



JAN - 2 2004

TO: Wynethea Walker  
Acting Director, Audit Liaison Staff  
Centers for Medicare & Medicaid Services

FROM: Dennis J. Duquette   
Deputy Inspector General  
for Audit Services

SUBJECT: Review of Claims Paid for Clinical Diagnostic Laboratory Services Under the  
Massachusetts Revised Fee Schedule—July 1999 Through March 2002  
(A-01-02-00015)

We are alerting you to the issuance of the subject final audit report within 5 business days from the date of this memorandum. A copy of the report is attached. We suggest that you share this report with the Center for Medicaid and State Operations and other components of the Centers for Medicare & Medicaid Services (CMS) involved with Medicaid program integrity and provider issues.

The objective of our review was to determine whether Medicaid payments for hospital outpatient laboratory and pathology tests complied with rates allowed by the Medicare program. We conducted this review as a followup on the Massachusetts Medicaid laboratory billing system.

Section 1903(i)(7) of the Social Security Act limits Medicaid payments for clinical laboratory tests to the amounts payable for the same tests under the Medicare fee schedule. However, our analysis showed that of the \$29 million in hospital outpatient laboratory claims submitted by the State for the period July 1999 through March 2002, \$8.2 million (\$4.1 million Federal share) exceeded the Medicare fee schedule amounts. The State's procedures were not adequate to ensure that amounts claimed for Medicaid laboratory services and submitted for Federal reimbursement complied with the Medicare fee schedule.

We recommended that Massachusetts (1) make an adjustment of \$8.2 million (\$4.1 million Federal share) on the next quarterly report of expenditures and (2) ensure that amounts claimed for hospital laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

In its June 23, 2003 response, Massachusetts stated that we lacked sufficient legal basis to conclude that it had exceeded the Medicare upper payment limit for laboratory services. The State said that its billing system for claiming Medicaid costs for Federal reimbursement complied with 42 CFR § 447.321(b) because aggregate Medicaid payments did not exceed the upper payment limit.

In a prior report (A-01-01-00001), we concluded that this argument was invalid. Our position has not changed. The regulations at 42 CFR § 447.321(b) implement section 1902(a)(30) of the Social Security Act, which generally requires that Medicaid payments be consistent with efficiency, economy, and quality of care. However, section 1903(i)(7) of the Social Security Act imposed a more specific limit for clinical diagnostic laboratory tests which supercedes the more general CMS requirements on aggregate limits for certain categories of services. The specific limit for clinical laboratory tests is implemented by section 6300 of CMS's "State Medicaid Manual," which provides that Federal funding is unavailable for any amount a State spends for clinical diagnostic laboratory tests performed by a physician, an independent laboratory, or a hospital that exceeds the amount that would be recognized under the Medicare fee schedules for tests performed under Medicare Part B.

Therefore, Massachusetts's reliance on the upper payment limit regulations in 42 CFR § 447.321(b) is misplaced, and we continue to believe that \$4.1 million was ineligible for Federal reimbursement.

If you have any questions or comments on this report, please do not hesitate to call me or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104. To facilitate identification, please refer to report number A-01-02-00015 in all correspondence.

Attachment



JAN - 7 2004

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

Report Number: A-01-02-00015

Mr. Douglas S. Brown  
Acting Commissioner  
Division of Medical Assistance  
Commonwealth of Massachusetts  
600 Washington Street, 5<sup>th</sup> Floor  
Boston, Massachusetts 02111

Dear Mr. Brown:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) report entitled "Review of Claims Paid for Clinical Diagnostic Laboratory Services Under Massachusetts Revised Fee Schedule—July 1999 Through March 2002." 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 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). As such, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

To facilitate identification, please refer to report number A-01-02-00015 in all correspondence.

Sincerely,

Michael J. Armstrong  
Regional Inspector General  
for Audit Services

Enclosures - as stated

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**Direct Reply to HHS Action Official:**

Charlotte Yeh, M.D.  
Regional Administrator  
U.S. Department of Health and Human Services  
Centers for Medicare & Medicaid Services, Region I  
JFK Federal Building, Room 2325  
Boston, Massachusetts 02203

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF CLAIMS PAID FOR  
CLINICAL DIAGNOSTIC  
LABORATORY SERVICES UNDER THE  
MASSACHUSETTS REVISED FEE  
SCHEDULE-JULY 1999 THROUGH  
MARCH 2002**



**JANUARY 2004  
A-01-02-00015**

## **EXECUTIVE SUMMARY**

### **BACKGROUND**

Medicaid, a federally aided State program established under title XIX of the Social Security Act, provides medical assistance to certain individuals and families with low income and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of the Centers for Medicare & Medicaid Services (CMS). In Massachusetts, the Division of Medical Assistance is responsible for administering the Medicaid program.

