DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Washington, D.C. 20201

MAR 24 2003

TO: Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette
Deputy Inspector General for Audit Services

SUBJECT: Office of Inspector General's Partnership Plan – New Jersey Office of the State Auditor's Report on *Department of Health and Senior Services, Division of Consumer Support, Medical Assistance to the Aged, Medical Day Care Program* (A-02-02-01026)

As part of the Office of Inspector General's partnership efforts with state auditors, we are transmitting the final report entitled, "Department of Health and Senior Services, Division of Consumer Support, Medical Assistance to the Aged, Medical Day Care Program." The audit addressed the state of New Jersey, Department of Health and Senior Services' (DHSS) administration of the Medical Day Care (MDC) program during the period July 1, 2000 to October 31, 2002. The New Jersey Office of the State Auditor (OSA) performed the review in conjunction with the Department of Health and Human Services, Office of Inspector General (OIG). The report was issued to the New Jersey State Legislature on February 25, 2003.

Our work relative to the OSA report was conducted as part of the continuing partnership efforts with state auditors to expand audit coverage of the Medicaid program. We have performed sufficient work to satisfy ourselves that the attached audit report can be relied upon and used by the Centers for Medicare & Medicaid Services (CMS) in meeting its program oversight responsibilities. As part of the review, we assisted the OSA by providing support and guidance as contained in the OIG's federal/state partnership plan. In addition, we provided OSA with research data and participated in many of the site visits to MDC providers. We suggest you share this report with the CMS components involved with program integrity, provider issues, and state Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objectives of the audit were to determine whether payments to MDC providers for health related services were reasonable, related to the department's programs, and recorded properly in the accounting system during the period July 1, 2000 to October 31, 2002. The OSA found that DHSS payments to MDC providers were related to the department's programs and were recorded properly in the accounting system. However, they could not determine the reasonableness of the cost of the MDC program due to program regulations not adequately defining the population to be served. Without explicit regulations defining the types of medical conditions which warrant MDC services, any medical condition diagnosed by a physician would be sufficient to enroll an individual in the program. In addition, OSA found DHSS was not aware that 78 MDC providers received $6 million in payments by participating in the

Department of Agriculture's Child and Adult Food program. The payments represent reimbursement of costs that are also included in the per diem rates made to the providers by DHSS. Further, OSA determined that DHSS had inadequate controls over provider reimbursements. As a result, the DHSS may have made approximately $619,000 ($309,500 federal share) in improper payments to MDCs during the audit period. Moreover, OSA identified claims totaling approximately $1 million ($500,000 federal share), which had potential conflicts due to the providers' billing methods.

The New Jersey state auditors recommended that DHSS:

- Immediately redefine existing regulations to clearly state eligibility requirements for participation in MDC services and adequately define the types of medical conditions which warrant services to ensure only the intended population is served.

- Reinstate its preadmission screening process to evaluate clients in order to determine the necessity, appropriate level, and frequency of MDC services. Participants not eligible for MDC could be referred to programs requiring less intensive medical services.

- Specify in the regulations that providers maintain detailed attendance records including the client's arrival and departure times for the program. The DHSS should also require that clients sign daily attendance sheets acknowledging that they were at the facility for the time specified. These records should be reviewed in conjunction with the DHSS on-site inspections.

- Require providers to send cost information in a standard format to facilitate DHSS' analysis of the financial information. The department should determine the cost and level of services being provided and the best methodology for reimbursing providers for services rendered.

- Require that all MDC providers participate in the Department of Agriculture's Child and Adult Food program and adjust the daily reimbursement rates to reflect payments made for food.

- Review all owners, sponsors, and staff members of pediatric MDC centers. Implement procedures to check owners of adult day care centers against the databases accessible to the Department of Human Services, Bureau of Program Integrity to determine whether owners have a criminal record. In addition, the department should implement procedures to, at a minimum, randomly perform background checks on facility employees.

- Make modifications to the administrative code to remove all conflicting regulations to ensure that program objectives and Medicaid requirements for the MDC program are being met by each office. The DHSS should also perform inspections of the pediatric MDCs.

- Fix responsibility and develop proper procedures to address the investigation and disposition of claims highlighted by edits in the automatic payment system.

  Specifically, DHSS should:

  1. Implement a system to monitor claim payments to determine their accuracy and propriety.

  2. Investigate the identified irregularities and collect any overpayments.

- Require uniformity in billing practices among providers indicating specific days that services were rendered.

