MAY 18 2006

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson
Inspector General

SUBJECT: Review of Medicaid Claims for School-Based Health Services in New Jersey (A-02-03-01003)

Attached is an advance copy of our final report on Medicaid claims for school-based health services in New Jersey. We will issue this report to New Jersey within 5 business days. This report is the second in a series on the State's Medicaid school health program.[1]

Our objective was to determine whether Federal Medicaid payments for school-based health services claimed by school health providers in New Jersey were in compliance with Federal and State requirements. Our audit period covered July 1, 1998, through June 30, 2001, when such payments totaled $101.1 million.

Pursuant to Federal laws and regulations, Federal guidance, State statute, or the Medicaid State plan, (1) a physician or another appropriate professional must make a referral or prescription for speech, physical therapy, occupational therapy, and nursing services; (2) individuals who meet Federal qualification standards must provide the services; (3) the services must be documented; (4) the services must actually be rendered to be billed; (5) the services must be identified in a child's individualized education plan (child's plan); (6) only specialized transportation may be billed on or after July 1, 1999; and (7) Federal Medicaid funding is not available for medical services, except inpatient psychiatric services, provided to residents of institutions for mental diseases who are under the age of 21.

Of the 150 school-based claims in our statistical sample, 109 did not comply with Federal laws and regulations, State statute, or the Medicaid State plan. Specifically:

- Forty-eight claims lacked a referral or prescription from a physician or another appropriate medical professional.
- Forty-three claims did not meet Federal provider qualification requirements.
- For 41 claims, we were unable to verify that the transportation services billed were rendered.

[1]The first report was entitled "Review of Payments for Transportation Services Made to Special Service School Districts Under New Jersey's Medicaid Program" (A-02-02-01022, issued April 17, 2003).

- For 37 claims, we were unable to verify that the school health services billed were rendered.

- For 26 claims, the services billed were not rendered or not supported.

- Nineteen claims did not include a recommendation for school-based health services in the child's plan.

- For four claims, nonspecialized transportation was billed on or after July 1, 1999.

- One claim was submitted for a medical service provided to a resident of an institution for mental diseases who was under the age of 21.

In our opinion, these deficiencies occurred because (1) the State did not provide proper or timely guidance concerning Federal Medicaid requirements to its school health providers, (2) school health providers did not comply with other State guidance that they had received, and (3) the State did not adequately monitor school health claims from providers for compliance with Federal and State requirements.

While 109 of the sampled school-based claims did not comply with Federal and State requirements, we determined that some of these claims were unallowable and that other claims containing transportation charges should be "set aside" for consideration by the Centers for Medicare & Medicaid Services (CMS) and the State.[2] Based on our sample, we estimated that $51,262,909 in Federal Medicaid funding was unallowable

We set aside certain claims containing transportation services for consideration by CMS and the State because Federal Medicaid law and regulations require that transportation services be documented but do not specify how the services should be documented. In these cases, neither the State nor the school health providers had documentation to support the actual dates on which students were transported. Nevertheless, there was evidence that related school health services were rendered on the dates on which transportation services were claimed and that some of the students who received those health services may have also received transportation services. Based on our sample, set-aside claims totaled an estimated $1,046,786 in Federal Medicaid funding.

We recommend that the State (1) refund $51,262,909 to the Federal Government, (2) work with CMS to resolve $1,046,786 in set-aside claims, (3) provide proper and timely guidance on Federal Medicaid criteria to its school health providers, (4) reinforce the need for school health providers to comply with Federal and State requirements, and (5) improve its monitoring of school health providers' claims to ensure compliance with Federal and State requirements.

In its comments on our draft report, the State asserted that it was currently unable to concur with our recommended financial adjustment of $51,262,909. The State indicated that it had initiated a

[2]The 109 sampled claims that did not comply with Federal or State requirements consisted of 87 claims that were totally unallowable; 16 claims, which included transportation charges, that were partially unallowable and partially set-aside; and 6 set-aside claims.

review of all claims and issues cited in the report and that it would share any inconsistencies between the results of the State's review and the audit findings with the Office of Inspector General and/or CMS. The State agreed to work with CMS to resolve all issues concerning the $1,046,786 in set-aside claims. The State also described procedural improvements addressing the three remaining recommendations.

After reviewing applicable Federal laws and regulations, State statute, the State plan, and New Jersey's comments on our draft report, we continue to believe that our findings and recommendations are valid.

If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or James P. Edert, Regional Inspector General for Audit Services, Region II, at (212) 264-4620. Please refer to report number A-02-03-01003.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES OFFICE OF INSPECTOR GENERAL

OFFICE OF AUDIT SERVICES
Region II
Jacob K. Javits Federal Building
New York, New York 10278
(212) 264-4620

MAY 19 2006

Report Number: A-02-03-01003

Mr. Kevin M. Ryan
Commissioner
New Jersey Department of Human Services
P.O. Box 700
Trenton, New Jersey 08625

Dear Mr. Ryan:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Medicaid Claims for School-Based Health Services in New Jersey." A copy of this report will be forwarded to the HHS action official noted on the next page for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR part 5).

Please refer to report number A-02-03-01003 in all correspondence.

Sincerely yours,

James P. Edert

James P. Edert
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Ms. Sue Kelly
Associate Regional Administrator
Division of Medicaid and Children's Health
Centers for Medicare & Medicaid Services, Region II
Department of Health and Human Services
26 Federal Plaza, Room 3811
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF MEDICAID CLAIMS FOR SCHOOL-BASED HEALTH SERVICES IN NEW JERSEY

Daniel R. Levinson
Inspector General

May 2006
A-02-03-01003

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

OBJECTIVE

Our objective was to determine whether Federal Medicaid payments for school-based health services claimed by school health providers in New Jersey were in compliance with Federal and State requirements. Our audit period covered July 1, 1998, through June 30, 2001, when such payments totaled $101.1 million.

SUMMARY OF FINDINGS

Of the 150 school-based claims in our statistical sample, 109 did not comply with Federal laws and regulations, State statute, or the Medicaid State plan. The primary Federal regulation governing physical therapy, occupational therapy, and speech pathology services is 42 CFR § 440.110. Other relevant Federal laws and regulations include sections 1902(a)(27) and 1903(c) of the Social Security Act and 42 CFR §§ 431.17 and 433.32. Relevant Federal guidance includes Office of Management and Budget Circular A-87 and a 1997 Centers for Medicare & Medicaid Services (CMS) Medicaid school-based technical assistance guide. Further, the Medicaid State plan, State statute, and State program guidelines issued to the provider community govern the allowability of school health services.

Pursuant to these requirements, (1) a physician or another appropriate professional must make a referral or prescription for speech, physical therapy, occupational therapy, and nursing services; (2) individuals who meet Federal qualification standards must provide the services; (3) the services must be documented; (4) the services must actually be rendered to be billed; (5) the services must be identified in a child's individualized education plan (child's plan); (6) only specialized transportation may be billed on or after July 1, 1999; and (7) Federal Medicaid funding is not available for medical services, except inpatient psychiatric services, provided to residents of institutions for mental diseases who are under the age of 21.

Of the 109 noncompliant claims:

- Forty-eight claims lacked a referral or prescription from a physician or another appropriate medical professional.

- Forty-three claims did not meet Federal provider qualification requirements.

- For 41 claims, we were unable to verify that the transportation services billed were rendered.

- For 37 claims, we were unable to verify that the school health services billed were rendered.

- For 26 claims, the services billed were not rendered or not supported.

- Nineteen claims did not include a recommendation for school-based health services in the child's plan.

- For four claims, nonspecialized transportation was billed on or after July 1, 1999.

- One claim was submitted for a medical service provided to a resident of an institution for mental diseases who was under the age of 21.

In our opinion, these deficiencies occurred because (1) the State did not provide proper or timely guidance concerning Federal Medicaid requirements to its school health providers, (2) school health providers did not comply with other State guidance that they had received, and (3) the State did not adequately monitor school health claims from providers for compliance with Federal and State requirements.

While 109 of the sampled school-based claims did not comply with Federal and State requirements, we determined that some of these claims were unallowable and that other claims containing transportation charges should be "set aside" for consideration by CMS and the State.[1] Based on our sample, we estimated that $51,262,909 in Federal Medicaid funding was unallowable.

We set aside certain claims containing transportation services for consideration by CMS and the State because Federal Medicaid law and regulations require that transportation services be documented but do not specify how the services should be documented. In these cases, neither the State nor the school health providers had documentation to support the actual dates on which students were transported. Nevertheless, there was evidence that related school health services were rendered on the dates on which transportation services were claimed and that some of the students who received those health services may have also received transportation services. Based on our sample, set-aside claims totaled an estimated $1,046,786 in Federal Medicaid funding.

