



DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

DEC 22 1998

Memorandum

Date

Michael Mangano
For June Gibbs Brown
Inspector General

Subject Office of Inspector General's Partnership Plan - New Jersey Medicaid Selected Programs (A-02-99-01001)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

We are transmitting for your information and use, the attached final report on an audit of New Jersey Medicaid selected programs for the period July 1, 1995 to July 31, 1997. This review was conducted by the State of New Jersey Office of the State Auditor (OSA).

The objective of the review was to assess whether financial transactions related to the selected programs, were reasonable and were recorded properly in the accounting system. The scope of their work was limited to the following services and policies within these programs: Home Care Services - Personal Care Assistance, Transportation Services - Invalid Coach, Medical Supplies and Durable Medical Equipment - Recycling Policy, and Outpatient Hospital - Nonphysician Outpatient Services.

This work was conducted as part of our partnership efforts with State auditors to expand audit coverage of the Medicaid program. As part of the review, we assisted the OSA by providing technical support and guidance through the Office of the Inspector General's Federal/State Partnership Plan. This included providing OSA Medicaid payment data for nonphysician outpatient services, audit reports regarding Medicare payments for nonphysician services, and the audit guide used by this office in conducting our most recent review of Medicare payments for nonphysician services. In addition, we have performed sufficient work to satisfy ourselves that the attached audit report can be relied upon and used by the Health Care Financing Administration (HCFA) in meeting its program oversight responsibilities.

The OSA found that the financial transactions included in their testing were related to the selected programs, were reasonable and were recorded properly in the accounting systems. However, certain internal control weaknesses and matters of compliance with laws and regulations meriting management's attention were noted, some of which will result in financial savings for the Medicaid program when implemented by the State of New Jersey.

- * Below are two examples of the program issues that could be improved and result in future dollar savings:

- ✓ A test of invalid coach transportation costs (which increased in expenditures from \$21 to \$39 million between 1994 and 1996) showed that half the claims did not have a related claim for a corresponding medical procedure for the period of time traveled. The OSA was able to match a portion of these claims to prescription drug claims which indicated the Medicaid recipients used the invalid transportation to pick-up prescriptions. Further testing showed 84 percent of the pharmacies who filled these prescriptions have free delivery available....thus the Medicaid transportation expenditures for these pharmacies could have been avoided.

- ✓ The State of New Jersey Medicaid program pays hospital claims based on Medicare principles using the Prospective Payment System diagnosis - related group classification. Medicare does not allow nonphysician outpatient services (such as radiology and laboratory services) to be billed if they were performed within a 72 window of time immediately preceding the day of the patient's admission to the hospital. Although the Medicaid reimbursement policy was changed in 1991 to move from a 24 hour window to the present 72 hour period, New Jersey Medicaid has continued to use the 24 hour time period. The OSA estimates that the New Jersey Medicaid program could save \$2 million annually if they moved to a 72 hour threshold.

The OSA noted several other procedural or reimbursement issues involving durable medical equipment, personal care assistant services, and payments for claims of services on dates that exceeded the beneficiaries death. We will be performing additional follow-up work in these areas to assess the actions taken by the New Jersey Department of Human Services and will keep you apprised of the results.

The OSA made a number of recommendations which include implementing several prepayment review processes to ensure that services are appropriate, improving prepayment edits, and other procedural recommendations to improve the efficiency of the Medicaid program. The OSA also recommended that the New Jersey State Department of Human Services change its policy regarding outpatient services prior to a hospital stay to coincide with the Federal regulations for Medicare.

As we do with all audit reports developed by nonfederal auditors, we have provided as an attachment a listing of the coded recommendations for your staff's use in working with the State to resolve findings and recommendations through our stewardship program. A summary of the recommendations contained in the OSA audit report is attached.

Page 3 - Nancy-Ann Min DeParle

We plan to share this report with other States to encourage their participation in our partnership efforts. If you have any questions about this review, please let me know or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachment

Summary of Recommendations
Contained in NJ OSA Report

<u>Recommendation Codes</u>	<u>Page</u>	<u>Resolution Amount</u>	<u>Agency</u>	<u>Recommendations</u>
299919101	6	N/A	HCFA	Take action to review the appropriateness of Personal Care Assistant services by having independent nurses perform an assessment.
299919102	6	N/A	HCFA	Develop electronic edits that result in the proper identification of the referring and attending physicians.
299919103	10	N/A	HCFA	Require that all requests for invalid coach service be submitted to the County Board of Social Services so that recipient needs can be evaluated.
299919104	10	N/A	HCFA	Revise the prior authorization process to include a limit on the number of trips and the total dollars for each authorization.
299919105	12	N/A	HCFA	Require that medical service provider numbers be recorded on both the prior authorization and the transportation claim so that they can be matched electronically.
299919106	12	N/A	HCFA	Use the information box on the monthly identification card to encourage recipients to seek free delivery of prescriptions.

