DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date SEP 22 1999

From June Gibbs Brown
Inspector General

Subject Office of Inspector General's Partnership Plan -- Commonwealth of Kentucky, Office of Public Accounts' Report on *Post Payment Review of Clinical Laboratory Services* (A-04-98-01185)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

We are transmitting for your information the final audit report entitled *Post Payment Review of Clinical Laboratory Services* for the Commonwealth of Kentucky's Medicaid program for the period January 1, 1994 through December 31, 1996. The objective of the review was to determine the adequacy of the Kentucky Cabinet for Health Services, Department for Medicaid Services procedures and controls over the processing of Medicaid payments to providers of certain clinical laboratory services.

This review was conducted as part of the Office of Inspector General's (OIG) partnership efforts with States' oversight agencies to expand audit coverage of the Medicaid program. As part of the review, the Office of Audit Services (OAS) assisted the Kentucky Auditor of Public Accounts (State auditors) by:

- providing guidance for identifying, through computer applications, a universe of potential overpaid claims resulting from certain chemistry, hematology, and urinalysis tests that were either improperly grouped or duplicative payments,
- selecting a statistical sample of claims for the State auditors to validate the medical payments, and
- appraising the sample results for the State auditors to report the estimated overpayments made.

The State auditors found the Department for Medicaid Services did not have adequate procedures or controls to ensure that reimbursement for Medicaid clinical laboratory tests did not exceed amounts allowed by the Medicare program, as required by section 6300 of the State Medicaid Manual. As a result, the auditors estimated the Department for Medicaid Services made potential overpayments of about $2.3 million ($1.6 million Federal share) to providers during Calendar Years 1994, 1995, and 1996.

The Kentucky Auditor of Public Accounts recommended the Department for Medicaid Services:

1. review, add, and improve, as necessary, the Medicaid Management Information System computer edit controls that identify improperly billed laboratory tests;

2. update the provider manuals and billing instructions to reflect Medicaid bundling and duplicate payment requirements;

3. pursue recovery of the $2.3 million of overpayments, where feasible, and document the basis for decisions to attempt or not attempt recoveries; and

4. upon recovery of funds from providers, make adjustments on the Quarterly Report of Expenditures to the Health Care Financing Administration for the Federal share of Medicaid funds.

The Kentucky Cabinet for Health Services, Department for Medicaid Services generally agreed with all the recommendations made by the Auditor of Public Accounts. As with all audit reports developed by non-federal auditors, we are providing as an attachment (Attachment A) a list of the coded recommendations for your staff's use in working with the Commonwealth of Kentucky to resolve the findings and recommendations through our stewardship program. In this regard 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.

We plan to share this report with other State Medicaid agencies in an effort to encourage their participation in the OIG's partnership efforts. If you have any questions about the review, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

Attachments

Summary of Recommendations

Recommendation Codes	Page	Amount	Resolution Agency	Recommendations
32290110	8-9	N/A	HHS/HCFA	Review, add, and improve, as necessary, the Medicaid Management Information System computer edit controls that identify improperly billed laboratory tests.
292610	8-9	N/A	HHS/HCFA	Monitor the results of the computer edit control updates and establish procedures and specific responsibility within the Department for Medicaid Services for periodically verifying the accuracy of the computer edits in the Medicaid Management Information System.
21693510	9	N/A	HHS/HCFA	Update the provider manuals and billing instructions to reflect Medicaid bundling and duplicate payment requirements.
20400903	9-10	$1,579,988	HHS/HCFA	Pursue recovery of the $2.3 ($1.6 million Federal share) million of overpayments where feasible. Document the basis for decisions to attempt or not to attempt recoveries.
20992210	9-10	N/A	HHS/HCFA	Upon recovery of funds from providers, make adjustments on the Quarterly Report of Expenditures to the Federal Health Care Financing Administration for the Federal share of Medicaid funds.
290610	10-11	N/A	HHS/HCFA	Determine the cause of duplicate data being submitted to HCFA's Medicaid Statistical Information System and correct the problem.

KENTUCKY'S MEDICAID PROGRAM

POST PAYMENT REVIEW OF CLINICAL LABORATORY SERVICES

AUGUST 1999 - PERFORMANCE AUDIT

EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS

The Auditor Of Public Accounts Ensures That Public Resources Are Protected, Accurately Valued, Properly Accounted For, And Effectively Employed To Raise The Quality Of Life Of Kentuckians.

EDWARD B. HATCHETT, JR.
AUDITOR OF PUBLIC ACCOUNTS

August 3, 1999

To the People of Kentucky
The Honorable Paul E. Patton, Governor, Commonwealth of Kentucky
The Honorable June Gibbs Brown, Inspector General, U.S. Department of Health and Human Services
John H. Morse, Secretary, Kentucky Cabinet for Health Services
Dennis Boyd, Commissioner, Kentucky Department for Medicaid Services

Re: Performance Audit of Medicaid Payments for Clinical Laboratory Services in Kentucky

Ladies and Gentlemen:

We present our report on Medicaid payments for Clinical Laboratory Services in Kentucky. Our audit was conducted in cooperation with and at the direction of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services.

We are distributing this report in accordance with the mandates of Kentucky Revised Statute 43.090. In addition, we are distributing copies to members of the committees of the General Assembly with oversight authority for the Medicaid program, as well as other interested parties.

After an appropriate period, we will contact the respective Medicaid officials to determine whether the report's recommendations have been implemented and will advise the Legislative Research Commission regarding the status of that implementation. Once the Cabinet has advised us that the recommendations have been implemented, they will be considered closed.

Our Division of Performance Audit evaluates the effectiveness and efficiency of government programs, conducts risk assessments of public resources, and benchmarks agency operations. We will be happy to discuss with you at any time this audit or the services offered by our office. If you have any questions, please call Harold McKinney, Acting Director of our Division of Performance Audit, or me.

I appreciate the courtesies and cooperation extended to our staff during the audit.

Respectfully submitted,

Edward B. Hatchett, Jr.
Auditor of Public Accounts

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Executive Summary

The Kentucky Cabinet for Health Services, Department for Medicaid Services did not have adequate controls to detect and prevent inappropriate payments for clinical laboratory tests. The Department was duplicating reimbursements to providers for some laboratory tests and paying providers for other tests that were not properly grouped for payment. Based on our sample results, we estimate that the Department made potential overpayments of $ 2.3 million to providers in calendar years 1994, 1995, and 1996.

Clinical laboratory services include chemistry, hematology, and urinalysis tests. These laboratory tests are performed to help physicians diagnose and treat ailments. The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

During calendar years 1994, 1995, and 1996, the Department for Medicaid Services processed 2,544,905 instances amounting to $24,428,386 of paid claims for clinical laboratory services involving chemistry, hematology, and/or urinalysis procedure codes. Each instance represents single or multiple claims for services provided by a health care provider to the same patient on the same day. Of those, 374,905 instances totaling $7,914,282 were identified by the U.S. Department of Health and Human Services, Office of Inspector General, as potential payment errors. We examined 150 randomly selected potential payment errors. The following table depicts our sample results and our projected overpayments for the chemistry, hematology, and urinalysis tests.

