Third Party Liability Process

January 1, 2000 to April 30, 2003
Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Third Party Liability Process for the period January 1, 2000 to April 30, 2003. If you would like a personal briefing, please call me at (609) 292-3700.
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Department of Human Services  
Division of Medical Assistance and Health Services  
Third Party Liability Process  

**Scope**

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services for the period January 1, 2000 to April 30, 2003. The scope of this audit was limited to the Medicaid Third Party Liability (TPL) Process. Recoveries for this process during our audit period were approximately $200 million. Our audit included financial activities accounted for in the state’s General Fund.

**Objectives**

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

The 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 financial transactions. We also read the budget message, reviewed financial trends, and interviewed agency personnel to obtain an understanding of the TPL Process and internal controls.

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. Sample populations were sorted and transactions were judgmentally selected for testing.

Conclusions

We found the financial transactions included in our testing were related to the Medicaid Third Party Liability Process and were recorded properly in the accounting systems. However, recoveries received by the Bureau of Third Party Liability were not reasonable. We found the division does not always input TPL information and social security numbers accurately and timely. We further noted that the division may not update medical insurance information when other insurance coverage is discovered or becomes available to the recipient. This results in repeatedly paying unwarranted claims and then paying a fee to recover the moneys. We also noted that increased efforts during the recovery process could increase recoveries.

Background

Third Party Liability (TPL) exists when a Medicaid recipient has health insurance coverage other than Medicaid. According to state regulations, if a Medicaid recipient has third party health insurance coverage, such as Medicare or private health insurance, the Medicaid service provider must bill the recipient’s primary coverage before billing Medicaid.

The division administers a computerized Medicaid Management Information System (MMIS), which maintains various information including Medicare and other TPL coverage. Medicaid service providers seek reimbursement of services by submitting claims to the division. Claims are subjected to various Medicaid system edits including Medicare and other third party health insurance coverage. Medicaid uses the amount paid by Medicare and other third party coverage to reduce the amount that Medicaid owes the provider. This methodology known as “cost avoidance” enables Medicaid to be the payer of last resort.
The division uses a vendor to assist in identifying TPL and to seek reimbursement from Medicare and other third-party insurers for a recovery fee.

**Determination of Primary Insurance Coverage**

The county boards of social services (CBSS) are responsible for the initial inquiry to determine if the Medicaid recipient has Medicare and/or other private health insurance. If the recipient has Medicare and/or other insurance, the county worker fills out the required TPL-1 form, which summarizes all of the recipient medical insurance information. This form, along with a copy of their insurance cards, is sent to the division to be inputted by three employees, one for Medicare information and two for other health insurance, into MMIS. The division does not track what TPL forms were received or inputted and does not have a procedure to independently verify the accuracy of the inputted information. This inputting process also could take months to complete, which forces the division to pay the claim and seek reimbursement at a later time.

All input documents are discarded without being shredded immediately after input into MMIS, which is a violation of the state’s record retention schedule. In addition, confidential information, such as social security number and health insurance information, which could become subject to unauthorized use, is on the TPL-1 form.

**Recommendation**

The division along with the county boards of social services, should develop a more timely method of recognizing Medicaid recipients with Medicare and/or other insurance to cost avoid claims, such as having the CBSS entering this information into MMIS during the intake process. Inputted information of the TPL-1 form should be independently verified. The input documents should be retained in compliance with the state’s record retention schedule.
Auditee’s Response

In an effort to improve our identification of TPL coverage, the Bureau of Third Party Liability (BTPL) has done the following:

- worked with HMS to establish a better crosswalk between the HMS report and the Medicaid Management Information System (MMIS) TPL resource file

- worked with an additional TPL contractor hired by the Office of Management and Budget, Public Consulting Group, Inc. (PCG), in identifying TPL coverage; and

- designed, tested and implemented a batch update process so that outside entities, such as TPL contractors, can enter verified TPL data directly into the MMIS TPL Resource File without BTPL intervention. We believe that these steps address any concerns about the timeliness of TPL data entry.

In reference to improperly discarding the TPL-1 forms, the division is in compliance with the state’s shredding and confidentiality requirements and, therefore, we do protect the confidentiality of our Medicaid recipients. Additionally, we are making an application to the Division of Archives and Records Management for the approval of a retention schedule of zero (0) days for form TPL-1 after data entry into the MMIS TPL Resource File.