Summary of Recommendations
Contained in NJ OSA Report

<u>Recommendation Codes</u>	<u>Page</u>	<u>Resolution Amount</u>	<u>Agency</u>	<u>Recommendations</u>
299919107	14	N/A	HCFA	Implement a program to recycle used equipment no longer needed by current eligible recipients.
299919108	14	N/A	HCFA	Mark all state property costing over \$1,000 as property of the State of New Jersey so that ownership is clearly defined.
299930101	15	N/A	HCFA	Change its policy regarding outpatient services prior to a hospital stay to coincide with the Federal regulations for Medicare.
299935101	16	N/A	HCFA	Take swifter action in stopping payments to providers suspected of abuse.
299935102	19	N/A	HCFA	Approve prior authorization in a reasonable time period, prior to the issuance of services.
299901101	19	N/A	HCFA	Perform a closer review of the prior authorization procedures to identify more adjustments and denials.
299915101	20	N/A	HCFA	Change the format of the Explanations of Medicaid Benefits form and the method of selection for the mailing to increase its effectiveness.

Summary of Recommendations
Contained in NJ OSA Report

<u>Recommendation Codes</u>	<u>Page</u>	<u>Resolution Amount</u>	<u>Agency</u>	<u>Recommendations</u>
332931101	22	N/A	HCFA	Consistently price claims for enteral nutrition for pharmacies and medical supply companies when possible.
299919109	23	N/A	HCFA	Ensure that all recipient claim data having an incorrect termination date be checked for accuracy.



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

Department of Human Services
Division of Medical Assistance
and Health Services
Selected Programs

July 1, 1995 to July 31, 1997

Richard L. Fair
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, Selected Programs for the period July 1, 1995 to July 31, 1997.

If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair
State Auditor
January 14, 1998

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**Department of Human Services
Division of Medical Assistance and Health Services
Selected Programs**

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Selected Programs for the period July 1, 1995 to July 31, 1997. Our audit included financial activities accounted for in the state's General Fund and the Casino Revenue Fund for the following selected programs; Home Care Services, Transportation Services, Medical Supplies and Durable Medical Equipment, and Outpatient Hospital Services. The annual expenditures for these selected programs are approximately \$620 million.

The scope of our audit was limited to the following services and policies within these programs.

- **Home Care Services - Personal Care Assistant Services**
- **Transportation Services - Invalid Coach**
- **Medical Supplies and Durable Medical Equipment - Recycling Policy**
- **Outpatient Hospital - Nonphysician Outpatient Services**

The above areas were selected in cooperation with the division.

The prime responsibility of the Division of Medical Assistance and Health Services is to provide comprehensive medical and health services and reimbursement for those services including diagnosis and treatment of acute illness or disability. Beneficiaries include New Jersey residents determined eligible for

financial assistance, pregnant women and certain dependent children, low-income disabled or blind persons, Supplemental Security Income recipients, children in foster home programs, persons qualifying for State's Medically Needy programs or Medical Assistance Only, and certain classes of refugees.

Objectives

The objectives of our audit were to determine whether financial transactions were related to the selected programs, were reasonable and were recorded properly in the accounting systems.

This audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section 1, 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, administrative code, circular letters promulgated by the State Comptroller, and policies of the agency. Provisions that we considered significant were documented and compliance with those requirements was verified by interview and observation and through our samples of financial transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal control structure.

A nonstatistical sampling approach was used. Our samples of financial transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. We also corresponded directly with Medicaid recipients in the programs selected for review. These recipients were selected judgmentally.

Conclusions

We found that the financial transactions included in our testing were related to the selected programs, were reasonable and were recorded properly in the accounting systems. In making this determination, we noted certain internal control weaknesses and matters of compliance with laws and regulations meriting management's attention.

