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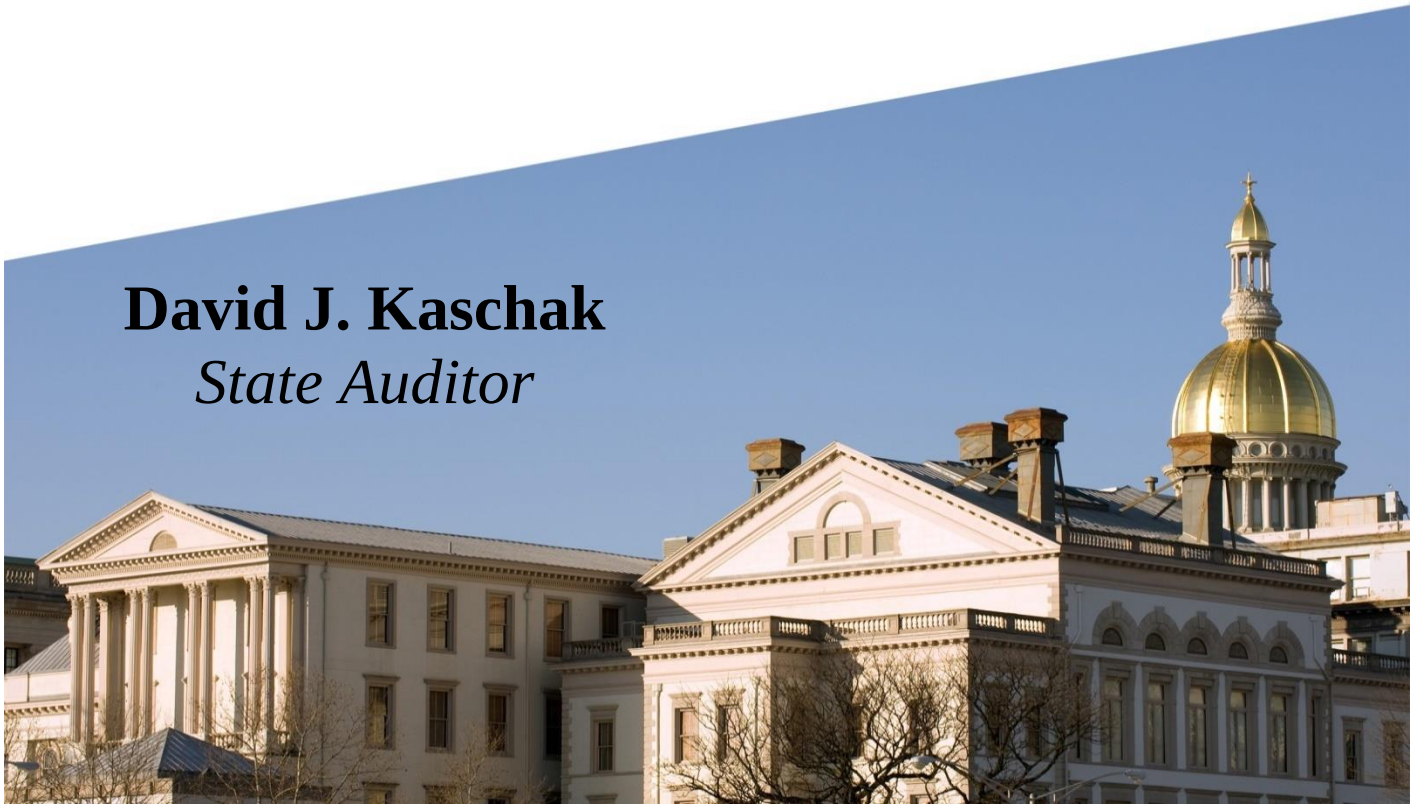
Department of Human Services
Division of Medical Assistance and Health Services
New Jersey Medicaid/New Jersey FamilyCare
Durable Medical Equipment and Medical Supplies

July 1, 2018 to October 31, 2022



David J. Kaschak
State Auditor

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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, New Jersey Medicaid/New Jersey FamilyCare, Durable Medical Equipment and Medical Supplies for the period of July 1, 2018 to October 31, 2022. If you would like a personal briefing, please call me at (609) 847-3470.

