



JUN 20 2001

Memorandum

Date

From

Subject

To

Thomas D. Roslewicz

Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Review of Fee Schedules Used for Reimbursement of Clinical Laboratory Services -
Connecticut Medicaid Program (A-01-01-00003)

Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare and Medicaid Services

This memorandum is to alert you to the issuance on **Friday, June 22, 2001** of our final report. A copy is attached.

We suggest you share this report with the Centers for Medicare and Medicaid Services (CMS) components involved with program integrity, provider issues, and contractor oversight, particularly the Center for Medicaid and State Operations.

The objective of the review was to determine the adequacy of the Connecticut Department of Social Services' (State agency) procedures and controls over Medicaid payments for clinical laboratory and pathology services. Specifically, we determined whether the State agency payments for these services exceeded Medicare fee schedule limits.

Our review showed that, contrary to Medicaid reimbursement requirements, the State agency's Medicaid reimbursements to providers for clinical laboratory and pathology services exceeded what the Medicare program recognizes as reimbursement for the same services. We found that the State agency had not updated their clinical laboratory fee schedule since 1994. However, during this time, Medicare fee schedules for many services had actually decreased. Our analysis of State agency payments made during the period January 1996 through December 1999 for clinical laboratory and pathology services showed overpayments totaling \$2,823,505 (\$1,411,752 Federal share) were made for these services.

We recommended that the State agency (1) implement procedures to update clinical laboratory fee schedules on a regular basis to ensure that amounts paid for clinical laboratory services do not exceed amounts that Medicare pays for the same services and (2) make a financial adjustment on the next Quarterly HCFA-64 Report of Title XIX expenditures in the amount of \$2,823,505 (\$1,411,752 Federal share). In its response to the draft report, the State agency agreed that Connecticut's Medicaid reimbursement exceeded the Medicare fee schedule limits. The State agency stated that it will adjust its next Quarterly HCFA-64

Page 2 - Neil Donovan

Report of Title XIX expenditures as recommended and also took action to update its laboratory fee schedule annually by obtaining the relevant information from Medicare.

Please note that the attached report was fully processed before the name change was made from the Health Care Financing Administration (HCFA) to the Centers for Medicare and Medicaid Services (CMS). Thus, references are made to HCFA.

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or Michael J. Armstrong, Regional Inspector General for Audit Services, Region I, at (617) 565-2689.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF FEE SCHEDULES USED
FOR REIMBURSEMENT OF CLINICAL
LABORATORY SERVICES -
CONNECTICUT MEDICAID PROGRAM**



**JUNE 2001
A-01-01-00003**



DEPARTMENT OF HEALTH & HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

CIN: A-01-01-00003

Ms. Patricia A. Wilson-Coker
Commissioner
State of Connecticut
Department of Social Services
25 Sigourney Street
Hartford, Connecticut 06106

Dear Ms. Wilson-Coker:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services' (OIG/OAS) report entitled, "Review of Fee Schedules Used for Reimbursement of Clinical Laboratory Services - Connecticut Medicaid Program." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG/OAS reports issued to the Department's grantees and contractors are made available to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR part 5.)

To facilitate identification, please refer to Common Identification Number A-01-01-00003 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosures - as stated

Page 2 - Ms. Patricia A. Wilson-Coker

Direct Reply to HHS Action Official:

Ronald Preston
Associate Regional Administrator
Division of Medicaid and State Operations
Health Care Financing Administration
Room 2275, JFK Federal Building
Boston, Massachusetts 02203

EXECUTIVE SUMMARY

BACKGROUND

Medicaid is a Federally aided State program established under Title XIX of the Social Security Act and provides medical assistance to certain individuals and families with low incomes and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of the Health Care Financing Administration (HCFA). In Connecticut, the Department of Social Services (State agency) is responsible for administering the Medicaid program. Under the Medicaid program, States are required to provide certain medical and other services such as clinical laboratory and pathology services. Reimbursement for these services falls within the guidelines of HCFA's State Medicaid Manual. Specifically, the State Medicaid Manual states that Federal matching funds will not be available to the extent a State pays more for laboratory tests performed by a physician, hospital outpatient laboratory, or an independent laboratory than the amount the Medicare program recognizes for such tests.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of our review was to determine the adequacy of the State agency's procedures and controls over Medicaid payments for clinical laboratory and pathology services. Specifically, we determined whether State agency payments made between January 1996 and December 1999 for these services exceeded Medicare fee schedule limits.