Personal Care Assistant Services

Personal care assistance services are provided through the division's Home Care Services program and have been in existence since 1984. The purpose of personal care is to accommodate long-term chronic or maintenance health care, as opposed to short-term skilled care required for some acute illnesses. The program is designed to provide care services by a certified personal care assistant (PCA) under the direction of a registered nurse, in accordance with the physician's certification of need for care. The services provided may include personal care, health related tasks and household duties.

There has been a significant increase in the personal care program cost over the past four years.

While other Medicaid programs have increased an average of 20 percent over the last four years, the Personal Care Assistance Program has increased 162 percent. Costs have risen from \$50 million in fiscal year 1993 to \$132 million in fiscal year 1997. In contrast, Home Health Services, which provides comprehensive nursing services, has remained relatively unchanged over the same time period.

During our review of the Personal Care Assistance Services program we noted the following:

- **There are no strict guidelines as to who may qualify for these services or independent detailed reviews of cases to determine why the recipients are receiving services.**
 - **There is no requirement for validating the accuracy of claim information regarding recipient diagnosis, attending and referring physicians.**
-

In the New Jersey Medicaid program there are no guidelines regarding who may qualify for personal care services.

As long as a doctor certifies that recipients need the service, they are eligible to receive PCA services. Every six months the case is reviewed by a registered nurse to reevaluate the recipient's need for continued care. In addition, the division requires prior authorization (PA) for weekly services exceeding 25 hours.

There is not an adequate case review or interviews with the recipients to determine why they are receiving PCA services. According to the fiscal year 1997 appropriation handbook, "Additional savings shall be achieved by an increase in the frequency of the assessments performed to determine the need, scope and duration of Personal Care Assistant services." These assessments refer to the nursing assessments performed every six months by an employee of the personal care provider. Since the nurse works for the provider who is providing the service, increasing the frequency of these assessments may have little effect on costs. Having the assessments performed by someone independent of the provider should make them more effective.

The division should require that the claim form contain accurate information regarding recipient diagnosis, attending and referring physicians.

The only electronic edit on the claim form is for the number of hours of service received. There are no edits for other claim form information such as diagnostic codes, referring physicians or attending physicians with which to analyze the reasonableness of claims. The division does not require this information to validate payment of the claim. In calendar year 1996, the referring physician was not identified for 85 percent of the total claim dollars paid. The attending physician was always listed as the personal care provider. A review of the diagnostic codes for PCA service recipients show that one of the most common illnesses requiring the service is hypertension.

Further review revealed that for some providers of PCA services their recipients had little or no related drug/medication costs which was contrary to the rest

of the population. In a test of 18 providers, which comprised approximately 60 percent of the program cost, we noted a high direct correlation between those recipients of PCA services and drug/medication related cost. Our analysis showed that 95 percent of these recipients were also taking some form of medication. However, we noted three providers whose recipients differed significantly from the rest of the population. Only 12 percent of their recipients had some form of medication cost.

These findings all raise questions as to the ability to determine the validity and need of the claim service.

Recommendation

We recommend that the division take action to review the appropriateness of PCA services. The assessment should be performed by nurses that are independent of the PCA provider. Also the division needs to develop electronic edits that result in a proper identification of the referring and attending physicians. This information could be analyzed to help determine the reasonableness of claims being paid. Diagnostic codes should be examined for trends by a particular provider. The nursing assessment could also verify the accuracy of the codes used on the claim form.

Auditee's Response

The Division agrees that more appropriate action is necessary to ensure the appropriateness of PCA services. However, there are Home Care Quality Assessments made by Medicaid District Offices (MDOs), however limited, due to available staff constraints.

The Bureau of Program Integrity (BPI) routinely reviews and investigates PCA providers. The Division has initiated limited reviews of PCA services, with anticipated expansion in the near future, which include medical record reviews and interviews with Medicaid beneficiaries to determine medical necessity for these services. Temporary nurses will be

hired by the Division of Medical Assistance and Health Services (DMAHS) to perform PCA assessments of Medicaid beneficiaries starting February 1, 1998. This project would be done on a pilot basis in Essex and Hudson Counties. The nurses would review 100 percent of cases at the onset and six-month reassessment periods thereafter. They will be required to make a determination of the appropriateness of the hours of service recommended by the PCA providers.

Diagnostic codes should be better utilized by the Division to assess the appropriateness of PCA services. However, it is recognized that these codes do not clearly identify medical necessity. These codes can serve as devices to flag PCA records for possible review during the post-payment review process currently utilized by the Division.



