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

Department of Human Services
Division of Medical Assistance and Health Services
Medicaid Provider Enrollment, Hearing Aid Services, and Drug Screenings

July 1, 2008 to June 30, 2011

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State Auditor

New Jersey State Legislature

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Enclosed is our report on the audit of the Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Enrollment, Hearing Aid Services, and Drug Screenings for the period of July 1, 2008 to June 30, 2011. If you would like a personal briefing, please call me at (609) 292-3700.

Stephen M. Eells
State Auditor
October 17, 2011

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Scope

We have completed an audit of the Department of Human Services, Division of Medical Assistance and Health Services (division), Medicaid provider enrollment process, hearing aid services, and drug screenings for the period July 1, 2008 through June 30, 2011. Our audit included the review of financial activities included in the State's General Fund. Expenditures are partially funded by the federal government. There are 33 provider types and approximately 33,000 providers delivering health care services to 1.3 million Medicaid recipients. Fiscal year 2010 payments for hearing aid services and drug screenings were $7.1 million and $8.5 million, respectively.

Objectives

The objective of our audit was to determine if the division has adequate controls in place when enrolling Medicaid providers. In addition, we determined whether payments to providers for hearing aid services and drug screenings were related to the program, reasonable, and proper. We also reviewed the effectiveness of the division's controls to contain and monitor these expenditures.

The audit was conducted pursuant to the State Auditor's responsibilities as set forth in Article VII, Section I, Paragraph 6 of the State Constitution and Title 52 of the New Jersey Statutes.

Methodology

Our audit was conducted in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States. In preparation for our testing, we studied legislation, the administrative code, circular letters promulgated by the Office of Management and Budget, and policies of the division. Provisions that we considered significant were documented and compliance with those requirements was verified by interview, observation, and through our sample of provider payments. We also read budget messages, reviewed financial trends, and interviewed division personnel to obtain an understanding of the programs and the internal controls.

A nonstatistical sampling approach was used. Our samples of providers were designed to provide conclusions about the provider enrollment process while our samples of claims were designed to provide conclusions about the validity of claims, as well as internal control and compliance attributes. Sample populations were sorted and claims were judgmentally selected for testing.

Conclusions

We found that the division has adequate controls in place when enrolling Medicaid providers. However in making this determination, we noted an internal control weakness meriting management's attention. Additionally, although payments to providers for hearing aid services and drug screenings relate to the program, the costs for these services were not reasonable. The division needs to improve its controls over monitoring and containing costs relating to these services.

We also recommend that the division coordinate with the Department of the Treasury to identify and recover debt owed by Medicaid providers.

Provider Enrollment

Controls over the enrollment of prosthetic and orthotic providers should be improved.

Overall the division has adequate controls in place for enrolling providers. However, we identified a weakness relating to the enrollment of prosthetic and orthotic (P&O) providers. P&O providers supply custom fabricated orthotic and/or prosthetic devices to enable recipients to function better and increase their mobility. Regulations require that to be an approved P&O provider, applicants must submit a copy of their facility and personnel certifications by the American Board for Certification in Orthotics and Prosthetics.

We tested 15 of the 93 P&O providers eligible as of March 2011 and found that seven had not submitted documentation of their facility and/or personnel certification with their application. Further review disclosed that none of the seven had the proper facility and personnel certifications to be enrolled as a P&O provider. During the period from July 1, 2008 to March 25, 2011, these seven providers had claims totaling $839,000.

In addition to processing Medicaid claim payments, the division's contracted fiscal agent also administers the provider enrollment process. While some high risk provider types are forwarded to other state agencies including the Medicaid Fraud Division prior to final approval, the fiscal agent has the sole authority to approve P&O providers. The fiscal agent failed to ensure that all P&O applicants possessed the required credentials.

The moratorium on durable medical equipment providers is being circumvented.

A moratorium on durable medical equipment (DME) providers has been in effect since July 2006 to ensure that only DME providers whose services are deemed necessary to meet special needs by the division become providers. Providers have circumvented the moratorium by enrolling as a P&O provider and then operating as a DME provider. We tested five P&O providers enrolled after the moratorium and found that four were operating as DME providers. Since their enrollment, the four providers billed $1.2 million in DME claims, but only $645 in P&O claims. Because P&O providers can sometimes have legitimate DME claims, the Medicaid system is set to allow P&O providers to submit DME claims when necessary. However, these four providers were clearly operating as a DME and should be examined further by the division.

Recommendation

The division should suspend the eligibility of providers that do not possess the proper certification until the required documentation is supplied. The division should also examine any P&O provider with excessive DME claims and determine if their services are necessary to meet special needs in accordance with the moratorium.

