DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date AUG 22 1997

From June Gibbs Brown
Inspector General

Subject Medicaid Payments for Clinical Laboratory Tests in Eight States (A-01-96-00004)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of the final report of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) entitled, "Medicaid Payments for Clinical Laboratory Tests in Eight States." The objective of this nationwide audit was to determine the adequacy of State agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests. Specifically, the audit was designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. The attached report is the second roll-up report that we have issued as part of our nationwide review and it summarizes the results of our review for eight States over 2 calendar years. We estimate that the eight State agencies potentially overpaid laboratory providers by about $6.5 million for chemistry, hematology, and urinalysis tests during our audit period. Further, we estimate that $3.2 million in additional annual savings is available if the eight State agencies implement our audit recommendations. Our prior report covered 14 States and involved about $27.4 million in overpayments. The audit was conducted as a joint Federal/State project under the OIG's Partnership Plan.

Officials in your office have concurred with our recommendations, set forth on page 10 of the attached report and have taken, or agreed to take, corrective action. We appreciate the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-96-00004 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR CLINICAL LABORATORY TESTS IN EIGHT STATES

JUNE GIBBS BROWN
Inspector General

AUGUST 1997
A-01-96-00004

SUMMARY

BACKGROUND

This report presents the consolidated results of our audits of Medicaid payments for outpatient clinical laboratory services in eight States. The audit is being conducted as a joint Federal/State project under the Office of Inspector General's (OIG) Partnership Plan. Staff from State auditor's offices and the OIG, Office of Audit Services (OAS) are continuing audit effort in an additional three States.

OBJECTIVE

The objective of the nationwide audit is to determine the adequacy of State agency procedures and controls over the payment of Medicaid laboratory claims. Specifically, the audit is designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. In doing so, we identified tests that were not grouped together (bundled into a panel or profile), for payment purposes. Proper grouping of tests helps to ensure that Medicaid agencies do not reimburse medical providers more for clinical laboratory tests than amounts that Medicare recognizes for the same services, as required by applicable laws and guidance.

SUMMARY OF FINDINGS

Our audit of Medicaid claims for outpatient clinical laboratory services in eight States disclosed that the Medicaid State agencies did not have adequate controls to detect and prevent inappropriate payments for laboratory tests. Contrary to applicable laws and guidance, the Medicaid State agencies paid medical providers more for clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients than the amounts Medicare recognizes for the same services. The inappropriate payments included potential overpayments for hematology profiles and indices that were duplicated or may have been medically unnecessary. As a result, we estimate that the eight State agencies potentially overpaid laboratory providers by about $6.5 million (Federal share $3.7 million) for chemistry, hematology, and urinalysis tests during our audit period. Further, we estimate that $3.2 million (Federal share $1.9 million) in additional annual savings is available if the eight State agencies implement our audit recommendations and providers continue to bill for clinical laboratory tests using the same methodology employed during our audit period.

Our analysis of potential overpayments in 23 States that participated in the Health Care Financing Administration's (HCFA) Medicaid Statistical Information System (MSIS) disclosed that the overwhelming majority of the identified overpayments were associated with a comparatively small number of laboratory providers. **Our review showed that less than**

25 percent of the laboratories with identified overpayments submitted 95 percent of the claims with potential overpayments. As a result, Medicaid State agencies may be able to recover a substantial portion of past overpayments by concentrating on those laboratories with the highest number of potential overpayments.

RECOMMENDATIONS

Individual reports were issued to each of the State agencies. The reports generally recommended that the State agencies: (1) install system edits and controls to detect and prevent the types of errors disclosed in our audit, (2) recover the Medicaid overpayments for clinical laboratory services identified in our audit, and (3) reimburse the Federal Government for its share of any recoveries made by the State agency. In response to our individual reports, two States agreed with reported findings and recommendations, four States partially agreed, while two States did not agree.

In our roll-up report on the first 14 States completed under our nationwide audit (A-01-95-00003), we recommended that HCFA: (1) reemphasize the Medicaid requirement that State agency payments for outpatient clinical laboratory services not exceed the amounts recognized by Medicare for the same services, (2) consider having State agencies update their provider billing instructions to reflect Medicare bundling procedures, and (3) follow-up on the estimated $27.4 million ($15.7 million Federal share) in potential overpayments identified in the 14 audits to ensure that the State agencies have implemented needed edits, initiated recovery actions, and credited the Federal Government for its share of any recoveries.

In its written comments on our initial roll-up report, HCFA fully concurred with our first and third recommendations and partially concurred with our second recommendation. Regarding our second recommendation, HCFA indicated that it planned to advise Medicaid State agencies that they should consider using the Medicare bundling procedures for the chemistry, hematology, and urinalysis tests examined in the OIG audit. However, HCFA will not tell the State agencies that they must use Medicare bundling procedures for other types of laboratory tests or medical services as long as they stay within the Medicare upper limit for payments and are consistent with the principles of efficiency, economy, and quality of care.

