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Series of Comptroller investigations uncovers pattern of improper Medicaid billings by Adult Medical Day Care facilities

Investigations find facilities billed state Medicaid program for patients not in attendance on dates in question

A series of Office of the State Comptroller (OSC) investigations has uncovered a pattern of waste of taxpayer funds at five Adult Medical Day Care (AMDC) facilities, while also raising questions about whether patients at those facilities are receiving proper care.

The OSC investigations found the AMDC facilities billed the state-funded Medicaid program for a range of services they could not substantiate and, in many cases, for individuals who were not even in attendance at the facility on the dates in question. The review, conducted by OSC's Medicaid Fraud Division, also found the state paid for services to individuals who did not appear to be medically or clinically eligible to receive AMDC care. OSC's review of patient records further uncovered a failure to perform or document essential clinical and medical tasks, such as monitoring blood sugar and blood pressure for patients who attended the facility for the purpose of receiving such services.

OSC obtained or is seeking financial recoveries from each of the five facilities referenced in the investigative report.

The AMDC program serves adults who have physical or cognitive impairments but do not require 24-hour inpatient care. In recent years, the state Medicaid program has paid an average of $195 million per year to AMDC facilities as reimbursement for providing medical services and assistance with activities of daily living, such as walking or eating.

"Adult Medical Day Care programs provide an important and necessary service, allowing individuals with specialized medical needs to remain active in the community rather than enter more intensive and expensive in-patient facilities," State Comptroller Matthew Boxer said. "It is apparent, however, that greater monitoring of AMDC facilities is needed. The state's Medicaid program pays these facilities to provide medical and clinical services. When in reality those services are not being provided, this office will move aggressively to recover any taxpayer funds that have been inappropriately spent."

A review of 50 pending Medicaid claims made by one AMDC facility found 90 percent of those claims did not have the documentation needed to support reimbursement. OSC rejected payment on all of those claims.

At the same facility, OSC also conducted a post-payment review of claims related to 28 individuals who purportedly attended the facility during the period under review. The facility could not provide any paperwork or documentation at all for six of those individuals. As to the remaining 22 files reviewed, OSC found that a number of the individuals were not present at the facility on the days the facility claimed to provide services to them. One of those individuals, for whom the state paid more than $10,000, never attended the facility at all.

Billing for individuals not actually in attendance was prevalent at other AMDC facilities as well. At one facility, OSC found the state had been billed daily for more than a month for services provided to an individual who actually was away on vacation that entire time. Another facility similarly billed for services supposedly rendered to an individual on 30 days on which he was absent.

A review of 228 claims at yet another facility found that for 133 of those claims the facility was not able to produce the required patient signature at the facility for the day in question, or required documentation of arrival or departure times recording the patient's attendance. The facility's transportation logs also were incomplete, making it impossible to determine if patients had spent the five hours at the facility needed to qualify for Medicaid reimbursement.

OSC's investigation also uncovered billings for a series of individuals who did not appear to be clinically eligible to participate in the AMDC program or otherwise did not appear to need the program's services. Conversely, there were numerous cases in which no documentation existed to demonstrate that the facility had provided care to patients who needed it.

In instances where the provision of services was documented, the documentation often contained striking errors that raised questions about the quality of care being provided. For example, one facility routinely documented that its staff administered insulin to a patient at times when the patient had not yet signed into the facility for the day. Another patient's file included separate, conflicting clinical charts for eight months of the year reviewed. At that same facility, records indicated that the staff routinely failed to perform required monitoring of the blood sugar and blood pressure of patients

diagnosed with diabetes, hypertension and other conditions that necessitated daily monitoring.

OSC's report makes several recommendations to improve oversight of AMDC facilities. For example, it recommends that the managed care organizations now responsible for these facilities conduct unannounced site visits at the facilities, as well as random and routine audits, to determine whether required services are being provided.

Medicaid Fraud Division Director Mark Anderson said the state's transition to managed care in the AMDC program presents a prime opportunity to revisit and strengthen current monitoring procedures. "The fiscal consequences of failure in this regard are significant," Anderson said. "If the costs to managed care organizations in administering the AMDC program are inflated due to waste and fraud, the state will bear the expense. We need a stronger system of oversight to prevent that from happening."

OSC will further implement enhanced oversight measures at the facilities referenced in the report, which will include periodic reviews of billing protocols and sample audit testing.

There are currently 134 AMDC facilities in New Jersey providing services to approximately 14,000 state residents. OSC selected the five facilities for its investigation based in part on referrals from the state Department of Health's inspection program and from the state Department of Human Services, as well as based on tips independently received by OSC. Boxer thanked both of those departments for their assistance with OSC's investigation.