Department of Human Services
Division of Medical Assistance
and Health Services
Durable Medical Equipment and Supplies

July 1, 2005 to December 31, 2007

Richard L. Fair
State Auditor
The Honorable Jon S. Corzine  
Governor of New Jersey

The Honorable Richard J. Codey  
President of the Senate

The Honorable Joseph J. Roberts, Jr.  
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, Durable Medical Equipment and Supplies for the period of July 1, 2005 to December 31, 2007. If you would like a personal briefing, please call me at (609) 292-3700.

Richard L. Fair  
State Auditor  
March 24, 2008
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Department of Human Services
Division of Medical Assistance and Health Services
Durable Medical Equipment and Supplies

Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services' (division) durable medical equipment and supplies for the period July 1, 2005 to December 31, 2007. Our audit included financial activities accounted for in the state’s General Fund for payments to durable medical equipment and supply providers for Medicaid recipients. Expenditures are funded by the federal government at a 50 percent rate. Annual payments for durable medical equipment and supplies were $41 million.

Objectives

The objective of our audit was to examine the effectiveness of the division's controls to contain durable medical equipment and supply expenditures. In making this determination we tested the propriety of claims.

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, and policies of the agency. Provisions we considered significant were documented, and compliance with those requirements was verified by interview, observation, and through our samples of financial transactions. We also 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 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

The division needs to improve controls over provider reimbursements to prevent improper payments for durable medical equipment and supplies and enhance its program oversight. We believe greater efficiencies could be realized by the division through competitive bidding for services by medical equipment and supply providers or reducing maximum allowable fees to reflect reasonable market prices.

Background

The New Jersey Medicaid program pays for medically necessary equipment and supplies for qualified low-income individuals. The division contracts with a fiscal agent to process service claims submitted for reimbursement by Medicaid providers. The claims are subject to edits to ensure all the required information has been submitted and the claim has met program requirements.

Reimbursement for durable medical equipment and supplies is based on a maximum fee allowance determined by the division. Where a maximum allowance has not been established, reimbursement shall be based on the lesser of the provider’s usual and customary charge to the general public or a calculated fee equal to 130 percent of a suppliers invoice cost or 80 percent of the manufacturer’s price list. Prior authorization is required for certain equipment and medical supplies. Staff at the division’s field offices review requests for prior authorization based on medical necessity and purchase/rental options. The division is developing a bid proposal for a broker to provide durable medical equipment and supply services. It is uncertain whether this proposal will result in cost savings.
Cost Reimbursement Compliance

The division assigns a maximum fee allowance for some products to ensure that the Medicaid program does not overpay for durable medical equipment (DME) and medical supplies. Currently, 65 percent of the DME and supply expenditures are priced based on a maximum fee allowance.

If a maximum fee allowance has not been established, the division allows and typically providers submit the catalog prices, wholesale costs, or retail prices as a basis for reimbursement. However, regulations require the reimbursement for these items be the lesser of the customary charge to the public, 130 percent of the supplier’s invoice cost, or 80 percent of the manufacturer’s suggested retail price (MSRP). The division should require providers to submit their cost data, customary charge, and the MSRP to ensure that its claims are the lesser of the three amounts.

To illustrate the financial impact, we selected a claim for a customized wheelchair submitted by a provider in fiscal year 2007. In this instance, the division paid $8,181 for a customized wheelchair based on 80 percent of MSRP. We requested and obtained the provider’s invoices which identified their cost of $4,388. If the division had enforced regulations the provider would have been reimbursed $5,705. The Medicaid program overpaid $2,476.

Recommendation

The division should require providers to submit sufficient documentation to ensure that the lesser reimbursement amount is used in calculating the claim payment.
The division should reduce their reimbursement fees for oxygen concentrators and incontinence briefs.

Oxygen Concentrators and Incontinence Briefs

Opportunities exist to reduce the costs of New Jersey’s Medicaid program by obtaining competitively bid term contracts or by reducing the maximum allowable fees paid for oxygen concentrators and related services and incontinence supplies.

