GUARDRAILS AGAINST MEDICAID FRAUD, WASTE AND ABUSE:

A PRESENTATION FOR NEW JERSEY ADULT MEDICAL DAY CARE PROVIDERS

STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER

December 4, 2024

Welcome to the presentation. We will begin momentarily.

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PRESENTED IN PARTNERSHIP BY:

Medicaid Fraud Division (MFD)

Division of Medical Assistance and Health Services (DMAHS)

Managed Care Organizations (MCOs)

Department of Health (DOH)

Medicaid Fraud Control Unit (MFCU)

BEFORE WE BEGIN…

THANK YOU

for participating in the

NJ FamilyCare program!

DISCLAIMER

- This presentation is intended for general educational purposes only.
- It does not replace your responsibility to seek professional guidance, observe all laws and regulations that pertain to your practice as a Medicaid provider and exercise sound, independent, professional judgment.

GOALS FOR TODAY: TO HELP YOU BETTER UNDERSTAND

- The Medicaid program regulatory oversight structure and compliance requirements
- Medicaid documentation requirements for payment
- Fraud, waste, and abuse obligations of providers (prevention and reporting)
- Red flag areas and the consequences for non-compliance by providers

QUESTIONS?

If you have questions throughout the presentation please put them in the Q & A.

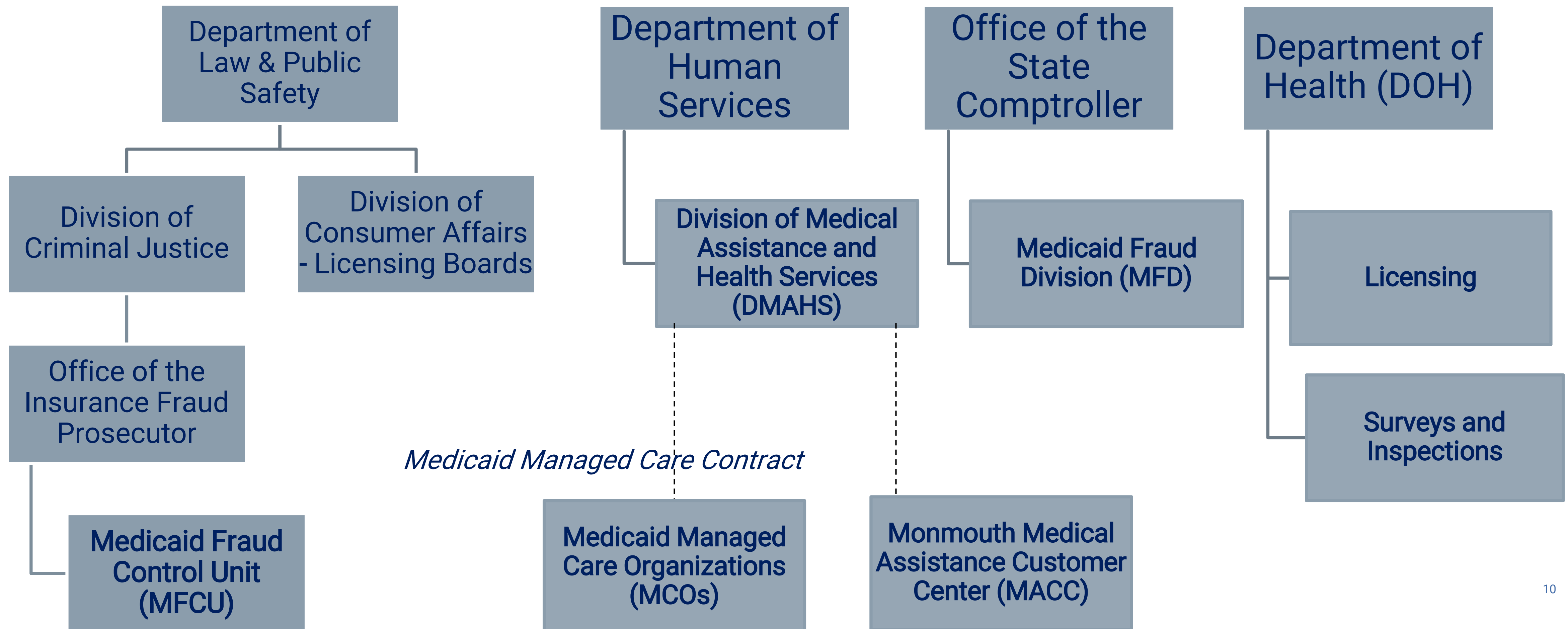
WHAT IS MEDICAID?

- Medicaid is a joint Federal and State program that provides funding for medical costs and specialized services for eligible individuals.
- Medicaid participation is voluntary. If you want to participate, you must know, accept and abide by the rules and regulations. Your continued participation requires compliance with the regulatory requirements.

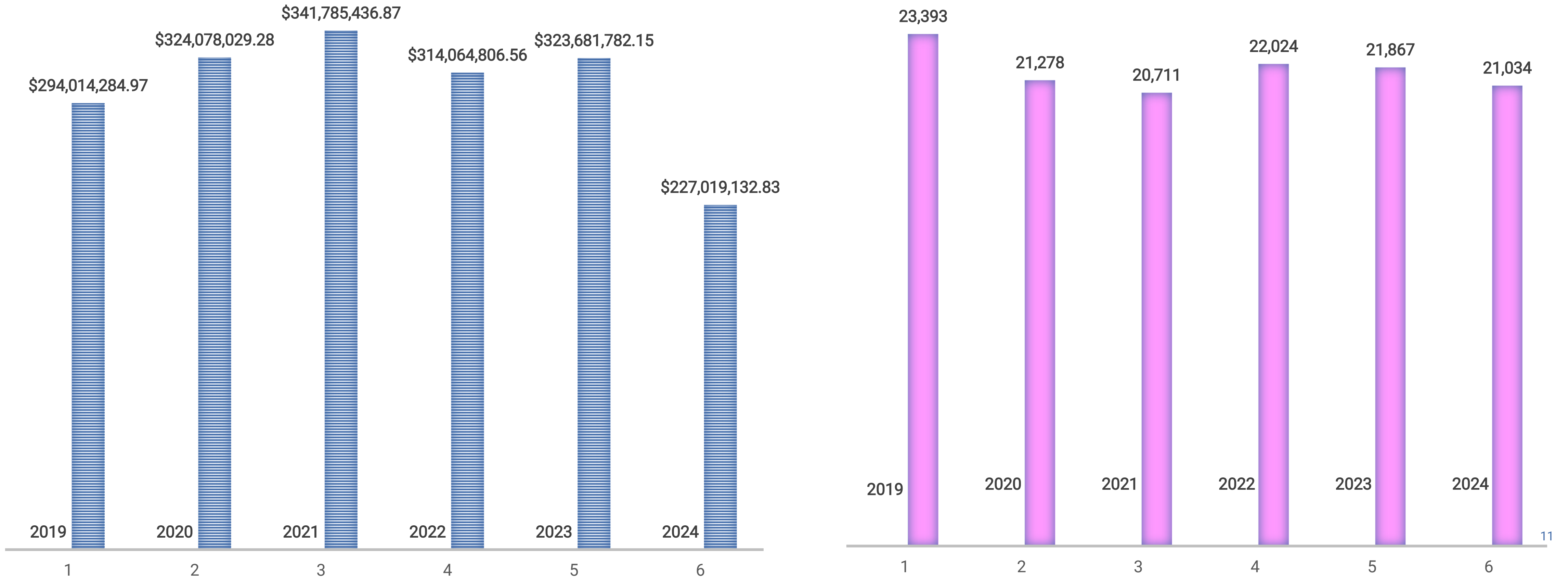
MEDICAID (NJ FAMILYCARE)

- Throughout this presentation the words Medicaid and NJ FamilyCare may be used interchangeably.
- NJ FamilyCare is the name of the Medicaid Program in New Jersey, and includes Medicaid, the Children's Health Insurance Program (CHIP), and Medicaid expansion, with services provided through the State and the five Medicaid Managed Care Organizations (MCOs).

