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

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

July 1, 2001 to December 31, 2002

Richard L. Fair
The Honorable James E. McGreevey  
Governor of New Jersey

The Honorable John O. Bennett  
President of the Senate

The Honorable Richard J. Codey  
President of the Senate

The Honorable Albio Sires  
Speaker of the General Assembly

Mr. Albert Porroni  
Executive Director  
Office of Legislative Services

Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Division of Disability Services, Selected Programs for the period July 1, 2001 to December 31, 2002. If you would like a personal briefing, please call me at (609) 292-3700.

March 6, 2003
# Table of Contents

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Scope</td>
<td>1</td>
</tr>
<tr>
<td>Objectives</td>
<td>1</td>
</tr>
<tr>
<td>Methodology</td>
<td>2</td>
</tr>
<tr>
<td>Conclusions</td>
<td>2</td>
</tr>
<tr>
<td>Findings and Recommendations</td>
<td></td>
</tr>
<tr>
<td>Personal Care Assistant Services</td>
<td>4</td>
</tr>
<tr>
<td>Transportation - Mobility Assistance</td>
<td></td>
</tr>
<tr>
<td>Vehicle Services</td>
<td>6</td>
</tr>
<tr>
<td>Conflict of Interest</td>
<td>8</td>
</tr>
<tr>
<td>Explanation of Medicaid Benefits</td>
<td>10</td>
</tr>
</tbody>
</table>
Department of Human Services
Division of Medical Assistance and Health Services
Division of Disability Services
Selected Programs

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services, Division of Disability Services, Selected Programs for the period July 1, 2001 through December 31, 2002. Our audit included expenditures accounted for in the state’s General Fund for the following selected programs:

- Home Care Services - Personal Care Assistant Services,
- Transportation Services - Mobility Assistance Vehicle Services,
- Medical Supplies and Durable Medical Equipment - Recycling Policy, and
- Outpatient Hospital - Non-physician Outpatient Services.

Annual expenditures for these programs were $677 million.

The Division of Medical Assistance and Health Services provides immediate and quality diagnosis and treatment of acute illness or disability, as well as health maintenance services to eligible residents. The Division of Disability Services provides information and referral services to people with disabilities and their families.

Objectives

The objectives of our audit were to determine whether expenditure transactions were related to the agency’s programs, were reasonable, and were recorded properly in the accounting systems. We also tested for resolution of significant conditions noted in our prior report.
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, observation, and through our samples of expenditure transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of expenditure transactions were designed to provide conclusions about the validity of transactions as well as internal control and compliance attributes. Sample populations were sorted and transactions were randomly and judgmentally selected for testing.

To ascertain the status of findings included in our prior report, we identified corrective action, if any, taken by the agency and performed tests on the system to determine if the corrective action was effective.

Conclusions

We found that the expenditure transactions included in our testing were related to the agency's programs, were reasonable, and were recorded properly in the accounting systems. In making this determination, we noted certain internal control weaknesses, matters of compliance with laws and regulations, and opportunities for cost savings meriting
management’s attention. We also found the agency has resolved the significant issues noted in our prior report, except for the matters related to explanation of Medicaid benefits, transportation services and personal care assistant services. These issues have been restated in our current report.
Independent assessments could save the PCA program $1 million a year.

Personal Care Assistant Services

Medicaid recipients can receive personal care assistant (PCA) services if they need help performing personal care, health related tasks and household duties. A physician must determine an individual’s need for these services which are provided by private vendors. The Division of Disability Services administers the PCA program which expends $231 million a year. Vendors providing the care determine the level of service needed on a case-by-case basis. The division can better monitor the program to ensure vendors are not providing more hours of service than are needed.

The division implemented a pilot project in 1998 to monitor cases in five counties. Temporary nurses were hired to perform independent assessments of the level of service provided. Within a three-year period the nurses reduced the number of hours of care needed in 4,100 of 17,000 cases they reviewed. This resulted in a reduction in hours claimed by providers which potentially saves the program $1 million a year. Due to staffing constraints, the division is unable to continue the pilot program or to expand it statewide. If providers are not adequately monitored, the savings achieved by the pilot project might decrease.

