



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

**Department of Human Services
Division of Mental Health and Addiction Services
Greystone Park Psychiatric Hospital**

July 1, 2010 to April 30, 2013

**Stephen M. Eells
State Auditor**

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Enclosed is our report on the audit of the Department of Human Services, Division of Mental Health and Addiction Services, Greystone Park Psychiatric Hospital for the period of July 1, 2010 to April 30, 2013. If you would like a personal briefing, please call me at (609) 847-3470.

A handwritten signature in black ink, appearing to read "Stephen M. Eells".

Stephen M. Eells
State Auditor
September 26, 2013

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Scope

We have completed an audit of the Department of Human Services, Division of Mental Health and Addiction Services, Greystone Park Psychiatric Hospital (hospital) for the period July 1, 2010 to April 30, 2013. Our audit included financial activities accounted for in the state's General Fund, as well as the hospital's non-appropriated accounts related to the client Welfare Fund, Patient Trust Fund, Rehabilitation Services Fund, and Occupational Therapy Fund.

The hospital provides services for mentally ill persons from Bergen, Essex, Hudson, Morris, Passaic, Somerset, Sussex, and Warren counties. As of April 30, 2013, the hospital had 549 patients. The hospital's average annual expenditures and revenues were \$97.5 million and \$19.4 million, respectively, for fiscal years 2011 and 2012. The major components of revenue are cost recoveries from Medicare, Medicaid, and the counties. We reviewed transactions recorded at the hospital level for county billings; however, an evaluation of the county per diem rate setting calculation was excluded from the scope of the audit.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the hospital's programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of the significant condition noted in our prior report dated May 31, 2005.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, 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, the administrative code, circular letters promulgated by the Department of the Treasury, and policies of the Department of Human Services and the hospital. Provisions we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our samples of financial transactions. We also read the budget messages, reviewed financial trends, and interviewed hospital personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions on our audit objectives, as well as internal controls and compliance. Sample populations were sorted and transactions were randomly and judgmentally selected for testing.

To ascertain the status of the finding included in our prior report, we identified corrective action taken by the agency and performed a walk through to determine if the corrective action was effective.

Conclusions

We found that the financial transactions included in our testing were related to the hospital's programs and were recorded properly in the accounting systems. We also found the financial transactions were reasonable, except for certain internal control weaknesses and inefficiencies related to Medicare claims resulting in lost revenue of \$4.6 million for Medicare Part A and \$1.5 million for Medicare Part B which also affected county billing reimbursements. We also found additional internal control and compliance issues meriting management's attention. The hospital has resolved the significant issue noted in our prior report.

Medicare Revenue

Medicare Part A Inpatient Hospital Insurance

Improved monitoring and oversight within the process of Medicare Part A billing could increase revenues to the hospital.

A projection of our sample results disclosed as much as \$4.6 million was not billed to Medicare and private Medicare providers for services covered under Medicare Part A. Medicare Part A covers limited inpatient hospital care including room and board. At least 45 percent of the 1,200 hospital patients admitted between July 1, 2010 and September 30, 2012 were covered by Medicare Part A. The Department of Human Services (DHS), Bureau of Cost Accounting and Analysis (bureau) bills Medicare Part A for patients determined eligible by the hospital upon admission. Medicare Part A reimburses the hospital an average per diem of \$615 for each eligible patient who had not yet exhausted their general and psychiatric hospital entitlements of up to 90 hospital days per admission and 190 psychiatric hospital days in their lifetime. The DHS collected a total of \$5.3 million in fiscal years 2011 and 2012 for hospital services covered by Medicare Part A.

Our review of Medicare Part A billing for 100 random hospital admissions between July 1, 2010 and September 30, 2012 disclosed \$348,000 in lost reimbursement opportunities.

- The hospital failed to submit complete or accurate eligibility data to the bureau for six admissions resulting in 253 covered days, or \$156,000, that were not billed.
- The bureau submitted late or erroneous bills for eight admissions resulting in the loss of reimbursement opportunities for 246 covered days, totaling \$151,000.
- Three admissions had their Medicare Part A benefits covered through a private Medicare provider. Neither the bureau nor the hospital billed for these admissions considering them to be the responsibility of the other. Reimbursements of \$41,000 for 67 covered days were lost as a result.

As of April 30, 2013, the bureau was able to recoup \$154,000 of the \$348,000 lost reimbursement opportunities after being notified of our results.

