

Report in Brief

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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL



Why OIG Did This Audit

A prior OIG audit found that Medicare paid providers that had billed for medically unnecessary laboratory tests. Our preliminary review of Medicare claims identified providers that billed for direct-measurement, low-density lipoprotein (LDL) cholesterol tests (direct LDL tests) and lipid panels (a blood test that reports four measures of lipids, including LDL cholesterol) for the same beneficiary on the same date of service; some of these providers billed the direct LDL test every time they billed the lipid panel. These claims were at risk of noncompliance with Medicare requirements because, according to the Centers for Medicare & Medicaid Services (CMS), billing for a direct LDL test in addition to a lipid panel, while sometimes medically necessary, should happen with only limited frequency.

Our objective was to determine whether payments made to providers for direct LDL tests that were billed in addition to lipid panels for the same beneficiary on the same date of service complied with Medicare requirements.

How OIG Did This Audit

Our audit covered Medicare Part B payments of about \$35 million for direct LDL tests that were billed in addition to lipid panels for the same beneficiary on the same date of service and that had dates of service from 2015 through 2019 (audit period).

Medicare Could Have Saved up to \$20 Million Over 5 Years if CMS Oversight Had Been Adequate To Prevent Payments for Medically Unnecessary Cholesterol Blood Tests

What OIG Found

Payments made to providers for direct LDL tests that were billed in addition to lipid panels did not comply with Medicare requirements. Under certain circumstances, it may be medically necessary for a provider to perform both tests for the same beneficiary on the same date of service. However, CMS and Medicare contractors explained that these circumstances should happen with only limited frequency. We determined that some providers billed LDL tests in addition to lipid panels for the same beneficiary on the same date of service more than 75 percent of the time. (We refer to such providers as “at-risk providers.”) In total, we identified \$20.4 million of Medicare payments made to at-risk providers for direct LDL tests.

Two Medicare contractors’ review of medical records associated with 20 judgmentally sampled claims found that all of the direct LDL tests billed in addition to lipid panels were medically unnecessary. Because the claim lines for the \$20.4 million in payments to at-risk providers for direct LDL tests had characteristics similar to the claim lines in the judgmental sample, we determined that up to \$20.4 million in payments were improper. If CMS had had oversight mechanisms to prevent such payments, Medicare could have saved up to \$20.4 million for our audit period.

What OIG Recommends and CMS Comments

We recommend that CMS direct the Medicare contractors to: (1) develop oversight mechanisms to identify at-risk providers and prevent improper payments to these providers, which could have saved up to \$20.4 million for our audit period, and (2) educate providers on the billing of direct LDL tests in addition to lipid panels. Our detailed recommendations are in the report.

CMS did not concur with our first recommendation and stated that ordering direct LDL tests and lipid panels together is permissible under Medicare payment rules on the basis of the physician’s clinical judgment. Regarding our second recommendation, CMS stated that it has already issued education on correct coding requirements for the proper use of modifiers on claim lines.

We maintain that our finding and recommendations are valid. Although we acknowledge that Medicare permits ordering direct LDL tests and lipid panels together, the at-risk providers in our audit routinely billed these tests together, and CMS’s education does not specifically address such billing.