The DHSS officials agreed with the report's recommendations and indicated steps they have taken or will take to implement the recommendations.

As we do with all audit reports developed by non-federal auditors, we have provided as an attachment, a list of coded recommendations for use by your staff in working with the state to resolve findings and recommendations through your stewardship program. The attachment provides a summary of the recommendations contained in the OSA audit report for the 28-month period ended October 31, 2002.

If you have any questions about this review, please let me know or have your staff contact George M. Reeb, Assistant Inspector General for the Centers for Medicare and Medicaid Audits, at (410) 786-7104.

Attachments

Attachment
A-02-02-01026

Summary of Recommendations
Contained in OSA Report

Recommendation Codes	Page	Federal Share Amount	Resolution Agency	Recommendations
30691910	5	N/A	CMS	1. Immediately redefine existing regulations to clearly state eligibility requirements for participation in MDC services and to adequately define the types of medical conditions which warrant services to ensure only the intended population is served.
29991910	8	N/A	CMS	2. Reinstate its preadmission screening process to evaluate clients in order to determine the necessity, appropriate level, and frequency of MDC services.
31791910	9	N/A	CMS	3. Specify in the regulations that providers maintain detailed attendance records including the client's arrival and departure times for the program. The DHSS should also require that clients sign daily attendance sheets acknowledging that they were at the facility for the time specified. These records should be reviewed in conjunction with the DHSS on-site inspections.

20991910	10	N/A	CMS	4. Require providers to send cost information in a standard format to facilitate DHSS' analysis of the financial information. The DHSS should determine the cost and level of services being provided and the best methodology for reimbursing providers for services rendered.
20534202	11	$3,000,000	CMS	5. Require that all MDC providers participate in the Department of Agriculture's Child and Adult Food program and adjust the daily reimbursement rates to reflect payments made for food.
21291910	12	N/A	CMS	6. Review all owners and sponsors and staff members of pediatric MDC centers. Specifically: • Implement, for adult day centers, procedures to determine whether owners have a criminal record. • Implement procedures to, at a minimum, randomly perform background checks on facility employees.
33190810	13	N/A	CMS	7. Make modifications to the administrative code to remove all conflicting regulations to ensure that each office is meeting program objectives and Medicaid requirements for the MDC program.

				Additionally, DHSS should perform inspections of the pediatric MDCs.
20400903	15	$309,500	CMS	8. Fix responsibility and develop proper procedures to address the investigation and disposition of claims highlighted by edits in the automatic payment system. Specifically: • Implement a system to monitor claim payments to determine their accuracy and propriety. • Investigate irregular claims totaling $619,000 ($44,000 paid for deceased beneficiaries, $99,000 for duplicate claims, $410,000 for services exceeding the maximum allowed days per week, and $66,000 for days paid when beneficiaries were in a hospital) and collect any overpayments.
20400902	15	$500,000	CMS	9. Require uniformity in billing practices amongst the providers indicating specific days that services were rendered.

New Jersey State Legislature
Office of Legislative Services
Office of the State Auditor

Department of Health and Senior Services
Division of Consumer Support
Medical Assistance to the Aged
Medical Day Care Program

July 1, 2000 to October 31, 2002

Richard L. Fair
State Auditor

New Jersey State Legislature

OFFICE OF LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR
125 SOUTH WARREN STREET
PO BOX 067
TRENTON NJ 08625-0067

ALBERT PORRONI
Executive Director
(609) 292-4625

RICHARD L. FAIR
State Auditor
(609) 292-3700
FAX (609) 633-0834

The Honorable James E. McGreevey
Governor of New Jersey

The Honorable John O. Bennett
President of the Senate

The Honorable Richard J. Codey
President of the Senate

The Honorable Albio Sires
Speaker of the General Assembly

Mr. Albert Porroni
Executive Director
Office of Legislative Services

Enclosed is our report on the audit of the Department of Health and Senior Services, Division of Consumer Support, Medical Assistance to the Aged, Medical Day Care Program for the period July 1, 2000 to October 31, 2002. If you would like a personal briefing, please call me at (609) 292-3700.

