



State of New Jersey
Department of Human Services
Division of Medical Assistance & Health Services

NEWSLETTER

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TO: Medical Suppliers- **For Action**
Physicians, Podiatrists, Nurse Practitioners, Vision Care, Health Maintenance Organizations – **For Information Only**

SUBJECT: **(REVISED) New Medical Supply Services Audit Contractor**

PURPOSE: To notify medical suppliers of the award of a new medical supplies audit contract to Health Management Systems, Inc. (HMS)

EFFECTIVE: July 1, 2010

BACKGROUND: HMS has been awarded the new State contract for auditing medical supply services provided by the New Jersey Department of Human Services. Audit services provided by Horizon Blue Cross/Blue Shield of New Jersey shall terminate on June 30, 2010. **This Newsletter replaces Newsletter Volume 20, No. 12 dated July 2010.**

ACTION: **Effective July 1, 2010,** on behalf of the Division of Medical Assistance & Health Services (DMAHS), HMS assumes responsibilities for auditing medical supply services with service dates on or after January 1, 2010. Horizon Blue Cross/Blue Shield of New Jersey audit responsibilities for claims with service dates prior to January 1, 2010 shall end on June 30, 2010. Medical suppliers are responsible for satisfying any audit requests and responding to any audit findings received from Horizon Blue Cross/Blue Shield of New Jersey prior to June 30, 2010.

In accordance with provisions under Federal law and the New Jersey Administrative Code (N.J.A.C.) 10:49-13.1, the Division of Medical Assistance and Health Services (DMAHS) is responsible for providing continuing review and evaluation of the care and services provided under the Medicaid/NJ FamilyCare program. This includes a review of utilization of services by medical suppliers. To accomplish such reviews, the Division has compiled a listing of documentation requirements which are consistent with common auditing practices. HMS shall conduct monthly on-site and desk audits designed to evaluate the utilization of medical supply services based on requirements currently contained within N.J.A.C. 10:49 and N.J.A.C. 10:59 referred to as the Administration Manual and Medical Supplier Manual, respectively. In addition, HMS shall monitor the documentation requirements listed on the enclosure to this Newsletter, which shall serve as further guidance for which provider compliance is expected until these requirements are proposed for adoption through the Office of Administrative Law (OAL) Process.

HMS may be reached at 1-800-310-0865. If you have any questions regarding this Newsletter, please contact Molina Medicaid Solutions Provider Services (formerly Unisys) at 1-800-776-6334.

In accordance with N.J.A.C. 10:49-9.8, providers are reminded of the following requirements:

1. To keep such records as are necessary to disclose fully the extent of the services provided, and, as required by N.J.S.A. 30:4D-12(d), to retain individual patient records for a minimum period of five (5) years from the date the service was rendered;
2. To furnish information for such services as the program may request;
3. That where such records do not document the extent of services billed, payment adjustments shall be necessary;
4. That the services billed on any claim and the amount charged therefore, are in accordance with the requirements of the New Jersey Medicaid and/or NJ FamilyCare programs;
5. That no part of the net amount payable under any claim has been paid, except that all available third party liability has been exhausted, in accordance with program requirements; and
6. That payment of such amount, after exhaustion of third party liability, will be accepted as payment in full without additional charge to the Medicaid or NJ FamilyCare beneficiary or to others on his behalf.

Depending on the audit results, HMS may refer individual cases to the Medicaid Fraud Division for expanded audits and/or investigation.

To report Medicaid Fraud or Abuse, call toll free the Office of the State Comptroller, Medicaid Fraud Division, at 1-888-937-2835, or visit the Office of the State Comptroller website at www.nj.gov/comptroller/divisions/medicaid/index.html.

RETAIN THIS NEWSLETTER FOR FUTURE REFERENCE

DEFINITIONS

"Invoice" means an unaltered document reflecting a supplier's actual acquisition cost, which shows the supplier as the addressee, item description, quantity, and cost. In addition, a complete invoice shall include the cover page; the item page; and the final page of the document.