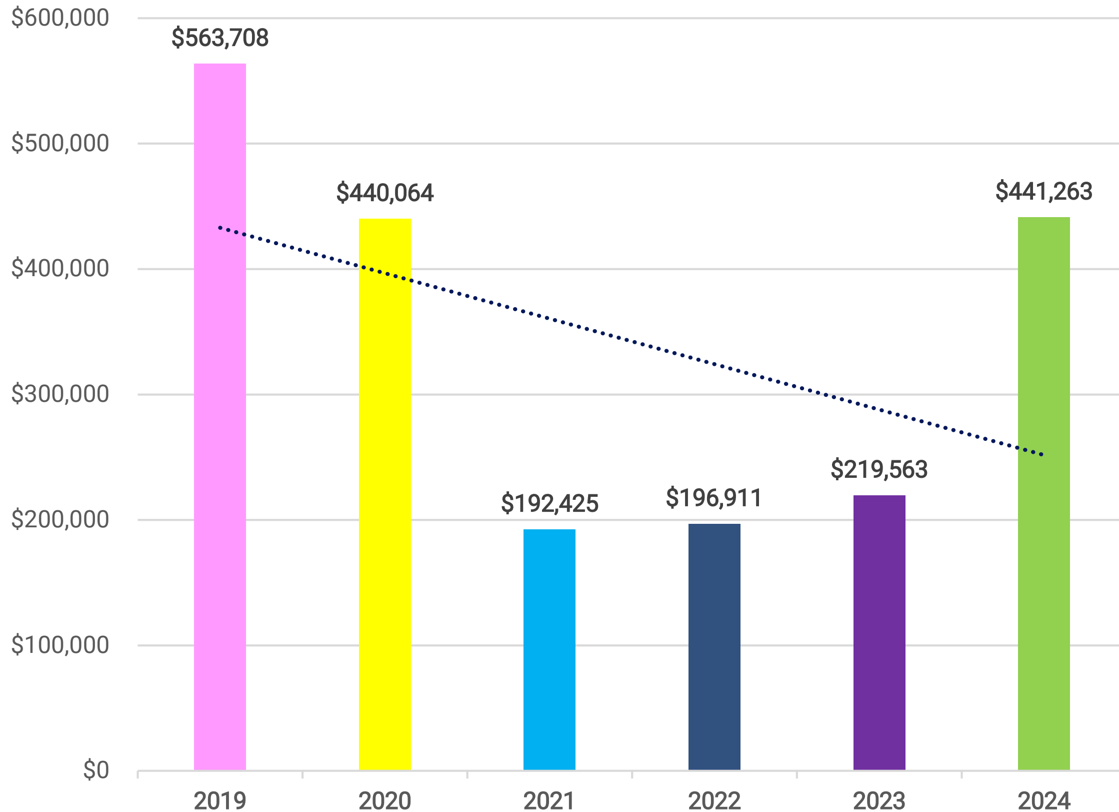
NEW JERSEY AGENCY ADMINISTRATION AND MEDICAID OVERSIGHT

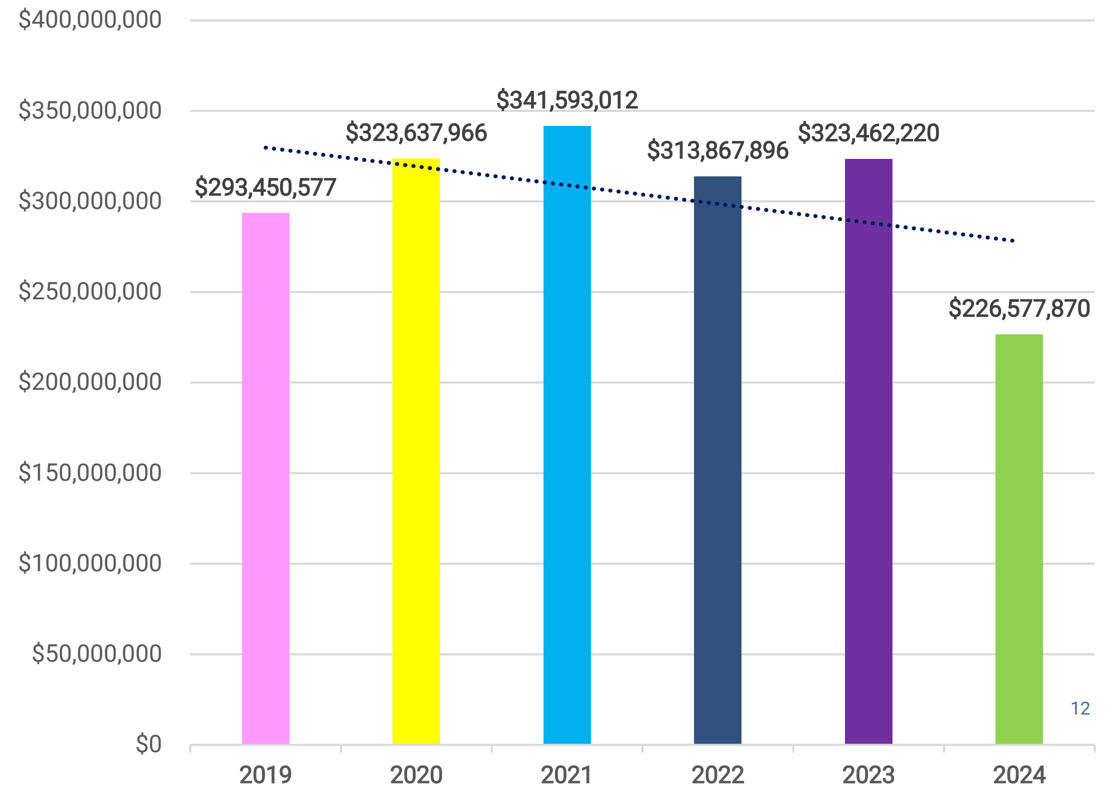


ADULT DAY HEALTH SERVICES (ADHS) PAYMENT AND RECIPIENT COUNT (2019-9/2024)

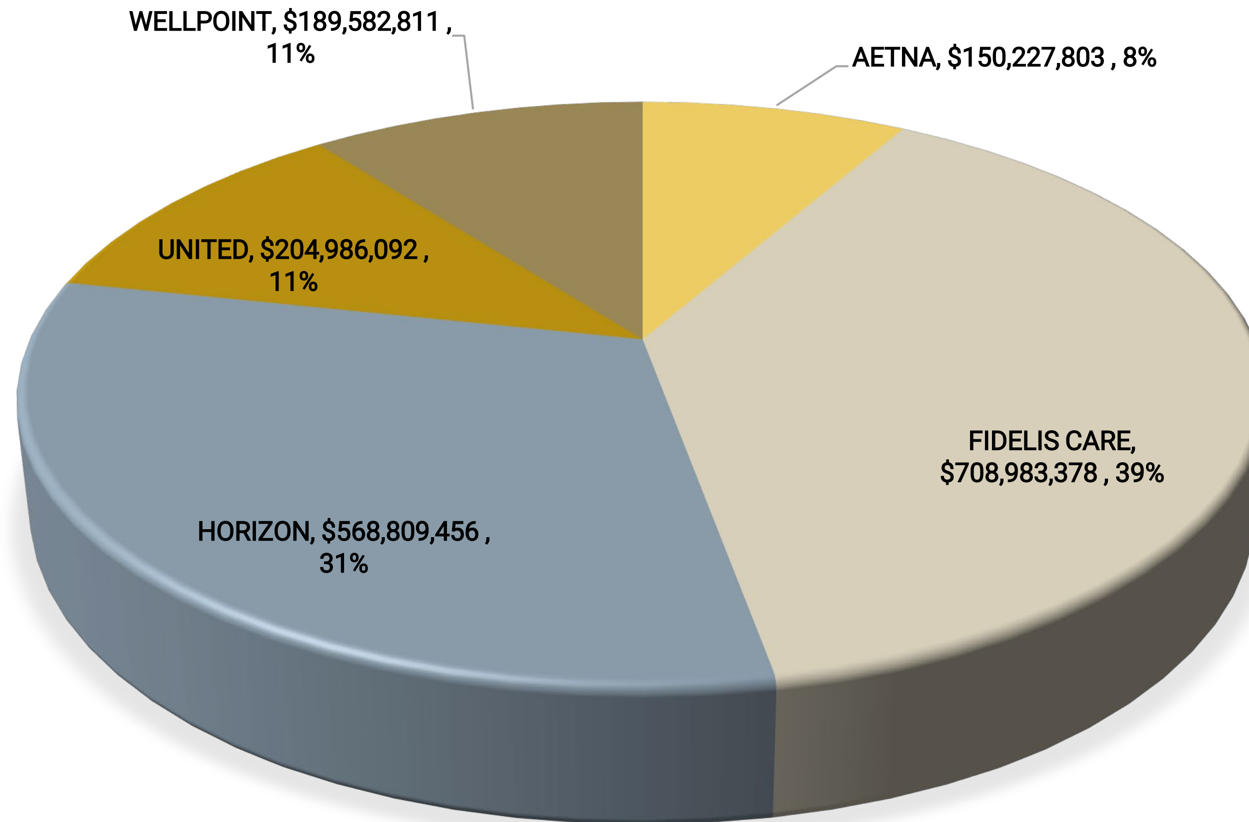


ADHS FEE FOR SERVICE & MANAGED CARE EXPOSURE





ADHS MEDICAID EXPOSURE BY MCO (2019-9/2024)



GUIDING REGULATIONS, AND NEWSLETTERS

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES (DMAHS)

Presented by: Geralyn Molinari, Director, Managed Provider Relations,
Department of Human Services, Division of Medical Assistance and Health Services

DMAHS

- The Division of Medical Assistance and Health Services (DMAHS) is part of the NJ Department of Human Services.
- DMAHS administers the state-and federally-funded Medicaid program for certain groups of low to moderate income people.

DMAHS REGULATIONS

WWW.NJMMIS.COM

- Home
- Site Requirements
- Help Index by Topic
- State & Fed Web Sites

- Account Links
- HIPAA Submitter Login
- Reset Password
- Login

- Communication
- Contact Provider Services
- Contact Webmaster
- Forgot My Password
- Provider Directory
- Provider Enrollment Application
- Provider Registration

State Web Links

For additional information on New Jersey Medicaid, please refer to the following sites:

- New Jersey Division of Medical Assistance and Health Services
  - N.J.A.C.(Regulation)
  - State Plan
  - Managed Care Contract
  - Public Notice
- New Jersey Department of Health
- New Jersey Division of Aging Services
- New Jersey Division of Consumer Affairs (NJ Doctorlist)
- New Jersey Office of State Comptroller – Medicaid Fraud Division

Federal & State Statutes and Regulations

- Important Notice to Providers with a High Medicaid Volume - Section 6032 of the Federal Deficit Reduction Act of 2005
- Federal Regulations and NJSA Code Quoted in Provider Agreement 42 CFR 455.100

Privacy Notice Legal Statement

N.J.A.C. 10:164-1.5
- Clinical eligibility and prior authorization for adult day health services

DMAHS NEWSLETTERS

- Medicaid Newsletters are used to introduce new programs or services, pending regulatory updates or general program guidance.
- Newsletters can be found on www.njmmis.com.
- Newsletters are searchable by provider type and subject.

21ST CENTURY CURES ACT
42 U.S.C. 1396u-2(d)

- The 21st Century Cures Act requires all Fee For Service (FFS) and MCO Enrolled providers to submit a completed 21st Century Cures Act application to Gainwell Technologies.
  - Providers under contract with multiple MCOs are only required to submit a single 21st Century Cures Act application to Gainwell.
- To download, go to:
  - www.njmmis.com
  - Select *Provider Enrollment Applications > 21st Century Cures Act Application*
- Questions can be directed to Gainwell Technologies Provider Enrollment Unit at 609-588-6036 or NJMMISproviderenrollment@gainwelltechnologies.com.

