

**Memorandum**

Date AUG 4 1993

From Bryan B. Mitchell
Principal Deputy Inspector GeneralSubject Reimbursement by Massachusetts Blue Cross for Laboratory Services Performed by
Hospitals as an Outpatient Service (A-01-92-00523)To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This is to alert you to the issuance on August 6, 1993, of our final report on the adequacy of procedures and controls over the processing of Medicare Part B payments made by the Massachusetts fiscal intermediary (FI) for clinical laboratory tests performed by hospitals as an outpatient service. Our review was limited to clinical laboratory tests which measure the chemical and hematological composition of blood. A copy of the report is attached.

Our review disclosed that in Calendar Year 1991 the FI overpaid Massachusetts hospitals \$2.25 million in claims for chemistry and hematology tests. We found that the FI's payment process did not detect claims for chemistry tests that should have been grouped together (bundled into a panel) for payment purposes. We also found that the FI's system is not able to detect and prevent payment of duplicate claims for chemistry and hematology tests.

We are recommending that the FI install edits to detect and prevent overpayments for unbundled or duplicate charges for chemistry and hematology tests performed by hospitals on an outpatient basis, and initiate recovery from hospitals for overpayments identified by this review.

The FI, in its response, concurred that overpayments resulted from chemistry unbundling and duplicate charges for chemistry and hematology tests. They agreed to develop edits to rebundle chemistry panel tests and to initiate recovery of overpayments once the edits are installed. The FI informed us that claims are processed through the Arkansas UB82 System (Arkansas System) which is a system shared with 20 other contractors. System changes needed to implement edits must

be approved by the Arkansas Executive Committee. The priority for system changes is decided by this Committee based on input from all contractors who share the system.

For duplicate payment of hematology tests, FI officials stated that contractors are precluded from installing edits to prevent these overpayments under the Health Care Financing Administration's (HCFA) national bundling initiative. Our discussions with HCFA regional officials, however, disclosed that hematology tests are not part of the national bundling initiative.

Based on our review of the FI's response, exit conference discussions, and discussions with HCFA officials, we found nothing which would preclude the FI, subject to evaluation by the Arkansas Executive Committee, from installing the necessary edits in their claims processing system to detect bundling errors and prevent duplicate payment of chemistry panels, hematology profiles, and related component tests. Officials at the HCFA regional office are in agreement with this conclusion.

We believe that the deficiencies disclosed in our report may also exist at the other 20 FIs using the Arkansas System as well as in other shared systems. We are currently analyzing nationwide payment data for clinical laboratory tests performed by hospitals as an outpatient service. Upon completion of our analysis of nationwide data, we will contact you to discuss our results and potential actions. However, in the meantime, HCFA should instruct the Arkansas Executive Committee to make the necessary changes.

For further information, contact:

Richard J. Ogden
Regional Inspector General
for Audit Services, Region I
(617)565-2689

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REIMBURSEMENT BY
MASSACHUSETTS BLUE CROSS
FOR LABORATORY SERVICES PERFORMED
BY HOSPITALS AS AN OUTPATIENT SERVICE**

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represents the findings and opinions of the HHS/OIG Office of Audit Services. Final determination on these matters will be made by authorized officials of the HHS operating division.



AUGUST 1993 A-01-92-00523



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-01-92-00523

Mr. Louis J. Resca
Vice President of Government Programs
Blue Cross and Blue Shield of Massachusetts, Inc.
100 Summer Street
Boston, Massachusetts 02110

Dear Mr. Resca:

This report presents the results of our review of Medicare Part B reimbursement for laboratory tests performed by hospitals as an outpatient service. The objective of our review was to determine the adequacy of procedures and controls over the processing of Medicare Part B payments made by Blue Cross and Blue Shield of Massachusetts, the fiscal intermediary (FI) for clinical laboratory tests performed by hospitals as an outpatient service. Our review was limited to those clinical laboratory tests which measure the chemical and hematological composition of blood.

