Department of Health and Human Services
DEPARTMENTAL APPEALS BOARD
Appellate Division

New Jersey Department of Human Services
Docket No. A-10-79
Decision No. 2415
September 29, 2011

DECISION

The New Jersey Department of Human Services (New Jersey) appeals a determination by the Centers for Medicare & Medicaid Services disallowing $50,500,277 in federal financial participation (FFP) claimed by New Jersey under title XIX of the Social Security Act for school-based services. CMS based the disallowance on an Office of the Inspector General (OIG) audit that reviewed a 150-unit sample of paid claims. Each sample unit, or claim, consisted of all school-based services for one student for one month during the period July 1, 1998 through June 30, 2001. The claim amount consisted of one fee for all health services (regardless of the number and type) on each date of service and/or a separate fee for any evaluation of the student's need for health services, as well as a daily fee for any transportation services. The OIG determined that the costs of some or all of the services in 109 of the sample claims were unallowable. CMS accepted the audit findings with respect to 108 of these claims and disallowed an amount based on a projection from the sample to the universe of claims for the audit period.

On appeal, New Jersey argues that the sampling methodology was not valid. In addition, New Jersey disputes some or all of the findings relating to one or more services in 51 of the 108 sample claims. During the proceedings before the Board, CMS determined that three disputed sample claims (sample #2-06, 2-24, and 2-45) were allowable in full. *See* CMS Br. at 45.

As discussed below, we conclude that the sampling methodology used by the OIG was valid. In addition, we reverse the disallowance with respect to the nursing services in sample #2-28, 3-06, 3-19, 3-22, 3-38, 3-40, and 3-42. We also remand the appeal with respect to the speech language therapy services in sample #1-21 and 3-16, the services in sample #2-36, the transportation services in sample #3-32, and the evaluation in sample #2-02. We uphold the disallowance with respect to the remaining claims.

Legal background

The federal Medicaid statute, title XIX of the Social Security Act (Act), authorizes a program that furnishes medical assistance to low-income individuals and families as well as to blind and disabled persons. Act § 1901. Each state operates its own Medicaid program in accordance with broad federal requirements and the terms of its approved Medicaid state plan. Act §§ 1902(a)(10), 1905(a). A state receives federal reimbursement, or FFP, for a share of its Medicaid program expenditures, primarily "medical assistance," that a state is authorized to provide (and in some cases must provide) under its Medicaid state plan. Act §§ 1903(a), 1905(a).

Expenditures for direct school-based health services that are among the services listed in section 1905(a) of the Act and furnished to Medicaid eligible children may be claimed as "medical assistance." In addition to meeting the medical needs of Medicaid-eligible students, school-based health services may fulfill requirements of the Individuals with Disabilities Education Act (IDEA), 20 U.S.C. § 1400. The IDEA requires states to ensure that all children with disabilities (regardless of Medicaid eligibility) "have available to them a free appropriate public education that emphasizes special education and related services designed to meet their unique needs[.]" 20 U.S.C. § 1400(d)(1)(A). For each child three years and older identified as disabled, a school must develop an "individualized education program" (IEP), which identifies the "special education and related services and supplementary aids and services to be provided to the child." 20 U.S.C. § 1414(d). Payment under Medicaid for covered services furnished to a child with a disability cannot be prohibited or restricted on the basis that the service is included in an IEP. Act § 1903(c). CMS has stated that its policy is that health-related services included in a child's IEP can be covered under Medicaid if all Medicaid requirements are met. *See Medicaid and School Health: A Technical Assistance Guide*, dated August 1997 (*Guide*)[1] at 15.

Section 1902(a)(27) of the Act and the implementing regulations at 42 C.F.R. § 431.107(b) provide that a state's agreement with Medicaid providers must require them to keep, and furnish upon request, any records necessary fully to disclose "the extent of the services" furnished to recipients. In addition, the state Medicaid agency must "[m]aintain an accounting system and supporting fiscal records to assure that claims for

[1] Both parties refer to the *Guide* in their briefing but neither party submitted a copy. We include in the record as DAB Exhibit 1 a copy of the *Guide* submitted by CMS in another Board proceeding (Texas Health and Human Services Commission, Docket No. A-08-87, CMS Exhibit 1).

Federal funds are in accord with applicable Federal requirements" and retain the records for three years from the date of submission of the final expenditure report or longer if the audit is not resolved. 42 C.F.R. § 433.32. The *Guide* states that "[r]elevant documentation includes the dates of service, who provided the service, where the service was provided, any required medical documentation related to the diagnosis or medical condition of the recipient, length of time required for service if relevant, and third party billing information." *Guide* at 40.

The uniform administrative requirements for grants to states place on a state the burden of documenting the allowability and allocability of costs for which reimbursement is claimed. *See* 45 C.F.R. §§ 74.50-74.53 (1999)(reporting and record retention requirements); *see also Oklahoma Health Care Authority*, Ruling No. 2008-4, at 4 (2008), citing *California Dept. of Health Services*, DAB No. 1606 (1996)("It is a fundamental principle that a state has the initial burden to document its costs and to show that its claim for reimbursement is proper.").[2]

The regulations at 42 C.F.R. Part 440 contain the general provisions relating to services reimbursable by Medicaid. We cite to those regulations as appropriate in our analysis below.

Analysis

I. Validity of statistical sampling methodology

As explained below, we conclude that New Jersey's challenge to the statistical sampling methodology has no merit.

What the auditors did

The following facts about the sampling methodology the auditors used are set out in Appendices A and B of the audit report and are undisputed:

- The auditors drew the sample from a sampling frame consisting of a computer file containing 195,532 school-based claims for federal funding and adjustments to those claims. The total amount reimbursed for those claims was $202,270,964.

[2] For the period for which the claims at issue here were made, the administrative requirements at 45 C.F.R. Part 74 (with certain exceptions not relevant here) applied to Medicaid and other HHS entitlement grants. In 2003, the Secretary made the administrative requirements at 45 C.F.R. Part 92 (rather than Part 74) applicable to these grants. *See* 68 Fed. Reg. 52,843 (Sept. 8, 2003).

The federal share was $101,135,482. New Jersey officials extracted the database from paid claims files maintained by the fiscal agent for New Jersey's Medicaid Management Information System (MMIS).

- Each sampling unit was a school-based claim, with corresponding adjustments, paid with Medicaid funds. Each claim represented all services provided to an individual school-aged student for one month during the audit period.
- The auditors used a stratified random sample to evaluate the population, separating the sampling frame into three strata:
  - Stratum 1 consisted of 93,788 claims for amounts less than $850;
  - Stratum 2 consisted of 74,979 claims for amounts from $850 to $1,899.99; and
  - Stratum 3 consisted of 26,765 claims of $1,900 or greater.
- The auditors selected a sample size of 150 claims, with 50 items from each stratum.
- To randomly select the sample units, the auditors used a statistical sampling software program (random number generator) from the OIG Office of Audit Services.
- The 150 claims selected include 254 services (81 speech-language pathology, 46 transportation, 31 nursing, 29 evaluation, 23 physical therapy, 23 occupational therapy, and 21 psychological counseling).
- To appraise the sample results, the auditors used software called a Variable Stratified Appraisal Program that is part of the Office of Audit Services RAT-STATS software package.
- The auditors used the lower limit of the two-sided 90% confidence interval as the estimate of the value of improper claims.[3]
- The midpoint value of improper claims as calculated by the auditors was $58,013,413; the lower limit was $51,262,909; and the upper limit was $64,763,917.

DHS1977 et seq. [4]

[3] The value included claims or parts of claims found unallowable. The auditors also separately projected a set-aside amount for transportation services if the auditors questioned the claim (or part of a claim) based solely on their finding that the claim lacked adequate documentation to support the number of transportation services billed.

[4] The documents in New Jersey's appeal file are paginated with the letters "DHS" preceding the page number.

The issue before us

We note at the outset that the courts and this Board have long upheld the use of statistically valid sampling methods as a basis of determining a disallowance amount. *See, e.g., Rosado v. Wyman*, 437 F.2d 619, 627-628 (2d Cir. 1970), *aff'd*, 402 U.S. 991(1970); *Georgia v. Califano*, 446 F. Supp. 404, 409-410 (N.D. Ga. 1977); *California Dept. of Social Services*, DAB No. 816, at 4-5 (1986). The Board has viewed a challenge to statistical sampling as an evidentiary question -- whether the sample findings are reliable evidence. *Ohio Dept. of Human Services*, DAB No. 1202, at 15 (1990). The Board has accepted as sufficiently reliable evidence establishing through a statistically valid sampling methodology that there is 95% probability that the improper payments were at least the amount determined by the auditors. *Maryland Dept. of Health*, DAB No. 2090 (2007); *Puerto Rico Dept. of Health*, DAB No. 2385 (2010) and cases cited therein.

As discussed below, New Jersey does not challenge the auditors' use of the OIG software programs for generating a random sample and for analyzing the sample results to calculate the midpoint (also referred to as the mean or point estimate), the standard error of the mean, and the confidence interval. Instead, New Jersey agrees that the statistical mathematics is acceptable "as long as the data for analysis is appropriate." NJ Reply Br. at 3-5. New Jersey alleges, however, that the issue is about "the sampling design which will collect the most appropriate data for statistical analysis." *Id.* at 5. While we explain below why we reject New Jersey's arguments about the sampling design, we stress here that New Jersey presented no evidence that convinces us that the sampling methodology used by the auditors was not a valid statistical basis for determining, with a 95% probability, that the amount of unallowable payments was at least the amount at the lower limit of the 90% two-sided confidence interval.