The division’s internal policy Number 62: Volume 8 requires providers in the pilot project counties to complete a prior authorization form for all cases. We noted 37 percent of our test cases in one county did not have the required form. Without the prior authorization form, the division cannot properly monitor these claims.

The division does not require sufficient information to analyze claims for certain correlations or trends. For example, we noted the system did not identify the referring physician for 95 percent of total claims paid. We further noted the system identified the
attending physician as the personal care provider in all cases. Complete and accurate physician information could be helpful in determining if relationships exist between certain physicians and PCA providers.

**Recommendation**

We recommend the division continue to perform independent assessments of cases and enforce the requirement of prior authorization. We also recommend the division require the identification of referring and attending physicians in all cases so it can better analyze claims.

**Auditee’s Response**

DDS assumed programmatic or fiscal responsibility for the administration of PCA services in July 2002. Under the auspices of DDS a system of 100 percent prior authorization for all PCA cases is being implemented. The new software has been ordered and a new assessment tool and PA form developed. A draft copy of the assessment tool will be piloted by a handful of selected providers throughout the state.

The new assessment tool will provide more information regarding the beneficiary’s medical appropriateness for the service. The PA and assessment tool must be filed jointly to the online intra (DHS)/internet system that is being developed. All 15,000 beneficiaries currently being serviced will have PA’s to be reviewed by DDS staff.

Home visits on a substantial number of random sampled cases will be carried out by DDS nurses and social workers as well as by the three remaining temp nurses still performing this task.
Transportation - Mobility Assistance Vehicle Services

The Division of Medical Assistance and Health Services (DMAHS) provides transportation services to Medicaid recipients who need medical services. Private vendors provide the transportation by ambulance, mobility assistance vehicle (MAV) and several lower modes. Medicaid transportation programs expend $57 million a year, $39.8 million of which is spent on MAV services, including $11 million for mileage. Medicaid recipients who are not ambulatory can use MAV if they receive prior authorization from the division. Vendors are paid for providing transportation to and from a medical facility and for mileage. Our review of MAV claims noted internal control weaknesses that increase the risk of overpayment.

- The division is converting to electronically submitted claims which are not accompanied by the transportation certification form which contains the trip destination and various signatures. This form is retained by the vendor. Without going to the vendor, there is no way to verify the claim destination matches the previously authorized destination, the service was actually received, or the mileage was reasonable.

- Vendors overbilled the division $134,000 by erroneously entering an additional payment code on the claim. The system paid the vendors for three one way trips instead of one round trip.

- The system allowed vendors to be paid twice for the same service. During fiscal year 2002 there were $250,000 in claims that were potential duplicates. We tested 99 multiple payments ($4,950) with the same service date and noted 12 duplicates totaling $600.
We also noted cost savings can be achieved by changing the rate structure for mileage paid to MAV and ambulance providers. Currently the rate is $1.50 per mile for the first 15 miles and $2.00 per mile from the first mile for trips of 16 miles or more. This adds $7.50 to each claim over 15 miles. By changing the rates for longer trips to $1.50 for the first 15 miles, the division would reduce MAV costs by $738,000 a year.

**Recommendation**

We recommend the division develop system edits and/or implement stronger controls to monitor MAV claims for mileage, overpayment and duplication. We also recommend the division change the mileage rate to $1.50 for the first 15 miles of trips in excess of 15 miles.

**Auditee’s Response**

**Issue 1** - The division acknowledges that the place of destination is not captured on electronically billed claims. Instead, transportation providers are required to enter the seven-digit provider ID of the treating provider at the place of destination on a transportation certification form.

The division agrees that risks are involved when approving any provider for electronic billing (EMC). Measures have been taken to reduce the risks by conducting post-payment reviews prior to approving applications for EMC billing by transportation providers.