Our review disclosed that the FI did not have adequate controls to ensure proper payment of chemistry and hematology claims when more than one test was performed on behalf of a Medicare recipient. Specifically, we found that the FI's payment process did not detect claims for chemistry tests that should have been grouped together (bundled into a panel) for payment purposes. Further, the FI's system is not able to detect and prevent payment of duplicate claims for chemistry and hematology tests. We found that duplicate payments were made for tests that were either claimed under more than one panel or claimed as part of a panel and also as individual tests.

Our review of 140 claims (70 for chemistry panel tests and 70 for hematology tests), statistically selected from calendar year (CY) 1991 claims valued at \$6,430,859, showed that 80 claims were overpaid. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the FI overpaid Massachusetts hospitals \$2.25 million for chemistry and hematology tests. At the 90 percent confidence level, the precision of this estimate is plus or minus 28.78 percent.

We are recommending that the FI install edits to detect and prevent overpayments for unbundled or duplicate charges for chemistry and hematology tests performed by hospitals on an outpatient basis, and initiate recovery of overpayments from hospitals for overpayments identified by this review.

The FI, in its response, concurred that overpayments resulted from chemistry unbundling and duplicate charges for chemistry and hematology tests. They also agreed to develop edits to rebundle chemistry panel tests. The FI uses the Arkansas UB82 System (Arkansas System) to process claims. The FI stated that the system changes required to implement these edits have to be approved by the Arkansas Executive Committee. The priority for these system changes will be decided by this Committee based on input from all contractors who share the system. After installation of these edits, the FI plans to initiate action to recover the overpayments.

For duplicate payment of hematology tests, FI officials stated that contractors are precluded from installing edits to prevent these overpayments under the Health Care Financing Administration's (HCFA) national bundling initiative. Our discussions with HCFA Regional officials, however, disclosed that the national bundling initiative applies only to those services included in physician payment reform and subject to the fee schedule for physicians' services. The hematology profiles and component tests contained in our report are specifically excluded from the physicians' fee schedule by Section 1848(j)(3) of Title XVIII of the Social Security Act. As such, these hematology tests are not part of the national bundling initiative.

Based on our review of the FI's response, exit conference discussions, and discussions with HCFA officials, we found nothing which would preclude the FI, subject to evaluation by the Arkansas Executive Committee, from installing the necessary edits in the claims processing system to detect bundling errors and prevent duplicate payment of chemistry panels, hematology profiles, and related component tests. The FI's comments are presented in its entirety as APPENDIX C to this report.

INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry and hematology 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. Hematology profiles consist of a group of hematology tests performed on an automated basis. Automated profiles include hematology component tests such as a hematocrit, hemoglobin, red and white blood cell count, 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 and red blood cell volume and platelet volume.

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, or independent laboratories. Claims for clinical laboratory services performed by hospital laboratories as an outpatient service are processed for payment by the FI. Claims for similar laboratory services by physicians and independent laboratories are processed through the Massachusetts Blue Shield (Carrier). Whether processed through the FI or the Carrier, however, all claims for clinical laboratory services are reimbursed based on the same Medicare fee schedules and are subject to guidelines published by the Medicare program under its Carriers Manual. Medicare pays 100 percent of the fee schedule amount or the actual charge for the laboratory service (whichever is lower) provided that the service is reasonable and necessary for the diagnosis or treatment of an illness or injury. We reviewed claims valued at \$11,709,641 from Massachusetts hospitals for outpatient clinical laboratory services involving chemistry panel and hematology profile tests during CY 1991. Of this amount, payments for more than one panel or for a panel and individual tests to the same recipient on the same date of service amounted to \$6,430,859.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine the adequacy of procedures and controls over the processing of Medicare Part B payments made by the FI for clinical laboratory tests performed by hospitals as an outpatient service. Our review was limited to those clinical laboratory tests which measure the chemical and hematological composition of blood.