The choice of a sampling unit, stratification, and sample size

New Jersey challenges the auditors' choice of a sampling design based on declarations by George D. Self, Ph.D., who is Chief of the Office of Statistical Analysis of New Jersey's Division of Medical Assistance and Health Services. Dr. Self's initial declaration (which New Jersey referred to as a "certification" and attached to its appeal brief) attests as follows:

> 9. The OIG audit intent was to examine the appropriateness of school based services provided, billed and paid. This should be verified by determining if services were properly documented – verifying delivery, were services provided by properly certified practitioners and were services delivered as part of the

> student's Individualized Education Program (IEP). This intended analysis requires a sampling of services, not months of billing . . . . The OIG audit's sample unit is a month of services to an individual student with a stratified design based on dollar ranges of a month of services.
>
> 10. The question is not whether a month of services were delivered and billed correctly but were individual services required by an IEP delivered appropriately by certified providers. A corrupting artifact of using months of services is that each month is associated with a single student and services delivered to that student by a single school. This restricts the sample size to only a few children and a few schools. If the IEP is inadequate or does not specify certain services delivered, all those types of services are rejected giving a false percentage of those service types in the population that may have been inappropriately provided. One incorrectly followed IEP out of hundreds of thousands could cause a significant sample percentage of services/claims to be rejected; this is not necessarily reflective of the population.
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> 11. Also by concentrating on a particular student month practices in one school will have an adverse effect on the accuracy of the sample statistics. An individual school may use an inappropriate provider or generally respond to the audit with poor documentation which would again result in the disallowance of a significant number of services that are not representative of the universe (Statewide).
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> 12. Therefore, a major flaw in the OIG current sampling design was measuring the appropriateness of a month of service claims. Grouping daily service claims into a larger unit for payment does not make it an appropriate sampling unit even if that grouping period is used for payments. The audit's stratification approach simply based on monthly claim size adds nothing to the design unless [a] student's health acuity is the element under examination. In this OIG audit the sampling design is so flawed that it results in incorrect statistical inferences with an inability to provide answers to the audit inquiry of interest as to whether the services to students were appropriate and documented correctly.

NJ Br., Att. ¶¶ 9-12.

Dr. Self goes on to assert that each subgroup of service differs substantially from other subgroups, and concludes: "Therefore, when you have a variety of services (5 basic types in this universe), it is inappropriate and will possibly skew the results to lump them together to develop an error rate." *Id.* at ¶ 15. According to Dr. Self, a "more logical approach would be to stratify by services type (5 strata)." *Id.*

Dr. Self also attests that the sample size was too small. In support, Dr. Self refers to Arkin, Herbert, Handbook of Sampling for Auditing and Accountants, McGraw-Hill, 1984 (Arkin Handbook), which he describes as "standard for auditors" and which he says would have required a sample size of over 600 "for findings of this audit with a ratio of accepted/rejected of 30%/70%." *Id.* ¶ 18.

With its response brief, CMS submitted the declaration of Alan H. Kvanli, Ph.D., a statistical consultant to HHS. Dr. Kvanli expresses his opinion that the "sampling design utilized by the Office of Inspector General was well thought out and most certainly was appropriate given the audit objectives [and] the sample was indeed representative of the universe . . . ." CMS Ex. 1 ¶ 10. He responds more specifically to Dr. Self's assertions about the sampling design, as follows:

> 11. Dr. Self claims that the stratification used in the sample design was ineffective. On occasion, there is more than one way to stratify a universe of claims. Generally, the dollar values of the paid amounts are used to form the strata since these are readily available to the auditor. Could the strata have been formed using the five service types as Dr. Self claims? That is simply another way to stratify, but it is my understanding that this was not a possibility here because the State billed all related services under one procedure code, and there was no way of knowing what specific related service was performed until the records were reviewed by the auditors.
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> 12. Nevertheless, the stratification based on the dollar amount of the claims was certainly effective in reducing the standard error in the overall estimated overpayment. . . .
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> 17. The Self Affidavit also claims this analysis requires a sampling of services, not months of billing. In fact, the sampling unit in the NJ audit was a Medicaid claim, which included all services provided to an individual student for one month. This is a commonly used sampling strategy and is both statistically and mathematically acceptable. By using a sample of 150 claims, each containing multiple services, the audit team was able to review a large number of services without having to stratify the universe by service type. The audit **did** review these individual services within the claim and determined the combined error (i.e., overpaid) amount for all services.
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> 18. The Self Affidavit further asserts that a "bad" [IEP] or school somehow distorts the projection results. It is quite likely that the universe and the sample contain inadequate IEPs and schools that did use inappropriate providers and/or provided insufficient documentation to the auditors. All types of IEPs and schools, both good and bad, had a known chance of selection, and the errors for all

> types of IEPs and schools were and should have been included in the sample and were projected in the estimate of the total overpayment. This raises the question of whether the choice of sampling unit used in the NJ audit magnif[ied] or distort[ed] the effect of "bad" IEPs or schools. This answer is no, since one could similarly argue that the results from the "good" IEPs and schools distort the projection in the other direction. There is no distortion in the NJ overpayment estimation procedure since a probability sample and an unbiased estimator were used to arrive at the result.
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> 19. The Self Affidavit goes on to claim that the OIG audit sample design added a bias selection of only a limited number of schools sampled to represent the entire state of New Jersey. Of course, the sample contained a limited number of schools since every sample contains only a portion of the corresponding universe.

Id. Dr. Kvanli also points out that Dr. Self's general statement purporting to certify that the sample was inappropriate and biased refers to the "determined error rates." *Id.* ¶ 21. According to Dr. Kvanli this statement indicates a fundamental lack of understanding of the objectives of the audit since there was no mention in the audit report of an "error rate" or of extrapolating any error rate to the universe. *Id.*

Dr. Kvanli similarly responds to Dr. Self's opinion on the sample size by attesting that the sample was not an attributes sample to determine an error rate and that the tables in the Arkin Handbook that Dr. Self uses to argue for a larger sample "pertain to attribute sampling, where the audit is concerned with the estimation of a universe proportion" and have "no relevance whatsoever to estimating a total overpayment amount, as was the case with the NJ audit." *Id.* ¶ 22.

With its Reply Brief, New Jersey attached a supplemental certification by Dr. Self. Dr. Self does not assert that the sample was in fact designed to determine an error rate nor does he explain how the tables in the Arkin Handbook on sample size are relevant. He attests, however, that the object or element of the audit "was the acceptance of medical services provided to students not the percentage of dollars spent for these services" and the "correct dollars spent is only dependent on the analysis of the acceptance of services delivery (allowed or disallowed, an attribute set of data)." NJ Reply Br., Att. ¶ 7. According to Dr. Self, this further supports a sampling design that is based on a selection of services and "if stratified to decrease the variance, then stratified by service type." *Id.* ¶ 8.

Dr. Self states:

> In summary, to sample monthly payment invoices because that is the easiest data to collect is inappropriate for a good sampling design even when the data is analyzed by RAT-STAT[S]. The issue is not about the statistical mathematics but the sampling design to collect the **most appropriate data** for statistical analysis. It is agreed that this proposed design is difficult to approach, but a more careful design must be devised given the State funds involved. With multiple millions of dollars involved, a design that is not quick and dirty must be developed. One possible approach that may work would be a two stage sampling design where first the sample would contain a much larger sample of monthly billings that could even by be stratified by county or regions of the State, using these invoices of monthly services as an approach to identifying a larger number of services. Then sample from these identified services.

Id. ¶ 9 (emphasis added).

We conclude that New Jersey's arguments about the sampling design have no merit. In reaching our conclusions, we give greater weight to Dr. Kvanli's opinion than to Dr. Self's opinion for several reasons. First, while both Dr. Self and Dr. Kvanli may be considered experts in statistical sampling, Dr. Kvanli has more experience in use of sampling for audits such as the one at issue, whereas Dr. Self's experience relates primarily to the use of statistical sampling as related to economics. *Compare* CMS Ex. 1, Att. (Kvanli resume) *with* NJ Br. Att. (Self resume). Second, Dr. Self's opinion in his initial certification that the audit sampling design "results in incorrect statistical inferences" appears to be based on his misconception that the purpose was to establish an "error rate." *Id.* ¶ 12. His later opinion is merely that the most appropriate data were not sampled. Dr. Self concedes in his supplemental certification that the statistical mathematics were correct and does not assert that the methodology was not statistically valid. Thus, he does not adequately respond to Dr. Kvanli's attestation that the methodology was "both statistically and mathematically acceptable." CMS Ex. 1 ¶ 17.

Dr. Self does suggest that the sampling design of choosing monthly claims could skew the results because of the potential effect of one child without an IEP or one school that failed to have qualified personnel or adequate documentation, but does not respond to Dr. Kvanli's point that claims with the opposite characteristics (such as a child with an IEP or a school with qualified personnel and adequate documentation) had the same likelihood of being chosen for the sample. Moreover, New Jersey has presented no evidence that the mix of services or schools represented by the sample claims was not representative of the universe of claims. Dr. Kvanli, on the other hand, provides an analysis that he says shows that the sample was representative, comparing the estimated total amount in the universe based on the sample with the known value of the total amount paid. CMS Ex. 1 ¶ 20.

