State of New Jersey

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Director

September 25, 2020

BY ELECTRONIC MAIL

Ms. Deborah Visconi
President and CEO
Bergen New Bridge Medical Center
f/k/a Bergen Regional Medical Center
230 East Ridgewood Avenue
Paramus, New Jersey 07652

RE: Revised Final Audit Report: Bergen New Bridge Medical Center

Dear Ms. Visconi:

As part of its oversight of the New Jersey Medicaid programs (Medicaid), the Office of the State Comptroller, Medicaid Fraud Division (MFD) conducted an audit of Medicaid claims submitted by and paid to Bergen Regional Medical Center, now known as Bergen New Bridge Medical Center (Bergen), for the period from January 1, 2013 through December 31, 2017 (audit period). MFD issued an Audit Report dated February 4, 2020. In that Audit Report, MFD offered Bergen the option to resubmit to DMAHS all or a portion of the claims at issue to seek payment consideration. Bergen chose to resubmit its claims. MFD hereby provides this Revised Final Audit Report to update the result of that resubmission process.

Executive Summary

MFD conducted an audit of Bergen's Medicaid claims to determine whether Bergen billed for certain inpatient services in accordance with applicable laws, regulations, and written guidance. Medicaid claims are billed and paid based on the nature of the service and whether the Medicaid program pays for the goods/services, or the Medicaid managed care organization (MCO) that administers health coverage on behalf of most Medicaid beneficiaries pays for the goods/services. When a provider bills the state Department of Human Services, Division of Medical Assistance and Health Services (DMAHS or state) for goods/services, these are referred to as fee-for-service (FFS) claims. When a provider

bills an MCO for the goods/services, these are referred to as encounter claims. MFD audited 266 "episodes of care," which included 564 FFS and encounter claims.[1] From this universe, MFD found that Bergen improperly billed and was paid for 171 of the 564 claims, totaling $1,126,983.54.

MFD found that for 116 of the 564 claims (20.6 percent), totaling $835,907.45, Bergen incorrectly billed FFS claims for inpatient services. In these instances, Bergen submitted claims with incorrect discharge codes indicating that beneficiaries had been discharged, when, in fact, the beneficiaries had been transferred to another area within the same hospital (under the same Medicaid Provider Identification Number). As a result, Bergen improperly billed two separate Diagnostic Related Group (DRG) claims, one paid by the MCO and the other paid on a FFS basis by the state, instead of one all-inclusive claim.[2] Further, for these claims, Bergen failed to provide to the state the information showing the claims payments by the MCOs for acute medical services, which the state would have considered in calculating its FFS payment had the state been aware that such payments had been made by an MCO. This incorrect coding and failure to provide required MCO payment information on claims violates *N.J.A.C.* 10:49-9.8(a) and is contrary to DMAHS Newsletter Volume 21, No. 09 (guidance to hospitals).

MFD also found that for 37 of the 564 claims (6.6 percent), totaling $201,826.38, Bergen improperly billed FFS inpatient claims in situations where beneficiaries were readmitted for the same or similar diagnosis within seven days of their previous discharge date. This practice violates *N.J.A.C.* 10:52-14.16, which requires that hospitals combine the second (readmission) claim with the original inpatient hospital services claim. Moreover, MFD found that for 17 of the 564 claims (3.0 percent), totaling $82,870.22, Bergen received FFS and MCO payments for the same beneficiary, for the same date of service, which violates *N.J.A.C.* 10:49-9.8. Lastly, MFD found that for 1 of the 564 claims (.002 percent), totaling $6,379.49, Bergen failed to provide medical records to document the services performed, which violates *N.J.A.C.* 10:49-9.8.

The Table below summarizes the audit findings, claims improperly billed and overpayment to Bergen.

1 For the purpose of this audit, an "episode of care" or "episode" encompasses two claims. The first claim covers the first hospital stay from admission to discharge. The second claim covers a second hospital admission that occurs within seven days from the beneficiary's previous discharge date.

2 According to N.J.A.C. 10:52-14.2, "Diagnosis Related Group means a patient classification system in which cases are grouped by shared characteristics of principal diagnosis, secondary diagnosis, procedures, age, sex and discharge status."