MEDICAID MANAGED CARE CONTRACT

- DMAHS has a contract with the following Medicaid Managed Care Organizations (MCOs):

  - Aetna Better Health of New Jersey
  - Wellpoint (formerly Amerigroup New Jersey, Inc.)
  - Horizon NJ Health
  - UnitedHealthcare Community Plan
  - Fidelis Care (formerly WellCare Health Plans of New Jersey, Inc.)

FACILITY LICENSING, INSPECTION AND SURVEYS

Presented by: Presented by Michael J. Kennedy, J.D., Executive Director
New Jersey Department of Health, Division of Certificate of Need and Licensing

LICENSURE PROCESS FOR ADULT DAY HEALTH SERVICES FACILITIES

- Rules for Adult Day Health Services Facility:
  - N.J.A.C. 8:43F, Standards for Licensure of Adult Day Health Services Facilities

- Medicaid rules for adult day health services:
  - N.J.A.C. 10:164.

NJ Health
New Jersey Department of Health

DEFINITION

- "Adult day health services facility" means a facility or a distinct part of a facility which is licensed by the New Jersey Department of Health to provide preventive, diagnostic, therapeutic, and rehabilitative services under medical and nursing supervision to meet the needs of functionally impaired adult participants who are not related to the members of the governing authority by marriage, blood, or adoption.
- Adult day health services facilities provide services to participants for a period of time, which does not exceed 12 hours during any calendar day.

NJ Health
New Jersey Department of Health

LICENSURE APPLICATION PROCEDURES AND REQUIREMENTS

- Applicants seeking to establish an Adult Day Health Services Facility must first submit to the Department of Health (Department), Certificate of Need and Healthcare Facility Licensure Program, a detailed project narrative and Project Application (form CN-6), which is available online at: www.state.nj.us/health/forms

- The project narrative shall include information as to what the applicant is seeking to establish, all services that will be provided, the location where such services will be provided, etc., and must be completed and signed by the applicant, not by the applicant's architectural firm.

LICENSURE APPLICATION PROCEDURES AND REQUIREMENTS

The project narrative and CN-6 form shall be submitted along with full-sized and scaled architectural plans.

1. Architectural plans must comply with physical plant requirements pursuant to N.J.A.C. 8:43F.
2. The applicant must read, understand, and comply with the Standards for Licensure of Adult Day Health Services Facilities requirements at N.J.A.C. 8:43F.
3. The applicant should also be familiar with the General Licensure Procedures and Standards Applicable to All Licensed Facilities found at N.J.A.C. 8:43E.
4. A Copy of the NJ Administrative Codes can be found at: http://www.lexisnexis.com/hottopics/njcode/

SUBMISSION OF DOCUMENTS

- Schematic drawing must be submitted via hard copy and may be sent to the following address:

Certificate of Need and Healthcare Facility Licensure Program
New Jersey Department of Health

First Class Mail: P.O. Box 358, Trenton, NJ 08625-0358

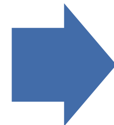
Overnight Mail: 120 South Stockton Street, 3rd Fl., Trenton, NJ 08608

*For functional review projects, add to the address
"Attention: Licensing / Functional Review"

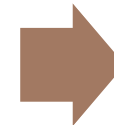
LICENSURE APPLICATION PROCEDURES AND REQUIREMENTS

HTTP://WWW.NJ.GOV/DCA/CODES/OFFICES/EPLANS.SHTML

Project narrative, CN-6 form, and architectural plans reviewed



If project meets physical plan requirements at N.J.A.C. 8:43F...



Dept will issue letter authorizing applicant to proceed with submission of approved plans to Dept of Community Affairs (Healthcare Plan Review Unit)

NJ Health
New Jersey Department of Health

LICENSURE APPLICATION PROCEDURES AND REQUIREMENTS

- After construction or renovation has begun, and the applicant is within 120 days of receiving a certificate of occupancy, the applicant shall submit a License Application (form LCS-9), available online at: www.state.nj.us/health/forms.
- The LCS-9 form must be completed in its entirety and must include a detailed cover letter and or project narrative.
- The application must be submitted with the required application fee of $1,500 + $10.00 per slot and an inspection fee of $450.00.
  - Payments may be made via e-pay or check.
  - If payment is made via e-pay, proof of payment must be submitted with the license application (LCS-9).

NJ Health
New Jersey Department of Health

LICENSURE APPLICATION PROCEDURES AND REQUIREMENTS

- If the application is being submitted via hardcopy, send to:

Certificate of Need and Healthcare Facility Licensure Program
New Jersey Department of Health

First Class Mail: P.O. Box 358, Trenton, NJ 08625-0358

Overnight Mail: 120 South Stockton Street, 3rd Fl., Trenton, NJ 08608

- If the application is being submitted electronically, send to: CNLapps@doh.nj.gov

OTHER DOCUMENTATION TO BE SUBMITTED WITH THE LCS-9 APPLICATION

- If the Adult Day Health Services Facility will be located in a leased space, a copy of the lease agreement must be provided.
- Attestation of compliance, signed by an owner or Administrator, attesting that they have read, understand, and are in compliance with N.J.A.C. 8:43F.
- The application form must identify 100% of the facility ownership.
  - A separate ownership chart may be provided which shall outline 100% of the ownership of the facility at each level of ownership.

OTHER DOCUMENTATION TO BE SUBMITTED WITH THE LCS-9 APPLICATION, CONTD.

- If the applicant owns, manages, or operates any out-of-state Adult Day Health Services facilities, they must provide a track record of each facility from the out-of-state licensing entity.

- If any applicant(s) that own 10% or more of the ownership or stock in the facility, who also owns/operates/manages any out-of-state facilities, you may contact the Department for forms to be completed related to track record compliance if you are unable to obtain the required information from the applicable out-of- state licensing entities.

NJ Health
New Jersey Department of Health

OTHER DOCUMENTATION TO BE SUBMITTED WITH THE LCS-9 APPLICATION, CONTD.

- Copy of Certificate of Occupancy issued by the Local Authority
- Copy of the DCA Partial Release/s
- CBI Clearance for all Owners and Administrator
- Applicant must also advise the anticipated date that the facility will be patient ready to open and operate.

NJ Health
New Jersey Department of Health

SURVEY

Application is completed and facility is ready to open:

- Program will submit the project to the Department's Health Facilities Survey & Field Operations Program (Survey) for review and scheduling of the initial on-site inspection survey.

Following initial on-site inspection:

- Survey team will provide Certificate of Need and Licensing with their recommendation.

If approval is recommended:

- Program will contact the applicant to provide verbal approval to open and operate, followed by issuing email approval.
- The applicant will receive a final letter and initial license to operate within approximately 6 weeks after receiving verbal approval.

NJ Health
New Jersey Department of Health

FOLLOWING INITIAL LICENSURE

- Following the initial on-site inspection, if the facility proposes changes to the facility’s physical plant, slots, shifts, other required services or ownership, the applicant may contact the Department for guidance.

- Applicants may ask to speak with the Licensing Analyst for their County by calling: 609-292-6552

LICENSURE RENEWAL

- Licenses - valid for one year; 30-day “grace period” to renew the license after expiration.
- Intake Unit handles licensure renewals and will automatically email the facility license renewal reminders:

Reminder	Notice Frequency
1st Reminder	Sent 90 days before license expiration
2nd Reminder	Sent 60 days before license expiration
3rd Reminder	Sent 30 days before license expiration
4th Reminder	Intake will call 15 days prior to license expiration

NJ Health
New Jersey Department of Health

LICENSURE RENEWAL

- If the license is not renewed by the end of the grace period:
  - Intake will notify the facility that an Enforcement Action Alert (EAA) will be submitted to the Office of Program Compliance (OPC) with a recommendation for an order to Cease and Desist (C&D) operations.
  - The facility will be notified that C&D is public, posted on the NJ DOH website, and shared with other agencies.

NJ Health
New Jersey Department of Health

SURRENDER OF LICENSE

- N.J.A.C. 8:43F-2.7
  - The facility shall notify each participant, the participant's physician, advanced practice nurse, or physician assistant, and any guarantors of payment at least 30 days prior to the voluntary surrender of a license, or as directed under an order of revocation, refusal to renew, or suspension of license. In such cases, the license shall be returned to the Division within seven working days after the voluntary surrender, revocation, non-renewal, or suspension of license.

Presented by: Ashley Scott, Senior Manager, Network Relations,
Aetna Better Health of New Jersey

MCO REQUIREMENTS FOR PARTICIPATION

- Participating with an MCO will allow your agency to provide services to eligible NJ Medicaid members enrolled with that plan.

- There are two main parts to this process:

Provider Credentialing

Provider Contracts

PROVIDER CREDENTIALING

- Credentialing is the way the MCO can verify that your agency has all the required documentation to participate.
- It ensures quality, compliance, and accountability.

CREDENTIALING REQUIREMENTS

Credentialing Application
- Detailed application form to collect necessary information

License
- Proof of valid and current professional license

Approval Letter
- Approval letter from the Department of Health (DOH)

Liability Insurance
- Evidence of liability insurance coverage

Tax ID
- Federal Tax Identification Number

National Provider Identifier (NPI)
- Unique identification number for health care providers

Certificate of Incorporation (INC)
- Legal document regarding the agency's formation

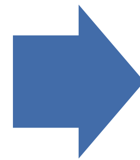
Business Registration Certificate
- Proof of business registration

PROVIDER CONTRACTS

- The contract makes your agency a participating provider with the MCO, allowing you to provide services to eligible MCO NJ Medicaid member that qualify for adult day health services.

