Memorandum

Date DEC 4 1996

From for June Gibbs Brown
Inspector General

Subject Medicaid Payments for Clinical Laboratory Tests in 14 States (A-01-95-00003)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services (HHS), Office of Inspector General's (OIG) report entitled, "Medicaid Payments for Clinical Laboratory Tests in 14 States." The objective of this nationwide audit is to determine the adequacy of State agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests. Specifically, the audit is designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. The attached report covers two calendar years and presents a summary of the results of our review for the first 14 States completed. The audit is being conducted as a joint Federal/State project under the OIG's Partnership Plan.

Officials in your office have generally concurred with our recommendations, set forth on page 11 of the attached report, and have agreed to take corrective action. We appreciate the cooperation given us in this audit.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-95-00003 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICAID PAYMENTS FOR CLINICAL LABORATORY TESTS IN 14 STATES

JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
A-01-95-00003

SUMMARY

BACKGROUND

This report presents the consolidated results of our audits of Medicaid payments for outpatient clinical laboratory services in 14 States. The audit is being conducted as a joint Federal/State project under the Office of Inspector General's Partnership Plan. Staff from State auditor's offices and the Office of Inspector General's (OIG) Office of Audit Services (OAS) are continuing audit effort in an additional 11 States.

OBJECTIVE

The objective of the nationwide audit is to determine the adequacy of State agency procedures and controls over the payment of Medicaid laboratory claims. Specifically, the audit is designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. In doing so, we identified tests that were not grouped together (bundled into a panel or profile), for payment purposes. Proper grouping of tests helps to ensure that Medicaid agencies do not reimburse medical providers more for clinical laboratory tests than amounts that Medicare recognizes for the same services, as required by applicable laws and guidance.

SUMMARY OF FINDINGS

Our audit of Medicaid claims for outpatient clinical laboratory services in 14 States disclosed that the Medicaid State agencies did not have adequate controls to detect and prevent inappropriate payments for laboratory tests. In this regard, the Medicaid State agencies paid medical providers more for clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients than the amounts Medicare recognizes for the same services, contrary to applicable laws and guidance. This included potential overpayments for hematology profiles and indices that were duplicated or may have been medically unnecessary. As a result, we estimate that the 14 State agencies potentially overpaid laboratory providers by about $27.4 million (Federal share $15.7 million) for chemistry, hematology, and urinalysis tests during our audit period. Assuming that overpayments would continue at the same rate, the savings that would result from correction of the problem at the State agencies audited are estimated at $13.8 million (Federal share $7.9 million) annually.

RECOMMENDATIONS

Individual reports were issued to each of the State agencies. The reports generally recommended that the State agencies: (1) install system edits and controls to detect and prevent the types of errors disclosed in our audit, (2) recover the Medicaid overpayments for clinical

laboratory services identified in our audit, and (3) reimburse the Federal Government for its share of any recoveries made by the State agency. In response to our individual reports, four States agreed with reported findings and recommendations, three States partially agreed, while three States did not agree. The final four States did not provide specific written comments.

We are also recommending that the Health Care Financing Administration (HCFA): (1) reemphasize the Medicaid requirement that State agency payments for outpatient clinical laboratory services not exceed the amounts recognized by Medicare for the same services, (2) consider having State agencies update their provider billing instructions to reflect Medicare bundling procedures, and (3) follow-up on the estimated $27.4 million ($15.7 million Federal share) in potential overpayments identified in our audits to ensure that the State agencies have implemented needed edits, initiated recovery actions, and credited the Federal Government for its share of any recoveries.

HCFA COMMENTS

In its written comments on our draft audit report (APPENDIX F), HCFA fully concurred with our first and third recommendations and partially concurred with our second recommendation. Regarding our second recommendation, HCFA plans to advise Medicaid State agencies that they should consider using the Medicare bundling procedures for the chemistry, hematology, and urinalysis tests examined in the OIG audit. However, HCFA will not tell the State agencies that they must use Medicare bundling procedures for other types of laboratory tests or medical services as long as they stay within the Medicare upper limit for payments and are consistent with the principles of efficiency, economy, and quality of care. The written comments also raised several points on how we identified laboratory overpayments.

OAS RESPONSE

We are pleased that HCFA has agreed to implement our recommendations and believe that HCFA's proposed corrective actions will lead to substantial savings in the Medicaid program. We have provided some clarifications on how we identified Medicaid overpayments during our audit of clinical laboratory services. This additional information should eliminate any misunderstandings.

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INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry, hematology, and urinalysis tests. The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

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. Chemistry tests designated by HCFA as frequently performed together on multichannel automated equipment must be grouped together and reimbursed at a single panel rate. Chemistry tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and are to be used when all of the component tests are performed. Some of the component tests of organ panels are also chemistry panel tests.

Hematology tests that are grouped and performed on an automated basis are classified as profiles. Automated profiles include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet count, differential white blood cell counts and a number of additional indices. Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices are red blood cell width, red blood cell volume, and platelet volume.

Urinalysis tests involve physical, chemical, or microscopic analysis or examination of urine. These tests measure certain components of the sample. A urinalysis may be ordered by the physician as a complete test which includes a microscopic examination or without the microscopic examination.

Within broad Federal guidelines, States design and administer their own Medicaid program under the general oversight of HCFA. A designated Medicaid agency in each State is responsible for claims processing, although many States use outside fiscal agents to actually process the claims. While most States maintain their own paid claims files, States may elect to participate in HCFA's Medicaid Statistical Information System (MSIS). The MSIS is operated by HCFA to collect Medicaid eligibility and claims data from participating States.

Funding for each State's Medicaid program is provided through State and Federal matching funds. Section 1903 (i) (7) of the Social Security Act provides that Medicaid payment for clinical laboratory tests shall not be made to the extent that such amount exceeds the amount that would be recognized under Part B of the Medicare program. Further, section 6300.1 of the State Medicaid Manual provides that Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician,

independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, section 6300.2 of the State Medicaid Manual provides that Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests.