"Usual and customary" means a medical supplier's charge to the general public for the same service billed to the Medicaid/NJ FamilyCare program.

PROVIDING AUDITORS ACCESS TO UTILIZATION RECORDS

- (a) Medical Suppliers agree to permit properly identified representatives of HMS to:
1. verify acquisition costs of medical supplies and equipment billed to the NJ FamilyCare/Medicaid program;
 2. verify usual and customary charges billed to the NJ FamilyCare/Medicaid program;
- and
3. inspect patient profiles.

PATIENT PROFILE REQUIREMENTS

(a) A unique patient profile shall be established and maintained by the medical supplier for each Medicaid/NJ FamilyCare beneficiary, to include but may not be limited to the following:

1. an original prescription written on a properly completed New Jersey Uniform Prescription Blank to include the prescriber's NPI and the beneficiary's date of birth;
2. NJ FamilyCare/Medicaid beneficiary identification number;
3. CMS certificate(s) of medical necessity or DME Information Forms (DIFs), if appropriate;
4. supplemental documentation determined necessary to validate medical necessity for billed medical supply services;

5. purchase invoice(s) that support 'by report' pricing of medical supply services;
6. proof of other insurance coverage, including Medicare;
7. proof of other insurance payment(s), including Medicare;
8. proof of denied payment requests by other insurance, including Medicare;
9. patient payment responsibility;
10. denial reason code(s) reported by other insurance, including Medicare;
11. patient complaint/resolution documentation;
12. statement of warranty;
13. consultation and evaluation reports;
14. appeal/fair hearing requests;
15. repair documentation, including type of repair and actual time expended;
16. proof of labor charge(s);
17. product identifiers, including Health Care Common Procedure Coding System (HCPCS) procedure code(s) and related modifiers;
18. description(s) of medical supplies and/or equipment prescribed;
19. ICD-9-CM medical diagnosis code(s);
20. brand-name dispensing authorization(s);
21. quantity dispensed (including refills);
22. service date(s); and
23. proof of delivery or customer certification(s).

(b) The medical supplier shall provide sufficient information with regard to its contractual agreement(s) and payment history with other private third party benefit plans to identify and verify number of claims and payments.

(c) All participating medical suppliers shall provide services within the scope of their Centers for Medicare and Medicaid Services (CMS) accreditation based on the medical necessity needs of the NJ FamilyCare/Medicaid beneficiary as determined by a written prescription in compliance with all current existing federal and State regulations.

(d) Medical suppliers are required to dispense the least expensive equipment or medical supply that meets the medical necessity needs of the NJ FamilyCare/Medicaid beneficiary.

(e) When a customer certification is not found during an on-site audit, a medical supplier will be provided the opportunity to submit a patient certification with an original prescription as part of the post-audit response to HMS within a timeframe agreed to by DMAHS.

(f) Scanned or electronically archived prescription images shall accurately reflect the original prescription.

(g) HMS shall verify the accuracy of NPI information reported on electronic medical supply claims. For paper claims, suppliers are required to continue to provide both the legacy provider number and the NPI for the ordering/referring practitioner.

(h) Documentation shall be maintained on file for a minimum of five (5) years from the date a service is rendered.

(i) Patient profiles shall be processed and maintained in accordance with Health Insurance Portability and Accountability (HIPAA) standards.

PRESCRIPTION REQUIREMENTS

(a) Unless electronically transmitted, a prescription shall be written by a practitioner, acting within the scope of lawful practice and after an examination or evaluation of the patient's condition. The medical supplier, collaborating with the practitioner shall develop an evaluation and treatment plan for the patient ensuring that appropriate follow-up is provided and that the equipment/medical supply are properly evaluated and integrated into the treatment plan developed for the patient.