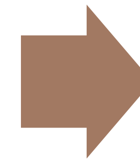
Creation

- Contracts are prepared by the MCO and sent to the agency



Review & Signature

- Agency reviews the contract terms and signs



Return for Countersignature

- Contract is returned to the MCO for final countersignature

SUBMISSION OF CREDENTIALING PACKAGE

- Once the entire credentialing package (including signed contract) is complete, it is submitted to the MCO Credentialing Department for processing.
- The credentialing process takes approximately 60 to 90 days for completion; consult with the MCO for specific timelines.

BACKGROUND CHECKS AND OWNERSHIP

Presented by: Marc Fernandez, Provider Relations Manager, UnitedHealth Group

BACKGROUND CHECK REQUIREMENTS

- Providers must submit a criminal history background check along with the attestation as part of the credentialing process - **no exceptions.**
- You must comply with N.J.S.A. 45:1-30 et seq:
  - Requires a criminal history background check for every person with a license or certificate as a health care professional.
- Policies and procedures that show compliance with state requirements to have a pre-employment criminal history check and/or background investigation on all staff members.

- Nursing facilities (NFs) should perform background checks based on CMS survey requirements.

OWNERSHIP REQUIREMENTS

- Completed application
- Licensed as appropriate for the service being contracted
- Proof of DOH of NJ Adult Day Health license
- Site visit required only if there is not Medicaid certification or accreditation by an approved entity
- Meet qualifications as outlined in the credentialing plan under CMS and NCQA
- Monthly verification that agency and/or employees have not been excluded from Medicare/Medicaid participation
- Evidence of compliance with all applicable laws and regulations, including Workman's Compensation and unemployment insurance and general liability insurance

OWNERSHIP REQUIREMENTS - CONTINUED

- For agency and employees, no felonies or listings on abuse and sex offender registries
- Documentation of verifying financial capacity to operate
- Documented service delivery assurances
- Compliance with HIPAA requirement
- Accurate completion of a Disclosure of Ownership and Control Interest Statement and disclosure of Ownership information at any time upon request
- Submission of a substitute W-9 Form
- Signed attestation for the accuracy and completion of all required forms
- Assignment of a valid Medicaid number
- Standards assessment and documentation review

OWNERSHIP REQUIREMENTS - CONTINUED

Notify the MCO in writing, following the timelines outlined in your provider contact(s), if any of the following events happen:

1. Bankruptcy or insolvency
2. Indictment, arrest, felony conviction or any criminal charge related to your practice or profession
3. Suspension, exclusion, debarment or other sanction from a state or federally funded health care program
4. Loss or suspension of your license to practice
5. Departure from your practice for any reason

MCO process may differ.
Please reach out directly to your MCO point of contact.

CHANGE OF OWNERSHIP (CHOW)

- Typically occurs when a Medicaid provider has been purchased (or leased) by another organization;
- Results in the transfer of the previous owner’s Medicaid Identification Number and provider agreement (including the previous owner's outstanding Medicaid debts) to the new owner.
- You must notify the MCO, following the timelines outlined in your provider contract(s), if you are acquired by, merge with, or decide to transfer some or all of your assets to another entity.

MCO process may differ.
Please reach out directly to your MCO point of contact.

FEE FOR SERVICE (FFS) ELIGIBILITY AND AUTHORIZATION

Presented by: William Keller, RN, Regional Staff Nurse,
Monmouth Medical Assistance Customer Center

FFS ELIGIBILITY AND AUTHORIZATION
N.J.A.C. 10:164-1.5

- Clinical eligibility and prior authorization for adult day health services
  - N.J.A.C. 10:164-1.5
- FFS Prior Authorization Clarification
  - Newsletter Volume 29, No. 05

FFS ELIGIBILITY AND AUTHORIZATION

- Prior authorization for FFS adult day health services is handled by DMAHS in the following scenarios:
  1. When a Medicaid beneficiary awaits enrollment in an MCO
     - Authorization - up to 90 days
  2. When there is a gap in managed care enrollment
     - Retroactive prior authorization must meet the following criteria:
       - Referred for prior authorization no later than 90 days after MCO disenrollment date
       - Valid MCO authorization at the time of MCO disenrollment
       - No break in Medicaid eligibility
     - Authorization - up to 90 days

FFS PRIOR AUTHORIZATION PROCESS

- Only NJ FamilyCare certified adult day health services providers can submit prior authorization documents for temporary FFS coverage for clinically eligible individuals.

- The adult day health services provider is responsible for submitting the following documents:
  - ✓ Prior Authorization FD-411 Form (PA)

  (and one of the following attachments)

  - ✓ Physician's Certification form PA-4a
  - ✓ NJ Department of Human Services, Division of Aging Services, Office of Community Choice Options (OCCO) approval letter for MDC
  - ✓ MCO Authorization

FFS PRIOR AUTHORIZATION PROCESS

- Adult day health services FFS Prior Authorizations can be submitted by fax, encrypted email, and/or snail mail.
- Please ensure all documents are included, and all required fields are completed, prior to submission.

Fax to:	Email to (encrypted):	Mailed to:
732-863-4450	william.keller@dhs.nj.gov	Monmouth Medical Assistance Customer Center 100 Daniels Way Freehold, NJ 07728

Presented by: Kate Andujar, MSN, RN, CCM, NE-BC, Associate Health Services Director – Community & State – New Jersey, UnitedHealthcare Community Plan

ADHS PURPOSE AND SCOPE
N.J.A.C. 10:164-1.1(A)

- The Adult Day Health Services (ADHS) Program is concerned with the fulfillment of the health needs of eligible individuals who could benefit from a health services alternative to total institutionalization.
- Provides medically necessary services in an ambulatory care setting to individuals who are nonresidents of the facility, and who, due to their physical and/or cognitive impairment, require such services supportive to their community living.
- ADHS is a Medicaid State Plan Benefit - Program can be accessed up to 5 days a week/for a minimum of 5 hours per day excluding transportation
- Transportation to/from program provided - not to exceed 1 hour each way

CLINICAL ELIGIBILITY AND PRIOR AUTHORIZATION FOR ADHS

N.J.A.C. 10:164-1.5

- Members must be determined eligible for Medicaid.
- Meet clinical eligibility requirements using NJ Choice Assessment completed by MCO staff in person.
- Once MCO completes assessment, if member meets clinical eligibility requirements they will send the Medical Day Care an authorization for member to attend.
- Redetermination of eligibility will occur at least annually; may occur any time a member's clinical status changes such that eligibility for services may have changed.

ELIGIBILITY FOR MEDICAL DAY CARE
N.J.A.C. 10:164-1.5(f)

- At least limited assistance in a minimum of two Activities of Daily Living (ADLs) and the facility will provide all the assistance for the claimed ADLs on-site in the facility.
- At least one skilled service provided daily on-site in the facility.
- Supervision/cueing in at least three ADLs and the facility will provide all the supervision/cueing for the claimed ADLs on-site in the facility; and, as identified by the assessment instrument prescribed by the Department, the individual:
  - Exhibits problems with short-term memory following multitask sequences, and in daily decision-making in new situations.

INELIGIBILITY FOR MEDICAL DAY CARE

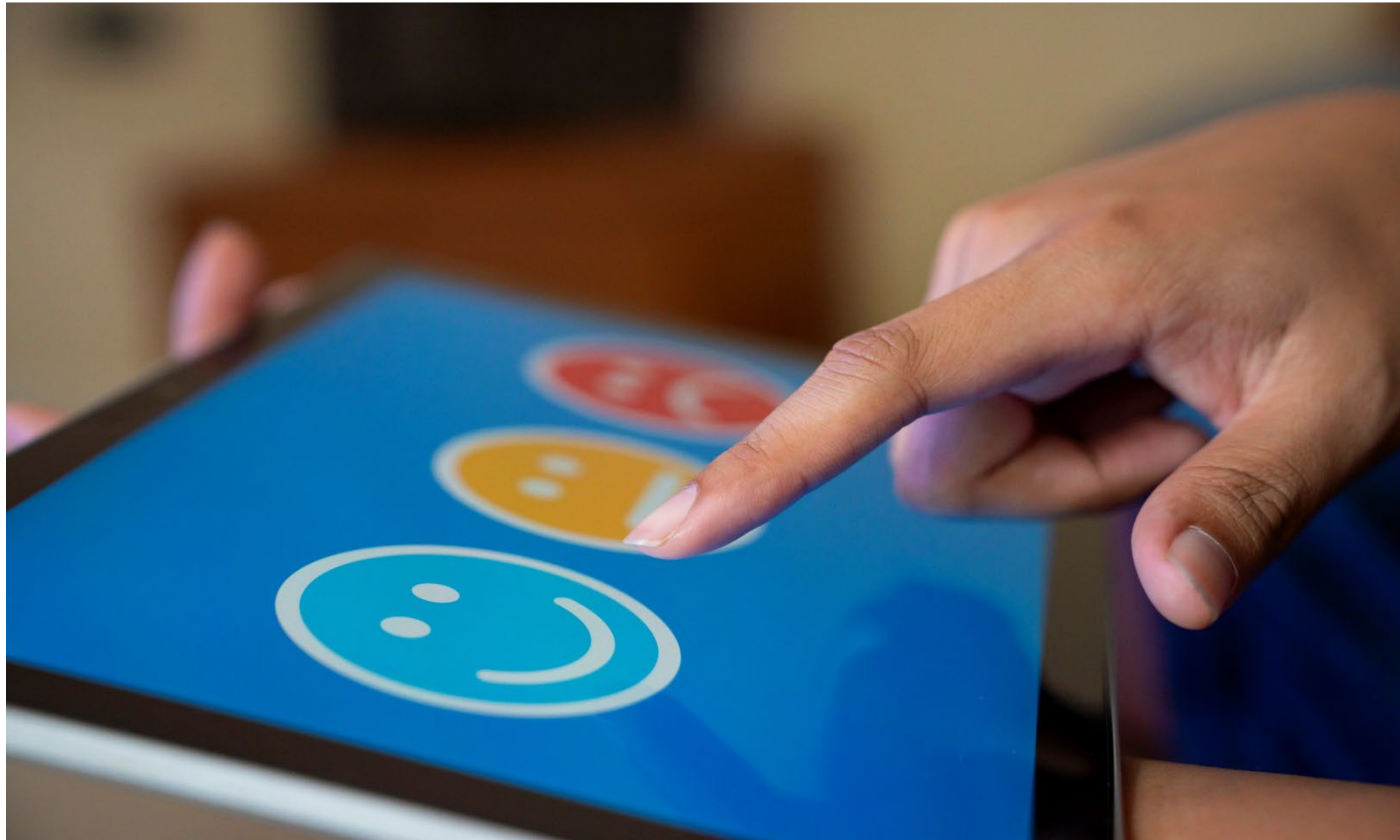
- ADHS will no longer be covered for Members who fail to attend approved services for one month (30 consecutive days); re-entry will require a new assessment and authorization.
- Individual receiving services that are duplicative or redundant
  - Example: PCA in the home for bathing assistance when bathing is considered one of two ADLs for ADHS eligibility and not being provided at the facility.
- Individual resides in a Residential Health Care or Assisted Living Facility
- Individual is receiving inpatient hospital or nursing facility care
- Rehabilitative therapies and/or medication administration are the only services that the individual will be receiving and no other criteria present.