OBJECTIVE, SCOPE, AND METHODOLOGY

We have conducted our nationwide audit in accordance with generally accepted government auditing standards. The objective of the nationwide audit is to determine the adequacy of State agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests. Specifically, the audit is designed to determine whether Medicaid payments for chemistry, hematology, and urinalysis tests exceeded amounts recognized by Medicare for the same tests or were duplicated. In doing so, we identified tests that were not grouped together, (bundled into a panel or profile), for payment purposes.

The initial State review was conducted by the Massachusetts State Auditors and was based on our extract and match of applicable procedure codes contained in a paid claims file provided by the State of Massachusetts. In order to expand the audit to other States, we performed similar extracts and matches on paid claims data contained in HCFA's MSIS. At the time of our audit, 24 States participated in contributing paid claims data to the MSIS. Based on the results of our initial extract and match in these 24 States, we initially selected 6 additional States for audit, each having potential overpayments that could exceed $1 million. An additional 7 States were selected for review based on available audit resources. State audit organizations issued 5 of 14 individual State reports summarized in this report and the OIG's OAS issued the remaining 9 reports.

To provide for consistent results in the conduct of the audit, an audit guide was prepared for use in all reviews including those performed by State auditor organizations. The guide provided instructions for extracting and matching procedures and audit steps for reviewing internal controls and verifying payments and computing overpayments.

Our review of the internal controls at each State agency was limited to an evaluation of that part of the claims processing function that related to the processing of claims for clinical laboratory services. Specifically, we reviewed State agency policies and procedures and instructions to providers related to the billing of clinical laboratory services. We also reviewed State agency documentation relating to manual and automated paneling and duplicate claim detection edits for chemistry, hematology, and urinalysis tests.

In order to test the reliability of HCFA's MSIS generated output and State agency payment files, we compared the payment data to source documents (i.e., billings and remittance advices) for the 2,138 randomly selected instances that we sampled in the 14 States. We did not assess the completeness of the HCFA and State agency data files nor did we evaluate the adequacy of the input controls.

This consolidated report covers the Calendar Years (CY) 1993 and 1994 Medicaid laboratory payments for 11 of the 14 States. The initial State review conducted in Massachusetts covered CYs 1992 and 1993, the most complete years available when the audit was initiated. In New Hampshire, the availability of computerized data limited the audit period to the 18-months ending June 1994. Our summary results included a limited audit period for the review in Texas because the sampling approach employed by the State Auditor's office restricted its sample selection to June and July of 1994.

From the States' respective paid claims files, we extracted the claims which contained applicable chemistry, hematology, and urinalysis tests that could be grouped together for payment purposes to ensure that payments would not exceed what Medicare would pay for the same tests. Using a series of computer applications, we identified instances of potential overpayments containing these types of laboratory tests (billed by the same provider for the same beneficiary on the same date of service) which could have been bundled, but were billed separately or duplicatively. We did not consider, as a potential Medicaid overpayment, those instances in which the State agency's respective Medicare carrier did not group together less than three chemistry tests or those tests designated by HCFA as optional.

We selected a sample of instances of potential overpayments for each of the categories under review (i.e., chemistry, hematology, and urinalysis) using a random number generator. We reviewed each of the payment instances identified by the random sample to determine whether an overpayment had been made. In order to determine the amount of overpayment, we analyzed each claim and determined the proper billing code. We then summed the line items included on the claim for each strata then deducted the upper payment limit that would have been paid based on the Medicare fee schedules. The resulting difference was identified as an overpayment. An example of the methodology employed in this calculation is included in APPENDIX A. We projected the number of instances of potential overpayments using an attribute sample appraisal methodology and the total dollar amount of overpayments using a variable sample appraisal methodology. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report.

The chemistry, hematology, and urinalysis tests that were part of our review are listed in the Physicians' Current Procedural Terminology manual and contained in APPENDIX B. APPENDIX C provides detailed information on the scope of our review in each of the 14 States.

We discussed the results of each of the 14 State audits with the respective State agencies and provided the State agencies and the HCFA regional offices with the audit reports. We also provided copies of the State agency reports to HCFA's headquarters in those cases where the estimated overpayments were reported to exceed $1 million.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report.

The audit of the 14 State agencies took place between November 1994 and March 1996. Staff from the State auditors' offices and the OIG's OAS are continuing audit effort in an additional 11 States.

FINDINGS AND RECOMMENDATIONS

Our review at 14 State Medicaid agencies disclosed that the States had not established adequate controls to detect and prevent inappropriate Medicaid payments. As a result, clinical laboratory service providers were paid approximately $27.4 million ($15.7 million Federal share) more for clinical laboratory tests during our audit period than the amounts Medicare recognizes for the same services.

In the individual reports addressed to each of the 14 State Medicaid agencies, we recommended that the State agencies implement controls to detect and prevent inappropriate payments for laboratory claims and recover the overpayments identified by our audits. Assuming that overpayments would continue at the same rate, the savings that would result from correction of the problem at the State agencies audited are estimated at $13.8 million (Federal share $7.9 million) annually. A statistical summary of the results of the reviews in each State is contained in APPENDIX D.

PAYMENTS EXCEEDING REQUIREMENTS

Our review at 14 State Medicaid agencies disclosed that, contrary to applicable laws and guidelines, the State Medicaid agencies paid medical providers more for clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients than the amounts Medicare recognizes for the same services. These excessive payments occurred because the States were paying a higher price for individual tests than they would have if the tests had been bundled into lower cost panels and profiles. Such unbundling occurs when a provider bills for chemistry tests performed on the same day for the same beneficiary for more than one different chemistry panel, or a chemistry panel and at least one individual panel test, or two or more individual panel tests.

Our review also identified potential overpayments for overlapping and duplicate clinical laboratory tests. Duplicate billings occur when individual laboratory tests were billed for the same patient for the same date of service as a panel or profile test which included the individual test. Duplicate billings also occur when two or more panels or profiles containing one or more of the same tests were billed for the same patient on the same date of service. Another situation which creates a potential overpayment is hematology indices billed with a hematology profile. Hematology indices are measurements and ratios calculated from the results of hematology tests. While both the profile tests and the indices are generated by a single, automated procedure, indices billed additionally should be based on a specific physician order.