Table 1: **Sampled Transactions with Overpayments — Calendar Years 1994, 1995, and 1996**

Stratum	Audit Sample			Over-Payment Estimate		
	Items Tested	Examined Value	Items Overpaid	Total Over-Payment	Federal Share	State Share
Chemistry	50	$1,321.19	20	$ 974,527	$ 674,762	$299,765
Hematology	50	1,006.95	41	1,268,780	882,817	385,963
Urinalysis	50	447.32	16	32,151	22,409	9,742
Total	150	$2,775.46	77	$2,275,458	$1,579,988	$695,470

Federal Percentages: 69.24 for 1994, 69.58 for 1995 and 69.70 for 1996 are based on federal fiscal year. Therefore, federal share may be slightly different due to calendar year sample. Source: Auditor Analysis

These overpayments occurred because the Department did not have adequate procedures or controls to ensure that reimbursements for the Medicaid clinical laboratory tests did not exceed amounts allowed by the Medicare program, as required by Section 6300 of the State Medicaid Manual.

We recommend that the Department for Medicaid Services update its Medicaid Services Manuals and improve the monitoring of the payment edits in its management information system. We also recommend that the department attempt to recover the $2.3 million in overpayments. The Department generally agreed with the recommendations. Its official comments are included in their entirety as Appendix VII.

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Abbreviations

HHS-OIG	U.S. Department of Health and Human Services, Office of Inspector General
KCHS	Kentucky Cabinet for Health Services
DMS	Department for Medicaid Services
HCFA	Health Care Financing Administration
MSIS	Medicaid Statistical Information System (Federal System)
MMIS	Medicaid Management Information System (Kentucky System)
CPT	Physicians' Current Procedural Terminology
CY	Calendar Year

Definitions

As Used In This Report

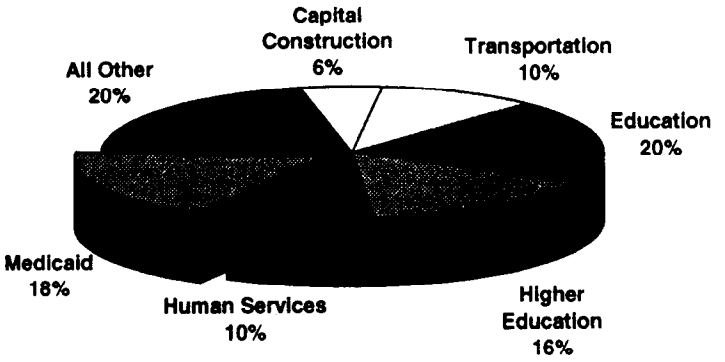
Bundling	Grouping tests according to Medicare requirements, which results in paying a lesser amount.
Duplicate Tests	Overlapping of laboratory tests which are billed separately (i.e. such as billing for a hematology profile and a hematology indices.)
Duplicate Payment	Multiple processing (payment) of the same tests due to overlapping or due to paying the same claim twice (i.e. same date, same provider, same recipient, same procedure code with supporting documentation).
Duplication of Paid claims data/records	Two exact claims in Medicaid Statistical Information System and/or Medicaid Management Information System containing the same date, same provider, same recipient, same procedure code without appropriate supporting documentation.
Instance	Potential payment error in which a provider is paid for clinical laboratory tests on behalf of the same beneficiary on the same date of service which were billed individually instead as part of a group, or were duplicative of each other.
Overlapping	Billing of 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.
Panel/Profile	A battery of tests grouped together.
Rebundling	Grouping together tests that are submitted or paid individually that should be paid as one.
Unbundling	Ungrouping of tests and paying them individually or as more than one profile when they should be paid as one profile.

Introduction

The Medicaid Program

Kentucky provides health care services to its eligible low-income residents through the Medicaid program, a jointly funded federal and state government program authorized by Title XIX of the federal Social Security Act. The Department for Medicaid Services of the Kentucky Cabinet for Health Services administers the program. Kentucky's Medicaid budget has increased more than 160% from less than $1 billion in 1990 to more than $2.6 billion in 1998. Today, Medicaid expenditures account for almost one-fifth of the Commonwealth's budget.

Figure 1: **Budget of the Commonwealth Expenditures For Fiscal Years 1999 and 2000**



Source: 1998-2000 Budget of the Commonwealth

Clinical Laboratory Services

Clinical laboratory services are included in Kentucky's Medicaid assistance program.[1] These services are provided by independent laboratories, physicians, and outpatient and nonpatient hospital services. Providers of each category of services receive billing instructions and manuals specific to their category. Specific clinical laboratory procedures covered in our audit made up approximately $24.4 million of Kentucky's Medicaid spending during calendar years 1994, 1995, and 1996.

Clinical laboratory services include chemistry, hematology, and urinalysis tests. 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 contents. Urinalysis tests involve the measurement of certain components of the sample, which may also include a microscopic examination. Services provided on behalf of a beneficiary on the same day by the same provider may be billed to Medicaid on a single claim or on multiple claims, depending on the number of tests provided.

[1] Part B of Title XVIII of the Social Security Act (Medicare Supplementary Medical Insurance), as amended, covers clinical laboratory services performed at hospitals, physicians' practices and independent laboratories. Title XIX (Medicaid) also covers clinical laboratory services subject to regulations of Title XVIII (Medicare, Part B) and published in its Carriers Manual.

Introduction

The Regulation and Processing of Clinical Laboratory Services Payments

Health Care Financing Administration Oversight

States design and administer the Medicaid program within broad federal guidelines and under the general oversight of the Health Care Financing Administration (HCFA). In Kentucky, the single state agency responsible for Medicaid is the Department for Medicaid Services in the Cabinet for Health Services. Many states, including Kentucky, use outside fiscal agents for claims processing. Since 1994, Kentucky has contracted with two fiscal agents for the operation of the Medicaid Management Information System, Electronic Data Systems, Inc. (EDS) (1994-1995) and Unisys Corporation (12/1/95 - present). The fiscal agent receives and processes all claims for medical services provided to Kentucky Medicaid recipients.

The health care provider sends claims to the fiscal agent either by mail or electronically. The fiscal agent assigns a control number, batches, and processes claims. They then edit, price, audit, and make weekly payments. This information flows through subsystems which report or process the data for different purposes to the Management and Administrative Reporting Subsystem (MARS).

MARS generates quarterly claims tapes that are submitted to the Medicaid Statistical Information System (MSIS), a federal government repository of states' Medicaid data. (See Appendix IV.) MSIS is operated by HCFA to collect from the participating states Medicaid eligibility data on the beneficiaries and adjudicated paid claims data on the medical services provided.

The Medicaid fiscal agent is required to operate an edit/audit processing function in accordance with Kentucky policy. This requirement assists in processing and paying claims for Medicaid Services in a way more closely aligned and consistent with Current Procedural Terminology (CPT) and International Classification of Diseases (ICD)-9 Criteria. (See Appendix II.) The auditing system evaluates billing information and determines coding accuracy of submitted claims.