Presented by: Colette Conroy, RN, BSN, MPA, Manager of Personal Care Agency/Medical Day Care Department, and Carol Cianfrone, RN, BSN, Sr. Director Medicaid Care Management Programs, Horizon NJ Health

THIS SECTION WILL ADDRESS THE FOLLOWING CATEGORIES FOR PAYMENT:

- Documentation
- Billing Guidelines
- Review of Discharge Criteria and Authorization Requirements
- Record Retention

DOCUMENTATION



INITIAL DOCUMENTATION

- An initial assessment shall be completed for each participant on the day of admission and shall include at least personal hygiene, immediate dietary needs, medications, ambulation, and diagnosis. Based on this initial assessment, a written initial plan of care shall be developed within five business days of the date the initial assessment is performed.
- A physician, advanced practice nurse or physician assistant shall provide orders for each participant's care beginning on the day of admission.
- Each physician, advanced practice nurse or physician assistant order shall be executed by the nursing, dietary, social work, activities, rehabilitation, or pharmacy service, as appropriate in accordance with professional standards of practice.

INITIAL DOCUMENTATION

A comprehensive assessment shall be completed for each participant within 14 days of the date the participant first attends the program. The comprehensive assessment shall include, at a minimum, evaluation of the following:

1. Cognitive patterns;

2. Communication/hearing patterns and vision;

3. Physical functioning;

4. Psychosocial well-being;

5. Medical condition/diagnoses;

6. Nutritional status and life- style;

7. Oral/dental status;

8. Skin condition;

9. Medication use; and

10. Special treatment and procedures, assistive devices.

DEVELOPMENT AND IMPLEMENTATION OF PLAN OF CARE
§ 8:43F-5.4

A written interdisciplinary plan of care shall be developed, based on the initial and interdisciplinary assessment, within 30 days of the date the participant first attends the program. The plan of care shall include, but not be limited to, the following:

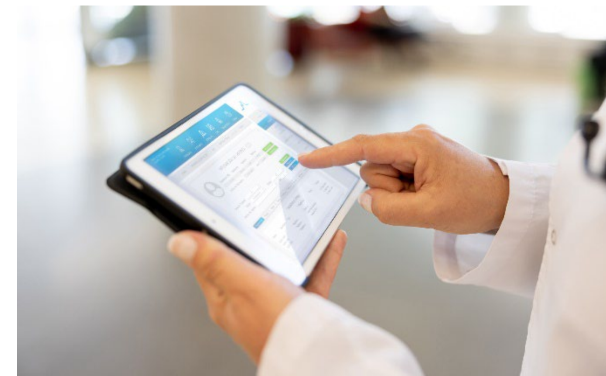
1. The participant's scheduled days of attendance;
2. The specific goals of care, if appropriate;
3. The participant's needs and preferences for himself or herself;
4. Orders for treatment or services, medications, and diet, if needed; and
5. The time intervals at which the participant's response to treatment will be reviewed.

DEVELOPMENT AND IMPLEMENTATION OF PLAN OF CARE - CONTINUED

- The interdisciplinary plan of care shall be based on the comprehensive assessments provided by nursing, dietary, activities, and social work staff; and when ordered by the physician, advanced practice or physician assistant, other health professionals, including pharmacy consultation, shall also provide assessments.
- **The plan of care shall include measurable objectives with interventions based on the participant's care needs and means of achieving each goal.**
- The complete plan of care shall include, if appropriate, rehabilitative/restorative measures, preventive intervention, and training and teaching of self-care.
- There shall be a scheduled review and evaluation in each service involved in the initial assessment, and in other areas that the physician, advanced practice nurse or physician assistant, or interdisciplinary team indicates are necessary.
- Reassessments shall be performed as necessary, based on participant's needs, but at least quarterly for adult participants.

CONTENTS OF MEDICAL RECORDS
§ 8:43F-15.3

- The participant's complete medical record shall include, but not be limited to, the following:
  1. Participant identification data, including name, date of admission, address, date of birth, race, religion (optional), sex, referral source, payment plan, marital status, and the name, address, and telephone number of the person(s) to be notified in an emergency, and travel directions to the participant's home;
  2. The participant's signed acknowledgment that the participant or the participant's legally authorized representative has been informed of, and given a copy of, participant's rights;
  3. An assessment of the participant's home environment;
  4. A summary of the admission interview;



CONTENTS OF MEDICAL RECORDS - CONTINUED

5. Assessments developed by each service providing care to the participant;
6. A plan of care;
7. Clinical notes, which shall be entered on the day service is rendered;
8. Progress notes;
9. A record of medications administered, including the name and strength of the medication, date and time of administration, dosage administered, method of administration, and signature of the person who administered the medication;

CONTENTS OF MEDICAL RECORDS - CONTINUED

11. A record of self-administered medications, if the participant self-administers medications;
12. Documentation of allergies in the medical record and on its outside front cover;
13. Documentation of dental, laboratory, and radiological services provided;
14. A record of referrals to other health care providers;
15. Documentation of consultations;
16. Any signed written informed consent forms;

CONTENTS OF MEDICAL RECORDS - CONTINUED

17. Documentation regarding an advance directive, if applicable;
18. A record of any treatment, medication, or service offered by personnel of the facility and refused by the participant;
19. All orders for treatment, medication, and diets, signed by a physician, advanced practice nurse or physician assistant. Physician, advanced practice nurse or physician assistant orders for speech-language pathology, physical therapy, and occupational therapy services shall include specific modalities and the frequency of treatment;
20. An attendance record listing all of the days on which the participant was in the facility;
21. A current photograph of the participant; and
22. The discharge summary, in accordance with N.J.S.A. 26:8-5 et seq.

BILLING GUIDELINES

BILLING GUIDELINES; REQUIRED SERVICES
§ 10:164-1.4

As a condition of per diem reimbursement in accordance with N.J.A.C. 10:164-1.6, ADHS facilities shall provide the following to adult beneficiaries:

1. The services required as a condition of licensure at N.J.A.C. 8:43F;
2. The service(s) each adult beneficiary requires to be clinically eligible pursuant to N.J.A.C. 10:164-1.5(f); and
3. A minimum of five hours of services per day, excluding transportation time between the ADHS facility and the adult beneficiary's home, not to exceed five days per week.
   - Transportation duration may not exceed 1 hour each way

BILLING GUIDELINES; REQUIRED SERVICES - CONTINUED
§ 10:164-1.4

- An ADHS facility may provide transportation to an adult beneficiary's medical appointment(s) as a service that can be applied toward meeting the minimum service hour requirement identified at above.
- The time that may be applied toward meeting the minimum hours of service per day that each beneficiary must receive pursuant to above includes transportation between the facility and the adult beneficiary's medical appointment and return trip to the facility, and the time spent at that beneficiary's medical appointment.
- The facility shall accommodate the special transportation needs of the beneficiary and medical equipment used by the beneficiary.