In order to perform our review, we extracted, from each States' paid claims file, those claims which contain the applicable clinical laboratory service codes that are subject to bundling. We then performed a match to identify potential instances of overpayment. For the 14 States reviewed, 31.4 million claims were extracted from the States' paid claims files for review. Our matching procedures identified 4.1 million instances in which the applicable procedure codes were either unbundled or duplicatively reimbursed (See Figure 1). Based on a statistical sample review in each State, we verified that the payment in question exceeded reimbursement requirements. For 2,138 instances of potential overpayments reviewed in the 14 States, we found that 1,843 were verified to be overpaid. Using a weighted average of errors reported in each State (See APPENDIX D), we estimate that 3.5 million (87 percent of 4.1 million instances of potential overpayments) were verified to be overpayments.

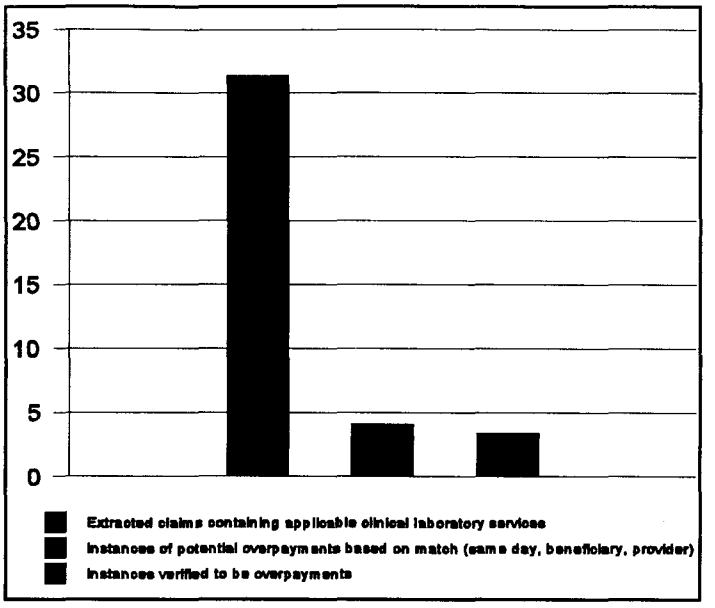

Figure 1 INSTANCES OF OVERPAYMENTS
(In Millions)

The rate of overpayments identified by this review, however, does not represent an overall program error rate for all laboratory services of the total Medicaid programs. Instead, this rate measures the percent of overpayments verified from the population of potential overpayments that were identified by our computer extract and match. While the rate of overpayments confirmed in our population was 87 percent, the dollar overpayments computed amounted to 32 percent of the dollars contained in the claims in our population, ($27.4 million of $87.3 million of claims in the population reviewed). Amounts correctly paid within each claim represent the appropriate amounts for properly grouped tests or panels or profiles and other unrelated tests contained in the claim.

CLINICAL LABORATORY SERVICE REIMBURSEMENT REQUIREMENTS

Medicaid Requirements. Policy for the reimbursement of clinical laboratory services under the Medicaid program derives much of its authority from provisions governing the Medicare program. In this regard, 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 such tests performed for an individual enrolled under part B of title XVIII [Medicare]...."

The reference to section 1833 (h) of the Social Security Act is a reference to the Medicare provision directing the Secretary to establish fee schedules for reimbursement for clinical diagnostic laboratory tests.

In addition, section 6300 of the State Medicaid Manual provides that:

"...clinical diagnostic 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. These fee schedules have been established on the Medicare carrier's service area (not exceeding a Statewide basis)...." "Effective with calendar quarters beginning on or after October 1, 1984 (for services rendered on or after July 1, 1984), Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests...."

Section 6300 further states that:

"...Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests... Each Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency...."

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

To correctly apply the above Medicaid payment principles, laboratory providers, and the Medicaid State agencies must also understand the related Medicare payment principles for laboratory services. Virtually all laboratories that provide services to Medicaid patients should be aware of the Medicare principles, since they also provide services to Medicare patients.

Medicare Requirements. Generally, Medicare claims for clinical laboratory services are reimbursed based on fee schedules and are subject to the guidelines published by HCFA in its Medicare Carriers Manual. Medicare pays the lower of the fee schedule amount or the actual charge for the service, provided that the service is reasonable and necessary.

Section 5114 of the Medicare Carriers Manual states that:

> ***"This Section sets out payment rules for diagnostic laboratory services, i.e., (1) outpatient clinical diagnostic laboratory tests subject to the fee schedule, and (2) other diagnostic laboratory tests...."***

Section 5114.1 continues on to list 21 tests which can be and are frequently performed as panels on automated equipment. Our review also identified three additional tests that HCFA has allowed Medicare carriers the option of adding to their list of chemistry panel tests. These additional tests include Creatinine Phosphokinase (CPK) (procedure codes 82550, 82555), Glutamyltranspetidase Gamma (GGT) (procedure code 82977) and Triglycerides (procedure code 84478).

Section 5114.1 also directs carriers to make payment at the lesser amount for the panel if the sum of the payment allowance for the separately billed tests exceeds the payment allowance for the panel that includes these tests.

Section 7103.1B of the Medicare Carriers Manual discusses duplicate payments and provides that if an overpayment to a supplier is caused by multiple processing of the same charge (e.g., through overlapping or duplicate bills), the supplier does not have a reasonable basis for assuming that the total payment it received was correct and thus should have questioned it. The supplier is, therefore, at fault and liable for the overpayment.

Based on the above criteria, Medicare providers are required to bundle outpatient laboratory tests into the applicable panel and profile test codes when the tests are performed for the same patient on the same date of service. While section 1833 (h) of the Social Security Act does not specifically address bundling of automated laboratory tests into panels, section 1833 (h) (2) (A) (i) authorizes the Secretary, in setting fee schedules, to make "...adjustments as the Secretary determines are justified by technological changes...." The bundling rules are justified by language in section 5114.1.L of the Medicare Carriers Manual referring to the "... numerous technological advances and innovations in the clinical laboratory field and the increased availability of automated testing equipment to all entities that perform clinical diagnostic laboratory tests...."