Currently, a recipient may rent an oxygen concentrator from any vendor for the fixed rental rate of $250 per month. This maximum allowable fee includes periodic maintenance and emergency service, and is the highest of the 28 states we reviewed. There are approximately 3,000 oxygen concentrators billed each month to the New Jersey Medicaid program at a cost of $3.4 million in fiscal year 2007. Our review of other states found Medicaid reimbursement rates ranging from $65.45 to $230.17 per month for equipment and services comparable to those that New Jersey Medicaid provides. Additionally, one state procured a term contract for its oxygen concentrator services with rates ranging between $40 and $64 depending upon the region of the state.

The Department of Military and Veterans Affairs, Menlo Park Memorial Home in Edison also rented oxygen concentrators utilizing a term contract. In fiscal year 2005, the monthly rental fee was $73.40 for the equipment and maintenance. The use of a term contracts for oxygen concentrators may achieve significant cost savings. Using Menlo Park Memorial Home’s contract rate, the division could achieve an annual federal and state savings of $1.4 million.

The division also has opportunities to reduce the costs for adult incontinence briefs. The division currently pays from $.70 to $.90 per brief. Currently, the state has a term contract for adult
disposable briefs for individuals in state institutions. The contract purchase price for adult briefs range from $.18 to $.29 depending on the size of the brief. Our review noted that had the division set Medicaid rates based on the state contract for incontinence briefs, the Medicaid program could have realized an annual federal and state cost savings of $5.3 million.

During our on site visits to providers, we found one provider had purchased incontinence briefs from a major warehouse discount store. The provider paid $.42 per unit for adult large disposable briefs, then submitted claims and was reimbursed $.70 per unit by the New Jersey Medicaid program.

**Recommendation**

We recommend the division consider using term contracts for oxygen concentrators and related services, and incontinence briefs and supplies for the New Jersey Medicaid program. Alternatively, the division should reduce its maximum allowable fees to reflect reasonable market prices.

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**Prior Authorization of Incontinence Supplies**

The Medicaid program pays for medically necessary supplies, such as disposable adult briefs and children diapers, shields, liners and pads, and disposable wipes. Prior to November 2004, the staff at the division’s field offices reviewed requests for prior authorization for these supplies and made decisions based on medical necessity.

In November 2004, the division removed the prior authorization requirements for incontinence supplies and implemented a maximum limit of 250 briefs per month. Our review found that shortly after the division’s removal of the prior authorizations, the number of beneficiaries and
claims for incontinence briefs increased as presented in the following chart.

![Chart showing Adult Briefs: Monthly Amount Paid vs Number of Recipients]

The elimination of the prior authorization increased the risk of fraud and abuse. We identified examples of this abuse in a subsequent finding.

**Recommendation**

The division should reevaluate the need for prior authorizations for incontinence briefs.

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**Durable Medical Equipment and Supply Claims for Nursing Home Residents**

The New Jersey Medicaid program does not cover routinely used medical supplies, durable medical equipment (DME), and other therapeutic equipment for residents of a nursing home. Pursuant to N.J.A.C. 8:85-2.15, such items are considered part of the nursing facilities’ responsibility for the care and treatment of its residents and are considered part of the nursing facilities’ cost. These costs should not be billed directly to the program by the supplier.

Our review found that 363 DME providers improperly billed the Medicaid program $2.1 million during our audit period for routine
medical equipment and supplies that should have been provided by the nursing facility. Routine items such as enteral feeding formulas, incontinence briefs, hospital beds, and standard wheelchairs should be the responsibility of the nursing facility.

The DME providers should have sought reimbursement for these routine items directly from the nursing care facility, rather than from the Medicaid program. The improper payments occurred because the state’s Medicaid Management Information System (MMIS) lacked the necessary edits and controls to deny such claims.

Recommendation

We recommend the division review its current MMIS edits and implement procedures that would monitor claim payments for routine medical items delivered to nursing home residents.

Inadequate Audits and Program Monitoring

There are currently 1,351 durable medical equipment providers enrolled to participate in the New Jersey Medicaid program. The division contracts with a company to perform desk audits and on site reviews. The on site reviews, however, are announced and the provider is told in advance which beneficiaries’ prescriptions and claims to have available for review.