States provide Medicaid reimbursement for services such as outpatient clinical laboratory tests. Reimbursement for these services must fall within the guidelines of CMS's Medicaid manual, which states that Federal matching funds will not be available to the extent a State pays more for outpatient clinical laboratory tests than the amount allowed for the same tests by the Medicare program.

### **OBJECTIVE**

The objective of our review was to determine whether Medicaid payments for hospital outpatient laboratory and pathology tests complied with rates allowed by the Medicare program.

### **SUMMARY OF FINDINGS**

Section 1903(i)(7) of the Social Security Act limits Medicaid payments for clinical laboratory tests to the amounts payable for the same tests under the Medicare fee schedule. However, our analysis showed that of the \$29 million in hospital outpatient laboratory claims submitted by the State for the period July 1999 through March 2002, \$8.2 million (\$4.1 million Federal share) exceeded the Medicare fee schedule amounts.<sup>1</sup> The State's procedures were not adequate to ensure that amounts claimed for reimbursement for Medicaid laboratory services and submitted for Federal reimbursement complied with the Medicare fee schedule.

### **RECOMMENDATIONS**

We recommended that Massachusetts:

- make an adjustment on the next quarterly report of expenditures for \$8.2 million (\$4.1 million Federal share) and
- ensure that amounts claimed for hospital laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

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<sup>1</sup> This amount reflects the \$31,181 in third-party liability recoveries the State collected from other insurers. Specifically, the State applied third-party liability recoveries to the Medicaid costs, and we compared the net result to the Medicare fee schedule.

## **AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In its June 23, 2003 response (see Appendix C), Massachusetts stated that we lacked sufficient legal basis to conclude that it had exceeded the Medicare upper payment limit for laboratory services. The State believed that its Medicaid billing system for claiming Medicaid costs for Federal reimbursement complied with 42 CFR § 447.321(b) in that aggregate Medicaid payments may not exceed the upper payment limit. The 42 CFR § 447.321(b) defines the aggregate for outpatient hospital services as not exceeding total payments received by all providers from beneficiaries and carriers or intermediaries for providing services under comparable circumstances under the Medicare program.

In a prior report (A-01-01-00001), we concluded that this argument was invalid. Our position has not changed. The regulations at 42 CFR § 447.321(b) implement section 1902(a)(30) of the Social Security Act, which generally requires that Medicaid payments be consistent with efficiency, economy, and quality of care. However, section 1903(i)(7) of the Social Security Act imposed a more specific limit for clinical diagnostic laboratory tests which supercedes the more general CMS requirements on aggregate limits for certain categories of services. The specific limit for clinical laboratory tests is implemented by section 6300 of CMS's "State Medicaid Manual," which provides that Federal funding is unavailable for any amount expended by a State for clinical diagnostic laboratory tests performed by a physician, an independent laboratory, or a hospital that exceeds the amount that would be recognized under the Medicare fee schedules for tests performed under Medicare Part B.

Therefore, Massachusetts's reliance on the upper payment limit regulations in 42 CFR § 447.321(b) is misplaced, and we continue to believe that \$4.1 million was ineligible for Federal reimbursement.

# **INTRODUCTION**

## **BACKGROUND**

Medicaid, a federally aided State program established under title XIX of the Social Security Act, provides medical assistance to certain individuals and families with low income and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of CMS. In Massachusetts, the Division of Medical Assistance is the State agency responsible for administering the Medicaid program. States provide services such as outpatient clinical laboratory tests. Reimbursement for these services must fall within the guidelines of CMS's "State Medicaid Manual," which states that Federal matching funds will not be available to the extent a State pays more for outpatient clinical laboratory tests than the amount allowed for the same tests by the Medicare program.

Pathology and laboratory tests are clinical laboratory tests performed by providers on behalf of patients to help physicians diagnose and treat ailments. Laboratory services include chemistry, hematology, and urinalysis tests. Pathology tests involve the study of cells, tissues, or organs. Chemistry tests involve the measurement of various chemical levels in the blood. Hematology tests measure aspects of the blood such as cell counts and clotting times. Urinalysis tests involve physical, chemical, or microscopic analysis or examination of urine.

Testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory. Providers use CMS's Health Care Common Procedural Coding System (HCPCS), codes 80002 to 89399, to identify clinical laboratory costs for reimbursement from the State agency. The State agency, in turn, seeks reimbursement from CMS for amounts paid on behalf of Medicaid beneficiaries. A State agency may process the claims or elect to use an outside fiscal agent to process them. The Massachusetts State agency uses an outside fiscal agent to process the incoming hospital claims and then submits these claims for Federal reimbursement.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

The objective of our review was to determine whether Medicaid payments for hospital outpatient laboratory and pathology tests complied with rates allowed by the Medicare program.

### **Scope**

We limited our internal control review to the State agency's procedures for calculating Medicaid payments for clinical laboratory services. Specifically, we compared the State agency's Medicaid paid laboratory claim amounts to the Medicare fee schedules provided by CMS for pathology and laboratory services identified under HCPCS codes 80002 through 89399.

We only accounted for those differences that exceeded the Medicare fee schedule because Federal laws require that all Medicaid laboratory claims be paid at or below the Medicare fee schedule. Accordingly, those that fell below the fee schedule amounts complied with Federal regulations. We also followed up on recommendations made in two prior Office of Inspector General (OIG) reports (see Appendix A) to determine if the State adequately resolved them.

## **Methodology**

To accomplish our objective, we obtained an extract from the State of all paid Medicaid claims for clinical laboratory services performed by hospitals from July 1999 to March 2002. We used the extract of paid claims to:

- compute what the Medicare payment should be by multiplying the Medicare fee schedule rate by the number of units billed, per HCPCS code;
- calculate the difference between the Medicaid amount claimed (paid amount) and the Medicare fee schedule multiplied by the appropriate number of units, per HCPCS code; and
- total the differences to determine the amount the State agency received in excess of the Medicare fee schedule.

To verify the accuracy of the State-provided Medicaid claim extract, we selected a nonstatistical sample of paid amounts used to calculate the amount the State agency was overpaid and traced them to the online records maintained on the State's paid claims history file, Massachusetts' Medicaid Management Information System.

We performed our fieldwork from December 2002 to February 2003 at the State agency in Boston. Our audit was conducted in accordance with generally accepted government auditing standards.

## **FINDINGS AND RECOMMENDATIONS**

Federal regulations limit Medicaid payments for clinical laboratory tests to amounts payable for the same test under the Medicare fee schedule. However, our analysis showed that, of the \$29 million in hospital outpatient laboratory claims submitted by the State for the period July 1999 through March 2002, \$8.2 million (\$4.1 million Federal share) exceeded the Medicare fee schedule amounts.<sup>2</sup> The State's procedures were not adequate to ensure that amounts claimed for Medicaid laboratory services and submitted for Federal reimbursement complied with the Medicare fee schedule.

### **APPLICABLE FEDERAL LAWS AND REGULATIONS**

Section 1903(i)(7) of the Act, expanded in section 6300 of the "State Medicaid Manual," provided that no Federal financial participation would be available with respect to any amounts expended for clinical diagnostic laboratory tests to the extent such amounts exceeded the amount that would be recognized under the Medicare program (known as the Medicare fee schedule).

Further, section 6300.5 of the "State Medicaid Manual" allows a Medicaid agency to enter into agreements to purchase laboratory services. However, States may not pay more in the aggregate

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<sup>2</sup> This amount reflects the \$31,181 in third-party liability recoveries the State collected from other insurers. Specifically, the State applied third-party liability recoveries to the Medicaid costs, and we compared the net result to the Medicare fee schedule.

for clinical laboratory tests than the amounts that would be paid under the Medicare fee schedule. In its January 15, 1997 letter to State Medicaid Directors, CMS provided additional guidance: “Medicaid restrictions simply 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.”

**HOSPITAL LABORATORY CLAIMS IN EXCESS OF THE MEDICARE FEE SCHEDULE**

Our analysis found that 728,414 (72 percent) of the 1,016,467 per-person, per-day hospital outpatient laboratory claims submitted to Medicaid for reimbursement exceeded the Medicare fee schedule. We identified the 728,414 overpaid claims by calculating the difference between paid claim information provided by the State agency and the applicable Medicare fee schedule on a per-person, per-day basis. As illustrated in Table 1, the State agency claimed \$29 million for 728,414 paid claims on a per-person, per-day basis whereas the aggregate payment level under the Medicare fee schedule amounted to \$20.8 million for the 728,414 claims in question.