On January 15, 1997, HCFA issued a State Medicaid Director letter clarifying Medicaid policy with respect to the bundling of laboratory tests and the upper limit of payments for such tests. Based on HCFA's acceptance of our previous recommendations and issuance of the State Medicaid Director letter, we have limited the recommendations in this roll-up report to the issues specifically affecting the eight State agencies reported on in this report.

HCFA COMMENTS

In its written comments on our draft roll-up report, HCFA concurred with our findings and recommendations.

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INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry, hematology, and urinalysis tests. The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

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 designated by HCFA as frequently performed together on multichannel automated equipment, can be grouped together and reimbursed at a single panel rate. Chemistry tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and are to be used when all of the component tests are performed. Some of the component tests of organ panels are also chemistry panel tests.

Hematology tests that are grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell count, and a number of additional indices. Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices are red blood cell width, red blood cell volume, and platelet volume.

Urinalysis tests involve physical, chemical, or microscopic analysis or examination of urine. These tests measure certain components of the sample. A urinalysis may be ordered by the physician as a complete test which includes a microscopic examination or without the microscopic examination.

Within broad Federal guidelines, States design and administer their own Medicaid program under the general oversight of HCFA. A designated Medicaid agency in each State is responsible for claims processing, although many States use outside fiscal agents to actually process the claims. While most States maintain their own paid claims files, States may elect to participate in HCFA's MSIS. The MSIS is operated by HCFA to collect Medicaid eligibility and claims data from participating States.

Funding for each State's Medicaid program is provided through State and Federal matching funds. Section 1903 (i) (7) of the Social Security Act provides that Medicaid payment for clinical laboratory tests shall not be made to the extent that such amount exceeds the amount that would be recognized under Part B of the Medicare program. Further, section 6300.1 of the State Medicaid Manual provides that Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a

physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, section 6300.2 of the State Medicaid Manual provides that Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests.

OBJECTIVE, SCOPE, AND METHODOLOGY

We have conducted our nationwide audit in accordance with generally accepted government auditing standards. The objective of the nationwide audit is to determine the adequacy of State agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests. Specifically, the audit is designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. In doing so, we identified tests that were not grouped together, (bundled into a panel or profile), for payment purposes.

The initial State review was conducted by the Massachusetts State Auditors and was based on our extract and match of applicable procedure codes contained in a paid claims file provided by the State of Massachusetts. In order to expand the audit to other States, we performed similar extracts and matches on paid claims data contained in HCFA's MSIS and paid claims files submitted by States that were not participating in MSIS. At the time of our audit, 23 States participated in contributing paid claims data to the MSIS. Based on the results of our initial extract and match, we selected States with the highest potential overpayments. State audit organizations issued 5 of the 14 individual State reports summarized in our initial roll-up report and the OIG's OAS issued the remaining 9 reports. This roll-up report summarizes one report issued by a State audit organization and seven reports issued by the OIG's OAS.

To provide for consistent results in the conduct of the audit, an audit guide was prepared for use in all reviews including those performed by State auditor organizations. The guide provided instructions for extracting and matching procedures and audit steps for reviewing internal controls and verifying payments and computing overpayments.

Our review of the internal controls at each State agency was limited to an evaluation of that part of the claims processing function that related to the processing of claims for clinical laboratory services. Specifically, we reviewed State agency policies and procedures and instructions to providers related to the billing of clinical laboratory services. We also reviewed State agency documentation relating to manual and automated paneling and duplicate claim detection edits for chemistry, hematology, and urinalysis tests.

In order to test the reliability of HCFA's MSIS generated output and State agency payment files, we compared the payment data to source documents (i.e., billings and remittance advices) for the 1,000 randomly selected instances that we sampled in the eight States. We

did not assess the completeness of the HCFA and State agency data files nor did we evaluate the adequacy of the input controls.

This consolidated report covers the Calendar Years (CY) 1993 and 1994 Medicaid laboratory payments for the eight States audited.

From the States' respective paid claims files, we extracted the claims which contained applicable chemistry, hematology, and urinalysis tests that could be grouped together for payment purposes to ensure that payments would not exceed what Medicare would pay for the same tests. Using a series of computer applications, we identified instances of potential overpayments containing these types of laboratory tests (billed by the same provider for the same beneficiary on the same date of service) which could have been bundled, but were billed separately or duplicatively. We did not consider, as a potential Medicaid overpayment, those instances in which the State agency's respective Medicare carrier did not group together less than three chemistry tests or those tests designated by HCFA as optional.

