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American Board of Physical Medicine and

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Physical Medicine and Rehabilitation

A specialist in Physical Medicine and Rehabilitation, also called a physiatrist, evaluates and treats patients with disorders or disabilities in the muscles, bones, and nervous system, including neck or back pain, sports and work injuries, stroke, brain injury, spinal cord injury, spasticity, and any other disability or disorder that affects function. A physiatrist may lead a team of medical professionals to help patients improve their physical, psychological, social, and vocational function, and are dedicated to the whole person, including treating pain, restoring function, and improving quality of life. Treatment modalities may include medications, injections, therapeutic exercise, electrodiagnosis, and any equipment required for daily activities.

Training required prior to initial board certification

Four years

Subspecialties

Certification in one of the following subspecialties requires additional training and assessment as specified by the board.

Brain Injury Medicine
A physiatrist who specializes in Brain Injury Medicine focuses on the prevention of brain injury as well as the evaluation, treatment and rehabilitation of individuals aged 15 or older with acquired brain injury. This specialist addresses a range of injury-related disorders that have psychosocial, educational, and vocational consequences, as well as related injuries of the central nervous system. He or she also works with an interdisciplinary team to facilitate recovery and improve patients' health and function.

Neuromuscular Medicine
A physiatrist who specializes in Neuromuscular Medicine focuses on the evaluation and treatment of disorders of nerve, muscle, or neuromuscular junction, including amyotrophic lateral sclerosis (ALS), peripheral neuropathies (e.g., diabetic), various muscular dystrophies, congenital and acquired myopathies, inflammatory myopathies (e.g., polymyositis), and neuromuscular transmission disorders (e.g., myasthenia gravis).

Pain Medicine
A physiatrist who specializes in Pain Medicine diagnoses and treats patients experiencing problems with

acute or chronic pain, or pain related to cancer, in both hospital and outpatient settings and coordinates patient care needs with other specialists.

Pediatric Rehabilitation Medicine

A physiatrist who specializes in Pediatric Rehabilitation Medicine diagnoses and manages congenital and childhood-onset impairments and disability such as cerebral palsy, spina bifida, acquired brain or spinal cord injury, amputation, sports injuries, and muscle and nerve diseases. This specialist works with an interdisciplinary team to improve a child's mobility and daily function at home, in the community, and at school by prescribing equipment and therapies and managing medical conditions such as spasticity, pain, bladder or bowel dysfunction, and nutrition.

Spinal Cord Injury Medicine

A physiatrist who specializes in Spinal Cord Injury Medicine evaluates and manages patients with spinal cord injuries caused by trauma or from medical conditions such as multiple sclerosis, Guillain Barré syndrome, arthritis, infection, transverse myelitis, cancer, and spina bifida. This specialist works with an interdisciplinary team and prescribes equipment and therapies to enhance mobility and self-care skills; manages medical conditions such as pressure ulcers, pain, spasticity, bladder and bowel dysfunction, respiratory health, and mood disorders; and works to help patients return to their communities and vocations.

Sports Medicine

A physiatrist who specializes in Sports Medicine focuses on the prevention, diagnosis, and treatment of injuries related to participating in sports and exercise. This specialist also treats illnesses and diseases that might have effects on health and physical performance.

Exhibit FF

PRACTICEPRO
4494 Derr Rd
Springfield, OH 45503-1445

To Whom It May Concern:

I find Dr. Margolin to be compliant with his billing standards. Based on my review of his billing and chart notes provided, Dr. Margolin is showing effort to be compliant with all known policies and guidelines. I have compared his billing to industry standards and find it very similar to other doctors of his specialty.

Sincerely,

David Deppen, ACS-PM
Billing Manager, Practice-Pro, LLC

Disclaimer: Practice-Pro LLC, and employees are not held responsible for any billing or collection issues that are the result of the providers services. The above statements are based on a review of a portion of the services provided, are not all inclusive, and cover only the known medical policies and guidelines. The provider retains full responsibility for proper billing and coding.

Exhibit GG

---------- Forwarded message ----------
From: **David Deppen** <ddeppen@practice-pro.net>
Date: 2013-03-11 11:39 GMT-04:00
Subject: RE: needle EMG coding
To: Leon Margolin <leon3087@gmail.com>

Here are the codes and the Utilization guidelines right from Medicare's policy for EMG and NCS:

95885: Needle electromyography, each extremity; done with nerve conduction study, limited
95886: Needle electromyography, each extremity; done with nerve conduction study, complete, 5 or more muscles studied, innervated by three or more nerves or four or more spinal levels

Utilization Guidelines
Services performed for excessive frequency are not medically necessary. Frequency is considered excessive when services are performed more frequently than generally accepted by peers and the reason for additional services is not justified by documentation.

The number of nerves tested should be the minimum necessary to address the clinical issue being evaluated. In almost all studies this will appropriately include evaluation of 1 or more nerves that have normal test results.

The following bullets summarize the reasonable maximum number of studies per diagnostic category necessary for a physician to arrive at a diagnosis in 90% of patients with that final diagnosis. In simple straightforward cases, fewer tests will be necessary, particularly when the most critical tests are normal. In the small number of cases that require testing in excess of these numbers, the physician must be able to justify the additional testing with supplementary documentation.

Carpal Tunnel (unilateral)
· Needle EMG - 1 test
· CPT codes 95907/95908Motor NCS with or w/o F-wave – 3 tests
· CPT code 95908 Sensory NCS – 4 tests

Carpal Tunnel (bilateral)
· Needle EMG - 2 tests
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95909 Sensory NCS – 6 tests

Radiculopathy
· Needle EMG - 2 tests
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 3 tests
· CPT code 95907 Sensory NCS – 2 tests
· CPT codes 95907 H-Reflex – 2 tests

Mononeuropathy
· Needle EMG - 1 test
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 3 tests
· CPT code 95908 Sensory NCS – 3 tests
· CPT codes 95934/95936 H-Reflex – 2 tests

Polyneuropathy/Mononeuropathy Multiplex
· Needle EMG - 3 tests
· CPT codes 95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95908 Sensory NCS – 4 tests
· CPT codes 95934/95936 H-Reflex – 2 tests

Myopathy
· Needle EMG - 2 tests
· CPT codes 95907 Motor NCS with or w/o F-wave – 2 tests
· CPT code 95907 Sensory NCS – 2 tests

Motor Neuronopathy
· Needle EMG - 4 tests
· CPT codes 95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95907 Sensory NCS – 2 tests

Plexopathy
· Needle EMG - 2 tests
· CPT codes 95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95909 Sensory NCS – 6 tests
· CPT codes 95934/95936 H-Reflex – 2 tests

Neuromuscular Junction
· Needle EMG - 2 tests
· CPT codes 95907 Motor NCS with or w/o F-wave – 2 tests
· CPT code 95907 Sensory NCS – 2 tests

Tarsal Tunnel (unilateral)
· Needle EMG - 1 test
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95908 Sensory NCS – 4 tests

Tarsal Tunnel (bilateral)
· Needle EMG - 2 tests
· CPT codes 95908/95909 Motor NCS with or w/o F-wave – 5 tests
· CPT code 95909 Sensory NCS – 6 tests

Weakness, Fatigue, Cramps or Twitching (focal)
· Needle EMG - 2 tests
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 3 tests
· CPT code 95908 Sensory NCS – 4 tests

Weakness, Fatigue, Cramps or Twitching (general)
· Needle EMG - 4 tests
· CPT codes 95907/95908Motor NCS with or w/o F-wave – 4 tests
· CPT code 95908 Sensory NCS – 4 tests

Pain, Numbness or Tingling (unilateral)
· Needle EMG - 1 test
· CPT codes 95907/95908 Motor NCS with or w/o F-wave – 3 tests
· CPT code 95908 Sensory NCS – 4 tests
· CPT codes 95934/95936 H-Reflex – 2 tests

Pain, Numbness or Tingling (bilateral)
· Needle EMG - 2 tests
· CPT codes 95908 Motor NCS with or w/o F-wave – 4 tests
· CPT code 95909 Sensory NCS – 6 tests
· CPT codes 95934/95936 H-Reflex – 2 tests

Thanks,

David Deppen
Practice-Pro LLC
937-322-4911

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From: Leon Margolin [mailto:leon3087@gmail.com]
Sent: Monday, March 11, 2013 11:33 AM
To: David Deppen
Subject: Re: needle EMG coding

OK - what are the codes and what are the regulations - please submit the EObs.