RECOMMENDATIONS

We recommend that the State:

- refund $51,262,909 to the Federal Government,

- work with CMS to resolve $1,046,786 in set-aside claims,

- provide proper and timely guidance on Federal Medicaid criteria to its school health providers,

- reinforce the need for school health providers to comply with Federal and State requirements, and

[1]The 109 sampled claims that did not comply with Federal or State requirements consisted of 87 claims that were totally unallowable; 16 claims, which included transportation charges, that were partially unallowable and partially set aside; and 6 set-aside claims.

- improve its monitoring of school health providers' claims to ensure compliance with Federal and State requirements.

STATE'S COMMENTS

In its comments on our draft report, the State asserted that it was currently unable to concur with our recommended financial adjustment of $51,262,909. The State indicated that it had initiated a review of all claims and issues cited in the report and that it would share any inconsistencies between the results of the State's review and the audit findings with the Office of Inspector General and/or CMS. The State agreed to work with CMS to resolve all issues concerning the $1,046,786 in set-aside claims. The State also described procedural improvements addressing the three remaining recommendations.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing applicable Federal laws and regulations, State statute, the State plan, and New Jersey's comments on our draft report, we continue to believe that our findings and recommendations are valid.

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APPENDIXES

Glossary of Abbreviations and Acronyms

AOTA	American Occupational Therapy Association
ASHA	American Speech-Language-Hearing Association
CCC	Certificate of Clinical Competence
CMS	Centers for Medicare & Medicaid Services
IDEA	Individuals with Disabilities Education Act
IEP	Individualized Education Plan

INTRODUCTION

BACKGROUND

The Medicaid Program

Pursuant to Title XIX of the Social Security Act (the Act), the Medicaid program pays the health care costs of persons who qualify because of medical condition, economic condition, or other qualifying factors. Medicaid costs are shared between the Federal Government and the States. Within the Federal Government, the Centers for Medicare & Medicaid Services (CMS) administers the Medicaid program.

To participate in Medicaid, a State must submit and receive CMS's approval of a State plan. The State plan is a comprehensive document describing the nature and scope of the State's Medicaid program and the State's obligations to the Federal Government. Medicaid pays for medically necessary services that are specified in Medicaid law when included in the State plan and when provided to individuals eligible under the State plan.

Medicaid Coverage of School Health Services

Section 411(k)(13) of the Medicare Catastrophic Coverage Act of 1988 (Public Law 100-360) amended section 1903(c) of the Act to permit Medicaid payment for medical services provided to children under the Individuals with Disabilities Education Act (IDEA) (originally enacted as Public Law 91-230 in 1970) through a child's individualized education plan (child's plan).

In August 1997, CMS issued a school-based guide entitled "Medicaid and School Health: A Technical Assistance Guide." According to this guide, school health-related services included in a child's plan may be covered if all relevant statutory and regulatory requirements are met. In addition, the guide provides that a State may cover services included in a child's plan as long as (1) the services are listed in section 1905(a) of the Act and are medically necessary; (2) all Federal and State regulations are followed, including those specifying provider qualifications; and (3) the services are included in the State plan or available under the Early and Periodic Screening, Diagnostic and Treatment Medicaid benefit. Covered services may include, but are not limited to, physical therapy, occupational therapy, speech pathology/therapy services, psychological counseling, nursing, and transportation services.

New Jersey's Medicaid Program

The New Jersey Department of Human Services is the State agency responsible for operating the Medicaid program. Within the New Jersey Department of Human Services, the Division of Medical Assistance and Health Services administers the Medicaid program.

The administrative responsibility for operating New Jersey's school-based program, known as the Special Education Medicaid Initiative, is shared among three State departments: Human Services, Education, and Treasury. The State also contracts with a billing agent called

DMG-MAXIMUS to help administer its Medicaid school health program. The responsibilities of each of these parties are as follows:

The New Jersey Department of Human Services, Division of Medical Assistance and Health Services:

- conducts Medicaid provider enrollment,
- issues Medicaid provider identification numbers to school health providers,
- provides Medicaid technical assistance to school health providers, and
- processes and adjudicates providers' claims through its Medicaid Management Information System fiscal intermediary, UNISYS.

The New Jersey Department of Education provides policy guidance to and certifies school health providers. The New Jersey Department of Treasury serves as the contract manager for the billing agent. Finally, the billing agent:

- receives and processes billing agreements and pupil registration information from school health providers;
- provides technical assistance on school-based program issues;
- conducts Medicaid eligibility verification for registered pupils;
- produces "turnaround documents" identifying Medicaid-eligible students and tracking logs that are used for billing, which it sends to school health providers;
- prepares monthly Medicaid claims based on the turnaround documents completed by the school health providers and submits those claims to UNISYS for payment; and
- provides onsite training and program compliance monitoring.

The primary State guidance for the administration and operation of the school-based program is the Special Education Medicaid Initiative Provider Handbook (State handbook). The State and the billing agent developed the State handbook using both education and Medicaid requirements. The State handbook is issued to all school health providers and contains detailed instructions on their responsibilities under the school-based program. Included in the State handbook are sections regarding provider enrollment, service descriptions, documentation requirements, practitioner qualifications, pupil registration, and billing instructions.

Pursuant to New Jersey's State plan, the following types of services make up the school-based program: (1) rehabilitative services, referred to as related school health services; (2) evaluation services; and (3) transportation.

Related school health services are occupational, physical, and speech-language therapies; audiology services; psychological counseling and psychotherapy; and nursing. The State reimburses providers for these services, using a bundled (or average) fee, if they are included in the child's plan. The State's Medicaid program pays only one fee per day regardless of the number or type of related school health services provided.

Evaluation services identify the need for specific services and prescribe the range and frequency of services that the student requires. Evaluation services can also include reevaluation or review of the current services specified in the child's plan. The State's Medicaid program pays evaluation services on a fee-for-service basis.

Transportation services are allowable when provided on the same day as a related service and when transportation is included in the child's plan. A May 21, 1999, letter from the Director of CMS's Center for Medicaid and State Operations to all State Medicaid directors stated that as of July 1, 1999, only specialized transportation could be billed to Medicaid. CMS noted that "specialized transportation" means that a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.

School health providers use pupil registration forms to notify the billing agent that Medicaid-eligible students are scheduled to be transported to school. If the providers have specified transportation, the billing agent automatically submits a transportation claim to Medicaid if related services or evaluation services for a student are claimed on the same day. The State's Medicaid program pays transportation services at a daily rate.

School health providers submit monthly turnaround documents to the billing agent showing the daily school-based services rendered during the month to each student. The billing agent prepares a monthly claim from the turnaround documents. A monthly school-based claim may consist of billings for multiple related school health services, evaluation services, and transportation services.

The Federal share of school-based health claims was 50 percent during our audit period. Under the State's Medicaid program, school health providers received 15 percent of the Federal share, while the State retained the remaining 85 percent. For the period July 1, 1998, through June 30, 2001, the State received more than $101 million of Federal Medicaid reimbursement for over 195,000 claims.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether Federal Medicaid payments for school-based health services claimed by school health providers in New Jersey were in compliance with Federal and State requirements.

Scope and Methodology

Our audit period covered July 1, 1998, through June 30, 2001. During our audit, we did not review the overall internal control structure of the State or the Medicaid program. Rather, we limited our internal control review to those controls that were significant to the objective of our audit.

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations, and guidelines;
- held discussions with State and billing agent officials to gain an understanding of the State's school-based program;
- obtained an understanding of computer edits and administrative controls regarding claiming Medicaid reimbursement for school-based services;
- received from the State a computer-generated universe of all Medicaid school-based claims totaling $204,717,816 ($102,358,908 Federal share) for the period July 1, 1998, through June 30, 2001;
- held discussions with State officials regarding the overall design and specifications of the application used to create the universe and performed various tests of the universe to obtain reasonable assurance of its accuracy and completeness; and
- eliminated $2,446,852 ($1,223,426 Federal share) of transportation services paid to special service school districts,[1] which we discussed in another report,[2] and obtained a revised universe of 195,532 school-based claims totaling $202,270,964 ($101,135,482 Federal share).

We used stratified random sampling techniques to select a sample of 150 claims from the universe of 195,532 claims. A sample claim represented all services provided to an individual student for a month during our audit period. The 150 claims included 254 services: 81 speech services, 46 transportation services, 31 nursing services, 29 evaluation services, 23 physical therapy services, 23 occupational therapy services, and 21 psychological counseling services. Appendix A contains the details of our sample design and methodology.