David J. Kaschak
State Auditor
April 19, 2023

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), New Jersey Medicaid/New Jersey FamilyCare (Medicaid), Durable Medical Equipment (DME) and Medical Supplies for the period July 1, 2018 through October 31, 2022. Our audit included a review of the Medicaid fee-for-service (FFS) and managed care program reimbursements to providers for DME and medical supply claims. Our audit did not include a review of Medicaid reimbursements to any other provider type or for beneficiaries enrolled in a Dual Eligible Special Needs Plan. As of December 21, 2022, there were 30,714 claims totaling $5.1 million that were reimbursed to providers by the FFS program and 4,141,147 claims totaling $329.7 million reimbursed to providers by the five managed care organizations (MCOs) for the managed care program for the period of July 1, 2018 through October 31, 2022.

Objectives

The objectives of our audit were to determine whether adequate controls were in place to properly monitor the FFS and managed care programs and ensure that reimbursements for FFS and managed care claims were reasonable and adequately supported.

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. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

In preparation for our testing, we studied the administrative code, federal regulations, and policies of both the division and the five MCOs. Provisions we considered significant were documented, and compliance with those requirements was verified by interviews with division personnel, observation, and through our review and testing of DME and medical supply claims. We also interviewed personnel from the division’s fiscal agent for the FFS program and from each of the five contracted MCOs to obtain an understanding of the programs and internal controls. In order to achieve our objectives, we performed various tests and analyses, as we determined necessary. Additional detail regarding our methodology and work performed can be found in the Appendix, as well as in the finding section when testing resulted in a reportable condition.

A nonstatistical sampling approach was used during our audit. Our samples of Medicaid DME and medical supply claims were designed to provide conclusions on our audit objectives, as well

as internal controls and compliance. Sample populations were sorted, and claims were both randomly and judgmentally selected for testing.

Data Reliability

We assessed the reliability of Medicaid claims data in the Medicaid Shared Data Warehouse (SDW) by testing the claims and interviewing key personnel of the division, the SDW's third-party contractor, and the division's fiscal agent knowledgeable about the data. We also reviewed existing reconciliations prepared by the SDW's third-party contractor to assess the data. We determined that the claims data in the SDW is sufficiently reliable for the purpose of this report. However, we did note several issues during our testing of claims data that resulted in a reportable condition.

Conclusions

We found the division generally had adequate controls in place to properly monitor the FFS and managed care programs 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 related to claims support, duplicate claims, rentals, miscellaneous codes, noncovered items, preauthorization, data reliability, and the Medicaid Supplier Manual. In addition, we made an observation regarding DME and medical supply items purchased from out-of-state providers compared to in-state providers.

Background

The Medicaid program covers DME and medical supplies, including enteral, total parenteral nutrition and other intravenous therapies for Medicaid beneficiaries. It provides health coverage for individuals and families with low incomes and limited resources. The federal government established Medicaid under Title XIX of the Social Security Act on July 30, 1965. States operate Medicaid programs in accordance with their own rules and criteria that vary within the broad framework established by the federal government. The federal government requires states to provide a basic set of medical services to eligible individuals. Beneficiaries who receive these services are either enrolled in the FFS program or the managed care program with one of the five MCOs. FFS is the traditional health insurance program, in which healthcare providers bill Medicaid directly for their services and the FFS claims are processed through the division's fiscal agent that manages the FFS program. FFS beneficiaries include those new to the program and not yet enrolled into a managed care program, those in long-term care who are not enrolled in Managed Long-Term Services and Supports (MLTSS), those in state institutions (psychiatric hospitals and developmental disability facilities), and those residing in Veterans Administration homes. Under managed care, beneficiaries choose one of the five MCOs contracted with the division to provide and manage healthcare services. For these beneficiaries, the division pays a capitation rate (monthly premium) per beneficiary to the MCO in which they are enrolled.

The division relies on both the FFS fiscal agent and the MCOs to monitor the Medicaid program based on policies and procedures set forth by the division to process claims submitted for reimbursement by Medicaid providers. The claims are subject to system edits to ensure all required information has been submitted and the claim has met program requirements. Reimbursements for DME and medical supply claims are based on each of the health plan's Medicaid fee schedules or negotiated contracted rates with individual providers, which may differ among the health plans. However, regardless of the methodology, the claim reimbursement should always be the lesser of the provider's usual and customary charge to the general public, or the allowable fee/rate established by the health plan.

DME and medical supply claims are initiated by the provider, which submits the claim to the health plan for reimbursement. That information then goes through the claim processing system edits for adjudication to determine whether the claim is approved or denied.

Claims Support

Providers did not always provide adequate support for the claims for which they billed.

All claims are subject to control edits prior to reimbursement by the health plans to ensure all the required information has been submitted and the claim has met program requirements. The division contracts with a fiscal agent to manage the FFS claim processing system, while the MCOs manage their own. Although all providers need to maintain adequate supporting documentation for each claim that they bill, the health plans do not always require the documentation to be submitted or review it prior to making payment.