Based on the 566 days that were not billed in our sample, we estimate Medicare and private Medicare providers were not billed for \$3.95 million and \$650,000, respectively, for eligible admissions during the 27-month period. If the \$4.6 million had been billed for these services, we estimate that total county payments to the state would have been reduced by as much as \$600,000.

Recommendation

We recommend the hospital and the bureau maximize Medicare Part A revenue by implementing controls and monitoring procedures to ensure the integrity of the eligibility data and timeliness and accuracy of billing for Medicare Part A. We also recommend the bureau retroactively review admissions and submit claims for all reimbursements that have the potential of being collected.

Medicare Part B Physician Services

The hospital should enforce billing for all allowable physician services for patients with Medicare Part B insurance.

The hospital failed to bill for services provided by staff physicians for half of Medicare Part B patients. Utilizing the lowest allowed billable rates, we estimated total revenue lost for Medicare Part B physician services for fiscal years 2011 and 2012 to be \$1.5 million. All services provided by physicians to Medicare Part B eligible patients must be billed on a fee-for-service basis. Physicians are required to properly document the service in the patient's medical record, keep accurate and legible patient notes, and state service complexity or time spent with each patient. According to the Department of Human Services (DHS) internal policy, claims and medical records shall be audited to determine if codes selected are appropriate, services are adequately documented, and whether all procedures documented have been claimed.

The hospital employs 44 psychiatrists and general practitioners at a total cost including fringe benefits of \$10.2 million per year. At least 492 of 1,108 admissions (44 percent) between July 1, 2010 and June 30, 2012 were covered by Medicare Part B. However, the hospital collected an average of only \$177,000 annually for physician services covered under Medicare Part B in fiscal years 2011 and 2012.

We compared hospital admission data that captures Medicare Part B eligibility to the billing data and found 52 percent of eligible admissions between July 1, 2010 and June 30, 2012 did not have a single physician service bill. Furthermore, 82 percent of eligible patients admitted for 90 days or less did not have any physician billing histories. Medicare Part B claims were submitted monthly for an average of 119 patients out of 212 patients covered by Medicare Part B for the period tested. The completeness or accuracy of hospital billing was not adequately reviewed by either the hospital or the DHS.

The hospital also failed to bill for 90 percent of services provided by the physicians on the admission date and for all services provided on the date of discharge resulting in \$101,000 lost revenue. An additional \$80,000 was billed properly, but the bills were denied because the staff physicians were not properly registered in the hospital's Medicare billing group. For example, six physicians worked over 90 days without proper registration, including two physicians who worked over a year without being in the proper billing group. The hospital had no direct access to billing data after it was submitted, and the bureau did not notify the hospital of denied claims. A periodic review of denied claims may have prevented this loss.

A review of medical charts for 15 patients with at least one physician claim discovered that only 32 percent of provided physician services were billed. The hospital biller cited legibility and lack of detail in physicians' notes to be the major causes for the low billing ratio. Services were not billed unless the service note expressly stated the symptoms or diagnoses, even though these were clearly stated on the same page in a patient's chart. We also noted inadequate oversight for physician services billing because the hospital biller is supervised by an individual not familiar with the Medicare billing process. Lack of communication between the DHS, the hospital biller, and the physicians is causing the hospital to underbill for Medicare Part B reimbursements. The value of the unclaimed services from our sample at the lowest billable rate was \$16,200. Based on the error rate of our sample, we estimate the hospital failed to bill \$1.3 million in additional reimbursements for services provided by staff physicians to patients eligible for Medicare Part B during fiscal years 2011 and 2012.

In addition to staff physicians, the hospital contracts with physicians in various disciplines to examine and treat patients at the hospital. The hospital paid \$393,000 for contracted physician services in fiscal years 2011 and 2012. The DHS policy states that contracted physicians have the same billing responsibilities as employee physicians. The hospital did not bill Medicare Part B for services provided by any contracted physician.

Medicare Part B recoveries lower the costs included in the per diem rate calculation. However, the additional recoveries would have had an insignificant effect on county billings.

Recommendation

We recommend the hospital implement monitoring procedures and adequate training to ensure maximum reimbursement for Medicare Part B physician services. Billings for physician services should be incorporated under the supervision of the hospital's business office and the hospital should also retroactively review all unclaimed billable services and submit for reimbursement. Additionally, as stated by DHS policy, the hospital should bill for services provided by contracted physicians.