(b) Unless written by an authorized out-of-state practitioner, written prescriptions shall be issued only on the New Jersey Prescription Blanks (NJPB) subject to the required security mandates of the New Jersey Prescription Blank Control Program.

1. Medical suppliers may utilize an attachment to the Prescription Blank to detail and itemize information pertaining to the equipment required to satisfy a prescription request, including items identified during an evaluation performed by a therapist. The attachment or supportive document shall also be signed by the prescribing practitioner.

(c) A practitioner shall include the following information on each written prescription:

1. the prescribing practitioner's full name, address, telephone number, license number, and proper academic degree or identification of professional practice for which licensed;
2. prescribing practitioner's National Provider Identifier (NPI) number;
3. full name, date of birth and address of the patient;
4. date written;
5. a full description of the equipment/medical supply being prescribed including, but not limited to type of equipment; manufacturer, if appropriate; fitting criteria, etc; for example, the phrase "wheelchair" or "patient needs wheelchair" is not acceptable. The type and style of wheelchair shall be described. Fitting criteria may be documented on a supportive document attached to the prescription and signed by the prescriber.
6. quantity of medical supplies authorized by the prescriber to be dispensed;
7. frequency of use for a medical supply, if appropriate;
8. length of time the medical equipment or supplies is required; the service period reported on the medical supply claim shall be appropriate for the quantity dispensed.
9. number of refills permitted or time limit for refills, or both, when appropriate (see (d) below);
10. a diagnosis documented on the prescription blank;
11. an original handwritten signature of the prescribing practitioner (stamped signatures are not acceptable);
12. If a health care facility or multi-prescriber prescription blank is utilized, the full name and license number of the prescribing practitioner shall be legibly printed at the top of

the prescription or the identity of the prescriber shall be designated by a checkmark or other legible means.

13. Other information related to coverage of the specific item or service.

(d) Prescriptions for medical supply services are valid for six (6) months from the written date on the prescription. For medical supply services determined medically necessary for greater than six (6) months, a new original prescription is required.

(e) Telephone-rendered prescriptions for medical supply services are not acceptable. Only hard-copy original, faxed or electronically-transmitted prescriptions are acceptable for dispensing a medical supply service. The facsimile prescription received by the medical supplier must be readily identified as having been transmitted from the prescriber's office.

(f) An original, faxed or electronically-transmitted prescription shall not be modified or altered.

(g) Adequate instructions to the patient regarding the frequency of use of equipment or medical supplies shall be clearly indicated on the prescription. A direction of "p.r.n." or "if needed" alone is not acceptable.

PROOF OF DELIVERY

(a) Medical suppliers may request payment for medical supply services only after the medical supply/equipment has been delivered to the beneficiary (see N.J.A.C. 10:49-9.9). All requests for payment shall be submitted timely, in accordance with N.J.A.C. 10:49-7.2.

(b) In situations where a covered service is not provided face-to-face, such as by mail or other delivery service, the provider shall maintain a signed delivery/shipping service

tracking slip or a tracking number and copy of the shipping invoice on file as proof that a delivery was received by a NJ FamilyCare/Medicaid beneficiary.

(c) When a medical supply service is provided face-to-face, the following “Authorization to Release Information and Payment Request” statement shall be available for review by a beneficiary when a customer certification is requested: “I authorize the release of any medical or other information necessary to process this claim. I also authorize payment of medical benefits to the undersigned supplier for services provided.”

PATIENT INSTRUCTIONS

(a) All medical supply recipients shall receive verbal and written instructions regarding the use of equipment or medical supplies dispensed.

(b) The medical supplier shall maintain on file all written materials provided to beneficiaries for instructional use.

(c) All materials shall be written at a fifth-grade education level to ensure that all instructions are clearly understood.

(d) All materials shall be available in languages other than English, when appropriate, to best serve the diverse language needs of the beneficiary community.

(d) The recipient of a medical supply service shall sign a statement confirming that he/she received and understood equipment/supply-related instructions.