Under the Medicare payment principles described above, the Secretary has imposed limitations on reimbursement for tests that can be performed as part of an automated battery or panel. Accordingly, laboratory bundling requirements are inseparable from the process of determining the proper Medicare payment amounts from the fee schedule. One way for a State to ensure that its Medicaid payments for laboratory services do not exceed the amounts recognized by Medicare for the same services is for, the State to establish controls that bundle laboratory tests in accordance with Medicare principles and select the appropriate fee from the relevant fee schedule.

STATE MEDICAID AGENCY POLICIES AND PROCEDURES

All 14 of the States that were reviewed needed to make additions or refinements to their claims processing systems to identify and prevent inappropriate payment for clinical laboratory services. Report discussions varied at length and in the number of causes for the overpayments. However, reports for most individual State audits further provided State agency reasons why edits were not implemented or discussed the specific weaknesses found. A brief summary of reasons provided or weaknesses identified is discussed below.

- Reviews in four States disclosed that the respective State agencies did not have edits or controls covering all of the applicable procedure codes, places of service, types of service, or billings involving multiple claim forms.

- State agencies in four States did not have procedures or controls to limit Medicaid payments to what the Medicare carrier pays for bundling two tests.

- State agencies in five States did not inform providers of all the clinical laboratory tests that are subject to bundling so that the providers could adjust their Medicaid billings accordingly.

- Officials at two State agencies indicated that the State agencies intentionally paid for both hematology profiles and the related indices that were generated on the same date of service because they believed that the indices were additional to what was included in the hematology profiles.

- State agencies in two States did not adjust their Medicaid laboratory fees so that they did not exceed the comparable amounts on the Medicare fee schedule for clinical laboratory tests.

POTENTIAL OVERPAYMENTS

We estimate that the 14 State agencies overpaid laboratory providers by a total of $27.4 million ($15.7 million Federal share) for chemistry, hematology, and urinalysis tests during our audit period. Figure 2 provides a breakout of estimated potential overpayments found in each category of clinical laboratory service. Further, we estimate that $13.8 million ($7.9 million Federal share) in additional annual savings is available if the 14 State agencies implement our audit recommendations. These estimates represent the sum of the dollar impact figures developed for the 14 individual State reports (See APPENDIX D).

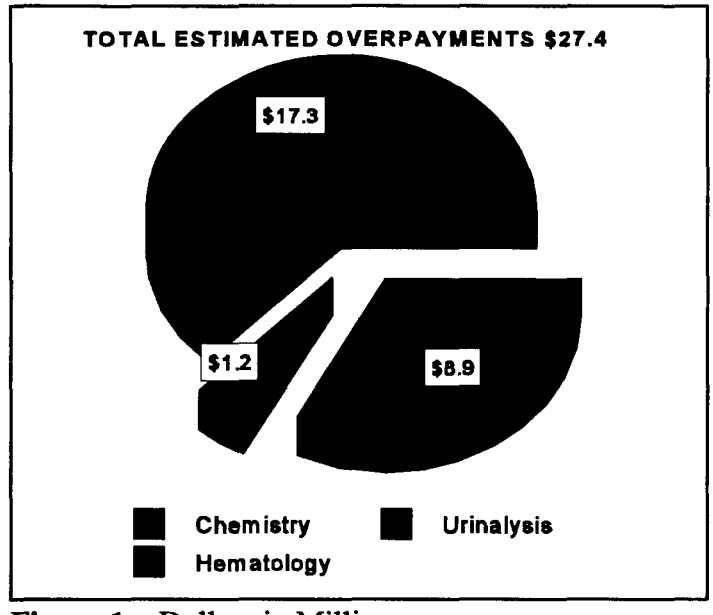

Figure 1 Dollars in Millions

INDIVIDUAL REPORT RECOMMENDATIONS AND RESPONSES

Individual audit reports were issued to each of the 14 State Medicaid agencies recommending that the agencies: (1) install system edits and controls to detect and prevent the types of bundling and duplicate claim errors disclosed in our audit, (2) recover the Medicaid overpayments for clinical laboratory services identified in our audit, and (3) reimburse the Federal Government for its share of any recoveries made by the State agency.

Four States responded to our draft audit reports by indicating that they were in complete agreement with our reported findings and recommendations. Three additional States advised us that they partially agreed with our findings and recommendations, while three States did not agree with our findings and recommendations. The final four States did not provide us with specific written comments on our reported findings and recommendations.

Two of the three States that partially agreed with our findings and recommendations agreed to implement edits to prevent inappropriate future payments for unbundled and duplicate laboratory claims. However, both States indicated that they should not be held responsible for overpayments during CYs 1993 and 1994 because Medicaid guidelines were not clear during that period. The remaining State agreed with our findings, but did not comment about what they had done or planned to do for corrective action.

The two of the three States that did not agree with our position both indicated that there were no Federal Medicaid requirements on bundling laboratory tests provided during CYs 1993 and

1994. As a result, they suggested that the States should not be held responsible for any overpayments associated with unbundling laboratory tests during that two year period. Both of these States implemented new "claim check" software during calendar year 1995 to improve their performance on Medicaid payments for unbundled and duplicate laboratory tests.

We believe that State agencies should be required to attempt to recover overpayments identified in our audit. While we agree that Medicaid guidance does not specify that bundling laboratory tests is required, there is no question that Federal provision requires that Medicaid payments not exceed what Medicare pays for the same tests. We believe the most reasonable way to ensure that Medicaid payments for clinical laboratory services do not exceed the amounts recognized by Medicare for the same services is to bundle laboratory services in accordance with Medicare principles. While responses from 4 State agencies did not specifically address the findings and recommendations, 9 of the remaining 10 State agency responses indicated general agreement that either procedures and controls were needed to ensure that (i) Medicaid did not pay more than amounts recognized by Medicare for the same services, (ii) such procedures and controls were already being implemented, and/or (iii) the States were proceeding or planning to proceed with recovery of potential overpayments.

In addition, two States believed that billing for hematology profiles (procedure codes 85023, 85024 or 85025) and for additional indices (procedure codes 85029 and/or 85030) for the same patient, on the same day by a single provider was appropriate. In this regard, the States believed that the additional indices did not duplicate indices that were provided under the profile.