Transportation - Invalid Coach

The Division of Medical Assistance and Health Services provides transportation to Medicaid recipients to obtain medical services through transportation service providers in accordance with N.J.A.C. 10:50-1.4. Transportation services are provided by invalid coach, ambulance, and several other lower modes. The type of transportation required is based on the recipient's medical condition. Invalid coach service needs prior authorization by a Medicaid District Office (MDO) and requires the recipient to be wheelchair bound or ambulatory but unable to take an alternative mode of transportation without assistance or supervision. The need for ambulance service is dependent on the severity of the recipient's condition and does not require prior authorization (PA). Lower modes of transportation are administered by the County Boards of Social Services who are reim-

bursed for costs incurred by Medicaid recipients. The rate for invalid coach is \$50 plus mileage compared to livery, a lower mode, for which there is only a mileage charge. Our review focused on expenditures for invalid coach services which increased from \$21 million to \$39 million between fiscal years 1994 and 1996. Invalid coach expenditures have risen 84 percent during this period, part of which is due to a rate increase.

During our review of the Transportation Invalid Coach Services we noted the following:

- **Medical justification and duration of services submitted by the transportation providers for prior authorizations are not being verified for accuracy.**
- **There is no validation that the prior authorization destinations agree with those on invalid coach claims.**
- **Recipients are using invalid coach to pick up prescription drugs when pharmacies provide free delivery services.**

Medicaid District Office prior authorization approvals are based on the medical justification and duration of service as submitted by the transportation provider.

The division controls invalid coach costs through the use of PA approved by the MDO. The PA documentation is prepared by the transportation service provider including medical justification and duration of services. A request for invalid coach authorization may be approved for an extended period of time when, in the opinion of the MDO staff person, the Medicaid recipient's health condition will not improve to the extent that a lower mode of service, such as taxi or bus, would be appropriate during the period under consideration. In most instances the MDO approval is based only on the medical justification submitted by the transportation provider. Due to staffing and time constraints the MDO relies on the validity of the information provided on the PA.

Controls to limit payments to only the preapproved destination should be established.

While the PA specifies travel to a specific destination there is no control to limit payments to only the approved destination. We found transportation service providers often submitted claims for travel to various locations under one valid PA. Since the PA does not limit the number of trips or the dollar amount, the provider is able to submit unlimited claims during the approved period. There are no requirements to match prior authorization destinations with the destinations on the invalid coach claims prior to payment. Prior authorizations are approved for a specific period of time and not specific destinations.

We reviewed a sample of Medicaid recipients with no other health insurance (e.g., Medicare) from seven counties during calendar year 1996. Since transportation is allowable only to obtain medical services, we expected to find transportation claims with corresponding medical services being provided on the same day. We obtained recipient data for calendar year 1996 and an analysis by recipient was performed to match transportation claims with other medical service by date of service. Given that these recipients had no other health insurance, all medical services should have been billed to Medicaid. If no other claims appeared for these days, we questioned the medical necessity of the transportation cost. We found that of the \$2.4 million of transportation costs reviewed, \$1.2 million of claims did not have corresponding medical procedures for the period of time traveled.

Recipients use invalid coach to pick up prescription drugs when pharmacies may provide free delivery.

In an attempt to resolve the unmatched transportation claims noted above, we compared the date of travel with the recipient's prescription drug file. We were able to match \$215,000 in transportation costs where the only other medical cost on that day was a prescription. While this is an allowable medical service for the use of invalid coach, the division does not encourage the recipient to seek free delivery. We

contacted 49 pharmacies that were associated with \$36,000 in transportation claims for recipients to obtain prescriptions. The pharmacies were asked if they offered free delivery to the recipient's home address. Thirty-three pharmacies indicated that such service was available. Medicaid could have avoided \$30,000 or 84 percent of the amount tested had the free delivery service been utilized. In addition, Medicaid recipients were contacted through a questionnaire and most indicated that they would be willing use the free delivery service. Our responses from recipients showed that approximately 90 percent of those that replied said they would be willing to use free delivery service rather than invalid coach.

Recommendation

We recommend that the Division of Medical Assistance and Health Services require all requests for invalid coach service to be submitted to the County Board of Social Services so that the recipient needs can be evaluated and possibly be satisfied by a lower mode of transportation. The PA process should be revised to include a limit on the number of trips and the total dollars for each authorization.