We selected a sample of instances of potential overpayments for each of the categories under review (i.e., chemistry, hematology, and urinalysis) using a random number generator. We reviewed each of the payment instances identified by the random sample to determine whether an overpayment had been made. In order to determine the amount of overpayment, we analyzed each claim and determined the proper billing code. We then summed the line items included on the claim for each stratum and deducted the upper payment limit that would have been paid based on the Medicare fee schedules. The resulting difference was identified as an overpayment. An example of the methodology employed in this calculation is included in APPENDIX A. We projected the number of instances of potential overpayments using an attribute sample appraisal methodology and the total dollar amount of overpayments using a variable sample appraisal methodology. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report.

The chemistry, hematology, and urinalysis tests that were part of our review are listed in the Physicians' Current Procedural Terminology (CPT) manual and contained in APPENDIX B. APPENDIX C provides detailed information on the scope of our review in each of the eight States.

We discussed the results of each of the eight State audits with the respective State agencies and provided the State agencies and the HCFA regional offices with the audit reports. We also provided copies of the State agency reports to HCFA's headquarters in those cases where the estimated overpayments were reported to exceed $1 million.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report.

The audit of the eight State agencies took place between April 1995 and March 1997. Staff from the State auditors' offices and the OIG's OAS are continuing audit effort in an additional three States.

We extended our audit work to determine whether the overpayments we identified were limited to a small group of laboratory providers or widespread. We initially examined the five States within our sample of eight that were participating in HCFA's MSIS. Subsequently, we extended this analysis to all 23 States participating in the MSIS at the time of our audit. In this regard, we examined the potential overpayments identified by our computerized applications for all 23 States. We combined the results for 22 of the States and maintained separate statistics for California, because California had more potential overpayments than the other 22 States combined. The results of our analysis are reported under the OTHER MATTERS section of this report.

FINDINGS AND RECOMMENDATIONS

Our review at eight State Medicaid agencies disclosed that the States had not established adequate controls to detect and prevent inappropriate Medicaid payments. As a result, clinical laboratory service providers were paid approximately $6.5 million ($3.7 million Federal share) more for clinical laboratory tests during our audit period than the amounts Medicare recognizes for the same services.

In the individual reports addressed to each of the eight State Medicaid agencies, we recommended that the State agencies implement controls to detect and prevent inappropriate payments for laboratory claims and recover the overpayments identified by our audits. A statistical summary of the results of the reviews in each State is contained in APPENDIX D.

PAYMENTS EXCEEDING REQUIREMENTS

Our review at eight State Medicaid agencies disclosed that, contrary to applicable laws and guidelines, the State Medicaid agencies paid medical providers more for clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients than the amounts Medicare recognizes for the same services. These excessive payments occurred because the States were paying a higher price for individual tests than they would have if the tests had been bundled into lower cost panels and profiles. Such unbundling occurs when a provider bills for chemistry tests performed on the same day for the same beneficiary for more than one different chemistry panel, or a chemistry panel and at least one individual panel test, or two or more individual panel tests.

Our review also identified potential overpayments for overlapping and duplicate clinical laboratory tests. Duplicate billings occur when individual laboratory tests were billed for the same patient for the same date of service as a panel or profile test which included the

individual test. Duplicate billings also occur when two or more panels or profiles containing one or more of the same tests were billed for the same patient on the same date of service. Another situation which creates a potential overpayment is hematology indices billed with a hematology profile. Hematology indices are measurements and ratios calculated from the results of hematology tests. While both the profile tests and the indices are generated by a single, automated procedure, indices billed additionally should be based on a specific physician order.

In order to perform our review, we extracted, from each State's paid claims file, those claims which contain the applicable clinical laboratory service codes that are subject to bundling. We then performed a match to identify potential instances of overpayment. For the eight States reviewed, our matching procedures identified 873,613 instances in which the applicable procedure codes were either unbundled or duplicatively reimbursed. Based on a statistical sample review in each State, we verified that the payment in question exceeded reimbursement requirements. For 1,000 instances of potential overpayments reviewed in the 8 States, we found that 820 were verified to be overpaid. Using a weighted average of errors reported in each State (see APPENDIX D), we estimate that 682,570 (78 percent of 873,613 instances of potential overpayments) were verified to be overpayments.

The rate of overpayments identified by this review, however, does not represent an overall program error rate for all laboratory services of the total Medicaid programs. Instead, this rate measures the percent of overpayments verified from the population of potential overpayments that were identified by our computer extract and match (see page 3, paragraphs 3 and 4). While the rate of overpayments confirmed in our population was 78 percent, the dollar overpayments computed amounted to 45 percent of the dollars contained in the claims in our population, ($6.5 million of $14.3 million of claims in the population reviewed). Amounts correctly paid within each claim represent the appropriate amounts for properly grouped tests or panels or profiles and other unrelated tests contained in the claim.

