Memorandum

Date JUL 17 2000

From for June Gibbs Brown
Inspector General

Subject Follow-Up Audit of Medicare Reimbursements to Hospital Outpatient Department Laboratories for Additional Hematology Indices (A-01-99-00521)

To

Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached are two copies of the Department of Health and Human Services, Office of Inspector General's final report entitled, "Follow-Up Audit of Medicare Reimbursements to Hospital Outpatient Department Laboratories for Additional Hematology Indices." The objective of the audit was to determine the extent and effectiveness of the Health Care Financing Administration's (HCFA) corrective actions to eliminate the procedure codes for additional indices from the Medicare fee schedules. The audit also determined the amount of payments made for additional hematology indices subsequent to the period of our last audit and prior to the implementation of corrective actions.

Our prior audit report, issued on November 16, 1998 under A-01-96-00527, showed that Medicare reimbursement for claims with additional hematology indices, when separately billed along with a hematology profile, was not appropriate for the following reasons: (1) Medicare contractor studies have determined that additional hematology indices are a by-product of the automated results provided by the hematology profile tests which calculate and measure all indices simultaneously; (2) additional hematology indices are not normally ordered or used by physicians for the care and treatment of their patients; (3) laboratory order forms do not allow for separate ordering of additional indices but the services are routinely billed to Medicare even though they are not needed by the physicians; and (4) billing of additional hematology indices is concentrated among relatively few providers, indicating that this is a billing practice used by certain providers to maximize revenue. The HCFA agreed with the conclusions in our prior report. The HCFA indicated that these codes are not valid for Medicare reimbursement and were to be removed from the Medicare fee schedules.

Our current audit determined that the procedure codes for additional hematology indices were removed from the Medicare fee schedules as well as from the Physicians' Current Procedural Terminology Manual, effective January 1999. However, we found that a significant number of payments for these services were made from the time our prior audit period ended (December 1995) to the date the procedure codes were eliminated from the fee

schedules. We did note, however, that the number of instances in which additional hematology indices were paid decreased significantly, from over 2 million instances in 1996 to about 108,000 instances in 1998. We attribute the decrease to edits implemented by HCFA and Medicare fiscal intermediaries (FI) to deny payment of additional hematology indices in certain billing situations. With regard to these payments, we selected a random sample of services with additional hematology indices procedure codes and verified that FIs reimbursed providers about $14 million for these additional hematology indicies. As noted above, we believe that these represent overpayments by the Medicare program based on the evidence identified in our prior audit.

We recommended that HCFA direct FIs to recover the estimated $14 million in overpayments made to providers for reimbursement of additional hematology indices for the period January 1996 through December 1998.

In its comments to our draft report, HCFA concurred with our recommendation and indicated that they will ensure that FIs begin appropriate recovery efforts. 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 should have any questions, please call 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-01-99-00521 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP AUDIT OF MEDICARE REIMBURSEMENTS TO HOSPITAL OUTPATIENT DEPARTMENT LABORATORIES FOR ADDITIONAL HEMATOLOGY INDICES

JUNE GIBBS BROWN
Inspector General

JULY 2000
A-01-99-00521

EXECUTIVE SUMMARY

BACKGROUND

This final report presents the results of our nationwide audit of Medicare reimbursement for clinical laboratory services involving additional hematology indices performed by hospitals as an outpatient service. The audit follows up on the Health Care Financing Administration's (HCFA) efforts to initiate corrective action regarding the inappropriate reimbursement of additional hematology indices when billed with a hematology profile service. This issue was addressed in our prior report entitled, "Review of Clinical Laboratory Tests Performed by Hospital Outpatient Department Laboratories" (A-01-96-00527), issued on November 16, 1998.

OBJECTIVE

The objective of this audit was to determine the extent and effectiveness of HCFA's corrective actions to eliminate the procedure codes for additional hematology indices from the Medicare fee schedules. We also identified the amount of payments made for additional hematology indices subsequent to the period of our last audit and prior to the implementation of corrective action.

