

**Memorandum**

Date . DEC 12 1995

From June Gibbs Brown
Inspector General *June G Brown*

Subject Office of Inspector General's Partnership Plan--Louisiana Legislative Auditors Office
Report on Laboratory Services

To (A-06-95-00031)

Bruce C. Vladeck
Administrator
Health Care Financing Administration

We are transmitting for your information and use, the attached final report on an audit of the Medicaid non-inpatient laboratory services program in Louisiana for the period from January 1, 1993 through December 31, 1994. This review was conducted by the Louisiana Legislative Auditor (LLA). This work was conducted as part of our partnership efforts with State Auditors to expand audit coverage of the Medicaid program. We have performed sufficient work to satisfy ourselves that the attached audit report can be relied upon and used by the Health Care Financing Administration (HCFA) in meeting its program oversight responsibilities.

The objectives of the review were to (1) review the policies and procedures in place to ensure that Medicaid non-inpatient laboratory services were billed and paid in accordance with Federal regulations and departmental policies and procedures; and (2) determine if Medicaid non-inpatient laboratory services were billed correctly by outpatient services, independent laboratories, and physicians and subsequently paid in accordance with the established policies and procedures.

The LLA found that the edits to ensure that the laboratory services are properly bundled were not sufficient to detect and prevent payments for tests that were not properly bundled and/or duplicated. Also, the failure to require the bundling of two individual automated tests could result in additional costs to the State and the Medicaid program. Finally, the Medicaid fee schedules were not updated in a timely manner.

The LLA recommended that:

- o As a result of the estimated overpayment of \$1,079,129 (Federal share \$792,808) for tests that should have been grouped together and billed as one test, these amounts be turned over to the proper authorities for investigation and recoupment from providers.

Page 2 - Bruce C. Vladeck

- o The computer edits be analyzed to determine why they are not operating as defined and consider adding additional edits.
- o Two individual automated chemistry tests be bundled into panels to reduce overpayments and billings that may circumvent policies and procedures at an estimated savings of \$324,729 (Federal share \$238,570).
- o Internal controls be established to ensure that the Medicaid fee schedule is updated timely.

As we do with all audit reports developed by nonfederal auditors, we provided as an attachment, a listing of the coded recommendations for your staff's use in working with the State to resolve findings and recommendations through our stewardship program. Attachment A provides a summary of the recommendations.

We plan to share this report with other States to encourage their participation in our partnership efforts. If you have any questions about this review, please let me know or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachment

ATTACHMENT A
CIN A-06-95-00031

<u>Recommendation Codes</u>	<u>Page</u>	<u>Amount</u>	<u>Resolution Agency</u>	<u>Recommendations</u>
302922101	6-8	N/A	HHS/HCFA	Potential Overpayments. We recommend HCFA require the State to strengthen procedures to ensure: (1) individual chemistry, hematology and urinalysis tests are properly bundled and billed as one claim;
302906101	6-8	N/A	HHS/HCFA	(2) duplicate payments are not made for the same procedure; and
302922171	6-8	792,808	HHS/HCFA	(3) the potential overpayments are referred to the proper authorities for recoupment from providers.
302916021	8-9	238,570	HHS/HCFA	Chemistry Tests Not Recognized in Panels. We recommend HCFA require the State to strengthen procedures to ensure individual automated chemistry tests are bundled into panel codes.
312935101	9	N/A	HHS/HCFA	Medicaid Fee Schedule. We recommend HCFA require the State to implement procedures to ensure the fee schedule establishing the maximum amount paid for medical procedures is updated in a timely manner.

STATE OF LOUISIANA LEGISLATIVE AUDITOR

**Department of Health and Hospitals
State of Louisiana
Baton Rouge, Louisiana**

August 16, 1995



Financial and Compliance Audit Division

***Daniel G. Kyle, Ph.D., CPA, CFE
Legislative Auditor***

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**DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA
Baton Rouge, Louisiana**

**Financial Related Audit
Dated June 16, 1995**

Under the provisions of state law, this report is a public document. A copy of this report has been submitted to the Governor, to the Attorney General, and to other public officials as required by state law. A copy of this report has been made available for public inspection at the Baton Rouge office of the Legislative Auditor.