To accomplish our objective we:

- o reviewed the FI's procedures for processing Medicare Part B claims from hospitals for outpatient laboratory services including chemistry panel and hematology profile tests;
- o extracted from HCFA's Medicare Provider Analysis and Review (MEDPAR) file claims processed by HCFA during CY 1991 that contained unbundled or duplicate charges for chemistry and hematology tests (See Appendices A and B). We tested the reliability of computer generated output by comparing data to source documents for our sampled claims. We did not, however, assess the completeness of the HCFA data files nor did we evaluate the adequacy of the input controls;
- o selected a random statistical sample of 70 chemistry claims from a population of 186,691 claims containing chemistry tests valued at \$4,570,057, and 70 claims for hematology from a population of 114,982 claims containing

hematology tests valued at \$1,860,802. These claims were taken from a universe of payments representing claims for more than one panel or for a panel and individual tests to the same recipient on the same date of service;

- o reviewed the randomly selected claims and supporting documentation from the FI to determine the propriety of the payment;
- o selected and visited five hospitals (which accounted for 21 chemistry claims in our sample) to validate findings and supporting documentation obtained at the FI;
- o utilized a variable sample appraisal methodology to estimate the amount of overpayment for chemistry and hematology tests.

Our review of internal controls was limited to an evaluation of that part of the claims processing function that related to the processing of outpatient claims for clinical laboratory services. Specifically, we reviewed intermediary guidelines and instructions to hospitals related to the billing for outpatient clinical laboratory services. We also reviewed FI documentation relating to manual and automated edits for panelling of chemistry tests and the detection of duplicate claims for both chemistry and hematology tests. At our request, the FI performed claims processing simulations to determine the system's ability to bundle related tests into appropriate panels for payment and to detect duplicate claims submitted for payment by hospitals.

We limited our review to claims recorded on the MEDPAR file during CY 1991. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report. Our calculation of estimated overpayments does not include the two percent Gramm-Rudman Reduction required under the Omnibus Reconciliation Act of 1990 for services rendered during the last two months of 1990. The impact of this reduction was not considered material to our review.

We performed our review between August 1992 and March 1993. During this period we visited the Massachusetts Blue Cross and Blue Shield offices in Braintree and Boston, Massachusetts, the Regional Office of HCFA in Boston, Massachusetts and the Patients' Accounts Divisions at selected Massachusetts hospitals. We were also in contact with officials at HCFA Central Office. An exit conference was held with FI officials on May 27, 1993.

RESULTS OF REVIEW

Our review found that the FI did not have adequate controls to detect and prevent payment of unbundled chemistry panels or duplicate charges for chemistry and hematology tests. We reviewed 140 claims (70 for chemistry panel tests and 70 for hematology tests) that were statistically selected from CY 1991 claims valued at

\$6,430,859. Our sample showed that 80 claims were overpaid. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the FI overpaid Massachusetts hospitals \$2.25 million for chemistry and hematology tests during CY 1991. At the 90 percent confidence level, the precision of this estimate is plus or minus 28.78 percent.

In discussing the absence of edit procedures for bundling and the detection of duplicates with the FI, we were informed that claims are processed through the Arkansas System which is a system shared with other contractors and approved by HCFA. As such, the FI believed that the edits in this system were adequate. We were informed that changes to this system must be made through a central maintenance request submitted to the Arkansas Executive Committee for review and consideration. The FI believes that such a request would not receive a high priority because the system is shared with 20 other contractors.

Chemistry Panel Tests

Our sample review of 70 claims containing potentially unbundled and duplicate chemistry laboratory charges disclosed that overpayment errors existed in 60 of these claims. These 60 claims contained unbundled and duplicate laboratory charges which were paid by the FI. These payment errors were identified to laboratory tests paid: under two separate panels; under a panel and as an individual test(s); as a duplicate payment for the same panel; as a duplicate payment for the same individual test; and in combinations of the above errors.

Section 3628 J of the FI Manual, "Clinical Diagnostic Laboratory Services Other Than to Inpatients, Laboratory Tests Utilizing Automated Equipment," states that "In the case of multi-channel automated and/or batch automated (e.g. SMAC, CHEMICAL PROFILES, ASTRA) laboratory determinations, ... there is normally only one charge for the battery of tests..." The FI is to "install edit procedures to identify situations where the provider bills individual tests where billing for the automated battery would be appropriate..." Such edits are to be based on practices established by the carrier(s) in the FI's locality.