Hearing Aid Services

The New Jersey Medicaid program provides hearing aids and related services to eligible recipients. Related services include dispensing fees, batteries, and repairs. Regulations require that recipients must first be medically cleared and referred by a physician prior to the prescribing of a hearing aid. For the period July 1, 2008 through June 27, 2011, claims for hearing aids and related services totaled $19.1 million for 12,300 recipients. Hearing aid and related services claims have increased from $3.6 million for 6,000 recipients in fiscal year 2007 to $7.1 million for 7,000 recipients in fiscal year 2010.

Monitoring of hearing aid service claims should be improved.

Our review found that the division has inadequate controls in place to monitor hearing aid claims. Hearing aid providers submit claims along with supporting documentation to the state's fiscal agent. These manual claims and their support are not critically reviewed for accuracy and controls are not adequate to detect or prevent provider billing errors or abuses.

The administrative code states that reimbursements for hearing aids will be at wholesale cost, which historically has been the provider's actual or net cost of obtaining the hearing aid from the manufacturer. However, the department issued a newsletter in 1992 that modified these regulations. The newsletter eliminated both prior authorization and the requirement that providers submit manufacturer invoices as proof of cost. Instead, the newsletter provided the option to use manufacturer price lists changing the reimbursement criteria from cost to single-unit pricing. The single unit price is the price a provider would pay for a single hearing aid, which is much higher than the provider's net cost since providers often receive significant discounts from hearing aid manufacturers.

Our initial review of 70 claims for hearing aids from 26 providers indicated only four claims showed a discount. We contacted a hearing aid manufacturer to obtain copies of four invoices we suspected had been altered. We found that the providers received substantial discounts from the manufacturer. These discounts did not appear on the invoices that were submitted to Medicaid for reimbursement. For example, one provider billed Medicaid $2,295 when the manufacturer's invoice, including the discount, showed a cost of $1,056. Another claim had a cost of $2,900, while the actual invoice was for $915. We conservatively estimated the average discount to be 50 percent. There is the strong likelihood of significant cost savings if the division were to reimburse providers at their net cost as required by the administrative code.

Our review indicated the program is in need of additional oversight. Twenty-six of 29 files reviewed did not contain a signed beneficiary agreement or confirmation from the recipient that the hearing aid was received. We also noted two providers had expired licenses. There were four claims that did not have the required medical clearance and eight claims for which the provider could not verify the make, model, and serial number of the hearing aid disbursed.

Other notable exceptions included one provider who admitted submitting 25 duplicate and 4 unsupported hearing aid claims of the 85 we tested, resulting in overpayments of $53,000. The provider's files were so poorly kept we could not confirm the validity of their other 56 claims reviewed totaling another $82,000. Another provider created invoices in an attempt to make them appear to be originals from the manufacturer. A third provider had a relative act as an intermediary company and submitted inflated invoices from that company rather than the actual invoice cost from the manufacturer. A fourth provider overcharged Medicaid on 37 of 40 transactions resulting in an overpayment of at least $31,000. Although we did not test all transactions for this provider, we noted 421 similarly priced transactions representing a potential of $270,000 in overpayments. All four providers were referred to the Division of Criminal Justice for further review. Our review also resulted in the identification of several thousand dollars in additional overpayments and provider errors that we reported to the division.

The division has no prior-authorization policy for hearing aids. Prior authorization of hearing aids costing more than a predefined amount would ensure that higher priced hearing aids are justified and appropriate. The following chart demonstrates how hearing aids claims vary.

Fiscal Year 2010	Average Claim	Highest Claim
Single Hearing Aid - In Ear	$ 845	$ 2,311
Single Hearing Aid - Behind Ear	$ 932	$ 2,445
Two Hearing Aids - In Ear	$ 1,603	$ 4,790
Two Hearing Aids - Behind Ear	$ 1,700	$ 4,790

We also noted a significant number of recipients receiving a questionable number of hearing aid services over a period of time. Although adjustments may be required, the average hearing aid has a life-span of approximately five years. Analysis of the five-year period from January 2006 through December 2010 disclosed that of the 13,700 unique recipients who received at least one hearing aid, 2,900 received two or more including 570 who received three or more. While hearing aids can be lost, stolen, or unrepairable, the division has no system edits to identify and review these requests for replacement hearing aids.

In summary, the division cannot rely upon the current controls to monitor this program. We noted other states have addressed similar abuses by implementing controls such as prior authorization, excluding high-priced digital devices without medical justification, and limiting the number of hearing aids a recipient may receive over a period of time.