Dr. Self does not in his supplemental certification reply to Dr. Kanvli's assertion that the Arkin Handbook tables on which Dr. Self initially relied for his argument on sample size have "no relevance whatsoever." CMS Ex. 1 ¶ 22. Contrary to what Dr. Self suggests, the objective of the audit was not simply to determine whether to accept or reject individual services and then to apply the resulting error rate (or accept/reject percentage) to the universe of services of that type. Instead, as Dr. Kvanli asserts, the purpose was to estimate a total overpayment amount.

The sample design does not need to be the most appropriate one in order for the results to be statistically valid. Here, there are several factors that suggest that the sampling design the auditors used had merits that Dr. Self's proposed design does not. First, New Jersey's payment method called for paying one daily rate for services other than transportation or evaluation, such as physical or occupational therapy, provided on any particular day.

If the auditors had stratified the sample according to the type of service, as Dr. Self suggests, the sample result of finding a particular service undocumented or otherwise unallowable would not be determinative of whether the payment at the daily rate should be allowed since there is the possibility that a different, allowable service provided on the same date would justify the payment. Analyzing only whether an individual service was allowable or unallowable could thus skew the results in a different way, unfavorable to New Jersey. Second, while Dr. Self suggests that the auditors may have chosen the design they did as a matter of convenience, he does not deny that the sampling unit was determined based on the fact that New Jersey did not maintain the data according to the type of service. Moreover, choosing a complicated two-stage audit design like the one proposed by Dr. Self, with a much larger sample, would have not only increased the burden on the auditors, but would also have increased the burden (and concomitant costs) on New Jersey and its schools. Perhaps for this reason, there is no evidence that New Jersey complained about the sampling design at the time it provided the claims data to the auditors. In addition, it appears to us that Dr. Self overstates the significance of the differences in the service items in arguing for a sample design based on the type of service. Factors that the audit looked at such as failing to properly document that a service was needed or provided, claiming a service for a day a student was not at school, or using unqualified personnel may depend on the policies and procedures a school or school system has in place rather than on the nature of the service provided.

In any event, as we discuss next, Dr. Self's suggestions for a more appropriate or effective sampling design are directed at increasing the precision of the sample results or, stated differently, reducing the margin of error. While this may be a goal of sampling, particularly in circumstances where the purpose of the sample is to determine an error rate based on the point estimate, New Jersey has not shown any prejudice to it from the methodology used, given that the disallowance was not based on the point estimate.

The sample precision/margin of error

In his declaration, Dr. Kvanli attests:

> According to the computer output generated using RAT-STATS, the precision percentage in the overall estimate is 12 percent using the 90 percent 2-sided confidence level. The precision percentage is obtained by dividing the half width of the 90 percent confidence interval by the point estimate of the total overpayment, expressed as a percentage. This is an excellent result in terms of sample precision and if the universe had not been stratified by the paid amounts, the resulting precision would likely have been much worse.

CMS Ex. 1 ¶13.

In his supplemental certification, Dr. Self attests that 12% is an "unacceptable margin of error" and that the usual standard is 5%. NJ Reply Br., Att. ¶ In support of this, Dr. Self does not cite to any statistical sampling treatise but asserts that CMS uses a 3% margin of error for its Medicaid Eligibility Quality Control (MEQC) system and the provider error rate measurement (PERM) system. Both of these systems, however, are designed to meet statutory requirements to determine error rates, and the point estimate of each error rate in those circumstances has consequences that require a high degree of confidence. (For a discussion of these systems, see 42 C.F.R. Part 431, subpart Q and 75 Fed. Reg. 48,816 (Aug. 11, 2010).) For the MEQC system, the precision of the point estimate of an error rate is important because the statute recognizes that a certain percentage of errors in determining individual eligibility for Medicaid is unavoidable and thus provides that no disallowance will be taken if a state's error rate is at or below that percentage, referred to as a "tolerance level" (which also happens to be 3%). Act § 1903(u). For the PERM program, CMS must estimate for Medicaid a national error rate bound by a confidence interval of 2.5 percentage points in either direction of the estimate, and therefore needs to collect state-level information "at a high level of confidence." 75 Fed. Reg. at 48,817. If the national error rate shows "significant improper payments" (defined as annual erroneous payments exceeding both 2.5% of program payments and a dollar threshold), then CMS must report this to Congress, as well as the actions to be taken to reduce the amount of erroneous payments. 75 Fed. Reg. at 48,816. Thus, these systems are not analogous to the audit here, where the disallowed amount was not based on the point estimate, but on the lower limit of the confidence interval.

Dr. Self does not deny that the audit's use of the lower limit of the two-sided confidence interval assures that there is a 95% probability that the value of the unallowable payments in the universe of claims is at least the amount disallowed. In other words, there is only a 5% chance of disallowing an allowable payment amount.

Dr. Self opines in his first "certification" that a better sampling design would "significantly improve the accuracy of the results, decreasing the sample error and increasing the precision." NJ Br., Att. ¶ 7. Dr. Kvanli responds that there is "no evidence that this is true." CMS Ex. 1 ¶ 16. He also attests that "improved precision would very likely **increase** the lower limit, resulting in a **larger** recovery amount for the federal government." *Id.* at ¶ 14 (emphasis in original). In reply, Dr. Self posits that, if the CMS guidelines for the MEQC and PERM had been followed, then –

> a larger sample size would have been required with a larger confidence interval from 1.64 to 1.96. These improved changes, larger sample size and increase[d] confidence interval, would result in a more accurate and expected smaller error percentage resulting in a smaller mean costs of disallowed medical service claims. This improved and lower statistic with a larger confidence interval would result in a larger confidence lower limit resulting in a lower audit financial claim for disallowed services. With an improved sampling design along with a larger sample size, an even greater lower percentage of errors would be expected and thus smaller disallowance of dollars.

¶ 10. This statement is confusing at best, but is clearly contingent on several premises we find to be unsupported. First, while improving the precision through a different sample design and larger sample would make the point estimate more likely to be accurate, that does not necessarily mean that the amount at the point estimate would be less than the amount the auditors got as the point estimate. Dr. Self suggests a smaller error percentage (and therefore a smaller "mean") would be "expected" but does not explain the basis for his expectation. Presumably, it is based on his view that the audit methodology was biased against New Jersey, but we have rejected that view for reasons stated above.

Second, while unexplained, Dr. Self's assertion that the confidence interval would increase from 1.64 to 1.96 appears to flow from his advocacy of the use of a 95% two-sided confidence interval (calculated by multiplying the standard error by 1.96), rather than the 90% two-sided confidence interval the auditors used. *See Ohio* at 10 (referring to multiplying the standard error by 1.96 to determine the high range of the 95% confidence interval). Presumably, multiplying the standard error amount **obtained from the audit sample** by 1.96, as opposed to 1.64, would yield a greater number and would give a larger confidence interval, so the amount at the lower limit of that confidence interval would be less than the lower limit amount the auditors calculated. But there is no reason to think that the standard error amount calculated for a **new sample**, done

according to Dr. Self's proposed design, would be the same as the standard error in the audit sample. Indeed, when Dr. Self initially suggested stratifying the sample according to the type of service, he explained that the reason for the stratification would be to "decrease the overall variance and thus decrease the measurement sampling error confidence interval." NJ Br., Att. ¶ 15. This suggests that he would expect the standard error to be less in a larger sample stratified according to the type of service. Thus, multiplying the resulting standard error by a higher amount (1.96) would not necessarily result in increasing the confidence interval and reducing the disallowed amount.

In any event, choice of the degree of confidence required involves a judgment regarding the risk of an erroneous result. It has long been standard practice of the HHS Office of the Inspector General to use the lower limit of the 90% two-sided confidence interval for audits such as this. *Colorado Dept. of Social Services*, DAB No. 1272 (1991), at 34. Use of the lower limit of the 90% two-sided confidence interval already favors the audited state, compared to use of the point estimate. While use of the lower limit of the 95% confidence interval would slightly decrease the chance that a disallowance amount is too great, it would also increase the already higher probability that the disallowed amount is too low and therefore increase the risk of permitting a state to retain federal funds claimed for unallowable costs.

In sum, we conclude that the auditors used a statistically valid sampling methodology that gives reliable evidence of the amount of unallowable claims.

II. Allowability of sample claims

Several of the arguments New Jersey raises on appeal apply to services in more than one sample claim. We first discuss these arguments and then turn to the more specific arguments relating to individual sample claims. We do not address some arguments raised by New Jersey with respect to a particular type of service in a sample claim where our conclusion regarding another argument is dispositive.

A. Speech therapy, occupational therapy and physical therapy services found unallowable based on a finding that there was no documentation of a prescription or referral

The OIG found that "Federal referral requirements" were not met for numerous speech therapy, occupational therapy and physical therapy services. DHS1968 (audit report at 7). It appears that the OIG was referring to the requirements in 42 C.F.R. § 440.110 for prescriptions as well as referrals. Section 440.110(a)(1) and (b)(1) define physical therapy and occupational therapy, respectively, as services "prescribed by a physician or

other licensed practitioner of the healing arts within the scope of his or her practice under State law" (emphasis added). Section 440.110(c)(1) defines services for individuals with speech, hearing, and language disorders as services "for which a patient is referred by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law" (emphasis added). New Jersey acknowledges that there was no documentation showing that a prescription or referral was actually made for the following services but argues that the services should not be found unallowable on this basis: sample #1-02 (physical therapy (PT)), 1-13 (occupational therapy (OT) and speech therapy (ST)), 1-15 (PT), 1-19 (ST), 1-26 (OT), 2-16 (ST), 2-38 (OT), 2-40 (OT), 2-48 (ST), 3-05 (OT), 3-08 (ST), 3-11 (ST), and 3-39 (ST). Below, we set out New Jersey's arguments and explain why we do not find them persuasive.