2013/3/11 David Deppen <ddeppen@practice-pro.net>
Dr. Margolin,

Please change the codes on your superbill to accurately reflect what you are doing and we will bill them out with whatever you mark. Please understand that there are some insurance policy that do limit the number of studies that are done and for what dx codes you use.

Thanks,
David Deppen
Practice-Pro LLC
937-322-4911

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From: Leon Margolin [mailto:leon3087@gmail.com]
Sent: Saturday, March 09, 2013 10:46 PM

Exhibit HH

---------- Forwarded message ----------
From: **Leon Margolin** <leon3087@gmail.com>
Date: 2013-11-26 12:10 GMT-05:00
Subject: Re: EMG documentation
To: "hccmab@aol.com" <hccmab@aol.com>

Thanks, we r selective with EMGs, however most of our patients are referred for chronic neck or back pain code 724.4 or 723.1 and have a similar test protocol.

We do document clinical necessity for each pts, we don't have any standing orders. We document that EMG test was reviewed in the progress note.

Please review EMG paperwork I sent and let me know.

Sent from my iPhone

On Nov 26, 2013, at 10:45 AM, hccmab@aol.com wrote:

As long as your testing meets medical necessity, you are fine, sounds like the good doctor Leak had a protocol of tests he performed on everybody and that is always a red flag. If you were seen billing the same stuff on all your patients then you would be under the radar, I do not remember seeing any patterns like that when I reviewed your documentation. An assessment and plan of care are the key to success so that the patient's medical conditions and symptoms support the testing and treatments you are providing. I have had several doctors that I could not help because they had a standard protocol for every patient that walked in the door got a battery of testing and the patient's conditions did not support the extensive workup. I am certainly available if you want to speak at 614-327-6974, I am in FL on holiday but I still work too especially when the weather is off and today it is very cloudy but warm so its a great time to catch up on emails.

Regarding the credentialing for Lydia, I think David has it under control it just takes so long, first you have to get credentialed with regular Medicaid before you can get credentialed with any of the medicaid managed care plans and it is a consuming process, I only do for my retainer clients because it does take so much time and patience, from what he is telling me I believe he is working in the right direction.
MaryAnn Baughman

Also, David has sent me a lot of information I can review regarding you A/R and EOB's and I will keep you informed of what I find

-----Original Message-----
From: Leon Margolin <leon3087@gmail.com>

Exhibit II

---------- Forwarded message ---------
From: **Leon Margolin** <leon3087@gmail.com>
Date: вт, 22 мая 2018 г. в 22:09
Subject: specific evidence of habitual neglect, continued duties failure by Caresource/ examples of patient complaints
To: <Peggy.Beat@caresource.com>
Cc: Plinke, Eric <eric.plinke@dinsmore.com>, <Katherine.Leff@caresource.com>, <Pamela.Morris@caresource.com>, <Kurt.Lenhart@caresource.com>, <Ivy.Spitzer@caresource.com>, <Christina.Turner@caresource.com>

Dear Mrs Beats,

I acknowledge receipt of your letter dated 12/20/17 in which you reject the grounds of termination I had asserted in my termination letter of 12/1/17 but accepts termination effective 12/11/17.

I do not agree that CareSource's actions did not constitute "habitual neglect" and "continued failure" of its duties. The improper recoupment by CareSource on the following dates and amounts demonstrate my position:

11/8/17 - #0001179 - $17,090.56
11/15/17 - #0266746 - $13,494.05

11/22/17 - #0485925 - $20,374.71

11/29/17 - #0697837 - $6655.89

12/6/17 - #0987013 - $9265.51

12/20/17 - #1523478 - $8909.92

According to my records there was no advance notice and no billing disputes related to services provided to these patients identified in these EOBs. This recoupment was started with no advance information being given to CPMI and the sole information I received at all was by your 11/16/17 email in response to my billing company inquiry about the stoppage of payments. This occurrence, along with the prior 2016 recoupment and stoppage of payment, also without explanation or advance notice, were among the CareSource acts which interrupted and impacted "the quality of care being delivered to the Covered Person" leading to my letter of 12/1/17. Many patients sent me complaints regarding CareSource (please find examples attached – PHI is blotted) and I believe this recoupment action is retaliation for the business integrity issues I raised in good faith in response to the review of the NCS services in 2017. Please provide me with information regarding the above referenced recoupments. As you know I am represented by the counsel please direct all your future communication to my counsel as per accepted professional standard:

Exhibit JJ

COMPREHENSIVE PAIN MANAGEMENT INSTITUTE, LLC
5245 E. Main Street, Columbus, OH; 43213
Ph. 614-557-6075, F. 614-453-8222

---------- Forwarded message ---------
От: **Leon Margolin** <leon3087@gmail.com>
Date: вс, 17 июн. 2018 г. в 18:12
Subject: Caresource - please confirm the receipt of the attached appeal
To: <9375312398@myfax.com>

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Instructions for Appeal from CareSource manual:

CHAPTER 12: PROVIDER APPEALS PROCEDURES

Appeals of Claims Denials or Adverse Decisions

If you do not agree with the decision of a processed claim, you will have 365 days from the date of service or discharge to file an appeal. If the claims appeal is not submitted in the required time frame, the claim will not be considered and the appeal will be denied. If the appeal is denied, health partners will be notified in writing. If the appeal is approved, payment will show on the health partner's Explanation of Payment (EOP).

Please note: If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim; you do not need to file an appeal. Health partners have 365 days from the date of service or discharge to submit a corrected claim.

How to Submit Appeals

Claims Appeals:

Health partners can submit claims through our secure Provider Portal, or in writing:

Provider Portal: https://providerportal.caresource.com/OH/

Under the Provider Portal, click on the "Claims Appeals" tab on the left.

Fax: 937-531-2398

Writing: CareSource
Attn: Health Partner Appeals
P.O. Box 2008
Dayton, OH 45401-2008

Use the Health Partner Claim Appeal Request Form located on our website. Please include:

- The member's name and CareSource member ID number
- The health partner's name and ID number
- The code(s) and reason why the determination should be reconsidered
- If you are submitting a timely filing appeal, you must send proof of original receipt of the appeal by fax or Electronic Data Information (EDI) for reconsideration
- If the appeal is regarding a clinical edit denial, the appeal must have all the supporting documentation as to the justification of reversing the determination

If you believe the claim was processed incorrectly due to incomplete, incorrect or unclear information on the claim, you should submit a corrected claim. You do not need to file an appeal.

Content of appeal:

As President of Comprehensive Pain Management Institute, LLC ("CPMI") and pursuant to Chapter 12 of the Provider Manual and Section 3.7 of the Provider Agreement, I am hereby appealing any and all overpayment determinations made by CareSource which have resulted in the off-setting of payments to CPMI for services previously rendered to CareSource beneficiaries. As background, when this off-set was first detected by my billing company, I enquired with Pamela Morris of CareSource on November 13, 2017. At that time, I had received no notice of any overpayment or other issue which would have led to the off-set and non-

payment to CPMI. In response to my inquiry, I received an email from CareSource Associate General Counsel, Peggy Beat, which indicated that she had research the matter and found that there was an overpayment by CareSource to CPMI. I have received no other notice or information as to this overpayment. I believe that this recoupment was initiated by Caresource in retaliation to the appropriate business integrity concerns I raised. It limited access to care for vulnerable Caresource population. Please consider this as an appeal of all claims and determinations involved in the overpayment referenced in Ms. Beat's November 16, 2017 email to me and any other overpayment determination made by CareSource involving CPMI for which I have likewise received no notice.

Sincerely,

Leon Margolin, M.D.

President, Comprehensive Pain Management Institute, LLC

Examples of the payments inappropriately withheld by Caresource:

11/8/17 - #0001179 - $17,090.56
11/15/17 - #0266746 - $13,494.05

11/22/17 - #0485925 - $20,374.71

11/29/17 - #0697837 - $6655.89

12/6/17 - #0987013 - $9265.51

12/20/17 - #1523478 - $8909.92

Exhibit KK

RE: the recent CareSource claims review and payments
Spitzer, Ivy K. Ivenore.Spitzer@caresource.com
Sent: 8/23/2016 5:34:41 PM
To: Leon Margolin <leon3087@gmail.com>

Dr. Margolin - I apologize for the late response, I have been out of the office. I am glad to hear that you have received the payments and it looks like all the recoveries that took place have been reimbursed. At this point of time if you feel that all money has been repaid there is no additional steps.