August 16, 1995

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June 16, 1995

Independent Auditor's Report

DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA
Baton Rouge, Louisiana

We have performed a financial related audit of the Medical Assistance Program (Medicaid - CFDA 93.778), a program within the Department of Health and Hospitals, for the period from January 1, 1993, through December 31, 1994. This audit was a joint project between the Louisiana Office of Legislative Auditor and the United States Department of Health and Human Services, Office of Inspector General, Office of Audit Services. The objectives of our audit were to (1) review the policies and procedures in place to ensure that Medicaid non-inpatient laboratory services are billed and paid in accordance with federal regulations and department policies and procedures; and (2) determine if Medicaid non-inpatient laboratory services were billed correctly by outpatient services, independent laboratories, and physicians and subsequently paid in accordance with the established policies and procedures.

Our audit was performed in accordance with *Government Auditing Standards*, issued by the Comptroller General of the United States, applicable to a financial related audit. Our limited procedures consisted of (1) examining selected department records; (2) interviewing certain department and Medicaid fiscal intermediary personnel; (3) reviewing applicable federal and Louisiana law and regulations; (4) reviewing pertinent department policies, procedures, rules, and regulations; and (5) making inquiries to the extent we considered necessary to achieve our purpose. Our procedures also included an assessment of the likelihood of irregularities and illegal acts, and any such matters that came to our attention are presented in our findings and recommendations.

These limited procedures are substantially less in scope than an audit of the financial statements in accordance with government auditing standards, the purpose of which is to provide assurance on the entity's presented financial statements, assess the entity's internal control structure, and assess the entity's compliance with laws and regulations that could materially impact its financial statements. Had we performed such an audit, or had we performed additional procedures, other matters might have come to our attention that would have been reported to you.

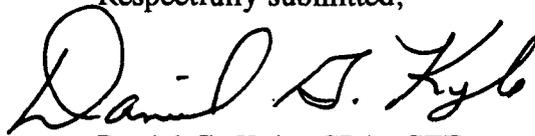
LEGISLATIVE AUDITOR

DEPARTMENT OF HEALTH AND HOSPITALS
STATE OF LOUISIANA

Based on the application of the procedures referred to previously, the accompanying findings and recommendations represent those conditions that we feel warrant attention by the appropriate parties. Management's responses to the findings and recommendations presented in this report are included in Attachment I.

This report is intended for the use of management of the Department of Health and Hospitals and should only be used by those who fully understand the limited purposes of the procedures performed. By state law, this report is a public document and has been distributed to appropriate public officials as required by Louisiana Revised Statute 24:516.

Respectfully submitted,

A handwritten signature in black ink that reads "Daniel G. Kyle". The signature is written in a cursive style with a large initial "D".

Daniel G. Kyle, CPA, CFE
Legislative Auditor

CGEW:BJJ:dl

(MEDICAID)



Office of Legislative Auditor

Executive Summary

Financial and Compliance Audit Division Financial Related Audit

Department of Health and Hospitals Medical Assistance Program Non-Inpatient Laboratory Services

The Department of Health and Hospitals (DHH) paid Medicaid providers \$13,498,644 from January 1, 1993, through December 31, 1994, for the limited non-inpatient laboratory services included in our financial related audit. Our financial related audit of these claims found that:

- DHH may have overpaid providers \$1,079,129 by not ensuring that certain individual tests that should have been grouped together and billed as one test (bundled) were paid correctly.
- DHH may have incurred a liability to the Health Care Financing Administration to repay the federal share of provider overpayments.
- DHH has not ensured that edits of these claims are effective to ensure that certain individual tests are properly bundled.
- DHH could have saved an estimated \$324,729 if it required bundling of pairs of specific laboratory tests.
- DHH has not updated the fee schedule, which establishes the maximum amounts Medicaid will pay for medical procedures, on a timely basis, resulting in potential noncompliance with federal, state, and departmental rules and regulations.

Daniel G. Kyle, Ph.D., CPA, CFE, Legislative Auditor
Phone No. (504) 339-3800

EXAMINATION OBJECTIVES

The objectives of our financial related audit were to review the Medicaid provider payments for non-inpatient laboratory services to:

- Review the policies and procedures in place to ensure that Medicaid non-inpatient laboratory services are billed and paid in accordance with federal regulations and department policies and procedures; and
- Determine if Medicaid non-inpatient laboratory services were billed correctly by outpatient services, independent laboratories, and physicians and subsequently paid in accordance with the established policies and procedures.