Private Insurance Revenue

Revenues could be increased by improving the follow-up procedures on denials of insurance authorizations and claims.

Between July 1, 2010 and September 30, 2012, the hospital billed private insurance companies \$3 million for 75 patients representing 165 claims. Although not all claims and services are covered by insurance plans, the hospital only collected approximately 10 percent, or \$300,000, of claims billed. Our review of the insurance claims found that many of them were questionably denied or left unpaid. Our review of the claims found the following.

- Internal reviews by insurance companies denied 21 claims totaling \$666,000 because the insurer concluded that the placements of the patients in a state psychiatric hospital were not a medical necessity and the patients should be treated on a partial hospitalization or outpatient basis. The medical necessity criteria, as stated in the denied claims, was not met because the review deemed the patient as not being in danger of causing imminent harm to self or others. However, all hospital admissions are approved by the courts and are based on a clinical certificate from a psychiatrist that indicates that the person is in need of involuntary commitment as authorized by N.J.S.A. 30:4-27 et seq. The statute states an individual has a mental illness that “causes the person to be dangerous to self or dangerous to others or property and who is unwilling to accept appropriate treatment voluntarily after it has been offered” and “other services are not appropriate or available to meet the person’s mental health care needs.”
- Claims of \$119,000 for one patient were denied because the “plan does not cover state hospital”, although the plan made a payment for a prior hospital admission of the patient in the same year.
- The hospital received prior authorization from insurance companies for \$19,000 covering five claims for services provided prior to September 30, 2011. However, payments have yet to be received.
- The hospital is appealing an additional 29 denied claims totaling \$900,000. Twenty of these claims totaling \$650,000 have been in appeal status since 2011 and have not been followed up by the hospital.
- The hospital submitted 25 claims in the amount of \$468,000 prior to September 30, 2012. These claims are still outstanding and no follow-up action has been taken by the hospital.

Regardless of the reason the claim was denied, the hospital submits to the insurance company a standard cover letter in response to each denied claim. The cover letter does not specifically respond to the reasons for denial or changes required to the claim to ensure processing by the insurance company. The hospital accompanies the cover letter with a portion of the medical records. Patient’s medical records submitted exclude initial doctors’ evaluations and fail to communicate patient symptoms that led to admission. Providing proper documentation will increase collections. For one claim that was denied because the private insurance internal review stated placement at the state psychiatric hospital was not necessary, the appeal included a letter from the patient’s county adjuster’s office detailing the reason for the involuntary commitment of the patient. Due to the county adjuster’s intervention to the appeal, the hospital collected \$89,000, or 75 percent, of the patient costs billed to the insurance company.

Private insurance recoveries were issued as credits to the counties at a rate of 15 percent of each county patient reimbursement during our audit period. The effect of these denied or uncollected claims to the counties is unknown due to the uncertainty of collection for the various claims.

Increasingly, Medicare and Medicaid plans are being offered by private companies. Total nationwide enrollment into private Medicare plans increased from 19 percent in 2007 to 27 percent in 2012. The hospital does not participate in HMO networks and does not bill Medicare Advantage plans. The hospital will continue to lose significant Medicare and Medicaid recoveries if patients choose to have their hospital benefits provided by Medicare Advantage and other HMO plans.

Recommendation

We recommend that the hospital improve procedures and adequately train personnel on private insurance billing and the appeal process. We also recommend the hospital establish in-network relationships with Medicare and Medicaid Managed Care Organizations.



Institutional Medicaid Revenue

Enhanced controls over the Medicaid application and billing process could increase reimbursements.

Hospital patients under age 21 and over age 65 who meet certain clinical and financial criteria are eligible for Institutional Medicaid. During our audit period, Institutional Medicaid paid the hospital \$546 per day for the care of eligible patients (50 percent federally funded). The hospital notifies Medicaid of all age-eligible patients shortly after admission. Subsequently, Medicaid will send an application directly to the patient. The hospital is not following up on the applications and some are never submitted. Hospital staff treats the failure to submit the application as a refusal to apply for Institutional Medicaid on behalf of the patient. We reviewed the billing for 25 patients out of 177 age-eligible admissions and found claims were not submitted for seven patients totaling \$260,000. In addition, our test disclosed two eligible patients failed to submit Medicaid applications and therefore, the hospital was not able to bill \$312,000 in reimbursements.