As and update, CareSource just updated our Interventional Pain Management Policy, which goes into effect 9/19/2016. I have attached it for your review.

Let me know if you have any questions. Have a good evening.

Ivy Spitzer
Resolution Manager, Health Partnership



230 North Main Street, Dayton, OH 45402
937.224.3300 | CareSource.com

p: 937.630.1029 | f: 937.396.0631
ivy.spitzer@caresource.com

From: Leon Margolin [mailto:leon3087@gmail.com]
Sent: Sunday, August 21, 2016 1:10 PM
To: Spitzer, Ivy K.
Subject: the recent CareSource claims review and payments

Dear Ivy:

It looks like the claims review process is complete. I appreciate the time and effort you and CareSource took in this claims review. The set offs were concerning in terms of the practice paying its bills and meeting payroll but the review was timely and appears to have been thorough. I understand that the set offs and prior claims were reviewed and corrected as part of this process and that is what was reflected in the recent payments. Is there anything else I need to do regarding this review?

Thank you again,

Dr. Margolin

Exhibit LL

CareSource™

eric.plinke@dinsmore.com

Received: Sep 19, 2017 11:10 AM
Expires: Nov 18, 2017 12:10 PM
From: nathan.duling@caresource.com
To: eric.plinke@dinsmore.com
Cc: matthew.nickley@caresource.com, katherine.leff@caresource.com, brian.depew@dinsmore.com, peggy.beat@caresource.com, janine.kumanchik@caresource.com
Subject: $ecure request for patient names
Attachments: image003.jpg

Hello Eric,

I am assisting with case #14-08384-OH on Comprehensive Pain Management Institute, LLC. I am contacting you today to request the names of patients described in your letter addressed to Katherine Leff, dated 7/28/17. On page two, section one of the letter you stated, "Twenty-one (21) of the thirty (30) patients included in the extrapolation sample had recognized clinical and medical exceptions to the AANEM policy. As set forth in the reports from Dr. Margolin, Mr. Deppen, and Mr. Cohen (Exhibits A, B, and C respectively), as well as in the enclosed medical records, eleven (11) of thirty (30) patients were being evaluated for carpal tunnel syndrome, while twelve (12) of the thirty (30) patients were on anticoagulation therapy or NSAIDs (two (2) out of the twelve (12) patients were both on anticoagulation and subject to carpal tunnel evaluations)."

We understand your statement to be broken down accordingly:

- 9 of the 30 were being evaluated for Carpal Tunnel
- 2 of the 30 were being evaluated for Carpal Tunnel & on anti-coagulation therapy or NSAIDs
- 10 of the 30 were on anti-coagulation therapy

21 of the 30 patients have medical exceptions

Patient names were not listed to show who meets the criteria of each bullet. Please supply the names of the patients in each category so that we may adequately respond.

Thank you,

NATHAN DULING

Fraud Examiner, Special Investigations Unit

230 North Main Street, Dayton, OH 45402

937.224.3300 | CareSource.com

p: 937.487.4084 f: 937.487.1643

Nathan.Duling@CareSource.com

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Exhibit MM

Supplemental Statistical Report in Support of Leon Margolin, M.D. and Comprehensive Pain Management Institute, LLC

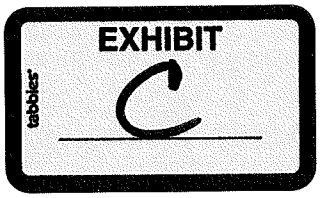
Challenge to the CareSource Extrapolation Analysis

Prepared by

Frank D. Cohen

July 11, 2017

1) My name is Frank Cohen and I am the Director of Analytics and Business Intelligence for DoctorsManagement, LLC, a Knoxville, TN based healthcare consulting firm. I have been actively and continuously employed in the healthcare field for 40 years. Since 1988, I have worked as a healthcare consultant with a particular focus on data analysis and healthcare related analytics.
2) My areas of expertise include applied statistics, predictive analytics, decision modeling and process improvement. I have authored several books on practice analytics, including *Mastering RBRVS, Lean Six Sigma for the Medical Practice* and most recently, *RVUs: Applications for Medical Practices.* In addition, I have participated in a significant number of studies related to healthcare analytics.
3) During the past seven years, I have been involved as an expert and/or consultant in several actions involving data mining and analysis of very large data sets. These include but are not limited to:
    a) *State of New York v. United Healthcare*
    b) *Darlery Franco, Et Al., v. Connecticut General Life Insurance Co., CIGNA corporation and Cigna Health Corporation*
    c) *IN RE: AETNA UCR Litigation*
    d) *Robert Sher, M.D. v. Oxford Health Plans, Inc.*



4) During the past four years, I have been involved as an expert and/or consultant in approximately 150 post-audit extrapolation mitigation and/or statistical analyses of medical practices and hospitals.

5) Additional information is available on my CV

My Assignment

6) I was retained by counsel for Dr. Leon Margolin to assist in reviewing the report a CareSource extrapolation audit conducted on claims submitted by Comprehensive Pain Management Institute Inc. (collectively referred to herein as "CPMI") 1/3/2013 through 10/7/2014 (Re: case #14-08384-OH).

7) My assignment included reviewing and analyzing the CareSource's claims concerning the steps that are defined under section E. PROCEDURE in their Corporate Policy/Procedure document revised 02/17. Within this policy and procedure document, CareSource states that in order to conduct an extrapolation, they need to define: (1) the universe of data to be reviewed; (2) the stratification selected; (3) the statistical validity of the sample; (4) the calculations for point estimates and error; and (5) the appropriateness of the extrapolation methodology.

Introduction

8) Section 8.4.2 of the CMS Program Integrity Manual[1] states the following:

   a) "If a particular probability sample design is properly executed, i.e., defining the universe, the frame, the sampling units, using proper randomization, accurately measuring the variables of interest, and using the correct formulas for estimation, then assertions that the sample and its resulting estimates are "not statistically valid" cannot legitimately be made."

[1] Pub 100-08 Medicare Program Integrity

9) While the above statement is specific to CMS and other government audits, it is also reflects generally accepted principles and practices amongst the statistical community. Accordingly, these criteria must be met in order for an extrapolation to take place.

10) Furthermore, in Section 4.1.5 of Chapter 8 of the Program Integrity Manual (PIM)[2], the guidelines state that *"The sampling methodology used to project overpayments must be reviewed by a statistician, or by a person with equivalent expertise in probability sampling and estimation methods."* In reviewing the entirety of the CareSource document provided to me by my client, I was unable to find any inclusion of information on the statistician required under this section, much less any mention that a statistician was even involved in creating the sampling methodology.

11) In order to arrive at my conclusions regarding these six criteria, I reviewed worksheets and documents provided to me by legal counsel for PHH. These included:

a) 14-08384-OH Comprehensive Pain Management Data for Encryption.xlsx

b) Attachment 2 - CPMI Random Probe Sample List .pdf

c) Attachment 3 - CPMI Medical Records Request.pdf

d) Attachment 4 - CPMI Sampling and Extrapolation Workbook.xlsx

e) Nerve Conduction Study Policy #1.pdf

f) Nerve Conduction Study Policy #2.pdf

g) Nerve Conduction Study Policy #3.pdf

12) Because the accuracy and applicability of an extrapolation is so heavily dependent upon the statistical validity of the sample, the first and perhaps the most important question to be answered is whether the sample is, in fact, statistically valid. In many cases, a sample is assumed valid if there

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[2] Medicare Program Integrity Manual, Chapter 8, section 4.1.5 – *Consultation with a Statistical Expert (Rev. 377, Issued: 05-27-11, Effective: 06-28-11, Implementation: 06-28-11)*

is a belief that the sample units were drawn randomly from the sampling frame or universe. The term 'random' is most often defined here as each audit unit of interest (beneficiary, claim, claim line, etc.) has an equal and non-zero chance of being selected. There is, however, an important difference between a sample being random and a sample being representative of the sampling frame from which it was drawn.