FINDINGS AND RECOMMENDATIONS

The following summarizes the findings and recommendations that resulted from our financial related audit of DHH payments for non-inpatient laboratory services. Detailed information relating to the findings and recommendations may be found on the page number referenced.

Overpayments

(Page 6)

Finding:

DHH may have overpaid Medicaid providers by an estimated \$1,079,129 for automated chemistry, hematology, and urinalysis laboratory procedures.

Recommendation:

DHH and its Program Integrity section should review the potential overpayments and refer them to the Surveillance Utilization Review System, DHH internal legal counsel, and/or the Louisiana Attorney General's Medicaid Fraud Control Unit for investigation and recoupment of any amounts due from providers for overpayments. In addition, the department should review the Medicaid Management Information System (MMIS) computer edits to determine why they are not operating as defined and should consider adding edits for hematology and urinalysis tests. Finally, DHH should determine what impact the above conditions may have on other categories of provider payments.

Questioned Costs

(Page 8)

Finding: As a result of potential provider overpayments, DHH may be liable for repayment of the federal share of those overpayments, estimated at \$792,808, to the Health Care Financing Administration (HCFA).

Recommendation: The department should refer the matter to its legal counsel and determine the share of provider overpayments that may be owed to HCFA. Also, management should ensure that provider payments are made in accordance with regulations to reduce the possibility that questioned costs would be incurred.

Chemistry Tests Not Recognized in Panels

(Page 8)

Finding: DHH does not require that two individual automated chemistry tests be bundled into panel codes and, as a result, may have incurred additional provider payments estimated at \$324,729.

Recommendation: DHH should consider requiring that two individual automated chemistry tests be bundled into panels to reduce provider overpayments and to reduce provider billings that may circumvent policies and procedures to ensure that providers are paid no more than allowed by Medicaid regulations.

Medicaid Fee Schedule

(Page 9)

Finding: DHH has not complied with Medicaid regulations to update changes to the Medicaid fee schedule on a timely basis.

Recommendation: DHH should establish internal controls to ensure that its Medicaid fee schedule is updated on a timely basis to ensure compliance with federal, state, and departmental regulations.

Chapter One: Introduction

CREATION AND DUTIES

The Department of Health and Hospitals (DHH or the department) was created in accordance with Title 36, Chapter 6 of the Louisiana Revised Statutes, as a part of the executive branch of government. DHH is charged with providing health and medical services for the uninsured and medically indigent citizens of Louisiana either directly, through the operation of health care facilities, or indirectly, by agreement with the Louisiana Health Care Authority (LHCA). Services provided by DHH include, but are not limited to, services for the mentally ill, for persons with mental retardation and developmental disabilities, for alcohol and drug abusers, public health services, and services provided under the Medicaid program. DHH oversees the operations of seven developmental centers, six mental hospitals, two long-term care hospitals, the state health department, various regulatory and licensing boards, mental health and substance abuse clinics, and other health related facilities located throughout Louisiana. The state's acute care hospitals were the responsibility of DHH until January 1, 1992, when they were transferred to LHCA in accordance with Act 390 of the 1991 Regular Session of the Louisiana Legislature.

BACKGROUND

Part B of Title XVIII of the Social Security Act (Medicare Part B), as amended, covers clinical laboratory (lab) services performed at hospitals, physicians' private practices, or independent labs. Reimbursement is based on fee schedules established by Medicare carriers and subject to instructions published by the Medicare program under its Carriers Manual. Medicare pays the lower of the fee schedule amount or the actual charge for the lab services. The Carriers Manual states that certain automated chemistry, hematology, and urinalysis tests should be grouped together (bundled) for payment purposes. These tests are generally performed in groups or combinations, and payment under the fee schedule reflects these groupings. When tests that are performed in groups are billed separately, the carrier is to pay the lower rate for the combined tests (also referred to as panels or profiles). Payments made for individual tests that are also included in panels result in "duplicate" or higher payments to the provider.

Title XIX of the Social Security Act (Medicaid - CFDA 93.778) also covers clinical lab services. Medicaid claims are processed for payment through the DHH fiscal intermediary, Unisys. The Health Care Financing Administration (HCFA) has established instructions that do not allow payments to exceed the Medicare limits. The state may establish its own fee schedule, but this schedule cannot exceed the Medicare carrier fee schedule in the state agency's service area.