New Jersey argues that it should not be penalized for failure to document referrals or prescriptions made prior to July 1, 1998, the beginning of the audit period. *See* NJ Br. at 18. According to New Jersey, the school districts in question may not have provided documentation of these referrals because "there could have been some confusion concerning whether the OIG requested older referrals[.]" *Id.* New Jersey notes that letters the OIG sent to the school districts requesting materials to support the claims being audited referred to documents "for the relevant time period under review," "applicable to the time period under review," for "each month during the time period under review," and "for the period under review." *Id.*, quoting DHS1980-1991.

Contrary to what New Jersey suggests, however, none of the quoted language appears in the OIG instructions requesting documentation of a referral or prescription for any of the three types of services in question here. For "speech pathology" services, the OIG requested "[d]ocumentation 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." DHS1982. Similarly, for occupational therapy services, the OIG requested "[d]ocumentation 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." DHS1985. Likewise, for physical therapy services, the OIG requested "[d]ocumentation 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)." DHS1988. Thus, there was no indication that the school district should limit its search for prescriptions or referrals to the period starting July 1, 1998. In any event, New Jersey does not explain why it could not have asked the school districts for

documentation of referrals that were made prior to that date once it became apparent that documentation was needed to support the claims. [5]

New Jersey also notes that some students who received services had transferred into the school district from another school district which retained the student's current IEP but that the OIG requested documentation from only the school districts in which the services were provided. New Jersey argues that since a prescription or referral could have been in the student's current IEP, New Jersey should not be held accountable for the lack of a prescription or referral. *See* NJ Br. at 18; NJ Reply at 12, 35. However, New Jersey does not explain why the "receiving" school district could not have obtained a copy of the student's current IEP from the "sending" school district if it believed that IEP contained a prescription or referral.[6]

New Jersey notes further that school districts might not have retained prescriptions or referrals for services to students who had graduated or left the school district for other reasons. However, New Jersey had an obligation to inform the school districts of the need to maintain documentation showing that services for which FFP was claimed were provided in accordance with federal requirements, at least for the applicable retention period. Moreover, New Jersey presented no evidence from any school district that it had the required documentation at one time.

New Jersey also argues that "current valid IEPs" meet the requirements for a prescription or referral by the current provider even if the IEP is not signed by someone authorized to write a prescription or make a referral as long as an earlier IEP contained a prescription or referral for the same type of services. NJ Br. at 22. New Jersey takes the position that the current provider is "automatically" included on the IEP team because the provider's "input is necessary for the formation of the second, third, etc., annual IEP regarding the services in their area of expertise." *Id*.

[5] New Jersey points out that CMS did not dispute that its regulations do not mandate that a prescription or referral must be issued annually or place any time limit on the period during which a prescription or referral can be in effect. *See* NJ Reply Br. at 10; *see also* NJ Br. at 17. We need not reach this question.

[6] In sample #3-06 (discussed elsewhere in this decision), the school district did not provide a copy of the student's IEP but the OIG did not question the claim on the ground that the services were not authorized in an IEP, stating that the sending district had retained the IEP and it was assuming the IEP was "in order." DHS1218. However, CMS was not required to assume that the services were in the IEP, nor, having done so, was it required to assume that the IEP contained a prescription or referral.

New Jersey's argument has no merit. For most of the sample claims, there is no documentation of a prescription or referral in an IEP covering a period earlier than the sample month.[7] New Jersey argues that the school districts may not have provided earlier IEPs due to a lack of clarity in the OIG's instructions, which requested IEPs "for the relevant time period under review." *See* NJ Br. at 18; DHS1980, 1983, 1985. Even if this request did not clearly encompass earlier IEPs, however, the requests for documentation of prescriptions or referrals necessarily covered any prescriptions or referrals in IEPs and, as discussed above, contained no indication that the school district should limit its search to the period starting July 1, 1998. In addition, New Jersey did not explain why it could not have requested school districts to provide earlier IEPs once it became aware that they might support its claims. Moreover, we do not agree with New Jersey that a provider who had not signed the IEP was automatically included on the IEP team. In *Oklahoma Health Care Authority*, DAB No. 2140 (2007), reconsideration denied, Ruling No. 2008-4 (2008), the Board rejected a similar argument, stating that the IDEA regulations "indicate that affirmative action must be taken by the parent or the local agency to include related services personnel on the IEP team." DAB No. 2140, at 6.

Finally, New Jersey asserts that "validly licensed and qualified medical personnel" would not have provided the services unless they were medically necessary. New Jersey argues that this supports an "inference" that the requisite prescription or referral was made in a prior year. NJ Br. at 18-19. New Jersey also appears to argue that this is a basis for finding the services allowable without any evidence of a prescription or referral at all. *Id*.; *see also id*. at 24 (stating that a provider's "ethical obligations" would prevent him or her from providing unnecessary services).

New Jersey had notice, however, that school-based services for which it claimed FFP had to meet federal Medicaid requirements. The Medicaid regulations set out conditions for Medicaid coverage of the services and require a physician (or other licensed practitioner of the healing arts) to prescribe physical and occupational therapy services or to refer the child for speech therapy services. *See* 42 C.F.R. § 440.110(a)(1), (b)(1), (c)(1). These regulations ensure that the services are medically necessary and reflect a policy choice not to rely solely on the provider's qualifications, much less to rely on the provider's ethics. Such assurance is particularly important in the context of distinguishing educational services, which do not qualify for Medicaid coverage (but for which IDEA funds are made available), and the related services that qualify for Medicaid coverage.

[7] New Jersey admits that the earlier IEP in sample #1-13 (at DHS0030) was signed by a "supervised therapist." NJ Br. at 33. Since the therapist was not licensed, she was not authorized to prescribe services under section 440.110(b)(1), which requires a prescription by a physician or other licensed practitioner of the healing arts.

Thus, even assuming a likelihood that a provider would not have provided the services without a prescription or referral, New Jersey could not expect to receive FFP unless it could show that the requirement for a prescription or referral was met. *Cf. Oklahoma Health Care Authority*, Ruling No. 2008-4, at 4 ("the fact that a child has a treatment plan or eventually receives a certain type of service under an IEP is not enough to show that the need for the service was documented as required by a licensed practitioner of the healing arts writing a prescription or making a referral for the service").

Accordingly, we conclude that the speech therapy, occupational therapy and physical therapy services at issue were properly disallowed on the ground that there was no documentation of the required prescription or referral.

B. Nursing services found unallowable based on a finding that there was no documentation of a prescription

For seven sample claims – sample #2-28, 3-06, 3-19, 3-22, 3-38, 3-40, and 3-42, the OIG found that either there was "[n]o referral/prescription for medication" or a "physician's referral/prescription for Nurse services and/or medications [was] not documented." DHS 0825, 1217, 1428, 1538, 1776, 1829, and 1852. The audit report states that "State guidance issued to school health providers requires physician prescriptions/orders for . . . certain nursing services." DHS1967. The audit report does not cite to any "State guidance" requiring a prescription or referral for the nursing services, however, and CMS does not contend that such a prescription or referral was required. Instead, the audit report notes that "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." *Id.*

We note that the OIG specifically found that the nursing services were provided by qualified providers – i.e., a school certified, registered nurse or a licensed practical nurse – and did not question whether the services were included in the student's IEP or whether they were provided on each of the dates of service included in each sample claim. *See* DHS0821-0826, DHS1213-1218, DHS1424-1430, DHS1534-1541, DHS1772-1777, DHS1825-1830, and DHS1848-1853; *see also* DHS1992-1996.[8] It is undisputed that the

[8] For some of the sample claims, New Jersey provided a medication administration record signed by the nurse showing that medication was administered to the student for each of the days in question. *See* DHS1545 (sample #3-22), DHS1834 (sample #3-40), and DHS1858 (sample #3-42). The audit report states with respect to sample #3-42 that the OIG was "[u]nable to verify that related health and evaluation services billed were actually rendered." DHS1992, DHS1996. Since the medication administration record establishes that nursing services were actually rendered, however, this finding appears to be limited to the speech therapy and/or physical therapy services.

nursing services in each of these sample claims consisted of medication administration. The IEPs document the children's medical diagnoses, and neither the OIG nor CMS questioned whether the students needed to be treated with medication for these diagnoses.

New Jersey argues that documentation of prescriptions for the medications unquestionably administered by the nurses was not required in order for the nursing services to be allowable. New Jersey argues that it is "unreasonable to assume that each nurse would provide medication without a valid prescription because, not only would the nurse be out of compliance with school board policy, but he or she would be liable for prosecution for providing unnecessary medications, thereby jeopardizing their license." NJ Br. at 20-21. New Jersey provided evidence of school district policies (cited below) regarding administration of medication to school children. New Jersey argues that the "prescription would be written on the medication container" and that "[f]ailure to see a paper prescription well after the medication was administered does not equate, in this instance, to the medications not being prescribed." NJ Reply Br. at 14. According to New Jersey, "the costs are documented in that the nurses provided the prescription medication to the child and there is no basis to disallow these services." *Id.*

CMS responds that an auditor may not assume compliance with federal and state requirements. CMS describes section 45:11-23 of the New Jersey Board of Nursing statute as a "[r]equirement that the written order of the prescribing physician is required before any medication may be administered" and points out that some school districts provided copies of prescriptions, while others did not. CMS Br. at 15, 19.