13) In simple terms, we want the sample to be representative of the sample frame from which it was drawn or, more colloquially, to "look like" the sample frame with regard to its characteristics. These characteristics might include what was paid for the procedure, coding characteristics, such as the differences between the vast array of procedure and service codes included in the HCPCS II coding universe. It may also have to do with specific characteristics found amongst the beneficiaries, which often more accurately define the types of diagnoses and treatments represented within the medical records.

14) Some characteristics, such as charge or paid amounts can be visualized by graphing data using histograms, for example. Non-valued characteristics, such as those subject to rules, regulations or guidelines, are more difficult to visualize in this way. For value-based characteristics, distribution and variance are two effective ways to look at representativeness of a sample to the universe (or sampling frame).

Executive Summary

15) While there are many problems with the expert's results of this audit, it is my opinion that the main problem is with the sample itself. Remember, Section E. of CareSource's Corporate Policy/Procedure document requires that certain procedures are followed to ensure that the sample is appropriate for extrapolation and as detailed throughout this report, it is my opinion that CareSource did not meet the minimum criteria as defined within their own policy guidelines.

16) It is simply not enough for a sample to be just random. As will be shown throughout this report and in general amongst the statistical community, the sample has to exhibit a high degree of precision, representativeness and homogeneity when compared to the sampling frame. In order for the sample to be considered as part of an extrapolation event, the sample *must* be representative of the universe to which the sample results will be inferred. This is not just statistically correct; it also concurs with good sense. It is simply illogical to attempt to take the results of a sample that does not statistically represent the universe and then try to extrapolate back to that universe for the purpose of estimating the impact of those erroneous results, particularly when attempting to extrapolate outside the bounds of the data set from which the sample was created.

17) In summary, CareSource:

a) Used the incorrect variable of interest when calculating the sample size, as cited by the OIG guidelines;

b) Failed to provide required information on the statistician, if any, that was involved in the design and analysis of the audit data;

c) Failed to provide the full universe, as required under both Section E. of their guidelines and Chapter 8 of the Program Integrity Manual;

d) Included, within the sample frame, data that should have been excluded due to policy guidelines;

e) Included data points within the sample that should have been excluded based on policy guidelines;

f) Included data points within both the sample frame and the sample that contained dates of service that were inappropriate based on specific clinical guidelines; and

g) Attempted to extrapolate the results of the audit to a sample frame that was not included when the sample was selected.

18) As supported throughout this report, it is my professional opinion that the sample, which was the basis for the extrapolation, did not meet the minimum requirements for either randomness or statistical significance and therefore was not a statistically valid sample. As such, the results of the audit cannot be used for the purposes of extrapolation.

Findings

19) Based on documentation provided by CareSource as well as data contained within "14-08384-OH Comprehensive Pain Management Data for Encryption.xlsx", the universe consisted of 981 claims with dates of service from 3/11/2013 through 10/7/2014. I was not, however, provided with the universe of claims data for this date range but rather the sample frame instead. The universe, by definition, would have contained *all* of the line-item data for the claims presented in this workbook. Instead, CareSource had already excluded all procedures codes except 95912 (Never Conduction Studies; 11-12 Studies), the focus of their audit.

20) The problem here is that, based on conversations with Dr. Margolin as well as information contained within the documentation provided by CareSource, claims that include procedure code 95886 along with 95912 validate payment and therefore should have been excluded from the sample frame used to select the sample. Since CareSource did not provide the universe, as required, I requested Dr. Margolin provide me with the full billing data for CPMI for the date range of the sample frame. I received the data from David Deppen, billing manager for Practice-Pro, LLC, CPMI's billing company.

21) During the analysis of the billing data, we discovered that there were dozens of examples where procedure code 95886 was an inclusive line within the claim that contained the targeted procedure code (95912) as well as claims with subsequent dates showing that the 95886 procedure was reported for that same patient. As such, these claims should not have been

included within the sample frame. In and of itself, this would completely negate the validity of the sample since there was some non-zero probability that an incorrect claim line could be included within the sample, creating a fatal error within the sampling methodology.

22) Contained within the CareSource documents was a statement that NCS is payable in the absend of a needle EMG when that particular patient is undergoing or has undergone an evaluation for carpal tunnel syndrome. In reviewing the universe of claims provided by Mr. Deppen, we found that some 6% of patients did, in fact, have a needle EMG performed and some 15% that reported carpal tunnel symptoms or neck pain did go through a carpal tunnel evaluation. As such, these claims should have been excluded from the sample frame, as well.

23) I believe that Mr. Deppen provided a detailed analysis of these exclusions in a separate document and I am repeating them here based on his data analysis. The information below reference tabs 1 and 2 from the workbook "14-08384-OH Comprehensive Pain Management Data for Encryption."

For the initial sample frame used to create the sample (tab 1):

01/03/2013-10/07/2014 – DOS range
982 Total Patients listed
164 Patient who had Neck Pain listed as ICD code (had carpal tunnel evaluation)
1 patient who had Carpal Tunnel listed as ICD code (had carpal tunnel evaluation)
1 patient had Neck Pain and Carpal Tunnel listed as ICD code (had carpal tunnel evaluation)
2 patient who had an EMG needle study performed

For the additional data set that was included in the extrapolation (tab 2):

10/8/14 – 9/3/16 – DOS range
1087 Total Patients listed
96 Patients who had Neck Pain listed as ICD code (had carpal tunnel evaluation)
11 Patients who had Carpal Tunnel listed as ICD code (had carpal tunnel evaluation)
123 patients who had an EMG needle Study performed

24) There is no other way to interpret these data, when considering the use of extrapolation, except as a fatally flawed methodology. It should quite clear, even to a non-statistician, that poisoning the sample frame with claims that should have been excluded, particular when applying a random

selection process to create the sample, will ultimately result in poisoned data being included in the sample. Fortunately, this is easy to test and Dr. Magolin was asked to examine the charts for each of the 30 claims selected for the sample and he reported that 21 of them (70%) contained exclusionary exemplars that require that these be removed from the sample. Specifically,

a) **12** should have been excluded because of anticoagulation therapy and NSAIDs medications (2 out of 12 were both on anticoagulation and subject to carpal tunnel evaluationss
b) 11 others were subject to carpal tunnel evaluations

25) Finally, notwithstanding the fatally flawed methods described so far, for some reason that defies statistical logic, CareSource chose to take the results of their audit using a flawed sample and extrapolate back not only to the original flawed sample frame, but then to include an additional 1,086 claims from a data set that not only was subject to the same flaws as stated above, but reported a data of service that was not inclusive of that of the sample. In essence, CareSource chose to extrapolate the results of the sample to a data set that was not considered when the sample was selected. There is nothing within the literature or among the statistical community that would render this as acceptable.

Conclusions

26) In conclusion, CareSource failed to meet their own criteria for extrapolation nor did their analysis represent standards that are commonly accepted within the statistical community. Specifically, CareSource did not define the universe or the sampling frame properly, did not define the sample properly, did not accurately measure the variable of interest and did not use the correct formula for estimation. In fact, their treatment of the sample and extrapolation in this case can easily be considered as egregious and by no stretch of the imagination would be considered as either a statistically valid or representative sample. Any one of the many errors committed by the CareSource would be reason enough to exclude the extrapolation from consideration - taken

together, they present an overwhelming case for excluding the extrapolation estimate. Therefore, it is my professional opinion that the extrapolation in this case is wholly inappropriate and should be disregarded in its entirety for the purpose of calculating overpayment amounts for this case.

July 21, 2017

Exhibit NN

8.4.1.2 - The Purpose of Statistical Sampling
(Rev. 906; Issued: 09-26-19; Effective: 01-02-19; Implementation: 01-02-19)

A statistical sample is used to estimate the amount of overpayment(s) made on claims. The Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), mandates that before using extrapolation (i.e., projection, extension, or expansion of known data) to determine overpayment amounts to be recovered by recoupment, offset, or otherwise, there must be a determination of sustained or high level of payment error, or documentation that educational intervention has failed to correct the payment error. By law, the determination that a sustained or high level of payment error exists is not subject to administrative or judicial review. In this chapter, details are provided on the use of statistical estimation (sometimes, especially in legal contexts, referred to as "extrapolation") to determine overpayment amounts.