HCFA publishes a State Medicaid Manual to provide guidance to states operating the Medicaid program. Section 6300.1 of this manual provides that federal matching funds will not be available to the extent a state pays more than Medicare recognizes for outpatient clinical lab tests performed by a physician, independent lab, or hospital.

Section 6300.2 of the State Medicaid Manual requires that Medicaid reimbursement for clinical lab tests not exceed the amount that Medicare recognizes for such tests. Each Medicare carrier in a respective state will provide its fee schedule to the state agency.

Section 6300.5 of the State Medicaid Manual allows states to enter into agreements to purchase lab services, but they may not pay more in the aggregate for these tests than the amount that would be paid for them under the Medicare fee schedule.

DHH has prepared and maintains a State Medicaid Services Manual to provide guidance to providers and ensure compliance with federal regulations. Chapter 13, *Independent Laboratory and Portable X-Ray Services*, and Chapter 15, *Physician Services*, require panelling of specific automated chemistry, hematology, and urinalysis tests by independent laboratories and physicians. The amount to be paid for these services will be the lesser of (1) the billed amount; (2) the Medicare allowed amount; or (3) the Medicaid allowed amount.

Prior reviews conducted by the U. S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services (OIG) of Medicare Part B payments through fiscal intermediaries and carriers for lab services found that payments were being made for lab tests that were not bundled or that were duplicated. In Massachusetts, the fiscal intermediary had overpaid hospitals \$2.25 million for fiscal year 1991, and the carrier had overpaid physicians and independent labs \$426,817 for fiscal year 1992. Subsequent OIG reviews found that this condition existed nationwide, resulting in substantial overpayments from the Medicare program.

As a result of the above condition, the OIG proposed that a joint project with the Louisiana Office of Legislative Auditor be conducted to examine payments for non-inpatient lab services in the Medicaid program to determine if there have been overpayments from the program and to identify the amount of such potential overpayments.

OBJECTIVES

The objectives of our financial related audit were to review the Medicaid provider payments for non-inpatient laboratory services to:

- Review the policies and procedures in place to ensure that Medicaid non-inpatient laboratory services are billed and paid in accordance with federal regulations and department policies and procedures; and
- Determine if Medicaid non-inpatient laboratory services were billed correctly by outpatient services, independent laboratories, and physicians and subsequently paid in accordance with the established policies and procedures.

Our audit of these lab services was a financial related audit for the calendar years 1993 and 1994 and was conducted jointly with the OIG's office. The test work was conducted based on a review of paid claims for lab services that are billable as a group or panel of codes for automated chemistry, hematology, and urinalysis tests.

REPORT ORGANIZATION

The remainder of this report is organized into one additional chapter, an appendix, and an attachment as follows:

- **Chapter Two** addresses the work performed and includes findings and recommendations.
- **Appendix A** provides a list of the procedure codes that were included in this financial related audit.
- **Attachment I** is DHH management's responses to findings and recommendations.

The findings and recommendations are presented in the executive summary as well as in Chapter Two.

Chapter Two: Work Performed

DESCRIPTION OF TESTS PERFORMED

As described in Chapter 1, our review of laboratory services was limited to automated chemistry, hematology, and urinalysis tests. Those claims that included at least one of the physicians' current procedural terminology (CPT) codes were "written" to a computer file (for a complete listing of the CPT codes included in this review, see the Appendix). These files were further reduced to the claims that appeared to include procedures that were not properly bundled.

Chemistry tests involve the measurement of various chemical levels in the blood while hematology tests are performed to count and measure blood cells and their content. Chemistry tests are frequently performed on automated equipment and are grouped together in panels.

Hematology tests that are grouped and performed on an automated basis are classified as profiles. These profiles include component tests such as hemoglobin, blood cell and platelet counts, and several other procedures (as indicated in the Appendix). Hematology indices are measurements and ratios of the results of the tests themselves, such as blood cell width and volume.

Urinalysis tests are physical, chemical, or microscopic analyses or examinations of urine involving the measurement of certain components of the urine sample. A urinalysis may be conducted as a complete test to include microscopy, as a test without microscopy, or a test with microscopy only.

Chemistry and hematology tests were each divided into two categories. With respect to chemistry tests, DHH does not require bundling of two automated tests. Only three or more tests must be bundled. Therefore, those Medicaid recipient claims of two automated tests were separated from claims for three or more tests. From the claims for two automated tests, we considered the potential cost savings to the department if these tests had been bundled into panel codes.