Additionally, on July 1, 2012 the fiscal agent for Medicaid started requiring the submission of more detailed billing information. No one at the hospital was properly or sufficiently trained to process claims using the new format until January 2013. At that time, the hospital realized that all staff physicians needed to obtain new Medicaid provider identifiers. Therefore, no claims were submitted to Medicaid between July 1, 2012 and April 30, 2013.

Recommendation

We recommend the hospital establish follow-up procedures for the submission of Medicaid applications, implement the required updated billing for Medicaid, and pursue all unclaimed reimbursements.



Purchasing and Fixed Assets

The hospital does not comply with applicable purchasing and fixed assets regulations.

The hospital did not always comply with Department of the Treasury Circular Letters related to delegated purchasing authority transactions (DPA) and fixed assets. Department of the Treasury Circular Letter 11-10-DPP defines a DPA as a transaction that cannot be procured through one of the four primary contracting methods and does not exceed the DPA threshold (\$36,000 in fiscal years 2011 and 2012). At least three quotes are required for purchases over \$1,000 and purchases or contracts should not be divided by vendor, dollar amount, or items to circumvent the dollar limit imposed. Additionally, for items and services that are not covered by one of the primary contracting methods, an agency should identify its purchase requirements and determine its anticipated fiscal year needs based upon its procurement history. If the anticipated fiscal year volume exceeds the \$36,000 DPA threshold, the agency must request the Purchase Bureau to perform the procurement.

The purchasing process at the hospital is decentralized where the individual sections obtain the bids for their purchase requests and will submit them to the business office to approve the requisition and prepare the purchase order. Our review of expenditures noted the following.

- The Department of the Treasury Circular Letter was not complied with for 16 out of 38 sampled DPA purchasing transactions totaling \$113,000. For example, we noted nine DPA transactions where the hospital did not obtain the required amount of quotes, six of which had no quotes. Two purchases bypassed state contract vendors. Additionally, a purchase of a \$45,400 snow guard roof railing system was split into two separate transactions in order to avoid purchasing regulations.
- Of 58 transactions tested, 16 totaling \$90,000 were for purchases made before the purchase order was prepared.

An additional test of 15 possible split order instances disclosed 10, amounting to \$159,000, were not in compliance with the Department of the Treasury Circular Letter. The hospital should have anticipated two vendors exceeding the DPA \$36,000 threshold because of prior fiscal year purchases of \$189,000 and \$45,000. Eight purchases failed to obtain quotes for purchases over \$1,000.

From July 1, 2010 through April 30, 2013, the hospital processed 9,600 purchase orders amounting to \$18.2 million. An analysis of the hospital's purchase orders noted 1,260 instances in which multiple purchase orders were created for vendors on the same day. This created excessive processing of up to 1,730 purchase orders, or 18 percent of all purchase orders processed. One vendor had 18 purchase orders generated on the same day.

Furthermore, Department of the Treasury Circular Letter 11-19-OMB states that all state agencies must maintain a fixed asset inventory record for tangible and intangible assets, including internally developed computer programs and purchased software, with an original cost of at least \$1,000 and an estimated useful life of three years or more. Although the hospital has a fixed asset listing for fax machines, copiers, and computers and computer applications, they do not keep a record of other fixed assets that meet the Department of the Treasury Circular Letter criteria. There were 57 other fixed assets purchased from July 1, 2010 through March 17, 2013 totaling \$305,000.

Recommendation

We recommend the hospital comply with applicable Department of the Treasury Circular Letters regarding delegated purchase authority transactions and fixed assets. The hospital should also plan purchases more efficiently to reduce the processing of excess purchase orders.



Improper Transaction Types

Improper transaction types circumvented budgetary controls.

The hospital improperly recorded five expenditure transactions (intra-governmental payment vouchers and expenditure modifications) totaling \$2.54 million instead of budget transactions (transfers of appropriations) to record the movement of monies from one appropriation account to another. Department of the Treasury Circular Letter 98-12-OMB states that additional approvals from the Department of the Treasury, Office of Management and Budget and the Office of Legislative Services are required for non-internal transfers of appropriation over \$300,000. Non-internal transfers represent transfers where the organization, appropriation source, or program differs on the transfer to and from lines.