8.4.1.3 - Steps for Conducting Statistical Sampling
(Rev. 906; Issued: 09-26-19; Effective: 01-02-19; Implementation: 01-02-19)

The major steps in conducting statistical sampling are --

(1) Identifying the provider/supplier;
(2) Identifying the period to be reviewed;
(3) Defining the universe (target population) and the sampling unit, and constructing the sampling frame;
(4) Assessing the distribution of the paid amounts in the sample frame to determine the sample design; it is very likely that the distribution of the overpayments will not be normal. However, there are many sampling methodologies (for example, use of the Central Limit Theorem) that may be used to accommodate non-normal distributions. The statistician should state the assumptions being made about the distribution and explain the sampling methodology selected as a result of that distribution.
(5) Performing the appropriate assessment(s) to determine whether the sample size is appropriate for the statistical analyses used, and identifying, relative to the sample size used, the corresponding confidence interval;
(6) Designing the sampling plan and selecting the sample from the sampling frame;
(7) Examining each of the sampling units and determining if there was an overpayment or an underpayment; and
(8) Estimating the overpayment. When an overpayment has been determined to exist, the contractor shall follow applicable instructions for notification and collection of the overpayment, unless otherwise directed by CMS.

For each step, the contractor shall provide complete and clear documentation sufficient to explain the action(s) taken in the step and to replicate, if needed, the statistical sampling.

8.4.1.4 - Determining When Statistical Sampling May Be Used
(Rev. 906; Issued: 09-26-19; Effective: 01-02-19; Implementation: 01-02-19)

The contractor shall use statistical sampling when it has been determined that a sustained or high level of payment error exists. The use of statistical sampling may be used after documented educational intervention has failed to correct the payment error. For purposes of extrapolation, a sustained or high level of payment error shall be determined to exist through a variety of means, including, but not limited to:

- high error rate determinations by the contractor or by other medical reviews (i.e., greater than or equal to 50 percent from a previous pre- or post-payment review);
- provider/supplier history (i.e., prior history of non-compliance for the same or similar billing issues, or historical pattern of non-compliant billing practices);
- CMS approval provided in connection to a payment suspension;
- information from law enforcement investigations;
- allegations of wrongdoing by current or former employees of a provider/supplier; and/or
- audits or evaluations conducted by the OIG.

When an overpayment is identified by data analysis alone, the contractor shall consult with its Contracting Officer's Representative (COR)/Business Function Lead (BFL) as defined in PIM Chapter 4, §4.7 – Investigations. In addition, if CMS approves the data driven overpayment, the contractor shall also consult with its COR/BFL on whether statistical sampling and extrapolation are necessary to identify the overpayment. Additionally, a UPIC shall consult with the appropriate MAC on whether an extrapolated overpayment is more efficient in processing a data-driven overpayment before requesting recoupment from the MAC.

If the contractor believes that statistical sampling and/or extrapolation should be used for purposes of estimation, and it does not meet any of the criteria listed above, it shall consult with its COR and BFL prior to creating a statistical sample and issuing a request for medical records from the provider/supplier. Examples of this may include, but are not limited to: billing for non-covered services, billing for services not rendered, etc. Extrapolation should not be used when the above criteria is not met unless prior approval is given by the COR and BFL.

Once a decision has been made that statistical sampling may be used, factors also to be considered for determining when to undertake statistical sampling for overpayment estimation instead of a claim-by-claim review, include, but are not limited to: the number of claims in the universe and the dollar values associated with those claims; available resources; and the cost effectiveness of the expected sampling results.

8.4.1.5 - Consultation With a Statistical Expert

(Rev. 906; Issued: 09-26-19; Effective: 01-02-19; Implementation: 01-02-19)

The sampling methodology used in estimations of overpayments must be reviewed and approved by a statistician or by a person with equivalent expertise in probability sampling and estimation methods. This is done to ensure that a statistically appropriate sample is drawn, and that appropriate methods for estimating the overpayments are

followed. The contractor shall obtain from the statistical expert a written approval of the methodology for the type of statistical sampling to be performed. Regardless of whether this sampling methodology is applied routinely and repeatedly, each time a sample size calculation or estimation is performed, a detailed methodology (See Section 8.4.7.1.) should be submitted by the statistical expert to the corresponding contractor.

Prior to releasing a findings letter or overpayment demand letter, the contractor shall have the statistical expert review the results of the sampling and any other subsequent overpayment estimation or extrapolation. The contractor shall verify that the statistical findings have been reviewed and agreed to by the contractor.

If questions or issues arise, the contractor shall also involve the statistical expert.

At a minimum, the statistical expert (either on-staff or consultant) shall meet one of the following criteria:

- Have significant coursework in probability and estimation methodologies, and at least 10 years of experience applying methods of statistical sampling and interpreting the results.
- Possesses a Bachelor's degree (e.g., B.A., B.S.) in statistics or in some related field (e.g., psychometrics, biostatistics, econometrics, mathematics) with significant coursework in probability and estimation methodologies, and at least 6 years of experience applying methods of statistical sampling and interpreting the results.
- Possesses a Master's degree (e.g., M.A., M.S.) in statistics or in some related field with significant coursework in probability and estimation methodologies, and at least 4 years of experience applying methods of statistical sampling and interpreting the results.
- Possess a Doctoral degree in statistics or in some related field with significant coursework in probability and estimation methodologies, and at least 1 year of experience applying methods of statistical sampling and interpreting the results.

If the contractor does not have staff with sufficient statistical experience as outlined here, it shall obtain such expert assistance prior to conducting statistical sampling.

8.4.1.6 - Use of Other Sampling Methodologies

(Rev. 906; Issued: 09-26-19; Effective: 01-02-19; Implementation: 01-02-19)

Once it is has been determined that statistical sampling may be used, nothing in these instructions precludes CMS or its contractor from relying on statistically sound sampling methodologies employed by other law enforcement agencies, including but not limited to the OIG, the DOJ, and/or the FBI. In these cases, a full explanation shall be provided explaining why the methodology was used and why it was statistically appropriate in the circumstances.

Exhibit OO

From: "Hayes, Lora" <lora.hayes@caresource.com>
Date: May 7, 2015 at 10:26:18 AM EDT
To: Leon Margolin <leon3087@gmail.com>
Subject: RE: It was nice meeting you in our office!

Dr. Margolin,

It was very nice meeting with you and your staff yesterday. I was very impressed with everything you do to care of patients. It was my pleasure getting to meet with you again. Please do not hesitate to contact me whenever I can be of assistance to you.

I have already recommend you this morning to a practice that needs to do referrals out for pain management and are being told they have to have MRI's done first. I told them I do not think you require that and that you do all of your own assessments etc.

LORA HAYES
HealthPartnership Representative

230 North Main Street, Dayton, OH 45402
937.224.3300 | CareSource.com

p: 937.531.3107 | f: 937.487.0304
Lora.Hayes@Caresource.com

From: Leon Margolin [mailto:leon3087@gmail.com]
Sent: Thursday, May 07, 2015 10:20 AM
To: Hayes, Lora
Subject: Fwd: It was nice meeting you in our office!

Dear Lora,

I was nice meeting you again in our office after meeting you in June 2013

I am glad we were able to discuss with you and provide you again with a sample of our policies, medical records and patient testimonials.

I attached a copy of the letter we sent to Caresource with the last chart request.

Please do not hesitate to call me 718-530-5953 should you have any questions.

Sincerely,

Leon Margolin MD, PhD

Exhibit PP

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Closed Corporate Integrity Agreements

Below are the names of entities that have entered into Corporate Integrity Agreements (CIA) in the past 10 years and whose CIA is now closed. The list is updated monthly with newly closed CIAs as knowing which entities have previously been subjected to a CIA may be relevant to patients, family members, health care industry professionals, and other stakeholders. A link to a government press release describing the circumstances that led to the CIA is provided if it's available; not all settlements are accompanied by a press release. For more information, including any CIA enforcement actions taken by OIG, please visit CIA Enforcement.