In addition, the Medicare Carriers Manual, Section 5114.1 L.2, entitled "Separately Billed Tests That Are Commonly Part of Automated Battery Tests" - states that if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the battery that includes these tests, make payment at the lesser amount for the battery. The payment allowance for a battery cannot exceed the payment allowances fee schedules for the individual tests. The limitation that payment for individual tests not exceed the payment allowance for the battery is applied whether a particular laboratory has or does not have the automated equipment.

Regarding duplicate payments, Section 3708.1 of the FI Manual states that a provider is liable for overpayments it received. In addition, Section 3708.2 E states that the provider is liable in situations when the error was due to overlapping or duplicate bills.

The FI's system for processing hospital outpatient laboratory services contains a list of codes assigned to blood chemistry tests which are commonly included in groups of tests performed on automated multichannel laboratory instruments and are therefore subject to paneling. The existing systems edit for chemistry panel tests contains logic to recode three or more individual tests into the applicable single panel code. If three or more of the individual tests are contained on the same claim, the system will group them into the appropriate single panel code according to the total number of panel tests (from 3 to 19 or more tests) contained on the claim. Our review disclosed, however, that the system cannot detect or roll up multichannel tests inappropriately coded under more than one panel code, duplicate units of the same panel code, or a panel code(s) and individual test code(s) to the higher appropriate panel code.

Regarding the detection of duplicates, the FI's system edits for duplicates based on provider number, service date, revenue code, and charge. We were informed by the FI that this system does not detect duplicate claims for more than one panel or individual test.

Our review of 70 claims disclosed that 60 of the 70 claims contained chemistry tests which were unbundled or duplicated for payment purposes. These 70 claims were selected on a scientific random basis from a population of 186,691 claims containing chemistry panel tests valued at \$4,570,057. Based on our statistical sample, we estimate that the FI overpaid hospitals a total of \$1,927,265.

Fifty of the 60 errors in our sample were bundling errors. Hospital systems are designed to bundle individual tests into panels when they submit them for payment. We found that some hospital billing systems are programmed to identify and roll up selected panel tests into one panel and treat the remaining tests as a second panel. These claims were paid as two separate panels by the FI. In other cases, when the hospital system does not identify the test as belonging to a specific panel, it groups those it can identify into one panel and submits the remaining tests individually. When the FI receives the claim, it recognizes the first panel and groups the individual tests (if more than two) into a second panel and pays the claim as two separate panels. If a panel and less than three tests are submitted in a claim, the FI pays the panel and the two tests separately.

For example, a number of hospitals are separately charging a four test panel under the umbrella term called electrolytes. Any remaining panel tests are rolled up into a second panel. Since the FI's system does not have edits to detect two panels submitted on the same claim together, reimbursement is made for two panels. The

reimbursement for the two panels is higher than if the tests were reimbursed as one panel. Officials at the FI stated that this billing practice is not in accordance with hospital billing guidelines.

Our sample also found that six claims consisted of duplicate payments for the same panel or individual test. Four of these claims involved two identical panels and two of the claims involved two identical individual tests. The FI's edit system does not identify these potential duplicates so that the required additional justification can be requested from hospitals. We verified one of the six claims to the hospital laboratory records. Hospital records show only one set of test results in the patient's medical records.

The remaining four claims contained errors which were a combination of the above conditions. Specifically, three of the four claims had errors related to billing under two panels. All four claims had overpayments from charges for individual tests in addition to a panel and two of the four claims had duplication errors where more than one test or a panel and a test was charged and paid without additional support or justification from hospitals. For example, in one of these claims, the hospital was paid for 10 identical panels, each of which contained 10 chemistry tests for the same patient on the same date of service. However, the hospital medical records support only one set of test results.

Hematology Profiles

Our review of 70 claims for hematology profiles disclosed duplicate charges for 20 of the 70 claims. These overpayments occur when hospitals submit claims for duplicate hematology profiles or for a profile and an individual test which is included in the hematology profile. These 70 claims were selected on a scientific random basis from a population of 114,982 claims containing hematology profile tests valued at \$1,860,802. Based on our statistical sample, we estimate that the FI paid hospitals \$322,853 in duplicate charges for automated hematology profiles and components of profiles.

