



STATE OF NEW JERSEY
OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

COMPLIANCE AUDIT
NEIGHBORHOOD HEALTH SERVICES
CORPORATION
FINAL AUDIT REPORT

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ACTING STATE COMPTROLLER

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Executive Summary

As part of its oversight of the Medicaid and New Jersey FamilyCare programs (Medicaid¹) the Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted an audit of Neighborhood Health Services Corporation (NHSC). NHSC is a Federally Qualified Health Center (FQHC). NHSC has a total of six locations in New Jersey which offer healthcare services to local communities.

The audit included a review of NHSC's operations for compliance with New Jersey and Federal regulations, a review of Medicaid recipients' clinical records to ascertain the services rendered at the facility, and the reconciliation of quarterly wrap-around² reports for the period audited.

From this audit, OSC determined that NHSC was overpaid and should reimburse the Medicaid program approximately \$2 million dollars. The overpayment is attributed to multiple factors. For example, NHSC did not obtain the proper approvals to operate three of its six locations in New Jersey. Also, NHSC failed to submit encounter claims to the respective Managed Care Organizations (MCOs), Amerigroup, Healthfirst, Horizon and United Healthcare, before reporting such claims to the Medicaid program. In addition, OSC noted clinical errors, duplicate billings, and ineligible recipients for whom claims should not have been paid by or on behalf of the Medicaid program.

Background

FQHC services are provided by physicians, physician assistants, advanced practice nurses, nurse midwives, psychologists, dentists and clinical social workers in accordance with New Jersey and Federal regulations. FQHCs operate in underserved communities, servicing individuals who have Medicaid, Medicare, private insurance, or no health insurance. FQHCs must provide services regardless of a patient's ability to pay or health insurance status. FQHCs are guaranteed a specific reimbursement amount for every Medicaid recipient encounter billed. A billable encounter occurs when a patient visits an FQHC, has face-to-face contact with a qualified practitioner and receives medically necessary services. FQHCs receive reimbursement either on a fee-for-service (FFS) basis directly from the Medicaid program or on a managed care basis (encounter).

FFS payments occur when a Medicaid recipient who is not enrolled in an MCO receives a medically necessary service from an FQHC. For Medicaid recipients who are enrolled in an MCO, the FQHC bills the MCO on an encounter basis. Based on the level of coverage, the MCO may pay all, a portion, or none of the encounter claim. When an MCO pays less

¹ The Division of Medical Assistance and Health Services (DMAHS) administers the state and federally funded New Jersey Medicaid and New Jersey FamilyCare programs for certain groups of low to moderate income adults and children.

² For services rendered at an FQHC, if a payment made by an MCO to the FQHC for such services is less than the total amount of the encounter claim, the Medicaid program makes a supplemental payment "wrap-around" to the FQHC to make up the difference.

than the total amount of an encounter claim, the Medicaid program makes a supplemental payment “wrap-around” to make up the difference.

FQHCs are required to submit quarterly wrap-around reports to the Medicaid program in order to receive supplemental payments for MCO encounter claims. The quarterly report documents the number of MCO encounters multiplied by the reimbursement rate per encounter, less the payments received by an FQHC from an MCO for each encounter, during the quarter. Medicaid program overpayments to an FQHC may occur when the FQHC submits overstated numbers of MCO encounters, understated MCO payments, or both.

NHSC’s six FQHC locations are comprised of a main facility located in Plainfield, New Jersey, and five satellite offices. Two of the five satellite offices (The Healthy Place & Cardinal) are located at schools in Plainfield, New Jersey, in close proximity to the main office. The remaining three satellite offices are located in Elizabeth, Newton and Phillipsburg, New Jersey. NHSC enrolled in the Medicaid program effective June 1, 1980. NHSC offers a wide array of health care services which include adult medicine, adolescent medicine, pediatrics, school-based services, obstetrics and gynecology, family planning, dentistry, health education, social services, and after-hours care.