Table
Summary of Overpayment

Audit Findings	Improperly Billed Claims	Overpayment
Improperly Billed FFS Inpatient Services	116	$835,907.45
Improperly Billed for FFS Readmissions	37	$201,826.38
Duplicate Payments for Same Dates of Service	17	$82,870.22
Undocumented Services	1	$6,379.49
Total	**171**	**$1,126,983.54**

In sum, MFD determined that 171 of the 564 claims (30.3 percent), totaling $1,126,983.54, constituted overpayments. To address these overpayments, MFD directed Bergen to advise whether it would agree with this finding, in which case MFD would void the claims and allow Bergen to resubmit these claims to DMAHS for its payment consideration. In the alternative, MFD advised that Bergen could administratively contest these findings without having the opportunity to resubmit claims for payment consideration. Bergen accepted the findings and chose to resubmit these claims for payment consideration. MFD noted in its Final Audit Report that it would update its Final Audit Report to memorialize which option Bergen chose and the outcome. This Revised Final Audit Report updates Bergen's actions and the outcome. In short, through the resubmission process, the state voided all of the claims, and determined that of the $1,126,983.54 in voided claims, Bergen was entitled to receive payment of $813,681.41, which was subsequently paid to Bergen, and the Medicaid program retained the remainder, $313,302.13.

Background

Bergen, located in Paramus, New Jersey, is one of New Jersey's largest medical facilities that provides a continuum of health care. Specifically, Bergen offers behavioral health services; acute medical services, including emergency services; surgical services; physical rehabilitation services; pharmacy; laboratory; and radiologic services. Bergen also has more than 26 medical specialties available through its Ambulatory Care Center. At the

start of the audit period, the Bergen Regional Medical Center, L.P., administered the day-to-day operations of Bergen. In October 2017, Care Plus Bergen, Inc. assumed responsibility for the administration of Bergen and later changed the name of the facility from Bergen Regional Medical Center to Bergen New Bridge Medical Center. New Jersey hospitals are required to adhere to state and federal regulations and applicable DMAHS newsletters when submitting Medicaid claims for reimbursement.

Objective

The objective of this audit was to evaluate claims billed by and paid to Bergen to determine whether these claims were billed and paid for in compliance with Medicaid requirements under state and federal laws, regulations, and guidance.

Scope

The audit period was January 1, 2013 through December 31, 2017. The audit was conducted under the authority of the Office of the State Comptroller as set forth in *N.J.S.A.* 52:15C-23 and the *Medicaid Program Integrity and Protection Act*, *N.J.S.A.* 30:4D-53 *et seq*.

Audit Methodology

MFD's methodology consisted of the following:

- Selecting 266 episodes representing 564 claims, totaling $3,322,771.90, from a population of 25,783 paid claims totaling $91,751,611.33, where the beneficiary's readmission date occurred within seven days of a previous discharge date; and,

- Reviewing Bergen's records to determine whether proper documentation existed for claims billed and paid to Bergen in accordance with *N.J.A.C.* 10:49-9.8, *N.J.A.C.* 10:52-14.16, DMAHS Newsletter Volume 21, No. 09, and other relevant state and federal laws and regulations.

Audit Findings

Improperly Billed FFS Inpatient Services

Payments for certain hospital services fall into two general categories. Some hospital services, such as medical services, are paid by MCOs pursuant to the state's contract with the MCOs. Other services, such as psychiatric services during our review period, are "carved out" of the MCO Contract, meaning that such services are not covered by the MCOs, but rather are paid by DMAHS directly on a FFS basis. When a hospital claim that is submitted to DMAHS for payment contains both FFS and MCO components, the hospital is required to identify the MCO component and the corresponding MCO payment. DMAHS considers the MCO payment in calculating the FFS payment. In

addition, when a beneficiary is transferred within a facility, regardless of whether all or a portion of the claim is to be paid by DMAHS or an MCO, the hospital must properly characterize the services as being part of a single continuous care admission rather than separate billing events (*e.g.*, admission through discharge is billing event #1; re-admission through discharge is billing event #2).

