New Jersey Legislature
Office of LEGISLATIVE SERVICES
OFFICE OF THE STATE AUDITOR

EXECUTIVE SUMMARY

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES
NEW JERSEY MEDICAID/NEW JERSEY FAMILYCARE
DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES
July 1, 2018 to October 31, 2022

We found the division generally had adequate controls in place to properly monitor the fee-for-service (FFS) and managed care organizations (MCO) and ensure that reimbursements for FFS and managed care claims were reasonable and adequately supported. In making these determinations, we noted issues meriting management's attention.

AUDIT HIGHLIGHTS

- Providers did not always provide adequate support for the claims for which they billed. We sampled 822 provider claim reimbursements totaling $368,531 for adequate supporting documentation. Based on our review of the supporting documentation provided by the providers and health plans, we found that 164 claims (20.5 percent) totaling $67,244 were not adequately supported by the billing providers.

- The claim processing systems of the division and the MCOs lacked the necessary edits to detect certain duplicate claim reimbursements. Our analysis found 24,452 claims totaling $3.7 million that we considered to be possible duplicate claims. We selected 163 instances encompassing 424 claims totaling $147,808 and found 16 duplicate claims totaling $1,709 billed by providers and reimbursed by one of the health plans.

- We performed an analysis of 93,009 rentals totaling $53.4 million to identify beneficiaries who had rental claims for a medical equipment item for more than 10 consecutive months. We tested 91 instances and determined that 46 exceeded the 10-month reimbursement limit. The estimated overpayments totaled $14,351.

- The division allowed FFS DME providers to decide which documentation they submitted to determine the reimbursement amount and did not verify that the amount submitted by the provider was as required by the administrative code. We also found the MCOs accepted manufacturer's invoices that were created by the provider for price verification.

- We noted 76,804 reimbursed claims for items possibly not covered under the Medicaid program totaling $3.1 million based on procedure codes and item descriptions listed in the administrative code. We selected 64 claims totaling $7,619 and requested justification from health plan providers. They did not provide an answer.

- The FFS program did not require preauthorization (PA) for medical supply claims when the total claim reimbursement is $100 or more. We tested 30 FFS claims and found 5 of the 30 claims tested (16.7 percent) for the FFS health plan did not have the required PA.

- The division's fiscal agent lacked system edits to verify the MCOs were submitting all of their adjustments/recoupments, which could possibly inflate Medicaid reimbursements.

- Comparing the costs of items purchased from out-of-state providers to in-state providers could be beneficial. We estimated out-of-state providers were reimbursed $1.67 million more for purchases and $335,384 more for rentals than the maximum amount paid to any in-state provider for the same procedure code and quantity.

AUDITEE RESPONSE

The department generally concurs with our findings and recommendations.

For the complete audit report or to print this Executive Summary, click on the attached files.