We obtained the claims data for the period July 1, 2018 through June 22, 2021 for both FFS and managed care programs. We used this data to perform a number of audit analyses, all of which included an attribute test for supporting documentation. The various test populations included:

- 7,274 instances encompassing 24,452 possible duplicate claims totaling $3.7 million. A random sample of 163 instances encompassing 424 claims totaling $147,808 was selected across all health plans.

- 76,804 claims for possible noncovered items totaling $3.1 million. A judgmental sample of 64 claims totaling $7,619 was selected across all health plans.

- 159,690 claims requiring preauthorization totaling $94,669,030. A random sample of 199 claims totaling $149,384 was selected across all health plans.

- 393,799 claims for incontinence supplies totaling $19 million. A random sample of 75 claims totaling $3,893 was selected across all health plans.

- 32,602 claims for miscellaneous procedure codes (E1399 and K0108) totaling $8.3 million. A random sample of 60 claims totaling $59,826 was selected across all health plans.

In total, we sampled 822 claim reimbursements across all health plans 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. Reasons for this determination included the following:

- 7 of the claims were missing either a prescription, medical necessity form, or physician order

- 20 of the claims did not have the required preauthorization

- 45 of the claims did not have proof of delivery

- 33 of the claims had issues with the prescription or medical necessity form

- 11 of the claims had issues with the preauthorization
- 26 of the claims had issues with the invoice or proof of delivery
- 24 of the claims had incorrect payment calculations
- 18 of the claims were duplicates
- 30 of the claims had no supporting documentation at all, as there was no response from the provider

The lack of supporting documentation provides an opportunity for improper reimbursement and a misappropriation of Medicaid funds.

Recommendation

We recommend the division improve its monitoring of providers for the FFS program to ensure that claims are adequately supported prior to reimbursements. Furthermore, we recommend the division require the MCOs do the same for the managed care program.

Duplicate Claims

System edits did not always prevent reimbursements for duplicate claims.

We analyzed claims data to identify possible duplicate claims by comparing several claim fields, including beneficiaries' current Medicaid ID, national provider identification number, procedure code, and claim service date.

Our initial analysis found 7,274 instances encompassing a combined 24,452 claims for both miscellaneous procedure codes and non-miscellaneous procedure codes that we considered to be possible duplicate claims. The total amount reimbursed for these claims was $3.7 million. We randomly selected 163 instances encompassing 424 claims totaling $147,808 across all health plans for testing, and we found the following issues:

- 16 claims totaling $1,709 were actual duplicate claims that were billed by providers and reimbursed by one of the health plans.
- 52 claims totaling $3,906 lacked adequate supporting documentation, thereby preventing us from determining whether they were duplicates.

The claim processing systems of the division and the MCOs lack the necessary edits to detect duplicate claim reimbursements. This lack of system edits could allow the total reimbursement

amounts to be inflated, which could affect the capitation rates used by the division to reimburse MCOs for their services, as the reimbursement amounts are a contributing factor when determining the capitation rates.

Recommendation

We recommend the division review and enhance its system edits to detect duplicate claims prior to reimbursement. In addition, we recommend the division request the MCOs to do the same for the managed care program.

Rentals

DME rentals have surpassed their monthly reimbursement limit and have exceeded the purchase price.

DME may be rented when the medical need for the equipment is of such duration that the rental is more economically practical than authorizing its purchase. For the FFS health plan, the rental is based on the New Jersey Administrative Code (N.J.A.C.) 10:59-1.8. Section (b)1 states that if the item has a maximum fee allowance of $100 or less, the monthly rental payment will be the amount billed or 20 percent of the approved purchase price, whichever is less, not exceeding six such payments. Section (b)2 states that if the item has an approved maximum fee allowance of more than $100, the monthly rental payment will be the amount billed or 12 percent of the fee, whichever is less, not exceeding ten payments. When such payments are met, the item shall be deemed to have been purchased. No further payments shall be made, and the equipment will be considered the property of the state. However, the five MCOs are not required to follow the administrative code regarding rentals. Certain rentals are reimbursed on a monthly fee that shall not exceed ten continuous monthly payments. When this occurs, it is deemed to have been purchased, and no further payment shall be made, unless Medicaid is the secondary payer of the claim.