On November 28, 2002, we issued letters to the 63 school health providers in our sample requesting documentation to support the 150 sampled claims. Appendix B contains the instructions that were attached to our letters. For school health providers that did not respond to

[1]Counties may establish a special service school district for the education and treatment of handicapped children if the need exists. Eight of New Jersey's twenty-one counties had established such districts.

[2]"Review of Payments for Transportation Services Made to Special Service School Districts Under New Jersey's Medicaid Program" (A-02-02-01022, issued April 17, 2003).

the initial request for documentation or that submitted incomplete information, we made a second written request.

We developed worksheets that contained the criteria applied to the sampled claims. We reviewed the documentation submitted by the sampled providers against those criteria to determine whether the claims were allowable. If we determined that a claim appeared unallowable based on our initial review, we followed up with provider officials to (1) determine whether additional documentation existed to support the claim, (2) obtain clarification of the submitted documentation, and (3) verify our review determinations.

If the sampled providers did not supply American Speech-Language-Hearing Association (ASHA) certification information, we contacted ASHA officials to determine whether either the service provider or the speech pathologist providing direction to the service provider was ASHA certified. Additionally, we contacted ASHA officials to determine whether a speech-language pathologist licensed or certified by New Jersey was equivalent to an individual who holds an ASHA Certificate of Clinical Competence (CCC). Also, if the providers did not submit State licensing information, we contacted the New Jersey Division of Consumer Affairs (the State licensing agency) to determine whether the providers were licensed.

We reviewed the 150 sampled claims in accordance with the State's reimbursement methodology. Under this methodology, multiple daily services were included on a monthly claim. The State paid only one fee per day to school health providers regardless of the number of daily related services provided. Therefore, if a provider rendered multiple related services on the same day and if one service complied with Federal and State criteria, we allowed the service and did not question any costs for that day**.**

We used a variable appraisal program to estimate the dollar impact of the improper Federal funding claimed in the total population of 195,532 school-based claims. We estimated both a recommended financial adjustment and a set-aside amount.

Our audit did not include a review of the State's rate-setting methodology. We are addressing this methodology in a separate audit (A-02-04-01017).

We performed fieldwork at the Division of Medical Assistance and Health Services in Mercerville, New Jersey.

We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Of the 150 school-based claims in our statistical sample, 109 did not comply with Federal laws and regulations, State statute, or the Medicaid State plan. The schedule below summarizes the deficiencies noted and the number of claims that contained each type of deficiency. Appendix C shows our determinations on the deficiencies in each sampled claim.

Summary of Deficiencies in Sampled Claims

Type of Deficiency	Number of Deficient Claims[3]
1. Referral or prescription requirements not met	48
2. Federal provider requirements not met	43
3. Unable to verify that transportation services billed were actually rendered	41
4. Unable to verify that related health and evaluation services billed were actually rendered	37
5. Services not rendered or not supported	26
6. Services not included in child's plan	19
7. Nonspecialized transportation claimed on or after July 1, 1999	4
8. Service claimed for a student in an institution for mental diseases	1

In our opinion, these deficiencies occurred because:

- The State did not provide proper or timely guidance concerning Federal Medicaid requirements to its school health providers.

- School health providers did not comply with other guidance that they had received.

- The State did not adequately monitor school health claims from providers for compliance with Federal and State requirements.

DEFICIENCIES NOTED IN SAMPLED CLAIMS

The sections below discuss the eight types of deficiencies noted in the sampled claims and the criteria that we applied in determining whether claims complied with Federal and State requirements.

1. Referral or Prescription Requirements Not Met

Federal regulations (42 CFR § 440.110(a)(b)(c)) require a referral from a physician or another licensed practitioner of the healing arts for physical therapy; occupational therapy; and services for individuals with speech, hearing, and language disorders. State guidance issued to school health providers requires physician prescriptions/orders for physical therapy and certain nursing services. For nursing services, the New Jersey Board of Nursing Statute 45:11-23 allows nurses to execute medical regimens as prescribed by a licensed (or otherwise legally authorized) physician or dentist.

[3]Total exceeds 109 because 65 claims contained more than 1 error.

Forty-eight of the one hundred and fifty sampled claims did not meet Federal referral or State prescription requirements. Referrals or prescriptions either did not exist or could not be located by the providers in our sample. The 48 claims included the following types of related services:[4]

- 37 speech services that did not meet Federal referral requirements,
- 15 nursing services that did not meet State prescription requirements,
- 11 occupational therapy services that did not meet Federal referral requirements, and
- 5 physical therapy services that did not meet Federal referral requirements.

2. Federal Provider Requirements Not Met

Federal regulations (42 CFR § 440.110) set forth provider credential requirements for physical, occupational, and speech therapy services. State guidance to the school health provider community reiterated the Federal provider credential requirements for physical and occupational therapy, but not for speech therapy. Specifically, State guidance did not inform school health providers that ASHA certification was required for practitioners who provide speech therapy services. Rather, State guidance provided that speech therapy practitioners were required only to meet New Jersey Department of Education certification requirements.

Forty-three sampled claims did not meet Federal provider requirements, as discussed below.[5]

Speech Therapy Provider Requirements Not Met

Federal regulations require that speech services be provided by or under the direction of an ASHA-certified speech-language pathologist, an individual with equivalent education and work experience necessary for the ASHA CCC, or an individual who has completed the academic program and is acquiring supervised work experience to qualify for the CCC (42 CFR § 440.110(c)).

In a December 28, 1993, letter, CMS asked State officials to provide assurance that speech providers would meet the qualifications of 42 CFR § 440.110(c). In an August 1, 1995, letter, the State assured CMS that it would bill Medicaid for only those services provided by or under the direction of speech-language practitioners who met those qualifications.

However, 40 sampled speech claims did not meet Federal requirements. Specifically, a Department of Education-certified speech correctionist provided speech services for 26 of the 40 claims, and a Department of Education-certified speech language specialist provided speech

[4]Total exceeds 48 because multiple related school health services were provided and billed on the same monthly claim.

[5]Total exceeds 43 because multiple related school health services were provided and billed on the same monthly claim.

services for 8 of the claims. None of these providers met the ASHA or ASHA equivalency requirements. For the remaining six claims, school health providers submitted no credentials. Our contacts with ASHA and our review of additional documentation submitted by the providers determined that the speech teachers were not ASHA certified. In a February 11, 2003, letter, ASHA officials informed us that a speech-language pathologist licensed or certified by New Jersey was not equivalent to an individual who holds the CCC from ASHA.

The 40 claims also did not meet the "under the direction of" requirements of 42 CFR § 440.110(c) and Medicaid State Operations Letter 95-12, issued on February 9, 1995. This letter stated:

> The Health Care Financing Administration's interpretation of the term "under the direction of a speech pathologist" is that the speech pathologist is individually involved with the patient under his or her direction and accepts ultimate responsibility for the actions of the personnel that he or she agrees to direct.[6] We advise States that the speech pathologist must see each patient at least once, have some input into the type of care provided, and review the patient after treatment has begun. The speech pathologist would also need to assume the legal responsibility for the services provided. Therefore, it would be clearly in the pathologist's own interest to maintain close oversight of any services for which he or she agrees to assume direction.

The 40 claims did not meet these requirements because:

- For 35 claims, school health providers did not submit any documentation that named the individuals who provided direction or any evidence that direction had been provided.

- For three claims, school health providers submitted the names of the individuals who they stated were providing direction. However, the providers did not submit any documentation to show direction. Moreover, we contacted ASHA and determined that these three individuals were not ASHA certified and did not meet ASHA equivalency requirements.

- For two claims, the school district that billed both claims submitted no evidence of direction. In a June 4, 2003, letter responding to our request for documentation, school district officials stated that the service provider for the two claims was under the direction of an ASHA-certified speech-language pathologist. We verified that the individual identified as providing direction was ASHA certified. However, the school district submitted no evidence that this individual saw the students, had input into their care, reviewed the students after treatment began, or met with the service provider.

Occupational Therapy Provider Requirements Not Met

Federal regulations (42 CFR § 440.110(b)) require that occupational therapy services be prescribed by a physician or another licensed practitioner of the healing arts, within the scope of

[6]CMS was formerly known as the Health Care Financing Administration.

his or her practice under State law, and be provided by or under the direction of a qualified occupational therapist. A "qualified occupational therapist" is registered by the American Occupational Therapy Association (AOTA) or a graduate of an occupational therapy program approved by the Committee on Allied Health Education and Accreditation of the American Medical Association and engaged in the supplemental clinical experience required before registration by AOTA.