The division overpaid for hearing aid batteries.

A system edit within the Medicaid Management Information System allows certain procedure codes to automatically process the claim if the value of the item is below a pre-defined limit. In the case of batteries, the limit was set in 2003 at $2 per battery and all claims below that amount were not reviewed. Our analysis of battery claims between July 1, 2008 and February 10, 2011 indicated a total of 943,000 batteries were reimbursed at a cost of $1.7 million for an average cost of $1.80 per battery. Research indicates the retail cost of these batteries to be approximately 50 cents.

By not monitoring and adjusting the allowable price for batteries, the division overpaid approximately $962,000 during the period analyzed. The division agreed with our conclusions and adjusted the price ceiling for batteries from $2 to 80 cents effective February 12, 2011. By changing the allowable price for batteries, we estimate the division will realize an annual cost savings of $367,000.

Recommendation

We recommend the division use the reimbursement methodology and guidelines set forth in the administrative code and take steps to improve its monitoring of hearing aid services. The division should consider prior authorizing hearing aids costing more than a predefined amount and when replacing any hearing aids dispensed within five years of a recipient's last hearing aid.

Drug Screenings

The New Jersey Medicaid program pays for drug screenings for recipients in treatment for substance abuse. Drug screening claims are billed based on a service unit that represents a specific drug class. The division has established a reimbursement rate of $5.20 per drug class and allows providers to test for up to ten drug classes per recipient per day. For the period July 1, 2008 through March 6, 2011, drug screening claims totaled $20.3 million for 70,000 recipients. The majority of screenings were performed by a laboratory at the request of a treatment facility ($13.6 million) or in-house by the facility providing treatment ($5.4 million). Drug screening claims have increased from $1.5 million for 13,500 recipients in fiscal year 2003 to $8.4 million for 27,000 recipients in fiscal year 2011.

Fiscal Year	Recipients	Claims	Payment (in millions)
2003	13,454	47,071	$1.5
2004	15,669	69,574	$2.4
2005	17,226	116,375	$4.3
2006	18,632	126,444	$4.7
2007	19,726	136,204	$5.3
2008	19,918	131,869	$5.6
2009	23,482	149,294	$6.5
2010	27,204	184,817	$8.5
2011	27,198	185,701	$8.4

Some recipients are excessively drug screened.

Analysis of 12,700 recipients with seven or more drug screening claims during the period July 1, 2008 through March 6, 2011 disclosed that approximately 6,000 recipients exceeded one screening every two weeks including 1,600 that exceeded one screening per week. Other than a system edit limiting providers to a maximum of ten drug classes per recipient per day, the division has no policy concerning the frequency of drug screenings. Standards established by the Department of Human Services, Division of Addiction Services (DAS) state that random drug screenings to identify continued drug abuse shall be conducted once every two weeks. Our review disclosed that excessive screening occurred regardless of whether it was performed by an independent laboratory or in-house by the facility providing treatment.

We also found that screening frequencies vary by treatment facility. Visits to various treatment facilities disclosed screening policies of two times a month, four times a month, and multiple times per week. One facility screened recipients as often as four times a week. Establishing a

policy concerning the frequency of drug screenings would help eliminate excessive screenings and reduce drug screening costs.

Finally, providers consistently bill at or near the maximum of ten service units. Of the 452,000 drug screening claims during the period reviewed, approximately 356,000 were for eight or more drug classes. We analyzed nine providers who accounted for $16.9 million of the $20.3 million in drug screening claims and found that six billed for the maximum allowable drug classes 80 to 99 percent of the time. According to DAS, a ten drug class screening is reasonable at the beginning of any drug treatment program, but consistently screening for as many as ten drug classes is a questionable practice.

The drug screening reimbursement rate should be reevaluated.

In comparison to neighboring states, the division's reimbursement rate appears to be generous. New York has established a maximum rate of $1.25 per unit. Pennsylvania's maximum allowable price per drug class screened is $3 per unit compared to $5.20 in New Jersey.

According to the New Jersey Department of Health and Senior Services' Clinical Laboratory Improvement Service (CLIS), reimbursing $5.20 for each and every drug class tested is excessive as the incremental cost of additional drug classes screened is minimal. CLIS suggested a more reasonable payment rate would be to pay $5.20 for the first drug class tested and a lesser amount for each additional drug class. We estimate that drug screening costs during fiscal year 2010 would have been reduced by $4.9 million had the division reimbursed $5.20 for the first drug class tested and $3 for each additional drug class.