While the description of hematology profiles contained in the CPT manual indicates that the profiles include indices, the specific indices that are normally produced under each profile are not listed. Likewise, the CPT manual does not identify indices contained in the procedure codes for additional indices (85029/85030), however, examples are provided. While indices are generally produced at the same time that the profile is performed, separate reimbursement of the examples described under additional indices should be based on a physician order for the additional indices.

Our concern is that the use of these procedure codes may not be based on a physician order for additional indices. Based on data available for 10 of 14 States reviewed for the audit period, only 8 percent of the providers accounted for 75 percent of the State's Medicaid billing for additional indices. We believe the medical necessity and ordering of such tests would not be confined to so few providers if the practice was appropriate. Accordingly, we believe that billing the combination of hematology profiles and additional indices on the same day for the same beneficiary reflects a potential overpayment that should continue to be subject to review. State agency officials generally agreed that the billing for additional indices by so few providers warrants review of the related reimbursements.

We believe that HCFA should reemphasize to State Medicaid agencies the Medicaid requirements related to reimbursing providers of clinical laboratory services under Medicaid and

the need for State Medicaid agencies to inform medical providers of such requirements in their billing instructions. We also believe that HCFA should follow up on recommendations made in the individual State Medicaid agency reports.

RECOMMENDATIONS

We are recommending that HCFA:

- reemphasize the Medicaid requirement that State agency payments for outpatient clinical laboratory services not exceed the amounts recognized by Medicare for the same services;

- consider having State agencies update their provider billing instructions to reflect Medicare bundling procedures; and

- follow-up on the potential overpayments identified in our audits to ensure that the States: (1) implemented procedures and controls to prevent inappropriate payments for unbundled or duplicate tests, (2) initiated action to recover the estimated $27.4 million ($15.7 million Federal share) in potential overpayments identified in our audits, and (3) appropriately credited the Federal Government with its share of any recoveries.

HCFA COMMENTS

In its written comments on our draft audit report (APPENDIX F), HCFA fully concurred with our first and third recommendations and partially concurred with our second recommendation. Specifically, HCFA advised us that it will issue a State Medicaid Director's letter that will:

- reemphasize what is contained in section 6300 of the State Medicaid Manual concerning States exceeding the Medicare upper limit;

- encourage the States to consider using the Medicare bundling procedures for the chemistry, hematology, and urinalysis tests examined in the OIG audit; and

- say that States are expected to recover duplicate payments and payments found in excess of what Medicare would have paid.

The written comments also indicated that the Systems Performance Review conducted by HCFA's Regional Offices will monitor State performance in these areas.

Regarding our second recommendation, HCFA advised us that it will not tell the State agencies that they must use Medicare bundling procedures for other types of laboratory tests or medical

services as long as the States stay within the Medicare upper limit for payments and are consistent with the principles of efficiency, economy, and quality of care.

The HCFA's response to our draft report included the following "Additional Comments":

- "...Medicare bundling practices are not required under the Medicaid program...."
- "...comparing bundling/unbundling methodologies is not an appropriate measure of whether the upper limits have been violated under Medicaid. Proper measures of upper limit compliance may have consisted of a comparison of fee schedules...."
- "...some States have noted that although tests were not bundled in the States as Medicare policy mandates, the upper limits required by Medicaid were still not exceeded. Inasmuch as this is a possibility, a State should not be held out of compliance for not following Medicare bundling practices...."
- "...three of the chemistry tests that OIG considered to be required to be bundled were not recognized nationally by Current Procedural Terminology (CPT) or Medicare as automated multichannel tests during the time period covered by the OIG audit, OIG claims of excessive payments and recoveries of these monies should not necessarily be required in this area...."
- "...the report should note that in some instances, Medicare carriers did not provide the State Medicaid agencies with the Medicare fee schedules in a timely manner, which may effect compliance with Medicare upper limits...."

OAS RESPONSE

We are pleased that HCFA has agreed to implement our recommendations and believe that HCFA's proposed corrective actions will lead to substantial savings in the Medicaid program. We have provided the following clarifications in response to the "Additional Comments" in HCFA's written response to our draft audit report. We hope that this additional information will eliminate any misunderstandings about our audit.

- Our report does not state that Medicare bundling practices are required under the Medicaid program. Rather, we indicated that incorporating the Medicare bundling requirements into Medicaid was one way to ensure that Medicaid does not pay more than Medicare for the same services (Draft Report, page 7, paragraph 6). We recommended that HCFA consider using the Medicare bundling practices under Medicaid. We are pleased that HCFA intends to encourage States to consider using Medicare bundling practices for the types of laboratory tests covered by our audit.

- Our initial identification of potential Medicaid overpayments was based, in part, on whether the State agencies had bundled applicable laboratory tests. However, our final determination on the dollar amount of potential overpayments was based on a comparison of what Medicaid paid for the laboratory tests versus what Medicare would have paid for the same tests. In estimating the Medicare payment, we considered the Medicare bundling requirements and respective Medicare Carrier fee schedule in effect during our audit period. We did not identify a Medicaid overpayment in those cases where the Medicaid State agency did not bundle laboratory tests and, nevertheless, did not pay more than the Medicare program recognizes for those tests. We used the dollar amount of potential overpayments to estimate the recoveries available to the Medicaid program.

- During our audit period, HCFA allowed Medicare Carriers the option of adding three automated multichannel chemistry tests to their list of panel tests. Our Medicaid audit in each of the 14 States considered whether the related Medicare Carrier(s) included the three "optional tests" as panel tests. If the related Carrier routinely bundled the optional tests into a chemistry panel for payment purposes, we considered this in determining how much Medicare should have paid for the services. Conversely, we did not bundle the optional tests for Medicaid payment purposes if the related Carrier did not bundle the tests under the Medicare program.

- Our audit in 14 States did not disclose a significant problem regarding Medicare Carriers not providing Medicaid State agencies with laboratory fee schedules in a timely manner.