<b>Audit Period</b>	<b>Number of Months</b>	<b>Paid Amount (in Millions)</b>	<b>Fee Schedule (in Millions)</b>	<b>Amount in Excess of the Fee Schedule (in Millions)</b>
Jul 1999 – Dec 1999	6	\$4.8	\$3.4	\$1.4
Jan 2000 – Dec 2000	12	9.3	6.7	2.6
Jan 2001– Dec 2001	12	13.5	9.9	3.6
Jan 2002 – Mar 2002	3	1.4	0.8	0.6
<b>Totals</b>		<b>\$29</b>	<b>\$20.8</b>	<b>\$8.2</b>

As provided by Federal regulations, we only considered claims that exceeded the Medicare fee schedule. Approximately \$8.2 million (\$4.1 million Federal share) in Medicaid laboratory claims in excess of the Medicare fee schedule amounts was paid for the period July 1999 through March 2002.<sup>3</sup>

As in our two prior reviews, we found that the State’s procedures were not adequate to ensure that Medicaid laboratory claims submitted for Federal reimbursement complied with the Medicare fee schedule (Appendix A). In response to our 1988 report entitled “Review of the Procedures Used by the Massachusetts Department of Public Welfare in Determining Reimbursement for Outpatient Clinical Diagnostic Laboratory Services” (A-01-87-00011), the State agreed to implement a new system to ensure that hospital outpatient laboratory claims do not exceed the Medicare fee schedule. The State also obtained \$99,510 (Federal financial participation) to cover 90 percent of the related costs for enhancement of its Medicaid Management Information System to ensure that Medicaid claims for outpatient clinical

<sup>3</sup> This amount has been reduced by \$31,181 in third-party liability recoveries that the State collected in excess of the Medicare fee schedule.

laboratory services are claimed for Federal reimbursement in accordance with Federal requirements.

However, Massachusetts did not address the issue of paying more than the Medicare fee schedule for clinical laboratory claims to hospitals when it implemented its new outpatient prospective payment system. Nor did Massachusetts ensure that the annual clinical laboratory fee schedule it used to bill Medicaid complied with the Medicare fee schedule and applicable Federal requirements. More recently, the State attempted to correct its processing of outpatient hospital laboratory claims by running a parallel system that can be reviewed apart from the main processing system. However, Massachusetts was unable to provide us with any evidence that the parallel system applied the Medicare fee schedule and that all claims were properly adjusted.

## **RECOMMENDATIONS**

We recommended that Massachusetts:

- make an adjustment on the next quarterly report of expenditures for \$8.2 million (\$4.1 million Federal share) and
- ensure that amounts claimed on hospital laboratory claims submitted for Federal reimbursement do not exceed the appropriate Medicare fee schedule amounts.

## **AUDITEE COMMENTS AND OIG RESPONSE**

In its June 23, 2003 response (see Appendix C), Massachusetts stated that we lacked sufficient legal basis to conclude that it had exceeded the Medicare upper payment limit for laboratory services. The State believed that its billing system for claiming Medicaid costs for Federal reimbursement complied with cited regulatory provisions and was in accordance with principles of efficiency, economy, and quality of care.

As discussed below, we believe that our final results are correct and our report need not be adjusted. We have summarized the auditee's relevant comments and provided our additional response below.

### **Auditee's Comments—Charging Clinical Laboratory Services in the Aggregate**

The State's response focused on 42 CFR § 447.321(b) in that aggregate Medicaid payments may not exceed the Medicare upper payment limits. The 42 CFR § 447.321(b) defined the aggregate for outpatient hospital services as not exceeding total payments received by all providers from beneficiaries and carriers or intermediaries for providing services under comparable circumstances under Medicare.

In this respect, the State claims its Ambulatory Procedure Group system was designed not to exceed, in the aggregate, what would be payable according to Medicare payment principles.

### **OIG Response**

In a prior report (A-01-01-00001), we concluded that this argument was invalid. Our position has not changed. Specifically, our prior report stated:

42 CFR 447.321(b) implemented section 1902(a)(30) of the Act, which required that payments be consistent with efficiency, economy, and quality of care. However, the audit focused on clinical diagnostic laboratory tests, which fell under section 1903(i)(7) of the Act. Therefore, section 1902(a)(30) of the Act and the cited 42 CFR do not apply.