February 25, 2003

Table of Contents

Department of Health and Senior Services
Division of Consumer Support
Medical Assistance to the Aged
Medical Day Care Program

Scope

We have completed an audit of the Department of Health and Senior Services, Division of Consumer Support, Medical Services for the Aged, Medical Day Care (MDC) Program for the period July 1, 2000 to October 31, 2002. Our audit included financial activities accounted for in the state's General Fund and Casino Revenue Fund for payments to medical day care facilities for Medicaid recipients. Expenditures are funded by the federal government at a 50 percent rate. The annual federal and state expenditures for these programs were approximately $85 million for 8,000 recipients.

Objectives

The objectives of our audit were to determine whether payments to MDC providers for health related services were reasonable, were related to the department's programs, and were recorded properly in the accounting system.

The audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States.

In preparation for our testing, we studied legislation, administrative code, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of financial transactions. We researched industry and governmental publications and audit reports from other states. We also read the budget

message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and internal controls. We also reviewed "Adult Day Health Services: A review of the Literature" prepared by Rutgers Center for State Health Policy (August 2002).

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Transactions were judgmentally selected.

The audit was conducted in conjunction with the US Department of Health and Human Services, Office of the Inspector General, Office of Audit Services (OIG,OAS). The OIG, OAS participated in the planning of the engagement and in many of the provider visits. The results of the audit will be provided to the OIG, OAS.

Conclusions

We found the payments to Medical Day Care providers were related to the department's programs and were recorded properly in the accounting system. However, we could not determine the reasonableness of the cost of the Medical Day Care Program due to program regulations not adequately defining the population to be served. Without explicit regulations defining the types of medical conditions which warrant MDC services, any medical condition diagnosed by a physician is sufficient to enroll an individual in the program. This program has apparently evolved from providing services as an alternative to nursing home care to providing services to any participant eligible for Medicaid and some providers are actively recruiting from senior housing to fill their allotted slots through the use of advertising circulars and open house visits. Although the department had enacted a moratorium on licensing new facilities, we found that providers who had filed their applications prior to the moratorium were still being processed for licensure. As of February 2003, 52 new facilities with a

capacity of 5400 slots have been approved. This could increase the program's participants by approximately 70 percent and program expenditures by $60 million. Existing regulations should be redefined to clearly state eligibility requirements for participation in MDC services. Participants not eligible for MDC services could be referred to programs requiring less intensive medical services.

In making this determination, we also found the department needs to implement controls over provider reimbursements to prevent improper payments from being processed. In addition, the department needs to improve its program oversight function.

Background

The Medical Day Care (MDC) Program was established to provide medically supervised, health-related services in an ambulatory care setting to persons who are non-residents of the facility, and who, due to their physical and/or mental impairment, need health maintenance and restorative services supportive to their community living. The services are to be provided for five hours per day for a maximum of five days per week. These services are directed at adults who do not require 24-hour inpatient institutional care. Participants are enrolled in the program by providers based on a physician's diagnosis.

Additionally, pediatric MDC services are to be available only for technology-dependent and/or medically unstable children who require ongoing care of a licensed practical or registered nurse in a developmentally appropriate environment.

New Jersey reimburses MDC providers on a per diem rate based on nursing home rates. Currently, these rates average $64 for adults and $222 for pediatric clients. The reimbursement of MDC provider claims is based on the premise that the information submitted by the facility is accurate.

Expenditures are funded by the federal government at a rate of 50 percent. The program has increased from 66 providers servicing 3000 clients at a cost of $27 million in fiscal year 1997 to 124 providers servicing 8000 clients at a cost of $85 million in fiscal year 2002. The department enacted a moratorium on licensing new facilities due to the number of applications filed with the department and the results of their surveys of MDC facilities which indicated significant licensure violations. However, 52 providers who had filed their applications prior to the moratorium were approved by the department and their licensure process is still continuing.

Eligibility Regulations

Regulations should be redefined to clearly state eligibility requirements to participate in MDC services.

The MDC program is authorized under Medicaid and was transferred to Department of Health and Senior Services from the Department of Human Services during a reorganization in 1996. There are two sets of regulations in existence for this program. These rules are not consistent and do not adequately define the types of medical conditions which warrant MDC services. The program has evolved to where services are being provided to any participant eligible for Medicaid.

Revisions to the administrative code were proposed in 1999. However, due to a number of negative comments these revisions were withdrawn and a task force comprised of department personnel and industry representatives was convened in spring 2000 to address these issues.

An internal review committee was convened to replace the task force in July 2002 for the purpose of amending the rules. To date no revisions have been adopted and no time frame has been established for the work of the committee to come to fruition.