School health providers did not submit the credentials of the individuals providing occupational therapy services for three sampled claims. We contacted the New Jersey Division of Consumer Affairs regarding certification and State licensure. The licensing agency was unable to find licensing information for the three individuals. Therefore, we had no assurance that they met Federal provider qualification requirements. Additionally, the school health providers did not submit any documentation identifying the individuals who may have provided direction.

Physical Therapy Provider Requirements Not Met

Federal regulations (42 CFR § 440.110(a)) require that physical therapy services be prescribed by a physician or another licensed practitioner of the healing arts, within the scope of his or her practice under State law, and be provided by or under the direction of a qualified physical therapist. A "qualified physical therapist" is a graduate of a physical therapy program approved by both the Committee on Allied Health Education and Accreditation and the American Physical Therapy Association or its equivalent and, where applicable, is licensed by the State.

For one sampled claim, a physical therapy assistant provided the service, but the school district did not submit any documentation that the provider was working under the direction of a qualified physical therapist as required by Federal regulations.

3. Unable To Verify That Transportation Services Billed Were Actually Rendered

Federal regulations (42 CFR §§ 431.17 and 433.32), as well as section 1902(a)(27) of the Act and CMS's August 1997 technical assistance guide, require that services claimed for Federal Medicaid funding be documented. Specifically, the guide states that relevant documentation includes the date and location of the service, the identity of the provider, and the length of time required for the service.

For 41 of the 46 sampled claims containing transportation services, school health providers did not submit documentation, such as a transportation log, to support the number of transportation services billed to Medicaid. Some providers maintained lists (bus routes) or bus rosters of students who were scheduled to be transported, but not documentation showing the actual days on which transportation was provided.

4. Unable To Verify That Related Health and Evaluation Services Billed Were Actually Rendered

Federal regulations (42 CFR §§ 431.17 and 433.32), as well as section 1902(a)(27) of the Act and CMS's August 1997 technical assistance guide, require that services claimed for Federal

Medicaid funding be documented. Specifically, the guide states that relevant documentation includes the date and location of the service, the identity of the provider, and the length of time required for the service. The State handbook has similar documentation requirements.

For 37 of the 150 sampled claims, school health providers submitted no documentation or the documentation submitted did not support the related school health or evaluation claims billed to Medicaid. Specifically, for 24 claims, providers did not submit any documentation to support the services rendered, and for 13 claims, the documentation submitted did not support the number of services billed. For example, a school health provider was reimbursed for five related services during 1 month. The child's plan recommended occupational therapy services; however, the provider did not submit any documentation showing that occupational therapy services had actually been rendered during the month. The provider did not submit any monthly turnaround document, student encounter log, or notes to support the services billed to Medicaid.

5. Services Not Rendered or Not Supported

Federal regulations (42 CFR §§ 431.17 and 433.32), as well as section 1902(a)(27) of the Act and CMS's August 1997 technical assistance guide, require that services claimed for Federal Medicaid funding be documented. The State handbook reiterates the requirement that school health providers must maintain records that document that a related service or an evaluation service was provided.

Federal regulations (42 CFR § 455.1(a)(2)) require States to have a method for verifying whether services reimbursed by Medicaid were actually furnished. Pursuant to 42 CFR § 455.18, State Medicaid claim forms must include a certification by providers that the information on the claims is true, accurate, and complete. Both the State's Medicaid Provider Electronic Billing Agreement for Providers with Billing Agents and the State's Medicaid Health Insurance Portability and Accountability Act Electronic Data Interchange Agreement for filing electronic claims require providers to certify that the information on their Medicaid claims is true, accurate, and complete. Providers and billing agents further certify that they agree to keep records necessary to fully disclose the extent of services provided, as required by section 1902(a)(27) of the Act.

For 26 sampled claims, school health providers received Medicaid payments for services that we determined were not rendered or not supported. Specifically:

- The attendance records for 12 claims showed that the students were absent on at least 1 of the days when school health providers claimed that services were provided and for which claims were submitted to and paid by Medicaid.

- The students' service records did not support the number of services reimbursed for 12 claims.

- For one claim, a school health provider submitted a duplicate claim for the same service.

- For one claim, school health provider officials advised us that the student was not enrolled in their school system.

6. Services Not Included in Child's Plan

Section 1903(c) of the Act permits Medicaid payment for medical services provided to children under IDEA if the services were included in a child's plan. Pursuant to Part B of IDEA, school districts must prepare a child's plan for each child that specifies all special education and related services that the child needs. The State handbook has similar requirements.

For 19 sampled claims, the child's plan did not identify or recommend the related school health or transportation services as required.

7. Nonspecialized Transportation Claimed on or After July 1, 1999

A May 21, 1999, letter from the Director of CMS's Center for Medicaid and State Operations to all State Medicaid directors stated that as of July 1, 1999, only specialized transportation could be billed to Medicaid. CMS noted that "specialized transportation" means that a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus.

Four claims for nonspecialized school bus transportation were billed to and paid by Medicaid after CMS's July 1, 1999, cutoff date.

8. Service Claimed for a Student in an Institution for Mental Diseases

Federal regulations (42 CFR §§ 441.13 and 435.1008) preclude Federal Medicaid funding for any medical services provided to residents of institutions for mental diseases who are under the age of 65, except for inpatient psychiatric services provided to individuals under the age of 21 and, in some instances, under the age of 22.

One claim for an evaluation service was improperly submitted for a student who was an inpatient of a State-operated psychiatric hospital that was an institution for mental diseases.

CAUSES OF DEFICIENCIES IN CLAIMS

As discussed below, we found three main causes of the deficient claims.

State Guidance Was Improper or Untimely

Some of the unallowable claims resulted from improper or untimely State guidance issued to the provider community about Federal requirements. Improper State guidance related to Federal referral requirements, speech-language pathologists' credentials, and documentation requirements for transportation services. For example, State program guidance did not require referrals for speech and occupational therapy services as required by Federal regulations. Additionally, State program guidance did not require ASHA certification or the equivalent for

providers of speech therapy services. Rather, State program guidance provided that speech therapy practitioners were required only to meet New Jersey Department of Education certification requirements. In a February 11, 2003, letter, ASHA officials informed us that a speech-language pathologist certified by New Jersey was not equivalent to an individual who holds the CCC from ASHA.

The State provided untimely guidance on billing specialized versus nonspecialized transportation. The May 21, 1999, CMS policy letter prohibiting the billing of nonspecialized transportation was effective July 1, 1999. However, the State did not notify the provider community of the policy change until it issued an October 18, 1999, letter, which stated that the effective date was November 1, 1999.

School Health Providers Did Not Comply With Guidance Related to Federal Requirements

School health providers also submitted unallowable claims because they did not comply with guidance that they had received from the State on Federal requirements. For example, the State handbook specifies that school health providers must maintain records documenting that a related service or an evaluation service was provided on a specific date. Without such documentation, we were unable to verify that services billed were actually rendered.

State Did Not Adequately Monitor Claims

The State did not adequately monitor school health claims from its providers. For instance, the State did not conduct any audits of school health providers' claims during our audit period. The majority of the State's monitoring efforts during our audit period were spent on training and familiarizing providers with the school-based program. Additionally, although the State developed a formal monitoring program guide in May 2001, the State did not use the guide until January 2003, well after our June 30, 2001, audit cutoff.

PROJECTION OF DEFICIENCIES TO UNIVERSE OF CLAIMS

While 109 of the sampled school-based claims did not comply with Federal and State requirements, we determined that some of these claims were unallowable and that other claims containing transportation charges should be "set aside" for consideration by CMS and the State.[7]

Recommended Financial Adjustment

We determined that 103 sampled claims were either partially or totally unallowable. Extrapolating the results of our sample, we estimate that the State improperly claimed between $51,262,909 and $64,763,917 in Federal funds. The midpoint of the confidence interval amounted to $58,013,413. The range shown has a 90-percent level of confidence with a sampling precision as a percentage of the midpoint of 11.64 percent. The details of our sample results and projection are shown in Appendix D.

[7]The 109 sampled claims that did not comply with Federal or State requirements consisted of 87 claims that were totally unallowable; 16 claims, which included transportation charges, that were partially unallowable and partially set aside; and 6 set-aside claims.