CLINICAL LABORATORY SERVICE REIMBURSEMENT REQUIREMENTS

Medicaid Requirements. Policy for the reimbursement of clinical laboratory services under the Medicaid program derives much of its authority from provisions governing the Medicare program. In this regard, section 1903 (i) (7) of the Social Security Act provides that:

> ***Payment under Medicaid shall not be made "... with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeds the amount that would be recognized under Section 1833 (h) for such tests performed for an individual enrolled under part B of title XVIII [Medicare]...."***

The reference to section 1833 (h) of the Social Security Act is a reference to the Medicare provision directing the Secretary to establish fee schedules for reimbursement for clinical diagnostic laboratory tests.

In addition, section 6300 of the State Medicaid Manual provides that:

> ***"...clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. These fee schedules have been established on the Medicare carrier's service area (not exceeding a Statewide basis)...." "Effective with calendar quarters beginning on or after October 1, 1984 (for services rendered on or after July 1, 1984), Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests...."***

Section 6300 further states that:

> ***"...Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests... Each Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency...."***
>
> ***"For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002 - 89399 of the Current Procedural Terminology...."***

To correctly apply the above Medicaid payment principles, laboratory providers and the Medicaid State agencies must also understand the related Medicare payment principles for laboratory services. Laboratories that provide services to Medicaid patients should be aware of the Medicare principles, since they also provide services to Medicare patients.

Medicare Requirements. Generally, Medicare claims for clinical laboratory services are reimbursed based on fee schedules and are subject to the guidelines published by HCFA in its Medicare Carriers Manual. Medicare pays the lower of the fee schedule amount or the actual charge for the service, provided that the service is reasonable and necessary.

Section 5114 of the Medicare Carriers Manual states that:

> ***"This Section sets out payment rules for diagnostic laboratory services, i.e., (1) outpatient clinical diagnostic laboratory tests subject to the fee schedule, and (2) other diagnostic laboratory tests...."***

Section 5114.1 continues on to list 21 tests which can be and are frequently performed as panels on automated equipment. Our review also identified three additional tests that HCFA has allowed Medicare carriers the option of adding to their list of chemistry panel tests. These additional tests include Creatinine Phosphokinase (CPK) (procedure codes 82550, 82555), Glutamyltranspetidase Gamma (GGT) (procedure code 82977) and Triglycerides (procedure code 84478).

Section 5114.1 also directs carriers to make payment at the lesser amount for the panel if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the panel that includes these tests.

Section 7103.1B of the Medicare Carriers Manual discusses duplicate payments and provides that if an overpayment to a supplier is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the supplier does not have a reasonable basis for assuming that the total payment it received was correct and thus should have questioned it. The supplier is, therefore, at fault and liable for the overpayment.

Based on the above criteria, Medicare providers are required to bundle outpatient laboratory tests into the applicable panel and profile test codes when the tests are performed for the same patient on the same date of service. While section 1833 (h) of the Social Security Act does not specifically address bundling of automated laboratory tests into panels, section 1833 (h) (2) (A) (i) authorizes the Secretary, in setting fee schedules, to make "...adjustments as the Secretary determines are justified by technological changes...." The bundling rules are justified by language in section 5114.1.L of the Medicare Carriers Manual referring to the "... numerous technological advances and innovations in the clinical laboratory field and the increased availability of automated testing equipment to all entities that perform clinical diagnostic laboratory tests...."

Under the Medicare payment principles described above, the Secretary has imposed limitations on reimbursement for tests that can be performed as part of an automated battery or panel. Accordingly, laboratory bundling requirements are inseparable from the process of determining the proper Medicare payment amounts from the fee schedule. One way for a State to ensure that its Medicaid payments for laboratory services do not exceed the amounts recognized by Medicare for the same services is for the State to establish controls that bundle laboratory tests in accordance with Medicare principles and select the appropriate fee from the relevant fee schedule.

STATE MEDICAID AGENCY POLICIES AND PROCEDURES

All eight of the States that were reviewed needed to make additions or refinements to their claims processing systems to identify and prevent inappropriate payment for clinical laboratory services. Report discussions varied at length and in the number of causes for the overpayments. However, reports for most individual State audits further provided State

agency reasons why edits were not implemented or discussed the specific weaknesses found. A brief summary of reasons provided or weaknesses identified is discussed below.

- Reviews in all eight States disclosed that the respective State agencies did not have edits or controls covering all of the applicable procedure codes, places of service, types of service, or billings involving multiple claim forms.

- The State agency in one State did not have procedures or controls to limit Medicaid payments to what the Medicare carrier pays for bundling two tests.

- The State agency in one State did not inform providers of all the clinical laboratory tests that are subject to bundling so that the providers could adjust their Medicaid billings accordingly.

- Officials at three State agencies indicated that the State agencies intentionally paid for both hematology profiles and the related indices that were generated on the same date of service because they believed that the indices were additional to what was included in the hematology profiles.

- State agencies in two States did not adjust their Medicaid laboratory fees so that they did not exceed the comparable amounts on the Medicare fee schedule for clinical laboratory tests.