MFD reviewed medical records for 564 claims in which the beneficiary's readmission date was within seven days of a previous discharge date. MFD found that for 116 of the 564 claims (20.6 percent), totaling $835,907.45, Bergen improperly billed FFS claims for inpatient services. Specifically, MFD found that Bergen submitted these claims with incorrect discharge codes indicating that beneficiaries were discharged from the hospital and readmitted on the same date when, in fact, they were transferred within the same hospital. Bergen utilized the same Medicaid Provider Identification Number with regard to both events. As a result, in some instances Bergen billed and was paid for two separate inpatient stays - one as a medical service paid by the MCO, and another as a psychiatric service paid by the state on a FFS basis. In these cases, before seeking FFS reimbursement for psychiatric services, Bergen should have submitted the MCO payment information to DMAHS for a proper calculation of the FFS portion of the stay. Because Bergen failed to provide DMAHS with the MCO payment amount for the medical portion of the hospital inpatient stay, DMAHS paid Bergen more for the FFS portion of these stays than it should have paid. In other instances, Bergen billed two inpatient stays both as FFS, instead of one all-inclusive FFS stay. In both cases, Bergen's incorrect claims submissions caused DMAHS to pay more for the claims than it should have paid, which resulted in overpayments to Bergen. As set forth below, these submissions violated *N.J.A.C.* 10:49-9.8(a). These claims submissions also are contrary to guidance set forth in DMAHS Newsletter Volume 21, No. 09.

N.J.A.C. 10:49-9.8(a) requires that "providers shall certify that the information furnished on the claim is true, accurate, and complete." For claims with an MCO component, Bergen's failure to include the true, accurate and complete information (*i.e.*, Bergen's use of incorrect discharge codes and its failure to provide the MCO payment information) resulted in DMAHS incorrectly calculating the claim payment amount. Similarly, for Bergen's claims that were entirely FFS, Bergen's failure to submit true, accurate and complete claims (*i.e.*, Bergen's improper submission of separate claims for what should have been billed as one all-inclusive claim) resulted in DMAHS paying more for such claims than it should have paid.

Pursuant to DMAHS Newsletter Volume 21, No. 09, hospitals submitting FFS claims to DMAHS for inpatient services must identify the portion of such claim(s) denied by an MCO so DMAHS can establish the appropriate reimbursement amount. This Newsletter includes specific guidance regarding the information that must be provided, including the requirement that the hospital must include the MCO's remittance advice, which is the document that explains the reason for payment/denial/adjustment. In those instances where the hospital failed to submit the requisite remittance advice, DMAHS calculated

the FFS reimbursement at a higher rate than it otherwise would have, which resulted in DMAHS making an overpayment to the hospital.

Improper Payments for FFS Readmission

MFD found that for 37 of the 564 claims (6.6 percent), totaling $201,826.38, Bergen improperly billed and was paid for FFS inpatient claims where the beneficiary was re-admitted for the "same or similar diagnosis" within one-to-seven days from the previous discharge date. For claims payment purposes, these two claims should have been combined into a single claim. For example, Bergen submitted a claim for a beneficiary who was discharged with diagnosis "F250" on May 27, 2016. Bergen readmitted the same beneficiary on May 30, 2016 (within seven days), with the same diagnosis "F250" and billed the readmission as a second claim. Bergen should have combined the readmission with the first admission as one claim for reimbursement. As set forth below, Bergen's submission of related claims as two inpatient stays instead of one claim violated *N.J.A.C.* 10:52-14.16.

Pursuant to *N.J.A.C.* 10:52-14.16,

> For New Jersey hospitals, if a patient is readmitted to the same hospital for the same or similar diagnosis within seven days, the second claim submitted for payment will be denied . . . . For these readmissions, requests for payment of services related to the two hospital inpatient stays shall be combined on the same claim form for reimbursement purposes.

Duplicate Payments for Same Dates of Service

MFD found that for 17 of the 564 claims (3.0 percent), totaling $82,870.22, Bergen received a FFS and an MCO payment for the same beneficiary for the same date of service. Specifically, MFD found remittance advices documenting MCO payments to Bergen for the same beneficiaries for whom Bergen also received FFS payments for the same dates of service. In some instances, the MCO payment and the FFS payments were exact duplicates, in others, the FFS payments paid at a substantially greater amount than the MCO payment. In either case, Bergen was paid twice for the same beneficiary's dates of service. For example, Bergen billed and received an MCO payment for a beneficiary who was admitted and discharged on September 2, 2017, and Bergen also received a FFS payment for the same beneficiary for the same date of service. Unlike the situations above, identified under Improperly Billed FFS Inpatient Services which involved discharges and readmissions, these instances involved a single continuous stay, which should not require both an MCO and FFS payment. As a result, these claims submissions are contrary to guidance set forth in DMAHS Newsletter Volume 21, No.09. Further, as set forth below, Bergen violated *N.J.A.C.* 10:49-9.8(a), by improperly billing the services provided.