Set-Aside Amount

We set aside other claims containing transportation charges because Federal Medicaid law and regulations require that transportation services be documented but do not specify how these services should be documented. In these cases, neither the State nor the school health providers could support the actual dates on which students were transported. Nevertheless, there was evidence that related school health services were rendered on the dates that transportation services were claimed and that some of the students who received those related services may have also received transportation services.

For 41 of the 46 sampled claims containing transportation services, school health providers did not submit documentation, such as a transportation log, to support the number of transportation services billed to Medicaid. We questioned 19 of the 41 claims in their entirety because of other deficiencies. We either partially or fully set aside 22 claims, including 16 claims with a partial set-aside amount and 6 claims with a full set-aside amount.

Extrapolating the results of our sample, we estimate that the amount that the State and CMS will need to resolve is between $1,046,786 and $2,575,973 in Federal funds. The midpoint of the confidence interval amounted to $1,811,380. The range shown has a 90-percent level of confidence with a sampling precision as a percentage of the midpoint of 42.21 percent. The details of our sample results and projection are shown in Appendix D.

RECOMMENDATIONS

We recommend that the State:

- refund $51,262,909 to the Federal Government,
- work with CMS to resolve $1,046,786 in set-aside claims,
- provide proper and timely guidance on Federal Medicaid criteria to its school health providers,
- reinforce the need for school health providers to comply with Federal and State requirements, and
- improve its monitoring of school health providers' claims to ensure compliance with Federal and State requirements.

STATE'S COMMENTS

In its March 2, 2006, written comments on our draft report, the State asserted that it was currently unable to concur with our recommended financial adjustment of $51,262,909. The State indicated that it had initiated a review of all claims and issues cited in the report and that it would share any inconsistencies between the results of the State's review and the audit findings with the Office of Inspector General and/or CMS.

The State agreed to work with CMS to resolve all issues concerning the $1,046,786 in set-aside claims for transportation services. The State also described procedural improvements addressing the three remaining recommendations.

The State's comments are included in their entirety as Appendix E.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

After reviewing applicable Federal laws and regulations, State statute, the State plan, and New Jersey's comments on our draft report, we continue to believe that our findings and recommendations are valid.

APPENDIXES

SAMPLE DESIGN AND METHODOLOGY

AUDIT OBJECTIVE

Our objective was to determine whether Federal Medicaid payments for school-based health services claimed by school health providers in New Jersey were in compliance with Federal and State requirements.

POPULATION

The population consisted of school-based health services (excluding transportation services claimed by special service school districts, which were included in a separate audit report) claimed for Federal Medicaid funding by the State during the period July 1, 1998, through June 30, 2001.

SAMPLING FRAME

The sampling frame was a computer file containing 195,532 school-based claims for Federal funding and adjustments to these claims. The total Medicaid reimbursement for the 195,532 claims was $202,270,964, of which the Federal share was $101,135,482. State officials extracted the database from paid claims files maintained at the Medicaid Management Information System fiscal agent.

SAMPLING UNIT

The sampling unit was a school-based claim, with corresponding adjustments, paid with Federal Medicaid funds. Each claim represented all services provided to an individual school-aged student for 1 month during our audit period.

SAMPLE DESIGN

We used a stratified random sample to evaluate the population of Medicaid school-based claims. We separated the sampling frame into three strata as follows:

- stratum 1—less than $850.00 (93,788 claims),
- stratum 2—$850.00 to $1,899.99 (74,979 claims), and
- stratum 3—$1,900.00 or greater (26,765 claims).

SAMPLE SIZE

We selected a sample size of 150 claims with 50 items from each stratum.

SOURCE OF THE RANDOM NUMBERS

The source of the random numbers was the Office of Audit Services Statistical Sampling Software dated September 2001. We used the Random Number Generator for our sample selection.

METHOD FOR SELECTING SAMPLE ITEMS

We numbered the claims in our sampling frame sequentially. We selected sets of random numbers for the 3 strata (50 claims from each stratum) and correlated the random numbers to the sequential numbers assigned to the claims in the sampling frame. We then created a list of the 150 sample items.

CHARACTERISTICS MEASURED

We based our determination of whether a claim was unallowable on applicable Federal and State regulations. In general, if any of the following characteristics applied, we considered the claim under review unallowable:

- The school health provider billed for services not rendered.
- No documentation was found.
- No service delivery documentation was provided to support services billed.
- No child's plan was found.
- The services were not included in a child's plan.
- Where applicable, services were not provided by or under the direction of an individual who met Federal Medicaid practitioner qualifications.
- No referral or prescription from a physician or another qualified practitioner was found for physical therapy, occupational therapy, speech therapy, or nursing services.
- Transportation was claimed on days when a related health service was not rendered.
- Nonspecialized transportation was billed on or after July 1, 1999.
- Medical services not related to inpatient psychiatric care were billed for residents of institutions for mental diseases who were under the age of 21.

If any service for a selected monthly sample claim was considered unallowable, that sample item was considered an error. We questioned only that portion of dollars associated with the unallowable service(s).

TREATMENT OF MISSING DOCUMENTATION

If supporting documentation was not found, we considered the sample item an error.

ESTIMATION METHODOLOGY

We used the Department of Health and Human Services, Office of Inspector General, Office of Audit Services Variables Appraisal Program in RAT-STATS to appraise the sample results. We used the lower limit at the 90-percent confidence level to estimate the cost recoveries associated with the improper claiming of Federal Medicaid funding under the school-based program.

For school-based transportation services, we separately projected as a set-aside amount a Medicaid claim (or portion thereof) questioned strictly for the lack of adequate documentation to support the number of transportation services billed.

DOCUMENTATION REQUESTED BY OUR AUDIT

Below are the instructions attached to the letters that we sent to the school health providers in our sample.

INSTRUCTIONS FOR SPEECH PATHOLOGY SERVICES

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for speech pathology services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the speech pathology services for the relevant time period under review.

2. The evaluation performed of the student's need for the speech pathology services applicable to the time period under review.

3. Service encounter records, logs, turnaround documents, or other documentation substantiating that the speech pathology services were rendered and documentation showing the specific number of speech pathology services rendered each month during the time period under review. Also, include the Parent Consent form.

4. Student and service provider attendance records for the period under review, as well as Remittance Advice for reimbursement received.

5. Documentation sufficient to show whether the speech pathology services were provided on an individual (one-on-one) or group basis during the relevant time period. If this varied from session to session, please provide documents sufficient to show how this varied. In addition, if the speech pathology services were provided on a group basis, please provide documents sufficient to show the number of students in the group.

6. Documentation identifying by name the service provider(s) who rendered the speech pathology services (i.e., who provided the services) to the student during the time period under review. If the service provider varied during the relevant time period, please provide documents identifying each provider and the time period that provider rendered speech pathology services to the student. In addition, with respect to each service provider identified by this documentation, please provide the following applicable to the relevant time period under review:

    (a) Documents sufficient to show the professional qualifications of the service provider for the period under review, including documents showing (i) whether the service provider was a teacher of the speech and hearing impaired/handicapped (hereinafter referred to as "speech teacher") or a speech pathologist, (ii) the professional licenses and certifications held by the service provider during the relevant time period (for example, a New Jersey State speech pathologist license), and (iii) if the service provider was a speech pathologist,

provide his or her Certificate of Clinical Competence (CCC) from the American Speech-Language-Hearing Association (ASHA). If a speech pathologist does not have a CCC, provide documents showing that he or she met the equivalency criteria, that is, had completed the equivalent educational requirements and work experience necessary for the CCC *or* had completed the academic program and was acquiring supervised work experience to qualify for the CCC.

(b) The service provider's progress notes relating to the speech pathology services rendered to the student during the relevant time period.

7. With respect to each service provider identified in response to paragraph 6 above who was not a speech pathologist with an ASHA CCC or did not meet the equivalency criteria, please provide documentation identifying by name the speech pathologist that "directed" the speech pathology services rendered to the student. In addition, with respect to each speech pathologist identified by this documentation, please provide the following:

(a) Documents sufficient to show the professional qualifications of the speech pathologist who provided the direction, including (i) the professional licenses and certifications held by the speech pathologist during the relevant time period (for example, a New Jersey State speech pathologist license), and (ii) his or her Certificate Clinical Competence (CCC) from the American Speech – Language-Hearing Association (ASHA). If a speech pathologist does not have a CCC, provide documents showing that he or she met the equivalency criteria, that is, had completed the equivalent educational requirements and work experience necessary for the CCC *or* had completed the academic program and was acquiring supervised work experience to qualify for the CCC.

(b) The service provider's progress notes relating to the speech pathology services rendered to the student during the relevant time period.