SUMMARY OF FINDINGS

Our review showed that, contrary to Medicaid reimbursement requirements, the State agency's Medicaid reimbursements to providers for clinical laboratory and pathology services exceeded what the Medicare program recognized as reimbursement for the same services. We found that the State agency had not updated their clinical laboratory fee schedule since 1994. However, during this time, Medicare fee schedules for many services actually decreased. Our analysis of State agency payments made during the period January 1996 through December 1999 for clinical laboratory and pathology services showed overpayments totaling \$2,823,505 (\$1,411,752 Federal share) were made for these services.

RECOMMENDATIONS

We recommended that the State agency:

- (1) Implement procedures to update clinical laboratory fee schedules on a regular basis to ensure that amounts paid for clinical laboratory services do not exceed amounts that Medicare pays for the same services; and
- (2) Make a financial adjustment on the next Quarterly HCFA-64 Report of Title XIX expenditures in the amount of \$2,823,505 (\$1,411,752 Federal share).

STATE AGENCY COMMENTS

In its response to the draft report, the State agency agreed that Connecticut's Medicaid reimbursement exceeded the Medicare fee schedule limits. The State agency stated that it will adjust its next Quarterly HCFA-64 Report of Title XIX expenditures as recommended. The State agency also took action to update its laboratory fee schedule annually by obtaining the relevant information from Medicare.

STATE AGENCY COMMENTS

In its response to the draft report, the State agency agreed that Connecticut's Medicaid reimbursement exceeded the Medicare fee schedule limits. The State agency stated that it will adjust its next Quarterly HCFA-64 Report of Title XIX expenditures as recommended. The State agency also took action to update its laboratory fee schedule annually by obtaining the relevant information from Medicare.

TABLE OF CONTENTS

	Page
INTRODUCTION	1
BACKGROUND	1
OBJECTIVE, SCOPE, AND METHODOLOGY	1
FINDINGS AND RECOMMENDATIONS	2
REIMBURSEMENT REQUIREMENTS FOR CLINICAL LABORATORY SERVICES	3
MEDICAID REIMBURSEMENTS EXCEEDED MEDICARE FEE SCHEDULES	4
RECOMMENDATIONS	5
STATE AGENCY COMMENTS	6
OIG/OAS RESPONSE	6
APPENDIX - STATE AGENCY COMMENTS TO DRAFT REPORT	

INTRODUCTION

BACKGROUND

Medicaid is a Federally aided State program which provides medical assistance to certain individuals and families with low incomes and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of the Health Care Financing Administration (HCFA). Medicaid, as established under Title XIX of the Social Security Act, requires States to provide certain medical and other services such as outpatient clinical laboratory tests. In Connecticut, the Department of Social Services (State agency) is responsible for administering the Medicaid program.

Laboratory and pathology tests are performed by providers on a patient's specimen to help physicians' diagnose and treat ailments. These tests are identified by the HCFA Common Procedural Coding System (HCPCS) under codes 80002 through 89399. Pathology tests involve the examination of cells, tissues, or organs. 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 content. Urinalysis tests involve the measurement of certain components of the sample, which may also include a microscopic examination.

Testing for laboratory and pathology services may be performed in a physicians office, a hospital outpatient laboratory, or by an independent laboratory. These providers submit claims for laboratory services performed on Medicaid recipients. Claims processing is the responsibility of a designated Medicaid agency in each State. The State agency contracted with Electronic Data Processing Services, Inc. to process medical service claims for reimbursement under the Medicaid program in Connecticut.