We performed an analysis of 93,009 rentals encompassing 616,312 claims (excluding claims for oxygen and miscellaneous codes), totaling $53.4 million, for the period July 1, 2018 through June 22, 2021 to identify beneficiaries who had rental claims for a medical equipment item for more than 10 consecutive months. We found one instance for FFS and 4,483 instances for managed care where the beneficiary had more than 10 consecutive monthly claims for the same item during our audit period. There was also one instance for FFS and 1,556 instances for managed care where there were more than 10 payments for the same item; however, the payments were not consecutive (a month gap or more).

We judgmentally selected a sample of the managed care instances to determine whether the reimbursement limit was exceeded. Our sample included 91 instances totaling $79,213 where the claim payments exceeded 10 months. We determined that 46 of these instances (50.6 percent)

exceeded the applicable 10-month reimbursement limit and the item should have been considered purchased. The estimated amounts of these overpayments totaled $14,351. Control edits in the managed care program did not always prevent a claim from being reimbursed after the DME item had exceeded the applicable monthly reimbursement limit.

After bringing our results to each of the MCO's attention, one MCO concurred that all of the instances provided were paid in error (other MCOs agreed with some of the errors, but not all). After we brought this issue to its attention, the MCO added an edit in its system to deny rental claims that exceeded the applicable monthly reimbursement limit.

In addition, we performed an analysis of all rental claims for the same period to identify any rental that exceeded the average purchase price of the item by more than $100. We found there were 1,660 instances totaling $1.9 million in rental payments for managed care where the total rental payment exceeded the average purchase price by more than $100. We estimate the overpayments of these items to be $845,482. We also found 23 instances totaling $8,225 for FFS where the estimated overpayment amounted to $4,581.

Allowing rental reimbursements to exceed the monthly reimbursement limit could affect capitation rates, as the reimbursement expenses are a contributing factor when determining the rates.

Recommendation

We recommend the division require the MCOs to review and enhance their system edits in the managed care program to prevent rentals from exceeding the monthly reimbursement limit and the purchase price.

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Reimbursement for Miscellaneous Codes

Reimbursement to providers for miscellaneous procedure codes may not always be reasonable or based on amounts that were adequately supported.

Most claims are reimbursed based on an established fee schedule that has been set by each of the health plans. However, there are procedure codes, such as miscellaneous codes, that do not have an established fee; therefore, the reimbursement is calculated differently, using various methodologies.

For the FFS health plan, reimbursement is based on N.J.A.C. 10:59-1.8 section (a)1, which states:

> *If there is no Medicaid/NJ FamilyCare Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public or a calculated maximum fee allowance equal to 130 percent of a supplier's*

invoice cost or 80 percent of the manufacturer's price list for supplies and equipment priced by report.

For the managed care health plans, four of the five MCOs negotiate rates with the providers for these procedure codes to reimburse at a percentage of the provider's bill charge, rather than following N.J.A.C. 10:59-1.8.

During our testing, we found that the division allows FFS providers to decide whether they will submit an invoice or the manufacturer's price to determine the reimbursement amount. In addition, the division does not verify that the amount being billed by the provider is its usual and customary charge. Therefore, the division cannot be certain that these claims have been reimbursed at the lesser amount as required by the administrative code.

In the managed care program, the MCOs require providers to submit the manufacturer's invoice for these claims; however, we found that the MCOs would also accept invoices that were created by the provider for price verification. We also noted instances where the amount being billed by the provider for these claims was an amount above the manufacturer suggested retail price (MSRP). For example, a provider billed $5,391 for an item, which was 80 percent above the MSRP of $2,995, and was reimbursed an amount above that MSRP. The cost to the provider was only $1,467.55 before any discounts. In addition, the MCOs did not verify whether the amount being billed by the providers was their usual and customary charge.

Claims should not be reimbursed by the health plans without verifying whether the bill charge amount is the provider's usual and customary charge. Reimbursements to providers should be adequately supported to ensure the accuracy, propriety, and reasonableness of the reimbursement. Allowing the providers to bill the health plans using various methodologies that are not always adequately supported, creates an opportunity for providers to inflate their bills beyond a reasonable amount, thus unnecessarily increasing the costs to the Medicaid program.

Recommendation

We recommend the division comply with the criteria as set forth in N.J.A.C. 10:59-1.8 for the FFS program. We also recommend the division require the MCOs review their reimbursement policies to ensure the reasonableness of the reimbursement methodology for miscellaneous procedure codes and that their reimbursements are adequately supported.

Noncovered Items

Reimbursements were made to providers for items not covered under the Medicaid program.