(i) any documents showing that the speech pathologist met with the speech teacher on a regular basis or had periodic contact with the speech teacher concerning the student;

(ii) any documents showing that the speech pathologist was available for consultation to assure that speech pathology services were provided in accordance with the student's IEP;

(iii) any documents reflecting any assessments or evaluations performed by the speech pathologist of the student's speech impairment or disability;

(iv) any documents showing the speech pathologist's involvement in deciding the type and extent of the speech pathology services to be provided to the student;

(v) any documents showing the speech pathologist's review of the student's IEP;

(vi) any documents showing the speech pathologist's involvement in preparing the treatment plan for the student;

(vii) any documents showing the speech pathologist's involvement in monitoring or evaluating the progress of the speech pathology services being provided by the speech teacher to the Medicaid student;

(viii) any documentation of performance appraisals and evaluations by the speech pathologist of the speech teacher's services to the student;

(ix) any documentation of the speech pathologist's observation of the speech pathology services rendered by the speech teacher to the student;

(x) any documentation of meetings between the speech pathologist and speech teacher (especially, those meetings in which the speech pathologist and speech teacher discussed the speech pathology services rendered or to be rendered to the student);

(xi) any documentation of the speech pathologist's review of the speech teacher's progress notes (especially, those documents reflecting that quarterly reviews were performed);

(xii) any other documents of any kind reflecting direction by the speech pathologist to the speech teacher to assure that appropriate speech pathology services were prescribed and provided based on the student's impairment or disability

8. Documentation showing that a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under state law) referred the student for the speech pathology services.

9. Documentation showing that a physician, registered nurse, nurse practitioner or speech pathologist or other licensed practitioner of the healing arts (within the scope of his or her practice under state law) recommended the speech pathology services, including, any order prescribing the service and the IEP reflecting the recommendation.

10. Any external or internal written communications (*e.g.*, correspondence, memoranda) or notes relating to the Medicaid claims for speech pathology or other school health services provided to the student.

INSTRUCTIONS FOR OCCUPATIONAL THERAPY SERVICES

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for occupational therapy services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the occupational therapy services for the relevant time period under review.

2. Service encounter records, logs, turnaround documents, or other documentation substantiating that the occupational therapy services were rendered and documentation showing the specific number of occupational therapy services rendered each month during the time period under review. Also, include the Parent Consent form.

3. Student and service provider attendance records for the period under review, as well as Remittance Advice for reimbursement received.

4. Documentation sufficient to show whether the occupational therapy services were provided on an individual (one-on-one) or group basis during the relevant time period. If this varied from session to session, please provide documents sufficient to show how this varied. In addition, if the occupational therapy services were provided on a group basis, please provide documents sufficient to show the number of students in the group.

5. Documentation identifying by name the service provider(s) who rendered the occupational therapy services (i.e., who provided the treatment) to the student during the relevant time period. If the service provider varied during the relevant time period, please provide documents identifying each provider and the time period that provider rendered occupational therapy services to the student. In addition, with respect to each service provider identified by this documentation, please provide the following:

   (a) Documents sufficient to show the professional qualifications of the service provider, including documents showing (i) the professional licenses, certifications or permits held by the service provider during the relevant time period, and (ii) if the service provider was an occupational therapist, documents showing that he or she was registered by the American Occupational Therapy Association (AOTA) or that he or she was a graduate of a program in occupational therapy and was engaged in the supplemental clinical experience required before registration by AOTA.

   (b) The service provider's progress notes relating to the occupational therapy services rendered to the student during the relevant time period.

6. With respect to each service provider identified in response to paragraph 5 above who was not an occupational therapist registered by AOTA (or who was not a graduate of a program in occupational therapy engaged in the supplemental clinical experience required before registration by AOTA, please provide documentation identifying the

occupational therapist who "directed" the occupational therapy services rendered by the service provider to the student. In addition, with respect to each occupational therapist identified by this documentation, please provide the following:

(a) Documents sufficient to show the professional qualifications of the occupational therapist who provided the direction, including (i) the professional licenses, certifications or permits held by him or her during the relevant time period (for example, a New Jersey State occupational therapist license), and (ii) his or her AOTA registration or documents showing that he or she was a graduate of a program in occupational therapy and was engaged in the supplemental clinical experience required before registration by AOTA.

(b) Documents reflecting the nature and extent of the direction that the occupational therapist rendered to the service provider. In particular, please provide the following:

(i) any documents showing that the occupational therapist met with the service provider on a regular basis or had periodic contact with the service provider concerning the student;

(ii) any documents showing that the occupational therapist was available for consultation to assure that the occupational therapy services were provided in accordance with the student's IEP;

(iii) any documents reflecting any assessments or evaluations performed by the occupational therapist of the student's impairment or disability;

(iv) any documents showing the occupational therapist's involvement in deciding the type and extent of the occupational therapy services to be provided to the student;

(v) any documents showing the occupational therapist's review of the student's IEP;

(vi) any documents showing the occupational therapist's involvement in preparing the treatment plan for the student;

(vii) any documents showing the occupational therapist's involvement in monitoring or evaluating the progress of the occupational therapy services being provided by the service provider to the student;

(viii) any documentation of performance appraisals and evaluations by the occupational therapist of the occupational therapy services rendered by the service provider to the student;

(ix) any documentation of the occupational therapist's observation of the occupational therapy services rendered by the service provider to the student;

(x) any documentation of meetings between the occupational therapist and service provider (especially, those meetings in which they discussed the occupational therapy services rendered or to be rendered to the student);

(xi) any documentation of the occupational therapist's review of the service provider's progress notes;

(xii) any other documents of any kind reflecting direction by the occupational therapist to the service provider to assure that appropriate occupational therapy services were prescribed and provided based on the student's impairment or disability.

7. Documentation showing that the occupational therapy services were prescribed or ordered by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under state law. In addition, please provide any documents showing that a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under state law) recommended the occupational therapy services and the IEP reflecting that recommendation.

8. Any external or internal written communications (*e.g.*, correspondence, memoranda) or notes relating to the Medicaid claims for the occupational therapy services provided to the student.

INSTRUCTIONS FOR PHYSICAL THERAPY SERVICES

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for physical therapy services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the physical therapy services for the relevant time period under review.

2. Service encounter records, logs, turnaround documents, or other documentation substantiating that the physical therapy services were rendered and documentation showing the specific number of physical therapy services rendered each month during the time period under review. Also, include the Parent Consent form.

3. Student and service provider attendance records for the period under review, as well as Remittance Advice for reimbursement received.

4. Documentation sufficient to show whether the physical therapy services were provided on an individual (one-on-one) or group basis during the relevant time period. If this

varied from session to session, please provide documents sufficient to show how this varied. In addition, if the services were provided on a group basis, please provide documents sufficient to show the number of students in the group.

5. Documentation identifying by name the service provider(s) who rendered the physical therapy services (i.e., who provided the treatment) to the student during the relevant time period. If the service provider varied during the relevant time period, please provide documents identifying each provider and the time period that provider rendered physical therapy services to the student. In addition, with respect to each service provider identified by this documentation, please provide the following:

   (a) Documents sufficient to show the professional qualifications of the service provider, including (i) the professional licenses, certifications or permits, if any, held by the service provider during the relevant time period (for example, a New Jersey State physical therapist license), and (ii) if the service provider was a physical therapist, documents showing that he or she was a graduate of an accredited physical therapy program (i.e., a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or the equivalent).

   (b) The service provider's progress notes relating to the physical therapy services rendered to the student during the relevant time period.

6. With respect to each service provider identified in response to paragraph 5 above who was not a New Jersey State licensed physical therapist who graduated from an accredited physical therapy program, please provide documentation identifying the physical therapist who "directed" the physical therapy services rendered by the service provider to the student.

7. In addition, with respect to each physical therapist identified by this documentation, please provide the following:

   (a) Documents sufficient to show the professional qualifications of the physical therapist who provided the direction, including (i) the professional licenses, certifications or permits held by the physical therapist during the relevant time period (for example, a New Jersey State physical therapist license), and (ii) documents showing that he or she was a graduate of an accredited physical therapy program (i.e., a program of physical therapy approved by both the Committee on Allied Health Education and Accreditation of the American Medical Association and the American Physical Therapy Association or the equivalent).