POTENTIAL OVERPAYMENTS

We estimate that the eight State agencies overpaid laboratory providers by a total of $6.5 million ($3.7 million Federal share) for chemistry, hematology, and urinalysis tests during our audit period. Further, we estimate that $3.2 million ($1.9 million Federal share) in additional annual savings is available if the eight State agencies implement our audit recommendations and providers continue to bill for clinical laboratory tests using the same methodology employed during our audit period. These estimates represent the sum of the dollar impact figures developed for the eight individual State reports (see APPENDIX D).

INDIVIDUAL REPORT RECOMMENDATIONS AND RESPONSES

Individual audit reports were issued to each of the eight State Medicaid agencies recommending that the agencies: (1) install system edits and controls to detect and prevent the types of bundling and duplicate claim errors disclosed in our audit, (2) recover the

Medicaid overpayments for clinical laboratory services identified in our audit, and (3) reimburse the Federal Government for its share of any recoveries made by the State agency.

Two States responded to our draft audit reports by indicating that they were in complete agreement with our reported findings and recommendations. Four additional States advised us that they partially agreed with our findings and recommendations, while two States did not agree with our findings and recommendations.

All four of the States that partially agreed with our findings and recommendations agreed to implement edits to prevent inappropriate future payments for unbundled and duplicate laboratory claims. However, two of the four States indicated that they should not be held responsible for overpayments during CYs 1993 and 1994 because Medicaid guidelines were not clear during that period. One of the four States questioned the methods the auditors used to estimate the amount of the overpayments for the audit period. The remaining State agreed with our findings, but did not explain why it did not intend to retroactively recover the identified potential overpayments.

The two States that did not agree with our position both indicated that it was inappropriate to apply Medicare bundling procedures to Medicaid payments.

We believe that State agencies should be required to attempt to recover overpayments identified in our audit. While we agree that Medicaid guidance does not specify that bundling laboratory tests is required, there is no question that Federal provision requires that Medicaid payments not exceed what Medicare pays for the same tests. We believe the most reasonable way to ensure that Medicaid payments for clinical laboratory services do not exceed the amounts recognized by Medicare for the same services is to bundle laboratory services in accordance with Medicare principles. Seven of the eight State agency responses indicated general agreement that procedures and controls were needed to ensure that (i) Medicaid did not pay more than amounts recognized by Medicare for the same services, (ii) such procedures and controls were already being implemented, and/or (iii) the States were proceeding or planning to proceed with recovery of potential overpayments.

We were also advised that one State believes that billing for hematology profiles (procedure codes 85023, 85024, or 85025) and for additional indices (procedure codes 85029 and/or 85030) for the same patient, on the same day by a single provider is appropriate. While the description of hematology profiles contained in the Physicians' CPT manual indicates that the profiles include indices, the specific indices that are normally produced under each profile are not listed. Likewise, the CPT manual does not identify indices contained in the procedure codes for additional indices (85029/85030), however, examples are provided. While indices are generally produced at the same time that the profile is performed, separate reimbursement of the examples described under additional indices should be based on a physician order for the additional indices.

Our concern is that the use of procedure codes 85029 and 85030 may not be based on a physician order for additional indices. Based on data available for 10 of the 14 States in our first roll-up report, only 8 percent of the providers accounted for 75 percent of the States' Medicaid billing for additional indices. We believe the medical necessity and ordering of such tests would not be confined to so few providers if the practice was appropriate. Accordingly, we believe that billing the combination of hematology profiles and additional indices on the same day for the same beneficiary reflects a potential overpayment that should continue to be subject to review. State agency officials generally agreed that the billing for additional indices by so few providers warrants review of the related reimbursements.

We believe that HCFA should reemphasize to State Medicaid agencies the Medicaid requirements related to reimbursing providers of clinical laboratory services under Medicaid and the need for State Medicaid agencies to inform medical providers of such requirements in their billing instructions. We also believe that HCFA should follow-up on recommendations made in the individual State Medicaid agency reports.

RECOMMENDATIONS

In view of HCFA's agreement with the recommendations in our first roll-up report and HCFA's recent issuance of a State Medicaid Director letter on this subject, we are limiting further recommendations to a HCFA follow-up on the eight states included in this roll-up report. We are recommending that the follow-up be designed to ensure that the eight State agencies:

- implemented procedures and controls to prevent inappropriate payments for unbundled and duplicate tests,
- initiated action to recover the estimated $6.5 million ($3.7 million Federal share) in potential overpayments identified in our audits, and
- appropriately credited the Federal Government with its share of any recoveries.

HCFA COMMENTS

In its written comments on our draft roll-up report, HCFA concurred with our findings and recommendations (APPENDIX F).

OTHER MATTERS

We extended our audit work on one issue beyond the eight sampled States mentioned above. Specifically, we analyzed the billing patterns of laboratories that had potential overpayments identified in our computerized applications. For the purpose of this one issue, we reviewed all 23 States that were part of HCFA's MSIS during our audit period (5 of these States were part of the sample of 8 States covered in this report). Our intent was to determine whether the potential overpayments were limited to a small group of laboratories or common to all laboratories.