APPENDICES

SAMPLE METHODOLOGY

This consolidated report covers CYs 1993 and 1994 Medicaid laboratory payments for 11 of the 14 States where we have completed an audit. Our pilot review in Massachusetts covered CYs 1992 and 1993. Our audit period in New Hampshire was limited to the 18-month period ending June 1994. The audit period in Texas was limited to June and July of 1994.

From HCFA's MSIS or the State Medicaid agency's paid claims file, we utilized computer applications to extract all claims containing:

-- chemistry panels and panel tests for chemistry procedure codes listed in the CPT manual (See APPENDIX B);

-- hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT manual (See APPENDIX B);

-- urinalysis and component tests listed in the CPT manual (See APPENDIX B).

We then performed a series of computer applications to identify all records for the same individual for the same date of service with HCFA's Common Procedure Coding System (HCPCS) line item charges for:

-- more than one chemistry panel; a chemistry panel and at least one individual panel test; or two or more panel tests;

-- more than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or hematology indices and a profile; and

-- a complete urinalysis test which includes microscopy; a urinalysis without microscopy; or a microscopy only.

This resulted in a sample population totaling more than $87.3 million for approximately 4.1 million instances of potential overpayments. Each instance is a potential payment error in which the State agency paid providers for clinical laboratory tests (on behalf of the same recipient on the same date of service) which were billed individually instead of as part of a group, or were duplicative of each other. An example of an overpayment follows.

SAMPLE METHODOLOGY (cont.)

Example of an Overpayment

Test Code	Test Name	Units		Paid Amount
Individual Test Codes				
82040	Albumin (chemistry test)	1		$7.00
82465	Cholesterol (chemistry test)	1		$6.47
84478	Triglycerides (chemistry test)	1		$8.54
			Total Paid	$22.01
Panel Test Code				
80003	for any 3 clinical, chemistry, automated, multichannel, tests	1		$10.85
Difference in Amounts Paid is an Overpayment:				**$11.16**

On a randomly selected basis, we examined 2,138 instances of potential overpayments involving claims for clinical laboratory services in the 14 States audited. The instances of potential overpayments were stratified into the clinical laboratory service categories of chemistry, hematology, and urinalysis. For each sampled instance, we requested and reviewed supporting documentation from the State agency consisting of copies of physician, hospital, or independent laboratory claims and related paid claims history. Our review disclosed 1,843 potential overpayments out of the 2,138 instances examined.

We projected the number of instances of potential overpayments using a stratified attribute sample appraisal methodology. We utilized a stratified variable appraisal process to quantify the potential overpayments for unbundled chemistry panel tests, duplicate hematology profile tests and unbundled or duplicate urinalysis tests in each of the 14 States, as shown on APPENDIX D. Our estimate is that the 14 State agencies overpaid laboratory providers by $27.4 million ($15.7 million Federal share) during our audit period.

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

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

Chemistry Panel Test CPT Code Description Subject to Panelling (35 CPT Codes)	CPT Codes
Albumin	82040
Albumin/globulin ratio	84170
Bilirubin Total OR Direct	82250
Bilirubin Total AND Direct	82251
Calcium	82310, 82315, 82320, 82325
Carbon Dioxide Content	82374
Chlorides	82435
Cholesterol	82465
Creatinine	82565
Globulin	82942
Glucose	82947
Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
Alkaline Phosphatase	84075, 84078
Phosphorus	84100
Potassium	84132
Total Protein	84155, 84160
Sodium	84295
Transaminase (SGOT)	84450, 84455

PHYSICIANS' CURRENT PROCEDURAL TERMINOLOGY MANUAL CODES

Chemistry Panel Test CPT Code Description Subject to Panelling (35 CPT Codes)	CPT Codes
Transaminase (SGPT)	84460, 84465
Blood Urea Nitrogen (BUN)	84520
Uric Acid	84550
Triglycerides	84478
Creatinine Phosphokinase (CPK)	82550, 82555
Glutamyltranspetidase, gamma	82977

Hematology Component Test CPT Code Description	CPT Codes
Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Calorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

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

Hematology Profile CPT Code Description	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

Urinalysis and Component Test CPT Code Description	CPT Codes
Urinalysis	81000
Urinalysis without microscopy	81002, 81003
Urinalysis microscopic only	81015

SCOPE STATISTICS

STATE	NO. OF CLAIMS EXTRACTED	TOTAL DOLLAR VALUE OF CLAIMS	INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION)	TOTAL DOLLAR VALUE OF INSTANCES	AUDIT PERIOD
New Hampshire	115,441	$ 988,692	17,227	$ 339,388	18 mos.
Massachusetts	2,866,516	19,486,811	294,449	6,584,801	2 CYs
Alabama	928,629	7,961,145	136,134	2,537,432	2 CYs
Georgia	2,747,593	22,264,915	359,320	7,676,288	2 CYs
North Carolina	N/A	17,243,578	237,156	4,493,724	2 CYs
Wisconsin	636,262	4,600,769	86,688	1,371,810	2 CYs
Ohio	4,347,332	81,578,003	539,928	28,915,874	2 CYs
Louisiana	Not Available	13,498,644	70,020	2,039,233	2 CYs
Texas	310,404	3,526,671	17,820	152,795	2 mos.
Iowa	389,654	2,962,274	24,415	437,802	2 CYs
Kansas	605,420	4,117,653	42,471	727,660	2 CYs
Missouri	1,840,042	14,000,528	186,447	3,290,000	2 CYs
California	15,202,332	109,500,000	1,788,567	26,400,000	2 CYs
Washington	1,426,294	10,855,053	259,257	2,300,000	2 CYs
TOTAL	31,415,919	$312,584,736	4,059,899	$87,266,807	