(b) Documents reflecting the nature and extent of the direction that the physical therapist rendered to the service provider. In particular, please provide the following:

(i) any documents showing that the physical therapist met with the service provider on a regular basis or had periodic contact with the service provider concerning the student;

(ii) any documents showing that the physical therapist was available for consultation to assure that the physical therapy services were provided in accordance with the student's IEP;

(iii) any documents reflecting any assessments or evaluations performed by the physical therapist of the student's impairment or disability;

(iv) any documents showing the physical therapist's involvement in deciding the type and extent of the physical therapy services to be provided to the student;

(v) any documents showing the physical therapist's review of the student's IEP;

(vi) any documents showing the physical therapist's involvement in preparing the treatment plan for the student;

(vii) any documents showing the physical therapist's involvement in monitoring or evaluating the progress of the physical therapy services being provided by the service provider to the student;

(viii) any documentation of performance appraisals and evaluations by the physical therapist of the physical therapy services rendered by the service provider to the student;

(ix) any documentation of the physical therapist's observation of the physical therapy services rendered by the service provider to the student;

(x) any documentation of meetings between the physical therapist and service provider (especially, those meetings in which they discussed the physical therapy services rendered or to be rendered to the student);

(xi) any documentation of the physical therapist's review of the service provider's progress notes;

(xii) any other documents of any kind reflecting direction by the physical therapist to the service provider to assure that appropriate physical therapy

services were prescribed and provided based on the student's impairment or disability.

8. Documentation showing that the physical therapy services were prescribed or ordered by a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under state law). In addition, please provide any documents showing that a physician or other licensed practitioner of the healing arts (within the scope of his or her practice under state law) recommended the physical therapy services and the IEP reflecting that recommendation.

9. Any external or internal written communications (*e.g.*, correspondence, memoranda) or notes relating to the Medicaid claims for the physical therapy services provided to the student during the relevant time period.

INSTRUCTIONS FOR PSYCHOLOGICAL COUNSELING SERVICES

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for psychological counseling services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the psychological counseling services for the relevant time period under review.

2. Any documents showing the person or entity who referred the student for the psychological counseling service and the evaluation performed of the student's need for those psychological counseling services provided during the relevant time period.

3. Service encounter records, logs, turnaround documents, or other documentation substantiating that the psychological counseling services were rendered and documentation showing the specific number of such services rendered each month during the relevant time period. Also, include the Parent Consent form.

4. Student and service provider attendance records for the period under review, as well as Remittance Advice for reimbursement received.

5. Documentation sufficient to show whether the services were provided on an individual (one-on-one) or group basis during the relevant time period. If this varied from session to session, please provide documents sufficient to show how this varied. In addition, if the services were provided on a group basis, please provide documents sufficient to show the number of students in the group.

6. Documentation identifying by name the service provider(s) who rendered the psychological counseling services (i.e., who provided the treatment) to the student during the relevant time period. If the service provider varied during the relevant time period, please provide documents identifying each provider and the time period that provider

rendered services to the student. In addition, with respect to each service provider identified by this documentation, please provide the following:

(a) Documents sufficient to show the professional qualifications of the service provider, including (i) whether the service provider was a clinical psychologist, certified school psychologist, certified social worker, certified school social worker (i.e., a social worker who was registered and certified in accordance with the New Jersey State education law and the rules of the Commissioner of Education), or a school counselor who is certified in accordance with New Jersey State education law, and (ii) the professional licenses, certifications, registrations or permits held by the service provider during the relevant time period.

(b) The service provider's progress notes relating to the psychological counseling services rendered to the student during the relevant time period.

7. Any external or internal written communications (*e.g*., correspondence, memoranda) or notes relating to the Medicaid claims for the psychological counseling services provided to the student during the relevant time period.

INSTRUCTIONS FOR NURSING SERVICES OR INDIVIDUAL HEALTH SERVICES

Please provide the following documents for those claims for Medicaid reimbursement for medical evaluations for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the nursing services provided for the time period under review.

2. Service encounter records, logs, turnaround documents, or other documentation substantiating that the nursing services were rendered and documentation showing the specific number of nursing services rendered each month during the time period under review. Also, include the Parent Consent form.

3. Student service attendance records for the period under review, as well as Remittance Advice for reimbursement received.

4. Documentation sufficient to show whether the nursing services were provided by a school certified nurse, a registered nurse (RN) or a licensed practical nurse (LPN).

5 Documentation showing that the service provider is licensed in the State of New Jersey, and there is a physician’s order for the services performed.

INSTRUCTIONS FOR TRANSPORTATION SERVICES

Please provide the following documents and information for the claim(s) for Medicaid reimbursement for transportation services for the student(s) identified by Enclosure A.

1. The student's Individualized Education Plan (IEP) recommending the type of transportation services provided for the time period under review.

2. Notes, minutes of meetings, or other documents reflecting or relating to consideration by the Child Study Team of the student's transportation needs for the relevant time period under review and relating to the recommendation on the IEP for the period under review.

3. Service encounter records, logs, turnaround documents, or other documentation substantiating that the transportation services were rendered on the dates for which the school district claimed Medicaid reimbursement for transportation for the student. Also, include the Parent Consent form.

4. Documentation sufficient to show the type of transportation service provided to the student (for example, an ambulette, invalid coach, specialized bus, regular school bus, or other) for each trip billed.

5. Documentation showing that the student was on a list of students who were required to be transported by the school district.

6. Student attendance records related to # 3 above for the period under review.

7. Any external or internal written communications (*e.g*., correspondence, memoranda) or notes relating to the Medicaid claims for the transportation services provided to the student during the relevant time period.

INSTRUCTIONS FOR MEDICAL EVALUATION CLAIMS

Please provide the following documents for those claims for Medicaid reimbursement for medical evaluations for the student(s) identified by Enclosure A.

1. The dated and signed evaluation or examination report or other documentation substantiating that the evaluation or examination was rendered and the date on which each evaluation or examination was provided.

2. Documentation identifying the person(s) who performed the evaluation(s) or examination(s). With respect to each such person, please provide documentation sufficient to show his or her professional title and credentials.

3. If the evaluation or examination was performed under the direction of another health-care professional, please provide documents identifying the person(s) who provided the

direction and, with respect to each such person, please provide documentation sufficient to show his or her professional title and credentials and the direction that he or she provided.

4. The written referral for the evaluation or examination and any documentation reflecting that a physician or other health care professional ordered the evaluation or examination.

5. Documentation showing that the medical evaluation or examination was part of the student's Individualized Education Plan (IEP).

DEFICIENCIES OF EACH SAMPLED CLAIM

Legend

1	Referral or prescription requirements not met
2	Federal provider requirements not met
3	Unable to verify that transportation services billed were actually rendered
4	Unable to verify that related health and evaluation services billed were actually rendered
5	Services not rendered or not supported
6	Services not included in child's plan
7	Nonspecialized transportation claimed on or after July 1, 1999
8	Service claimed for a student in an institution for mental diseases

Office of Inspector General Review Determinations on the 150 Sampled Claims

Claim No.	1	2	3	4	5	6	7	8	No. of Deficiencies
S1-1	X	X	X	X					4
S1-2	X								1
S1-3									0
S1-4									0
S1-5			X						1
S1-6			X						1
S1-7									0
S1-8		X							1
S1-9			X						1
S1-10									0
S1-11				X					1
S1-12			X	X					2
S1-13	X	X							2
S1-14	X		X			X			3
S1-15	X		X						2
S1-16	X	X			X				3
S1-17									0
S1-18									0
S1-19	X								1
S1-20		X			X				2
S1-21		X							1
S1-22									0
S1-23					X				1
S1-24									0
S1-25	X	X	X		X		X		5

Claim No.	1	2	3	4	5	6	7	8	No. of Deficiencies
S1-26	X		X						2
S1-27	X	X	X		X		X		5
S1-28					X				1
S1-29	X	X							2
S1-30									0
S1-31									0
S1-32									0
S1-33		X							1
S1-34		X	X						2
S1-35									0
S1-36									0
S1-37			X	X			X		3
S1-38	X	X							2
S1-39					X				1
S1-40				X					1
S1-41									0
S1-42	X	X							2
S1-43			X	X					2
S1-44									0
S1-45									0
S1-46	X		X				X		3
S1-47	X	X	X						3
S1-48			X	X		X			3
S1-49									0
S1-50	X	X	X						3
S2-1				X					1
S2-2				X					1
S2-3									0
S2-4									0
S2-5									0
S2-6				X					1
S2-7			X			X			2
S2-8				X					1
S2-9	X	X							2
S2-10									0
S2-11									0
S2-12		X	X			X			3
S2-13					X				1