Objective

The objective of this audit was to determine whether NHSC was operating in conformance with applicable New Jersey and Federal statutes and regulations. Also, OSC reconciled NHSC’s quarterly wrap-around reports to determine whether there were over or under payments. The audit 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.*

Scope

OSC reviewed and reconciled NHSC’s quarterly wrap-around reports, performed a clinical review of NHSC’s medical records, and ascertained NHSC’s compliance with applicable New Jersey and Federal regulations. The audit period was July 1, 2010 through June 30, 2012. The scope of the clinical review was limited to a sample of 66 recipients from NHSC’s main location in Plainfield, New Jersey.

Audit Methodology

The audit methodology included the following:

- a. Verification of Centers for Medicare & Medicaid Services (CMS) approval for NHSC to operate each location as an FQHC;
- b. Reconciliation of the quarterly wrap-around reports NHSC submitted to the Medicaid program with information NHSC submitted to MCOs for the period audited;
- c. Review of clinical notes for a statistical sample of recipients from NHSC’s main

- location in Plainfield, New Jersey;
- d. Verification of clinical practitioners' enrollment in the Medicaid program utilizing the New Jersey Medicaid Management Information System (NJMMIS);
- e. Verification of sample recipient's enrollment in the Medicaid program;
- f. Verification of the timely filing of NHSC's financial statements;
- g. Verification of the existence of contractual agreements between NHSC and physicians;
- h. Evaluation of the efficiency and effectiveness of NHSC's billing processes; and
- i. Site visits.

Any reference throughout the report relating to MCO Medicaid encounter data pertains to the encounter data that OSC obtained from NHSC on March 19, 2013. The data was validated by NHSC and consists of all encounters billed to the Medicaid program for quarterly wrap-around report payments, for services rendered during the audit period.

Audit Findings

1. Approval from Centers for Medicare & Medicaid Services (CMS) to Operate as a Federally Qualified Health Center

Pursuant to *N.J.A.C. 10:66-1.3* and *42 C.F.R. 491.5*, each FQHC, including each satellite location, is required to have an approval from CMS and the Medicaid program to operate. CMS requires the submission of a completed 855A application-Medicare Enrollment for Institutional Providers. CMS must receive, accept and approve the completed 855A application before a provider can operate as an FQHC. Also, the FQHC is required to have a copy of the 'Notice of Grant Award' which is issued by the Health Resources and Services Administration (HRSA). HRSA is a Federal agency responsible for improving access to health care by strengthening the health care workforce, building healthy communities and achieving health equity. In addition, each FQHC is required to assure CMS that it has met the requirements of *42 C.F.R. 405 Subpart X* regarding FQHC services and *42 C.F.R. Part 491, except for 491.3* regarding the certification of certain health facilities.

OSC found that NHSC's Newton, Phillipsburg, and The Healthy Place satellite locations were not approved by CMS.

Although NHSC provided OSC with copies of its 855A Medicare enrollment applications for the Newton and Phillipsburg satellite locations, OSC determined that these applications were not approved by CMS during our audit period. Based on this lack of CMS approval, OSC seeks to recover a total overpayment of \$1,022,307 for all encounter payments made for claims reported on quarterly wrap-around reports, and FFS claim payments emanating from these three facilities.

Recommendation:

OSC recommends that NHSC ensures that it completes, submits and obtains the required CMS approvals for each of its locations before it operates or submits claims for any of its locations.

2. Wrap-Around Encounter Reconciliation

FQHCs submit wrap-around reports to the Medicaid program on a quarterly basis. These quarterly reports contain the encounters and receipts for encounters paid by each respective MCO for services rendered to recipients in the Medicaid program. The Medicaid program then reimburses the FQHCs at a guaranteed reimbursement per encounter, to offset the difference between the cost to the FQHC of the services performed and the amount that the MCO reimbursed the FQHC for such services.

OSC's review of NHSC's MCO Medicaid encounter claims data for services rendered during the audit period found that the claims data submitted to Medicaid did not reconcile with the encounters that NHSC billed to the MCOs.

OSC identified 3,796 encounters that were reported to the Medicaid program on quarterly wrap-around reports that were not located in the encounter data that NHSC submitted to the MCOs. For these 3,796 encounter claims OSC seeks to recover a total overpayment of \$520,828.