Auditee's Response

Currently, Medicaid District Offices' attempt to determine an individual's need for a mobility assistance vehicle (MAV) service, and ability to access alternative modes of service, based on the information appearing on the PA form. The information on the PA form is completed by the MAV provider. Logically, the units (counties) that provide alternative modes of transportation are in the best position to decide if an individual is or is not capable of utilizing their services.

A similar downgrading and referral process takes place in Essex and Hudson Counties, except that the County Boards of Social Services are not participating. The Essex MDO downgrades/denies requests for MAV services when the service is deemed to be

unnecessary, and beneficiaries are referred for livery service.

In addition, under the PCA project mentioned above, the nurses will include in their assessment whether the beneficiaries require invalid coach services if the need arises. This information could then be relayed back to the MDO staff and checked before prior authorization is granted for this service.

Extensive efforts have been made by the Office of Provider and Beneficiary Relations and BPI to monitor and investigate fraud and abuse in the invalid coach industry.

As an alternative to the observation concerning transportation, the Division has initiated a trial transportation project in a limited number of counties which utilizes commercial bus passes. Medicaid District Offices participating in the project disperse bus passes to certain beneficiaries where the use of a bus pass is cost effective. This approach eliminates concerns regarding the appropriateness of destinations and increases the personal responsibilities of individual beneficiaries. Outside of the trial counties, the Division will consider matching paid claims for destination charges with transportation claims. Exceptions from this matching process will become the focus of a post-payment review performed by the Division.

Current regulations, N.J.A.C. 10:50-1.5(d), permit PA approvals for extended periods of time (up to one year) when an individual's condition is not expected to improve. If an individual truly needs MAV service for a condition that is not expected to improve (wheelchair-bound amputee, for example) it is reasonable to approve the individual for an extended period of time. The Division will consider limiting the number of trips and total dollars for each authorization.

Recommendation

While the PA form shows the destination(s), this information is not entered into the computer system and is not used to verify the invalid coach claims prior to payment. The division should require the medical service provider number(s) to be recorded on both the PA and the transportation claim. The medical service provider number on the transportation claim could then be matched electronically to the PA. By matching the destination on the claim to the approved medical providers, the transportation provider would only be reimbursed for trips to the approved medical destinations.

Auditee's Response

The Division would encounter several barriers if the medical service provider number was included on the transportation claim. For example, Medicaid-eligible individuals are permitted to receive transportation services to providers who may or may not be enrolled in the New Jersey Medicaid Program. This observation will be mitigated by the implementation of the Division's transportation project, issuing bus passes.

Recommendation

Monthly identification cards are issued by the division to each recipient. The division should use the information box on the cards to encourage recipients to seek free delivery of prescriptions.

Auditee's Response

It is important to note that prescription delivery is not a required service by providers of pharmaceutical services. There may be situations in which paid transportation may be medically necessary and appropriate. However, every effort will be made by the Division to encourage the use of free prescription delivery services available in the community.

A recent newsletter (Volume 7 Number 42 dated July 1997) was issued that addressed the issue of invalid coach transportation services to pharmacies. It stated, "Invalid coach service is generally NOT authorized when provided solely for the purpose of

dropping off or filling a prescription. Therefore, the MDO will not approve transportation to a pharmacy unless there are no alternative means to receive the service. Contact the appropriate MDO when questions arise on a case-by-case basis."

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Durable Medical Equipment (DME) - Recycling

The Division of Medical Assistance and Health Services should develop procedures to recycle used medical equipment that is no longer needed by the recipient for whom it was purchased.

The New Jersey Administrative Code 10:59-1.11 states, "The New Jersey Medicaid Program shall recycle returned durable medical equipment items when the Program has determined that the cost of pickup, refurbishing and/or repair and delivery is more economical than purchase of a new item." The division has considered implementing a recycling program for the past few years, but no procedures have been finalized as of the end of our fieldwork.