Unisys, Kentucky's current fiscal agent, uses proprietary software (currently HBOC ClaimCheck) which includes editing and auditing such items as:

- Procedure unbundling,
- Incidental procedures,
- Mutually exclusive procedures, and
- Duplicate procedure auditing.

Medicaid claims for clinical laboratory services are reimbursed based on fee schedules or rates set forth in state Medicaid policy and the Medicare program. Medicare pays the lesser of the national limit as published by HCFA annually, an individual carrier fee schedule, or the actual charge for the service, providing that the service is reasonable and necessary.

Introduction

Medicare[2] Regulations

Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives unless found not at fault. Section 7103.1B 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.

Medicaid Regulations

Section 6300.1 of the State Medicaid Manual states that federal matching funds will not be available to the extent a state pays more for outpatient clinical laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, Section 6300.2 states that payment for clinical laboratory tests under the Medicaid program may not exceed the amount recognized by the Medicare program. Under Medicaid, clinical laboratory services are reimbursed at the lower of the Medicare fee schedule amount or the actual charge.

Under Medicare, the carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains and updates the fee schedule and provides it to the state Medicaid agency in its locality. Kentucky's Medicare carrier, AdminaStar Federal, Inc., provides the Department for Medicaid Services fee schedules on electronic tapes.

State statutes, regulations, and manuals for independent laboratories, physicians, and hospitals concur with the Medicare Carriers Manual and the State Medicaid Manual policies. (See Appendix III.)

Audit Objectives

This performance audit constitutes an initiative by the Auditor of Public Accounts to participate in an federal/state joint audit partnership plan led by the U.S. Department of Health and Human Services, Office of the Inspector General (HHS-OIG). The HHS-OIG began the partnership program as a collaborative effort to reduce waste, fraud, and abuse of Medicaid and Medicare funds. The audit methodology was provided by HHS-OIG and was based on similar work in other states. This audit was designed to address the following question:

- Did the Department for Medicaid Services Have Adequate Controls Over Medicaid Laboratory Payments?

[2] The Medicare program is the federal health insurance program. It provides insurance to people age 65 and over and those who have permanent kidney failure and certain people with disabilities.

Introduction

Specifically, the audit was designed to determine whether certain chemistry, hematology, and urinalysis tests were appropriately grouped (bundled into a panel or profile) and tests were not duplicated for payment purposes. This audit was conducted in accordance with Generally Accepted Government Auditing Standards as issued by the Comptroller General of the United States. Appendix I contains the scope and methodology of this performance audit.

Did the Department for Medicaid Services Have Adequate Controls Over Medicaid Laboratory Payments?

Summary

Tests performed during the audit showed that 77 of the 150 sampled items were overpaid. Each instance represents a payment error in which the Department for Medicaid Services (DMS) either (1) paid a provider for clinical laboratory tests on an individual test basis instead of as part of a group, or (2) made duplicate payments on behalf of the same recipient on the same date of service.

By projecting the results of our sample over a population of potential payment errors, we estimate that the Department overpaid providers $2,275,458 for chemistry, hematology, and urinalysis tests. The federal government's share of the potential savings would be $1,579,988 and Kentucky's portion would be $695,470. The U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG), identified the population of potential payment errors using computer assisted audit techniques.

The Medicaid payment processing systems lacked adequate controls to detect and prevent reimbursements for clinical laboratory tests that exceeded amounts allowed by Medicare. Controls such as edit routines built into computer software to screen provider billings did not always work properly. This allowed the Department for Medicaid Services to reimburse providers for laboratory services unbundled or duplicated for payment purposes.

We did not perform an information systems audit of the computer software and hardware and thus did not determine the degree to which all procedure edits were actually implemented or whether edits were turned off on occasion. We can conclude, however, that the system of controls in place for calendar years 1994, 1995, and 1996 was not working adequately in accordance with the HCFA requirements and local Medicare carrier policies for clinical laboratory services paid by Medicaid funding.

We noted that the Department was appropriately updating fee schedules for laboratory tests or making adjustments to provider payments as necessary to ensure that the proper price was paid for each test, even when an inappropriate payment for unbundling and duplicate charges occurred.

Chemistry Tests

Chemistry tests frequently performed through the use of automated equipment are grouped as a battery of tests and reimbursed at a 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 the component tests are performed. Many of the component tests of organ panels are also chemistry test panels.

Our audit showed that 20 of the 50 sampled instances contained overpayments for unbundled and other duplicated charges for chemistry panel tests. The Department's claims processing system operated by the fiscal agent did not always detect and prevent instances involving claims from providers that contained unbundled individual chemistry panel tests, a panel test plus individual panel tests, or more than one panel test. These tests should have been grouped into the appropriate panel for payment purposes and billed at a lower rate.

Did the Department for Medicaid Services Have Adequate Controls Over Medicaid Laboratory Payments?

We randomly selected 50 instances from a population of 146,775 instances involving claims containing potentially unbundled chemistry panel tests valued at $3,643,250. Based on our statistical sample, we estimate that Kentucky's Department for Medicaid Services overpaid providers $974,527 for unbundled or duplicated chemistry panel tests.

The 20 instances consisted of:

- 8 instances involving claims containing a chemistry panel and individual chemistry panel tests,
- 5 instances involving claims containing more than one individual chemistry panel tests,
- 2 instances containing duplicate chemistry panels, and
- 5 instances for duplicative charges for other reasons.

The State Medicaid Manual specifies that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. Section 5114.1.L.2 of the Medicare Carriers Manual provides that if the carrier receives claims for laboratory services in which the physician or laboratory has separately billed for tests that are available as part of an automated multichannel chemistry panel test, and in the carrier's judgement, such panel tests are frequently performed and available for physicians' use, the carrier should make payment at the lesser amount for the panel. The limitation that payment for individual tests not exceed the payment allowance for the panel is applied whether a particular laboratory has or does not have the automated multichannel equipment.[3]

Hematology Profiles

Hematology tests that are grouped and performed by using automated equipment 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 counts, 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.

Forty-one of the 50 instances contain duplicate payments for hematology profiles and indices for the same recipient on the same date of service. The hematology tests are grouped into profiles of specific hematology tests. Hematology tests can also be performed individually.

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[3]Kentucky's Medicare Carrier, AdminaStar, adopted national Medicare policy on October 1, 1995 for three additional procedure codes (82550, 84478, 82977) to be grouped in a chemistry panel for payment purposes. We identified an additional 21 of the 50 sampled instances as chemistry panel tests that were not properly grouped (unbundled and/or duplicate payments) in 1994 and 1995. They were not included as overpayments since the implementation date of the Medicare policy by Kentucky's local carrier did not occur until October 1995.

These 50 instances were selected on a random basis from a population of 196,278 instances involving claims containing potential duplicate billings of hematology tests valued at $3,987,932. Based on our statistical sample, we estimate that Kentucky's Department for Medicaid Services made duplicate payments to providers totaling $1,268,780 for hematology tests.

Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile, which already includes the individual test; or when two hematology profiles are billed for the same patient on the same date of service. Another form of inappropriate billing occurs when hematology indices are billed along with a billing for a related hematology profile.