Hematology tests initially included prenatal tests. These CPT codes are distinct from the regular hematology test codes, and payments for prenatal tests are greater than regular hematology tests. The department has allowed higher payments for these codes, in part, as incentive to gynecologists to practice in areas where there are shortages of their services. Prenatal tests were examined separately from the regular hematology tests.

From the four categories, 250 claims were examined. These claims were chosen from random numbers generated by the Office of Inspector General using computerized statistical analysis tools. Once the random numbers were generated, they were matched against the specific records in the populations for examination. Documentation supporting the electronically or manually submitted claims was reviewed along with the record of provider payments (remittance advices) to determine the appropriateness of the payment.

Appropriateness of the payment was determined by comparing the CPT codes billed to the CPT code(s) that should have been billed based on a review of the CPT manuals and on how the tests should be bundled. The amounts paid for the CPT codes were also compared to the fee schedules to determine if DHH had paid more than the amount allowed for these procedures.

We reviewed DHH policies and procedures relating to provider billings for clinical lab services and departmental documentation relating to the manual and automated edits for bundling and/or duplication of the procedures billed. We evaluated the appropriateness of procedures and controls based on the procedures described above and developed the findings and recommendations that follow.

FINDINGS AND RECOMMENDATIONS

Following are the findings and recommendations of our financial related audit of the Medicaid provider payments for non-inpatient laboratory services.

OVERPAYMENTS

DHH may have overpaid Medicaid providers by an estimated \$1,079,129 for automated chemistry, hematology, and urinalysis laboratory procedures. Medicare, Medicaid, and Louisiana rules and regulations (see pages 1 and 2) govern the provider payments for laboratory services and require that certain automated tests for chemistry, hematology, and urinalysis be "bundled" into panels for billing purposes. Our examination of provider payments for the calendar years 1993 and 1994 disclosed the following:

1. Of 50 claims sampled for automated chemistry billings, 46 claims (92 percent) resulted in potential overpayments. When statistically projected to the population of 62,924 claims totaling \$1,954,371, the potential overpayment to providers is \$1,048,616, or 53.65 percent of the population dollars.
2. Of 50 claims sampled for automated hematology billings, all items resulted in potential overpayments. When statistically projected to the population of 1,993

claims totaling \$35,319, the potential overpayment to providers is \$11,234, or 31.81 percent of the population dollars.

Three of the claims sampled involved duplicate payments for the same procedure for the same recipient on the same date of service in which the servicing provider and the servicing provider's physician group each billed for the services.

3. Of 50 claims sampled for automated prenatal hematology billings, 34 claims resulted in potential overpayments. When statistically projected to the population of 368 claims totaling \$9,608, the potential overpayment to providers is \$1,129, or 11.75 percent of the population dollars.

Of the 34 prenatal claims resulting in potential overpayments, 4 were overpayments to DHH operated facilities, and 30 were overpayments to a single private provider.

4. Of 50 claims sampled for automated urinalysis billings, all items resulted in potential overpayments. When statistically projected to the population of 4,735 claims totaling \$39,935, the potential overpayment to providers is \$18,150, or 45.45 per cent of the population dollars.

One of the claims sampled involved a duplicate payment for the same procedure for the same recipient on the same date of service in which the servicing provider and the servicing provider's physician group each billed for the services.

We estimate that total overpayments to providers total \$1,079,129.

While the Medicaid Management Information System (MMIS), which is operated by the fiscal intermediary, Unisys, includes edits to ensure that automated chemistry tests are properly bundled, these edits do not appear to be sufficient to detect and prevent payment for tests that are not properly bundled and/or duplicated. In addition, there are no edits to ensure hematology and urinalysis tests are properly bundled. As a result, overpayments that are significant either in dollars or as a percentage of total claims for a specific category, as described above, may occur. This condition indicates that additional provider overpayments in other areas may have occurred and not been detected timely.

DHH and its Program Integrity section should review the potential overpayments and refer them to the Surveillance Utilization Review System, DHH internal legal counsel, and/or the Louisiana Attorney General's Medicaid Fraud Control Unit for investigation and recoupment of any amounts due from providers for overpayments. In addition, the department should review the MMIS computer edits to determine why they are not operating as defined and should consider adding edits for hematology and urinalysis tests. Finally, DHH should

determine what impact the previous conditions may have on other categories of provider payments.