Alternative drug screening methods should be considered.

Another opportunity for cost savings is for the division to utilize on-site instant screening cups as an alternative to performing all screenings in a laboratory environment. Instant screening cups can test for up to twelve drug classes with built-in validity testing. Drug screening costs would be significantly reduced as only positive test results would require confirmation by laboratory testing. Instant on-site screening would be a more cost-efficient drug screening method at a cost of approximately $9 for a ten-drug-class screening instead of the current $52 cost.

Monitoring of drug screening authorizations should be improved.

Regulations state that each drug screening requires a signed order by a physician or other licensed practitioner. Regulations allow patient specific standing orders that can be in effect for up to a year. Most drug screening claims are authorized by standing orders. The orders typically indicate that the frequency and duration of testing will be determined by the treating facility. Our review of standing orders disclosed that standing orders are not always patient specific. We noted two clinics, with their own in-house laboratory using universal standing orders for all patients. One laboratory with significant drug screening claims had no signed orders on file, choosing instead to enter into agreements with treatment facilities to provide a predetermined

panel of drug screenings as requested by each facility. We also noted a treatment facility with numerous standing orders signed by a physician's assistant after their license was voluntarily surrendered because of alleged inappropriate activity.

One laboratory appears to be questionably billing additional drug screening procedures.

The division paid for various additional drug screening procedures including the confirmation of a positive screening, the interpretation of screening results by a medical review officer, and tests to ensure sample validity. Analysis disclosed that a single laboratory accounted for $1 million of the $1.2 million paid for these additional procedures from July 1, 2008 through March 6, 2011. Although not all of the $1 million was billed inappropriately, the laboratory appears to be billing some of these additional procedures unnecessarily or excessively.

- The laboratory billed $397,000 for the confirmation of positive screenings using a procedure code that is reimbursed at $21.50 per unit when the procedure code used by all other laboratories for confirmations is reimbursed at only $15 per unit. The laboratory's use of the more expensive procedure code did not appear to be appropriate and resulted in $120,000 in additional costs.

- The laboratory also accounts for $355,000 of the $360,000 in claims for the interpretation of screening results by a medical review officer. According to the Clinical Laboratory Improvement Service, the medical review of these Medicaid drug screenings is not necessary. The laboratory billed for a medical review of nearly every drug screening it performed whether the screening was positive or negative.

- Finally, the laboratory appears to be excessively performing validity testing. The laboratory accounted for $316,000 of the $452,000 in claims for two validity testing procedures. Although validity testing is appropriate on a limited basis, constantly testing samples for validity should be questioned by the division.

Recommendations

The division should review its policies and procedures related to drug screenings. Specifically, the division should:

- Review its reimbursement methodology for drug screenings and consider (1) reducing the amount paid per drug class screened, (2) reducing the number of service units billable per day, and (3) limiting the number of drug screenings allowed per month.

- Consider utilizing on-site instant drug screening methods as an alternative to performing all screenings in a laboratory environment.

- Ensure that all drug screening claims are supported by patient specific signed orders by a physician or other licensed practitioner.

- Determine the appropriateness of any additional drug screening procedures billed.

Medicaid Provider Debt

Medicaid providers owe debt to the state or federal government.

Active providers in the Medicaid program were found to have debts recorded in the State's Set-off of Individual Liability (SOIL) program. The Department of the Treasury, Division of Taxation administers several set-off programs. The purpose of these programs is to prevent an individual or business from receiving a payment from the government while owing money to the government. Per statute, child support and Division of Taxation debt has precedence over all other debt types when payments are received.

A match of eligible providers with the SOIL database disclosed 479 providers with debts totaling $20.2 million including $3.9 million owed to New Jersey as of February 2011. Analysis revealed 155 of the 479 had claims totaling $29.5 million since their debt was recorded by the SOIL program. The 155 providers accounted for $7.4 million of the $20.2 million including $1.5 million owed to New Jersey.

A more current analysis based on fiscal year 2011 claims revealed that, assuming a ten percent lien on payments to providers with debt, the division could have withheld $140,000, either partially or completely offsetting the debt of 168 providers. (See column two in the chart below.)

	Debt	FY 2011 Collectable Debt
Internal Revenue Service	$ 16,292,473	$ 81,421
NJ Division of Taxation	$ 3,069,504	$ 40,772
NJ Higher Education Student Assistance Authority	$ 404,101	$ 418
NJ Division of Revenue	$ 303,678	$ 11,823
NJ Division of Family Development and Child Support	$ 90,674	$ 2,416
Other	$ 68,645	$ 3,321
Totals	$ 20,229,075	$ 140,171

Recommendation

We recommend the division and the Department of the Treasury coordinate efforts to identify and recover debt owed by Medicaid providers.

