



## State of New Jersey

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OFFICE OF THE STATE COMPTROLLER  
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**PHILIP JAMES DEGNAN**  
*State Comptroller*

**JOSH LICHTBLAU**  
*Director*

September 1, 2016

### VIA CERTIFIED AND ELECTRONIC MAIL

Nancy L. Eddy, MBA, CHC  
Director of Operations Monitoring  
Fresenius Medical Care  
920 Winter Street  
Waltham, MA 02451

RE: Final Audit Report – Fresenius Medical Care d/b/a  
St. Barnabas RCG Dialysis – Livingston

Dear Ms. Eddy:

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid), the Office of the State Comptroller's Medicaid Fraud Division (OSC) conducted an audit of Fresenius Medical Care d/b/a St. Barnabas RCG Dialysis – Livingston (Fresenius – Livingston). This Final Audit Report includes OSC's findings and your response.

#### Executive Summary

The audit included a review of renal dialysis claims where beneficiaries were dual-eligible under both the Medicaid and Medicare plans. These claims were not paid consistently with the New Jersey Administrative Code (*N.J.A.C.*) 10:52-2.12 (c), which requires renal dialysis services for end stage renal dialysis (ESRD) to be reimbursed by Medicaid or NJ FamilyCare fee-for-service (FFS) only when the individual is a Medicaid or NJ FamilyCare FFS beneficiary and not a Medicare beneficiary.

During this audit, OSC determined that Fresenius – Livingston was overpaid \$10,710.30 for renal dialysis services. The overpayment resulted from instances where OSC found renal dialysis claims were billed to Medicaid, when these dual-eligible claims should have been billed to Medicare, according to the Medicaid regulations.

### **Background**

Fresenius Medical Care (Fresenius) is the parent organization of St. Barnabas RCG Dialysis – Livingston, which provides ESRD services. ESRD occurs when the kidneys are no longer able to function at a level needed for day-to-day life. Renal dialysis services are performed to improve the level of kidney function by filtering waste and fluid out of an individual's blood. Fresenius services individuals who have Medicaid, Medicare, employer group health plans, and private insurance.

### **Objective**

The objective of this audit was to determine if Fresenius – Livingston is appropriately billing Medicaid for renal dialysis services in accordance with Medicaid regulations.

### **Scope**

The scope of this audit entailed a review of Medicaid recipients with Medicare coverage where Medicaid paid for renal dialysis services. The audit period was from January 1, 2011 through November 25, 2015. The review was conducted under the authority of the *Medicaid Program Integrity and Protection Act, N.J.S.A. 30:4D-53 et seq.*, and the OSC enabling statute, *N.J.S.A. 52:15C-1, et seq.*

### **Audit Findings**

Pursuant to *N.J.A.C. 10:52-2.12 (c)*, “Renal dialysis services for ESRD and Medicare approved ‘add-on’ costs shall be reimbursable by Medicaid or NJ FamilyCare fee-for-service only when the individual is a Medicaid or NJ FamilyCare fee-for-service beneficiary and not a Medicare beneficiary, or during the time frame when ESRD services are not Medicare reimbursable.”

OSC identified 38 paid FFS claims totaling \$10,710.30 for renal dialysis services, where the beneficiary had both Medicare and Medicaid coverage. The Medicare beneficiary coverage period began on October 1, 2010, and is still active. Fresenius – Livingston should have submitted the claims for dialysis services to Medicare instead of Medicaid, since the services fall within the Medicare coverage period.

OSC seeks the recovery of \$10,710.30 from Fresenius – Livingston for services that should have been billed to Medicare and not to Medicaid in accordance with *N.J.A.C. 10:52-2.12 (c)*.

**Recommendation**

OSC recommends that Fresenius – Livingston prepare a Corrective Action Plan (CAP) that would be submitted for OSC review and approval. The CAP will specify the processes to be implemented to address the instances where certain dialysis services were billed to New Jersey Medicaid for a beneficiary who was also covered by Medicare.

**Auditee Response**

Fresenius agreed with the audit findings and has paid \$10,710.30 to the Medicaid program. In addition, Fresenius has provided OSC with a CAP that includes a process to review the status of dual-eligible beneficiaries.

Fresenius' response is attached as Appendix A.

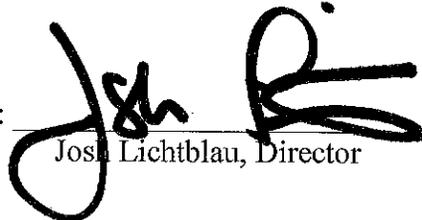
**OSC Response**

Based upon OSC's audit findings, Fresenius has paid the Medicaid program \$10,710.30. In addition, Fresenius has complied with OSC's request for a CAP. The CAP, as outlined in their response, provided processes to check the status of dual-eligible beneficiaries to ensure compliance with *N.J.A.C. 10:52-2.12 (c)* (Appendix A). Based upon Fresenius' payment and submission of an acceptable CAP, no further action is necessary.

Sincerely,

OFFICE OF THE STATE COMPTROLLER  
Medicaid Fraud Division

By:

  
Josh Lichtblau, Director

Enc.

cc: Michael McCoy, Manager of Fiscal Integrity  
Michael Morgese, Audit Supervisor



*Nancy L. Eddy, MBA, CHC, CHPC  
Director Operations Monitoring*

June 21, 2016

Sent Via USPS Overnight Mail

Josh Lichtblau, Director  
State of New Jersey  
Office of the State Comptroller  
Medicaid Fraud Division  
P.O. Box 025  
Trenton, NJ 08625-0025

**RE: Draft Audit Report -- Fresenius Medical Care d/b/a St. Barnabas RCG Dialysis - Livingston**

Dear Mr. Lichtblau:

We are in receipt of the Draft Audit Report (Exhibit B) for the above referenced dialysis clinic. We have reviewed the audit findings and are in agreement with the finding. Attached is Fresenius Medical Care check number 007585387 in the amount of \$16,629.15 for services billed to NJ Medicaid, for a beneficiary that was also covered by Medicare. Please apply a portion of this check (\$10,710.30) in repayment for services provided by St. Barnabas – Livingston, [REDACTED]

Correction Action Plan

As recommended by the Office of State Comptroller (OSC) we provide our Correction Action Plan which includes standard processes implemented to review the status of dual-eligible beneficiaries in the State of New Jersey. The process that has been implemented is outlined below:

- All Medicaid primary patients are identified on a worklist in our insurance verification clearinghouse
- Insurance verification is conducted twice per month
- Upon Medicaid notification of Medicare eligibility, Medicare eligibility is verified
- Quarterly review of all patients for insurance eligibility and change in work or home status

Sincerely,

Nancy L. Eddy  
Director Operations Monitoring

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