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, hospital outpatient laboratory, or an independent laboratory than the amount Medicare recognizes for such tests. Under Medicare, clinical laboratory services are reimbursed at the lower of the fee schedule amount or the actual charge. The Medicare carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains the fee schedule for these services and provides it to the State Medicaid agency in its locality. The United HealthCare Insurance Company was the Medicare Part B Carrier for the State of Connecticut during the period of this review. Guidelines for processing provider claims are contained in HCFA's Medicare Carriers Manual.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine the adequacy of the State agency's procedures and controls over Medicaid payments for clinical laboratory and pathology services. Specifically, we determined whether State agency reimbursements for these services exceeded Medicare fee schedule limits. In this regard, we identified all HCPCS between 80002 and 89399 for which the State agency Medicaid reimbursement rates were more than the Medicare fee schedule rates.

We extracted from the State agency's paid claims files all clinical laboratory and pathology services paid during the period January 1996 through December 1999. From this extract, we:

- C computed the allowable Medicare total payment by multiplying the number of Medicaid services per HCPCS code by the Medicare fee schedule amount;
- C calculated the difference per HCPCS code of the amount paid by the State agency and the allowable Medicare limit; and
- C identified the total amount the State agency paid in excess of Medicare.

To test the reliability of computer generated output, we compared data to source documents for a judgmental sample of items and reviewed supporting documentation from the State agency detail payment history files to determine the propriety of the payments made for sample items.

We recently performed another audit of State agency payments of clinical laboratory services. The scope of the audit included 60 chemistry, hematology and urinalysis HCPCS that were subject to unbundling and/or duplicate payments. The results of this audit are included in the report entitled, "Follow Up Review of Reimbursements for Clinical Laboratory Services Connecticut Medicaid Program" (A-01-00-00003). In addition to determining overpayments that were related to unbundling and/or duplicate payments, we also determined that a portion of the overpayments were related to reimbursements in excess of the Medicare fee schedule. As a result, we excluded these specific overpayment amounts from the scope of our current audit.

We performed our review between April and October 2000 at the State agency's main office in Hartford, Connecticut.

FINDINGS AND RECOMMENDATIONS

According to the State Medicaid Manual, Federal matching funds will not be available to the extent a State pays more for outpatient clinical laboratory services provided by a physician, hospital outpatient laboratory, or an independent laboratory than the amount the Medicare

program recognizes for such services. Our review showed that the State agency's Medicaid reimbursements to providers for clinical laboratory and pathology services were in excess of what the Medicare program recognizes as reimbursement for these services. Our analysis of State agency payments made during the period January 1996 through December 1999 for services included in HCPCS 80002 through 89399 showed overpayments totaling \$2,823,505 (\$1,411,752 Federal share) were made for these services.

Policy for the reimbursement of clinical laboratory services under the Medicaid program is based on provisions governing the Medicare program. 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 tests performed for an individual enrolled under part B of title XVIII [Medicare]...."

Section 5114.1 of the Medicare Carriers Manual specifies that payment for these type of tests are reimbursed on the basis of fee schedules. Specifically, section 5114.1B states:

"For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology...."

This section of the Carriers Manual also notes that certain tests included in this series are not subject to fee schedule provisions. For purposes of our analysis, we excluded these HCPCS codes.

Section 6300.1 of the State Medicaid Manual further discusses Medicaid reimbursement requirements as follows:

"...clinical 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...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:

“...Medicare fee schedules will be updated on January 1 of each year. The Medicare fee schedules...will be furnished to the State Medicaid agency on magnetic tape by the Medicare carriers within the respective State....”