We do not "assume" here that the nurses would not administer medications to school children without a prescription. For the reasons explained below, we conclude that no federal or state law or guidance required that, in order to document allowability of nursing services under Medicaid, the schools had to have and retain the physician's written orders. New Jersey was therefore entitled to be paid for the services because the OIG did not find them unallowable on any basis other than the failure to document the written order.

Nursing services are a covered service under the Medicaid regulations at 42 C.F.R. § 440.60(a), which covers "any medical or remedial care or services, other than physicians' services, provided by licensed practitioners within the scope of practice under State law." *See Guide* at 19-20 (stating that this "category is used by states to cover such services as . . . nursing services other than those nursing services specifically identified in the Medicaid statute and regulations (such as private duty nursing, home health nurses or nurse practitioners)"); *see also* CMS Ex. 2, at CMS12 (12/28/93 letter from Associate Regional Administrator stating that "a registered licensed professional nurse . . . can be a

Medicaid provider in accord with the regulations at 42 CFR 440.60"). Unlike the regulations in 42 C.F.R. § 440.110 pertaining to occupational therapy, physical therapy, and speech therapy services, section 440.60(a) does not on its face require a prescription or referral by a physician or other licensed practitioner of the healing arts in order for the services to be covered. Instead, section 440.60(a) states that the services must be provided "by licensed practitioners within the scope of practice under State law." The federal regulation thus looks to state law to define the scope of practice of the service provider.

New Jersey law states in relevant part:

> The practice of nursing as a registered professional nurse is defined as diagnosing and treating human responses to actual or potential physical and emotional health problems, through such services as casefinding, health teaching, health counseling, and provision of care supportive to or restorative of life and wellbeing, and executing medical regimens as prescribed by a licensed or otherwise legally authorized physician or dentist.

NJ Stat. Ann., 45:11-23 (1998) (emphasis added). The administration of medication is presumably a "medical regimen." Medication administration is thus within the scope of nursing practice under New Jersey law only if the nurse administers the medication "as prescribed" by the physician.

However, CMS cited no State regulation or other State-level guidance interpreting this statutory provision as requiring a nurse to maintain a copy of the prescription for each medication the nurse administers to a student or otherwise addressing how compliance with this provision should be established. The only evidence before us that arguably provides any information on this issue consists of the written policies of three of the school districts whose claims were audited. Two of these policies require that the "written order of the prescribing physician . . . shall be kept on file in the office of the school nurse." *See, e.g.*, DHS 0854 (Burlington County) and DHS 1220 (Mercer County). The third policy requires only that nurses consult the label on the container of prescribed medication before administering the medication. *See, e.g.*, DHS1548 (Bergen County). The Bergen County policy does not indicate that the nurse is required to retain the container, copy the label or otherwise document that he or she was aware of the prescription. Moreover, the Burlington County and Mercer County policies do not indicate that the prescription must be retained if the student is no longer receiving the medication. Thus, the school district policies do not establish that the New Jersey statute

was interpreted by the school districts, much less by the State itself, to require a provider to have in its possession the physician's written order for any medication administered by a school nurse to a student and to retain that documentation.[9] While it may have been a good practice to require a copy of the prescription to assure the safety of the children, the record before us does not provide a basis for finding that it was a required practice. On the other hand, the school district policies provide some assurance that the nurses would be aware of the prescriptions and could meet their duty to administer the medications "as prescribed." Absent any basis in the record for a finding that the medications were not being administered as prescribed, we consider this to be sufficient assurance that the nursing services were within the scope of the nurses' practice under State law, which is all that federal law specifically requires.

We therefore reverse the disallowance with respect to the sample claims in question (except with respect to transportation services, discussed later in this decision).

C. Speech therapy services found unallowable on the ground that the provider was not qualified

The OIG found that federal requirements for speech therapy services were not met in 40 sample claims. Section 440.110(c)(1) requires that speech therapy services be provided "by or under the direction of a speech pathologist or audiologist." [10] A "speech pathologist" is "an individual who meets one of the following conditions:

(i) Has a certificate of clinical competence from the American Speech and Hearing Association.
(ii) Has completed the equivalent educational requirements and work experience necessary for the certificate.
(iii) Has completed the academic program and is acquiring supervised work experience to qualify for the certificate.

42 C.F.R. § 440.110(c)(2). The OIG found that the speech therapy services in most of the 40 sample claims were provided by individuals certified by the New Jersey Department of Education as speech correctionists or speech language specialists and that

[9] We note that the OIG did find prescriptions in the case of 16 sample claims. *See* CMS Br. at 19. However, there is no indication that the schools retained these records as part of any express requirement under State law or even directives from their school districts.

[10] The issue here is only whether providers were qualified as speech pathologists, not audiologists.

these individuals were not qualified as speech pathologists. The OIG also found that no credentials were submitted for the individuals who provided speech therapy services in the remaining sample claims. *See* DHS1968-1969. The OIG further found that New Jersey did not document that any of the individuals at issue provided the services "under the direction" of an individual who was qualified as a speech pathologist. *See* DHS1969. New Jersey concedes that individuals who were certified by the New Jersey Department of Education did not qualify as speech pathologists under section 440.110(c)(2)(i). *See* NJ Reply Br. at 17. New Jersey argues, however, that individuals who were licensed by the New Jersey Department of Law and Public Safety, Division of Consumer Affairs, as speech-language pathologists had "completed the equivalent educational requirements and work experience necessary" for a certificate of clinical competence (CCC) from the American Speech and Hearing Association (ASHA) and therefore qualified as speech pathologists under section 440.110(c)(2)(ii).[11] *See* NJ Br. at 29; *see also* NJ Reply Br. at 17. New Jersey also argues that some individuals who did not qualify as speech pathologists provided the services "under the direction of" an ASHA-certified speech pathologist and thus properly provided speech therapy services under section 440.110(c)(1). We discuss each of these arguments in turn below. [12]

1. Whether State-licensed speech-language pathologists qualified as speech pathologists

According to New Jersey, the speech therapy services in sample #1-13, 1-21, 1-42, 3-16, and 3-26 were provided by an individual who had a State license as a speech-language pathologist.[13] New Jersey argues that the State license was sufficient to qualify the individual as a speech pathologist under section 440.110(c)(2)(ii).[14] That section provides that an individual who has completed educational requirements and work experience that are "equivalent" to the educational requirements and work experience required for an ASHA CCC qualifies as a speech pathologist.

The OIG and CMS relied on a letter from ASHA that details the differences between the two sets of requirements and concludes that they "are substantive and should not be

[11] ASHA is now known as the American Speech-Language-Hearing Association. *See* CMS Ex. 4, at 2.

[12] New Jersey asserts that the individual who provided speech therapy in sample #1-47 was ASHA-certified. NJ Br. at 40. CMS agrees, but argues that the speech services were nevertheless unallowable on another ground which we discuss separately below. CMS Br. at 32.

[13] The OIG identified the service in sample #3-26 as "1 unit of evaluation service" but indicated that the evaluation was for speech therapy. DHS1659. Although New Jersey set a separate payment rate for "evaluation," New Jersey does not deny that evaluation of the need for speech therapy services is itself a type of speech therapy service.

[14] New Jersey does not assert that any of the State-licensed speech-language pathologists exceeded the requirements for State licensing.

deemed equivalent for any purpose." CMS Ex. 4, at 1 (2/11/03 letter from Director, Government Relations and Public Policy, ASHA, to OIG). New Jersey does not dispute that ASHA's letter accurately describes the applicable requirements. New Jersey concedes that there were differences between the ASHA certification requirements and the licensing requirements, particularly prior to January 1, 1993, when the State licensing requirements changed, but argues that the differences were not "substantive" and questions whether they could have had "any substantial impact." NJ Br. at 31; NJ Reply Br. at 18; *see also id.* at 19-20. However, New Jersey did not provide any evidence (such as expert testimony) regarding whether State licensing requirements were equivalent to the ASHA certification requirements.

The word "equivalent" is not synonymous with "identical." *See, e.g.*, World English Dictionary, at http://dictionary.reference.com/(defining "equivalent" as "equal or interchangeable in value, quantity significance, etc."); Merriam-Webster Online Dictionary, at http://www.merriam-webster.com/dictionary (defining "equivalent" as "equal in force, amount or value," "like in signification or import," and "corresponding or virtually identical especially in effect or function"). Thus, the fact that the requirements for a CCC and the requirements for State licensure as a speech-language pathologist are not identical is not dispositive. As discussed below, however, a comparison of the requirements shows that there were clear differences between the ASHA certification requirements and the requirements for State licensure as a speech-language pathologist both before and after January 1, 1993. Accordingly, we conclude that State licensure was insufficient to show that the licensee had completed the equivalent educational requirements and work experience necessary for a CCC and therefore qualified as a speech pathologist.

The ASHA letter notes that applicants for a CCC must have a master's or doctoral degree, whereas the New Jersey licensure requirements allow for a "master's degree or equivalent." CMS Ex. 4, at 1. Thus, ASHA states, "services from a New Jersey licensee may be delivered by a practitioner without a graduate degree." *Id*. New Jersey argues that it is immaterial whether an individual has a master's degree as long as the individual completed the coursework required for the degree.[15] *See* NJ Reply Br. at 18. The ASHA letter acknowledges that the number of credit hours and course distribution requirements for State licensure "mirror the requirement for the CCC" after January 1, 1993. CMS Ex. 4, at 1. However, the ASHA letter states, and New Jersey does not dispute, that prior to that date, only 60 semester hours of coursework were required for a New Jersey license while 75 semester hours of coursework were required for the CCC. *See id*.