Pursuant to *N.J.A.C.* 10:49-9.8(a), "providers shall certify that the information furnished on the claim is true, accurate, and complete."

Undocumented Services

MFD found that for 1 of the 564 claims (.002 percent), totaling $6,379.49, Bergen did not maintain the appropriate documentation for the claim billed. Specifically, for this one claim, Bergen failed to provide a medical record documenting the service performed. As set forth below, this failure to maintain appropriate records violated *N.J.A.C.* 10:49-9.8(b) (1).

Pursuant to *N.J.A.C* 10:49-9.8 (b) (1), providers are required "to keep such records as are necessary to disclose fully the extent of services provided."

Summary of Overpayments

MFD determined that for the period from January 1, 2013 through December 31, 2017, Bergen improperly billed and received payment for 171 of the 564 claims, totaling $1,126,983.54. For purposes of ascertaining a recovery amount, MFD combined the dollars in error for all improper claims, which constituted 116 claims for $835,907.45, 37 claims for $201,826.38, 17 claims for $82,870.22, and 1 claim for $6,379.49. In sum, by adding the dollars in error for each finding, MFD determined that Bergen received an overpayment for 171 claims totaling $1,126,983.54. MFD offered Bergen the option either to challenge the audit findings and the overpayment amount, or, if it agreed with the audit findings, to resubmit all or a portion of these claims to DMAHS for review and, as appropriate, payment of all or a portion of the resubmitted claims. MFD explained that if Bergen chose to resubmit claims, MFD would monitor the process and update this report to show the final amount of payment for the resubmitted claims.

Recommendations

As part of the February 4, 2020 Audit Report, MFD recommended that Bergen should:

1. Using the process and timeframe outlined below, address the 171 claims that MFD found Bergen improperly billed and for which it received payment, totaling $1,126,983.54.
2. Follow the DMAHS Newsletter Volume No. 21 No. 09 billing instructions for submitting claims for FFS reimbursement for Medicaid covered services that are carved out of the managed care contract for future billings.
3. Follow *N.J.A.C.* 10:52-14.16 when submitting claims for readmission that have a same or similar diagnosis and occur within 7 days of a previous discharge.
4. Provide training to its staff to foster compliance with Medicaid requirements under applicable state and federal laws, regulations and Medicaid Newsletters.
5. Provide MFD with a Corrective Action Plan (CAP) indicating the steps it will take to correct the deficiencies identified in this report.

Bergen's Response

After being apprised of MFD's preliminary findings, Bergen, through counsel, submitted a written response and CAP. *See* Appendix A. In essence, through its response, Bergen stated that it agreed with MFD's preliminary findings. Bergen's CAP addressed MFD's findings and recommendations. As part of its response, Bergen noted that Bergen Regional Medical Center LP (BRMCLP), the prior management company, sought clarification and information regarding two questions.

First, BRMCLP stated that it

> is unclear as to the individual claim detail, or the relevant MCO contract for each claim to determine whether it is appropriate for the Division to classify a distinct-part unit based on the Medicaid Provider Identification Number alone. In addition, BRMCLP is unable to substantiate whether the stays could be termed as a 'continuous care admission' when the discharge and admit times are not contemporaneous. (DAR at 4.) That is, Appendix A cites a number of claims that do not share similar admission and discharge times. Without additional information, BRMCLP cannot assess the veracity of the finding.

Second, BRMCLP stated that N.J.A.C 10:52-14.16 indicates that

> the 'same or similar principal diagnosis' is defined for certain period claims as those 'principal diagnoses with the same first three digits' in accordance with ICD-9 (Id.) Yet, many of the episodes cited within the appropriate reference period indicate claim diagnosis codes with dissimilar first three digits. BRMCLP is unclear as to why these episodes with varying diagnoses were included as adverse findings.