Failure to implement a recycling program costs the program by not reusing medical equipment with a remaining useful life. We selected eight specially designed wheelchairs purchased in the last two years at a cost of between \$2,600 and \$7,300 per chair. We attempted to visit the recipients to determine if they had received the equipment purchased by the division. Only five of the eight recipients were still in the program and using the wheelchairs. One recipient was deceased and his family donated the wheelchair to the nursing facility he was living in when he died. Another recipient, also in a nursing facility, could no longer use the wheelchair and the family took it home. Both of these wheelchairs were used by the recipient for less than one year. A third recipient received two wheelchairs (one manual and one motorized) in less than twelve months. The recipient was terminated from the program six months after receiving the second wheelchair. If

other health insurance was available to the terminated individual, the division could recycle these wheelchairs to its recipients.

According to the New Jersey Administrative Code (10:59-1.7), ownership of such equipment vests with the division and the recipient is granted a possessory interest for as long as they need the item. Based on discussions with nursing facility personnel, they are given no direction as to the proper disposition of equipment that is no longer needed. In some cases, the company that sold the equipment is contacted by the nursing home regarding disposition of the item. It is apparent that some of the nursing facilities are unaware of the fact that this property belongs to the Medicaid Program and not the recipient.

Recommendation

We recommend that the division implement a program to recycle used equipment no longer needed by current eligible recipients of the program. In addition, all state property costing over \$1,000 should be marked as property of the State of New Jersey so the ownership is clearly defined.

Auditee's Response

The Division is currently completing a recycling Request for Proposals (RFP). It is uncertain of the success of this initiative; based on a survey of all other state Medicaid agencies, no other agency has a recycling program. In fact, this process is so unpopular, there is only one recycler in New Jersey that operates as a nonprofit agency.

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Outpatient Hospital - Nonphysician Outpatient Services

The division can save about \$2 million a year if they follow Medicare's policy regarding nonphysician, outpatient services prior to admission to the hospital.

The State of New Jersey Medicaid program pays hospital claims based on Medicare principles. Under the Medicare PPS (prospective payment system), Medicare fiscal intermediaries reimburse hospitals at a predetermined rate for inpatient services depending on the illness and its classification under a DRG (diagnosis-related-group). As implemented by the Health Care Financing Administration, separate payments for nonphysician, outpatient services, such as radiology and laboratory services which are provided on the day (24 hours) before admission to the same hospital or during an inpatient stay, exclusive of the day of discharge, are not permitted. The cost of such services are included in the PPS rates for each DRG.

Effective January 1, 1991, the Omnibus Budget Reconciliation Act of 1990 expanded the period during which outpatient services could not be billed separately to 72 hours immediately preceding the day of the patient's admission. The division has not taken action to change the DRG payment window from 24 to 72 hours. This could save an estimated \$2 million annually. The division is currently in the process of developing a policy to implement this change.

Recommendation

We recommend that the division change its policy regarding outpatient services prior to a hospital stay to coincide with the federal regulations for Medicare.

Auditee's Response

The Division is in the process of amending Medicaid's regulations to conform with Medicare's 72-hour rule. The Bureau of Third Party Liability Policy and Recoveries has identified services that should be included in the DRG for an inpatient stay.

Suspension of Provider Claims

Faster suspension of payments to providers suspected of abuse is needed.

The division's Office of Program Integrity is responsible for most of the pre and post payment reviews. During our audit period, these reviews have been directed towards pharmacies and laboratories suspected of abuse. In addition, the Division of Criminal Justice (DCJ) has a Medicaid Fraud Control Unit (MFCU). Both of these units have limited resources. The DCJ has a staff of only 11 people in its MFCU that was once a 40 person operation. Most of the claim reviews are performed after the claims have been paid. Faster action to limit potential overpayments needs to be taken to prevent the loss of Medicaid funds. For example, although suspected of abuse one provider has received over \$10 million.

A recent innovation to review payments for large variations has been instituted. While payments are tracked for deviations, there is no formal written procedure in place to suspend payment. Once paid the division investigates and seeks reimbursement, if necessary.

Recommendation

We recommend that the division take swifter action in stopping payments to providers suspected of abuse. A large number of claims could be submitted and paid in a short period with no edit in place to prevent payment. When a provider exceeds a predetermined limit in a weekly period all claims should be suspended until prepayment review can be conducted.