#|A|B|C|D|E|F|G|H|I|J|K|L|M|N|O|P|Q|R|S|T|U|V|W|X|Y|Z

#

PROVIDER	CITY, STATE	EFFECTIVE	CLOSED	PRESS RELEASE
21ST CENTURY ONCOLOGY, LLC	FORT MYERS, FL	12-17-2015	04-12-2019	LINK

A

PROVIDER	CITY, STATE	EFFECTIVE	CLOSED	PRESS RELEASE
A & C HEALTH CARE SERVICES, INC.		1/4/2008	10/26/2011	
AA HEALTHCARE MANAGEMENT, SEE EXTENDICARE HEALTH SERVICES, INC.	SKOKIE, IL	10/03/14	11-25-2020	LINK
ABBOTT LABORATORIES	ABBOTT PARK, IL	10/11/2012	07/25/2018	LINK
ABICHANDANI, LACHMAN K., M.D.	CHESTERFIELD, MO; SAINT LOUIS, MO	11/9/2012	11/9/2017	
ABRAHAM, AKRAM R., M.D., P.C. AND ABRAHAM MEDICAL CLINIC	HOLLIS, OK	6/13/2012	8/18/2017	
ACELL, INC.	COLUMBIA, MD	05-13-2019	06/09/2021	
ADESOKAN, YINKA; FAMILY DERMATOLOGY, P.C., FAMILY DERMATOLOGY OF PENNSYLVANIA, P.C., AND FAMILY DERMATOLOGY OF DELAWARE, P.A.	LILBURN, GA	04-21-2015	04-21-2020	LINK

BELOIT OPERATIONS, LLC SEE EXTENDICARE HEALTH SERVICES, INC.	MILWAUKEE, WI	01/01/19	11-25-2020	LINK
BETHANY LUTHERAN HOME, INC.	COUNCIL BLUFFS, IA	5/31/2012	10/2/2017	LINK
BHC SIERRA VISTA HOSPITAL, INC.	SACRAMENTO, CA	4/23/2012	9/12/2017	
BIESEK, GENESIO W., M.D. AND MANCHESTER INTERNAL MEDICINE ASSOCIATES, P.C.	MANCHESTER, NH	1/21/2009	2/14/2014	
BIOVAIL CORPORATION N/K/A VALEANT PHARMACEUTICALS INTERNATIONAL	MISSISSAUGA, ONTARIO, XX	9/11/2009	3/12/2015	
BOEHRINGER INGELHEIM PHARMACEUTICALS, INC.	RIDGEFIELD, CT	10/22/2012	5/24/2018	LINK
BORIO, JOSEPH, D.C. AND BORIO CHIROPRACTIC HEALTH CENTER	CICERO, NY	10/31/2014	1/2/2018	LINK
BOSTON SCIENTIFIC CORPORATION	WASHINGTOIN, DC	12/23/2009	4/23/2015	
BOTSCH, NOEL R., R.PH AND PHARMACY I.V. ASSOC. OF DEXTER, INC. DBA OPTION CARE PHARMACY DBA SPECIAL DESIGN HEALTH CARE	CAPE GIRARDEAU, MO	8/11/2009	1/8/2014	
BROOKS, NORMAN A., M.D., AND NORMAN A. BROOKS, INC. D/B/A THE SKIN CANCER MEDICAL CENTER	ENCINO, CA	03-30-2017	01-08-2021	LINK
BROOKHAVEN HOSPITAL	TULSA, OK	3/10/2008	3/17/2011	
BURTON, DANIEL J. AND HARMONY CARE HOSPICE, INC.	COLUMBIA, SC	11/15/2012	11/15/2017	LINK
BYRAM HEALTHCARE CENTERS, INC.	HUNTINGTON BEACH, CA	04-29-2016	02/10/2022	LINK

C TOP

PROVIDER	CITY, STATE	EFFECTIVE	CLOSED	PRESS RELEASE
CALLOWAY LABORATORIES, INC. (AMENDED AND RESTATED)	WOBURN, MA	05-15-2014	07-09-2019	LINK
CARDIAC MONITORING SERVICES	IRVINE, CA	2/24/2010	5/6/2015	
CARDIOVASCULAR SYSTEMS, INC.	ST. PAUL, MN	06-28-2016	09-27-2021	LINK
CAREALL, LLC; CAREALL MANAGEMENT, LLC, F/K/A DIVERSIFIED HEALTH MANAGEMENT, INC.; THE JAMES W. CARELL 2007 FAMILY TRUST; J.W. CARELL DYNASTY TRUST; AND J. W. CARELL ENTERPRISES LLC SEE CAREALL, INC.	COOKEVILLE, TN	10-29-2014	07-31-2018	LINK
CARELL, JAMES W. AND CAREALL MANAGEMENT, LLC	NASHVILLE, TN	8/10/2012	6/11/2015	LINK
CAREMED PHARMACEUTICAL SERVICES; SORKIN'S RX LTD.	LAKE SUCCESS, NY	12-01-2014	06-22-2020	LINK
CARESOURCE	DAYTON, OH	1/31/2011	7/7/2016	LINK
CARITAS CARNEY MEDICAL GROUP	DORCHESTER, MA	8/4/2008	10/18/2011	
CARLSON THERAPY NETWORK, P.C.	BROOKFIELD, CT; CHESHIRE, CT	9/10/2008	11/18/2013	
CATHEDRAL HEALTH SERVICES, INC.	NEWARK, NJ	1/23/2008	4/24/2013	
CATHEDRAL ROCK	FORT WORTH, TX	1/6/2010	11/16/2012	

Exhibit QQ

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Department of Justice

Office of Public Affairs

FOR IMMEDIATE RELEASE Tuesday, February 1, 2011

Ohio-Based Managed Care Plan Contractor CareSource & Entities to Pay $26 Million to Resolve False Claims Allegations

WASHINGTON - CareSource, CareSource Management Group Co. and CareSource USA Holding Co. have agreed to pay the United States and the state of Ohio $26 million to resolve allegations that they caused Medicaid to make payments for assessments and case managements they failed to provide to children and adults, the Justice Department announced today.

CareSource, which is headquartered in Dayton, Ohio, provides managed care benefits to Medicaid beneficiaries in Ohio, Indiana and Michigan. The settlement resolves allegations that between January 2001 and December 2006, the CareSource entities knowingly failed to provide required screening, assessment and case management for adults, and children with special health care needs. As a result, it was alleged that CareSource received millions of dollars in Medicaid funds to which it was not entitled. The CareSource entities subsequently submitted false data to the state of Ohio so that it appeared they were providing these required services to improperly retain incentives received from Ohio Medicaid and to avoid penalties.

"Cash-strapped Medicaid programs, such as Ohio's, can ill afford conduct such as this, designed to improve this company's bottom line at the expense of a program benefitting the poor and disabled," said Tony West, Assistant Attorney General for the Civil Division.

"This settlement will help ensure the provision of crucial services to Medicaid patients, especially children with special health care needs," said Carter M. Stewart, U.S. Attorney for the Southern District of Ohio. "The cooperation between federal and state agencies, along with assistance from the former employees who brought this issue to the government's attention, demonstrates the determination necessary to protect the public's precious health care resources."

This settlement resolves a whistleblower action filed under the False Claims Act by two former employees at CareSource, Laura Rupert and Robin Herzog. The whistleblowers filed a suit in the Southern District of Ohio on behalf of the United States when they became aware of CareSource's practices and sought to rectify the harms caused to these Medicaid recipients. The False Claims Act's *qui tam,* or whistleblower, provisions allow private persons with knowledge of fraud to file suit on behalf of the United States and share in any recovery. As part of this settlement, Rupert and Herzog will receive a share of the federal portion of the settlement totaling approximately $3.1 million.

This settlement is part of the government's emphasis on combating health care fraud and another step for the Health Care Fraud Prevention and Enforcement Action Team (HEAT), which was announced in May 2009 by Attorney General Eric Holder and Kathleen Sebelius, Secretary of the Department of Health and Human Services (HHS). The partnership between the two departments has focused efforts to reduce and prevent Medicare and Medicaid fraud through enhanced cooperation. One of the most powerful tools in that effort is the False Claims Act, which the Justice Department has used to recover approximately $5.3 billion since January 2009 in cases involving fraud against federal health care programs. The Justice Department's total recoveries in False Claims Act cases since January 2009 have topped $6.8 billion.