SUMMARY OF FINDINGS

Our prior audit of clinical laboratory services provided by hospital outpatient department laboratories, which included the period January 1994 through December 1995, showed that Medicare reimbursement for additional hematology indices, when separately billed along with a hematology profile, was not appropriate for the following reasons: (1) Medicare contractor studies have determined that additional hematology indices are a by-product of the automated results provided by the hematology profile tests which calculate and measure all indices simultaneously; (2) additional hematology indices are not normally ordered or used by physicians for the care and treatment of their patients; (3) laboratory order forms do not allow for separate ordering of additional hematology indices, but the services are routinely billed to Medicare even though they are not needed by the physicians; and (4) billing of additional hematology indices is concentrated among relatively few providers, indicating that this is a billing practice used by certain providers to maximize revenue. In response to our prior report, HCFA agreed with our conclusion that additional hematology indices are not valid codes for Medicare reimbursement and were to be removed from the Medicare fee schedules.

Our current audit determined that these procedure codes were removed from the Medicare fee schedules as well as the Physicians' Current Procedural Terminology (CPT) Manual, effective January 1999. However, we found that payments for additional hematology indices continued to be made by Medicare through December 1998 even though the number of instances of paid indices had decreased significantly, from over 2 million instances in 1996 to about 108,000 instances in 1998. We attribute this decrease to edits implemented by HCFA and Medicare fiscal intermediaries (FI) to deny payment of additional hematology indices in certain billing situations. For the payments made during the period of our current audit (January 1996 through December 1998), we selected a random sample of services with additional hematology indices procedure

codes and verified that FIs reimbursed providers about $14 million. As noted above, we believe that these represent overpayments to the Medicare program based on the evidence identified in our prior audit.

RECOMMENDATION

We recommended that HCFA direct FIs to recover the estimated $14 million in overpayments made to providers for reimbursement of additional hematology indices.

HCFA COMMENTS

In its written comments on our draft report (See APPENDIX C), HCFA concurred with our recommendation and indicated that it will ensure that FIs begin appropriate recovery efforts.

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INTRODUCTION

BACKGROUND

Hematology tests are among commonly performed clinical laboratory services requested by physicians to diagnose and treat patients. These tests are normally grouped together and performed on an automated basis or classified as profiles. Automated profiles may include hematology component tests such as hematocrit, hemoglobin, red and white blood cell counts, platelet counts, differential white blood cell counts, and a number of indices. Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices performed as part of the hematology profile are red blood cell width, red blood cell volume, and platelet volume.

In general, Part B of Title XVIII of the Social Security Act (Medicare Supplemental Medical Insurance), as amended, provides for reimbursement of outpatient clinical laboratory services performed at hospitals, physicians' practices, or independent laboratories. Claims for clinical laboratory tests performed on a hospital outpatient basis are processed for payment by Medicare FIs. The FIs reimburse claims for clinical laboratory services based on Medicare fee schedules subject to guidelines published in the Medicare Intermediary Manual. Medicare pays 100 percent of the fee schedule amount or 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.

During our previous audit of clinical laboratory claims processed by Medicare FIs, the results of which are included in audit report A-01-96-00527, issued to the HCFA Administrator on November 16, 1998, we determined that separate billing for the additional hematology indices was not appropriate and resulted in overpayments to the Medicare program. In this regard, we noted that Medicare contractor studies had determined that the additional hematology indices were merely a by-product of the automated process that produces the hematology profile results and calculates and measures all indices simultaneously. In addition, the prior audit found that most physicians did not separately order or use the additional hematology indices in the care and treatment of their patients and that providers billed Medicare for the additional hematology indices as a routine billing practice. Other Office of Inspector General, Office of Audit Services (OIG/OAS) audits of Medicare clinical laboratory claims submitted by independent laboratories and physicians and audits of clinical laboratory claims paid under the Medicaid program have disclosed the same type of overpayment situations.

OBJECTIVE, SCOPE, AND METHODOLOGY

The objective of this follow-up audit was to determine the extent and effectiveness of HCFA's corrective actions to eliminate the procedure codes for additional hematology indices from the Medicare fee schedules. We also identified the amount of payments made for additional hematology indices subsequent to the period of our last audit and prior to the implementation of corrective actions.