The division’s Bureau of Program Integrity (BPI) is also charged with the responsibility of monitoring Medicaid providers. Drastic reductions in the staff positions at BPI from 53 in 2004 to 26 currently, coupled with a policy of not pursuing provider fraud or abuse cases under a $50,000 threshold, has hindered the unit from detecting,
investigating, and recovering funds from Medicaid fraud or misuse.

During our audit and field visits we found the following problems which emphasize the need for increased monitoring efforts over providers.

- During the six-month period from January to June 2007, a provider submitted $30,000 more in claims for incontinence briefs than the provider had available. Although the provider billed the Medicaid program for approximately 48,000 adult incontinence briefs, documents support the purchase of only 10,000 briefs and the facility had no inventory storage.

- A similar review of a second provider revealed a lack of support for the purchases of adult briefs, disposable under pads, and compression stockings. The provider submitted claims with quantities approximately two, three, and five times greater, respectively, than the amounts supported by the provider's purchase records. The amount paid for these unsupported quantities was approximately $93,000, which is roughly half of the total amount paid to the provider.

- The invoices of the above providers indicated significant quantities of panty liners had been purchased. Although there is a procedure code for this item, neither provider had any claims with this code in fiscal year 2007. We suspect the items may have been substituted and billed as other items with a higher reimbursement rate.

The above issues have been referred to the Division of Criminal Justice for further investigation.
Additionally, over 1,000 beneficiaries received more than one blood pressure monitor within our audit period. We found numerous instances where the beneficiary received as many as three. Many blood pressure monitors come with a manufacturer’s five-year or life-time warranty. Often major drug store chains will replace old or defective blood pressure monitors at no cost. The division should have denied these claims totaling $100,000 for the additional monitors.

**Recommendations**

The division should improve its current monitoring over durable medical equipment and supply providers by including reviews of inventory purchases. In addition, the division should review its medical criteria for the frequency of providing blood pressure monitors.

We recognize that legislation establishing a Medicaid Inspector General has been passed; however, this position remains vacant. This agency will enhance the state’s efforts to investigate Medicaid fraud and abuse once it becomes operational.

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**Overuse of Miscellaneous Procedure Codes**

The division accounts for various types of durable medical equipment (DME) purchases through the use of equipment identification codes or procedure codes. Due to the limited number of codes available to identify medical equipment and supplies, the division uses several “miscellaneous” procedure codes. Our review of DME expenditures found the largest dollar expenditure category was in miscellaneous procedure codes with claims totaling $13.8 million during our audit period.

By allowing the overuse of miscellaneous billing
codes, the division is unable to properly report or monitor items purchased in these categories on the MMIS. Although certain items are prior authorized by the division, limiting the use of miscellaneous procedure codes could enhance overall monitoring of DME claims.

**Recommendation**

The division should review its current use of miscellaneous procedure codes and restrict their use by utilizing additional codes to identify specific equipment or parts.

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**Durable Medical Equipment Recycling Contract**

The division entered into a contract with a medical equipment recycling vendor in January 2004 to recycle Medicaid purchased durable medical equipment (DME). According to the contract, the vendor was to be paid a fee for the tracking, retrieving, sanitizing, and shelving of state-owned DME.

Our review found the contractor had submitted claims for the recycling of newly purchased equipment delivered to beneficiaries. The contractor received the entire fee for only the tagging of new equipment. The division knew about this practice and authorized the vendor to submit claims and receive the entire payment for services that were only partially rendered. Services for the pickup, sanitizing, refurbishing, and storing of certain equipment were never rendered. In fiscal year 2006, the contract for the recycling program ended. In March 2007, the division's records relating to the contract were subpoenaed and are currently under investigation by the Division of Criminal Justice.

Based on our analysis of claims paid to the vendor, we estimate $3 million may be owed
back to the state and federal governments by the vendor for services paid but never rendered.

**Recommendation**

We recommend the division work with the Division of Criminal Justice to review claims paid to the contractor and seek collection of overpayments for recycling services that the division never received.
March 17, 2008

Stephen M. Eells  
Office of Legislative Services  
Office of the State Auditor  
125 South Warren Street  
P O Box 067  
Trenton, NJ 08625-0067

Dear Mr. Eells:

This is in response to your March 4, 2008 letter to Commissioner Jennifer Velez concerning the Office of Legislative Services (OLS) draft audit report entitled “Department of Human Services, Division of Medical Assistance and Health Services, Durable Medical Equipment and Supplies.” Your letter provides an opportunity to comment on the draft audit report.