Claim No.	1	2	3	4	5	6	7	8	No. of Deficiencies
S2-14					X				1
S2-15									0
S2-16	X				X				2
S2-17			X	X		X			3
S2-18		X							1
S2-19			X	X	X				3
S2-20				X					1
S2-21									0
S2-22			X		X				2
S2-23		X	X	X					3
S2-24		X				X			2
S2-25	X	X		X					3
S2-26			X	X					2
S2-27				X					1
S2-28	X								1
S2-29	X	X							2
S2-30		X	X						2
S2-31				X	X				2
S2-32	X	X		X		X			4
S2-33			X						1
S2-34			X	X					2
S2-35				X					1
S2-36	X		X	X					3
S2-37				X					1
S2-38	X	X	X		X				4
S2-39		X	X						2
S2-40	X		X			X			3
S2-41			X						1
S2-42									0
S2-43		X							1
S2-44									0
S2-45				X					1
S2-46	X	X	X						3
S2-47				X					1
S2-48	X								1
S2-49	X	X							2
S2-50			X						1
S3-1	X	X				X			3

Claim No.	1	2	3	4	5	6	7	8	No. of Deficiencies
S3-2	X	X			X	X			4
S3-3				X					1
S3-4									0
S3-5	X	X		X					3
S3-6	X	X							2
S3-7									0
S3-8	X	X		X	X				4
S3-9	X	X			X	X			4
S3-10									0
S3-11*	X		X			XX			4
S3-12	X	X			X	X			4
S3-13									0
S3-14									0
S3-15					X				1
S3-16		X							1
S3-17					X				1
S3-18			X		X	X			3
S3-19	X								1
S3-20	X	X							2
S3-21			X			X			2
S3-22	X	X							2
S3-23									0
S3-24				X	X				2
S3-25				X					1
S3-26	X	X		X					3
S3-27			X	X					2
S3-28									0
S3-29									0
S3-30									0
S3-31									0
S3-32			X		X				2
S3-33								X	1
S3-34				X	X				2
S3-35			X	X					2
S3-36									0
S3-37	X	X			X				3
S3-38	X								1
S3-39	X								1

Claim No.	1	2	3	4	5	6	7	8	No. of Deficiencies
S3-40	X								1
S3-41	X					X			2
S3-42	X	X		X					3
S3-43						X			1
S3-44					X				1
S3-45									0
S3-46									0
S3-47	X	X	X			X			4
S3-48									0
S3-49	X			X		X			3
S3-50									0
Total	48	43	41	37	26	19	4	1	

*For this claim, the child's plan did not include the related service or the transportation service.

SAMPLE RESULTS AND PROJECTIONS

The results of our review of the 150 Federal Medicaid school-based claims were as follows:

Sample Results and Recommended Financial Adjustment

Stratum Number	Claims in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Improper Claims	Value of Improper Claims (Federal Share)
1	93,788	$19,910,834.37	50	$10,278.00	30	$5,038.88
2	74,979	45,909,773.56	50	31,630.28	38	20,018.39
3	26,765	35,314,874.06	50	62,875.70	35	34,639.48
Total	**195,532**	**$101,135,481.99**	**150**	**$104,783.98**	**103**	**$59,696.75**

Projection of Sample Results
(Precision at the 90-Percent Confidence Level)

Midpoint	$58,013,413
Lower Limit	$51,262,909
Upper Limit	$64,763,917
Precision Percent	11.64%

Sample Results and Set-Aside Amount

Stratum Number	Claims in Universe	Value of Universe (Federal Share)	Sample Size	Value of Sample (Federal Share)	Set-Aside Claims	Value of Set-Aside Claims (Federal Share)
1	93,788	$19,910,834.37	50	$10,278.00	9	$220.91
2	74,979	45,909,773.56	50	31,630.28	10	727.63
3	26,765	35,314,874.06	50	62,875.70	3	571.41
Total	**195,532**	**$101,135,481.99**	**150**	**$104,783.98**	**22**	**$1,519.95**

Projection of Sample Results
(Precision at the 90-Percent Confidence Level)

Midpoint	$1,811,380
Lower Limit	$1,046,786
Upper Limit	$2,575,973
Precision Percent	42.21%

State of New Jersey
DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
P.O. Box 712
Trenton, NJ 08625-0712
Telephone 1-800-356-1561

JON S. CORZINE
Governor

KEVIN M. RYAN
Commissioner

ANN CLEMENCY KOHLER
Director

March 2, 2006

Timothy J. Horgan
Regional Inspector General
for Audit Services
Office of the Inspector General
Office of Audit Services
Jacob K. Javits Federal Building
26 Federal Plaza
New York, New York 10278

Report Number A-02-03-01003

Dear Mr. Horgan:

This is in response to your correspondence of August 25, 2005 concerning the draft audit report titled "Review of Medicaid Claims for School-Based Health Services in New Jersey". Your correspondence provides an opportunity to comment on the draft audit report.

The draft report states that 109 of 150 claims reviewed did not comply with federal laws and regulations, State statute, or the Medicaid State Plan. The report cited several deficiencies in the 109 claims questioned and indicated these deficiencies occurred because:

1) the State did not provide proper or timely guidance concerning federal Medicaid requirements to school health providers;
2) school health providers did not comply with State guidance they had received; and
3) the State did not adequately monitor school health claims for compliance with federal and State requirements.

Based on the claims sampled, the draft report estimates that $51,262,909 in federal Medicaid funding was unallowable.

The draft report includes five recommendations. These recommendations and the State's response are provided below:

Refund $51,262,909 to the Federal Government:

The State is currently unable to concur with this recommendation. The quantity and age of the items reviewed and questioned by the auditors; the number of providers involved; and the coordination of various responsible agencies require an extensive effort to independently confirm this finding. The State has initiated a review and is committed to performing a complete investigation of all claims and issues cited in the report as soon as possible. Any inconsistency between the results of State's examination and the audit findings will immediately be shared with your staff and/or the Center for Medicare and Medicaid Services (CMS).

Work with CMS to resolve $1,046,786 in set-aside claims:

The State will work with CMS to resolve all issues concerning claims for transportation services.

Provide proper and timely guidance on Federal Medicaid criteria to its school health providers:

During the audit, the State sent numerous procedural memos and notices to districts to provide clarification and guidance on policy and requirements. The State also provided informal reviews to address deficiencies and train districts. Annual regional trainings were also used to provide proper and timely guidance on program guidelines. Where specific concerns were identified district specific training in a one-on-one setting was provided. The State is currently updating the provider handbook to further inform and advise providers on the requirements for delivery and reimbursement of health services. Additionally, numerous meetings and training sessions have been held and are scheduled for this purpose.

Reinforce the need for school health providers to comply with Federal and State requirements:

The State began formal, documented monitoring in 2002 after recognizing the need for more oversight. The results of the monitoring are used to develop compliance strategies to further promote compliance with Federal and State requirements. Areas of concern were addressed in trainings and through procedural memos. The State has initiated further development and implementation of even more comprehensive and stringent procedures to assure compliance with federal and State requirements by school health providers.

Improve its monitoring of school health providers' claims to ensure compliance with Federal and State requirements:

The compliance procedures devised by the State as mentioned above include significant monitoring activities designed to further assure compliance with federal and State requirements.

The State has undertaken action over the past several years to address many of the deficiencies noted. In 2002, the monitoring process became more formalized and the State has accumulated written results of district monitoring. In cases where incomplete or insufficient support for the service was provided, those claims were recovered from the school district and training occurred to enhance their understanding of the program and requirements. The state has continued to enhance the monitoring procedures over time and is currently engaged in an extensive effort to improve the performance of all aspects of delivering school-based health services. This work was initiated in response to concerns recognized by the State and has more recently been focused on matters identified during this audit. The State has selected a new, experienced vendor to assist with this effort; involved additional State resources with related proficiencies; begun implementing automated data systems at schools; initiated reviews of applicable procedures; provided additional information and assistance to providers; and developed and implemented procedural improvements. This effort has been beneficial in enhancing the oversight and management of the delivery of school base health services and addressing the issues cited by the auditors. These efforts will continue and will be expanded as needed to focus on compliance with all federal and State requirements.

Please note that the considerate and professional approach of your audit staff has been commendable and is greatly appreciated. If you have any questions or require additional information, please contact me or David Lowenthal, Bureau of Federal Reporting at (609) 588-2820.

Sincerely,

Ann Clemency Kohler

Ann Clemency Kohler,
Director

ACK:dl
c: Kevin M. Ryan
David Lowenthal

ACKNOWLEDGMENTS

This report was prepared under the direction of James P. Edert, Regional Inspector General for Audit Services, Region II. Other principal Office of Audit Services staff who contributed include:

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