Recommendation

We recommend the department immediately redefine existing regulations to clearly state eligibility requirements for participation in MDC services and to adequately define the types of medical conditions which warrant services to ensure only the intended population is served.

Auditee's Response

The department concurs with the recommendation and is presently in the process of completing a draft of amendments to N.J.A.C. 8:86 which will set forth conditions which an adult must satisfy in order to be eligible for adult day health services.

Prior Authorization for Services

The department should reinstate its preadmission screening process to determine the necessity, appropriate level, and frequency of MDC services.

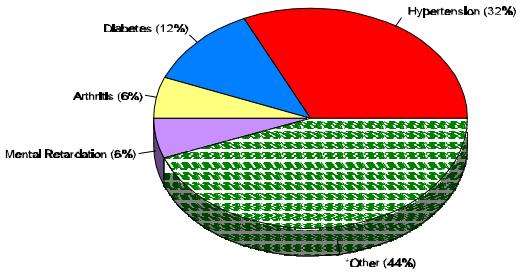
Originally, prior authorization by medical district office professional staff was a requirement before a client could receive MDC services. The prior authorization process, which could act as a significant anti-fraud measure to better ensure appropriate utilization of the service, was eliminated in March 1991 in the Department of Human Services' effort to encourage growth in the industry. Currently MDC services rendered are based on any diagnosis from a physician and the providers' evaluations of the clients.

National surveys have shown that the most commonly reported diagnoses among MDC program participants included Alzheimer's Disease or some type of dementia disorder, mental retardation or developmental disability, chronic mental illness, or some type of physical problems such as stroke, heart disease, hypertension or diabetes. Many were functionally dependent, needing assistance with anywhere from one to three activities of daily living (ADLs), including either toileting or eating. ADLs are defined as the functions or tasks of self-care, including at least mobility, transferring, walking, grooming, bathing, dressing and undressing, eating, and toileting. ADLs measure clients' dependency and are used to determine eligibility for nursing home admissions by DHSS in their assessment tools.

Our review of diagnosis codes on billing documents submitted by New Jersey MDC providers indicated the primary diagnoses for clients participating in the program were hypertension, diabetes, arthritis, and mental retardation.

Summary of MDC Services by Diagnosis Code

*Other is comprised of many diagnoses that were each 4 percent or less of the total.



In December 2001, the department performed an inspection blitz of 22 licensed MDC centers. The unannounced inspections included a review of client eligibility. Seventeen centers had significant eligibility issues. The inspectors found that of 188 clients reviewed, 144 or 77 percent were determined ineligible for MDC services based on the set of regulations set forth by the department that included ADLs.

During our visits to eight MDC providers, we reviewed the medical records for a sample of clients attending the facilities with comparable results. The providers' nursing assessments indicated that 71 of 106 clients reviewed were not dependent on the providers' care staff for any ADLs.

The above suggests that without explicit regulations defining eligible conditions and a prescreening mechanism, a client could be enrolled at an MDC facility based on a physician's diagnosis which may not warrant MDC services. Prior authorization and evaluation of clients would determine the necessity, appropriate level, and frequency of services. Currently, 12 other states require pre-admission screening by state health officials prior to receiving services.

We reviewed client charts to determine the diagnosing physicians. At one provider, 27 of the 30 randomly selected clients attending the facility were diagnosed by the same personal physician. Another provider's records indicated that 82 of the 120 clients attending the center were diagnosed by the same physician. The department does not have adequate controls in place to provide assurances that the diagnosing physician or physician's immediate family does not have significant beneficial interest in the facility. Such interests are required to be disclosed by the physician pursuant to N.J.S.A. 45:9-22.5.

Recommendation

We recommend the department reinstate its preadmission screening process to evaluate clients in order to determine the necessity, appropriate level, and frequency of MDC services. Participants not eligible for MDC could be referred to programs requiring less intensive medical services.

Auditee's Response

The department is presently in the process of reviewing its options regarding a prior authorization policy.

Attendance Records

Attendance records should provide sufficient documentation to ensure clients are receiving the level of services required by law.

The MDC providers are required to maintain various types of records, including an attendance record. Although providers maintained daily attendance records, the records at four of six adult centers visited did not provide adequate assurance of attendance by the recipients for the days noted.

These attendance records reviewed did not have clients' signatures documenting or acknowledging they received services or the times of arrivals or departures from the center. Since the department does not review attendance records, it has no assurances that clients received the five hours of services that are required and paid for by the

program. This lack of internal control is compounded when MDC facilities are located in the same building as senior residential centers.