MEDICAID REIMBURSEMENTS EXCEEDED MEDICARE FEE SCHEDULES

We found that the State agency's Medicaid reimbursements to providers for clinical laboratory and pathology services were in excess of what the Medicare program recognizes as reimbursement for these services. As part of our review, we extracted from the State agency's paid claims files all clinical laboratory and pathology services paid during the period January 1996 through December 1999. During this period the State agency paid for 688 different clinical laboratory and pathology service codes included in HCPCS 80002 through 89399. Of these codes, we identified 628 codes in which the State agency fee schedule exceeded what Medicare pays for the same services at some time during our audit period. Examples of some of the overpayments follows:

HCPCS	State Agency Payment	Medicare Fee Schedule	Amount Overpaid Per Service
80061	\$29.61	\$18.51	\$11.10
82553	37.19	15.95	21.24
83898	108.47	23.17	85.30
84443	27.01	23.21	3.80
85025	12.40	10.74	1.66

To determine the amount overpaid by the State agency, we identified all services that included clinical laboratory HCPCS that were paid by the State agency at rates per service that exceeded the amount recognized as the Medicare allowable rate of payment. We determined the total number of services and payments made by the State agency for each HCPCS that exceeded the Medicare rate. We multiplied the number of paid services by the Medicare allowable rate of payment and determined the difference between the State agency payments and the allowable Medicare payments. For example, the State agency paid 8,399 services for HCPCS 80101 in

Calendar Year 1998 that were in excess of what the Medicare fee schedule allowed. As a result, providers were overpaid as follows:

State Agency Paid	\$ 180,093
Medicare Allowed (8,399 x \$19.03/service)	<u>159,833</u>
Amount Overpaid for HCPCS 80101	\$ <u>20,260</u>

Overall, we found that the State agency overpaid providers \$2,823,505 (\$1,411,752 Federal share) during the period January 1996 through December 1999 for services included in HCPCS 80002 through 89399 as follows:

Calendar Year	# of HCPCS Overpaid	Amount Overpaid
1996	552	\$ 663,225
1997	480	337,553
1998	535	1,063,904
1999	504	758,823
Total Overpayments		\$2,823,505

We determined that the 60 HCPCS with the highest volume of overpayments accounted for about 75 percent of the total overpayments.

We found that the State agency had not updated their clinical laboratory fee schedules for hospital outpatient laboratory services since 1993 and for independent laboratory services since 1994. As a result, the amounts used to reimburse clinical laboratory services were greater than what the Medicare fee schedules allowed for the same services. Discussions with State agency personnel regarding this issue showed that they believed fees for these laboratory services were increasing each year and that, by not updating the fee schedules, savings on these reimbursements would accrue. However, because of technological improvements that made it more efficient to process these type of laboratory tests, the costs of performing the tests decreased. As a result, the Medicare program took advantage of the decreases by reducing its fee schedules used for reimbursing these services. State agency officials stated that the fee schedule used for independent laboratories was finally updated in December 1998 and for hospital outpatient laboratories in July 2000. To avoid such overpayments, we believe the State agency should update their fee schedules on a regular basis.

RECOMMENDATIONS

We recommended that the State agency:

- (1) Implement procedures to update clinical laboratory fee schedules on a regular basis to ensure that amounts paid for clinical laboratory services do not exceed amounts that Medicare pays for the same services; and
- (2) Make a financial adjustment on the next Quarterly HCFA-64 Report of Title XIX expenditures in the amount of \$2,823,505 (\$1,411,752 Federal share).

STATE AGENCY COMMENTS

In response to the draft report, the State agency agreed that Connecticut's Medicaid reimbursement for laboratory services exceeded the Medicare fee schedule limits and stated that it will adjust its next Quarterly HCFA-64 Report of Title XIX expenditures as requested. The State agency also stated that it will be updating its laboratory fee schedule annually by obtaining the relevant information from Medicare. The State agency response offered additional comments regarding our application of the Medicare payment limits. In this regard, the State agency noted that we applied the limit on a test-by-test basis to determine if the Medicaid payment exceeded the Medicare limits. The State agency stated that for other services the typical Medicaid policy is that Medicaid should not pay more than what Medicare pays in the aggregate for the reimbursement of such services. The State agency believed that the language in the Social Security Act and State Medicaid Manual would seem to support an argument that the intention was to also ensure that Medicaid payments for laboratory services in the aggregate do not exceed what Medicare pays for such services.