We are examining the cost effectiveness of hiring an additional staff person for the purpose of independently verifying inputted information from the TPL-1 form.
Accurate social security numbers are essential to determine other health insurance coverage.

Social security number matches are used by the division to research if the Medicaid recipient has other insurance. Inaccurate social security numbers negate the effectiveness of this process. We analyzed the Medicaid eligibility file and found more than 75,000 recipient social security numbers were fictitious or duplicated. There are no edits in MMIS that would verify if a social security number is valid. The erroneous social security numbers were entered by the county board of social services during the intake process. The following are examples of fictitious social security numbers and the number of Medicaid recipients with these fictitious social security numbers:

<table>
<thead>
<tr>
<th>SSN</th>
<th># of Medicaid Recipients with that SS Number</th>
<th>SSN</th>
<th># of Medicaid Recipients with that SS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>0000000000</td>
<td>13,690</td>
<td>999102002</td>
<td>77</td>
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<tr>
<td>9999999999</td>
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<td>8888888888</td>
<td>2,006</td>
<td>888102002</td>
<td>67</td>
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<tr>
<td>3333333333</td>
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<td>66</td>
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<td>9990000000</td>
<td>380</td>
<td>888072002</td>
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<tr>
<td>1111111111</td>
<td>291</td>
<td>009009009</td>
<td>64</td>
</tr>
<tr>
<td>0909090900</td>
<td>238</td>
<td>999062002</td>
<td>64</td>
</tr>
<tr>
<td>999012002</td>
<td>117</td>
<td>555555555</td>
<td>53</td>
</tr>
<tr>
<td>999092002</td>
<td>93</td>
<td>123456789</td>
<td>40</td>
</tr>
<tr>
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<td>93</td>
<td>2222222222</td>
<td>39</td>
</tr>
<tr>
<td>999082002</td>
<td>91</td>
<td>4444444444</td>
<td>18</td>
</tr>
<tr>
<td>999022002</td>
<td>80</td>
<td>6666666666</td>
<td>12</td>
</tr>
<tr>
<td>999072002</td>
<td>80</td>
<td>7777777777</td>
<td>12</td>
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We performed a match by social security number of the Medicaid files to the Department of Labor Wage Reporting System (WRS) files, which identify individuals collecting W-2 wages in the State of New York.
Jersey. We found 80 out of 112 sampled cases where the social security number seems to be a valid number but the name on the Medicaid file does not match the name in the WRS files. This could indicate that a Medicaid recipient is using another person’s social security number.

This match also identified 2600 state employees on Medicaid. We did not test for Medicaid eligibility, but rather to verify that the Medicaid recipient is being identified as having other insurance on the Medicaid system. Our sample of 82 of these state employees disclosed:

- MMIS had erroneous social security numbers for 35 Medicaid recipients. The social security numbers matched but their names or other information did not match.

- Forty-seven state employees are not being identified with TPL on MMIS. These state employees are receiving health benefits from the State of New Jersey and they should have been identified with other insurance on the Medicaid eligibility system.

**Recommendation**

The division should verify the accuracy of social security numbers, modify MMIS to reject invalid social security numbers and periodically compare their files to other databases and then investigate exceptions.

**Auditee’s Response**

The Medicaid Management Information System requires social security numbers. At times, newborns and both legal and restricted aliens are assigned fictitious social security numbers in order to fulfill this MMIS requirement. It is felt that this practice applies mainly to newborns. These numbers should only be used until valid social security numbers are assigned.

To rectify this practice, a management report will be run for each county to determine if legitimate social security numbers were issued. This will allow the
county to eliminate numbers that are obviously not valid social security numbers, i.e. 999999999. In addition, we are exploring the use of an outside vendor to conduct matches with various external data sets such as tax assessors, credit bureaus, and bank records in order to purify the eligibility file.

Medicare records should be updated on a regular basis on MMIS.