Recommendation:

To ensure that NHSC only seeks wrap-around payments when warranted, OSC recommends that NHSC strengthen its internal controls over the review of encounter data submitted to MCOs by reconciling encounter data submitted to MCOs with encounter data submitted to the Medicaid program and promptly advising the Medicaid program of any errors in its quarterly submissions.

3. Clinical Review of Sample Recipients

Pursuant to *N.J.A.C. 8:43G-15.3*, healthcare practitioners who provide clinical services to patients are required to enter progress notes into the patient's medical record once the services are rendered. These notes are used to provide a full and accurate description of the care provided at the time rendered as well as evaluations in response to treatment.

Pursuant to *N.J.A.C. 10:66-1.6*, records retained by independent clinics shall fully disclose any services rendered to recipients in the Medicaid program. Recipient records shall include progress notes for each visit that supports the procedure codes billed.

Based on a statistically valid sample, OSC performed a clinical review of 66 Medicaid recipients with 676 claims totaling \$32,530. The sample was selected to determine whether the services billed by NHSC were supported by medical records. OSC noted 41 claims with errors equating to a nine percent error rate. The error rate is based on the dollar value of claim errors

in relation to the total value of sample claims. The errors are attributed to the following:

- a. There were 23 occurrences where the medical records did not support that the services billed by NHSC were rendered, resulting in a total overpayment of \$1,707.
- b. There were 14 occurrences where the servicing provider identified on NHSC's billing record did not match the servicing provider in the clinical record, resulting in a total overpayment of \$588.
- c. There were four occurrences where the provider's signature was missing on the clinical note, resulting in a total overpayment of \$548.

An extrapolation takes the error rate observed during the review of sample claims and projects that rate of error across the universe of paid claims for the audit period. OSC's extrapolation of the clinical errors over the universe of paid claims results in a cumulative overpayment of \$182,689 for encounters reported during the audit period, which OSC seeks to recover.

Recommendation:

NHSC should strengthen internal controls over physician documentation to ensure that physicians accurately record the services rendered and sign evaluations in each recipient's clinical file. Also, NHSC should strengthen internal controls over its billing process to ensure that servicing providers are accurately recorded on billing records.

4. Clinical Practitioner Services Prior to Enrollment in the Medicaid Program

Pursuant to *N.J.A.C. 10:66-1.3*, all clinical practitioners affiliated with a clinic are required to enroll in the Medicaid program in order to obtain individual Medicaid provider numbers. In addition, clinical practitioners must be credentialed by each MCO in order to provide services.

OSC's review of the records of NHSC's clinical practitioners who provided service to Medicaid recipients during the audit period revealed that seven clinical practitioners were not enrolled in the Medicaid program at the time services were rendered. Also, the seven clinical practitioners were not credentialed by the respective MCOs. These clinical practitioners were responsible for a total of 625 encounters. OSC seeks to recover for 524³ encounters totaling \$71,785.

Recommendation:

OSC recommends that NHSC strengthen controls over its processes, policies and procedures to ensure that clinical practitioners are enrolled in the Medicaid program and are credentialed by the respective MCOs before they provide any services.

³ 101 of the 625 encounters are included in the Wrap-around Encounter Reconciliation in finding #2. Consequently, to avoid duplicate recoveries, those 101 encounters are not included in this finding.

5. Fee-for-Service Claims Identified in Encounter Data

Pursuant to *N.J.A.C. 10:74-8.5*, if a recipient needs services from the Medicaid program prior to the completion of the MCO enrollment process, care shall be rendered by FFS providers who are enrolled in the Medicaid program. These providers are required to bill the Medicaid program under the normal FFS system.

OSC's review of paid FFS claims revealed that NHSC billed and received payment for 152 FFS claims directly from the Medicaid program and submitted and were paid for the same claims as encounters to the Medicaid program on quarterly wrap-around reports during our audit period. This resulted in duplicate payments for the services rendered totaling \$21,049, which OSC seeks to recover.

Recommendation:

OSC recommends that NHSC establish internal controls to identify duplicate claims. Going forward, NHSC should not include FFS claims in the quarterly wrap-around report and for any duplicate claims for which NHSC receives duplicate payments, NHSC should notify the Medicaid program of same and return all such funds.