REVIEW OF DISCHARGE CRITERIA AND AUTHORIZATION REQUIREMENTS

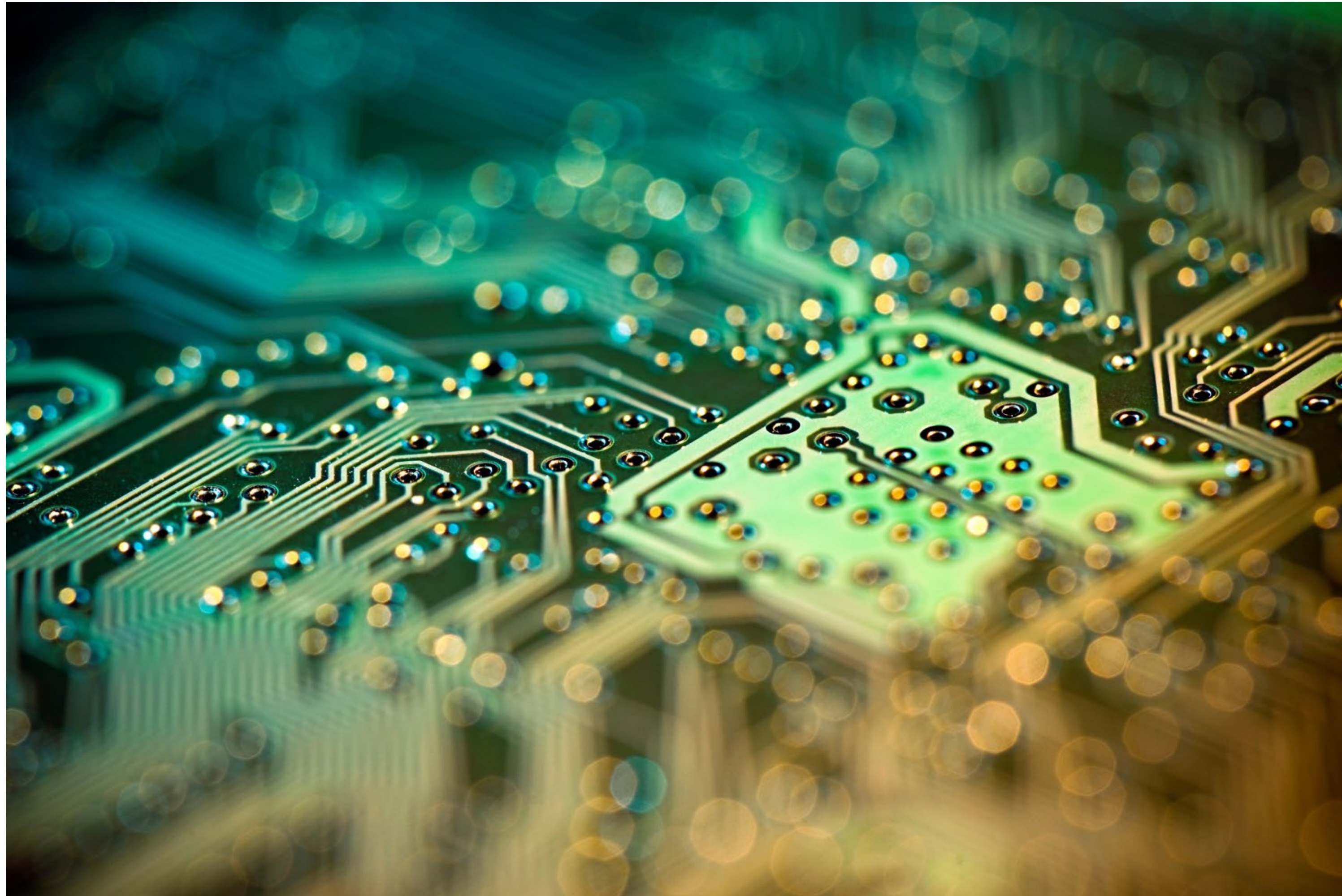
DISCHARGE PLANNING
§ 8:43F-5.4

- The plan of care shall include documented discharge planning, which shall address the participant’s changing status that may alter the appropriateness of day care and necessitate helping the caregiver to access alternative resources.
  - The plans for discharge shall be in compliance with N.J.A.C. 10:164, regarding Medicaid eligibility criteria, if applicable.
  - As part of the documented plans for discharge, the facility shall assist the participant and, if applicable, the participant's caregiver and/or family members, in accessing alternative resources.
- The participant and, if indicated, the participant's caregiver and/or family members shall assist in developing the plans for discharge.
- The facility shall maintain signed attestations by the participant or the participant's authorized representative that the facility has provided him or her with a written explanation of the facility's policies and procedures regarding discharge planning, and that he or she agrees with it.

REVIEW OF DISCHARGE CRITERIA

- When an adult beneficiary presents a change in status that facility staff document in the plan of care pursuant to N.J.A.C. 8:43F-5.4 and that may alter the beneficiary's eligibility to receive ADHS, the facility shall:
  - Discharge the beneficiary pursuant to N.J.A.C. 8:43F; or
  - Contact the Department to request a clinical eligibility assessment for that beneficiary by submitting a pre-numbered prior authorization request form in accordance with N.J.A.C. 10:164-1.3(a)3 and providing the reason for the request.

RECORDS RETENTION



RECORDS RETENTION; MEDICAL RECORDS POLICIES AND PROCEDURES

§ 8:43F-15.4

- The record shall be protected against loss, destruction, or unauthorized use. Medical records shall be retained for a period of 10 years following the most recent discharge of the participant. A summary sheet shall be retained for a period of 20 years, and X-ray films or reproductions thereof shall be retained for a period of five years, in accordance with N.J.S.A. 26:8-5.
- The facility shall develop policies regarding the specific period of time within which the medical record shall be completed following participant discharge and disciplinary action for non-compliance.
- The facility shall develop a procedure for the transfer of participant information when the participant is transferred to another health care facility.
- If the facility plans to cease operation it shall notify the Department in writing, before cessation of operation, of the location where medical records will be stored and of methods for their retrieval.

COMPLIANCE AND THE MEDICAID FRAUD DIVISION

Presented by: Tracy Livingston, Assistant Director, Data and Fiscal,
Office of the State Comptroller, Medicaid Fraud Division

ABOUT THE MEDICAID FRAUD DIVISION (MFD)

- New Jersey "Medicaid Program Integrity and Protection Act", N.J.S.A. 30:4D-53 et seq.
  - Established the Office of the Medicaid Inspector General to detect, prevent, and investigate Medicaid fraud and abuse, recover improperly expended Medicaid funds, enforce Medicaid rules and regulations, audit cost reports and claims, and review quality of care given to Medicaid recipients.
- These functions, powers and duties were later transferred to the Office of the State Comptroller (OSC), and are carried out by the Medicaid Fraud Division (MFD).

PROGRAM INTEGRITY (PI) OVERSIGHT

- Refers to the system of monitoring and auditing facilities that provide adult day health services to ensure they are:
  - billing Medicaid accurately;
  - delivering appropriate care;
  - and not engaging in fraudulent practices.

MFD OVERSIGHT FUNCTIONS

Program Integrity Oversight

- Enforce Medicaid rules and regulations
- Audit and investigate potential fraud, waste and abuse by providers and recipients
- Recover improperly expended Medicaid funds
- Coordinate PI oversight efforts among State agencies that provide and administer Medicaid services and programs.
- Exclude or terminate providers from the Medicaid program where necessary

WHY IS PI OVERSIGHT IMPORTANT?

Protecting Medicaid Funds

- helps ensure that Medicaid dollars are used effectively to provide quality care to eligible individuals.

Maintaining Quality of Care

- helps to ensure that adult day health services facilities are delivering appropriate and necessary care to patients.

CONSEQUENCES

Non-compliance with Medicaid rules, standards and regulations regarding service may constitute acts of fraud, waste or abuse of Medicaid funds.

Presented by: Yvonne Jordan, Senior Investigator, Wellpoint

WHAT IS FWA?

Fraud

- **N.J.S.A. 30:4D-55**
- An intentional deception or misrepresentation made by any person with the knowledge that the deception could result in some unauthorized benefit.

Waste

- Considered a legal violation for civil purposes and can result in a recovery of an overpayment, debarment from the Medicaid program and penalties.
- Not *usually* considered a criminal act.

Abuse

- **N.J.S.A. 30:4D-55**
- Provider practices that are inconsistent with proper, sound fiscal, business, or professional or service delivery practices.
- Practices that result in:
  - unnecessary costs to or improper payment by Medicaid; or
  - reimbursement for services that are not necessary, not approved, not documented, that are outside those specifically authorized.

FWA - EXAMPLES

Fraud

- billing for services that were not rendered
- billing for services while the member is inpatient
- transportation time used as time spent onsite

Waste

- overutilization
- misuse of resources
- overuse of supplies
- billing for services that are not medically necessary

Abuse

- services billed exceed the prior authorized approved amount

CIVIL MEDICAID FRAUD, WASTE AND ABUSE - CONSEQUENCES

- Civil judgments and liens
- Exclusion from the Medicaid/Medicare programs
- Referral for criminal prosecution
- Restitution/Recovery of overpayments
- Additional penalties in addition to repaying Medicaid overpayments

MEDICAID FRAUD DIVISION: ACTIONS, INELIGIBLE PROVIDERS, SELF-DISCLOSURES, AND THIRD PARTY LIABILITY

Presented by: Khia O’Neal, CPC, CPMA Assistant Division Director, Investigations,
Office of the State Comptroller, Medicaid Fraud Division

MFD RECOVERY ACTIONS

- Once an overpayment has been identified as a result of an investigation or audit, MFD initiates actions for recoupment of improperly paid funds, MFD may:

Send a notice of Estimated Overpayment, Notice of Intent and, Notice of Claim

Add penalties, including false claim penalties between $13,946 and $27,894 per claim

File a Certificate of Debt on real estate property owned by a provider/owner of business

Seek to withhold future Medicaid payments until the overpayment is satisfied

INELIGIBLE PROVIDERS

- An ineligible provider is someone who is excluded from participation in Federal or State funded health care programs.
  - Debarred, disqualified, suspended, or excluded providers are considered ineligible providers.
- Any products or services that an ineligible provider directly or indirectly furnishes, orders or prescribes are not eligible for payment under those programs (N.J.A.C. 10:49-11.1(b)).
- It is incumbent upon providers to perform Ineligible Provider Checks, upon hire and monthly thereafter:
  - NJMMIS Newsletter Volume 33, Number 02

MEDICAID INELIGIBLE PROVIDER LIST REQUIREMENTS

1. State of New Jersey Ineligible Provider report (mandatory): https://nj.gov/comptroller/doc/nj_debarment_list.pdf
2. Federal exclusions database (mandatory): https://exclusions.oig.hhs.gov/
3. N.J. Treasurer's exclusions database (mandatory): http://www.state.nj.us/treasury/revenue/debarment/debarsearch.shtml
4. N.J. Division of Consumer Affairs licensure databases (mandatory): http://www.njconsumeraffairs.gov/Pages/verification.aspx
5. N.J. Department of Health licensure database (mandatory):http://www.state.nj.us/health/guide/find-select-provider/
6. Federal exclusions and licensure database (optional and fee-based): https://www.npdb.hrsa.gov/hcorg/pds.jsp
7. If the provider is out of state, you must also check that state's exclusion/debarment list

SELF-DISCLOSURE

- Providers who find problems within their own organizations, must reveal those issues to MFD and return inappropriate payments. https://nj.gov/comptroller/resources/#collapseSub30/

- Affordable Care Act §6402 and N.J.A.C. §10:49-1.5 (b)(1), (7)
  - require that any overpayments from Medicaid and/or Medicare must be returned within 60 days of identifying that they have been improperly received.

