



State of New Jersey

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FINAL AUDIT REPORT SILVER CARE PROVIDER ID: [REDACTED] May 3, 2012

Background

Silver Care is a multi-faceted health care facility that provides a wide range of specialized services. Its ventilator care unit which is located in Cherry Hill, New Jersey specializes in ventilator management; tracheostomy and airway care, and offers long term care to the community. The facility enrolled in the Medicaid program effective May 2003.

Objective

The Medicaid Fraud Division of the Office of the State Comptroller (OSC) conducted a limited scope audit of Silver Care's ventilator unit. The objective of the audit was to examine claims and claim reporting procedures for this facility to determine if Medicaid was billed prematurely. Per N.J.A.C.10:49-7.3, Medicaid and NJ FamilyCare benefits are last-payment benefits. Also, 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 first and to the fullest extent in meeting the cost of the medical needs of the Medicaid or NJ FamilyCare beneficiary. This audit was conducted as a desk review.

Scope

The scope of this audit was limited to a review of a sample of 12 Medicaid recipients with paid claims totaling \$152,701. The period of our review was January 2007 through December 2010. 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 N.J.S.A. § 52:15C-23.

AUDIT FINDING

Premature Medicaid Billing

Medicaid was billed \$87,359 prematurely for 7 of 12 (58%) recipients in our sample for whom Medicare was available and for whom the provider did not establish that Medicare certified beds were unavailable. Per N.J.A.C. 8:85-1.18(c) & (d), Medicare covers eligible beneficiaries needing post hospital skilled nursing care when they are placed in Medicare certified facilities.

Also, Medicare eligible residents shall be placed in Medicare certified beds. The premature Medicaid billing is attributed to the provider's inability to establish that Medicare certified beds were unavailable for the Medicare eligible recipients in our sample for the period audited.

Recommendation:

We recommend that Silver Care's ventilator unit reimburse Medicaid a total of \$87,359 for seven recipients in our sample. The provider failed to establish that Medicare certified beds were unavailable for these recipients, due to a bed decertification. (Decertifying beds means to make the beds ineligible for reimbursement under either the Medicare or Medicaid program). The provider admitted that Medicare was available when Medicaid was billed. Going forward, we recommend that decertification of beds at all Silver Care facilities be clearly delineated in future correspondence to the appropriate Medicare and Medicaid authorities.

Response:

As a result of your audit, you have concluded that an amount of \$87,359.00 was paid to the Facility incorrectly. We have worked cooperatively during this audit, and, as you know, we disagree with the amount identified. Specifically, our disagreements are as follow:

- *\$20,873.95 of the amount relates to a resident who remains in the Facility, and the allegation is that the Facility did not bill Medicare for the resident's full 100 days prior to billing Medicaid. After you raised the issue, the Facility corrected the matter so that Medicare has been billed for its full 100 days, and the Medicaid Program has paid the proper amount. There should be no recoupment for this resident;*
- *The remainder of the amount relates to residents no longer in the Facility for whom the Medicaid Program was billed without the Medicare Program being billed first. This situation was created by the fact that the State did not properly act on the Facility's request to de-certify certain beds from the Medicare program. The Facility billed under the assumption that the State had acted upon its de-certification request; and*
- *Had the Medicaid Program notified the facility in a timely manner that its claims were rejected because the beds were certified, the facility could have billed Medicare and received payment for services.*

We understand, however, that we will have the right to raise these disagreements in the future and that your audit will now be finalized. We appreciate the courtesy that you have shown us during the audit process.

Conclusion:

We have reviewed the provider's response. The total amount of \$87,359 has been reduced to \$66,485.05. This reduction is based on the provider's prompt corrective action plan upon the realization that Medicare bed decertification was not in effect at the facility during our audit period. As a result of our audit, the provider immediately began billing Medicare for one recipient for whom Medicaid would have been billed erroneously, resulting in additional cost savings of \$35,695.05.

With regard to the facility's decertification request, the facility did not provide sufficient evidence to OSC to substantiate their claim.