act for the purpose of proving that said services were rendered; unless the evidence is found to be clear and convincing by the finder of fact;

N.J.S.A. 30:4D-12(d)&(e). Unnecessary Use of Care and Services; Methods and Procedures; Maintenance of Records Required for Reimbursement

IV. SUMMARY OF OVERPAYMENTS

Of the 250 claims tested, the auditors found that 67 claims failed to meet the statutory and regulatory requirements outlined above. Consequently, the auditors found that these claims constituted overpayments. Applying the principles discussed above regarding the determination of the overpayment, the auditors determined that the identified overpayments for the 67 discrepant sampled claims for services totaled $465.20. When extrapolated to the universe of claims from which the sample was drawn, the point estimate overpayment amount totals $42,785.00. The calculation of this amount is illustrated in Appendices A and B. Accordingly, the total amount of the overpayment that must be returned to New Jersey is $42,785.00.

After being apprised of the findings above, the Provider, through counsel, submitted a response dated December 21, 2016 (attached as Appendix C). In that response, the Provider took issue with the underlying use of an extrapolation methodology, stating, in part, the following:

"The statistical problem which arises in the analysis of the draft report is that, in fact, of the 22,907 patient visits a full 57% of them had insurance which under no circumstances would pay for temperature gradient or thermography [93740] and therefore could not under any circumstances form the basis of an overcharge." The Provider also stated, "[a]dditionally that 9821 visits as a universe includes the visits covered by Horizon New Jersey Health. As my client has explained Horizon New Jersey health codes office visits as 99212 through 99215 all of those code numbers are paid and the fixed amount of [redacted], therefore all such visits should also be excluded from the universe figures."

The Provider's response that patient visits for thermography (93740) should not form the basis for an overcharge, because 13,086 claims for 93740 from 2011 to 2013 were denied by the MCO, is not a supportable argument. The 22,907 claim universe for this audit included only paid claims of which 4,381 were for procedure code 93740.

In addition several of the Horizon NJ Health office visits, 99212 through 99215, included in this audit universe were paid an amount other than [redacted]; therefore this is also not a supportable argument. Since the Provider's response did not include any sufficient reliable documentation to support her position, no adjustments will be made to the audit analysis or the extrapolation. Therefore, we stand by the original extrapolated amount. The Provider must reimburse the Medicaid program $42,785.

V. RECOMMENDATIONS

Based on the findings cited in this audit report, the Provider is directed to repay the Medicaid program $42,785, and to take corrective action to ensure adherence with all federal and state laws and regulations and billing instructions provided under the Medicaid program. Pursuant to *N.J.A.C.* 10:49-11.1, continued violation(s) may result in the termination or suspension of the Provider's eligibility to provide services in the Medicaid program.

VI. SGS COMMENTS

In her response, the Provider did not state whether she agreed or disagreed with the Audit findings, recommendations, or assessment. Rather, she appears to have taken issue with the application of an extrapolation method to the sample of claims. Specifically, she states that "of the 22,907 patient visits…13,086 of them had insurance which under no circumstances would pay for temperature gradient or thermography (93740) and therefore could not under any circumstances form the basis of an overcharge." She goes on to state that "Horizon New Jersey Health codes office visits as 99212 through 99215..are paid…the fixed amount of [redacted] …therefore…should be excluded from the universe figures." These positions do not account for the fact that only paid claims were included in the claims universe as well as several Horizon New Jersey Health office visits "99212 through 99215" for amounts other than [redacted]. Given that the auditors utilized a proper sampling methodology and otherwise performed the extrapolation in an appropriate manner, the Provider has not given any supportable reason to discount or modify the audit findings. Accordingly, the Provider is directed to repay to the Medicaid program the full amount identified, $42,785, and implement specific policies and procedures to address the Audit's Recommendations.