QUESTIONED COSTS

As a result of potential provider overpayments, DHH may be liable for repayment of the federal share of those overpayments, estimated at \$792,808, to the Health Care Financing Administration (HCFA). The Code of Federal Regulations, 42 CFR 433.312 - 433.320 establish the guidelines for repayment of the federal share of identified provider overpayments. States must repay the federal share of these overpayments within 60 days of the date of discovery, regardless of whether the overpayments have been collected from providers. The amount of the refund of the overpayment(s) is to be reported on the quarterly report to HCFA (the HCFA-64 report) for the quarter in which this 60-day period expires.

As shown in the previous finding, we have estimated that provider overpayments total \$1,079,129. Of this amount, we estimate \$792,808 has been drawn from HCFA as the federal share of allowable Medicaid administrative costs, based on allocating the payments evenly over the quarters that we reviewed.

The department should refer the matter to its legal counsel and determine the share of provider overpayments that may be owed to HCFA. Also, management should ensure that provider payments are made in accordance with regulations to reduce the possibility that questioned costs would be incurred.

CHEMISTRY TESTS NOT RECOGNIZED IN PANELS

DHH does not require that two individual automated chemistry tests be bundled into panel codes and, as a result, may have incurred additional provider payments estimated at \$324,729. Good business practices would dictate that the department consider the effect of not bundling two individual tests into panels, thereby reducing the possibility of additional or unnecessary provider payments. While Medicare and hence Medicaid do not require bundling of two tests into panels, the provider fee schedule issued by Medicare and Medicaid, which establish the amounts to be paid to providers for specific procedures, includes a procedure code for billing two individual tests as a panel.

Our examination of individual automated chemistry tests disclosed that the department could have bundled 35,382 claims representing \$487,864 at a potential savings of \$324,729.

Failure to require bundling of two individual automated chemistry tests can result in further additional costs to the state in those instances where a provider performs three tests that must be bundled according to Medicaid regulations but determines that billing for two of these tests will pay more than the single panel code for the three procedures.

DHH should consider requiring that two individual automated chemistry tests be bundled into panels to reduce provider overpayments and to reduce provider billings that may circumvent policies and procedures to ensure that providers are paid no more than allowed by Medicaid regulations.

MEDICAID FEE SCHEDULE

DHH has not complied with Medicaid regulations to update changes to the Medicaid fee schedule on a timely basis. Medicare, Medicaid, and Louisiana rules and regulations (see pages 1 and 2) govern provider payments for laboratory services and require that the amount paid for Medicaid procedures be the lesser of (1) the billed amount; (2) the Medicare allowed amount; or (3) the Medicaid allowed amount.

Generally, DHH updates its fee schedule once per year, to coincide with the beginning of each state fiscal year. The fee schedule lists the amount that Medicare and hence Medicaid will pay for medical procedures billed by providers. Medicare submits a fee schedule on electronic media (i.e., magnetic tape) to the department once per year. During our audit, we found that Medicare also sends periodic updates of its fee schedule at different times throughout the year with effective dates, but DHH is not updating its fee schedule from these notices.

Failure to update the Medicaid fee schedule from the Medicare notices may subject the department to noncompliance with Medicaid regulations in those instances where allowable charges are decreased, but DHH continues to pay at a higher rate no longer allowed. In addition, noncompliance may then result in questioned costs that may be required to be returned to the federal government.

DHH should establish internal controls to ensure that its Medicaid fee schedule is updated on a timely basis to ensure compliance with federal, state, and departmental regulations.

Appendix A

CHEMISTRY PROCEDURE CODES REVIEWED

<u>CPT Number (Individual Tests)</u>	<u>Description</u>
82040	Albumin
84170	Albumin/globulin ratio
82250	Bilirubin Total or Direct
82251	Bilirubin Total and Direct
82310, 82315, 82320, 82325	Calcium
82374	Carbon Dioxide Content
82435	Chlorides
82465	Cholesterol
82565	Creatinine
82942	Globulin
92947	Glucose
83610, 83615, 83620, 83624	Lactic Dehydrogenase (LDH)
84075	Alkaline Phosphatase
84100	Phosphorus
84132	Potassium
84155, 84160	Total Protein
84295	Sodium
84450, 84455	Transaminase (SGOT)
84460, 84465	Transaminase (SGPT)
84520	Blood Urea Nitrogen (BUN)
84550	Uric Acid
84478	Triglycerides
82550, 82555	Creatinine Phosphokinase (CPK)
82977	Glutamyl Transpetidase, Gamma