Unrecorded Medicare Coverage

Under a federal buy-in agreement, states may enroll individuals in the Medicare Part A and Medicare Part B programs and pay their premiums, currently $316 and $58.70 a month, respectively. The purpose of this is to provide Medicare health insurance, which reduces costs to the Medicaid program. The division pays Medicare approximately $125 million annually. The Medicare buy-in system should automatically update the MMIS files. We performed a test which noted 60 Medicaid recipients for whom the division paid Medicare premiums, but whose files were not updated for this coverage on MMIS. Upon notification, the division identified an additional 1,600 Medicaid recipients with the same problem. By not updating its files, the division estimates that it paid unnecessary Medicaid claims of more than $5 million annually. Although the division’s TPL vendor may detect these errors and recover some of the payments, Medicaid would still pay up to $500,000 annually in avoidable fees. This problem has been occurring for years and should be addressed in a future enhancement project by the division.

Recommendation

The division should correct the MMIS cross-link problem to cost avoid claims.

Auditee’s Response

The division is designing a new system to link the MMIS to the Medicare source; however, the cross-match between the Medicare and the Medicaid eligibility files is dependent upon the schedule of CMS, which maintains the Medicare data, which can take up to three months to complete. This is
Medicaid TPL records should be updated as soon as private insurance is known.

Insurance Information Not Being Updated

The division uses a vendor to assist in identifying TPL and to seek reimbursements from Medicare and other third-party sources. A recovery fee of approximately 10 percent is paid for this service which totals $5 million annually. Once the division is notified of other insurance coverage through the vendor, the division should update the MMIS files. The division is not always updating the files. Thus the division is paying unnecessary recovery fees relating to previously identified recipients with insurance and is unable to cost avoid on subsequent claims.

We determined that during our audit period the division recovered $32 million of TPL claims for recipients previously identified as having TPL by the vendor and paid the vendor approximately $3 million in recovery fees. In addition, there is $140 million in open claims for which the division is seeking recoveries through their vendor. If this occurs, the division would unnecessarily pay a recovery fee of approximately $14 million to the vendor.

**Recommendation**

The division should update the MMIS files as soon as TPL is known so the division can cost avoid claims.

**Auditee’s Response**

The division can not independently verify the amount in this finding. However, we have a change order with the vendor and a project request with Unisys to improve the TPL update process. This improvement will be implemented in September 2003.
Denied claims should be reviewed for potential recoveries.

According to the division’s TPL vendor’s records, Medicare and/or other insurance carriers denied approximately $500 million of claims from calendar years 2000 to 2002. The division has no follow-up procedure in place to review the validity of the claims being denied.

Recommendation

The division should establish a follow-up procedure for the review of denied claims to determine if additional recoveries are due.

Auditee’s Response

We believe that many of the $500 million in claims identified as being “denied” in fact were unadjudicated, which often occurs when carriers determine that there is no liability for a claim or coverage of the patient who incurred the claim. However, the vendor is responsible for following-up on denied claims as part of their contract. The BTPL also recognized this deficiency and identified it in its Internal Control Report for 2002. A corrective action plan (CAP) was requested to address HMS’s follow-up procedures but was subsequently rejected. The division has again requested a more acceptable CAP. The one submitted did not require adjudication of every TPL claim and, more importantly, it was not effective. Additionally, the division is considering allowing the other TPL vendor to follow-up on all unadjudicated HMS TPL claims after 180 days.

Data matches would enhance the division’s ability to monitor lawsuit recoveries.

Tort/Casualty Insurance Recoveries

The division receives Medicaid claim recoveries totaling approximately $9 million annually for tort cases, which are primarily civil lawsuits. The division currently has several methods to determine if it is receiving all tort type recoveries that are due to the division. One relies on the plaintiff’s lawyer involved in the tort cases, as it is the lawyer’s
responsibility to send the recoveries to the division. We received a file of all open and closed tort court cases from the Superior Court and compared the file to the division’s Medicaid eligibility file. We identified 140,000 name matches between the two files, which include names as either plaintiff or defendant. The division could increase recoveries by using this information to help identify potential tort recoveries.

**Recommendation**

The division should periodically obtain the tort file from the Superior Court, perform the appropriate matches to identify potential recoveries and then seek those recoveries.

**Auditee’s Response**

It is the responsibility of a beneficiary’s attorney under N.J.S.A. 30:4D-7.1b not only to notify DMAHS of any tort recovery, but also to fully reimburse DMAHS from the proceeds of that recover. It is also the responsibility of the beneficiary’s attorney to notify the division when a tort action is initiated.