Section 3708.1 of the FI Manual states that a provider is liable for overpayments it received. In addition, Section 3708.2 E states that the provider is liable in situations when the error was due to overlapping or duplicate bills.

Ten of the 20 claims found in error were due to hospital submission of charges for a single hematology profile claimed as two separate profiles. This occurred because the FI's claims processing system does not have an edit to detect and deny hematology profile charges submitted under more than one profile.

The remaining 10 claims involved charges for a profile and for an individual test when the individual test was part of a profile. We found that duplicate payments were made because the FI's claims processing system does not have edits to detect and deny duplicate hematology profiles or for a profile and an individual test which is included in the hematology profile.

RECOMMENDATIONS

We are recommending that the FI install the necessary edits to detect bundling errors and duplicate claims for chemistry panels and hematology profiles. We are also recommending that the FI recover Medicare Part B overpayments for clinical laboratory services identified in this review. Based on our audit, we estimate that approximately \$2.25 million should be recovered for CY 1991.

AUDITEE COMMENTS

In its response dated May 18, 1993, the FI stated that they would develop edit specifications to match the bundling criteria of its carrier for automated multi-channel chemistry panel tests. These edit requirements would be submitted to the Arkansas System's Executive Committee for action. Upon installation of these edits, the FI agreed to initiate a recovery program for the unbundled chemistry panel tests.

The FI's response, however, did not address the corrective actions necessary to prevent the duplicate payments for the same panel or individual chemistry tests. At the exit conference, FI officials stated that edits to detect and prevent these duplicate payments do not exist. The FI officials agreed that the current system will pay for duplicate panels or tests if submitted on the same claim by the hospitals.

Regarding duplicate payment of hematology profiles and individual tests, the FI's response stated that contractors were precluded from implementing local bundling procedures. At the exit conference, FI officials explained that duplicate payments involving a hematology profile and an individual component test or two different profiles are bundling issues. In our report, we consider these instances to be duplicate payments. As a bundling issue, FI officials stated that HCFA prohibits contractors from bundling these charges to prevent the duplicate payment unless these hematology profiles and tests are part of the listed procedures under HCFA's national bundling initiative.

The FI also stated that the identification of duplicate payments from charges for more than one unit of the same hematology profile or individual test is being accomplished through focused medical review (FMR) screens.

OAS RESPONSE

Although FI officials agreed that the current system will pay for duplicate panels or tests if submitted on the same claim by the hospitals, they did not address how our recommendations would be implemented. We believe this area should be addressed since 8 of the 60 claims contained errors related to duplicate billings.

Our discussions with HCFA Regional officials disclosed that the national bundling initiative applies only to those services included in physician payment reform and subject to the fee schedule for physicians' services. The hematology profiles and component tests contained in our report are specifically excluded from the physicians' fee schedule by Section 1848(j)(3) of Title XVIII of the Social Security Act. As such, these hematology services are not part of the national bundling initiative. Reimbursement of hematology profiles and tests are based on a separate clinical laboratory fee schedule.

Regarding the use of FMR screens to detect and prevent duplicate payment of more than one unit of the same hematology profile or individual tests, we found that the FMR is used to screen for medical necessity and not for duplicate payments. Further, a FMR is directed at a specific diagnosis and would not detect or prevent duplicates for other diagnosis' that are not part of the established screen for medical necessity. During the exit conference, FI officials agreed that the FMR screens would not be effective in preventing duplicate payments.

Based on our review of the FI's response, exit conference discussions, and discussions with HCFA officials, we found nothing which would preclude the FI, subject to evaluation by the Arkansas Executive Committee, from installing the necessary edits in the claims processing system to detect bundling errors and prevent duplicate payment of chemistry panels, hematology profiles, and related component tests.