The Medicaid program does not cover medical supplies, routinely used DME, and other therapeutic equipment/supplies essential to furnish the services offered by a facility for the care and treatment of its residents. Pursuant to the Medical Supplier Manual, New Jersey Administrative Code (N.J.A.C.) 10:59-1.4(a)4, such items are considered part of a nursing facility's per diem and, therefore, are not covered. Examples of these items include but are not limited to hospital beds (including mattress and side rails), oxygen and related equipment, nebulizers, and medical supplies, such as incontinency pads, bandages, dressings, pads used to save labor or linen, catheters, and rubber gloves. In addition, N.J.A.C. 10:59-1.4(b) lists items that are considered noncovered, which include but are not limited to the following: first aid supplies or medicine chest items (gauze, adhesive tape, bandages, and cotton), humidifiers, mattresses (orthopedic or mattresses without FDA approval), pads (heating, hydrocollators, sanitary, thermophore), and scales.

Based on our review of the procedure codes and the descriptions of the items listed in the administrative code, there were 76,804 claims for possible noncovered items totaling $3.1 million billed by providers and reimbursed by the health plans. Of those claims, 459 totaling $18,568 were reimbursed by the FFS health plan and 76,345 claims totaling $3.1 million were reimbursed by the five MCOs of the managed care health plan.

We sorted the 76,804 claims by health plan and selected a judgmental sample of 64 claims totaling $7,619 across all health plans. We asked each of the health plans if the claims should have been reimbursed based on the administrative code. After reaching out several times, the health plans did not provide us with an answer and made no determination as to whether these reimbursements should have been made based on the administrative code. Therefore, we could not determine whether these claims were proper.

The providers should not have sought reimbursement and the health plans should not have reimbursed for routine items that are covered by a nursing facility's per diem rates or for items considered to be noncovered according to N.J.A.C 10:59-1.4. The possible improper reimbursements by the health plans demonstrate a lack of edits and controls within their claim processing systems. Reimbursing for items that should not have been covered in the managed care program could affect the capitation rates, as the reimbursement expense is a contributing factor when determining the rates.

Recommendation

We recommend the division comply with N.J.A.C. 10:59-1.4 and clearly identify which procedure codes are considered to be noncovered and which procedures are included in nursing facilities' per diem rates. We also recommend the division implement procedures to monitor

claim reimbursements for these noncovered items for the FFS program to ensure that only covered items are reimbursed. Furthermore, we recommend the division require the MCOs to do the same for the managed care program.

Preauthorization

The FFS program does not require preauthorization for medical supply claims when the total claim reimbursement is $100 or more.

Preauthorization (PA) is required for claims meeting certain criteria established by each of the individual health plans and is intended to reflect decisions regarding medical necessity and purchase/rental options for Medicaid beneficiaries. When a claim requires a PA, the provider must obtain authorization from the health plan it is billing. The health plan is responsible for providing a disposition to the PA request. The approval of the PA by the health plan is not a guarantee of payment, as reimbursement of the claim is determined by the claim processing edits established by the health plan for adjudication.

Based on each of the health plans' PA criteria, we drew a random sample from each health plan, totaling 199 claims and $149,384. We tested the effectiveness of the health plans' internal controls over their preauthorization process. We found that all health plans had sufficient controls over their PA processes, except for the FFS health plan. Our testing of this control found 5 of the 30 claims tested (16.7 percent) for the FFS health plan did not have the required PA. According to N.J.A.C. 10:59-1.6 (d), medical supplies with a purchase price of $100 or more requires a PA in the FFS program. However, a system edit in the New Jersey Medicaid Management Information System (the computerized claims processing and information system that supports the Medicaid program) requires a PA when a single item is $100 or more. The system does not consider when multiple purchases of the same item have a total purchase price of $100 or more. For claims such as these, a PA should also be required but is not. Furthermore, the $100 purchase price threshold, as stated in the administrative code, may need to be reviewed to determine if that amount should be increased to accommodate for rising prices.

Recommendation

The division should implement controls in the FFS program to require PAs for all medical supplies where the purchase price is $100 or more, whether it is for one item or multiple items that are the same. In addition, we recommend the division review N.J.A.C. 10:59-1.6 (d) to determine if the purchase price of $100 requiring a PA should be increased.

Data Reliability

System edits do not always accurately process and accept managed care claims for recording purposes into the New Jersey Medicaid Shared Data Warehouse (SDW).

During our audit, we had determined that the claims data in the SDW was sufficient for the purpose of our audit findings and conclusions in this report. However, we noted exceptions with managed care claims data during our testing that could affect the monthly capitation rates used by the division to reimburse MCOs for their services.

