



State of New Jersey

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Final Audit Report

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Background

The Medicaid Fraud Division of the Office of the State Comptroller (OSC) performed a review of The Chateau (Chateau), a facility located in Rochelle Park, New Jersey. The Chateau offers both nursing home and skilled nursing facility services. The facility enrolled in the Medicaid program in October 2006. The Chateau utilizes the services of a third party biller. An algorithm identified potential recipients for whom the periods of skilled service should have been reimbursed by Medicare. Medicare uses a period of time referred to as a benefit period, to keep track of how many days of skilled nursing facility (SNF) benefits recipients' use, and how many are still available. Medicare recipients can get up to 100 days of SNF coverage in a benefit period.

Per N.J.A.C.10:49-7.3, Medicaid and NJ FamilyCare benefits are last-payment benefits. In addition, the regulation states that all third party liability (TPL), for example, health insurance, Medicare, CHAMPUS, prepaid health plans, workers' compensation and auto insurance, shall, if available, be used to the fullest extent in meeting the cost of the medical needs of the Medicaid or NJ FamilyCare beneficiary.

Objective

OSC conducted a limited scope desk audit of The Chateau. The objective of this audit was to examine claims and claim reporting procedures for The Chateau to determine if Medicaid was billed prematurely.

Scope

The scope of this audit was limited to a review of a sample of eight dual eligible Medicare/Medicaid recipients with paid claims totaling \$111,698 for the period January 2007 through December 2010. However, subsequent discussions with the provider warranted an expansion of the scope of the audit to include a review of additional Medicaid claims totaling \$277,954 for the same eight recipients in our sample over an expanded period from October 2006 through December 2010. The audit is conducted under the authority of the *Medicaid Program Integrity and Protection Act* (N.J.S.A. 30:4D-53 *et seq.*) and N.J.S.A. § 52:15C-23.

AUDIT FINDINGS

Premature Medicaid Billings

Based on our review, we determined the following:

1. A review of the medical billings for 7 recipients, disclosed that the Chateau received payments totaling \$99,000 prematurely from the Medicaid program because Medicare should have been billed first. Pursuant to N.J.A.C. 10:49-7.3(b), Medicaid is the payer of last resort. However, The Chateau did not always exhaust all Medicare benefits before billing Medicaid for the recipients we reviewed.
2. In addition, during the review, we identified and discussed other erroneous billing adjustments that are indicative of internal control weaknesses. These weaknesses should be addressed in a timely manner to avoid further violations of Medicaid regulations.

Recommendation

We recommend The Chateau reimburse the Medicaid program a total of \$99, 000 which should have been billed to Medicare for the recipients reviewed in our sample for the period audited. The recommendation above is specific to claims The Chateau submitted to the Medicaid program for reimbursement; therefore, we are seeking recovery from The Chateau, not the Medicare program.

Response:

The Chateau agreed with the findings except for the amount of the recovery. The Chateau requested a reduction in the amount of the Medicaid recoupment as a concession for subsequent billings to the Medicare program which reduced the overall Medicaid compensation to this provider.

OBSERVATION

Insufficient Internal Controls Over Provider Payment Systems:

The premature Medicaid billings are indicative of insufficient internal controls with regard to provider enforcement of NJ Medicaid Third Party Liability (TPL) billing requirements. OSC recommends that The Chateau strengthen internal controls over the Medicaid billing process through a compliance program. A successful compliance program increases the likelihood of compliance and reduces the potential for waste, abuse and fraud at an early stage, thereby minimizing financial loss to the government, to taxpayers and the providers.

The U.S. Department of Health and Human Services, Office of Inspector General (HHS OIG) offers compliance guidance for 3rd party billing companies. The Chateau should encourage all third party billers with whom it contracts to develop a compliance program. This would help the provider to more efficiently monitor adherence to Federal, State and program requirements. A compliance program supports the integrity of a billing company's informational systems and includes the establishment of standards for high

quality data submission (accuracy, reliability, timeliness and validity). Written policies, training, internal monitoring, a backup system and a prompt response to detected errors support effective internal controls. The Chateau is encouraged to include these requirements in their contracts with billing companies to avoid billing errors in the future, as appropriate.

CONCLUSION

We have reviewed the provider's response. OSC considered, but did not grant the concession requested by this provider and is seeking reimbursement for paid claims that should not have been billed to Medicaid. Also, OSC recommends that this provider strengthen internal controls over its billing processes. In addition, OSC requires this provider to conduct a self audit of all dual eligible claims not reviewed during this audit period. OSC will evaluate the provider's progress in this regard as these measures are intended to foster compliance with Medicaid regulations and reduce future billing errors.