MFD Comments

MFD noted that Bergen was in agreement with MFD's findings. With respect to BRMCLP's comments/questions, MFD noted that BRMCLP was not the auditee and, thus, MFD was not obligated to address its comments/questions. Notwithstanding that, MFD did so. With respect to BRMCLP's first point, MFD performed its analysis based on billing and patient records provided by Bergen, along with information, such as Medicaid guidelines and other guidance provided by DMAHS, Office of Preventive Health Services, Utilization Management Unit. Accordingly, MFD saw no reason why BRMCLP should have difficulty tracking and analyzing the claims at issue. Moreover, BRMCLP's claim that it was not able to substantiate the discharge claims because the discharge and admission times did not match was puzzling because it makes sense that these times would differ given the time it takes to move a patient from one unit to another. Accordingly, MFD saw no basis to modify its findings based on this comment/question.

As for BRMCLP's point regarding MFD's interpretation and application of N.J.A.C 10:52-14.16, MFD's findings were based on Bergen's own DRG classification. A DRG is a patient classification system used by hospitals to bill claims that are grouped by shared characteristics such as principal diagnosis, secondary diagnosis, procedure, age, sex and discharge status. In other words, by billing a DRG, the hospital has itself determined that the underlying claims that fall into the DRG are the "same or similar" for billing purposes. The claims noted in this report were all within the DRG and, thus, considered the same or similar to the principal diagnoses codes. Simply put, MFD used Bergen's own categorization of its claims to reach this finding. Accordingly, MFD saw no reason to modify this finding.

Bergen provided a CAP to address all of MFD's recommendations above and thereby correct the deficiencies cited in this report. The lone outstanding issue was how Bergen would address the improperly billed and paid claims totaling $1,126,983.54. To address these improperly billed claims, MFD requested that Bergen advise in writing within twenty (20) days of the February 4, 2020 report which of the following two options it would pursue. First, Bergen could have sought to resubmit the claims at issue to DMAHS for payment consideration. If Bergen chose that option, MFD would void all 171 claims totaling $1,126,983.54 and Bergen would be given 20 days from the date of the remittance advice that was sent to resubmit these claims along with appropriate documentation to DMAHS for its payment consideration. Should Bergen have sought to challenge DMAHS' payment determination on the resubmitted claims, it would have done so through existing processes for such challenges. Alternatively, notwithstanding that, it agreed to MFD's findings, Bergen was permitted to contest MFD's findings through an administrative process. If Bergen had chosen that option, it would not have been permitted to resubmit its claims to DMAHS for payment consideration. MFD advised that it would update the Audit Report to memorialize which option Bergen chose and the outcome of same. That update is set forth in the Executive Summary above and the MFD Audit Update below.

Thank you for your attention to this matter.

Sincerely,

KEVIN D. WALSH
ACTING STATE COMPTROLLER

DATE: 09/25/2020

By: /s/ Josh Lichtblau
Josh Lichtblau
Director
Medicaid Fraud Division

Attachment:
Appendix A – Bergen's response

Cc: Kay Ehrenkrantz, Deputy Director, MFD
Don Catinello, Supervising Regulatory Officer, MFD
Glenn Geib, Recovery Supervisor, MFD
Michael Morgese, Audit Supervisor, MFD
Mauro Raguseo, Executive Director, Bergen County Improvement Authority
Brian Foley, Esq., Legal Counsel, NBMC

MFD Audit Update – September 25, 2020

On February 24, 2020, Bergen notified MFD that it had chosen to resubmit the 171 claims at issue for payment consideration and would not contest MFD's audit findings. The state then voided all 171 claims and recovered the full amount at issue, $1,126,983.54. Bergen proceeded to resubmit these claims along with appropriate documentation to DMAHS for reprocessing and claim payment consideration. In July 2020, DMAHS determined that of the $1,126,983.54 in voided claims, Bergen was entitled to receive payment of $813,681.41, which DMAHS subsequently paid to Bergen. In sum, as a result of this audit and resubmission process, MFD found that Bergen improperly billed and received an overpayment of $313,302.13 ($1,126,983.54 - $813,681.41 = $313,302.13), which the Medicaid program recovered as part of the initial voiding process.