Based on departmental procedures and Medicare and Medicaid regulations, if three or more of the previously mentioned tests are performed for an individual, they should be billed as a panel test, based on the following:

<u>CPT Number (Panel Tests)</u>	<u>Description (Quantity of Automated Multichannel Tests)</u>
80002	1 or 2 Tests
80003	3 Tests
80004	4 Tests
80005	5 Tests
80006	6 Tests
80007	7 Tests
80008	8 Tests
80009	9 Tests
80010	10 Tests
80011	11 Tests
80012	12 Tests
80016	13 - 16 Tests
80018	17 - 18 Tests
80019	19 or More Tests
80050	General Health Panel
80058	Hepatic Function Panel

A provider should not bill for an individual test and a panel test. For example, if a claim includes a CPT code 82310 *and* a CPT panel code 80005, then the provider should have billed and been paid for a CPT panel code 80006. In addition, a provider should not bill a combination of the above codes. For example, if a claim includes CPT panel codes 80004 and 80006, then the provider should have billed and been paid for a CPT panel code 80010.

HEMATOLOGY TESTS REVIEWED

CPT Number (Component Tests)	Description
85041	Red Blood Cell Count (RBC) Only
85048	White Blood Cell Count (WBC) Only
85018	Hemoglobin, Colorimetric (Hgb)
85014	Hematocrit (Hct)
85007	Manual Differential WBC Count
85595	Platelet Count (Electronic Technique)
85029	Automated Hemogram Indices (1 to 3)
85030	Automated Hemogram Indices (4 or more)
85021 (Profile)	Hemogram (RBC, WBC, Hgb, Hct, Indices)
85022 (Profile)	Hemogram and Manual Differential
85023 (Profile)	Hemogram, Platelet, and Manual Differential
85024 (Profile)	Hemogram, Platelet, Partial Automated Differential
85025 (Profile)	Hemogram, Platelet, Complete Automated Differential
85027 (Profile)	Hemogram and Platelet
Z9001	Prenatal Lab Panel - 1 to 3 Tests
Z9002	Prenatal Lab Panel - 4 to 5 Tests
Z9003	Prenatal Lab Panel - 6 or More Tests

A profile, such as the CPT code 85021, should not be billed with a CPT code 85041 for a red blood cell count since CPT code 85021 already considers the blood cell count as a part of the profile. The indices, CPT codes 85029 and 85030, should not be billed together. However, it is possible that a manual differential (CPT code 85007) and an automated profile (CPT codes 85024 and 85025) could be billed together if the profile was inconclusive, warranting the manual differential. Prenatal lab panel CPT codes should not be billed together or in combination with other hematology codes.

URINALYSIS TESTS REVIEWED

<u>CPT Number</u>	<u>Description</u>
81000	Urinalysis
81002	Urinalysis without Microscopy, Manual
81003	Urinalysis without Microscopy, Automated
81015	Urinalysis, Microscopic Only

A urinalysis CPT code 81000 should not be billed with another code. If a provider bills any of the other three codes in combination, then only 81000 should have been billed. Generally, CPT codes 81002 and 81003 should not be billed together.

The above examples of how CPT codes are bundled are not meant to be all inclusive. The CPT codes reviewed in this financial related audit are based on guidance provided in the American Medical Association's CPT Code Book, Medicare and Medicaid regulations, and manuals prepared and distributed by DHH.

Attachment I
Management's Responses



STATE OF LOUISIANA
DEPARTMENT OF HEALTH AND HOSPITALS



Edwin W. Edwards
GOVERNOR

June 30, 1995

Daniel G. Kyle, Ph.D., CPA
Office of Legislative Auditor
1600 N. 3rd St., 1st Floor
Baton Rouge, LA

Dear Dr. Kyle:

We are responding to the findings and recommendations presented to our office on June 15, 1995 regarding your financial related audit of the Medicaid provider payments for non-inpatient laboratory services.