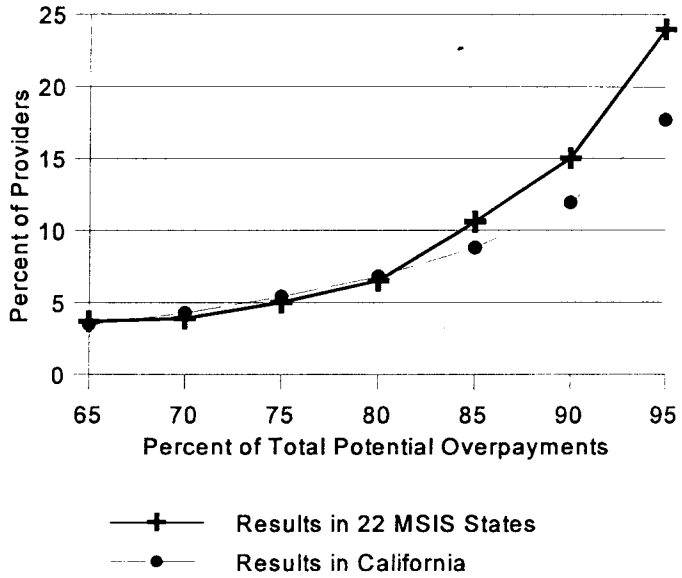

Figure 1 - Relationship between percent of laboratories and their share of overpayments.

Our analysis of the total potential overpayments for 23 MSIS States showed that less than 25 percent of the laboratories with identified overpayments submitted 95 percent of the claims with potential overpayments. On a State by State basis, as few as 16 percent of the laboratories to as many as 42 percent of the laboratories submitted 95 percent of the claims in the State with potential overpayments. Figure 1 charts the relationship between the percent of laboratory providers and their respective share of total potential overpayments. We combined the results for 22 of the States and maintained separate statistics for California, because California had more potential overpayments than the other 22 States combined. As previously explained, this information suggests that Medicaid State agencies may be able to recover a substantial portion of past overpayments by concentrating on those laboratories with the highest number of potential overpayments.

APPENDICES

SAMPLE METHODOLOGY

This consolidated report covers CYs 1993 and 1994 Medicaid laboratory payments for eight States where we have completed an audit.

From HCFA's MSIS or the State Medicaid agency's paid claims file, we utilized computer applications to extract all claims containing:

- chemistry panels and panel tests for chemistry procedure codes listed in the CPT manual (see APPENDIX B);
- hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT manual (see APPENDIX B);
- urinalysis and component tests listed in the CPT manual (see APPENDIX B).

We then performed a series of computer applications to identify all records for the same individual for the same date of service with HCFA's Common Procedure Coding System line item charges for:

- more than one chemistry panel; a chemistry panel and at least one individual panel test; or two or more panel tests;
- more than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or hematology indices and a profile; and
- a complete urinalysis test which includes microscopy; a urinalysis without microscopy; or a microscopy only.

This resulted in a sample population totaling more than $14.3 million for approximately 874,000 instances of potential overpayments. Each instance is a potential payment error in which the State agency paid providers for clinical laboratory tests (on behalf of the same recipient on the same date of service) which were billed individually instead of as part of a group, or were duplicative of each other. An example of an overpayment follows.

Example of an Overpayment

Test Code	Test Name	Units	Paid Amount
Individual Test Codes			
82040	Albumin (chemistry test)	1	$ 7.00
82465	Cholesterol (chemistry test)	1	$ 6.47
84478	Triglycerides (chemistry test)	1	$ 8.54
	Total Paid		$22.01
Panel Test Code			
80003	for any 3 clinical, chemistry, automated, multichannel, tests	1	$10.85
Difference in Amounts Paid is an Overpayment:			**$11.16**

On a randomly selected basis, we examined 1,000 instances of potential overpayments involving claims for clinical laboratory services in the eight States audited. The instances of potential overpayments were stratified into the clinical laboratory service categories of chemistry, hematology, and urinalysis. For each sampled instance, we requested and reviewed supporting documentation from the State agency consisting of copies of physician, hospital, or independent laboratory claims and related paid claims history. Our review disclosed 820 potential overpayments out of the 1,000 instances examined.

We projected the number of instances of potential overpayments using a stratified attribute sample appraisal methodology. We utilized a stratified variable appraisal process to quantify the potential overpayments for unbundled chemistry panel tests, duplicate hematology profile tests and unbundled or duplicate urinalysis tests in each of the eight States, as shown on APPENDIX D. Our estimate is that the eight State agencies overpaid laboratory providers by $6.5 million ($3.7 million Federal share) during our audit period.