Auditee's Response

This observation fails to take into account all of the positive steps DMAHS has taken to stop the flow of Medicaid dollars lost to fraud and abuse as quickly as possible. These measures include the following:

- (i) the extensive use of prepayment monitoring to stop the payment of suspect claims to providers until

the provider can demonstrate that the claims are clean and should be paid;

(ii) the use of a federal regulation authorizing States to withhold payments to providers pending conclusion of an investigation when there is reliable evidence of fraud or willful misrepresentation;

(iii) the extensive use of authority to suspend a provider from the Medicaid program for good cause prior to a hearing;

(iv) the use of a procedure by which the Division of Criminal Justice can share the outcome of its criminal investigations with DMAHS while the investigation is still in progress, permitting DMAHS to take action under (i)-(iii) above;

(v) the use of weekly variance reports to focus on providers having unusual fluctuations in earnings.

The last sentence of the first paragraph, "For example, although suspected of abuse, one provider has received over \$10 million." That provider was under criminal investigation. When that investigation was concluded, DMAHS acted in a timely manner to initiate its own investigation. The DMAHS investigation has been concluded, and appropriate action will be taken by DMAHS to stop any further overpayments and to recover past overpayments.

The fifth sentence of the first paragraph mentions that the Medical Fraud Control Unit (MFCU) has a staff of only 11 people. MFCU currently has 16 professional staff. This increase in staff will expedite investigations.

The last sentence of the section on "Suspension of Provider Claims" states: "When a provider exceeds a predetermined limit in a weekly period all claims should be suspended until prepayment review can be conducted." While this type of procedure would quickly stop the flow of payments to suspect providers, its inflexibility would also unfortunately affect cash flow to good providers who may have

reasonable explanations for exceeding predetermined limits. While it would catch the guilty earlier, it could also destroy the practices of the innocent. While we should carefully evaluate this recommendation, we need to strike a proper balance between stopping incorrect payments as soon as possible while minimizing the harm to good providers.

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Prior Authorization (PA)

Prior authorizations for recipient services are rarely denied or modified.

According to the NJMMIS (New Jersey Medicaid Management Information System) Module Overview, the purpose of PA is to allow the state to determine which services require special consideration prior to the delivery of services. The advantage of this is to ensure appropriate care is being given to a Medicaid recipient.

We found that the PA document is rarely denied and that in some cases, services or equipment is delivered prior to the approval of the Prior Authorization document. A report of approvals, modifications and denials for private duty nursing services showed that between February 1996 and March 1997, 711 PAs were approved, only 22 were modified, and none were denied. In some cases the provider is given verbal approval over the phone prior to submitting the written PA.

In addition, we requested a report on all prior authorizations that have been approved, modified and denied. This information was not available even though the report is included in a list of all reports available through the service provider (UNISYS). Efforts to produce the report did not succeed since the information needed to produce the report is either not recorded on the PA form or is not entered into the system. Based on conversations with division

staff it can be concluded that few prior authorizations are denied. The effect of this is to limit the effectiveness of the PA as a method of controlling costs or limiting inappropriate care. The provider waits for confirmation of the PA and then submits claims against the PA for services, some of which may have already been rendered.

Recommendation

To be effective, the PA must be approved in a reasonable time period, prior to the issuance of services. Also, closer review of the procedure should result in more adjustments and denials.

Auditee's Response

The Division agrees with this observation and will attempt with the limited staffing to alleviate this situation.

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Explanation of Medicaid Benefits

The division is required by the Health Care Finance Administration to send out confirmations, called Explanations of Medicaid Benefits or EOMBs, to recipients on a monthly basis. The forms contain a brief list of services provided to the recipient by a specific provider; no other services are reported. The recipient is requested to respond to four questions: Did you receive the services that Medicaid has paid for that are listed? Are you covered by other health insurance? Was any Medicaid payment related in any way to an accident? Do you have any other comments, information, or questions?

Questionnaires sent to Medicaid recipients provide limited useful information.

Each month the division sends out 550 EOMB forms to recipients selected randomly. We reviewed the provider selection summary for March 1997 and December 1996. The services for which the forms were mailed included mostly medical doctors. No areas of higher risk such as pharmacy, laboratories or

transportation were selected. The number of forms returned during our audit period ranged from 11 to 26 percent monthly. The forms are logged in a computer and forwarded to the appropriate office within the division, if necessary.

Most of the forms are not returned (74 to 89 percent) or include little useful feedback. Rarely, if ever has the recipient claimed to have not received the services listed. When this does happen it is often investigated and determined to be a mistake by the recipient, due to a misunderstanding. The form provides no detail as to the services provided. This may result in confusion, the recipient may have actually received services but the service differs from what the form states.