The State Medicaid Manual specifies that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. For overpayments and duplicate bills, Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives unless found not at fault. Section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

Kentucky's Medicare Carrier implemented local policy in March of 1991 to deny payment of hematology indices when performed on the same date of service with hematology profiles. Therefore, the policy should have been used for Medicaid payment purposes as well.

In the 1997 Medicare program audit, "Clinical Laboratory Tests Performed by Independent Laboratories and Physicians;" the Department of Health and Human Services, Office of Inspector General, concluded from a survey that physicians did not order, receive, or need the additional indices that were paid by the program.

Urinalysis Tests

Urinalysis tests involve physical, chemical, or microscopic analysis or examination of urine. Urinalysis tests involve the measurement of certain components of the sample.

Fifty instances were selected on a random basis from a population of 31,852 instances involving claims containing potential duplicate billings of urinalysis tests valued at $283,100. Our review of 50 instances involving urinalysis claims disclosed that 16 of the 50 instances contained urinalysis tests that were unbundled or duplicated for payment purposes. Based on our sample results, we estimate that the Department overpaid providers $32,151 for unbundled or duplicated urinalysis tests.

A complete urinalysis includes testing for components and a microscopic examination; however, providers can perform and bill different levels of urinalysis testing. Providers may therefore perform a urinalysis with microscopic examination, a urinalysis without microscopic examination, or a microscopic examination only. Based on the test performed and billed, unbundling or duplication of billing can occur among these tests.

For instance, if both a urinalyses without microscopy is billed along with a microscopy only, the Medicare Manual specifies that a urinalysis with microscopy be billed. The charge for the combined procedure is less than the sum of the charges for the two procedures billed individually.[4]

We also noted that payments to preventive-care providers such as public health agencies are based on a rate set by Medicaid rather than a Medicare fee schedule. In five instances of our sample, health department providers were reimbursed at a rate set below the Medicare fee schedule for the same procedure. However, all five sample items were overpaid because the procedures were billed and paid for as individual tests instead of as bundled tests. The individual tests produced charges higher in total than Medicare allowed for them as bundled charges.

MMIS Edits Should Be Reviewed and Verified

Department Should Improve Controls Over Laboratory Payments

Our finding that 77 of the 150 instances in our three samples were inappropriately billed and paid demonstrates the need for improving edit controls in the MMIS. For each of the three types of laboratory tests reviewed, computer control edits were either not functioning or were inaccurately designed thereby allowing improper transactions to be processed by the MMIS.

For example, the urinalysis overpayments occurred because the providers in our sample either (1) billed for individual tests that should have been bundled and billed at a lesser charge, or (2) submitted duplicate billings for the same services. One instance we reviewed was entered manually into the MMIS for payment on March 19, 1996. Subsequently, an electronic payment was entered into MMIS and paid on June 1, 1996. If the edits had been working, the second payment would not have been allowed.

In a few instances, unbundling and/or duplicate charges also occurred when services provided to a beneficiary on the same date of service were submitted on more than one claim. The Department's Medicaid claim form provides for only six line items of services. A provider would have to submit another claim form if more than six service items were rendered. Each form is assigned a separate claim number when processed by the Medicaid fiscal agent. Computer edits should be comprehensive enough to identify unbundled or duplicate charges that are contained both within and between claims.

The hematology overpayments in our sample occurred because the providers billed for individual profiles that were part of another profile or billed for additional indices that are unallowable under the policy of Kentucky's Medicare carrier. The Department's claims processing system operated by the fiscal agent lacked the database-edit routines that could have detected the erroneous billings and prevented the overpayment.

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[4] Section 5114.1 F of the Medicare Carriers Manual states that if a urinalysis examination that does not include microscopy (CPT codes 81002 or 81003) and a microscopic only (81015) are both billed, payment should be as though the combined service (CPT code 81000 – urinalysis with microscopy) had been billed.

Did the Department for Medicaid Services Have Adequate Controls Over Medicaid Laboratory Payments?

The finding that Kentucky's MMIS computer control edits need to be improved mirrors findings in reports by the federal Department of Health and Human Service's Office of the Inspector General (HHS-OIG). The HHS-OIG identified $33.9 million in overpayments due to inadequate controls in a 1995 report covering 14 states and in a 1997 report covering 8 states.

We recommend that the Department review, add, and improve as necessary the computer control edits over laboratory test payments. To ensure that edits continually function, the Department should assign specific responsibility for periodically sampling transactions, searching for duplicate payments, and determining whether the edits are functioning properly.

Provider Manuals and Instructions Should Be Updated

Provider manuals and instructions for each type of laboratory tests should be updated to better explain the distinctions between proper and improper billing procedures. For instance, instructions for chemistry tests in the Department's Medicaid Physician Manual lists procedure codes for up to six automated multichannel tests, but does not specifically address which tests should be bundled. Further, these bundling requirements are not contained in the Department's instructions to independent laboratories or in the section of the Hospital Services Manual for outpatient laboratory services.

The Department's instruction manuals should be revised to address the specific bundling requirements. In addition, instructions to all providers should be more consistent with Medicare in that reimbursement levels should be at the lower panel rates regardless of whether the laboratory tests are performed on automated multichannel equipment or by manual grouping of the tests. These instruction manuals should also be revised to reflect the Medicare policies that prohibit the duplicate billing of hematology panels, individual tests, and indices.

We recommend that the Department review and update the provider laboratory manuals and instructions.

Overpayments Should Be Recovered From Providers

The Department should review the transactions of the providers with the largest overpayments and attempt collection of the $2.3 million in overpayments where feasible. The Department should document all decisions made with regard to the collection process including decisions not to proceed with collections. Alternatives such as third-party collectors or the withholding of future payments should be explored.

Kentucky's Medicaid program, as a jointly funded effort of the state and federal governments, receives partial reimbursement from the federal government based on the amount of expenditures reported. If the state recovers from any providers, the reported expenditures should be readjusted and the federal government portion of the Medicaid funding returned.

We recommend that the Department for Medicaid Services pursue recovery of the $2.3 million in overpayments from providers and return or credit the appropriate portion of any recoveries to the federal government.

Information Reported To the Federal Health Care Financing Administration Should Be Corrected

In 47 of the 150 instances reviewed, it appeared that an exact duplicate payment was made on behalf of the same recipient to the same provider for the same service on the same day. Since the sample of instances was pulled from the federal Medicaid Statistical Information System (MSIS) database, we sought to verify whether Kentucky's Medicaid Management Information Systems (MMIS) also indicated that duplicate payments were made.

We requested MMIS ad hoc reports and claims history on paid claims data from our sample. Those reports also showed that these payments were made twice for the same recipient, on the same date of service, with the same procedure code, to the same provider, thus appearing as duplicate payments. However, the Department for Medicaid, through its fiscal agent, could find only one record of billing and one record of remittance. The following table gives a break down of the duplicate computer entries by type of laboratory test.