CHRIS CHRISTIE
Governor

KIM GUADAGNO
Lt. Governor

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October 5, 2011

John J. Termyna, Assistant State Auditor
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Trenton, NJ 08625-0067

Dear Mr. Termyna:

This is in response to your letter of September 7, 2011 to Commissioner Velez concerning the Office of Legislative Services (OLS) draft audit report entitled **"Department of Human Services, Division of Medical Assistance and Health Services, Medicaid Provider Enrollment, Hearing Aid Services, and Drug Screenings".** Your letter provides an opportunity to comment on the draft audit report.

The objective of the audit was to determine whether the Division of Medical Assistance and Health Services (DMAHS) has adequate controls in place when enrolling Medicaid Providers. In addition, the auditors determined whether payments to providers for hearing aid services and drug screenings were related to the program, reasonable, and proper. The auditors also reviewed the effectiveness of DMAHS's controls to contain and monitor these expenditures.

The draft audit report concluded that DMAHS needs to improve its controls over monitoring and containing costs relating to these services. The draft audit report also recommends that DMAHS coordinate with the Department of the Treasury to identify and recover debt owed by Medicaid providers. The specific auditor's recommendations and the DMAHS's responses are provided below:

Provider Enrollment:

Recommendation:

The division should suspend the eligibility of providers that do not possess the proper certification until the required documentation is supplied. The division should also examine any P&O provider with excessive DME claims and determine if their services are necessary to meet special needs in accordance with the moratorium.

Response:

DMAHS agrees with the auditor's recommendation and is in the process of instituting procedures to comply with the recommendation.

Hearing Aid Services:

Recommendation:

We recommend the division use the reimbursement methodology and guidelines set forth in the administrative code and take steps to improve its monitoring of hearing aid services. The division should consider prior authorizing hearing aids costing more than a predefined amount and when replacing any hearing aids dispensed within five years of a recipient's last hearing aid.

Response:

DMAHS is in the process of revising the Administrative Code as it relates to hearing aids and related services in order to change our reimbursement policies. The changes will address changes in industry practices and will require proof of costs before reimbursement is authorized. Prior authorizations will be required for high cost devices and when hearing aids are replaced within five years. DMAHS is also reviewing its monitoring policies. As noted in the report, the price ceiling for batteries was adjusted by DMAHS in February 2011to $.80.

Drug Screenings:

Recommendation:

The division should review its policies and procedures related to drug screenings. Specifically, the division should:

- *Review its reimbursement methodology for drug screenings and consider (1) reducing the amount paid per drug class screened, (2) reducing the number of service units billable per day, and (3) limiting the number of drug screenings allowed per month.*

  Response:

  In September 2011, DMAHS issued a Newsletter Volume 21, #20 effective October 1, 2011 that addresses the above recommended changes. Based upon provider feedback from this Newsletter, DMAHS will make some changes to these policy changes to reflect the fact that the Division of Family Development's federally funded Substance Abuse Initiative requires more frequent testing to accommodate requirements for testing for going back to work.

- *Consider utilizing on-site instant drug screening methods as an alternative to performing all screenings in a laboratory environment.*

  Response:

  DMAHS recommends on-site instant drug screening methods but this is a prerogative of each testing center and cannot be mandated by DMAHS.

- *Ensure that all drug screening claims are supported by patient specific signed orders by a physician or other licensed practitioner.*

Response:

DMAHS agrees with this recommendation and is considering auditing drug screening claims.

- *Determine the appropriateness of any additional drug screening procedures billed.*

Response:

DMAHS agrees with this recommendation and is considering auditing drug screening claims.

Medicaid Provider Debt:

Recommendation:

We recommend the division and the Department of the Treasury coordinate efforts to identify and recover debt owed by Medicaid providers.

Response:

DMAHS will schedule a meeting with the Department of Treasury to discuss the recovery of debts owed by Medicaid providers. However, DMAHS believes it would be impractical to offset Medicaid provider payments against the State's SOIL database. Monthly, our MMIS payment system processes and pays millions of Medicaid provider claims on an almost real-time basis so delaying this complex process to match with "SOIL" would seriously disrupt our payment processes and negatively impact our service levels.

If you have any questions or require additional information, please contact me or Richard Hurd at 609-588-2550.

Sincerely,

Valerie Harr

Valerie Harr
Director

VH:H
c: Jennifer Velez
Richard Hurd