Two expenditure transactions of \$600,000 and \$850,000 were used to move monies from the Patient Care and Health Services program to the Administration and Support Services program. The expenses were recorded to the food object code and thus inflated total cost of food for the year by \$1.45 million. Also in fiscal year 2011, an expenditure transaction between the Division of Management and Budget at the Department of Human Services (DHS) and Greystone Park for \$300,000 was incorrectly used to cover a fuel deficit at another hospital causing an overstatement of fuel expenses at Greystone Park.

There were two expenditure transactions for \$370,000 and \$420,000 in fiscal year 2011 where expenditure modifications were used to move Federal Disproportionate Share Hospital (DSH) funds to state appropriation accounts in order to cover deficits when state funds were exhausted as stated by DHS management. DSH payments provide help to those hospitals that serve a significantly disproportionate number of low-income patients.

Although intra-governmental payment vouchers and expenditure modifications were improperly transacted, they were accounted for appropriately for county billing purposes.

Recommendation

We recommend that the hospital and the DHS use transfers of appropriations, when appropriate.



Welfare Fund

Welfare Fund type purchases are being funded by state appropriations.

Welfare funds should be utilized for entertainment purposes, community activities, arts, crafts, recreational activities and equipment, and certain items to enhance the comfort and living conditions of the general population of the hospital. The Department of Human Services Welfare Fund Manual advises that a large surplus of welfare funds should not be maintained. The hospital has bank statement balances totaling \$455,000 for the welfare of patients. In fiscal year 2012, the hospital had receipts of \$41,000 and disbursements of \$60,000. We performed a review of charges to appropriation accounts through March 17, 2013 noting purchases of holiday decorations, board games, movie rentals, and art supplies. As much as \$53,000 could have been purchased using the welfare fund.

In addition to accounts listed above, there is a non-profit organization ancillary to the hospital that assists with supplying funds for patient welfare. The Greystone Park Association (GPA) is a non-profit organization formed in 1948 to support in the welfare and rehabilitation of the patients at the hospital. The GPA operates a thrift shop and a candy store, located at the hospital, to raise money for the patients. March 2013 bank statement balances amounted to \$250,000 for the GPA. The GPA had inflows of \$53,000 and outflows of \$38,000 in fiscal year 2012. These funds are used for unit parties, patient field trips, and various other needs of the patients.

Recommendation

We recommend that the hospital utilize the welfare fund to pay for purchases of items or events that benefit the entire population. The hospital should also request additional funds from the GPA to assist in the welfare of the patients.



Food Service Personnel

Food Service personnel should have meal purchases deducted from their bi-weekly pay.

The Department of Human Services policy over food service personnel require employee meal purchases be transacted through a \$24 bi-weekly payroll check deduction unless medically excused. Our review of the employee plan meal deductions for pay period ending July 13, 2012 found only 23 out of 93 food service employees (25 percent) had biweekly meal deductions. The hospital personnel officer partially implemented corrective actions by enrolling 36 additional food service employees to its meal plan for the pay period ending September 7, 2012. The payroll department staff had inadvertently failed to reinstate food service employees following leave of absences to the employee meal plan and did not periodically analyze employee meal deductions recorded on the payroll registers. Overall, based on the corrective action taken, the hospital will generate additional funding of \$22,000 annually to offset employee meal cost.

Recommendation

We recommend the hospital personnel unit reconcile employee meal deductions per payroll register to all eligible food service employees periodically.



Observation

Conditional Extension Pending Placement

The Department of Human Services and the hospital should continue developing ways to release Conditional Extension Pending Placement patients in a timely manner.

Patients are deemed Conditional Extension Pending Placement (CEPP) status when they are determined to be ready for discharge by the court, but have no appropriate community-based placement available. Patients have a right to refuse placement in a community setting even if placement is available. The hospital management provided the breakdown of CEPP status on May 20, 2013 as follows.

Reason	Percentage
Accepted and in the process of placement	26
Appropriate placement or services not available	18
Patient or guardian refusing placement	18
Referred and being evaluated	12
Immigration barriers	8
Other	18
Total	100

As of March 11, 2013, 135 out of the hospital's 545 patients (25 percent) have been designated CEPP status. One patient has been on CEPP status since November 2001. Based on our analysis of the hospital's daily per capita cost for patients per DHS State Budgets for fiscal years 2002 through 2013, and the amount of days each individual has been on CEPP status, we estimate that the hospital has spent \$21.9 million on these 135 patients while they have been designated CEPP. The number of CEPP patients at the hospital has improved significantly over the past few years. On July 1, 2010, the hospital had 208 of 490 patients (42 percent) that were deemed CEPP.