Table 2. Occurrences of Duplication of Data in MSIS and MMIS

Laboratory Tests	Occurrences	Percent of Sample
Chemistry	11	22%
Hematology	6	12%
Urinalysis	30	60%
Total	**47**	**Avg. 31.33%**

Source: Auditor of Public Accounts based on a sample extracted by HHS-OIG from MSIS
These data were not included in our estimates of recovery.

These 47 instances differed from the 77 instances used to calculate the $2.3 million in identified overpayments. In the case of duplicate billing for the 77 instances, we obtained multiple billing and/or remittance records. The agency responded that they found only one billing or remittance for the 47 instances. They said that true duplicates did not exist and that there was a programming/reporting problem that caused duplicate information to be displayed on the ad hoc reports. The agency's complete explanation is provided in Appendix VI.

Given that most of the sample of suspect duplicates were from a period of time prior to the contract with Kentucky's current fiscal agent, Unisys, we could not determine why these paid claims are duplicates in the MSIS.[5] We did not include these instances in our calculated overpayments.

We recommend that the Department for Medicaid Services determine what is causing duplicate paid claims to be reported to HCFA and whether reliable information is being submitted to the MSIS. The lack of adequate information could cause inaccurate statistical information published by HCFA regardless of whether the claims are true duplicates for financial reporting.

Fee Schedules Were Updated Correctly

Medicaid claims for clinical laboratory services are reimbursed according to fee schedules allowable by the Medicare program or reimbursed according to rates set by state Medicaid policy. We determined that payments based on a fee schedule were correct, or where outdated fee schedules were used on initial payments, adjustments were made to correct the payment. We also determined that rates were in compliance with the Department of Medicaid's rate policy. (See Appendix I.)

[5] There were real duplicate payments made during the tenure of Unisys; however, we were able to find documentation to confirm that adjustments had been made to those claims. We also obtained evidence of additional edits that were implemented and completed in 1997 that corrected this inadequate control for duplicates made in 1996.

Did the Department for Medicaid Services Have Adequate Controls Over Medicaid Laboratory Payments?

Recommendations

We rec mmend that Kentuc' y Cabinet for Health Services, Department for Medicaid Services:

(1) Review, add, and improve as necessary the Medicaid Management Information System computer edit controls that identify improperly billed laboratory tests.

(2) Monitor the results of the computer edit control updates and establish procedures and specific responsibility within the Department for Medicaid Services for periodically verifying the accuracy of the computer edits in the Medicaid Management Information System.

(3) Update the provider manuals and billing instructions to reflect Medicaid bundling and duplicate payment requirements.

(4) Pursue recovery of the $2.3 million of overpayments where feasible. Document the basis for decisions to attempt or not attempt recoveries.

(5) Upon recovery of funds from providers, make adjustments on the Quarterly Report of Expenditures to the federal Health Care Financing Administration for the federal share of Medicaid funds.

(6) Determine the cause of duplicate data being submitted to HCFA's Medicaid Statistical Information System and correct the problem.

Response to Agency Comments

Representatives of the Kentucky Cabinet for Health Services, Department for Medicaid Services, generally agreed with all of the recommendations noted above. However, we want to clarify information noted in response to recommendations 4 and 6.

As a follow-up to recommendation 4, the Auditor of Public Accounts can provide specific claim data for the overpayments found in the sample selected during our audit. However, we can only provide a list of providers from the population of potential overpayments. The retrieval of claims and remittance advices for these potential overpayments is the responsibility of the agency.

The duplicate data referred to in recommendation 6 are the 47 instances noted on page 10 of our audit. We could not find duplicate claims and duplicate remittances for these 47 instances and therefore did not include them as overpayments. As noted in the body of our audit, these duplicate data were found in both Kentucky's Medicaid Management Information System as well as the Medicaid Statistical Information System. The information appeared in the agency's ad hoc reports of sample instances requested by our office. The agency responded that a programming/reporting problem caused duplicate data to be displayed as noted in Appendix VI.

The agency's response states that footnote 5 on page 11 shows that a duplicate situation existed for a period and that it was corrected and adjustments were made to these claims. The footnote is referring to true duplicates with supporting documentation for both the claim and the adjustment. The footnote is used to show the difference between supported duplicate claims and adjustments and the

duplicated data in both MMIS and MSIS that could not be explained by hard-copy documentation. There would not be a need for adjustments if this were a programming/reporting problem rather than actual duplicate payments. It appears that some data in both MMIS and MSIS are incorrect for the period of our audit. It is necessary for the agency to resolve this problem in order to ensure that reliable information is submitted to HCFA.

The complete text of the official comments by the Cabinet for Health Services, Department for Medicaid Services is included in its entirety as Appendix VII.

Scope and Methodology

Appendix I

Scope

We conducted our audit in accordance with generally accepted government auditing standards. It was conducted in cooperation with the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services, using methodology and guidance provided under the auspices of the "Partnership Plan (for) Federal/State Joint Audits of the Medicaid Program." The audit's purpose was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers for clinical laboratory services.

Our audit was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests for the calendar years 1994, 1995, and 1996. The HHS-OIG provided the Auditor of Public Accounts with a statistical sample. Fieldwork was performed by the Auditor of Public accounts between June 15, 1998 and November 17, 1998.

Based on results of fieldwork, the HHS-OIG, Office of Audit Services projected an estimated recovery that the Department for Medicaid should recover from providers.

The scope of the audit was limited to the effectiveness of management controls as they relate to the edit/audit system of claims processing in accordance to HCFA's Medicaid clinical laboratory requirements and by Medicare, Part B policy. We did not assess the completeness of data in MMIS files nor did we evaluate the adequacy of input controls. Also, we did not review the controls and edits for the Clinical Laboratory Improvement Amendments (CLIA).

Methodology

We tested our sample to determine the propriety of the payments made to providers by the Kentucky Department for Medicaid Services (DMS). The reliability of the computer-generated data was tested by comparing randomly selected instances to source documents provided by the DMS through its fiscal agent, Unisys. The following source documents were reviewed:

- Billing Claims for all sample items (HCFA 1500 and UB 92),
- Related Remittance Statements (Advices),
- Ad hoc reports from MMIS,
- On-site screens and printed screens from Kentucky's paid claims history file,
- Fee schedules for 60 percentile and 62 percentile from Kentucky's Medicare Carrier (AdminaStar, Inc)., and the Kentucky's Claim History File (from Independent Labs and MMIS Sections). We compared the Medicare Carriers' fee schedules printout to actual history file fees in the system, and
- Rates set by Agency for Provider 20.

We reviewed the following federal and state laws and regulations relating to clinical laboratories:

- State Medicaid Manual,
- Medicare Carriers Manual,
- Related Kentucky Revised Statutes and Kentucky Administrative Regulations,
- Sections of Medicare Intermediary Manual,

- Local Medicare Carriers' Bulletins relating to policy,
- Physicians' Current Procedural Terminology for calendar years 94, 95, and 96,
- Audit Guide of HHS-OIG relating to clinical services, and
- State Plan for Clinical Laboratory Services.