We reviewed the attendance records at eight providers. At one facility, 67 clients appearing on attendance sheets were never picked up by the facility's bus drivers according to the transportation logs. The provider was paid $4,200 for those clients for the two days reviewed.

Recommendation

We recommend the department specify in the regulations that providers maintain detailed attendance records including the clients' arrival and departure times for the program. The department should also require that clients sign daily attendance sheets acknowledging that they were at the facility for the time specified. These records should be reviewed by DHSS in conjunction with their on-site inspections.

Auditee's Response

The department agrees with the recommendation and is in the process of reviewing existing regulations for future amendments. Also, the Division of Long Term Care Systems intends to review records in conjunction with their on-site inspections.

Cost Reports

The department should require adequate financial disclosures by providers to ensure that MDC reimbursements rates for services are reasonable.

Prior to May 2002, DHSS had never required MDC providers to submit annual cost reports detailing the expenditures for the program. In May 2002 the department requested that providers submit the financial information. The department received only 62 of the 124 providers' cost reports. The reports received varied in the amount and content of the expenditure information. There have been no reviews of this information by the department.

In accordance with N.J.A.C. 8:86-1.3, a MDC center operated by a public or private agency or organization shall submit a cost study on an annual basis which details the expenditures of the medical day care center. MDC center costs shall be segregated from other operational costs.

The department's MDC reimbursement rates are based on a percentage of nursing facility per diem rates. This percentage hasn't changed since the inception of the program. With the additional information provided by cost reports, the division could better analyze and establish relevant reimbursement rates to provide these services. This information could also be useful in monitoring the level of care provided.

Recommendation

We recommend the department require providers to send cost information in a standard format to facilitate the department's analysis of the financial information. The department should determine the cost and level of services being provided and the best methodology for reimbursing providers for services rendered.

Auditee's Response

The department agrees with this recommendation.

Reimbursement for Food

The department should require all providers to participate in the USDA Child and Adult and Food Program and adjust reimbursement rates for the subsidies.

Since the DHSS has not adequately monitored the fiscal operations of the providers, it was not aware that 78 providers received $6 million in payments by participating in the Department of Agriculture's Child and Adult Food Program. This federal program is designed to provide assistance to various public and private nonprofit organizations including MDC centers. The payments made by the Department of Agriculture represent the

reimbursement of costs that are also being included in the per diem rates for payments made to the providers by the DHSS.

Recommendation

The department should require that all MDC providers participate in the food program and adjust the daily reimbursement rates to reflect payments made for food by the Department of Agriculture.

Auditee's Response

The department is presently in the process of researching this subject with the Department of Agriculture.

Criminal Background Checks

The department should implement procedures for random criminal background checks on providers.

The DHSS provider license application requires the applicants to disclose whether officers or partners or any individual named in the application have ever been charged or convicted of, or pled guilty or no contest to any federal or state crime. The department relies on the providers making full disclosure on their applications and on the providers having procedures in place to perform background checks on their employees. However, the DHSS does not perform criminal background checks on applicants.

The Department of Human Services, Division of Medical Assistance, Bureau of Program Integrity has access to various data bases including Promis Gavel to perform criminal background checks. A review of three providers' employees by the bureau resulted in the identification of three employees with criminal or disciplinary records working at the centers. Although time consuming, some form of review should be performed in order to ensure the safety of the programs' participants.

Currently, there are seven pediatric MDC centers licensed by DHSS. The department has not complied with state laws that require that all child care center owners, sponsors, staff members and employment

applicants undergo criminal history record background checks through the Division of State Police and Federal Bureau of Investigation as condition of continued or new employment at child care centers statewide.

Recommendation

We recommend the department review all owners and sponsors and staff members of pediatric MDC centers.

For adult day centers, we recommend DHSS implement procedures to check owners against the data bases accessible to the Department of Human Services, Bureau of Program Integrity to determine whether owners have a criminal record. In addition, we recommend the department implement procedures to, at a minimum, randomly perform background checks on facility employees. This could be done on a rotating basis of all MDC providers.

Auditee's Response

Adult Centers - The department agrees with this recommendation and is developing an implementation plan.

Pediatric Centers - The department agrees with this recommendation and is developing an implementation plan, including amendments to the regulations.