Claims for the managed care program are processed and reimbursed by the five MCOs that the division contracts with to provide medical and health services to New Jersey Medicaid beneficiaries. The claims are electronically submitted daily by the MCOs to the division's fiscal agent for recording purposes. The fiscal agent will submit a file that itemizes all processed claim records that the MCOs are responsible for accepting and processing according to the HMO System Guide. This shall include the disposition (approved or denied) for each claim record the MCO submits, along with the error(s) for every denied claim recorded that the division's fiscal agent denied. Within 90 days, the MCO is responsible for matching the claims records from the fiscal agent's file against their data file(s) to correct any denied claim records and discrepancies noted by the fiscal agent. The MCOs then resubmit the corrected claims according to the requirements listed in the HMO Systems Guide. However, the division's fiscal agent does not reconcile the claims or files that were received by the MCOs that had once been rejected and have now been resubmitted. It is the responsibility of the MCOs to ensure all claims that should have been submitted were accepted. The claims data in the SDW may not always reflect the MCOs adjustments/recoupments.

As noted in an earlier finding, during our previous testing of duplicate claims from a population of 163 instances, totaling 424 claims amounting to $147,808, we found 10 claims totaling $30,525 that were duplicates. However, the providers were not reimbursed by the MCO that submitted the claims. Rather, the MCO had submitted the claim record twice and the fiscal agent accepted and recorded them as different claims. This occurred because the edit logic in the fiscal agent's claim processing system allows managed care claims, for certain procedure codes, to bypass the duplicate edit check. We also found seven claims for items totaling $1,325 that were also included in other claims the MCO had submitted to the fiscal agent. This occurs when the MCOs bundle individual claim line items and submit them to the division's fiscal agent as one claim. When these are submitted to the division's fiscal agent, it appears as if a new claim has been submitted. At this point, the claim has been submitted more than once. This was not detected by the fiscal agent. In addition, we found 12 claims where the MCOs made an adjustment/recoupment to the claims with no adjustment/recoupment recorded in the SDW.

The division's fiscal agent lacks the necessary system edits to identify and prevent the MCOs from submitting the same claims more than once. When this happens, those duplicate claims are accepted and recorded as valid claims in the SDW, thereby inflating the number of valid claims. There is a lack of controls to verify that the MCOs are submitting all of their claim

adjustments/recoupments. These claim processing discrepancies could possibly inflate Medicaid reimbursements, which could affect the capitation rates as the reimbursement expenses are a contributing factor when determining the capitation rates.

Recommendations

We recommend the division review the system edits of the fiscal agent and make the necessary changes to prevent managed care claims from being duplicated in the SDW. We also recommend the division require the MCOs to review their claim submission processes when bundling line items for submission to the fiscal agent in order for each item to be properly accounted for in the SDW. Furthermore, we recommend the division implement a process to ensure all MCO adjustment/recoupments are submitted and recorded in the SDW.

Medical Supplier Manual

The Medical Supplier Manual does not support current policies and procedures.

During our audit, we found that N.J.A.C. 10:59, the Medical Supplier Manual, is in need of updating. The most recent updates were made in June 2020. However, the changes did not reflect all those that should have been included.

An example of a needed update includes removing Section 1.11 "Recycling durable medical equipment." This refers to the division using the services of a DME recycling contractor to recycle certain DME for reuse. The division no longer uses a recycling contractor or recycles DME. We also found that not all active procedure codes are listed in the manual. In addition, we found duplicated procedure codes in the manual. It is vital that the manual is regularly updated so users, including the division, the MCOs, and providers, have access to the most current policies and procedures.

Recommendations

We recommend the division review the manual and make the necessary changes that are required to bring N.J.A.C. 10:59 up to date with current regulations, policies, and procedures.

Observation

In-State and Out-of-State Reimbursements Cost Comparison

Comparing the cost of DME and medical supply items purchased from out-of-state providers to in-state providers could prove beneficial.

We analyzed the DME and medical supply claims data in the SDW from July 1, 2018 through June 22, 2021 by health plan, quantity, and procedure code (excluding miscellaneous procedure codes). We found 49,158 claims totaling $5.3 million for purchases and 1,209 claims totaling $1 million for rentals where out-of-state servicing providers were paid more than the maximum amount paid to any in-state provider for the same procedure code and quantity by the same health plan.

We estimate that those out-of-state providers were reimbursed a total of $1.67 million more for purchases and $335,384 more for rentals than the maximum amount paid to any in-state provider by the same health plan for the same procedure code and quantity.