Appendix A

Bergen New Bridge Medical Center

Deborah D. Visconi
President and Chief Executive Officer

December 20, 2019

State of New Jersey
Office of the State Comptroller
Medicaid Fraud Division
P.O. Box 025
Trenton, New Jersey 08625-0025
Attention: Michael M. Morgese, Audit Supervisor

RE: Draft Audit Report: Bergen New Bridge Medical Center

Dear Mr. Morgese:

Kindly accept this correspondence as the written response and Corrective Action Plan, in connection with the Draft Audit Report dated December 9, 2019, in the audit of Medicaid claims submitted and paid for services at the facility, formerly known as Bergen Regional Medical Center ("Bergen Regional") and now known as Bergen New Bridge Medical Center during the period January 1, 2013 through December 31, 2017.. The facility is owned by the County of Bergen, and the license is held by the Bergen County Improvement Authority. The facility was managed by Bergen Regional Medical Center, L.P. ("BRMCLP") until October 1, 2017. From that date to the present, the facility has been managed by Care Plus Bergen, Inc. ("Care Plus"). All of the claims at issue in the audit, except one, arose during the period when BRMCLP managed the facility, and prior to Care Plus taking over the management of the facility on October 1, 2017.

1. As a result of the new Behavioral Health Carve-In regulation that was implemented on October 1, 2018, all inpatient services are currently covered by the Managed Care Organizations (MCOs). Therefore, claims are currently submitted to the appropriate MCO in accordance with the billing regulations established by each plan. The plans recognize each service provided to the patients as separate and distinct (i.e. medical, detoxification, behavioral health) and paid according to the negotiated contracted rates.

2. Currently, after a patient is discharged, the hospital holds the inpatient claim in the billing system for five days before submitting it to the appropriate payer for payment. The five days allows for the claim to be reviewed and coded in a timely manner. In compliance with N.J.A.C. 10:52-14.16, the facility will create a custom report in the billing system to identify all Medicaid discharges and any readmissions within seven days containing the same or similar principal diagnosis code. This report will be reviewed on a weekly basis and any readmissions will be identified. If the initial admission has already been submitted for payment, it will be voided upon adjudication and the second admission will be added to it and resubmitted for payment. If

the initial claim has not been submitted, the claims will be combined in our financial system and submitted on the same claim form for reimbursement.

3. Currently, the facility provides monthly ongoing education to the staff in the Patient Financial Services Department to ensure that the staff are aware of any changes in healthcare billing regulations. At these sessions, management reviews any updates to applicable state and federal laws including a discussion about any new Medicaid Newsletters that have been published. In addition, billing changes for any other payer are provided and reviewed with the staff. Billing scenarios are supplied for reference and further guidance.

4. Upon receipt of the voided claims, the facility will be re-submit the claims as outlined in the Draft Audit Report within 20 business days from the remittance advice date, in accordance with the instructions set forth in the Medicaid Newsletter Volume 21-09.

Corrective Action Plan

Additionally, to avoid any of the issues identified in the Draft Audit Report, the following steps/procedures will be implemented:

- Fee For Service ("FFS") Inpatient Services – the 116 claims identified represent the patients being transferred within the organization from the Medical Division to the Behavioral Health Division or vice versa. If, in the future this scenario does occur, the MCO will be billed first. Upon adjudication, Bergen will then submit the claim to the state for the FFS payment. The claim will include the payment made by the MCO for the acute medical services so the State can correctly calculate and make the FFS payment. Additionally, the HIM department will verify that the correct discharge status code has been assigned prior to billing. These steps will ensure compliance with N.J.A.C 10.49-9.8(a) and the billing procedures in the Medicaid Newsletter, Volume 21 – 09. For services fully carved out, the billing will be submitted in accordance with the specific plan requirements and as described in #3 above.

- FFS Readmissions – the 37 claims identified either represent patients fully covered by FFS Medicaid being transferred within the organization from the Medical Division to the Behavioral Health Division (or vice versa) or a readmission to the facility within 7 days containing a similar principal diagnosis code. In compliance with N.J.A.C 10:52-14.16, the facility will create a custom report in the billing system to identify all Medicaid discharges and any readmissions within seven days containing the same or similar principal diagnosis code. This report will be reviewed on a weekly basis and any readmissions will be identified. If the initial admission has already been submitted for payment, it will be voided upon adjudication and the second admission will be added to it and resubmitted for payment. If the initial claim has not been submitted, the claims will be combined in our financial system and submitted on the same claim form for reimbursement. Additionally, if an FFS patient is moved from one unit to another in the hospital (acute medical to psychiatric), the services provided will all be submitted on the same claim form for reimbursement.