SUMMARY OF STATE RESULTS

STATE	INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION)	SAMPLE SIZE	SAMPLE ERRORS	ESTIMATED ERRORS	LOWER LIMIT	UPPER LIMIT
New Hampshire	17,227	100	99	17,076	16,829	17,323
Massachusetts	294,449	150	146	280,544	269,465	291,623
Alabama	136,134	100	85	115,750	107,688	123,811
Georgia	359,320	150	141	348,411	341,068	355,755
North Carolina	237,156	300	297	234,516	231,841	237,190
Wisconsin	86,688	100	89	78,278	74,311	82,245
Ohio	539,928	150	147	527,175	514,748	539,602
Louisiana	70,020	200	180	64,868	60,858	68,878
Texas	17,820	138	100	11,693	10,127	13,259
Iowa	24,415	150	139	22,777	21,899	23,655
Kansas	42,471	150	102	39,487	38,123	40,851
Missouri	186,447	150	121	151,431	144,432	158,430
California	1,788,567	150	116	1,481,399	1,388,157	1,574,640
Washington	259,257	150	81	153,311	135,528	171,094
TOTAL	4,059,899	2,138	1,843	3,526,716		

ESTIMATED ERRORS / INSTANCES OF POTENTIAL OVERPAYMENTS (POPULATION) = 3,526,716 / 4,059,899 = 87%

SUMMARY OF STATE RESULTS

STATE	DOLLAR VALUE (POPULATION)	ESTIMATED TOTAL DOLLAR ERRORS	ESTIMATED FFP DOLLAR ERRORS	PRECISION (+/- PERCENT)
New Hampshire	$ 339,388	$ 160,485	$ 80,243	25.04
Massachusetts	6,584,801	3,423,796	1,711,898	20.27
Alabama	2,537,432	1,142,337	813,458	14.86
Georgia	7,676,288	3,454,548	2,151,967	10.48
North Carolina	4,493,724	1,961,660	1,282,509	6.06
Wisconsin	1,371,810	569,093	343,561	14.87
Ohio	28,915,874	5,238,882	3,174,762	18.60
Louisiana	2,039,233	1,079,129	792,808	10.96
Texas	152,795	66,448[1]	42,646	[2]
Iowa	437,802	171,025	107,096	10.08
Kansas	727,660	344,254	202,766	8.87
Missouri	3,290,000	1,091,587	653,315	13.59
California	26,400,000	8,026,980	4,013,490	13.55
Washington	2,300,000	716,445	372,337	14.60
TOTAL	$87,266,807	$27,446,669	$15,742,856	

ESTIMATED TOTAL DOLLAR ERRORS / DOLLAR VALUE (POPULATION) = $27,446,669 / $87,266,807 = 32%

[1] Texas State Auditors reported audit results based on the lower bound for estimated amounts. The estimates for the other 13 states are based on the point estimate.

[2] State Auditors did not calculate an OVERALL Precision Percentage for Texas. Precision for each stratum was a follows:

Chemistry = 32.25%
Hematology = 15.41%
Urinalysis = 15.70%

SUMMARY OF STATE RESULTS

STATE	ESTIMATED ONE YEAR TOTAL SAVINGS[3]	ESTIMATED ONE YEAR FFP SAVINGS
New Hampshire	$ 106,990	$ 53,495
Massachusetts	1,711,898	855,949
Alabama	571,169	406,729
Georgia	1,727,274	1,075,984
North Carolina	980,830	641,255
Wisconsin	284,547	171,781
Ohio	2,619,441	1,587,381
Louisiana	539,565	396,404
Texas	66,448	42,646
Iowa	85,513	53,548
Kansas	172,127	101,383
Missouri	545,794	326,658
California	4,013,490	2,006,745
Washington	358,223	186,169
TOTAL	$13,783,309	$7,906,127

[3] Except for New Hampshire and Texas, each State's estimated one-year total savings were determined by annualizing (dividing by 2) the estimated total dollar errors that were projected for calendar years 1993 and 1994 (for Massachusetts, the pilot review, estimated total dollar errors that were projected for calendar years 1992 and 1993). For the State of New Hampshire, estimated one-year total savings were determined by annualizing the estimated total dollar errors for the 18 month period ending June 1994 (dividing by 18, multiplying by 12). For the State of Texas, annualized savings was limited to the overpayments identified by the state auditors in the months of June and July 1994.

SUMMARY OF STATE RESULTS

STATE	NO. OF INSTANCES OF POTENTIAL OVERPAYMENTS				POTENTIAL OVERPAYMENTS			
	TOTAL	CHEMISTRY	HEMATOLOGY	URINALYSIS	TOTAL	CHEMISTRY	HEMATOLOGY	URINALYSIS
New Hampshire	99	49	50	N/A	$ 160,485	$ 127,572	$ 32,913	$ N/A
Massachusetts	146	46	50	50	$ 3,423,796	2,856,040	381,837	185,919
Alabama	85	43	42	N/A	1,142,337	753,185	389,152	N/A
Georgia	141	50	49	42	3,454,548	1,909,812	1,395,670	149,066
North Carolina	297	100	98	99	1,961,660	946,139	846,655	168,866
Wisconsin	89	41	48	N/A	569,093	280,676	288,417	N/A
Ohio	147	49	48	50	5,238,882	4,502,818	470,648	265,416
Louisiana	180	46	84	50	1,079,129	1,048,616	12,363	18,150
Texas	100	22	42	36	66,448	43,660	13,502	9,286
Iowa	139	49	44	46	171,025	141,656	21,534	7,835
Kansas	102	45	50	07	344,254	183,578	160,419	257
Missouri	121	21	50	50	1,091,587	386,689	661,656	43,242
California	116	34	46	36	8,026,980	3,966,460	3,727,988	332,532
Washington	81	20	36	25	716,445	186,240	474,573	55,632
TOTAL	1,843	615	737	491	$27,446,669	$17,333,141	$8,877,327	$1,236,201

INDIVIDUAL STATE REVIEWS INCLUDED IN NATIONWIDE AUDIT

STATE	CIN NUMBER	RESPONSIBLE AUDIT ORGANIZATION
New Hampshire	A-01-95-00005	Office of Inspector General
Massachusetts	A-01-96-00001	State Auditor's Office
Alabama	A-04-95-01108	Office of Inspector General
Georgia	A-04-95-01109	Office of Inspector General
North Carolina	A-04-95-01113	State Auditor's Office
Wisconsin	A-05-95-00035	Office of Inspector General
Ohio	A-05-96-00019	State Auditor's Office
Louisiana	A-06-95-00031	State Auditor's Office
Texas	A-06-95-00078	State Auditor's Office
Iowa	A-07-95-01139	Office of Inspector General
Kansas	A-07-95-01147	Office of Inspector General
Missouri	A-07-95-01138	Office of Inspector General
California	A-09-95-00072	Office of Inspector General
Washington	A-10-95-00002	Office of Inspector General