Our review of internal controls was limited to an evaluation of that part of the claims processing function that related to claims for clinical laboratory services. We reviewed DMS policies and procedures and instructions to providers related to the billing of clinical laboratory services. We also reviewed DMS documents relating to manual and automated edits for bundling of chemistry and urinalysis tests and the detection of duplicate claims for both hematology and urinalysis tests. Specifically, we reviewed the following:

- Independent Laboratory and Other Lab and X-Ray Services Manual,
- Physicians Manual,
- Hospital Services Manual,
- HCFA 1500 and related billing instructions to independent laboratories and physicians,
- UB-92 and related billing instructions for hospitals,
- Provider agreements,
- Interagency agreements relating to rate setting,
- Electronic filing agreements,
- Other MAP forms included in manuals,
- Request for Proposal relating to Unisys' (fiscal agent) to implement edit/audit system for Medicaid payments,
- GMIS (HBOC) ClaimCheck documents relating to edit/audits that affect clinical laboratory services (specifically, edits for bundling of chemistry and urinalysis tests and the detection of duplicate claims for both hematology and urinalysis tests), and
- MMIS Pricing Manual.

We also reviewed the following information:

- Clinical laboratory audits from other states and
- HHS-OIG's " Review of Clinical Laboratory Tests Performed by Independent Laboratories and Physicians."

We limited our review to claims paid by the DMS during calendar years 1994 through 1996. Details of the methodology used in selecting and appraising the sample are contained in the following section.

Sample Selection and Analysis

Computer generated applications were used to extract from the Health Care Financing Administration's (HCFA) Medicaid Statistical Information System (MSIS) paid claims file for calendar years (CY) 1994, 1995, and 1996 containing:

- Automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physicians' Current Procedural Terminology (CPT) manual (See APPENDIX II),
- Hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT manual (See APPENDIX II), and
- Urinalysis and component tests listed in the CPT manual (See APPENDIX II).

The above file extract yielded a total of $24,428,386 in payments for chemistry, hematology, and urinalysis tests in CY's 1994, 1995, and 1996. This total consisted of 669,139 records totaling $9,152,791 relating to chemistry panel tests, 1,113,357 records totaling $12,638,258 relating to hematology profile tests, and 762,409 records totaling $2,637,337 relating to urinalysis tests.

Then computer applications were performed to extract 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 different 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 and microscopy, a urinalysis without microscopy, or a microscopy only.

The above file extract yielded a total of $7,914,282 in payments for chemistry, hematology, and urinalysis tests in CY's 1994, 1995, and 1996. This total consisted of 146,775 instances totaling $3,643,250 relating to chemistry panel tests, 196,278 instances totaling $3,987,932 relating to hematology profile tests, and 31,852 instances totaling $283,100 relating to urinalysis tests.

Each instance is a potential payment error in which the Department for Medicaid Services paid more than Medicare would have paid to providers for clinical laboratory tests, which were billed individually instead of as part of a group, or were duplicative (on behalf of the same beneficiary on the same date of service).

On a scientific stratified random selection basis, we examined 150 instances involving claims from three strata. The first stratum consisted of a randomly generated statistical sample of 50 potentially unbundled instances involving chemistry panel tests totaling $1,321.19. The second stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving hematology profiles or profile component tests totaling $1,006.95. The third stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving urinalysis tests totaling $447.32.

For the sample items, we requested and reviewed supporting documentation from the Department for Medicaid Services consisting of copies of physician, hospital or independent laboratory claims; electronic paid claims detail for claims submitted electronically; explanation of benefits paid; and related paid claims history.

A standard scientific estimation process was used to quantify overpayments for unbundled chemistry panel tests and duplicate hematology profile tests, and unbundled or duplicate urinalysis tests, as shown in the following tables:

Table 3: Audit Findings—Evaluation of Sample from Calendar Years 1994, 1995, and 1996

Stratums	Number of Instances	Number Sampled	Examined Value	Number with Over-payments	Overpayments in Sample	Estimated Recovery
Chemistry Tests	146,775	50	$1,321.19	20	$331.98	$ 974,527
Hematology Tests	196,278	50	1,006.95	41	323.21	1,268,780
Urinalysis Tests	31,852	50	447.32	16	50.47	32,151
Totals	**374,905**	**150**	**$2,775.46**	**77**	**$705.66**	**$2,275,458**

Source: Auditor of Public Accounts and U.S. Department of Health and Human Service, Office of the Inspector General

The results of the scientific sample of chemistry tests disclosed that 20 of 50 instances we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $974,527 paid for unbundled chemistry panel tests could be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 39.92 percent.

The results of the scientific sample of hematology tests disclosed that 41 of the instances we reviewed contained duplicate payments for hematology profiles and profile component tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $1,268,980 in

duplicate payments for hematology profile tests could be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 16.84 percent.

The results of the scientific sample of urinalysis tests disclosed that 16 of the 50 instances we reviewed represented overpayments for unbundled and duplicate urinalysis tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $32,151 paid for unbundled and duplicate urinalysis tests could be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 39.36 percent.

A variable sample appraisal methodology was used to estimate the amount of overpayment for chemistry, hematology, and urinalysis tests for the calendar years 1994, 1995, and 1996.

Review of Fee Schedules

We obtained fee schedules from the Kentucky Medicare Carrier and later retrieved fees from the Department for Medicaid Services' claims history file. We matched fee schedules to determine if the agency was monitoring and updating fees submitted on electronic tapes by the Medicare Carrier. All fee schedules appeared to match.

We examined fees in our sample of 150 chemistry, hematology and urinalysis laboratory tests. We found that on several occasions the wrong fee was used; however, adjustments were made at a later date. According to agency staff, the new fee schedules may not be implemented at the date the fee changes (usually the beginning of a calendar year); however, mass adjustments are made at a later date to correct the wrong fee. We found this to be true. In only one instance could we not find an adjustment for the initial incorrect fee charged.

Further, payments to preventive care providers (Type 20 - health departments) are based on a set rate by the agency rather than a Medicare fee schedule. The Department for Medicaid Services and the Department for Public Health (formerly the Department for Health Services) sign an Interagency Agreement. We also obtained those rates set for calendar years 1994, 1995, and 1996 for the specific procedure codes in our audit. We had five payments made to these type providers. We confirmed that the rates were set below the fee schedule requirements. Therefore, we conclude that the agency is using the correct laboratory rates according to requirements set out in the State Medicaid Manual.

CPT Codes Included in Scope of Audit

Appendix II

The following CPT codes from the Health Care Financing Administration's Common Procedural Coding System were reviewed for unbundling and duplicate charges:

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

CHEMISTRY

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

CPT Codes	*Individual Chemistry Tests Subject to Paneling CPT Codes*
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
82947	Glucose
83610, 83615, 83620, 83624	Lactic Dehydrogenase (LDH)
84075	Alkaline Phosphate
84100	Phosphorus
84132	Potassium
84155, 84160	Total Protein
84295	Sodium
84450, 84455	Transaminase (SOGT)
84460, 84465	Transaminase (SGPT)
84520	Uric Acid

84478	*Triglycerides
82550	* reatinine Phosphokir ıse (CPK)
82977	*Glutamyl transpetidase, gamma

HEMATOLOGY PROFILES AND COMPONENTS

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

CPT Codes	*Hematology Component Test CPT Codes*
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)

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

URINALYSIS

CPT Codes	*Urinalysis and Component Test CPT Code Description*
81000	Urinalysis (complete) with microscopy
81002, 81003	Urinalysis without microscopy
81015	Urinalysis microscopic only

*Added by Kentucky's Medicare Carrier by policy effective 10-1-95

State statutes, regulations, and policies

[illegible]

[illegible]

Medicaid

[illegible] Medicaid Program shall [illegible] independent laboratory for any service at a rate which exceeds: (1) the laboratory's actual charge for the service, or (2) The Title XVIII Part B (Medicare) reasonable or prevailing charge for the service.