This settlement was the result of a coordinated effort by the Commercial Litigation Branch of the Justice Department's Civil Division; the U.S. Attorney's Office for the Southern District of Ohio; the Health Care Fraud Section of the Ohio Attorney General's Office; and HHS Office of Inspector General in investigating and resolving the allegations.

Component(s):
Civil Division

Press Release Number:
11-138

Exhibit RR

---------- Forwarded message ---------
From: **Leon Margolin** <leon3087@gmail.com>
Date: пн, 13 нояб. 2017 г. в 14:41
Subject: the abrupt cessation of all payments by Caresource/patient safety
To: <Pamela.Morris@caresource.com>, <Peggy.Beat@caresource.com>
Cc: Brown, Harry M. <hbrown@beneschlaw.com>, DePew, Brian <BDePew@beneschlaw.com>, <Katherine.Leff@caresource.com>, <Kurt.Lenhart@caresource.com>, <Ivy.Spitzer@caresource.com>

By e mail and certified mail

Dear Ms. Morris,

My billing company has brought to my attention that Caresource has stopped any payments to my practice without any warning or explanation (EOB attached). They billing tried to reach Caresource but was not able to get an explanation to this situation.

Please explain the reason for this step and whether is was done as a retaliation to the recent business integrity concern and ethical committee review request dated October 19, 2017. Please clarify if this is the response Caresource mentioned in the communication from Ms. Beat dated October 30th.

We have expressed in the past the potential serious patient safety concern caused by such action. I will need to take appropriate steps to protect my patients including appropriate documentation on the patient charts as required by the guidelines, the SMBO regulations and the ethical policy of CMS and Medicaid.

Please respond in writing within the next 3 business days.

Sincerely,

Dr. Margolin

--
Confidentiality Notice: This e-mail message, including any attachments, is for the sole use of the intended recipient(s) and may contain confidential and privileged information. Any unauthorized review, use, disclosure or distribution is prohibited. If you are not the intended recipient, please contact the sender by reply e-mail and destroy all copies of the original message.

Exhibit SS

[redacted]

Addendum credentialing communications to Caresource:

fri, 19 nov. 2021 г. в 14:00, Tiffany Clauss <tiffany.clauss@unifiedrcm.com>:
Hello,

I am following up with this email. I have not heard back from anyone in contracting with Caresource. I sent in the contract over 90 days ago and have not heard back.

Warmest Regards,

Tiffany Clauss
Chief Revenue Officer

P. 888-505-7773
D. 614-412-7422
F. 614-443-0997

From: Brewer, Michelle L. <Michelle.Brewer@caresource.com>
Sent: Friday, October 29, 2021 7:12 PM
To: Tiffany Clauss <tiffany.clauss@unifiedrcm.com>
Subject: Leon Margolin, MD

Hi Tiffany,

I hope this email finds you well. I am trying to credential Dr. Margolin, however, his CAQH application has been expired since 10/20/2020. If you do not have access to the CAQH website to update and re-attest his CAQH application, please complete and return the attached application and have Dr. Margolin sign and date it. If you have any questions or need assistance, please let me know.

Thank you,

Michelle

Michelle Brewer
Provider Enrollment Coordinator II

220 E Monument Avenue
Dayton, OH 45402
937.224.3300 | CareSource.com

Exhibit TT

SPRINGFIELD NEWS-SUN
Clark and Champaign Counties' Hometown News

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Ohio Medicaid announces CareSource wins bid to keep managing billions in state benefits

Caption

BUSINESS

By Kaitlin Schroeder

April 9, 2021

Advertisement

The state chose CareSource and five other insurance companies for a massive contract to manage benefits for the $20 billion Ohio Medicaid program.

These contracts announced Friday are the largest the state has ever issued, and the rules for how the money is spent is one of the most influential policy tools the state has. The contracts are the main

business line for Dayton-based CareSource, one of the largest area employers.

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The new system is intended to overhaul clunky bureaucracy and make the health insurance program more user friendly for the 1 in 4 Ohioans covered.

“This is a bold, new vision for Ohio’s Medicaid program — one that focuses on people and not just the business of managed care,” Ohio Medicaid Director Maureen Corcoran said.

Ohio Medicaid aims to launch the new system in early 2022. Any company that wants to protest the decision will need to file a protest by April 23.

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CareSource and the other insurance companies working with Ohio Medicaid were asked to refer requests for comment back to the state.

The contracts announced Friday are preliminary because they are not signed yet.

It's not clear yet how the new system will impact CareSource's core business — managing 1.3 million Ohioans' Medicaid benefits — compared to the old system or whether CareSource will lose market share.

Advertisement

Ohio Medicaid covers 3.2 million people with low incomes or certain disabilities, including more than 412,000 people in the local nine-county region. About 90% of Ohioans who are covered by Medicaid don't have their benefits managed directly by the state government. Instead, people get an insurance plan managed by insurance companies like CareSource.

Nearly half of Ohio children, half of Ohio births and the majority of nursing home care is covered by Medicaid. By rebidding the contracts and resetting the conditions for how the money gets spent, the DeWine administration is trying to engineer better outcomes for the different Ohioans with Medicaid.

Some examples of these changes include that providers will be able to work out one Medicaid contract, instead of having to broker deals with all the different Medicaid plans. Claims billing and prior authorizations will be processed through a single system instead of with each plan individually.

Loren Anthes, who researches Ohio Medicaid for Cleveland-based Center for Community Solutions, said providers can get bogged down in all the paperwork and redundancy that can come with Medicaid payments.

“By simplifying things, streamlining them administratively, means doctors and nurses and other folks who are serving the Medicaid population can focus more on delivering care, rather than appropriately managing the red tape,” Anthes said.

In addition, some of the changes include:

- A new separate program will help kids with lots of behavioral health needs and help their families navigate the different systems their child gets services from. Aetna will manage this new separate program.
- Insurance plans like CareSource must contribute 3% of annual profits to community reinvestment, and that number eventually increases to 5%.
- Ohio’s Medicaid plans will work with a single company that will transparently manage pharmacy benefits.
- There will also be provider advisory councils so that providers can be heard by the insurance companies.

Jim Tassie, Ohio Medicaid deputy director, said the department wants insurers in the new system to work together, “not competing against each other by offering certain bonuses or trinkets,” but instead working for a holistic, collective impact on the Medicaid population.

Along with working more with each other, Tassie said the insurance plans will work more with community organizations.

“One of the things that we learned from many of our members is they turn to their community organizations, whether it’s their community action agency or a federally qualified health center or even their primary care provider. Those are the folks to whom they look to get guidance on their health care,” Tassie said, adding that this is part of the reason why the insurers have to give some of their profits back to the community.

The new program will be carved up among six insurance companies with the possibility of a seventh.

Along with CareSource, others selected were UnitedHealthcare, Humana, Molina Healthcare, AmeriHealth Caritas, and Anthem Blue Cross and Blue Shield.

Centene's subsidiary Buckeye Community Health Plan could potentially be added to the program as a seventh but the department wrote that it is "deferring for additional consideration" on that decision. Centene is currently contesting a lawsuit filed by Ohio Attorney General Dave Yost.

When the state was deciding who to award these contracts to, they gave each of the bidding insurance companies a score and CareSource scored the lowest. UnitedHealthcare scored the highest.

Some people in the Dayton-area with Medicaid are covered by one of the insurance plans that lost their bid.

Members will continue to receive services with their current managed care plans until the transition in early 2022 and will not lose coverage. Members will have the opportunity to select a new plan during the 2021 open enrollment period later this summer. If members do not select a plan, one will be automatically assigned to them.

In Other News

1 Drone programs at Springfield airport expected to drive future job...

2 Air Force starting critical care training program at Beavercreek...

3 Pungent, blooming tree to be banned in Ohio next year

4 Gas prices dip, but expected to rise again with no long-term relief in...

5 P&G suspends operations in Ukraine, scales back in Russia

About the Author



Kaitlin Schroeder

Kaitlin Schroeder is a health care and business reporter with the Dayton Daily News. She covers the local hospitals, CareSource, public health, nursing homes, caregiving, and other related topics.