6. Ineligible Recipients Identified in Encounter Data

Medicaid eligibility is required in order to receive funding from the Medicaid program. Federal law requires states to provide Medicaid health coverage to certain population groups and give them the flexibility to cover others. At a minimum, states must set individual eligibility criteria at federal minimum standards. These standards include residency, immigration status and Federal income guidelines.

Pursuant to *N.J.A.C. 10:49-2.10*, each Medicaid program recipient, except for nursing facility recipients, is provided a Medicaid identification number printed on either a form or eligibility card. The recipient shall present this form or card to a provider, as proof of eligibility, every time a service is to be provided.

Pursuant to *N.J.A.C. 10:74-8.1* and *N.J.A.C. 8:83-6.5*, persons eligible for the Medicaid program and eligible children who reside in geographically defined enrollment areas designated for mandatory MCO enrollment are required to enroll in the MCO of their choice. If no choice is made, an MCO shall be assigned for them.

Also, New Jersey residents are not eligible for Medicaid if they are currently receiving Pharmaceutical Assistance to the Aged and Disabled (PAAD).

OSC's review of the MCO Medicaid encounter data obtained from NHSC for the audit period found that NHSC billed the Medicaid program for recipients who did not have Medicaid identification numbers when quarterly wrap-around reports were submitted.

Specifically, OSC's review found the following:

- a. There were 45 occurrences where encounters were billed to Medicaid for 12 recipients who were participants in the PAAD program, resulting in an overpayment of \$6,184.
- b. There were 24 occurrences where encounters were billed to Medicaid for 13 recipients whose eligibility could not be verified in NJMMIS, resulting in an overpayment of \$3,305.
- c. There were 14 occurrences where encounters were billed to Medicaid for six recipients who were enrolled in the Medicaid program, but were not enrolled in an MCO on the date of service, resulting in an overpayment of \$1,923. These encounters should have been billed as FFS claims.
- d. There were 15 occurrences where encounters were billed to Medicaid for nine recipients who did not have Medicaid coverage on the date of service, resulting in an overpayment of \$2,067.

Overall, OSC identified 98 encounters totaling \$13,479 for 40 ineligible recipients and seeks to recover on 25⁴ of these encounters, for 39 recipients totaling \$3,433.

Recommendation:

OSC recommends that NHSC establish a process to identify and eliminate claims for ineligible recipients prior to submitting quarterly wrap-around reports to the Medicaid program.

Also, OSC recommends that the Medicaid program conduct ongoing reviews to ascertain that recipients reported on wrap-around reports are eligible for the Medicaid program.

7. Filing of Audited Financial Statements

Pursuant to *N.J.A.C. 10:66-4.3*, the audited financial statements of an FQHC shall be submitted to the Medicaid program within 150 days of the FQHC's fiscal year end.

OSC noted that neither the 2011 nor 2012 NHSC audited financial statements were submitted to the Medicaid program within 150 days of NHSC's June 30th fiscal year end.

Recommendation:

OSC recommends that NHSC file audited financial statements with the appropriate governing bodies in a timely manner to ensure compliance with applicable New Jersey regulations. Also, DMAHS should modify its contract with the FQHCs to include language that would enable it to impose monetary sanctions against FQHCs when they violate New Jersey regulations and requirements.

⁴ The remaining encounters are included in finding #1 Approval from CMS to operate as an FQHC and finding #2 Wrap-around Encounter Reconciliation.

In addition, OSC recommends that Medicaid strengthen its reporting process to ensure the timely submission of audited financial statements in order to assess the financial well-being of the FQHCs.

8. Contractual Agreements between NHSC and Physicians

Pursuant to *N.J.A.C. 10:66-1.3*, for a physician to be affiliated with an FQHC there shall be a contractual agreement or some other type of formal, written agreement on file at the facility by which the physician is obligated to supervise the care provided to recipients in the Medicaid program. The contract or formal agreement must indicate the physician's responsibilities and compensation.