Appendix

Methodologies to Achieve Audit Objectives

Except where otherwise noted, the following audit procedures used information in the New Jersey Medicaid Shared Data Warehouse and claim documentation provided by providers and health plans for DME and medical supply claims between July 1, 2018 and June 22, 2021.

We performed a match of the Medicaid claims data to the Vital Statistics Death file to determine whether controls were in place and functioning to prevent providers from billing and being reimbursed for claims for deceased beneficiaries.

We performed a match of Medicaid providers that were debarred/disqualified from providing services as of March 2, 2021 to the Medicaid claims data to determine whether system edits were in place and functioning to prevent these providers from billing and being reimbursed for claims.

State of New Jersey
Department of Human Services

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PHILIP D. MURPHY
Governor

SARAH ADELMAN
Commissioner

SHEILA Y. OLIVER
Lt. Governor

April 18, 2023

David J. Kaschak
State Auditor
Office of the State Auditor
125 South Warren Street
P.O. Box 067
Trenton, NJ 08625-067

Dear Mr. Kaschak:

The Department of Human Services (the Department) is in receipt of the Office of the State Auditor's (OSA) draft audit report titled "Department of Human Services Division of Medical Assistance and Health Services New Jersey Medicaid/New Jersey FamilyCare Durable Medical Equipment and Medical Supplies". The Department agrees with OSA's conclusion that the division had adequate controls in place to properly monitor the fee-for-service (FFS) and managed care programs and ensure that reimbursements for FFS and managed care claims were reasonable and adequately supported. Additionally, the Department generally agrees with OSA's findings and recommendations and will address these recommendations. We appreciate OSA's review and thank you for the opportunity to comment on the draft report.

Please accept the following responses to the draft audit recommendations:

OSA Recommendation

We recommend the division improve its monitoring of providers for the FFS program to ensure that claims are adequately supported prior to reimbursements. Furthermore, we recommend the division require the MCOs do the same for the managed care program.

Response

The Division of Medical Assistance and Health Services (DMAHS) agrees that methods to monitor provider's compliance with billing requirements for Durable Medical Equipment (DME) can be improved

with increased monitoring. However, DMAHS notes that when a prior authorization (PA) is required, DMAHS does require all necessary information prior to approval of DME or medical supplies requests.

OSA also questioned the appropriateness of several Medical Necessity Forms (MNF) that were created by the DME provider. DMAHS considers an MNF acceptable if it contains the required information identifying the item requested and documentation which supports medical necessity. The practitioner's signature verifies that the information on the MNF is correct.

DMHAS will share the results of this audit with our managed care plans to help improve its monitoring of providers for the FFS program.

OSA Recommendation

We recommend the division review and enhance its system edits to detect duplicate claims prior to reimbursement. In addition, we recommend the division request the MCOs to do the same for the managed care program.

Response

The DMAHS FFS program has edits in place to prevent the same provider from billing the same service for the same date of service. As a result, all DME claims are matched to prevent billing for the same provider number, same recipient number, and the same claim service date. This edit is complex and contains multiple exceptions for identified services including DME and medical supplies billed with a revenue code. DMHAS will share the results of this audit with our managed care plans so that they can evaluate their editing process for improvement.

OSA Recommendation

We recommend the division require the MCOs to review and enhance their system edits in the managed care program to prevent rentals from exceeding the monthly reimbursement limit and the purchase price

Response

In addition to existing edits that review consecutive rental months, DMAHS intends to train staff to utilize the PA process to determine if an item should be rented or purchased. If a rental is appropriate, an RR modifier (signifying a rental) will be added to the base code on the PA. The sale price for the item will be calculated and multiplied by 12% to arrive at a monthly cost for the rental. The allowable rental months in the PA will be set for 10 months. If rental payments are made for ten months, then the item will be considered purchased and no further rental units will be allowed. Staff will be instructed how to authorize rental PAs and perform a look back to ensure they are not authorizing the inappropriate continuation of a rental. The results of this audit will also be shared with managed care plans so they can evaluate how their systems adjudicate rental claims.

OSA Recommendation

We recommend the division comply with the criteria as set forth in N.J.A.C. 10:59-1.8 for the FFS program. We also recommend the division require the MCOs review their reimbursement policies to ensure the reasonableness of the reimbursement methodology for miscellaneous procedure codes and that their reimbursements are adequately supported.

Response

N.J.A.C. 10:59-1.8(a)1 provides: If there is no Medicaid/NJ FamilyCare Fee schedule, reimbursement shall be based on the lesser of the provider's usual and customary charge to the general public or a calculated maximum fee allowance equal to 130 percent of a supplier's invoice cost or 80 percent of the manufacturer's price list for supplies and equipment priced by report. While OSA interprets this regulation to mean the lesser of three potential prices, the rule allows the lesser of the usual and customary charge or either of the two options identified. However, DMAHS will consider clarifying this language with the next revision of N.J.A.C 10:59.