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

Chemistry Panel CPT Code Description	CPT Codes
1 or 2 clinical chemistry automated multichannel test(s)	80002
3 clinical chemistry automated multichannel tests	80003
4 clinical chemistry automated multichannel tests	80004
5 clinical chemistry automated multichannel tests	80005
6 clinical chemistry automated multichannel tests	80006
7 clinical chemistry automated multichannel tests	80007
8 clinical chemistry automated multichannel tests	80008
9 clinical chemistry automated multichannel tests	80009
10 clinical chemistry automated multichannel test	80010
11 clinical chemistry automated multichannel tests	80011
12 clinical chemistry automated multichannel tests	80012
13-16 clinical chemistry automated multichannel tests	80016
17-18 clinical chemistry automated multichannel tests	80018
19 or more clinical chemistry automated multichannel tests	80019
General Health Panel	80050
Hepatic Function Panel	80058

Chemistry Panel Test CPT Code Description Subject to Paneling (35 CPT Codes)	CPT Codes
Albumin	82040
Albumin/globulin ratio	84170
Bilirubin Total OR Direct	82250
Bilirubin Total AND Direct	82251
Calcium	82310, 82315, 82320, 82325
Carbon Dioxide Content	82374
Chlorides	82435
Cholesterol	82465
Creatinine	82565
Globulin	82942
Glucose	82947
Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
Alkaline Phosphatase	84075, 84078
Phosphorus	84100
Potassium	84132
Total Protein	84155, 84160
Sodium	84295
Transaminase (SGOT)	84450, 84455

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

Chemistry Panel Test CPT Code Description Subject to Paneling (35 CPT Codes)	CPT Codes
Transaminase (SGPT)	84460, 84465
Blood Urea Nitrogen (BUN)	84520
Uric Acid	84550
Triglycerides	84478
Creatinine Phosphokinase (CPK)	82550, 82555
Glutamyltranspetidase, gamma	82977

Hematology Component Test CPT Code Description	CPT Codes
Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Calorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Additional Hematology Component Tests - Indices	CPT Codes
Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Hematology Profile CPT Code Description	CPT Codes
Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram / Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027

Urinalysis and Component Test CPT Code Description	CPT Codes
Urinalysis	81000
Urinalysis without microscopy	81002, 81003
Urinalysis microscopic only	81015

SCOPE STATISTICS

STATE	INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION)	TOTAL DOLLAR VALUE OF INSTANCES	AUDIT PERIOD
Connecticut	90,974	$ 2,237,391	CY 1993 & 1994
New Jersey	122,962	1,806,831	CY 1993 & 1994
Maryland	29,229	612,137	CY 1993 & 1994
Virginia	109,847	2,845,161	CY 1993 & 1994
West Virginia	82,861	2,415,317	CY 1993 & 1994
Illinois	318,051	3,235,319	CY 1993 &1994
Arkansas	26,737	497,625	CY 1993 & 1994
Utah	92,952	698,482	CY 1993 & 1994
TOTALS	873,613	$14,348,263	

SUMMARY OF STATE RESULTS

STATE	INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION)	SAMPLE SIZE	SAMPLE ERRORS	ESTIMATED ERRORS	LOWER LIMIT	UPPER LIMIT
Connecticut	90,974	150	95	45,631	39,505	51,756
New Jersey	122,962	150	95	82,587	74,027	91,148
Maryland	29,229	100	97	28,402	27,611	29,193
Virginia	109,847	100	99	109,437	108,763	110,111
West Virginia	82,861	100	100	82,861	82,861	82,861
Illinois	318,051	100	79	222,252	195,802	248,702
Arkansas	26,737	150	105	18,448	16,635	20,261
Utah	92,952	150	150	92,952	92,952	92,952
TOTALS	873,613	1000	820	682,570		

$$\frac{\text{ESTIMATED ERRORS}}{\text{INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION)}} \quad \frac{682{,}570}{873{,}613} = 78\%$$

SUMMARY OF STATE RESULTS

STATE	DOLLAR VALUE (POPULATION)	ESTIMATED TOTAL DOLLAR ERRORS	ESTIMATED FFP DOLLAR ERRORS	PRECISION (+ / -) PERCENT
Connecticut	$ 2,237,391	$ 427,068	$ 213,534	35.82
New Jersey	1,806,831	297,427	148,714	16.87
Maryland	612,137	254,932	127,466	6.92
Virginia	2,845,161	1,446,925	723,463	12.87
West Virginia	2,415,317	1,378,601	1,047,789	14.80
Illinois	3,235,319	2,194,072	1,097,036	21.13
Arkansas	497,625	167,162	123,048	28.74
Utah	698,482	319,972	239,329	[1]
TOTALS	$14,348,263	$6,486,159	$3,720,379	

$$\frac{\text{ESTIMATED TOTAL DOLLAR ERRORS}}{\text{DOLLAR VALUE}} = \frac{\$6{,}486{,}159}{\$14{,}348{,}263} = 45\%$$

