STATE OF NEW JERSEY

OFFICE OF THE STATE COMPTROLLER
MEDICAID FRAUD DIVISION

COMPLIANCE AUDIT

SOUTH JERSEY EXTENDED CARE
FINAL AUDIT REPORT

A. Matthew Boxer
COMPTROLLER

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Executive Summary

As part of its oversight of the Medicaid and New Jersey FamilyCare programs, the Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted a limited scope pilot audit of South Jersey Extended Care (South Jersey). The audit involved Medicaid recipients residing in a long term care facility who were also eligible for Medicare benefits (dual eligible). We reviewed claims which identified recipients for whom Medicaid was improperly billed for skilled services while they were residing in the long term care facility (LTC).

Molina Medicaid Solutions (Molina) is the State's fiscal agent and assists the State in meeting current and future Medicaid Information Technology Architecture (MITA) and regulatory healthcare requirements. Molina developed an algorithm that identified dually eligible Medicaid and Medicare recipients for whom skilled services should have been covered by Medicare. Testing was limited to verifying Medicare utilization, leave of absence days, and recipients' date of death.

During our audit, OSC determined that South Jersey was overpaid for 2 claims totaling $3,669 and 14 days of service totaling $2,802 because Medicare benefits were available at the time Medicaid was billed.

Background

South Jersey is a LTC located in Bridgeton, NJ. The facility enrolled in the New Jersey Medicaid program effective December 1, 1984. South Jersey provides rehabilitative and long term care to its patients.

An algorithm produced by Molina identified potential recipients for whom the periods of skilled service should have been reimbursed by Medicare. Medicare uses a period of time referred to as a benefit period, to keep track of how many days of skilled nursing facility (SNF) benefits a recipient uses, and how many are still available. Medicare recipients can get up to 100 days of SNF coverage in a benefit period.

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

Objective
The objective of this audit was to examine claims which our records indicated should have been paid by Medicare. 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 52:15C-23.

Scope
The scope of this audit was limited to a review of 17 dual eligible Medicare/Medicaid recipients with claims totaling $78,128. Our records indicated that these recipients received skilled care; however, Medicaid was billed for this service although the recipients had Medicare eligibility and the Medicare benefit periods were not exhausted at the time of service. South Jersey was given the opportunity to submit evidence that these claims were submitted to and denied by Medicare, and to provide any other documentation deemed necessary to support the apparent premature billings to Medicaid.

Audit Test Work
Testing was limited to the following:

a) Verification of Medicare utilization days (Reviewed recipients' benefit periods and days of Medicare eligibility available.)
b) Verification of leave of absence days (Periods when recipients were not in a nursing facility.)
c) Verified there were no payments for service after a recipients' date of death.

Review of Clinical Documentation
A review of the 17 recipients' clinical records was performed by a qualified Medical Review Analyst (MRA) within Medicaid Fraud Division's Investigations Unit (Investigations), to determine the degree of care (skilled or custodial) received by the recipients.

Audit Findings
Based on Investigations review of the recipients' records, the following audit findings were noted:

I. MFD determined that the Medicaid program overpaid South Jersey for 2 claims totaling $3,669. The reason for this overpayment is South Jersey prematurely billed Medicaid for 1 of the 17 recipients in the sample when the recipient was eligible for Medicare and the Medicare benefit period was not utilized at the time of service.

II. MFD determined that the Medicaid program overpaid South Jersey for 14 days totaling $2,802. The reason for this overpayment is South Jersey prematurely billed Medicaid for 2 of the 17 recipients in the sample when 14 days of skilled care were rendered and the Medicare benefit period was not exhausted.

Recommendation

Based on our audit findings, MFD recommends that South Jersey reimburse the Medicaid program $6,471 because Medicare benefits were not exhausted during the audit period when these claims were paid by Medicaid. This amount includes the totals referenced in I and II above.

Response

We will adjust the two claims. Bill as identified for the fourteen (14) days and reimburse Medicaid the $6,471.

Conclusion

We have reviewed the provider's response. The total amount of $6,471 has been paid in full. The provider should ensure that Medicare benefits are exhausted before billing Medicaid for skilled services in the future.