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September 23, 2013

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Dear Mr. Termyna:

This is in response to your letter of August 1, 2013 to Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled *Department of Human Services, Division of Mental Health and Addiction Services, Greystone Park Psychiatric Hospital*. Your letter provides an opportunity to comment on the draft audit report.

The objective of the audit was to determine whether financial transactions were related to the hospital's programs, were reasonable, and were recorded properly in the accounting systems.

The Audit found that the financial transactions included in your testing were related to the hospital's programs and were recorded properly in the accounting systems. It also found that the financial transactions were reasonable, except for certain internal control weaknesses and inefficiencies related to Medicare claims, which also affected county billing reimbursements. The audit found additional internal control and compliance issues meriting management's attention, and found that the hospital has resolved an issue noted in your prior report from May 2005.

Department staff met with your auditors on two recent occasions to provide additional information, which we believe supports a lower estimate of missed Medicare Part A claims. As outlined below in our response to the audit findings, we will be implementing improved controls in an effort to maximize Medicare claims and address all issues identified by the audit.

Medicare Part A

Audit Finding: See Page 3 of the Audit Report

Audit Recommendation:

The Audit recommends that the hospital and the bureau maximize Medicare Part A revenue by implementing controls and monitoring procedures to ensure the integrity of the eligibility data and timeliness and accuracy of billing for Medicare Part A. The Audit also recommends that the bureau retroactively review admissions and submit claims for all reimbursements that have the potential of being collected.

Agency/Hospital Response:

The Department agrees with the auditor's finding of \$348,000 in billing exceptions discovered in the audit sample of 100 patients. We also agree with the audit recommendations for improvement to systems and process. We do not believe, however, that \$4.6 million represents a reasonable upper limit estimate of unbilled Medicare Part A claims during the 27 month period covered by the audit. Correspondingly, we do not believe that \$600,000 is a reasonable upper limit estimate of County overpayments to the State. We note that total billing for State Psychiatric hospitals to all counties over the 27 month period covered by the audit is predicted to be approximately \$100 million when all actual cost, recovery and placement data has been reconciled. Based upon this office's direct review of more than half of the 1,242 patient episodes covered by the audit, we believe that the upper limit estimate of missed Medicare Part A billings and corresponding overpayments by Counties is approximately half of what was suggested by the auditors. We also believe that a significant portion of any estimated missed Medicare billings is ultimately discovered and billed by Hospital and Department staff because the Department routinely continues to process claims beyond the time frames of the audit. Regarding County payments to the State, county billings are adjusted to reflect paid Medicare claims at each point in time that Medicare reimbursement is received.

With estimates of missed billing notwithstanding, the Department does believe that improvements to our process and surrounding controls are needed in order to maximize Medicare billing and shorten the time frame needed to prepare and submit claims. It is our intention to build in a number of improvements, including but not limited to an improved method for determining patient Medicare eligibility, follow up efforts to confirm Medicare eligibility and a more streamlined effort and process between hospital and Department staff.

Medicare Part B

Audit Finding: See Page 4 and 5 of the Audit Report

Audit Recommendation:

The audit recommends that the hospital implement monitoring procedures and adequate training to ensure maximum reimbursement for Medicare Part B physician services. Billings for physician services should be incorporated under the supervision of the hospital's business office and the hospital should also retroactively review all unclaimed billable services and submit for reimbursement. Additionally, as stated by DHS policy, the hospital should bill for services provide by contracted physicians.

Agency/Hospital Response:

As of June 10, 2013, MBS replaced the legacy Meditrak application to submit and bill Medicare Part B Physician Services. The GPH Audit focused on Fiscal Years 2011 and 2012, during which time Meditrak was operational. The new application has improved upon those findings cited as deficiencies in this audit.

MBS includes a validation check for every Medicare Part B Policy Rule, testing for medical necessity and the integrity between the procedure documented and the diagnoses cited. Passing all levels of editing deems the claim complete and billable.