Licensing of Pediatric Day Care Centers

Conflicting regulations should be modified to ensure program objectives are properly met.

N.J.A.C. 8:86-1.5 6(b) states "The maximum daily census in any pediatric medical day care center shall be 27 children." Five of the seven licensed pediatric centers were granted slots exceeding the 27 children maximum by the Division of Long Term Care Systems. Three of the facilities were granted 16, 18, and 23 slots over the maximum.

This was the result of the department having two sets of regulations governing the MDC program. N.J.A.C. 8:43F provides the standards for licensure of adult and pediatric MDC which is administered by the Division of Long Term Care Licensing and Certification Unit. The Office of Waiver and Program Administration oversees regulations governing MDC services outlined in Chapter 86 of the Administrative Code which comply with the federal Medicaid waiver requirements and require that the maximum daily census for pediatric centers not exceed 27 children. The Division of Long Term Care Licensing and Certification Unit approved licensed slots in excess of the maximum set by the Office of Waiver and Program Administration.

Additionally, our review of the DHSS Assessment and Survey Unit's inspection reports indicates that the department has not performed surveys or inspections of the pediatric MDC's.

Recommendation

We recommend the department make modifications to the administrative code to remove all conflicting regulations to ensure that program objectives and Medicaid requirements for the MDC program are being met by each office.

Additionally, we recommend the DHSS perform inspections of the pediatric MDCs.

Auditee's Response

The department agrees with the recommendation and is in the process of reviewing current regulations to ensure consistency between the rules governing licensure and the rules governing Medicaid services, including the limitation of pediatric day centers to 27 slots, as discussed in the OLS report.

Claim Payments

Controls should be established to prevent improper claims submitted by providers from being reimbursed.

Approximately 8,000 Medicaid beneficiaries participated in medical day care (MDC) services provided by 124 licensed facilities during fiscal year 2002. The industry has grown dramatically, with 10 to 15 facilities applying for licensure each year.

New Jersey reimburses MDC providers on a per diem rate based on nursing home rates. Currently, the per diem is $64 for adults and $222 for pediatric.

The reimbursement of MDC provider claims is based on the premise that the information submitted by the facility is accurate. Our review of program expenditures noted inadequate processing controls and a lack of department reviews of payments. The Department of Health and Senior Services (DHSS) contracts with a fiscal agent to process and reimburse Medicaid providers for service claims submitted. The system checks claim information and data validity against claim requirements called edits. Currently, there are approximately 1000 edits in the automated system to prevent the processing of improper payments submitted for different Medicaid programs. Each program is responsible to determine what the edit disposition will be. Management has decided the edit disposition for claims with conflicts or other irregularities for the MDC program do not deny payment. However, there were no reviews of these irregular claims that were paid and reported as possible errors, even though the fiscal agent had notified both the DHSS and the Department of Human Services' Fraud and Abuse unit about the existence of duplicate payments.

Our tests noted the following irregular claims were processed and errors were never detected or resolved. MDC providers submitted:

- 712 claims totaling $44,000 which were paid for services after the clients' date of death;

- 1,604 duplicate claims totaling $99,000 which were paid to two providers submitting claims for the same clients on the same date of service during our audit period;

- 6649 claims totaling $410,000 which were paid for services exceeding the five days maximum allowed per week by N.J.A.C. 8: 86-1.4; and

- 1070 claims totaling $66,000 for dates when clients were reported hospitalized by hospital claims.

We also noted 14,842 claims totaling $1 million which had potential conflicts due to the providers' billing methods. There is no uniformity in billing practices of the providers. The department does not require providers to indicate specific service dates on the claim. This requirement would facilitate the detection of improper billings for the same recipients by two or more providers and the monitoring of the number of service units per week.

Recommendation

We recommend the department fix responsibility and develop proper procedures to address the investigation and disposition of claims highlighted by edits in the automatic payment system.

The department should implement a system to monitor claim payments to determine their accuracy and propriety.

The department should investigate the above irregularities and collect any overpayments.

In addition, the department should require uniformity in billing practices amongst the providers indicating specific days that services were rendered.

Auditee's Response

The department agrees with these recommendations. Medical Day Care claims are already matched against the Bureau of Vital Statistics' deceased files. The department has initiated a recovery process for

claims paid after the death of a beneficiary. The department is in the process of recovering 28 MDC claims in the amount of $2,025.30 for the period from October 1, 2002 to December 31, 2002.