We sent a questionnaire to 500 recipients that received personal care and transportation services. The return rate was approximately 50 percent. The replies were very informative and detailed. A number of subsequent questions regarding the quality of service and need for the services were raised. By investing some time and effort in the development of the questionnaire, information obtained, may be more useful to the division.

Recommendation

By changing the format of the form and the method of selection for the mailing, the division could increase the effectiveness of the EOMB. The form should include all services provided to the recipient for the past few months. In addition, the descriptions should be more detailed and in nonmedical terms so as to be easily understood. By asking more useful questions about the services provided, the division should be able to better serve its recipients.

Auditee's Response

The Division agrees that by changing the format of the form and the method of selection for mailing, the effectiveness of the EOMB could be increased. The form would include all services provided to the

recipient for the past few months. In addition, the descriptions should be more detailed and in nonmedical terms to be easily understood. By asking more useful questions about the services provided, the Division should be able to better serve its beneficiaries. This will be one of the responsibilities of one of the new units in the BPI. BPI has already met with the OLS auditors to discuss the responses to the OLS questionnaire, and BPI has taken or will be taking appropriate action to address those responses.

It is also recognized that the form is not the only tool available to the Division to assess the quality of health care provided to the recipients. Through a network of Medicaid District Offices, the Division maintains channels of communication between participating providers of Medicaid services and beneficiaries. This network has also been effective for measuring the satisfaction of both beneficiaries and providers with Medicaid-covered services.

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Enteral Nutrition

The Medicaid program pays for nutrition supplements if prescribed by a doctor. During 1996 the division paid claims totaling \$6.7 million for enteral (e.g., Ensure) nutrition. Of that total, \$1.7 million was provided to the recipients by medical supply companies, the rest was supplied by pharmacies. When provided by a medical supply company the calculation of the claim is higher than a pharmacy claim. A comparison of claims paid as pharmacy claims with medical supply claims showed that pharmacy claims cost the program 30 percent less than claims paid through medical supply companies. This is allowable under the existing regulations.

Current regulations allow claims for enteral nutrition to be paid under different pricing methods.

Recommendation

In the future, when possible, claims for enteral nutrition should be priced consistently for pharmacies and medical supply companies. The regulations should be changed to require this.

Auditee's Response

The Division is aware of differences in reimbursement based on its current payment formulas for nutritional supplements. Percentages used in these formulas are intended, for most products, to ensure equality in reimbursement, regardless of the type of provider receiving payments.

Unfortunately, a provider's decision to submit a price list or invoice is dependent, in part, on its acquisition source. Providers able to purchase in large quantities likely purchase from manufacturers and receive an invoice document. Those who purchase in small quantities likely purchase from wholesalers and receive a price list document. The Division's payment formula reflects our best efforts to accommodate differences in acquisition, and differences between invoices costs and list prices which vary inconsistently by product and manufacturer.

In the past, DMAHS' attempted to limit coverage for these products to only pharmacies. This policy change would have eliminated any and all concerns regarding differential reimbursement. Unfortunately, public concerns regarding access to services prevented its adoption.

It should be noted that disparities in payments for these services are unavoidable due to differences in acquisition sources for these products. Also, the extent to which a provider can maximize volume purchasing of these products has a direct impact on acquisition costs. It should also be noted that in the past, the Division attempted to limit coverage of enteral nutritional products to pharmacies, essentially eliminating the issue of differential reimbursement based on provider type. However, public concerns

regarding access to services prevented this policy change from being adopted.

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Deceased Recipients

Follow up of claim data for deceased recipients should be enhanced.

The division recently began matching the dates of death of beneficiaries with records provided by the Department of Health and Senior Services, Bureau of Vital Statistics. The purpose of this match was to update their records regarding the date of death and prevent the improper payment of claims after that date. As part of our review, we examined the claim data for deceased recipients where the date on the division's files differed from what the Department of Health records revealed. We tested 76 recipients for claims processed after the date of death. For 13 recipients we found claims with a date of service after the date of death. The total dollars for these claims were less than \$8,000. While the amount is not significant, it demonstrates a weakness in the system. While the division corrected the termination date, they failed to correct any claims submitted that were for services provided after the date of death.

Recommendation

We recommend that all recipient claim data for those having an incorrect termination date be checked for accuracy.

Auditee's Response

DMAHS is developing a project to recoup payments for services purportedly rendered after the death of the beneficiaries involved.

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