OSC's review of NHSC's contractual agreements for physicians employed by NHSC during our period of review identified 37 of 45 physicians who did not have contractual agreements during our audit period.

Recommendation:

OSC recommends that NHSC enter into and maintain contractual agreements for all physicians in accordance with applicable New Jersey regulations and requirements. Also, DMAHS should modify its contract with the FQHCs to include language that would enable it to impose monetary sanctions against FQHCs when they violate New Jersey regulations and requirements.

9. Servicing Provider Number on Claims

Pursuant to *N.J.A.C. 10:49-3.4*, when a provider submits claims, it must separately indicate the billing provider and servicing provider number. A seven digit provider servicing number shall be assigned to all providers approved for participation in the Medicaid program and shall be entered upon all claims submitted.

OSC's review of NHSC's FFS and encounter claims during the audit period revealed that NHSC consistently used provider ID [REDACTED] for both the billing provider and servicing provider, even though these numbers should have been different because the billing provider is different from the servicing provider.

Recommendation:

OSC recommends that NHSC establish a process to ensure that physicians performing services have valid servicing provider numbers and such numbers are reflected in the billing. Also, NHSC's staff should be reminded to document servicing provider numbers on claims.

10. Billing Review

A super bill is an internal document used by NHSC to record the type of recipient visit,

diagnosis, and, if applicable, any injections, immunizations, or vaccinations administered during a visit. Super bills are used by NHSC to document MCO encounters and are considered integral to the billing process because they substantiate the services that were rendered by a practitioner.

OSC's review of super bills for the sample of 66 recipients reviewed during the audit period found the following:

- a. There were 73 instances where NHSC did not provide super bills. Nevertheless, an encounter was located in the MCO Medicaid encounter data and clinical notations substantiated that services were rendered.
- b. There were 22 instances where OSC noted that super bills existed for recipients for whom NHSC's master patient visit record had no record for that date. Nevertheless, clinical notes substantiated that services were rendered.
- c. There were four instances where super bills existed that were not supported by clinical evaluations or notes.⁵

Recommendation:

OSC recommends that NHSC strengthen its internal billing process to ensure that the information contained in super bills is comprehensive, accurate and fully consistent with the services rendered and offer training to foster accurate reporting to the Medicaid program.

Audit Observations

1. Site Visits

OSC conducted site visits at five of NHSC's locations. During these visits, OSC held discussions with various employees regarding policies, procedures, processes and practices. Site visits were conducted at NHSC's main location and at four satellite locations: The Healthy Place; Elizabeth; Newton; and Phillipsburg. OSC noted the following:

- a. Medical waste at the main location was disposed of by housekeeping.
- b. Medication administration logs were not always properly completed.
- c. An expired ambulatory care license was on display in the lobby of the Phillipsburg satellite. However, NHSC furnished a valid current license for this location to OSC.

⁵ These encounters are accounted for in the extrapolation found in finding #3 Clinical Review of Sample Recipients.

Recommendation:

OSC recommends that NHSC strengthen its policies, procedures, processes and practices for the proper disposal of medical waste, medication administration and the display of a current license at each location.

2. Electronic Billing System

NHSC implemented an Electronic Health Record System (EHR) effective June 1, 2012 for dental services. The EHR will foster timely and accurate reporting of dental encounter data to the Medicaid program. OSC noted the following:

- a. NHSC did not include dental encounters for NHSC's Newton and Elizabeth locations prior to June 2012 in the MCO Medicaid encounter data.

Recommendation:

OSC recommends that NHSC consider an independent validation of the EHR system to ensure the accuracy and reliability of electronic health records.

Auditee Response

Please see Appendix A for NHSC's response.

Comptroller's Notes on Auditee Response

Please see Appendix B for the Comptroller's response to auditee.