- Providers who follow the protocols for a proper self-disclosure can avoid imposition of penalties.

- MFD's Self Disclosure Form: https://nj.gov/comptroller/news/docs/self_disclosure_form.pdf

SELF-DISCLOSURE PROTOCOL

- The self-disclosure must include:
  - A summary of the identified issue(s) including the underlying cause;
  - The Medicaid program rules potentially implicated;
  - The nature and extent of any investigation or audit conducted to identify and determine the amount of overpayment;
  - All corrective action(s) taken;
  - An Excel file including a detailed list of claims paid that comprise the overpayments;
  - An attestation of accuracy and completeness; and
  - The name and contact information of the individual making the report on behalf of the provider.

SELF-DISCLOSURE: STATISTICAL SAMPLING & EXTRAPOLATION

- If the self-disclosure involves statistical sampling and extrapolation:
  - Work must be performed by qualified personnel.
  - Provide an Excel file containing, at a minimum, the:
    - Sampling Plan;
    - Universe/ Sampling Frame;
    - Sample with the results of the Sample Review (i.e., for each claim indicate if it is in error, explain what the error is, and explain how much money should have been paid/ how much money was overpaid);
    - Random Numbers (used to select random sample) / Seed Number (to replicate sample);
    - Extrapolation Methodology / Output; and
    - Explanation or description of all software used to perform the sample and extrapolation.

SELF-DISCLOSURE: SAMPLING & EXTRAPOLATION RESOURCES

- OIG Self-Disclosure Protocol (discusses Sampling/ Extrapolation on pages 6-8)
  - https://oig.hhs.gov/compliance/self-disclosure-info/self-disclosure-protocol/
- OIG Statistical Sampling and Extrapolation Software: RAT-STATS
  - https://oig.hhs.gov/compliance/rat-stats/
- Medicaid Fraud Control Unit (MFCU) Sampling Guidance
  - https://oig.hhs.gov/fraud/medicaid-fraud-control-units-mfcu/files/MFCU-Sampling-Guidance.pdf
- CMS Medicare Program Integrity Manual (MPIM), Chapter 8 – Statistical Sampling for Overpayment Estimation
  - https://www.cms.gov/regulations-and-guidance/guidance/manuals/downloads/pim83c08.pdf

THIRD-PARTY LIABILITY (TPL)

- Third-Party Liability exists when any entity or party is or may be liable to pay all or part of the cost of medical assistance payable by the Medicaid program.
  - Examples: Medicare, commercial health insurance, Tricare
- By law, Medicaid is the payer of last resort. All TPL shall, if available, be used first and to the fullest extent to pay claims before Medicaid/NJ FamilyCare pays for the care of the Medicaid recipient.
- It is a violation of Section 1902(a)(25)(D) of the Federal Social Security Act to refuse to furnish covered services to any Medicaid beneficiary because of a third party's potential liability to pay for services (N.J.A.C. 10:49-7.3).

Name	Contact Information
TPL Hotline	(609) 826-4702
TPL Hotline en Español	(609) 777-2753

CASE EXAMPLES

Presented by: Ryan Thuman, Senior Investigator, Special Investigations Unit, Fidelis Care

RED FLAG AREAS

- OSC released a report titled "Adult Medical Day Care Providers Improperly Billed NJ Medicaid" on 10/31/2023 which identified the following findings:

Issue	Code Violation
Billing for services provided to beneficiaries who were also inpatient at a facility	In violation of N.J.A.C. 10:164-1.5(g)(3)
Billing in excess of five days of service in a week for an individual beneficiary	In violation of N.J.A.C. 10:164-1.6(i)
Billing for services for the same day, same service, and same beneficiary as another ADHS provider	In violation of N.J.A.C. 10:49-9.8 and N.J.A.C. 10:164-1.5(g)(1)

EXAMPLE 1

AMDC billed for services provided to beneficiaries who were also inpatient at a facility (in violation of N.J.A.C. 10:164-1.5(g)(3)):

- Data analytics identified the provider was billing for Adult Day Health Services (ADHS), despite the patients being confined to an inpatient facility during the time the services were supposedly provided.
- Discrepancies between admission and discharge dates were identified:
  - patients receiving ADHS on days they were either fully or partially hospitalized.
  - billing records show that services were provided on days when the beneficiaries were only in the hospital for part of the day, raising concerns about their legitimacy of these claims.
- In 2021 Fidelis Care (formerly WellCare) conducted an overlap project that identified a total of 61 AMDC where members received adult day health services while being in an inpatient facility.

EXAMPLE 1: SAMPLE CLAIMS

AMDC_Clm ICN Idn	Hosp_Clm ICN Idn	AMDC_Rcp Latest First Name	AMDC_Clm Service Date	AMDC_Clm Service Thru Date	Hosp_Clm Service Date	Hosp_Clm Service Thru Date	Clm Billing Prov Name	ClaimsClm Billing Prov Name	AMDC_Clm Proc Code	Hosp_Clm DRG Cde	AMDC_Recoverable _Clm Payment Amount	Hosp_Clm Payment Amount
		Recipient 1	10/13/2021	10/13/2021	10/12/2021	10/16/2021	AMDC PROVIDER		S5102	7204	$86.10	
		Recipient 2	04/20/2020	04/20/2020	04/16/2020	04/27/2020	AMDC PROVIDER		S5102	7204	$73.50	
		Recipient 3	09/02/2020	09/02/2020	09/01/2020	09/03/2020	AMDC PROVIDER		S5102	2471	$73.50	
		Recipient 4	03/15/2022	03/15/2022	03/14/2022	03/23/2022	AMDC PROVIDER		S5102	7113	$86.10	
		Recipient 5	08/12/2021	08/12/2021	08/11/2021	08/13/2021	AMDC PROVIDER		S5102	7701	$86.10	
		Recipient 6	07/12/2023	07/12/2023	07/11/2023	08/07/2023	AMDC PROVIDER		S5102	3083	$89.55	
		Recipient 7	08/31/2020	08/31/2020	08/30/2020	09/09/2020	AMDC PROVIDER		S5102	3082	$73.50	
											$568.35	

EXAMPLE 2

AMDC billed in excess of five days of service in a week for an individual beneficiary (in violation of N.J.A.C. 10:164-1.6(i))

- AMDC provider was identified as billing for services more than five days per week.
  - Policy - only 5 days of service are reimbursable within the society calendar week Sunday through Saturday.
- Data analytics revealed that this provider consistently billed for six consecutive days of service, exceeding the allowable limit.

EXAMPLE 2-SAMPLE CLAIMS

Clm ICN Idn	Rcp Name	Clm Service Date	WEEK NUMBER	Day of Week of Service Date	Clm Proc Curr Name with Mods	Clm Proc Code	Clm Payment Date (FFS)/Processing Date(ENC)	Clm Payment Amount	RECOVERABLE?	Recoverable Clm Payment Amount
	Recipient1		Week #38	MON	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	NO	-
	Recipient1		Week #38	TUE	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	NO	-
	Recipient1		Week #38	WED	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	NO	-
	Recipient1		Week #38	THU	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	NO	-
	Recipient1		Week #38	FRI	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	NO	-
	Recipient1		Week #38	SAT	MEDICAL DAY CARE VISIT	S5102	10/16/2019	$73.50	RECOVER_6th_DAY	$73.50
	Recipient2		Week #2	SUN	MEDICAL DAY CARE VISIT	S5102	08/02/2023	$86.10	NO	-
	Recipient2		Week #2	MON	MEDICAL DAY CARE VISIT	S5102	02/01/2023	$86.10	NO	-
	Recipient2		Week #2	TUE	MEDICAL DAY CARE VISIT	S5102	02/01/2023	$86.10	NO	-
	Recipient2		Week #2	WED	MEDICAL DAY CARE VISIT	S5102	02/01/2023	$86.10	NO	-
	Recipient2		Week #2	THU	MEDICAL DAY CARE VISIT	S5102	02/01/2023	$86.10	NO	-
	Recipient2		Week #2	FRI	MEDICAL DAY CARE VISIT	S5102	02/01/2023	$86.10	RECOVER_6th_DAY	$86.10

EXAMPLE 3

AMDC billed for services for the same day, same service, and same beneficiary as another AMDC provider (in violation of N.J.A.C. 10:49-9.8 and N.J.A.C. 10:164-1.5(g)(1))

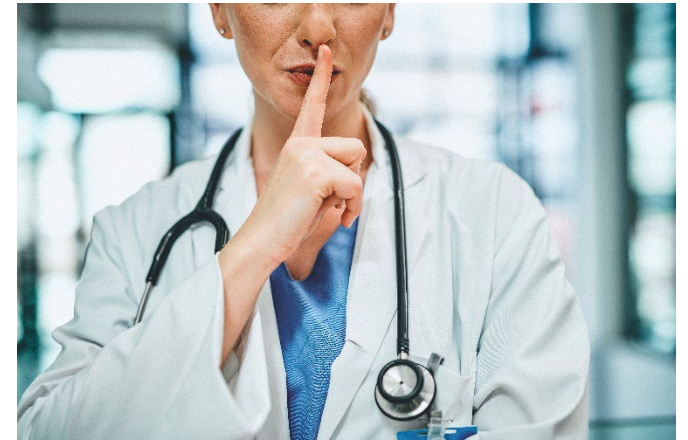
- Investigation revealed an AMDC provider was billing for the same services, on the same day, for same member as another AMDC.
- This is in direct violation of Medicaid policy N.J.A.C. 10:49-9.8 and N.J.A.C. 10:164-1.5(g)(1)), which prohibits 2 providers from billing for identical services from the same patient on the same day.
- The data analytics flagged this duplicate billing pattern, raising concerns about potentially fraudulent activity.