- Duplicate Payments for Same Dates of Service – the 17 claims identified represent several different scenarios. The first scenario is where the MCO made a payment, but it was recapped at a later date. The second scenario involves the claims that were part of the recycling project as indicated in the April 2017 Medicaid Alert. Per the Alert, due to the incorrect inpatient DRG grouping in the pricer software, claims with dates of service on or after 10/1/15 and before 10/1/16 were recycled. When the claims were recycled, the remittance advice showed a takeback of the initial payment and then the repayment of the claim with the same exact payment amount. The last scenario involves claims where the MCO was billed initially and a payment received, but the facility did not report this as a Third Party Liability (TPL) on the FFS claim. As stated above, if, in the future this scenario does occur, the MCO will be billed first. Upon adjudication, we will then submit the claim to the State for the FFS payment. The claim will include the payment made by the MCO for the other services so the State can correctly include it in the FFS payment calculation. These steps will ensure compliance with N.J.A.C 10.49-9.8(a) and the billing procedures in the Medicaid Newsletter, Volume 21 – 09. For services fully carved out, the billing will be submitted in accordance with the specific plan requirements and as described in #3 above. Additionally, as part of our ongoing education the staff have all been re-educated and trained on billing FFS claims with a prior payment made by a third party.

- Undocumented Services – The Draft Audit Report identified one date of service for one patient that was not documented properly. Effective August 1, 2019, we have implemented a 100% electronic medical record, and each patient that is admitted is assigned a permanent medical record number. Charting for each patient is documented in the electronic medical records system. The records can be viewed online or printed if necessary. This process will not allow for undocumented services.

- Training – The monthly ongoing education to the staff will be reviewed to ensure compliance with Medicaid requirements under applicable state and federal laws, regulations and Medicaid Newsletters in accordance with the audit recommendations.

The facility has taken actions to correct any deficiencies identified in the draft audit report as described herein. This written response and corrective action plan, however, shall not be construed as an admission, or concession of liability against the facility. The prior management company, BRMCLP, has requested additional information in connection with the audit for the period until October 1, 2017. Please see the questions from BRMCLP, annexed hereto as Attachment A.

Thank you for the opportunity to address the draft audit report.

Sincerely,

BERGEN NEW BRIDGE MEDICAL CENTER

By: _____
Deborah D. Visconi
President and Chief Executive Officer

BERGEN COUNTY IMPROVEMENT AUTHORITY

By: _____
Mauro Raguseo
Executive Director

ATTACHMENT A

Questions raised by BRMCLP:

First, the draft audit report indicates that certain FFS claims were billed using the same Medicaid Provider Identification Number for patients "transferred within the same hospital." (DAR at 5.) BRMCLP is unclear as to the individual claim details, or the relevant Medicaid MCO contract for each claim, to determine whether it is appropriate for the Division to classify a distinct-part unit based on the Medicaid Provider Identification Number alone. In addition, BRMCLP is unable to substantiate whether the stays could be termed as a "continuous care admission" when the discharge and admit times are not contemporaneous. (DAR at 4.) That is, Appendix A cites a number of claims that do not share similar admission and discharge times. Without additional information, BRMCLP cannot assess the veracity of this finding.

Second, the draft audit report notes $201,826.38 in improper payments for FFS readmissions. It indicates that the claims related to beneficiaries "re-admitted for the 'same or similar diagnosis' within one-to-seven days from the previous discharge date." (DAR at 5-6). In total, Appendix B indicates 37 such claims. In referring to this rule, the draft audit report cites N.J.A.C. 10:52-14.16. That regulation indicates the "same or similar principal diagnosis" is defined for certain period claims as those "principal diagnoses with the same first three digits" in accordance with ICD-9. (Id.) Yet, many of the episodes cited within the appropriate reference period indicate claim diagnosis codes with dissimilar first three digits. BRMCLP is unclear as to why these episodes with varying diagnoses were included as adverse findings.

Bergen New Bridge Medical Center
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