OSA also noted that DMAHS does not verify providers' stated usual and customary charges. A usual and customary charge is the fee a provider charges to greater than 50% of customers regardless of the payment source. DMAHS does not have the authority to request claims payment for services they do not reimburse. The provider is required to report their usual and customary charge on the claim and the edit will pay the lesser of the charge or the calculated fee payment.

Managed care plans often contract different rates with different providers. Providers list their contracted rate on their claim. Contracting with providers for DME rates should continue to be within the purview of the managed care plans. These findings will be shared with the managed care plans so they may review their current contracting and billing procedures.

OSA Recommendation

We recommend the division comply with N.J.A.C. 10:59-1.4 and clearly identify what procedure codes are considered to be non-covered and what procedures are included in the nursing facilities' per diem rates. We also recommend the division implement procedures to monitor claim reimbursements for these non-covered items for the FFS program to ensure that only covered items are reimbursed. Furthermore, we recommend the division require the MCOs to do the same for the managed care program.

Response

Because of the complexity of the DME items such as beds and wheelchairs, providers bill with a base code that requires detailed explanation of the item purchased, including all accessories. The item as a whole is evaluated to determine if it is unique to an individual or if it can be utilized by multiple individuals in the facility. Only items unique to an individual should be reimbursed. When determined appropriate for reimbursement, each line of the claim is evaluated for medical necessity and only those items determined necessary are included in the fee calculation. This process is consistent with N.J.A.C 10:59-1.4(a)5 which allows coverage for certain DME that is not routinely used in a nursing facility but is required due to the unique medical needs of an individual resident. DMAHS believes this process is sufficient to ensure medical necessity is met and appropriate payment is made.

PAs are sometimes submitted without identifying where the member is located. In these circumstances, staff will be instructed to verify addresses to ensure DME/Supplies are not inappropriately authorized.

The findings of this audit will be shared with the managed care plans so they can evaluate their DME policy for individuals residing in an institutional setting.

OSA Recommendation

The Division should implement controls in the FFS program to require PAs for all medical supplies where the purchase price is $100 or more, whether it is for one item or multiple items that are the same. In addition, we recommend the division review N.J.A.C. 10:59-1.6(d) to determine if the purchase price of $100 requiring a PA should be increased.

Response

As recommended, DMAHS will review N.J.A.C. 10:59-1.6(d) to determine if the $100 threshold should be increased.

OSA Recommendation

We recommend the division review the system edits of the fiscal agent and make the necessary changes to prevent managed care claims from being duplicated in the SDW. We also recommend the division require the MCOs to review their claim submission processes when bundling line items for submission to the fiscal agent in order for each item to be properly accounted for in the SDW. Furthermore, we recommend the division implement a process to ensure all MCO adjustment/recoupments are submitted and recorded in the SDW.

Response

The MCOs currently have edits in place for duplicate claims, however, the division will also review the system edits of the fiscal agent and make appropriate changes to prevent managed care claims from being duplicated in the SDW. Additionally, the claim submission processes when bundling line items for submission will be a part of the survey for the MCOs related to the audit findings where they describe their current processes in order to help identify areas for improvement.

OSA Recommendation

We recommend the division review the manual and make the necessary changes that are required to bring N.J.A.C 10:59 up to date with current regulations, policies, and procedures.

Response

As recommended, DMAHS will review N.J.A.C. 10:59 and make the necessary changes that are required to bring N.J.A.C 10:59 up to date with current regulations, policies, and procedures.

OSA Observation

Comparing the cost of DMEE and medical supply items purchased from in-state providers to out-of-state providers could prove beneficial.

Response

The division does not deal with many out of state DME providers in FFS, however it is more common with our managed care plans that may leverage their commercial plan contracts, especially for medical supplies. This will be included in the survey for the MCOs related to the audit findings where they describe their current processes in order to help identify areas for improvement.

Thank you again for the opportunity to review and respond to OSA's draft audit report. We welcome any opportunity to ensure that adequate controls are in place to properly monitor the FFS and managed care programs and ensure that reimbursements for FFS and managed care claims are reasonable and adequately supported.

Sincerely,

Sarah Adelman

Digitally signed by Sarah Adelman
Date: 2023.04.18 16:23:19 -04'00'

Sarah Adelman
Commissioner