Dr. Sohaila Khan
Appendix A
Audit Findings Claim Detail

Sample #	Recipient ID	Recipient Name	Claim Service Date	Claim Pay (FFS)/ Processing (ENC) Date	Claim HMO Payment Date	Claim Source Code	Clm Submitting Prov Name	Procedure Code Billed	Amount Paid	Correct Procedure Code	Amount Per Audit *	Over Payment	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. No Documentation (Missing Thermography Test Results)	2. Incorrect Procedure Code - Evaluation & Management (E&M) Code
1	[redacted]		12/13/12	01/30/13	12/31/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740	[redacted]		[redacted]					X	
2			08/13/12	09/26/12	09/04/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
4			10/22/12	12/19/12	11/26/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
6			03/09/13	05/01/13	04/03/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
9			07/15/11	08/31/11	08/09/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
12			05/26/12	07/18/12	06/27/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
13			06/25/12	09/26/12	08/13/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
15			03/26/12	06/06/12	04/24/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
16			01/24/12	06/06/12	03/15/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
17			08/13/13	10/23/13	09/25/13	ENC	AMERIGROUP CORPORATION	93740								X	
19			04/15/13	06/05/13	05/18/13	ENC	AMERIGROUP CORPORATION	93740								X	
22			09/06/12	11/28/12	10/08/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
24			02/04/12	03/14/12	03/01/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
25			07/10/12	09/26/12	08/13/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
26			12/01/12	01/30/13	12/18/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
31			12/27/11	02/29/12	01/30/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
32			10/20/12	12/19/12	11/12/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
33			12/12/11	01/25/12	01/07/12	ENC	AMERIGROUP CORPORATION	93740								X	
34			12/21/12	01/30/13	01/09/13	ENC	AMERIGROUP CORPORATION	93740								X	
36			12/04/12	01/30/13	12/24/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
37			05/08/12	07/18/12	06/11/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
39			08/16/11	10/26/11	09/06/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
40			09/24/11	11/30/11	10/25/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
41			11/23/12	01/16/13	12/08/12	ENC	AMERIGROUP CORPORATION	93740								X	
42			10/13/11	11/30/11	11/03/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
43			09/22/11	11/30/11	10/17/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
45			04/17/12	06/27/12	05/14/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
47			10/09/12	11/28/12	11/07/12	ENC	AMERIGROUP CORPORATION	93740								X	
50			08/12/11	10/26/11	09/13/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
51			11/01/11	12/28/11	11/24/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
54			09/18/12	11/28/12	10/22/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
55			12/27/11	02/29/12	01/24/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
58			03/23/12	06/06/12	04/24/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
60			06/21/12	09/26/12	08/27/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
61			07/10/12	09/26/12	08/13/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
62			07/23/12	08/22/12		FFS		93740								X	
64			01/28/13	08/06/14	12/04/13	ENC	AMERIGROUP CORPORATION	93740								X	
65			11/15/12	01/30/13	12/11/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
66			09/19/11	11/30/11	10/10/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
67			01/08/13	02/20/13	01/28/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
69			01/31/13	03/20/13	02/18/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	

Dr. Sohaila Khan
Appendix A
Audit Findings Claim Detail

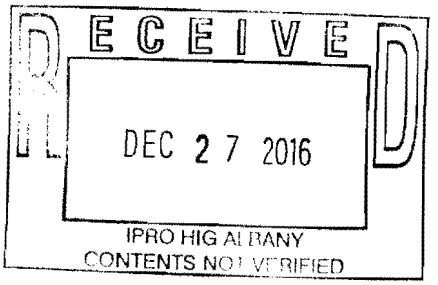
Sample #	Recipient ID	Recipient Name	Claim Service Date	Claim Pay (FFS)/ Processing (ENC) Date	Claim HMO Payment Date	Claim Source Code	Clm Submitting Prov Name	Procedure Code Billed	Amount Paid	Correct Procedure Code	Amount Per Audit *	Over Payment	Federal Fiscal Year	Federal Share %	Federal Share Amount	1. No Documentation (Missing Thermography Test Results)	2. Incorrect Procedure Code - Evaluation & Management (E&M) Code
70	[redacted]		11/09/12	12/19/12	12/03/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740	[redacted]		[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	X	
72			07/26/12	09/26/12	09/05/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
73			01/14/12	03/14/12	02/14/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
74			10/18/12	01/30/13	12/11/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
77			11/08/11	12/07/11	11/19/11	ENC	AMERIGROUP CORPORATION	93740								X	
78			07/12/11	08/24/11	08/03/11	ENC	AMERIGROUP CORPORATION	93740								X	
79			09/25/12	11/28/12	11/03/12	ENC	AMERIGROUP CORPORATION	93740								X	
80			03/19/12	06/06/12	04/19/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
82			01/21/13	05/08/13	02/20/13	ENC	AMERIGROUP CORPORATION	93740								X	
84			12/27/11	02/29/12	01/30/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
85			04/25/11	05/25/11		FFS		93740								X	
86			01/31/13	03/20/13	02/18/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	93740								X	
196			11/22/11	12/21/11	12/03/11	ENC	AMERIGROUP CORPORATION	99214		99213							X
204			04/02/13	05/22/13	04/29/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
205			07/10/12	09/26/12	08/13/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99212							X
206			01/28/13	03/20/13	02/18/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
208			08/06/12	09/26/12	08/27/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99213		99212							X
214			12/07/13	02/26/14	12/28/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
218			03/08/12	06/06/12	03/29/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
219			10/08/11	11/30/11	11/01/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
221			08/25/11	10/26/11	10/04/11	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99215		99213							X
226			12/07/12	01/09/13		FFS		99215		99214							X
230			09/03/13	01/08/14	10/10/13	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99215		99214							X
235			10/23/12	12/19/12	11/28/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
246			12/12/13	03/26/14	01/08/14	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99215		99214							X
249			02/04/12	03/14/12	03/01/12	ENC	UNITEDHEALTHCARE COMMUNITY-NJ	99214		99213							X
												$ 465.20			[redacted]	**53**	**14**