OTHER MATTERS

Hematology Indices

In addition to the overpayments disclosed by our sample of 140 claims, we found that during CY 1991 the FI overpaid hospitals \$68,637 for 31,948 claims for indices which are part of a hematology profile. The amount overpaid and number of claims were extracted in total from CY 1991 HCFA hematology claims approved for payment based on hospital billings which contain charges for both a hematology profile and the additional indices. Reimbursement for the calculation of indices are included in the payment for the hematology profile tests. It is the Carrier's practice not to pay for

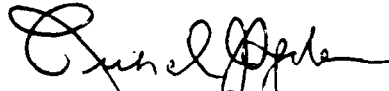
indices in addition to hospital charges for hematology profiles when they are detected. We found, however, that the FI system edits were not adequate to detect and prevent the payment of duplicate claims for hematology indices.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, 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).

Final determination as to actions 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. To facilitate identification, please refer to Common Identification Number A-01-92-00523 in all correspondence relating to this report.

If you have any questions, please contact Mr. Roger Normand at (617) 565-2693 or Mr. Daniel Lew at (617) 565-2707.

Sincerely yours,



Richard J. Ogden
Regional Inspector General
for Audit Services

Enclosures - as stated

Direct Reply to HHS Action Official:

Ms. Norma E. Burke
Associate Regional Administrator
for Medicare
Health Care Financing Administration
Room 2375, JFK Federal Building
Boston, Massachusetts 02203

SAMPLE METHODOLOGY

From HCFA's MEDPAR files, we extracted all Region I outpatient claims processed by HCFA during calendar year 1991. We limited our review to those claims processed for payment in 1991 by Massachusetts Blue Cross (Fiscal Intermediary #200). Using computer applications we extracted all claims containing:

1. automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physician's Current Procedural Terminology (CPT) handbook. (See APPENDIX B)
2. hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT handbook. (See APPENDIX B)

The above extract yielded a total of \$11,709,641 in payments for chemistry panel and hematology profile tests in CY 1991. This total consisted of 418,191 claims totaling \$7,243,771 relating to chemistry panel tests and 363,441 claims totaling \$4,465,870 related to hematology profile tests. Included in the \$4,465,870 for hematology profile tests is \$68,637 relating to 31,948 claims containing duplicate payments for indices. The amount associated with the duplicate indices payments of \$68,637 was excluded from our sample.

We then performed computer applications to extract all records for the same date of service with HCPCS line item charges for:

1. more than one unit of a chemistry panel or panel test; or more than one different chemistry panel or panel test.
2. more than one automated hematology profile under different profile codes; more than one unit of the same profile; or a component normally included as part of the profile in addition to the profile.

This extract resulted in a sample population totaling \$6,430,859 consisting of two strata which includes potentially unbundled and duplicate chemistry and hematology tests. The first strata consists of 186,691 claims from 96 hospitals totaling \$4,570,057 for potentially unbundled and duplicate chemistry panel tests. The second strata consisted of 114,982 claims from 89 hospitals totaling \$1,860,802 for potentially unbundled and duplicate hematology profile tests.

On a scientific stratified selection basis, we examined 140 claims from two strata. The first stratum consisted of a randomly generated statistical sample of 70 potentially unbundled and duplicate claims totaling \$1,721 for chemistry panel tests. The second

SAMPLE METHODOLOGY

stratum consisted of a randomly generated statistical sample of 70 potentially unbundled and duplicate claims totaling \$1,177 for hematology profile or profile component tests.

For the sample claims, we requested and reviewed supporting documentation from the FI consisting of copies of hospital claims or paid claims detail for claims submitted electronically, remittance advices, and any other documentation that may have been submitted by the hospitals to the FI to support or justify payment of chemistry panel and hematology profile tests as claimed.

We utilized a standard scientific estimation process to quantify overpayments for unbundled and duplicate chemistry panel tests and duplicate hematology profile tests as shown in the schedules below.