OIG/OAS RESPONSE

We commend the State agency's actions to adjust the Medicaid expenditures for the overpayments identified in our report and their action to update the laboratory fee schedules annually to ensure that they agree with the allowable Medicare fees for these services. With respect to the comments regarding the interpretation of the Medicare payment limits, we noted HCFA's letter to the State Medicaid Directors dated January 15, 1997 which provided clarification of Medicaid policy relative to the interpretation of the upper payment limit for laboratory tests. This letter stated that "...Medicaid restrictions...confine the aggregate payment for laboratory tests performed for the same patient on the same day to the aggregate payment which would be made by Medicare...." Based on this, we believe that our application of the Medicare payment limit for our analysis of laboratory services was in accordance with HCFA's policy clarification.

APPENDIX



STATE OF CONNECTICUT

DEPARTMENT OF SOCIAL SERVICES

OFFICE OF THE COMMISSIONER

Pat Wilson-Coker, JD, MSW
COMMISSIONER

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May 2, 2001

Michael J. Armstrong
Regional Inspector General for Audit Services
Department of Health and Human Services
John F. Kennedy Federal Building
Boston, Massachusetts 02203

Dear Mr. Armstrong:

SUBJECT: CIN A-01-01-00003

Thank you for sharing with me a draft copy of the OIG Audit Services' report entitled "Review of Fee Schedules Used for Reimbursement of Clinical Laboratory Services - Connecticut Medicaid Program." I appreciate the opportunity to offer comments before publication of the final report.

The Department of Social Services does not dispute the report's major finding that Connecticut Medicaid's reimbursement exceeded Medicare fee schedule limits in the cases analyzed, and will adjust its next quarterly report of Title XIX expenditures as requested. I would like to point out, though, that some of the points made in the audit are debatable or do not reflect current practice in the Connecticut Medicaid program.

The finding is based on language from the Social Security Act, and the State Medicaid Manual, both of which say that Medicaid reimbursement for laboratory "tests" should not exceed Medicare limits. The draft report applies this language on a test by test basis. The interpretation is that if Medicaid pays more than Medicare for one or a handful of individual laboratory procedures, that is an overpayment contrary to the Statute. In the case of other services the typical policy is that Medicaid should not pay more than Medicare in aggregate so that as long as Medicaid paid less in total than Medicare for a given bundle of services there is no overpayment. The use of the term "tests" and not "test" in both the Act and the State Medicaid Manual would seem to support an argument that the intention was to ensure that Medicaid payments for laboratory services in the aggregate do not exceed what Medicare would pay for laboratory services in the aggregate.

It is true that during the period that is the subject of the report the Connecticut Medicaid Program did not update its laboratory fee schedule annually, thereby missing those instances where the Medicare limit was downgraded. That is no longer the case. The Department of Social Services now updates its laboratory fee schedule annually by

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- 2 -

obtaining the relevant information from Medicare. Although it is not the subject of an in-depth treatment in the draft report, the auditors did have a discussion with my staff concerning bundling and unbundling various procedure codes during the course of processing claims to ensure that the lower rate is paid. This is something that the Connecticut Medicaid claims payment system does not do, and we are not aware of any regulatory or other instructions that the Medicaid claims processing system must process claims in the same way as Medicare does.

Again, thank you for affording me the opportunity to comment on the draft report. If you have any questions about this, please contact David Parrella, Director of Medical Care Administration at (860) 424-5116.

Sincerely,



Patricia A. Wilson-Coker
Commissioner

JL/jl

cc: Deputy Commissioner Starkowski, David Parrella, Rose Ciarcia, Marcia Mains,
Adele Kusnitz, James Linnane