It is our understanding from the exit conference with OLS that the file given to OLS contained not only tort cases, but all civil litigation filed with the Clerk of the Superior Court. If this is correct, then the file contained court cases, e.g., contract and divorce matters, from which the division has no legal right to make a recovery. Also, since the file included closed as well as open cases, it contained cases in which the division has already made a recovery.

For the reasons stated above, the 140,000 name matches include cases in which the division has no right to make a recovery. We believe this is grossly overstated since it includes name matches of beneficiaries who are defendants as well as plaintiffs, many of which involve cases in which the division has no right to make a recovery.

Since the match was largely by name, much of the information generated may be unusable, particularly when the match generated common last names or
multiple hits with the same last name. However, the division will evaluate the OLS match results with its TPL contractor, HMS.

We will also explore with HMS the feasibility of conducting periodic matches either with the Superior Court tort file, or other available litigation databases. It should be noted the division has periodically explored the feasibility of conducting a tort match with the NJ court records. The major reason such a match has never been conducted is the absence of a common identifier in the Superior Court litigation records, such as social security number, that could produce a more targeted, manageable and meaningful match with the Medicaid eligibility file. If legislation or court rule required that such an identifier be made a part of the Superior Court’s litigation database, that would result in significant progress toward a realistic tort match.

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**Circumventing the Lock Box**

The division uses a bank lock box service for receipt of TPL vendor recoveries. The TPL vendor instructs the third party insurer to send checks made payable to the State of New Jersey to the lock box. We found that four checks totaling $8 million had not been sent to the bank lock box. Division personnel picked up the checks and then deposited the checks. The bank lock box procedure is imperative because the division has no follow-up procedure to justify why claims are being denied. By circumventing the bank lock box procedure, the division incurs the risk that the checks could be misplaced or stolen.

**Recommendation**

The division should follow the procedures in place for bank lock box services.

**Auditee’s Response**

These were checks from Horizon BCBSNJ that were paid as a result of settlements on claims. The procedure put in place by the Office of the Attorney
General is to close out the settlement by signing agreement documents at the time the check is hand delivered, which necessitates division personnel physically appearing at the Horizon BCBSNJ comptrollers’ office in Newark, New Jersey.

The lock box bank does not accept walk-in deposits and there are no Post Offices nearby, while a bank with a Medicaid account is around the corner from the Horizon BCBSNJ office. Rather than risk loss of the checks through additional travel, these checks were deposited directly into the Medicaid account, gaining an additional $4,000 in interest that would have been lost through the mail delay. It must be noted that all TPL recovery checks are secure to the extent that they must be made out to “Treasurer, State of New Jersey”.

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**Medicaid Overpayments**

Medicaid is the payer of last resort and should pay the least amount possible.

**Recommendation**

The division should modify their computer system to pay the lower of DRG rate or amounts billed.

**Auditee’s Response**

DMAHS does not believe a modification to the MMIS payment system should be made to pay the
lower of the DRG rate or the amount billed for inpatient hospital services due to the disconnect of a hospital’s Chargemaster, its actual cost and the NJ Medicaid’s DRG payment system. If such a modification was implemented for low cost outliers, a corresponding adjustment would have to be made on high cost outliers where current payments do not cover costs in order to maintain a fair and equitable reimbursement system.

New Jersey acute care hospitals are required to charge all payers the same for identical services. This payment is based on each facility’s established Chargemaster. Thus, hospitals are prevented from charging Medicaid a lower or higher charge than what is established by the Chargemaster.

Secondly, NJ Medicaid pays hospitals a fixed amount for inpatient services based on the diagnosis-related group (DRG) which reflects the patient’s diagnosis and the procedures performed. By its very design, DRG rate setting is based on standards and costs in the aggregate, not charges. Therefore, for any given case, a hospital’s costs may be somewhat more or less than the DRG payment, but overall DRG payment rates are set at a level that should yield an efficiently operated hospital a reasonable margin. In some cases, hospitals profit because they are efficient. In other cases, they lose dollars because costs exceed the standards. In the aggregate however, NJ Medicaid pays less than 100 percent of costs to all hospitals.