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administratio

The Administrator
Washington, D.C. 20201

DATE: OCT 18 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Medicaid Payments for Clinical Laboratory Tests in 14 States," (A-01-95-00003)

We reviewed the above-referenced report that examines the adequacy of state agency procedures and controls over the payment of Medicaid claims for clinical laboratory tests.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Comments of the Health Care Financing Administration (HCFA)
on Office of Inspector General (OIG) Draft Report
"Medicaid Payments for Clinical Laboratory
Tests in 14 States," (A-01-95-00003)

OIG Recommendation

HCFA should reemphasize the Medicaid requirement that state agency payments for outpatient clinical laboratory services not exceed the amounts recognized by Medicare for the same services.

HCFA Response

We concur. A State Medicaid Director's letter will reemphasize what is contained in section 6300 of the State Medicaid Manual, i.e., that states must not exceed the Medicare upper limit.

OIG Recommendation

HCFA should consider having state agencies update their provider billing instructions to reflect Medicare bundling procedures.

HCFA Recommendation

We concur partially. We plan to say in the State Medicaid Director's letter that states should consider using the Medicare bundling procedures for the chemistry, hematology, and urinalysis lab tests looked at in the OIG audit. Presently the bundling procedures for these tests are appropriate, given the state of the automated multichannel lab testing equipment and the direction provided by national policy and coding experts. Also, we feel that these bundling procedures are also now consistent with the principles of efficiency, economy, and quality of care. We will not be telling states, however, that they must use Medicare bundling procedures for other lab tests or medical services. As long as state agencies stay within the Medicare upper limit and are consistent with the principles of efficiency, economy, and quality of care, they are free to use these or other methodologies to meet their own needs. In fact, we assume that state agencies already have payment and bundling policies that are different from Medicare's in some areas and service categories.

OIG Recommendation

HCFA should follow-up on the potential overpayments identified in our audits to ensure

that the states: (1) implemented procedures and controls to prevent inappropriate payments for unbundled or duplicate tests, (2) initiated action to recover the estimated $27.4 million ($15.7 million Federal share) in potential overpayments identified in our audits, and (3) appropriately credited the Federal Government with its share of any recoveries.

HCFA Recommendation

We concur. The State Medicaid Director's letter will say that states are expected to recover duplicate payments and payments found in excess of what Medicare would have paid. The letter will encourage and ask the states to consider using the Medicare bundling policies for the particular lab tests used in the OIG audit. Also, as part of the Systems Performance Review, HCFA's Regional Offices will have an opportunity to monitor state performance in these areas.

Additional Comments

The report summary notes that to identify violations of the Medicaid upper limit requirements, tests not grouped together were assumed to be excessive of the amount Medicare pays for the same tests. As you note, "We believe the most reasonable way to ensure that Medicaid payments for clinical laboratory services do not exceed the amounts recognized by Medicare for the same services is to bundle laboratory services in accordance with Medicare principles." (Draft Report, p. 10).

However, Medicare bundling practices are not required under the Medicaid program. The Medicaid program is organized to promote flexibility for states, and the opportunity to create innovative methods within the individual state programs. Section 6300 of the State Medicaid Manual states, "These guidelines are designed to provide assistance to the state Medicaid agencies in implementing, where applicable, the limitations of the Medicare fee schedules and the specimen collection fees into payment procedures. *The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the state Medicaid program.*" (Emphasis added).

Medicare upper limits for laboratory services are clearly a requirement under the Medicaid program. However, as we have clarified in a conference call earlier with OIG, comparing bundling/unbundling methodologies is not an appropriate measure of whether the upper limits have been violated under Medicaid. Proper measures of upper limit compliance may have consisted of a comparison of fee schedules.

Some states have noted that although tests were not bundled in the state as Medicare policy mandates, the upper limits required by Medicaid were still not exceeded. Inasmuch as this is a possibility, a state should not be held out of compliance for not following Medicare bundling practices. While it may seem reasonable to assume that unbundling lab tests may result in a violation of the Medicare upper limit, again, Federal law does not require state Medicaid agencies to bundle, and it would be contrary to the nature of the Medicaid program to require states to do so.

In addition, since three of the chemistry tests that OIG considered to be required to be bundled were not recognized nationally by Current Procedural Terminology (CPT) or Medicare as automated multichannel tests during the time period covered by the OIG audit, OIG claims of excessive payments and recoveries of these monies should not necessarily be required in this area.

We do believe that the grouping of tests may help to decrease duplicate billing practices. Duplicate billing practices clearly violate Federal Medicaid requirements that costs be consistent with the efficiency, economy, and quality of care. In addition, we believe that the Medicare grouping of tests may be a useful and cost-effective methodology to follow.

However, due to the Federal/state nature of the Medicaid program, we cannot force state agencies to adopt these Medicare reimbursement methodologies. Medicaid can only strongly encourage the bundling of laboratory tests - which we intend to do. This policy will be clearly enunciated in an All State Medicaid Director letter.

The report should note that in some instances, Medicare carriers did not provide the state Medicaid agencies with the Medicare fee schedules in a timely manner, which may affect compliance with Medicare upper limits.

States that commented that there were no Federal Medicaid requirements on bundling laboratory tests provided during calendar year 1993 and 1994 (Draft Report p. 9) are correct as there are no current Federal Medicaid requirements.

We found no mention of CLIA certification, which is required for services to be covered.

Technical Comments

On page 4, the first sentence in the "Payments Exceeding Requirements" section, we suggest changing the language "the amounts Medicare recognizes" to "should have been paid."

Page 4

We believe that the last sentence of paragraph 4 on page 10 is unclear. How do we know that "all" of the indices are performed at the same them? This information should be clarified.

We suggest adding the following sentence to the end of paragraph 5 on page 10: "A CPT coding change is also warranted to incorporate all the hematology indices together."