[15] We need not decide here whether the lack of a graduate degree was material in view of our conclusion below that the educational requirements for individuals licensed after January 1, 1993 were significantly different in other respects.

The ASHA letter also notes that completion of a 350-hour clinical practicum is required for a CCC. *See* CMS Ex. 4, at 2. New Jersey required a 350-hour clinical practicum for State licensure as of January 1, 1993, but required only a 300-hour clinical practicum prior to that date.[16] *See id*. The ASHA letter further notes that ASHA requires that the clinical practicum be supervised by a CCC holder. *See* CMS Ex. 4, at 2. New Jersey, on the other hand, had no requirement regarding the qualifications of the person supervising the clinical practicum prior to January 1, 1993 and, after that date, required only that the clinical practicum be supervised by a state licensee or the licensee of another state with "substantially equivalent" standards. *See id*.

As indicated above, there were clear differences in the number of credit hours, course distribution requirements, and number of clinical practicum hours required for a CCC and State licensure prior to January 1, 1993. In addition, the requirements with respect to the qualifications of the person supervising the practicum differed both before and after that date. Accordingly, the individuals who were licensed as speech-language pathologists had not completed "equivalent educational requirements" as required by section 440.110(c)(2)(ii), regardless of when these individuals were licensed.[17]

With respect to the work requirements, the ASHA letter states that completion of a 36-week full-time clinical fellowship is required for both a CCC and State licensure. *See* CMS Ex. 4, at 2. ASHA requires that the fellowship be supervised by a CCC holder while New Jersey requires that the fellowship be supervised by a State licensee. *Id*. Thus, the supervisor of a clinical fellowship for State licensure did not have to meet the same educational requirements as the supervisor of a clinical fellowship for a CCC.

In addition, the ASHA letter states that "CCC requirements provide that the clinical fellowship supervisor engage in no fewer than 36 supervisory activities during the clinical fellowship experience including 18 on-site observations of direct client contact as well as 18 other monitoring activities;" that the supervisor "conduct three formal evaluations of the applicant's progress in the development of professional skills;" and that "80% of the work week must be in direct clinical activities related to the management process of individuals who exhibit communication disabilities." *Id*. New Jersey does not allege that there was any State requirement equivalent to the ASHA

[16] The term "practicum" is defined as "the part of a [college or university] course consisting of practical work in a particular field." World English Dictionary, at http://dictionary.reference.com. Accordingly, we consider the requirement for a practicum an educational requirement.

[17] New Jersey "admits that some of its [speech therapy] providers received degrees before 1993." NJ Reply Br. at 18.

requirement for 18 other monitoring activities or with respect to the percentage of the work week devoted to direct clinical activities.[18]

Accordingly, the requirements for a State license were not equivalent to the requirements for ASHA certification with respect to either education or work experience. We therefore conclude that there is no basis for finding that speech therapists who held only State licenses qualified as speech pathologists under section 440.110(c)(2)(ii).

New Jersey also argues, however, that the State-licensed speech-language pathologists who provided the speech therapy services in sample #1-21 and 3-16 qualified as speech pathologists because they had at one time been ASHA-certified although their certification expired before the services in question were provided. *See* NJ Br. at 36, 54; NJ Reply Br. at 27, 36-37. CMS appears to take the position, and we agree, that these individuals did not qualify as speech pathologists under section 440.110(c)(2)(i) at the time they provided the services on the ground that they were ASHA-certified because they were not currently certified by ASHA. *See* CMS Br. at 29-30, 40. Nevertheless, if the requirements they met for ASHA certification were the same as the requirements for ASHA certification at the time they provided the services, they would have qualified as speech pathologists under section 440.110(c)(2)(ii) on the alternative ground that they met educational and work requirements equivalent to those required for ASHA certification. The record does not show when the individuals became ASHA-certified or whether there was any change in the ASHA requirements after that date. We therefore remand the appeal with respect to the speech therapy services in these two sample claims in order to give New Jersey a reasonable opportunity to provide additional evidence to show when the two individuals in question were certified and that the ASHA requirements did not change between their dates of certification and the time the services at issue were provided.

Inasmuch as the OIG found the speech therapy services in sample #1-21 and 3-16 unallowable only on the ground that the providers were not qualified, the services would be allowable if New Jersey establishes that the providers were in fact qualified.

[18] New Jersey asserts that its requirement that the supervisor provide one hour of on-site supervision for each 20 hours of direct face-to-face evaluation or therapeutic services rendered by the supervisee is equivalent to ASHA's requirement with respect to the frequency of on-site supervision. *See* NJ Reply Br. at 19. New Jersey also asserts that the absence of any State requirement for formal evaluations does "not make the supervision unequal, just documented differently." *Id*. at 20. We need not address these assertions since there are other grounds for finding that the requirements for work experience were not equivalent.

2. Whether speech therapy services were provided "under the direction of" a speech pathologist

New Jersey asserts that the speech therapy services in sample #1-20, 1-33, 1-38, 2-43, and 3-20 were provided "under the direction" of a speech pathologist within the meaning of section 440.110(c). The Board addressed the meaning of the phrase "under the direction of" in *Maryland Dept. of Health and Mental Hygiene*, stating in part:

> The federal regulatory definition of "services for individuals with speech, hearing, and language disorders" as services provided "under the direction of" a speech pathologist (where a speech pathologist is not the direct service provider) is not satisfied by a showing that the speech therapist worked under the general supervision of a speech pathologist. . . . [S]uch services are not provided "under the direction of" a speech pathologist when the speech therapist was not in any way directed by the speech pathologist in the provision of services to the particular student.

DAB No. 2090, at 2. The Board continued:

> Since section 440.110(c)(1) requires that the services be provided under the direction of a speech pathologist, however, it is not sufficient to show that the person who provided the services was under the general supervision of a speech pathologist. Moreover, since elsewhere in the regulations CMS uses the phrase "under the supervision of" (*see, e.g.,* 42 C.F.R. § 409.31(a) (skilled nursing and skilled rehabilitation services must be furnished directly by, or under the supervision of, specified personnel)), CMS's use of the phrase "under the direction of" here indicates that CMS intended to distinguish between "supervision" and "direction."

Id. at 10 (emphasis added). As discussed below, we conclude that New Jersey failed to show that a speech pathologist directed the speech therapy services provided by the speech therapist in any of the disputed sample claims.

According to New Jersey, a speech pathologist who qualified as such based on ASHA certification performed the initial evaluation of the student in both sample #1-20 and #1-33.[19] New Jersey also notes that the speech pathologist in sample #1-33 was at the

[19] For sample #1-20, there is no documentation of an evaluation for speech therapy in the record; however, the OIG found that a speech pathologist made a referral for speech therapy. *See* DHS0145. New Jersey may have inadvertently stated that there was an evaluation rather than a referral.

student's eligibility conference. Based on the speech pathologist's initial involvement with each student, New Jersey argues that the speech pathologist must have thereafter directed the services provided by the speech therapist to the student. *See* NJ Reply Br. at 27-28. Similarly, New Jersey appears to argue based on the fact that a speech pathologist made the referral for speech therapy services in sample #2-43 that the speech pathologist must have thereafter directed the provision of those services. *See* NJ Br. at 48; NJ Reply Br. at 34. However, New Jersey points to nothing in the record indicating that the speech pathologist was actually involved with the student after the evaluation or referral. Thus, New Jersey's view that the speech therapist provided the services in each of these claims "under the direction" of the speech pathologist is based on mere speculation.

New Jersey also asserts that a speech pathologist provided the speech therapy services in sample #1-38 on the first date of service (which was not disallowed) and that thereafter both the speech pathologist and the speech therapist "worked as a team" to provide the services, thus "far exceed[ing] the 'under the direction' guidelines." NJ Br. at 39; *see also* NJ Reply Br. at 28. As noted above, a speech pathologist's initial involvement with a student is not sufficient to establish any continued involvement. Moreover, New Jersey points to no evidence regarding the roles of the speech pathologist and the speech therapist in the provision of speech therapy services to the student after the first date of service.

Finally, New Jersey asserts that the speech therapist in sample #3-20 was in a clinical internship working toward State licensure as a speech-language pathologist and that the speech therapist in sample #2-43 (which we also discussed above) was in a clinical internship/fellowship working toward both State licensure and ASHA certification. New Jersey argues that because such fellowships or internships must be supervised by an "ASHA equivalent provider," the speech therapist must have provided the services at issue under the direction of such a provider. *See* NJ Br. at 48, 55; NJ Reply Br. at 34. However, New Jersey points to nothing in the record for either sample claim to support its assertion that the speech therapist provided the services during a clinical internship or fellowship.

In addition, New Jersey does not identify the individual allegedly supervising the internship/fellowship. If that individual was only State-licensed as a speech-language pathologist, that was not sufficient to qualify him/her as a speech pathologist within the meaning of section 440.110(c) for the reasons we discussed above. Furthermore, even if the supervisory activities specified in the requirements for ASHA certification and State

licensure could be considered directing the provision of speech therapy services, neither of these requirements ensure that the claimed services provided to the particular students in the sample claims at issue were in fact supervised.

Accordingly, we conclude that the speech therapy services in these sample claims were not provided "under the direction" of a speech pathologist.