[redacted]

Dr. Sohaila Khan
Appendix B
Extrapolation of Sample Findings

Number of Claims in Universe	22,907
Number of Claims in Sample	250
Total Amount Paid for Claims in Universe	$759,308.61
Total Amount Paid for Claims in Sample	$8,079.23
Number of Claims Disallowed in Sample	67
Stratified Point Estimate	$42,785

Paul A. De Sarno, Esq.
207 Washington Road
Sayreville, New Jersey 08872
732-238-0404 (fax) 732-238-0330
DeSarnoLawOffice@gmail.com



December 21, 2016

Via certified mail #7013 3020 0002 2414 3727
Ravi Kunnakkat, CPA, Audit Manager
IPRO healthcare integrity group
20 Corporate Woods Blvd.
Albany, NY 12211-2370

RE: CMS audit number 1-45809839

Dear Mr. Kunnakkat:

Please be advised I am the Attorney representing Dr. Sohaila Khan, MD with regard to the above referenced audit. I refer you to my client's correspondence to you dated December 6, 2016 and December 13, 2016 both forwarded to you by certified mail which indicate certain corrections to the assumptions contained within the draft audit findings forwarded to my client on November 22, 2016. I am attaching additional copies of my client's letters, and her internal audit of claims dated 11/30/16 for your reference. The information contained in her letters should clear up some of the questions you had posed in your draft report and I would urge you to take the new information to account in your calculations.

Clearly the error in coding a patient as having received temperature gradient (having the patient's temperature taken) was not intended to represent that the patient had received a thermography which is clearly a much more involved procedure. In some significant part the language provided by the insurers was the source of some of the confusion. There is no allegation being made that my client deliberately intended to receive payment for services she did not render. Nevertheless my client wishes to rectify the situation in a manner which makes logical and mathematical sense in full compliance with the regulations.

To that end I am requesting that you take into consideration that the calculations made in the draft report grossly overestimate the maximum possible amount of medical patients who might have even possibly been subject to the overcharge. On page 4 of your draft report the audit scope is central to this inadvertent exaggeration. The universe used in your report was 22,907 which is in fact the total number of patient visits to my client over the last 3 years. It is my understanding that from that universe, 250 claims were randomly chosen for review. The main finding was that in 53 instances a code for thermography was entered for which in fact there was no thermography, there was in fact a temperature gradient taken for each of those patients.

The statistical problem which arises in the analysis of the draft report is that, in fact, of the 22,907 patient visits a full 57% of them had insurance which under no circumstances would pay for temperature gradient or thermography and therefore could not under any circumstances form the basis of an overcharge. In other words it is simply impossible for my client to have generated an overcharge (as unintentional as that may have been) because there was no insurance payable regardless of whether the coding for taking the patient's temperature was in fact in error for that 57% of the total universe.