Appendix A



Neighborhood Health Services Corporation

Neighborhood Health Center Plainfield
1700-58 Myrtle Avenue
Plainfield, New Jersey 07063
908.753.6401

Neighborhood Health Center Elizabeth
184 First Street
Elizabeth, New Jersey 07206
908.355.4459

Neighborhood Health Center The Healthy Place
427 Darrow Avenue
Plainfield, New Jersey 07060
908.731.4288

Neighborhood Health Center Phillipsburg
427-429 South Main Street
Phillipsburg, New Jersey 08865
908.454.4600

Neighborhood Health Center Newton
238 Spring Street
Newton, New Jersey 07860
973.383.7001

Neighborhood Health Center Cardinal
950 Park Avenue
Plainfield, New Jersey 07060
908.754.5840

May 29, 2015

Mr. Brandon Peay, CFE
Auditor, Medicaid Fraud Division
Office of the State Comptroller
20 West State Street, 4th Floor
Trenton, New Jersey 08625

Re: Audit response to March 10, 2015 Draft Audit Report

1. Approval from Centers for Medicare & Medicaid Services (CMS) to operate as a Federally Qualified Health Center

OSC Findings: Unable to confirm CMS approval for The Healthy Place, NHC Newton and NHC Phillipsburg to operate as FQHCs. OSC is requesting \$1,022,307 in recovery.

NHSC Response: NHSC submitted CMS 855A applications for NHC Newton and NHC Phillipsburg to CMS to participate as Medicare providers. During the audit period, July 1, 2010 to June 30, 2012, the applications were not finalized and NHSC did not bill or receive any reimbursement from Medicare for services at these sites during this period. OSC is seeking recovery of payments made through Medicaid because the CMS approvals to qualify for FQHC reimbursement were not available during the audit to cover the audit period. NHSC has subsequently received the CMS approval letters for NHC Newton and NHC Phillipsburg. Copies are attached.

NHSC was a valid Medicaid provider during the audit period for NHC Newton and NHC Phillipsburg and the approval letters from Molina to participate in Medicaid were accepted by OSC in 2013. NHSC did not bill Medicare for any services during the audit period or receive payment for any Medicare services during the audit period. The payments received by Medicaid were based on NHSC's FQHC status for NHC Newton and NHC Phillipsburg. NHSC is requesting that consideration be given to the difference between the Medicaid reimbursement rate and the FQHC Medicaid reimbursement rate. Since NHSC has confirmation of its enrollment and participation as a Medicaid provider, it is our position that the entire claim reimbursement should not be subject to recapture.

NHSC is a non-profit organization serving vulnerable patient populations for over forty-five years. At this time, NHSC is struggling to maintain financial solvency and filed for bankruptcy reorganization on January 7, 2015. The potential of a one million dollar assessment will create a significant hardship for NHSC's continued service to its communities.

NHSC is aware of the importance of compliance with all federal, state and local regulations and will continue to make improvements in this area as part of the reorganization. Any consideration to reduce or eliminate the financial impact of the administrative non-compliance with this regulatory requirement will be greatly appreciated.

2. Wrap-Around Encounter Reconciliation

OSC Findings: 4,069 encounters were not submitted to the Managed Care Organizations (MCOs) prior to submission to the State of NJ Medicaid program for Wraparound processing. OSC is requesting \$558,553 in recovery.

NHSC Response: NHSC contends that the encounters were correctly submitted to the MCOs and processed prior to submission to the State of NJ Medicaid program. To date, NHSC has provided over 400 examples of encounters showing MCO processing and in some instances payments. NHSC is requesting that OSC remove this finding and associated request for financial recovery.

3. Clinical Review of Sample Recipients

OSC Findings: 41 claims identified with missing, incomplete or inaccurate medical records. OSC is requesting \$288,837.

NHSC Response: NHSC has identified 34 progress notes from patient medical records. Copies attached as Appendix 3. Please review and update audit findings.

4. Clinical Practitioner Services prior to enrollment in the Medicaid program

OSC Findings: 7 clinical providers were not enrolled in Medicaid program and/or credentialed by the MCO at the time services were rendered. OSC is requesting \$71,785 in recovery.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to ensure that all clinical providers are enrolled in the Medicaid program and are credentialed by the respective MCOs.

5. Fee for service claims identified in encounter data

OSC Findings: 214 Fee for Service (FFS) claims submitted to State Medicaid program for Wraparound processing. These patients were identified by OSC as FFS or "straight" Medicaid patients, which would be ineligible for submission for Wraparound processing. OSC is requesting \$29,363 in recovery.