The law and instructions that do apply, section 1903(i)(7) of the Act and section 6300 of the State Medicaid Manual provided that Federal financial participation is unavailable with respect to any amount expended [by a State] for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amount exceeded the amount that would be recognized under [the Medicare fee schedules] for such tests performed for an individual enrolled under [the Part B Medicare program]. In terms of claiming costs in the aggregate, the actual language of section 1903(i)(7) does not refer to “total amount” paid by a State, or even “the amount” paid by a State. Rather, the statutory limits apply to “any amount” paid by a State.

Congress has in numerous instances enacted Medicare or Medicaid payment limits that have been explicitly made subject to aggregation. Consequently, if Congress intended that the limits established by section 1903(i)(7) of the Act be determined on the basis of aggregated payments, it more than likely would have said so. Further, the actual language of section 1903(i)(7) is inconsistent with aggregation. Congress’ use of the disjunctive “or” (rather than the conjunctive “and”) when referring to physicians, independent laboratories, and hospitals, and its reference to these entities and to Medicare beneficiaries in the singular (rather than in the plural) strongly suggest that aggregation was not contemplated. The language of the statute states that the State’s compliance with the payment limits is determined not on the basis of aggregated payments, but by focusing on the specific amounts paid by the State for clinical diagnostic laboratory tests provided by physicians, laboratories, or hospitals to individual beneficiaries.

In its January 15, 1997 letter to all State Medicaid Directors, CMS specifically notified the States of its position on aggregation. At that time, CMS’s policy interpretation confined the aggregate payments for Medicaid laboratory tests for the same person on the same day to the aggregate payment that would be made by Medicare. The Departmental Appeals Board, DAB number 1619:

*“ . . . consistently held that if a federal agency’s interpretation of a statute or regulation it is charged with enforcing is a reasonable one, and the State had notice of [such interpretation], then it will be upheld by the Board.”*

Consequently, because the State agency had notice of this interpretation prior to the period covered by the draft audit report, we believe CMS’s position is binding on the State. However, recent discussions with CMS indicate payments for laboratory services should be paid on a test-by-test basis to be more consistent with Medicare.

We used CMS’s January 15, 1997 letter to State Medicaid directors as a basis to calculate the \$8.2 million Massachusetts paid in excess of the Medicare fee schedule for 728,414 claims on a per-person, per-day basis.<sup>4</sup> However, if we calculated the amount the State agency paid in excess of the Medicare fee schedule on a test-by-test basis (the method implied under the Social Security Act and the State Medicaid Manual), the amount overpaid increases to over \$11.3 million for 1,534,566 claims. The difference of \$3.1 million (\$11.3 million less \$8.2 million) and 806,152 transactions stems from services that were grouped on a per-person, per-day basis, versus treated separately on a test-by-test basis (see Table 2).

	<b>Number of Transactions</b>	<b>Amount Paid (Millions)</b>	<b>Fee Schedule</b>	<b>Difference</b>
Per-Person, Per-Day (transactions grouped by day)	728,414	\$29.0	\$20.8	\$8.2
Test-By-Test (transactions treated individually by test)	1,534,566	27.5	16.2	11.3
<b>Difference</b>	<b>806,152</b>	<b>\$1.5</b>	<b>\$4.6</b>	<b>\$3.1</b>

**Table 2 – Excess Payments (Per-Person, Per-Day vs. Test-by-Test)**

Accordingly, the State agency benefited from grouping services on a per-person, per-day basis because some of the services were paid under the Medicare fee schedule, which offset services that exceeded Medicare. Conversely, services paid under the Medicare fee schedule on a test-by-test basis were excluded from the calculation of the amount overclaimed by the State. Removing these services reduced the amount paid from \$29 million to \$27.5 million and contributed to increases in overpayments from \$8.2 million to \$11.3 million (see Appendix B for a comparison of the methodology used to calculate the amount overpaid on a per-person, per-day basis and on a test-by-test basis).

**Auditee’s Comments—The MassHealth Ambulatory Procedure Group Payment System**

The State’s Ambulatory Procedure Group payment system was designed to bundle services and set payment rates based on the totality of services provided during a specified time period (a “window”). The State pays only for procedures identified as significant; it does not claim most nonsignificant services, such as lab charges, for Federal reimbursement. The State implied that we overstated our results by not considering underpayments that may have occurred for laboratory services receiving zero payments.