D. Transportation services found unallowable based on finding that there was no documentation showing that the services were actually rendered

Section 440.170(a) of 42 C.F.R. permits states to furnish "transportation," which "includes expenses for transportation and other related travel expenses determined to be necessary by the agency to secure medical examinations and treatment for a recipient," as an optional covered Medicaid service.[20] To be allowable as a school-based service, transportation must be included in the student's IEP and provided on the same day as a related service. DHS1964. CMS advised State Medicaid Directors in a May 21, 1999 letter that, as of July 1, 1999, Medicaid would cover only "specialized transportation," meaning that "a child requires transportation in a vehicle adapted to serve the needs of the disabled, including a specially adapted school bus." *Id*.

The OIG found that for 41 of the 46 sample claims that included transportation services, the school districts "did not submit documentation, such as a transportation log, to support the number of transportation services billed to Medicaid." DHS1970. According to the OIG, "[s]ome 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." *Id*.

New Jersey disputes the following sample claims that were disallowed on this ground: sample #1-01, 1-05, 1-06, 1-09, 1-15, 1-26, 1-34, 1-47, 1-50, 2-19, 2-22, 2-23, 2-26, 2-30, 2-33, 2-34, 2-36, 2-38, 2-40, 3-11, 3-32 and 3-43.[21] *See* NJ Br. at 28 and NJ Reply Br. at 24. New Jersey takes the position that there was "sufficient documentation" that

[20] Under section 440.170(a)(2), the transportation must be furnished by a provider to whom a direct vendor payment can be made by the state agency. If other arrangements are made, transportation costs may be claimed as an administrative cost.

[21] The OIG also found that transportation services in sample #3-43 were unallowable because they were for nonspecialized transportation after the July 1, 1999 cutoff in the letter to the State Medicaid Directors. We need not address New Jersey's argument that the services should not have been disallowed on this basis because we conclude that the services were properly disallowed on the basis discussed in this section.

transportation services were provided on a particular date if three factors were present: "(1) the student must possess disabilities necessitating the provision of transportation or special transportation services; (2) transportation or special transportation must be indicated in the student's IEP; and (3) the student must have received one or more allowable related service on the day that the transportation was billed." NJ Br. at 25-26; *see also* NJ Reply Br. at 21. New Jersey asserts that the three factors were present in all but four of the sample claims (sample #1-15, 1-34, 2-19, and 3-38). New Jersey admits that the student in each of those four sample claims did not have a severe disability, but maintains that this was not necessary because nonspecialized transportation was allowable when the services were provided (prior to July 1, 1999). *See* NJ Br. at 28.

CMS takes the position that a state must be able to document "that a particular trip for a particular student occurred on a particular date[.]" CMS Br. at 27. CMS notes that "bus logs do provide assurances that the individual was actually transported on a bus" on a particular date." *Id*. Thus, according to CMS, although bus logs "were not specifically required," the transportation services not supported by a bus log were unallowable in the absence of other documentation showing that the services were actually rendered. *Id.* CMS also states that "[i]t is entirely possible, for instance, that a disabled child was brought to school one day by her parents." *Id*.

New Jersey characterizes the last statement by CMS as "conjecture," but does not deny that it was possible that a student's parents or someone else could have transported the student to and/or from school on any given day. NJ Reply Br. at 23. Instead, New Jersey asserts that it is "totally inconceivable that, where a claim consists of multiple transportation services . . ., the parents or guardians would have transported such severely disabled child <u>on all of the dates of service</u>." *Id.* (emphasis added).

We conclude that the transportation services in all of the sample claims but sample claim #3-32 were properly disallowed. According to New Jersey, the student in that sample claim "received specialized transportation services that were above and beyond the normal routine because she was wheelchair bound and lived on the 2nd floor of an apartment building." NJ Br. at 59. In particular, New Jersey asserts that "[t]he student's guardian, who was also disabled, could not get the student to the curb for pick up so other arrangements had to be made for a specialized van with two attendants to pick her up and carry her down to the transportation." *Id*. The facts asserted by New Jersey, if proven, would show it was highly unlikely that the student was transported to school by her guardian or someone else instead of by the transportation provider with which the school had an arrangement. However, New Jersey does not cite any evidence in the record to

support its assertions, nor do we find any such evidence. Accordingly, we remand the case to give New Jersey a reasonable opportunity to provide such evidence. If New Jersey provides such evidence, the transportation services would be allowable since it is undisputed that there was an allowable health service on the dates for which transportation services were billed.

It seems likely that at least some of the transportation services in the remaining claims were actually rendered since it is undisputed that transportation services were authorized in the students' IEPs and that the students were at school on the dates in question. The fact that the transportation had been arranged for some of the students (as shown by the bus routes or rosters of children scheduled to be transported) arguably makes it more likely that the services in those sample claims were rendered. However, none of these factors definitively establishes that the services were actually provided on each of the dates of service in each disputed sample claim. We therefore have no way of identifying which of the transportation services were in fact rendered. Accordingly, we are compelled to uphold the entire amount disallowed for transportation services except with respect to the remanded sample claim.[22]

E. Other arguments regarding individual sample claims

In this section, we address other arguments made by New Jersey regarding some of the sample claims.

Sample #1-26 – occupational therapy services disallowed on the ground that there was no prescription

New Jersey argues that there was a "referral," i.e., prescription, for the occupational therapy services provided in February 2000 because a registered nurse signed the IEP dated December 1, 1999. *See* NJ Br. at 37 and DHS0205. CMS responds that "an R.N. is not qualified to sign a referral for Occupational Therapy." CMS Br. at 30. Section 440.110(b)(1) defines occupational therapy as "services prescribed by a physician or other licensed practitioner of the healing arts within the scope of his or her practice under State law. . . ." New Jersey does not point to anything in the New Jersey law defining the practice of nursing (quoted earlier) to show that a registered nurse licensed in New Jersey is authorized to write any type of prescription, much less a prescription for occupational therapy services. Accordingly, we uphold the disallowance of these services.

[22] Even if these transportation services were otherwise allowable, some of them would be unallowable because the student did not receive an allowable health service on the date for which transportation services were billed.

Sample #1-42 – occupational therapy services disallowed on the ground that there was no prescription

New Jersey argues that there was a "referral," i.e., prescription, for the occupational therapy services provided in March 1999 because a licensed occupational therapist signed the student's IEP. *See* NJ Br. at 39 and DHS0402. CMS correctly points out that the IEP in the record was only in effect beginning 4/16/99, after the services were provided, and thus cannot serve as a valid prescription for the services disallowed.[23] *See* CMS Br. at 31. Accordingly, we uphold the disallowance of these services.

Sample #1-47 – speech therapy services disallowed on the ground that there was no referral

New Jersey argues that there was a referral for the speech therapy services because an ASHA-certified speech pathologist signed the student's IEP. *See* NJ Br. at 40. CMS responds that this individual was not a State-licensed speech-language pathologist and thus was not authorized to prescribe services under section 440.110(b)(1), which requires a prescription by a physician or other licensed practitioner of the healing arts. *See* CMS Br. at 32 and DHS0473. New Jersey does not dispute that this individual was not State-licensed, but argues that it is illogical to conclude, as CMS did, that she had authority to provide the services but not to make the referral. *See* NJ Br. at 29. That conclusion follows from the clear language of the regulations, however. Accordingly, we uphold the disallowance of these services.

Sample #2-02 – evaluation disallowed on the ground that the student did not receive an evaluation in the sample month

New Jersey does not dispute that the student did not receive an evaluation in the sample month (May 2000). However, New Jersey argues that the disallowance for this sample claim should not be projected to the universe of claims because a "unique situation" caused the claim to be in error. NJ Br. at 40. According to New Jersey, the student was actually evaluated in April 2000, and the evaluation claimed for May 2000 was provided to his brother rather than to him. *See id*. In response, CMS takes the position that there is no reason why "unique errors that might come about in the billing process" should not be extrapolated. CMS Br. at 32.

[23] For the same reason, the State-licensed speech-language pathologist's signature on the IEP was not a valid referral. The speech therapy services are also unallowable on another basis discussed earlier in this decision.

It appears to us that, unless New Jersey could show that the billing error did not result in an overpayment, the disallowance for this claim could properly be projected to the universe of claims from which the sample was drawn. Even if it is unlikely that there is another claim in the universe resulting from a billing error made for exactly the same reason, New Jersey provides no basis for us to conclude that no other claims resulted from billing errors caused by confusion over children's names. Projecting the disallowance for this claim to the universe thus properly reflects the prevalence of any such billing errors during the audit period. Such billing errors could potentially result in overpayments if, for example, they resulted in payment for a service that would not have been made to the school for the correct child because the child had received a different service on the same date for which the school received payment.

New Jersey's evidence regarding sample #2-02 is, however, sufficient to raise a question about whether any overpayment to the school, in fact, resulted from the billing error at issue. New Jersey submitted the turnaround document that shows circling of an "E" (meaning "evaluation") for a student named "Ricardo" with the same last name as a student named "Bryan" who appears above him on the preprinted list of pupils. DHS0515. A handwritten note on that document states "should have billed as Bryan, not Ricardo – void Ricardo, bill Bryan" but that note is unsigned. No "E" is circled for Bryan for the sample month (May 2000) and no other service is noted for either Ricardo or Bryan on the turnaround document, so it does not appear that the error could have resulted in a duplicate claim for two evaluations or a payment for two evaluations on one date during the month. To show that the error did not result in an overpayment, however, New Jersey would have to show that, in fact, the school furnished an allowable evaluation for Bryan in the month at issue. Accordingly, we remand this case to give New Jersey a reasonable opportunity to provide such evidence. If New Jersey provides such evidence and CMS accepts it, the parties should consult with their statisticians about how to treat such a sample claim for purposes of extrapolating from the sample to the universe of claims.