Therefore of the 22,907 patient visits, some 13,086 (57%) could not possibly have generated an overcharge. For the remaining 9,821 visits the possibility of an overcharge exists, but it is highly unlikely to have occurred with any great frequency. In your random sampling of 250 cases your finding was in 53 of them this error in coding occurred. That would be roughly one in 5 or 21% of the time there was this coding error. Assuming the 21% is accurate and utilizing only those visits for which an overcharge for this code is even possible that would indicate the possibility of overcharges occurring for 2,062 (rounding up) patient visits.

It is grossly unfair to include in the universe such a large number of patient visits which could not possibly have generated any payment regardless of how or if "temperature gradient" was coded because those insurers simply do not compensate doctors for it in any event. The universe of claims should not include patient visits which could not possibly have generated an overcharge; therefore the universe should be 9,821at most, and not 22,907. This results in a more accurate and much lower payment amount which I am unable to calculate due to my not knowing whether or not you're taking into consideration my clients other updates and the additional factual material she has provided.

Additionally that 9821 visits as a universe includes the visits covered by Horizon New Jersey Health. As my client has explained Horizon New Jersey health codes office visits as 99212 through 99215 all of those code numbers are paid and the fixed amount of [redacted], therefore all such visits should also be excluded from the universe figures.

Many of the other areas of concern raised by your draft report are addressed in my client's direct correspondence with you. My client's correspondence also corrects factual assumptions with regard to the reports finding numbers 1, 1B, and 2. Please advise if you will be taking the additional information we have given you into account in revising your audit report. Both I and my client are ready, willing and able to discuss this matter with you at any time should you determine that it would be helpful towards generating the most accurate final report possible.

Very truly yours,

Paul A. De Sarno

PAD/pad
cc: Dr. Sohaila Khan, MD

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859
[redacted]

DATE: 11/30/16

CLAIMS SUBMITTED TO HORIZON NJ HEALTH & OTHER INSURANCES THAT DID NOT PAY FOR CODE 93740. FROM 2011 TO 2013
HORIZON NJ HEALTH 2011: 4181 2012: 4155 2013: 4316 --- OTHER INSURANCES 2011: 72 2012: 194 2013: 168
TOTAL CLAIMS 13086

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859
[redacted]

DATE: 12/06/16

BY CERTIFIED MAIL

RAVI KUNNAKKAT, CPA, AUDIT MANAGER
IPRO HEALTHCARE INTEGRITY GROUP
20 CORPORATE WOODS BLVD.
ALBANY, NY 12211-2370

RE; CMS AUDIT NUMBER: 1-45809839

Dear Mr. Kunnakkat,

We acknowledge receipt of IPRO's letter dated 11/22/16. We will be sending additional information/documents regarding the above matter.

Mr. Paul De Sarno , Esq who will be representing us, will be contacting you. Please feel free to contact him at the following address/ telephone number, should you have any questions.

PAUL A. DE SARNO, ESQ
ATTORNEY AT LAW
207 WASHINGTON RD.
SAYREVILLE, NJ 08872
TEL: 732- 238-0404 FAX: 732-238-0330

Sincerely,

Sohaila Khan MD

cc: Paul De Sarno ESQ

SOHAILA KHAN MD
11 BURLEW PLACE
PARLIN, NJ 08859
[redacted]

DATE: 12/13/16

BY CERTIFIED MAIL

RAVI KUNNAKKAT, CPA, AUDIT MANAGER
IPRO HEALTHCARE INTEGRITY GROUP
20 CORPORATE WOODS BLVD.
ALBANY, NY 12211-2370

RE; CMS AUDIT NUMBER: 1-45809839

Dear Mr. Kunnakkat,

Enclosed please find additional documents/ information regarding the following samples number.
(1) Audit finding 2.
18,196,204,205,210,214,218,221,223,226,230,241,246 & 249.
(2) Audit finding 1b.
3,21,7,10,14
(3) Audit finding 1.
234, 116

With reference to sample # 223. Based on our recollection of Healthfirst claim payments, the difference between codes 99212 & 99213 was approximately [redacted]. Please correct the charged amount from [redacted] to [redacted].

Please also be advised that Horizon NJ Health and Healthfirst did not pay for code 93740 and also, Horizon NJ Health has a standard fee schedule for 99212-99215 and therefore, these should not be included in the "number of claims in universe" when calculating for the above codes.

Please contact us at [redacted], should you have any questions.

Sincerely,

Sohaila Khan MD

cc: Paul De Sarno ESQ.

Number of pages including cover letter: 36