**OIG Response**

We did not test laboratory services with significant procedures that were bundled under the State’s Ambulatory Procedure Group payment system because (1) the State did not isolate laboratory charges and (2) it built in factors that accounted for laboratory claims in the payment

<sup>4</sup> Aggregate payments for laboratory tests were calculated based on the same person on the same day and compared to the Medicare fee schedule.

for significant procedures. Therefore, the State was reimbursed for laboratory charges. Specifically, Massachusetts' Ambulatory Procedure Group policy manual states that "In the APG system, different services provided during the same visit may be grouped into a single payment unit . . ." Instead, we tested individual laboratory claims and took into account those claims that fell above and below the Medicare fee schedule on a per-person, per-day basis based on the January 15, 1997 guidelines CMS sent to State Medicaid directors. Therefore, the \$8.2 million we identified is a net result of overcharges and undercharges for individual laboratory claims.

All points aside, the State agency plans to start claiming laboratory services in accordance with the Medicaid fee schedule in October 2003.

## APPENDICES

A-01-87-00011	04/06/88	10/01/85 – 12/31/86	\$844,750	(1) Establish procedures to ensure hospital outpatient laboratory claims do not exceed the Medicare fee schedule	Open*
				(2) Make financial adjustment of \$844,750	Paid 6/30/88
				(3) Determine inappropriate payments from 1/1/87 until establishment of Medicare's fee schedule limits and make appropriate adjustments	Open
A-01-01-00001	05/08/01	01/01/98 - 06/30/99	\$344,816	(1) Implement processes to ensure that the Division of Medical Assistance uses the appropriate fee schedules	Open
				(2) Make financial adjustment of \$344,816	Paid 6/30/01

\* The State received \$99,510 in Federal financial participation to cover 90 percent of the cost to enhance its Massachusetts Medicaid Management Information System to ensure that Medicaid claims for outpatient clinical laboratory services are claimed for Federal reimbursement in accordance with Federal requirements.

## COMPARISON OF PAYMENT METHODOLOGY PER-PERSON, PER-DAY VS. TEST-BY-TEST

Using the requirements outlined in the 1997 letter to the State Medicaid directors, clinical diagnostic laboratory services on a per-person, per-day basis should be grouped together, treated as one transaction, and compared to the Medicare fee schedule. Table 1, for example, demonstrates a per-person, per-day transaction (labeled as Transaction Number 1) in which the services for a single patient on July 1, 1999 were grouped together and compared to the Medicare fee schedule. The State received \$85.39 for this transaction, which exceeded the Medicare fee schedule by \$27.86.

Transaction Number	HCPCS Code	Date of Service	Paid Amount	Fee Schedule	Over/(Under) Payment
1	80007	07/01/1999	\$14.46	\$11.29	\$3.17
	80058	07/01/1999	14.40	10.84	3.56
	85651	07/01/1999	7.31	4.91	2.40
	86618	07/01/1999	41.91	19.75	22.16
	85025	07/01/1999	7.31	10.74	(3.43)
	<b>Total</b>		<b>\$85.39</b>	<b>\$57.53</b>	<b>\$27.86</b>

**Table 1 – Example of a Per-Person, Per-Day Transaction**

By contrast, CMS's current and more stringent interpretation of the Social Security Act requires that each clinical diagnostic laboratory service provided on the same day for the same patient service be considered independently of the others—that is, they should not be grouped. This is the test-by-test methodology. Using the same patient information shown in Table 1, Table 2 shows that these ungrouped transactions increase the State's share of Medicaid costs. Because any transaction paid at or below the Medicare fee schedule was in compliance with the Social Security Act, we did not include the fifth transaction in our calculation of overpaid claims. The first four transactions, however, were individually compared to the Medicare fee schedule, resulting in an overpayment of \$31.29. The difference of \$3.43 in overpayments (\$31.29 less \$27.86) is the difference in the fifth transaction for Table 2 (\$10.74 less \$7.31).

Transaction Number	HCPCS Code	Date of Service	Paid Amount	Fee Schedule	Overpayment
1	80007	07/01/1999	\$14.46	\$11.29	\$3.17
2	80058	07/01/1999	14.40	10.84	3.56
3	85651	07/01/1999	7.31	4.91	2.40
4	86618	07/01/1999	41.91	19.75	22.16
	<b>Total</b>		<b>\$78.08</b>	<b>\$46.79</b>	<b>\$31.29</b>
5	85025	07/01/1999	7.31	10.74	0

**Table 2 – Example of Test-By-Test Transactions**