The conclusion of the audit is the Division of Medical Assistance and Health Services (DMAHS) needs to improve controls over provider reimbursements to prevent improper payments for durable medical equipment and supplies and enhance its program oversight. Greater efficiencies could be realized by DMAHS through competitive bidding for services by medical equipment and supply providers or reducing maximum allowable fees to reflect reasonable market prices.

In response to the overall conclusion, it is agreed that greater efficiencies could be realized through competitive bidding. It is for this reason the legislature approved the Appropriations Act which mandated that the Division contract out for the management of this service. The RFP is not written as there was an agreement with the Purchase Bureau that once the Transportation Broker RFP was released, they would immediately assign a buyer for DME.

In the meantime, it is not possible, given limited resources, to negotiate separate contracts for specific items. Further, the rates referenced in the findings are for institutions where there are few delivery sites and purchases can be made in large volumes. For Medicaid clients living in the community, purchases are small but frequent and must be widely available across the State. There is an institutional
bias against allowing larger, more infrequent purchases of product given the prevalence of waste and potential abuse.

The findings, OLS recommendations and DMAHS responses are provided below:

**FINDING 1: Cost Reimbursement Compliance**

The division assigns a maximum fee allowance for some products to ensure that the Medicaid program does not overpay for durable medical equipment (DME) and medical supplies. Currently, 65 percent of the DME and supply expenditures are priced based on a maximum fee allowance.

If a maximum fee allowance has not been established, the division allows and typically providers submit the catalog prices, wholesale costs, or retail prices as a basis for reimbursement. However, regulations require the reimbursement for these items be the lesser of, the customary charge to the public, 130 percent of the supplier’s invoice cost, or 80 percent of the manufacturer’s suggested retail price (MSRP). The division should require providers to submit their cost data, customary charge, and the MSRP to ensure that its costs are reasonable.

To illustrate the financial impact, we selected a claim for a customized wheel chair submitted by a provider in fiscal year 2007. In this instance, the division paid $8,181 for a customized wheelchair based on 80 percent of MSRP. We requested and obtained the provider’s invoices which identified their cost of $4,388. If the division had enforced regulations the provider would have been reimbursed $5,705. The Medicaid program overpaid $2,476.

**RECOMMENDATION:**

The division should require providers to submit sufficient documentation to ensure that the lesser reimbursement amount is used in calculating the claim request.

**DMAHS RESPONSE:**

The Division does not concur with the auditor’s finding. The applicable regulation 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”. While the auditor’s interpretation may be considered reasonable, the process applied by the Division is at least equally reasonable. The regulation can be interpreted to allow payment at the lesser of the provider’s usual and customary charge to the general public or a calculated
maximum fee allowance. The latter being either 130 percent of a supplier’s invoice cost or 80 percent of the manufacturer’s price list for supplies and equipment at the provider’s discretion. Therefore, it appears that the example cited by the auditor can be considered in accordance with the regulation.

While the Division agrees that savings can be achieved by reducing payments to providers, in this case a regulatory revision will be required.

Given the high volume and relatively low cost of each transaction, it is not practical to require providers to submit three forms of documentation for each article submitted for reimbursement. Further, to the extent that this recommendation is limited only to those claims submitted “by report,” this will be less of an issue, going forward (see specific finding). The Division will move to implementation of one reimbursement mechanism (vs. three); that is, as soon as practicable the Division will limit the documentation required to the purchaser’s invoice. While we realize this may be a disincentive for providers from purchasing the lowest cost items, it is our belief that retail merchants buy in bulk and do not want to carry expensive inventory on their books; that the market will control overspending. By comparison, use of the MSRP would include that same bias (more expensive item) and “customary charge” is not a “real” number, as was identified when the Governor required transparency of drug costs – it was determined that the only “benchmark” information available from pharmacies was from claims paid in Medicaid Fee For Service – that information now is posted on the Division of Consumer Affairs website.