We reviewed claims containing services for additional hematology indices, identified in CPT and HCFA's Common Procedure Coding System (HCPCS) as procedure codes 85029 and/or 85030, which were paid during the period January 1996 through December 1998. To obtain the population of these procedure codes, we extracted payments for procedure codes 85029 and 85030 from HCFA's 100 Percent Standard Analytical File for the audit period. Our extract identified a nationwide population of 2,617,215 additional hematology indices paid during the period.

In order to test the reliability of HCFA's 100 Percent Standard Analytical File, we compared the payment data to source documents (i.e., billings, remittance advices, and other payment documentation), for 240 randomly selected services involving these procedure codes from 8 randomly selected FIs. To select the FIs, we utilized a multistage sample based on probability-proportional-to-size weighted by the number of paid services containing potential overpayments at each FI. The 8 randomly selected FIs accounted for 1,180,567 of the 2,617,215 services with procedure codes 85029 and/or 85030 that were processed for payment (See APPENDIX A).

For each of the 240 sample services, we verified the payment amount for the service by comparing amounts actually paid versus amounts that should have been paid based on HCFA and local FI Medicare reimbursement policies and practices, and the appropriate Medicare fee schedules. We projected the total dollar amount of overpayments using a variable sample appraisal methodology.

Our review of internal controls at each FI was limited to an evaluation of that part of the claims processing function that related to the processing of claims for additional hematology indices. Specifically, we reviewed each of the eight FIs' policies, procedures, and instructions to providers related to the billing of additional hematology indices. We also reviewed FI documentation relating to manual and automated edits for payments for such services. We did not assess the completeness of HCFA data files nor did we evaluate the adequacy of the input controls.

We conducted our nationwide audit in accordance with generally accepted government auditing standards. Audit work was conducted between May 1999 and December 1999 at the HCFA central office and through contact with the eight FIs in our sample. A separate follow-up audit of clinical laboratory services provided by independent laboratories and physicians, including a review of additional hematology indices, has also been performed (A-01-99-00522).

FINDINGS AND RECOMMENDATIONS

Prior Audit Results

In our prior audit of clinical laboratory services provided by hospital outpatient department laboratories, we determined that some claims for hematology services included a hematology profile procedure code (85021, 85022, 85023, 85024, 85025, or 85027) and an additional

hematology indices procedure code (85029 and/or 85030). Based on evidence accumulated during the prior audit as well as other OIG/OAS audits of similar services provided by independent laboratories and physicians and audits of these services paid under the Medicaid program, we concluded that reimbursement of additional hematology indices was inappropriate for the following reasons: (1) Medicare contractor studies have determined such tests are a by-product of the automated results provided by the hematology profile tests which calculate and measure all indices simultaneously; (2) additional hematology indices are not normally ordered or used by physicians for the care and treatment of their patients; (3) laboratory order forms do not allow separate ordering of additional hematology indices, but the services are routinely billed to Medicare even though they are not needed by the physicians; and (4) billing for additional hematology indices is concentrated among relatively few providers, indicating that this is a billing practice used by certain providers to maximize revenue. The prior audit identified over $21 million in hematology overpayments, the majority of which related to inappropriate payments for additional hematology indices, and an additional $15 million that could be saved for the Medicare program if HCFA had developed policies to preclude payment for additional hematology indices.

In response to the prior audit report, HCFA agreed with our audit conclusions and recommendations and stated that "We will revise our coding instructions to indicate that these codes are not valid for Medicare and we will remove them from our fee schedule."

Current Audit Results

Our discussions with HCFA personnel found that the procedure codes for additional hematology indices were simultaneously eliminated from the CPT manual, HCPCS, and the Medicare fee schedules, effective January 1999. However, during the interim period from the time of our last audit until the elimination of the procedure codes from the Medicare fee schedules, we determined that payments of about $14 million for additional hematology indices were made by Medicare FIs for claims submitted by hospital outpatient department laboratories. We believe that these represent potential inappropriate payments for additional hematology indices based on the factors identified during our various audits of this issue.