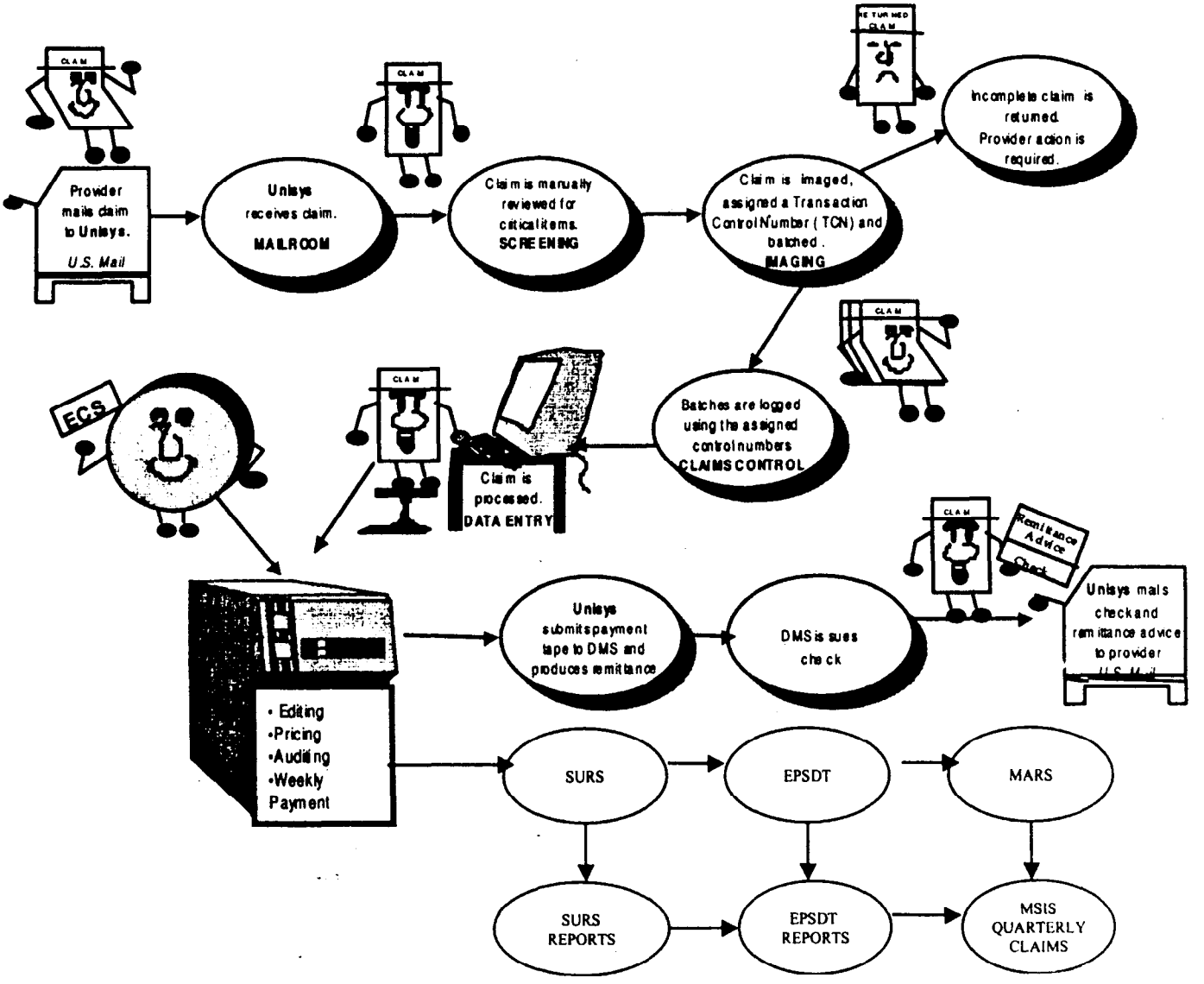
Physician Manual, Kentucky Medicaid Program

Reimbursement for physician laboratory services shall be based on the lesser of the physician's usual and customary actual billed charges, or Medicare allowable rates. For laboratory services with no established allowable payment rates, reimbursement shall be based on sixty-five (65) percent of the usual and customary actual billed charges.

Hospital Services Manual

The Deficit Reduction Act of 1984 requires hospital outpatient and nonpatient laboratory services to be paid in accordance with a fee schedule. It states that there will be a separate fee schedule for outpatient laboratory services and a separate fee schedule for nonpatient laboratory services.

CLAIM FLOW



Source: Kentucky Department for Medicaid Services

CLAIMCHECK VERSION EDITS

[illegible]

- [illegible] ClaimCheck (currently HTCC/ClaimCheck) included rebundling edits for [illegible] 85021-85027, in Database Version [illegible] and released in [illegible] following [illegible] implementation [illegible] Medicare [illegible]

[illegible] implementation in that quarter or later for the [illegible] procedures in our [illegible]

[illegible]

- The ClaimCheck database contains no edit relationship between procedure codes [illegible] and codes 85029-85030.

However, the Kentucky Medicaid carrier denied claims with [illegible] and related indices as far back as March 1991.

- ClaimCheck included edits for rebundling (mutually exclusive) relationships between 85029 and 85030 indices by the third CY quarter of 1995 (Version 16).

- ClaimCheck had had a rebundled relationship between 85021-85027 since at least the first quarter of 1994 (Version 13). Therefore, this relationship edit should have existed in initial implementation of July 1994.

However we detected an instance in our sample in which two or more hematology profiles were billed separately after that date.

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

TO : Margaret Hurst
Auditor
Office of Public Accounts

FROM: Kay Kirkland KK/MR
Acting Director
Division of Financial Management & Analysis

DATE: October 16, 1998

SUBJECT: Request for Source Documents

Enclosed please find copies of the source documents you requested for the audit you are conducting. Copies of any credit or adjustment documentation is also included.

As previously discussed with you, the original report used to select the samples, contained duplicate Transaction Control Numbers(TCN). These claims were not actual duplicates, but were displayed on the report as a result of a file storage problem that caused the TCNs to report more than once. At the time the reports were produced three years of history were stored on VSAM disk files, and two years were stored on tape. Each month a new month of history is added to the VSAM files and the oldest month is dropped from the VSAM and added to tape. Also at this time certain specified claims are added to a LifeTime file. When reports were produced at that time they used all three files. The tape files and the Life Time files contained some duplicate data causing duplicate claims to appear on the reports. Since that time all data used for reporting purposes are contained on VSAM files, eliminating this problem.