MEDICAID FRAUD CONTROL UNIT (MFCU)

Presented by: Sergeant Michael Rosati,
Medicaid Fraud Control Unit

MEDICAID FRAUD CONTROL UNIT (MFCU)

Medicaid Fraud is a serious crime.



- The MFCU, within the Office of the Insurance Fraud (OIFP) is the criminal oversight entity.
- MFCU investigates and prosecutes Medicaid Fraud.
- The MFCU utilizes attorneys, investigators, nurses, auditors and other support staff to police the Medicaid system.

MEDICAID FRAUD CONTROL UNIT (MFCU)

- The MFCU investigates and prosecutes alleged criminal actions:
  - Allegations of physical abuse to beneficiaries.
  - Healthcare Providers who are suspected of defrauding the Medicaid Program.
  - Fraudulent activities by providers against the Medicaid program.
  - Fraud in the administration of the program.
  - Fraud against other federally or state funded health care programs where there is a Medicaid nexus.

MEDICAID FRAUD IS THEFT. REPORT IT. END IT.

Medicaid is the nation's public health insurance program for people with low income.

Nearly 1 in 5 Americans rely on Medicaid to provide essential healthcare coverage. Over 40% of Medicaid recipients are children, and 25% of recipients are elderly or have an intellectual or developmental disability. Medicaid provides an essential healthcare safety net for the most vulnerable in our society.

Medicaid fraud is the intentional provision of false information to obtain benefits from the Medicaid program.

Fraud, abuse, and waste in the Medicaid program cost billions of dollars every year. Fraud drains resources from people who really need them including children, seniors, and people with disabilities. Fraud can include knowingly providing false information to obtain benefits, but it also includes practices that are inconsistent with acceptable fiscal, business, or medical practices that unnecessarily increase costs.

Medicaid fraud can take many forms:

- Providing false information on a Medicaid application to obtain benefits you are not entitled to
- Billing for medical services that were not provided
- Billing for medical procedures that are unnecessary or excessive
- Physician "kickbacks" for referrals
- And many more...

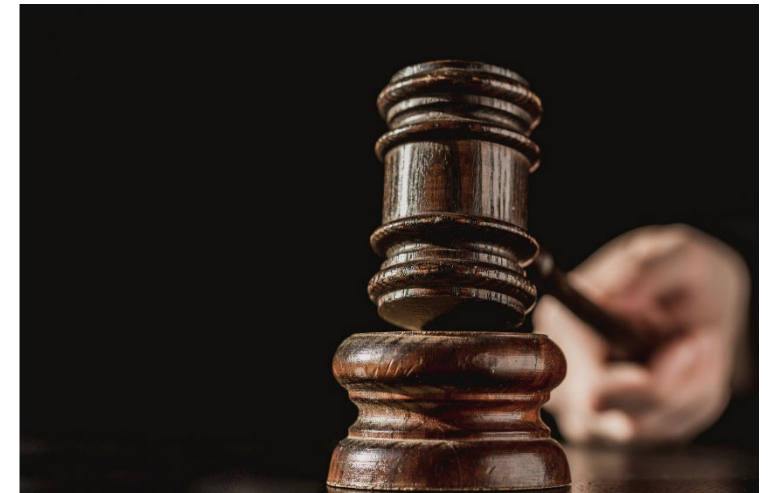
REPORT IT. END IT.

Medicaid Fraud Tip Hotline

1-609-292-1272

CRIMINAL HEALTH CARE CLAIMS FRAUD
N.J.S.A. 2C:21-4.3

- It is illegal to submit a false claim to the Medicaid program or an insurance company in order to be paid for health care services which were not received or provided.
- Punishable by up to 10 years in state prison
- In addition to all other criminal penalties allowed by law, a violator may be subject to a fine up to five times the amount of any false claims.
- Suspension or debarment from government funded healthcare programs
- Forfeiture of professional license



FALSE CLAIMS

Did you know…

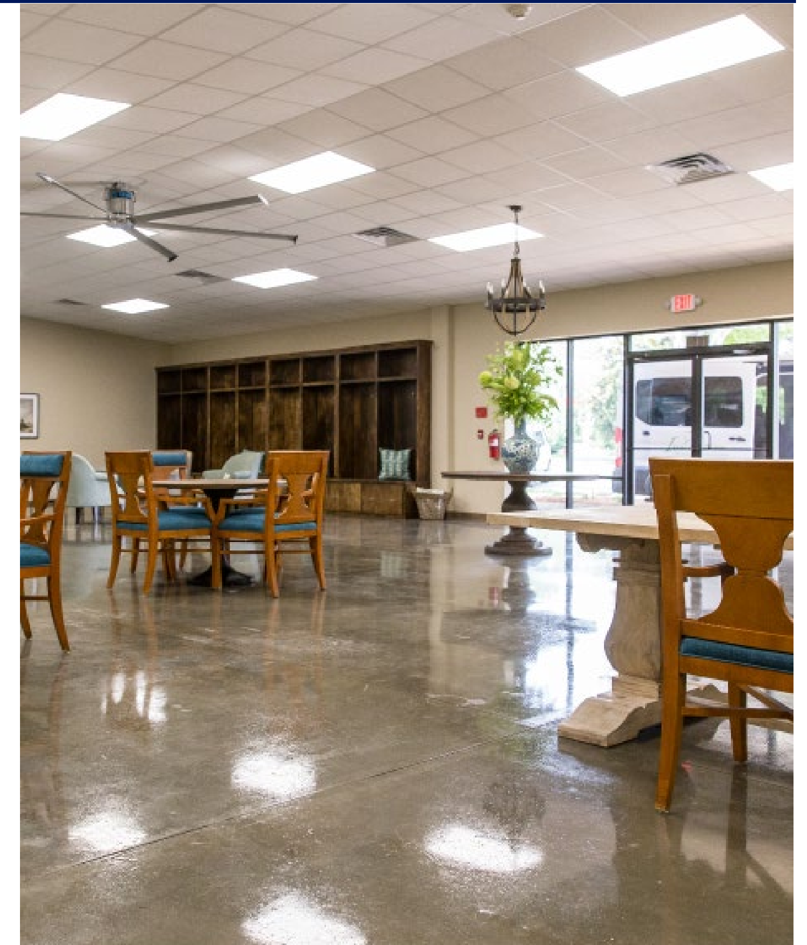
- If you are a practitioner and hold a professional license, you only need to submit one false claim to be convicted.
- Willful ignorance of the truth or falsity of a claim is not a defense.
- You can be found guilty of Health Care Claims Fraud even if your claims were not intentionally fraudulent.

MEDICAID FRAUD: IN THE NEWS

Manager of Adult Medical Day Care in Atlantic County Sentenced to State Prison for Health Care Claims Fraud

MEDICAID FRAUD: INVESTIGATION

- The Manager/Director and client outreach coordinator engaged in a fraud scheme: submitting false claims to Medicaid for Adult Medical Day Care services.
- False claims billed for:
  - Services that were not actually rendered; and
  - Services that were not medically necessary.
- Investigation included:
  - Use of an undercover officer;
    - Admissions, solicitations and real-time evidence
  - Physical surveillance; and
  - Search warrant – and review of records.



MEDICAID FRAUD: OUTCOME & PENALTIES

- The Defendant plead guilty to second-degree Health Care Claims Fraud.
  - Admitted to the submission of false claims over a four-year period.
  - Sentenced to three-years in state prison.
  - Eight-year debarment from participation in any government funded health insurance program.
  - Ordered to pay $147,076 in fines and penalties
  - The related AMDC facility went out of business

Ignorance of the law excuses no one.

It is the provider's responsibility to know the laws.

WRAP UP

FRAUD, WASTE, AND ABUSE REPORTING

Name	Contact Number	FWA Reporting Website
Aetna Better Health of New Jersey	(855) 282-8272	Aetna FWA Reporting
Fidelis Care	(866) 685-8664	Fidelis Care FWA Reporting
Horizon NJ Health	(855)-372-8320	HNJH FWA Reporting
UnitedHealthcare Community Plan	(844) 359-7736	UHC FWA Reporting
Wellpoint	(866) 847-8247	Wellpoint FWA Reporting
NJ Office of the State Comptroller, Medicaid Fraud Division	(888) 937-2835	MFD FWA Reporting
NJ Medicaid Fraud Control Unit	(609) 292-1272	NJMFCU@njdcj.org

QUESTIONS? PLEASE CONTACT US!

- Department of Health:
  - Email: CNLapps@doh.nj.gov
- Medicaid Fraud Division (MFD)
  - Email: provider-education@osc.nj.gov
  - Website: https://nj.gov/comptroller/about/work/medicaid/
- Medicaid Fraud Control Unit (MFCU)
  - Email: NJMFCU@njdcj.org
  - Website: https://www.njoag.gov/about/divisions-and-offices/office-of-the-insurance-fraud-prosecutor-home/medicaid-fraud-control-unit/

QUESTIONS?

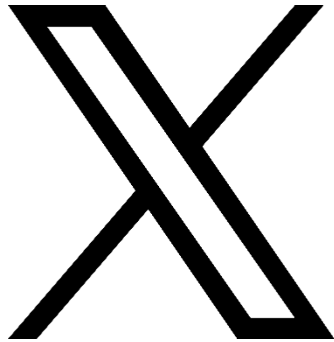
Any questions we are unable to answer today, please submit in writing to:

provider-education@osc.nj.gov

HOW DID WE DO?

Please respond to a brief poll to help us know how we did!

KEEP IN TOUCH



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