NHSC Response: NHSC has identified 19 claims for patients who were enrolled in an MCO on the date of service; these claims were eligible for Wraparound processing. Copies attached as Appendix 5. Please review and update audit findings.

6. Ineligible recipients identified in encounter data

OSC Findings: 98 encounters reviewed for recipients ineligible for Medicaid and/or ineligible for Medicaid on date of service. OSC is requesting \$3,433 in recovery.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to identify and eliminate ineligible participants prior to submitting quarterly Wraparound reports.

7. Filing of Audited Financial Statements

OSC Findings: The 2011 and 2012 FYE Audited Financial Statements were not submitted within 150 days of NHSC's June 30th fiscal year end.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to ensure timely filings.

8. Contractual agreements between NHSC and Physicians

OSC Findings: 37 physicians did not have active contractual agreements during the audit period.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to ensure all provider contracts are kept up to date.

9. Servicing provider number on claims

OSC Findings: NHSC used facility provider ID [REDACTED] for both the billing provider and servicing provider.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to ensure that the correct servicing provider IDs are used for all claim submissions.

10. Billing Review

OSC Findings: Several instances were noted where super bills were missing but clinical records existed to substantiate the billing. There were 4 instances where super bills were produced but clinical notes were found.

NHSC Response: NHSC agrees with this finding and will follow OSC recommendations to strengthen internal controls to strengthen billing processes and provide staff training to foster accurate reporting to the Medicaid program.

Audit Observations

A. Site Visits

OSC Observations A: Medical waste at the main location is disposed of by housekeeping.

OSC Observations B: Medication administration logs were not always properly completed.

OSC Observations C: Expired ambulatory care license on display at NHC Phillipsburg. Valid license provided to OSC during the visit.

NHSC Response A: Medical waste is properly disposed of by Facilities staff in accordance with CDC, OSHA and other regulatory bodies.

NHSC Response B: NHSC will review internal policies and practices regarding the medication administration logs. Effective December 2012, NHSC discontinued maintenance and distribution of sample medications.

NHSC Response C: NHSC will review its policies, procedures and processes regarding the proper display of current licenses at all sites.

B. Electronic Billing System

OSC Observations: NHSC did not include all Dental encounters for NHC Newton and NHC Elizabeth prior to June 2012.

NHSC Response: NHSC agrees with and will implement independent validation of electronic health records to ensure accuracy and reliability of EHR records.



State of New Jersey

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APPENDIX B

Neighborhood Health Services Corporation Audit Report

Comptroller's Notes on the Auditee's Response

Finding #1

The finding remains unchanged because NHSC did not meet the requirements established in New Jersey regulations. Pursuant to *N.J.A.C 10:66 1.3 (c)(2)*, Federally qualified health centers are required to obtain approval from the Centers for Medicare & Medicaid Services (CMS) as Federally qualified health centers and licensure by the New Jersey Department of Health and Senior Services for participation in the New Jersey Medicaid and New Jersey FamilyCare programs before receiving reimbursement for services. OSC understands NHSC did not bill or receive any reimbursement from Medicare for services rendered in NHSC's Newton and Phillipsburg locations during OSC's audit period. However, that does not change the fact that NHSC was required to have obtained approval from CMS to have participated and been reimbursed for services in the Medicaid program and it had not done so for its Newton, Phillipsburg and the Healthy Place satellite locations during the period referenced in this finding. The scope of OSC's audit and findings were limited to Medicaid payments and adherence to the New Jersey regulatory requirements and, thus, these findings remain unchanged.

Finding #2

OSC made adjustments to this finding to the extent new NHSC documentation was supported by MCO data.

Finding #3

A majority of the progress notes were previously reviewed by OSC's Medical Review Analyst. However, changes were made where warranted by new progress notes that the provider

furnished. Additionally, the total recovery for this finding was reduced based on updates to the OSC extrapolation methodology.

Finding # 5

OSC considered new information furnished by the provider and reduced the recovery amount attributed to this finding accordingly.

The provider agreed with the findings that were not referenced above.