**Issue 2** - The division conducted a post-payment review to investigate this finding. Based on the results of the review, it appears that providers provided more than one trip per day, an allowable situation, and billed appropriately. In the examples reviewed, separate and distinct trips were provided.

**Issue 3** - The division conducted a post-payment review to investigate this finding. Two providers were terminated in January 2003.
In the remaining four instances, it is determined that the services provided on the dates in question are not duplicate services. In all cases reviewed, beneficiaries received more than one trip on the service date in question, an allowable situation.

The problem identified by the auditors has been resolved, i.e. claims paid although the “76” (repeat service) modifier was not billed.

In the case of one provider who was billed incorrectly and received payment for four round trips on a single service date, the provider has submitted a written explanation and adjustment forms to repay the program for the incorrectly billed claims.

**Issue 4** - The higher mileage rate from the first mile was deemed necessary because beneficiaries were experiencing access problems in areas of rural South Jersey. Many providers were unwilling to provide long-distance trips. Beneficiaries continue to experience access problems in these areas if they are stretcher-bound and residing in a private home.

Dramatic increases in insurance rates are causing many transportation providers to curtail necessary services and, in some cases, to close longstanding businesses.

It is recommended that the division continue to make a distinction in mileage rates from the first mile. Any proposed rate reduction would certainly lead to an exacerbation of existing access problems.

**Conflict of Interest**

Department policy requires employees to disclose any potential conflict of interest. Every three years employees submit a questionnaire which discloses any outside employment, business, license or public.
office. An ethics review board must approve any outside employment disclosed by the employee. By signing the disclosure questionnaire, employees agree to re-file it when they undertake any new outside employment or covered activity. We reviewed the questionnaires for 50 employees in medical professional titles and noted, through a comparison to wage reporting records, five of them had outside employment that was not included in human resource files. Currently the agency does not monitor for changes in employees’ circumstances or enforce the re-filing requirement. Delays in reporting could result in untimely decisions by the ethics review board.

**Recommendation**

We recommend the Division of Medical Assistance and Health Services and the Division of Disability Services monitor employees’ outside employment by using the Department of Labor’s wage reporting system. The divisions should also remind employees of their disclosure responsibilities on a yearly basis.

**Auditee’s Response**

The Division of Disability Services does monitor employees’ outside employment, has forms for all employees on file, and has always done so.

After conferring with the Executive Commission on Ethical Standards, appropriate action has been taken with respect to the five employees identified in the audit. We are currently evaluating both internally and with DHS the recommendation that we use the Wage Labor file on a periodic basis to monitor the reporting of outside employment by DMAHS staff.

DMAHS agrees to remind employees of their disclosure responsibilities on a yearly basis.
Questionnaires can be useful in recovering erroneous payments.

Explanation of Medicaid Benefits

Federal regulations require the DMAHS to mail confirmations, called Explanations of Medicaid Benefits (EOMB), to Medicaid recipients on a monthly basis. The confirmation shows a randomly selected service(s) provided to the recipient by a specific provider. It is designed to determine if the recipient actually received the services, and if the recipient has any other coverage that could have paid the claim. The recipient is asked to review the claim information for accuracy, answer the questions on the form and return it. The division reviews the returned forms and investigates any discrepancies noted by the recipient. This process can result in recovery of erroneous or improper claims.

During fiscal year 2002 recipients returned only 1,147 of the 6,588 forms (17 percent) mailed by the division. Only 25 of these responses were referred for further action. The federal government, which uses a different methodology, receives feedback from more than 60 percent of its surveys for similar programs. Several factors may contribute to the division’s low response rate:

- The form is two-sided; therefore recipients might not notice the reverse side.
- The form could be confused as a bill for service.
- A self-addressed postage paid envelope is not included in the mailing.
- The division does not follow up with a second request.

Recommendation

The division, by changing the design of the EOMB form and including a self-addressed postage paid envelope in the mailing, might increase its response rate resulting in more recoveries.
Auditee’s Response

DMAHS is currently evaluating the four recommendations made in the draft OLS audit report, and will pursue those recommendations that we determine to be productive and feasible.