FINDING 2: Oxygen Concentrators and Incontinence Briefs

Opportunities exist to reduce the costs of New Jersey’s Medicaid program by obtaining competitively bid term contracts or by reducing the maximum allowable fees paid for oxygen concentrators and related services and incontinence supplies.

Currently, a recipient may rent an oxygen concentrator from any vendor for the fixed rental rate of $250 per month. This maximum allowable fee includes periodic maintenance and emergency service, and is the highest of the 28 states we reviewed. There are approximately 3,000 oxygen concentrators billed each month to the New Jersey Medicaid program at a cost of $3.4 million in fiscal year 2007. Our review of other states found Medicaid reimbursement rates ranging from $65.45 to $230.17 per month for equipment and services comparable to those that New Jersey Medicaid provides. Additionally, one state procured a term contract for its oxygen concentrator services with rates ranging between $40 and $64 depending upon the region of the state.
The Department of Military and Veterans Affairs, Menlo Park Memorial Home in Edison also rented oxygen concentrators utilizing a term contract. In fiscal year 2005, the monthly rental fee was $73.40 for the equipment and maintenance. The use of a term contracts for oxygen concentrators may achieve significant cost savings. Using Menlo Park Memorial Home's contract rate, the division could achieve an annual savings of $1.4 million.

The division also has opportunities to reduce the costs for adult incontinence briefs. The division currently pays from $.70 to $.90 per brief. Currently, the state has a term contract for adult disposable briefs for individuals in state institutions. The contract purchase price for adult briefs range from $.18 to $.29 depending on the size of the brief. Our review noted that had the division set Medicaid rates based on the state contract for incontinence briefs, the Medicaid program could have realized an annual cost savings of $5.3 million.

During our on site visits to providers, we found one provider had purchased incontinence briefs from a major warehouse discount store. The provider paid $.42 per unit for adult large disposable briefs, then submitted claims and was reimbursed $.70 per unit by the New Jersey Medicaid program.

RECOMMENDATION:

We recommend the division consider using term contracts for oxygen concentrators and related services and incontinence briefs and supplies for the New Jersey Medicaid program. Alternatively, the division should reduce its maximum allowable fees to reflect reasonable market prices.

DMAHS RESPONSE:

As stated above, in the response to “Conclusions” it is not practicable for the Division to negotiate contracts for these types of services nor could we append to a contract servicing three Veterans Homes or even vendors servicing the institutions given the material difference in the scope of service. However, the Division does accept the recommendation of the auditor’s and will reduce its maximum allowable fees. This process requires coordination with the Office of Administrative Law; the fees are included in regulation and therefore, require formal regulatory process to make a change. The Division will reduce its rate for oxygen concentrators.

FINDING 3: Prior Authorization of Incontinence Supplies

The Medicaid program pays for medically necessary supplies, such as disposable adult briefs and children diapers, shields, liners and pads, and disposable wipes.
Prior to November 2004, the staff at the division's field offices reviewed requests for prior authorization for these supplies and made decisions based on medical necessity.

In November 2004, the division removed the prior authorization requirements for incontinence supplies and implemented a maximum limit of 250 briefs per month. Our review found that shortly after the division’s removal of the prior authorizations, the number of beneficiaries and claims for incontinence briefs increased. The elimination of the prior authorization increased the risk of fraud and abuse. We identified examples of this abuse in a subsequent finding.

RECOMMENDATION:

The division should reevaluate the need for prior authorizations for incontinence briefs.

DMAHS RESPONSE:

A decision was made several years ago to increase the number of incontinence briefs to a maximum of 250 per month. Assuming a 30-day month, that is eight (8) briefs per day. A cost benefit analysis was done and it was determined that the skills and experience of the physicians in the Medicaid Customer Service Centers were more efficiently applied to clinical matters vs. determining whether, in fact, a client needed to be cleaned less than eight (8) times per day. Whether or not a client is/is not abusing the eight-day limit would require home visitations and a daily log to be kept by the client. Again, the cost of having physicians track incontinence briefs was determined not an efficient use of resources. Further, the Division does not have sufficient staff to do home visits.