Finding:

The first finding involved potential overpayments to Medicaid providers for automated chemistry, hematology and urinalysis laboratory procedures. You pointed out that the fiscal intermediary did not appear to have sufficient edits to detect and prevent payment for tests that are not properly bundled and/or duplicated. No system edits are in place to assure that hematology and urinalysis tests are properly bundled.

Agency Response:

We concur that the edits in place at the Medicaid fiscal intermediary, Unisys, do not appear sufficient to assure proper bundling of automated laboratory tests. Upon careful examination of the system edit, it was discovered that although there was a combination edit to examine a specific range of individual codes against a specific range of automated channel codes, a second table had to be updated whenever new individual laboratory codes were added to the procedure formulary file. We will have staff complete a user request form to instruct the Unisys programmer to update the table and add all missing codes. Staff will now be cognizant of the fact that the table must be considered whenever any new laboratory codes are added to our procedure formulary file.

The system edit for duplicating editing is based on the billing provider number. On the examples we received from your staff, the billing provider was different and the attending provider number was the same.

Daniel G. Kyle, Ph.D., CPA

June 30, 1995

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Each such occurrence must be looked at individually and a contact with the provider for medical records documentation as it is possible that a patient may have been seen by an individual practitioner and also in a group practice setting on the same day and two legitimate lab tests were performed. Agency staff will confer with physician consultants and determine what types of edits are appropriate for the prenatal hematology and the urinalysis tests to assure proper bundling.

Finding:

Medicaid policy does not require the bundling of two individual automated chemistry tests into a panel code.

Agency Response:

We concur that we should carefully examine the possibility of requiring the bundling of two codes. Medical consultants will be utilized in determining the feasibility as well as the exact set of circumstances under which the bundling is appropriate and when possibly not appropriate. If a provider actually performs three laboratory tests and only bills for two, only a review of provider medical records could establish these facts.

The Department attempts to develop the proper balance between an automated claims processing system and manual review of individual claims. In circumstances where a particular practice is never acceptable then an automated system edit that denies the practice is the ideal solution. If a practice is sometimes acceptable, the edit can be automated only to the extent that the acceptable circumstances can be precisely quantified. If judgment must be exercised, then a manual or post payment review is the method which must be utilized. We will examine our SURS subsystem exception reporting parameters/criteria to determine if some potential overpayment situations could be programmed to except out for review.

Finding:

The Medicaid fee schedule for laboratory procedures is only updated once a year. The Medicaid agency does not act on periodic updates sent throughout the year which could result in noncompliance with federal pricing regulations.

Agency Response:

We concur that only updating the laboratory fee pricing files could result in noncompliance with federal pricing regulations. Agency staff has been instructed to evaluate all periodic pricing changes sent from the Medicare intermediary to determine if any of the prices have been lowered. We will immediately update any codes that have had a price reduction rather than waiting until the annual file update.

Daniel G. Kyle, Ph.D., CPA

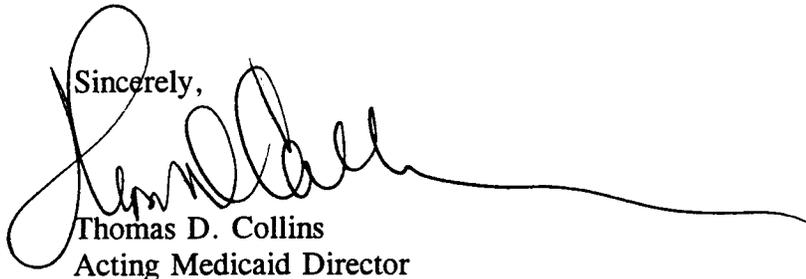
June 30, 1995

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I have appointed a special project team composed of staff from the Program, SURS, and Claims Processing Sections to work on developing and/or fine tuning existing edits. This team will work with our fiscal intermediary, Unisys, to review any potential overpayment situations and take the necessary recovery actions. In situations where a system claim recovery is possible we will void claims and the recovery action can be immediate and automated. If medical records must be examined, then a complete investigation may be appropriate. Agency protocol for referrals to the Attorney General will be followed if warranted.

If clarifications or further information is needed, please advise.

Sincerely,

A handwritten signature in black ink, appearing to read "Tom Collins", with a long horizontal flourish extending to the right.

Thomas D. Collins
Acting Medicaid Director

TDC/CS/sb

cc: Bruce Gomez
Don Gregory
Bob Patience
Dexa Alexander