Exhibit UU

MedPro Group
a Berkshire Hathaway company

Account #	: 993-866-637RE
Invoice Date	: 01/10/2022
Policy Number	: C58062
Extension Contract Amount	: $2,608
Due Date	: 05/02/2022
Amount Enclosed:	

Your payment must be received on or before the above due date.
Please indicate your account # on your check.

Certified Mail / Return Receipt – Personal & Confidential
COMPREHENSIVE PAIN MANAGEMENT INSTITUTE
5245 EAST MAIN STREET
COLUMBUS, OH 43213

Remit to:
THE MEDICAL PROTECTIVE COMPANY
23289 NETWORK PLACE
CHICAGO IL 60673-1232

Please detach and return the top portion with your payment.

RE: Professional Liability Coverage
Policy Number : C58062
Expiration Date : 3/3/2022
Extension Contract Amount: $2,608
Notice of Non - Renewal

Dear Dr. Margolin :

We regret to inform you that Medical Protective will not be in a position to renew your current policy, which expires on 03/03/2022. As a result, you should make arrangements to replace your coverage with another carrier. Your billing for an Extension Contract from our Company at $1,000,000/$3,000,000 limits for the period of 03/03/2017 to 03/03/2022 is $2,608.

Pursuant to our underwriting guidelines, Insureds whose medical, dental, or DEA license or Medicare, Medicaid, or hospital privileges have been investigated, revoked or put on probation may not be offered renewal.

According to our records, it appears you have agreed to pay $650,000 to the US government to resolve False Claims Acts allegations. Because of the nature of this matter, we have decided not to renew your coverage..

Since your policy was issued on a Claims-Made basis, it provides no protection for claims filed after its expiration date – no matter when services were rendered.

You can protect yourself from future claims by selecting any one of the following:

1. Buy an Extension Contract from the Medical Protective Company. This extends the time for reporting claims based on services rendered between the retroactive date and the termination date of your Medical Protective policy.
2. Buy a claims-made policy through a separate professional liability carrier which maintains the same retroactive date as you had on your Medical Protective policy.

MedPro Group
a Berkshire Hathaway company

You MUST take one of these actions or you will have no coverage for future reported claims arising from the period of 03/03/2017 to 03/03/2022.

Lack of payment by the above specified Due Date will be deemed a rejection of such offer.

Policy: C58062
Account: 993-866-637RE

Additionally, you have 10 days to request of us a copy of your loss experience for at least the last three policy years, or the period of time during which you were coverage, whichever is less.

This is an offer for coverage and such coverage cannot be automatically paid for via any previously established automated bill payment options ("Auto Payments"). If you would like to purchase this Extension Contract please remit payment via check or our Customer Service Team at 800-4MEDPRO to discuss other payment methods.

Sincerely,
Drew Matz, Underwriter
MidEast Underwriting Team Underwriting Team
THE MEDICAL PROTECTIVE COMPANY

cc: file 113 GALLAGHER HEALTHCARE

20200417_nrcmreas

Exhibit VV

Patient Complaints to CareSource re Disruption to Care

Member names, signatures, dates and other identifiers have been redacted (HIPAA Safe Harbor, 45 C.F.R. § 164.514(b)(2)).

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	To CareSource: As of [redacted] 2017, I was not allowed to see my physicians without warning, You cut off access to care. I had to wait for another insurance (Medicaid Plan) to kick in. You caused me to suffer. It was negligent of you, as a company, Thank You For Dr. Leon Margolin for continuing to see me. [redacted]

[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted]

PATIENT NAME: [redacted]

COMMUNICATION LOG

DATE/TIME	NOTES
	TO: CARESOURCE
	Caresource disrupted my medical care w/ DR. MARGOLIN in my [redacted] 2017 Until 2018 I tried to contact them. No Answer or return calls. VERY UNPROFESSIONAL (Careless) My life was on hold because my disabilities I'd like to be heard - to this doesn't happen to anyone else.
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

PATIENT NAME: [redacted]

COMMUNICATION LOG

DATE/TIME	NOTES
[redacted]	Care soure block my access to care to Dr. Margolin The Dis-Regarded my medicle Proples and try switch me back Care Soure dishonest way. I think Care Soure not honest and don't care about members
	Thank [redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

[redacted]

[redacted]	NOTES
	Care Sav[redacted] has not helped me since [redacted] 2017 and I want to thank Dr Margolin Care Savvy has blocked my access to care and it was very difficult for me. It was not right what they did to me. And I would like to thank Dr Margolin for seeing me all caking for me.

[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted] COMMUNICATION LOG

DATE/TIME	NOTES
[redacted]	
	Caresource blocked my care with
	Dr. Margolin which in turn I
	had to switch insurance plans
	Because of caresource doing this
	I had to change all of my
	insurance information with my
	pharmacy as well as my endo.
	This took many hours. It was
	an aggrevating thing and I
	appreciate Dr. Margolin and his
	staff for working with me
	while I switched to Molina
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute
COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	CARE SOURCE BLOCKED MY ACCESS CARE TO DOC TO MARGOLIN. I THINK THAT'S NOT RIGHT. I THINK CARE SOURCE DON'T CARE ABOUT THIER PAICIE PATIENTS. THEIR DIDN'T CARE CAREFUL TO LEAVE ME WITHOUT A DOCTOR LIKE DR MARGOLIN. I THANK MY DOCK FOR STILL SEEMING ME.
	[redacted]

[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted]

COMMUNICATION LOG

DATE/TIME	NOTES
[redacted]	Concerning CARE SOURCE. I am very displeased with the way CARE SOURCE operates with regard to my access to care. They wouldn't pay there bills and it created a situation with my provider and my access to care. I had to switch providers but in the mean time I endured 2 weeks of pain and sleepless nights until I could get my appropriate paperwork with a new insurance provider worked out. Very displeased w/ CARE SOURCE and denying or affecting care and needs as a patient. [redacted] Spoke with them on a few occasions (CARESOURCE) and it was just a run around over the phone and transferred to no one except a busy signal and/or continuous ringing.
	[redacted]

[redacted]

LEON MARGOLIN, MD PhD

[redacted]uprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME:

DATE/TIME	NOTES
[redacted]	Care Source was given me a hard time so I had to get a new insurce Driver but Dr. Margolin helps me a lot making sure imokay.
	Care Source blocked my insurce to Dr. Margolin and this is Not Right
	[redacted]
	Thank you.

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

[redacted] [redacted]

DATE/TIME	NOTES
	Im really upset with Caresource. because the blocked my actes to care. I its not right Thank You [redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	Care Source blocked my access for care and it went thru. Severe pain and discomfort. I am very Thankful to Dr. margolin for his medical care.
	[redacted]

[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted] COMMUNICATION LOG

[redacted]	NOTES
	Care source is blocking my care to Dr Margolin to access my care I had to switch to different insurance it was different to me Thank you to Dr Margolin to keep trying me
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
	I learned very abruptly that CareSource stopped paying my medical bills with Dr. Margolin. Thankfully Dr. Margolin continued to care for me while CareSource blocked me.
	[redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	[redacted] Very unhappy with Caresource was unable to get medication for pain for a whole month pain is at max level due to no coverage. Caresource has block my access of care and no longer am I able to see my doctor Margolin. I am thankful to Dr. Margolin and his staff for seeing me the last two months. [redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

[redacted] COMMUNICATION LOG

DATE/TIME [redacted]	NOTES
	To whom it may concern Care Source blocked my access to Care with Dr Margolin very abruptly. It has caused me extreme hardship. I think it is unfair and inappropriate for them to do so. Thank goodness that Dr Margolin still sees me until I was able to switch Insurance. Because I do not know what I would have done. Thank you [redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
[redacted]	Caresource Blocked My access to My Care with Dr. Margolin and I Thought it was so Wrong they Should Not have did things like that to Dr. Margolin. Dr. Margolin is a Caring Doctor and a Wonderful Person. I Care deeply for Dr. Margolin and his Staff [redacted]

LEON MARGOLIN, MD PhD
Comprehensive Pain Management Institute

COMMUNICATION LOG

PATIENT NAME: [redacted]

DATE/TIME	NOTES
	[redacted] was a patient [redacted] Margolian office has been my pain management doctor for over a year. I'm really dissatisfaied that Care Source dropped all of their clients for his office. I don't understand why this has happened. He isn't the only provider affected by the change. Please look into this and change your policy back.
	Thank you