Sample #2-23 – evaluation disallowed on the ground that there were no evaluation documents

New Jersey argues that there are evaluations attached to the student's IEP for the period beginning 10/16/98 (submitted for the first time with New Jersey's appeal file) which document that there was an evaluation in the claim month, September 1998. *See* NJ Br. at 43; NJ Reply Br. at 31. New Jersey points by way of example to a form captioned

"Goals & Objectives" which includes the name of a registered occupational therapist and lists the goals and objectives of occupational therapy. *Id.*; DHS0701- 0702. However, the form shows a "D.O.E." (date of evaluation) of 9/30/96. While the record also includes a preliminary report of an occupational therapy assessment, the D.O.E. on that report is 9/22/97. DHS0728. Thus, neither document is evidence of an evaluation in the September 1998 claim month.

There is also a form showing Goal #5 and objectives for which the "person responsible" is a "speech-language specialist." DHS0700. However, the record does not show who did any speech therapy evaluation, much less that an evaluation was performed by an individual who was ASHA-certified or the equivalent, as required by section 440.110(c)(2). Notes that appear to relate to an assessment of the student's speech and language skills are unsigned and undated. DHS0737-0740. Accordingly, we uphold the disallowance of these services.

Sample #2-26 – services disallowed on the ground that there was no documentation verifying that services were actually rendered

New Jersey does not dispute the OIG's finding that there were no service encounter logs or provider attendance logs for this sample claim. New Jersey argues, however, that "a reasonable assumption can be made that the services provided were speech services" because the OIG found that "this is the only health related service authorized in the IEP" and that the services "were provided by an ASHA-certified practitioner." NJ Br. at 44; NJ Reply Br. at 32; DHS0763, DHS0777. New Jersey also asserts that the turnaround document for the claim month supports the amount claimed. *See* NJ Br. at 44. The turnaround document shows six dates of service (the number claimed) but does not specify the type of services. DHS0769. New Jersey also points to "goals and progress notes" as support for its position that the planned speech therapy services were provided. *See* NJ Br. at 44.

The fact that the only services (other than transportation) authorized by the IEP were speech therapy services does not show that such services were actually rendered. In addition, while it appears that the OIG found that the individual identified by the school district as the speech therapist was ASHA-certified, the OIG did not find that this individual actually provided speech therapy services. *See* DHS0762-0766. Neither the document stating the goals (or "objectives") for the student nor the progress notes are signed or dated, and they are insufficient to show that speech therapy services were provided on any particular date. *See* DHS0779-0780. Moreover, a turnaround document is simply a document submitted by the school health provider to a billing agent for use in

preparing the monthly claim for the student (*see* DHS1964), not documentation of the underlying services. Thus, contrary to what New Jersey argues, the turnaround document provides no basis for finding that the services claimed were actually rendered. Accordingly, we uphold the disallowance of these services.

Sample #3-11 – speech therapy services disallowed on the ground that there was no referral

New Jersey argues that a physician's examination report dated 4/15/99, which states that the student "will require ongoing Special Education in a self-contained class with emphasis on communication skills," constitutes a referral for the speech therapy services provided in October 1999. NJ Br. at 53. We agree with CMS that this is not a referral for speech therapy services. *See* CMS Br. at 39. Although the report mentions that speech therapy was started for the student when he entered the Special Education Program, the report states only that the student "will require ongoing Special Education . . . with emphasis on communication skills" without specifying the need for speech therapy services, much less specifying the appropriate frequency and duration of any such services. DHS1132-1335. Accordingly, we uphold the disallowance of these services.

Sample #2-36 - services disallowed on the ground that there was no documentation verifying that services were actually rendered

The OIG disallowed three of five services for sample #2-36 on the ground that there was no documentation verifying that physical therapy services were actually rendered on three of the five dates for which the school billed for services. *See* DHS0866. New Jersey argues that occupational therapy services were provided on these three dates (8/1/00, 8/3/00, and 8/10/00) and that a services log documents this. *See* NJ Br. at 46. The services log is identified as a "Related Services Log" for "OT" and shows the provider's first initial and last name. DHS0878. For two of the three dates of service, the column for comments contains a checkmark and the word "job." For one of the dates of service, the column for comments contains a checkmark and the word "chart." The services log also shows the duration of each of the three services as 10 minutes. It appears from earlier entries on the services log that arrangements were made for the student to have a part-time job and that the student was to keep a chart recording her attendance. An undated chart included in the record immediately following the services log has handwritten notes indicating that the child was pre-vocational and identifying problems, such as fine motor skills, for which occupational therapy services are appropriate. *See* DHS0867.

CMS responds that the services log does not provide sufficient detail about the services and that New Jersey did not explain what "job" refers to. *See* CMS Br. at 36. As indicated above, however, the services log entries for the dates in question, read in the context of the previous entries together with the chart, could reasonably be viewed as describing occupational therapy services.

CMS also asserts that New Jersey "does not show that occupational therapy was provided by a qualified provider." CMS Br. at 36. The OIG made no finding regarding the qualifications of the occupational therapist. However, the signature of the provider appears on the student's job chart followed by "COTA/L 3/24/06" (DHS0879), and New Jersey asserts that she was "a New Jersey licensed OT #46TA09041700." NJ Reply at 33. Thus, it appears that the occupational therapist became State-licensed in 2006, well before the claim month and year.

However, it is unclear whether the student's IEP authorized occupational therapy services on the dates in question. The IEP shows that occupational therapy services were authorized from 2/26/00 to 6/30/00 and from 9/1/00 to 2/9/01. DHS0872. While the IEP states that the evaluation team "proposes that the student's educational program be extended throughout the summer months" (DHS0870), there is no indication whether this proposal was adopted before the services in question were provided. DHS0870.

We therefore conclude that the appeal with respect to the health services disallowed for sample #2-36 should be remanded to give New Jersey a reasonable opportunity to submit additional evidence showing that the student's IEP authorized occupational therapy services for the dates in question as well as any additional evidence CMS may require to establish that the services documented in the record qualified as occupational therapy services and that the provider was licensed at the time the services were provided.

Sample #2-38 - occupational therapy services disallowed on the ground that there was no referral

New Jersey admits that the student in sample #2-38 was absent from school on one of the dates of service (4/19/99) for which occupational therapy services were claimed. *See* NJ Br. at 46. However, New Jersey argues that this error should not be projected to the universe of claims because it was a "clerical" rather than a "systemic" error. *Id*. New Jersey provided no expert testimony to support this argument. CMS responds that "there is no reason why a clerical error cannot be extrapolated to the entire population," noting that "it is likely typical of other clerical errors that might come about in the billing process." CMS Br. at 36. We agree. Not only is it likely that there are other claims in

the universe resulting from similar billing errors, but billing for a service not provided would clearly result in an overpayment. Projecting the disallowance for this sample claim to the universe thus properly reflects the prevalence of any such billing errors during the audit period. Accordingly, we uphold the disallowance of this service.

Sample #3-20 – occupational therapy services disallowed on the ground that there was no prescription

New Jersey argues that the signature of a State-licensed occupational therapist on the IEP constituted a valid referral, i.e., prescription, for occupational therapy services. *See* NJ Br. at 56; NJ Reply Br. at 37; DHS1467, DHS1473. CMS takes the position that this was not a valid prescription because "the services were not ordered by a licensed physician, registered physician assistant or a licensed nurse practitioner." CMS Br. at 41. Section 440.110(b)(1) provides that occupational therapy services may be prescribed by a physician "or other licensed practitioner of the healing arts within the scope of his or her practice under State law[.]" New Jersey presented no evidence to show, however, that "prescribing" such services is within the scope of practice of a licensed occupational therapist under New Jersey law. Accordingly, we uphold the disallowance of these services.

Conclusion

For the foregoing reasons, we reverse the disallowance with respect to the nursing services in sample #2-28, 3-06, 3-19, 3-22, 3-38, 3-40, and 3-42. We remand the disallowance with respect to the speech therapy services in sample #1-21 and 3-16, the services in sample #2-36, the transportation services in sample #3-32, and the evaluation in sample #2-02. We uphold the disallowance with respect to the remaining claims except sample #2-06, 2-24, and 2-45, which CMS found allowable during the proceedings before us.[24]

On remand, CMS should afford New Jersey a reasonable opportunity to provide additional evidence with respect to the five remanded sample claims, as explained above. CMS should issue a new determination with respect to any of these sample claims for which New Jersey provides additional evidence and should explain any finding that this evidence does not justify a reduction of the disallowance amount. If New Jersey is

[24] In its initial brief, New Jersey disputed the disallowance of the health services in sample #2-19 and 3-25. *See* NJ Br. at 42-43 and 57-58. However, CMS responded, and New Jersey does not dispute, that the OIG had already recalculated the disallowance to allow these services. *See* CMS Br. at 33, 42; NJ Reply Br. at 31, 38.

dissatisfied with CMS's determination in whole or in part, it may appeal that determination pursuant to 45 C.F.R. Part 16. Any such appeal must be limited to the five remanded sample claims and any issue regarding recalculation of the disallowance amount based on our findings here and the further findings on remand.

/s/
Stephen M. Godek

/s/
Sheila Ann Hegy

/s/
Judith A. Ballard
Presiding Board Member