FINDING 4: Durable Medical Equipment and Supply Claims for Nursing Home Residents

The New Jersey Medicaid program does not cover routinely used medical supplies, durable medical equipment (DME), and other therapeutic equipment for residents of a nursing home. Pursuant to N.J.A.C. 8:85-2.15, such items are considered part of the nursing facilities’ responsibility for the care and treatment of its residents and are considered part of the nursing facilities’ cost. These costs should not be billed directly to the program by the supplier.

Our review found that 363 DME providers improperly billed the Medicaid program $2.1 million during our audit period for routine medical equipment and supplies that should have been provided by the nursing facility. Routine items such as
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enteral feeding formulas, incontinence briefs, hospital beds, and standard wheelchairs should be the responsibility of the nursing facility.

The DME providers should have sought reimbursement for these routine items directly from the nursing care facility, rather than from the Medicaid program. The improper payments occurred because the state’s Medicaid Management Information System (MMIS) lacked the necessary edits and controls to deny such claims.

RECOMMENDATION:

We recommend the division review its current MMIS edits and implement procedures that would monitor claim payments for routine medical items delivered to nursing home residents.

DMAHS RESPONSE:

It is agreed that the edits will be reviewed and tested to assure compliance. In the meantime, the individual claims selected for this study must be pulled to determine whether the provider utilized the correct “place of service” code. If the provider did not specify “nursing facility” as the place of service, the claim would not be blocked. This is a provider compliance issue; however, efforts will be made to create an edit to block these claims. Additionally, a review will be completed and recoveries, if appropriate, will be made.

FINDING 5: Inadequate Audits and Program Monitoring

There are currently 1,351 durable medical equipment providers enrolled to participate in the New Jersey Medicaid program. The division contracts with a company to perform desk audits and on site reviews. The on site reviews, however are announced and the provider is told in advance which beneficiaries’ prescriptions and claims to have available for review.

The division’s Bureau of Program Integrity (BPI) is also charged with the responsibility of monitoring Medicaid providers. Drastic reductions in the staff positions at BPI from 53 in 2004 to 26 currently, coupled with a policy of not pursuing provider fraud or abuse cases under a $50,000 threshold, has hindered the unit from detecting, investigating, and recovering funds from Medicaid fraud or misuse.

During our audit and field visits we found the following problems which emphasize the need for increased monitoring efforts over providers.
During the six-month period from January to June 2007, a provider submitted $30,000 more in claims for incontinence briefs than the provider had available. Although the provider billed the Medicaid program for approximately 48,000 adult incontinence briefs, documents support the purchase of only 10,000 briefs and the facility had no inventory storage.

A similar review of a second provider revealed a lack of support for the purchases of adult briefs, disposable under pads, and compression stockings. The provider submitted claims with quantities approximately two, three, and five times greater, respectively, than the amounts supported by the provider’s purchase records. The amount paid for these unsupported quantities was approximately $93,000, which is roughly half of the total amount paid to the provider.

The invoices of the above providers indicated significant quantities of panty liners had been purchased. Although there is a procedure code for this item, neither provider had any claims with this code in fiscal year 2007. We suspect the items may have been substituted and billed as other items with a higher reimbursement rate.

The above issues have been referred to the Division of Criminal Justice for further investigation.

Additionally, over 1,000 beneficiaries received more than one blood pressure monitor within our audit period. We found numerous instances where the beneficiary received as many as three. Many blood pressure monitors come with a manufacturer’s five-year or life-time warranty. Often major drug store chains will replace old or defective blood pressure monitors at no cost. The division should have denied these claims totaling $100,000 for the additional monitors.

**RECOMMENDATION:**

The division should improve its current monitoring over durable medical equipment and supply providers by including reviews of inventory purchases. In addition, the division should review its medical criteria for the frequency of providing blood pressure monitors.

We recognize that legislation establishing a Medicaid Inspector General has been passed; however, this position remains vacant. This agency will enhance the state’s efforts to investigate Medicaid fraud and abuse, once it becomes operational.
DMAHS RESPONSE:

Once again, the Division is aware of the need for more thorough and timely monitoring and will be pursuing a vendor to provide the level of oversight that is required. In the meantime, since the warranty on blood pressure monitors varies by manufacturer/supplier, the Division will solicit a recommendation from its Physician Advisory Council and will implement a change (reduction) in frequency; to be determined.