MBS provides numerous reports to review claim status from initial entry, through iterations of correcting a rejected claim, to ultimately paid status. Rejected claims are now corrected by the hospital. The hospital sees all rejections and reasons for rejection. The interpretation of Medicare reason and remark codes will direct the hospital as to who must be communicated with to get the claim corrected and re-submitted for reimbursement. DHS Office of Finance reporting will monitor the completeness and accuracy of claims.

Numerous financial reports are available in MBS and will be utilized by hospital Senior Management to monitor Medicare Part B Revenue.

MBS records Physician Certification submissions, effective dates and reassignment of benefits. Recording of Physician Certification can be accessed by the MBS Hospital Administrator or the Medical Director's Office. MBS will provide notifications to the physician indicating non-compliance and tardiness certification. MBS will provide reporting to calculate potential loss of revenue per physician.

Private Insurance

Audit Finding: See Page 5, 6 and 7 of the Audit Report

Audit Recommendation:

The audit recommends that the hospital improve procedures and adequately train personnel on private insurance billing and the appeal process. The audit also recommends that the hospital establish in-network relationships with Medicare and Medicaid Managed Care Organizations.

Agency/Hospital Response:

We agree with the audit's recommendation to provide additional training, and will also examine the possibility of establishing in-network relationships with Medicare and Medicaid managed care organizations.

Institutional Medicaid Revenue

Audit Finding: See Page 7 of the Audit Report

Audit Recommendation:

We recommend the hospital establish follow-up procedures for the submission of Medicaid applications, implement the required updated billing for Medicaid, and pursue all unclaimed reimbursements.

Agency/Hospital Response:

We agree with the Audit's recommendation.

Purchasing and Fixed Assets

Audit Finding: The hospital does not comply with applicable purchasing and fixed assets regulations.

Audit Recommendation:

The audit recommends the hospital comply with applicable Department of Treasury Circular Letters regarding delegated purchase authority transactions and fixed assets. The hospital should also plan purchases more efficiently to reduce the processing of excess purchase orders.

Agency/Hospital Response:

GPPH will continue to adhere to the State of New Jersey Department of Treasury's Circular Letters: 11-10-DPP Delegated Purchasing Authority (DPA) and 11-19-OMB Asset Inventory Requirements (Equipment – Tangible and Intangible). We have purchased a centralized inventory control system that will permit us to track all of our fixed assets in accordance with the circular letter.

Improper Transaction Types

Audit Finding: Improper transaction types circumvented budgetary controls.

Audit Recommendation: The audit recommends that the hospital and DHS use transfers of appropriations, when appropriate.

Agency/Hospital Response:

The Department has reinforced to Greystone Park Psychiatric Hospital (GPPH) the importance of utilizing TA's (Transfers of Appropriations).

Welfare Fund

Audit Finding: Welfare Fund type purchases are being funded by state appropriations.

Audit Recommendation:

The audit recommends that the hospital utilize the Welfare Fund to pay for purchases of items or events that benefit the entire population. The hospital should also request additional funds from the GPA to assist in the welfare of the patients.

Agency/Hospital Response:

The Department will take this recommendation under advisement and consult with the Hospital's Board of Trustees.

Food Service Personnel

Audit Finding: Food Service personnel should have meal purchases deducted from their bi-weekly pay.

Audit Recommendation:

The audit recommends that the hospital personnel unit reconcile employee meal deductions per payroll register to all eligible food service employees periodically.

Agency/Hospital Response:

We agree with the Audit's recommendation and have taken proactive steps to remediate this concern.

Conditional Extension Pending Placement

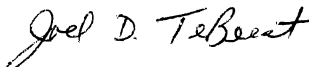
Audit Observation:

The Department of Human Services and the hospital should continue developing ways to release Conditional Extension Pending Placement (CEPP) patients in a timely manner.

Agency/Hospital Response:

The Department's Olmstead efforts are governed by a settlement agreement, reached in 2007 with Disability Rights New Jersey. This settlement agreement dictates, in part, the timeframes during which a patient may remain on CEPP status. The Division's budget continues to be supported with funding to meet its Olmstead obligations.

Sincerely,



Joel D. TeBeest, CPA
Director
Office of Finance

- C: Jennifer Velez, Commissioner, DHS
Christopher Bailey, Assistant Commissioner, DHS
Lynn Kovich, Assistant Commissioner, DHS, DMAHS
Janet Monroe, CEO, Greystone Park Psychiatric Hos