COSTS RECOMMENDED FOR RECOVERY

<u>Stratum</u>	<u>Number of Items</u>	<u>Number Sampled</u>	<u>Examined Value</u>	<u>Number of Errors</u>	<u>Error in Sample</u>	<u>Estimated Recovery</u>
Chemistry Panels	186,691	70	\$1,721	60	\$722.63	\$1,927,265
Hematology Profiles	<u>114,982</u>	<u>70</u>	<u>1,177</u>	<u>20</u>	<u>196.55</u>	<u>322,853</u>
	<u>301,673</u>	<u>140</u>	<u>\$2,898</u>	<u>80</u>	<u>\$919.18</u>	<u>\$2,250,118</u>

The results of the scientific sample of Stratum 1 chemistry panel claims disclosed that 60 of the 70 claims we reviewed represented overpayments for unbundled and duplicate chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$1,927,265 paid for unbundled and duplicate chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 33.09 percent.

The results of the scientific sample of Stratum 2, hematology profile claims, disclosed that 20 of the 70 claims 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 \$322,853 in duplicate payments for hematology profile tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 48.15 percent.

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCSChemistry Panel CPT Codes

80002	1 or 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

Chemistry Tests Subject to Panelling (34 CPT Codes)

1. Albumin	82040
2. Albumin/globulin ratio	84170
3. Bilirubin Total OR Direct	82250
4. Bilirubin Total AND Direct	82251
5. Calcium	82310, 82315, 82320, 82325
6. Carbon Dioxide Content	82374
7. Chlorides	82435
8. Cholesterol	82465
9. Creatinine	82565
10. Globulin	82942
11. Glucose	82947
12. Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
13. Alkaline Phosphatase	84075
14. Phosphorous	84100
15. Potassium	84132
16. Total Protein	84155, 84160
17. Sodium	84295
18. Transaminase (SGOT)	84450, 84455
19. Transaminase (SGPT)	84460, 84465
20. Blood Urea Nitrogen (BUN)	84520
21. Uric Acid	84550
22. Triglycerides	84478
23. Creatinine phosphokinase (CPK)	82550, 82555
24. Glutamyl transpetidase, gamma	82977

AUTOMATED HEMATOLOGY PROFILE and COMPONENT TEST HCPCSHematology Component Test CPT Codes

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Colorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Additional Hematology Component Tests - Indices

Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Hematology Profile CPT Codes

Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027

C&S Administrative
Services for
MEDICARE

APPENDIX C
Medicare A

Federal Medicare
Intermediary and Carrier

P.O. Box 2194
Boston, MA 02106

May 18, 1993

Richard J. Ogden
Regional Inspector General
for Audit Services
Region I
JFK Federal Building
Boston, MA 02203

Subject: CIN: A-01-92-00523

Dear Mr. Ogden:

The following are our comments on the draft report regarding payments made by Blue Cross and Blue Shield of Massachusetts, the fiscal intermediary, for clinical laboratory tests performed by hospitals as outpatient services:

Chemistry Panels

We are in the process of developing edit specifications to match the Carrier criteria for bundling multi-channel automated chemistry panels. The system changes required to implement these edits must be made by the standard system maintainer. As indicated in page four of your report, the change must be evaluated by the Arkansas Executive Committee which will then assign a priority ranking based on input from all contractors who share the Arkansas System.

Once the edits have been installed, we will initiate the recovery program for chemistry panels.

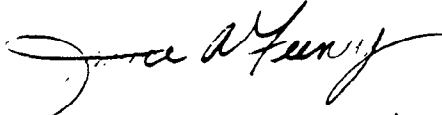
Hematology

The Carrier Medical Director has recently submitted recommendations to HCFA regarding bundling of hematology codes. Since the inception of HCFA's national bundling initiative in 1991, contractors are precluded from implementing local bundling. If HCFA instructs carriers to bundle hematology codes, we will implement the appropriate edits at that time.

Richard J. Ogden - Page 2
May 18, 1993

In the interim, hematology codes were added to our focused medical review screens in December, 1991. We will continue to deny services in the absence of documentation demonstrating medical necessity.

Sincerely,

A handwritten signature in cursive script, appearing to read "Janice A. Feeney".

Janice A. Feeney, Director
Medicare A Customer Operations

JAF/am

cc: L. Resca
M. Kanof, MD