The contract with Blue Cross auditors requires acquisition audits and we will continue surveillance. In accordance with our requirements, if a pharmacy or free standing DME vendor is suspected of fraud or abuse; same will be referred to the Bureau of Program Integrity.

FINDING 6: Overuse of Miscellaneous Procedure Codes

The division accounts for various types of durable medical equipment (DME) purchases through the use of equipment identification codes or procedure codes. Due to the limited number of codes available to identify medical equipment and supplies, the division uses several "miscellaneous" procedure codes. Our review of DME expenditures found the largest dollar expenditure category was in miscellaneous procedure codes with claims totaling $13.8 million during our audit period.

By allowing the overuse of miscellaneous billing codes, the division is unable to properly report or monitor items purchased in these categories on the MMIS. Although certain items are prior authorized by the division, limiting the use of miscellaneous procedure codes could enhance overall monitoring of DME claims.

RECOMMENDATION:

The division should review its current use of miscellaneous procedure codes and restrict their use by utilizing additional codes to identify specific equipment or parts.

DMAHS RESPONSE:

A review of the number of codes available from the American Medical Association indicates that there are close to 100 codes in our system that could have a maximum allowable fee attached. However, in fact, there are fewer than twenty (20) of those codes that can be prospectively priced; all others must be by report. The Division agrees that those twenty (20+) codes will have a maximum allowable
fee assigned and same will be implemented once the regulations have been amended.

**FINDING 7: Durable Medical Equipment Recycling Contract**

The division entered into a contract with a medical equipment recycling vendor in January 2004 to recycle Medicaid purchased durable medical equipment (DME). According to the contract, the vendor was to be paid a fee for the tracking, retrieving, sanitizing, and shelving of state-owned DME.

Our review found the contractor had submitted claims for the recycling of newly purchased equipment delivered to beneficiaries. The contractor received the entire fee for only the tagging of new equipment. The division knew about this practice and authorized the vendor to submit claims and receive the entire payment for services that were only partially rendered. Services for the pickup, sanitizing, refurbishing, and storing of certain equipment were never rendered. In fiscal year 2006, the contract for the recycling program ended. In March 2007, the division's records relating to the contract were subpoenaed and are currently under investigation by the Division of Criminal Justice.

Based on our analysis of claims paid to the vendor, we estimate $3 million may be owed back to the state and federal governments by the vendor for services paid but never rendered.

**RECOMMENDATION:**

We recommend the division work with the Division of Criminal Justice to review claims paid to the contractor and seek collection of overpayments for recycling services that the division never received.

**DMAHS RESPONSE:**

The contract for recycling services was terminated in June, 2006. Currently the Division of Criminal Justice has initiated a review of the vendor. The Division cannot interfere with an ongoing investigation. However, it should be noted that when the contract was signed, it was agreed that a specified percentage would be paid at the time the equipment was tagged and entered into inventory. It has been determined that the amount paid was correct. The specified percentage did "assume" that the equipment would eventually be recovered, sanitized, repaired, etc., and returned to service. It was not stipulated in the contract how that specified percentage would be allocated. Due to the termination of the contract, the back end services were never required. The findings in the report assume ten (10%) percent for "tagging and entering into inventory;" and "assume" recovery of
90%. There is no basis for use of this percentage and may or may not reflect the intent of the original contract.

Based on the information provided above, I am requesting a revision to the first finding and recommendation in the draft audit report. The finding and recommendation should be revised to reflect the actual text of the cited regulation and the reasonable interpretation applied by DMAHS.

The opportunity to review and comment on this draft report is appreciated. The courtesy and professionalism of the audit staff throughout the period is acknowledged. If you have any questions or require additional information, please contact me or David Lowenthal at (609) 588-7933.

Sincerely,

John R. Guhl
Director

JRG:L
c: Jennifer Velez
   David Lowenthal
bc: Ann Clemency Kohler

D080080 – Durable Medical Equipment and Supplies