Attached are copies of the Audit Report, with duplicate audits highlighted, produced for this time period that indicates the audit were in place and were performing as designed for that time period.

Also included is a copy of the results of the most recent Systems Performance Review(SPR), prepared by the Health Care Financing Administration showing duplicate claim edits were present and the system had no errors for the records checked during the review period. For this factor the MMIS scored 300 out of a possible 300 points.

If you require additional information contact Keith Morris of my staff.

KK:KM

cc: Mary Rhodes
Peggie Goff
Keith Morris

CABINET FOR HEALTH SERVICES
COMMONWEALTH OF KENTUCKY
FRANKFORT, 40621-0001

DEPARTMENT FOR MEDICAID SERVICES
"An Equal Opportunity Employer M/F/D"

June 9, 1999

Harold McKinney, Acting Director
Auditor of Public Accounts
Performance Audit Division
2501 Georgetown Road, Suite 2
Frankfort, Kentucky 40601-5539

Dear Mr. McKinney:

We appreciate the opportunity to review and comment on the draft audit "Post Payment of Clinical Laboratory Services."

The following is the Department for Medicaid Services responses relative to the recommendations listed on page twelve of the report.

Recommendation #1:

Review, add, and improve as necessary the Medicaid Management Information System computer edit controls that identify improperly billed laboratory tests.

Response:

The Department for Medicaid Services agrees with the audit results and recommendations and recognizes the need for improvement. DMS currently review the system edits through weekly cycle reports, a claim sampling process, and discrepancies received from policy staff, fiscal agent staff and the provider community. As a result of the audit findings, DMS will monitor the edit process more closely to identify areas in need of improvement. Additionally, a unit will be put in place at our fiscal agent, which is UNISYS, for detection of erroneous billing. This unit will assist the Department in monitoring all areas of the MMIS including but not limited to identifying improperly billed laboratory tests.

Recommendation #2:

Monitor the results of the computer edit control updates and establish procedures and specific responsibility within the Department for Medicaid Services for periodically verifying the accuracy of the computer edits in the Medicaid Management Information System.

Page two

Response:

Response is same as #1.

Recommendation #3:

Update the provider manuals and billing instructions to reflect Medicaid bundling and duplicate payment requirements.

Response:

The Physician and Preventive Health manuals have been updated. The Department is currently in the process of reviewing the remainder of the provider manuals and will update as necessary.

Recommendation #4:

Pursue recovery of the $2.3 million of overpayments where feasible. Document the basis for decisions to attempt or not attempt recoveries.

Response:

Prior to the Department for Medicaid Services requesting recoupment of overpayments, specific claim documentation by provider should be provided to the Department for review. The Department must have specific claim data on which to base a request for repayment of any over-payments, rather than an extrapolation of a sample of the population. The need for this information was verbalized during the exit conference of May 28, 1999, with you, and Margaret Hurst, of your staff and Duane Dringenburg, Neville Wise, Betsy Dunnigan, and Cheryl Brady of my staff. Further response to this recommendation will be forwarded upon completion of the Department's review of the claim data of all instances of overpayment identified during your audit.

Recommendation #5:

Upon recovery of funds from providers, make adjustments on the Quarterly Report of Expenditures to the federal Health Care Financing Administration for the federal share of Medicaid funds.

Response:

All funds that may be recovered via the detection of overpayments will be accurately refunded to HCFA. The Department will calculate the benefits match rate in effect at the time of original payment and return the HCFA federal share match.

Page three

Recommendation #6:

Determine the cause of duplicate data being submitted to HCFA's Medicaid Statistical Information System and correct the problem.

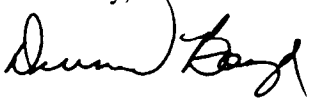
Response:

Review of the submission standards for the MSIS reflects that HCFA's data center apply stringent submission rules to the files that are allowed into the National Medicaid claims data base, Kentucky complies with all these standards. While the MSIS submission will be monitored more closely as a result of the audit findings, it is the understanding of Medicaid staff that when or if a true duplicate claim is paid, that claim would be accepted via the MSIS submission standards. The correction to this erroneous payment is only reflected in the first quarterly submission of the MSIS tapes where there has been a void and recoupment performed on these claims. Therefore, a long view of the accumulated HCFA files are required before it can be stated there is incorrect data being sent to HCFA. The submission rules allow for subsequent submissions of voids, credits and other claims adjustments to the MSIS, also known as the 2082 Tape option. As footnote 5 on page 11 of the Performance audit shows that a duplicate situation existed for a period, it states that it was corrected and adjustments were made to these claims. The quarter after the adjustments are made they would be forwarded to HCFA, at that time it is possible for the MSIS to match the adjustments to the original paid claims and thus correct any apparent reporting anomalies.

The Department for Medicaid Services will continue to monitor the MSIS submissions closely, to guard against any incorrect submissions.

Should you have any questions relative to the responses, you may contact Betsy Dunnigan or Deborah Green at (502)564-6511.

Sincerely,



Dennis Boyd
Commissioner

DB/pm

cc: Betsy Dunnigan
Deborah Green

Auditor of Public Accounts Information

Appendix VIII

Contributors To This Report

Edward B. Hatchett, Jr., Auditor of Public Accounts

Harold McKinney, Acting Director of Performance Audit
James A. Rose III, CPA, CGFM, Former Director, Division of Performance Audit
Margaret Hurst, CPA, Performance Auditor
Bill Moore, CFE, Performance Auditor

Obtaining Audit Reports

Copies of this report or other previously issued reports can be obtained for a nominal fee by faxing the APA office at 502-564-2912. Alternatively, you may

order by mail:	Report Request Auditor of Public Accounts 144 Capitol Annex Frankfort, Kentucky 40601
visit :	8 AM to 4:30 PM weekdays
email:	Hatchett@apa1.aud.state.ky.us
browse our web site:	http://www.state.ky.us/agencies/apa

Services Offered By Our Office

The staff of the APA office performs a host of services for governmental entities across the state. Our primary concern is the protection of taxpayer funds and furtherance of good government by elected officials and their staffs. Our services include:

Performance Audits: The Division of Performance Audit conducts performance audits, performance measurement reviews, benchmarking studies, and risk assessments of government entities and programs at the state and local level in order to identify opportunities for increased efficiency and effectiveness.

Financial Audits: The Division of Financial Audit conducts financial statement and other financial-related engagements for both state and local government entities. Annually the division releases its opinion on the Commonwealth of Kentucky's financial statements and use of federal funds.

Investigations: Our fraud hotline, 1-800-KY-ALERT (592-5378), and referrals from various agencies and citizens produce numerous cases of suspected fraud and misuse of public funds. Staff conduct investigations in order to determine whether referral of a case to prosecutorial offices is warranted.

Training and Consultation: We annually conduct training sessions and offer consultation for government officials across the state. These events are designed to assist officials in the accounting and compliance aspects of their positions.

General Questions

General questions should be directed to Donna Dixon, Intergovernmental Liaison, at (502) 564-5841 or the address above.