[1] State Auditors did not calculate an OVERALL Precision Percentage for Utah. The precision for each stratum was as follows:

Chemistry = 18.31%
Hematology = 4.76%
Urinalysis = 26.50%

SUMMARY OF STATE RESULTS

STATE	ESTIMATED ONE YEAR TOTAL SAVINGS	ESTIMATED ONE YEAR FFP SAVINGS
Connecticut	$ 213,534	$ 106,767
New Jersey	148,714	74,357
Maryland	127,466	63,733
Virginia	723,463	361,732
West Virginia	689,301	523,895
Illinois	1,097,036	548,518
Arkansas	83,581	61,524
Utah	159,986	119,665
TOTALS	$3,243,081	$1,860,191

SUMMARY OF STATE RESULTS

STATE	NO. OF INSTANCES OF POTENTIAL OVERPAYMENTS				POTENTIAL OVERPAYMENTS			
	TOTAL	CHEMISTRY	HEMATOLOGY	URINALYSIS	TOTAL	CHEMISTRY	HEMATOLOGY	URINALYSIS
Connecticut	95	14	47	34	$ 427,068	$ 274,257	$ 109,870	$ 42,941
New Jersey	95	25	47	23	297,427	165,115	130,133	2,179
Maryland	97	97	0	0	254,932	254,932	0	0
Virginia	99	50	0	49	1,446,925	1,355,680	0	91,245
West Virginia	100	100	0	0	1,378,601	1,378,601	0	0
Illinois	79	29	50	0	2,194,072	1,880,946	313,126	0
Arkansas	105	32	31	42	167,162	124,543	20,833	21,786
Utah	150	50	50	50	319,972	190,624	119,735	9,613
TOTALS	820	397	225	198	$6,486,159	$5,624,698	$693,697	$167,764

INDIVIDUAL STATE REVIEWS INCLUDED IN NATIONWIDE AUDIT

STATE	CIN NUMBER	RESPONSIBLE AUDIT ORGANIZATION
Connecticut	A-01-95-00006	Office of Inspector General
New Jersey	A-02-95-01009	Office of Inspector General
Maryland	A-03-96-00200	Office of Inspector General
Virginia	A-03-96-00202	Office of Inspector General
West Virginia	A-03-96-00203	Office of Inspector General
Illinois	A-05-95-00062	Office of Inspector General
Arkansas	A-06-96-00002	Office of Inspector General
Utah	A-06-95-00100	State Auditor's Office

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE JUL 14 1997

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Clinical Laboratory Tests in Eight States," (A-01-96-00004)

We reviewed the above-referenced report concerning the adequacy of state agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests.

Our detailed comments are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

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EAIG
SAIG
PDIG ✓
DIG-AS
DIG-EC
DIG-EI
DIG-OI
DIG-MP
AIG-LC
OGC/IG
ExecSec ✓
Date Sent 7-17

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OFFICE OF INSPECTOR GENERAL

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report entitled:
"Medicaid Payments for Clinical Laboratory Tests in Eight States,"
(A-01-96-00004)

OIG Recommendation

HCFA follow-up be designed to ensure that the eight state agencies:

- implement procedures and controls to prevent inappropriate payments for unbundled and duplicate tests;
- initiate action to recover the estimated $6.5 million ($3.7 million Federal share) in potential overpayments identified in our audits; and
- appropriately credit the Federal Government with its share of any recoveries.

HCFA Response

We concur. HCFA already concurred with OIG's first report auditing 14 states, that recommended reemphasizing the Medicaid requirements that state agency payments for these services not exceed the amount recognized by Medicare for the same services (sections 1903(I)(7) and 1833(h) of the Social Security Act), and recovering overpayments by the Federal Government. HCFA partially concurred with OIG's recommendations that state agencies update their provider billing instructions to reflect Medicare bundling procedures by limiting the procedures to chemistry, hematology, and urinalysis tests. This study focuses on those tests.

Based on sections 5114.1 and 7103.1B of the Medicare Carriers Manual, Medicare providers must bundle laboratory tests for the same patient on the same date of service. Section 6300 of the State Medicaid Manual requires reimbursement to not exceed Medicare rates, making bundling a procedure worth implementing in meeting that rate requirement. Since the law clearly states that Medicaid payments not exceed Medicare payment rates, and some states are resisting using the bundling technique, HCFA needs to oversee procedures designed to prevent inappropriate payments for unbundled and duplicative tests.

Since less than 25 percent of the providers submitted 95 percent of the overpayments, payment recovery should not be difficult and corrective action can be concentrated on a few providers. Seven out of eight audited states agree that procedures and controls need to be implemented or are being implemented and/or they were planning or proceeding with recovery of overpayments.

This indicates that states know overpayments are a problem and additional action is necessary.

HCFA will request that its regional offices ask the state agencies to seek recovery of any overpayments made to the laboratories, and refund the Federal share of any recoveries received.