Our current review of payments of additional hematology indices, for the 3-year period ended December 31, 1998, showed that, although payments continued to be made by FIs, the number of such paid services had decreased significantly, as illustrated below:

Calendar Year	Number of Paid Services
1996	2,023,287
1997	485,871
1998	108,057

We attribute the decrease in the number of instances in which additional hematology indices were paid to the fact that HCFA and the FIs implemented various edits to deny payment of additional hematology indices in certain billing situations. In this regard, we found that edits effective October 4, 1996 included in the Medicare Intermediary Manual - Part 3 - Claims Processing - Transmittal No. 1686 had the effect of limiting the billing circumstances in which additional hematology indices would still be paid by Medicare when billed with other hematology procedure codes. Additional edits were implemented by the Florida and Arkansas Shared Claims Processing Systems. These claims processing systems are utilized by most FIs for processing Medicare claims payments for these types of services. These edits, implemented or made available to FIs in 1997 and 1998, had the effect of further reducing the circumstances in which additional hematology indices would be paid by Medicare.

In addition to these edits, we found that some FIs also implemented local medical review policies to deny payment for additional hematology indices unless they were medically necessary. For example, we followed up with the eight FIs that were included in our prior audit and noted that four of the FIs implemented policies to deny payment of additional hematology indices unless medical necessity was documented. Of the FIs included in our current review, we found that one had a local policy to deny payment of additional hematology indices if not medically necessary.

Despite the edits and policies that have been implemented to deny payment of additional hematology indices, we still identified a significant number of payments made for these services during the period January 1996 through December 1998. Based on our review of a random sample to verify payments, we determined that hospitals claimed 2,617,215 services for additional hematology indices and were paid an estimated amount of $13,977,526 (See APPENDIX B). We believe that these represent overpayments to the Medicare program because they are for services that were inappropriate for Medicare reimbursement.

Our conclusion that these services represent overpayments is based on various factors identified during our prior and current audits of clinical laboratory claims as follows:

- Many Medicare contractors had developed policies to either deny separate payment for additional hematology indices or only pay based on documented medical need. This was especially evident among Medicare carriers as our survey of all carriers nationwide determined that 38 of 52 carriers had such policies. As noted previously, our follow up with the eight FIs included in our prior audit disclosed that four either had non-payment policies for additional hematology indices in effect or have implemented such policies since the time of our last audit. These policies were usually developed after studies by the contractors' advisory committees determined that additional hematology indices were seldom clinically useful or were merely a by-product of analysis performed on automated equipment which produces the hematology tests and calculates and measures all indices simultaneously.

- During our prior audit, we noted that in most cases the laboratories did not provide the opportunity for the physician to order additional hematology indices separately. In this regard, laboratory order forms did not provide a separate line on the form to enable the physician to order additional hematology indices, if necessary. Instead, the physician was provided the additional hematology indices and laboratories routinely billed separately for the services even though the physician had not indicated a need for the additional hematology indices.

- The prior audit showed that only 27 percent of the hospital outpatient department laboratories accounted for 75 percent of the additional hematology indices billed. For our current audit period, we have determined that only 23 percent of the hospital outpatient department laboratories accounted for 80 percent of the billed services indicating that the practice is even more concentrated among relatively few providers. Accordingly, we believe that billings for additional hematology indices were driven by the billing practices of certain providers rather than medical need.

- The prior audit also identified one hospital outpatient department laboratory, included in our sample, performed a self-review of its billing practices for additional hematology indices and determined that it incorrectly billed additional hematology indices along with a complete blood count (CBC) hematology profile. The provider indicated that the automated equipment that was used to perform the CBC automatically performs and reports the additional hematology indices. The provider further indicated that only a select group of physicians used the additional hematology indices information. As a result, the provider refunded $404,070 to the FI for overpayments for additional hematology indices and discontinued the practice of billing additional hematology indices with the profile.

- Similar audits conducted by OIG/OAS on the issue of billing additional hematology indices have identified the same problems. In this regard, we have performed Medicare audits of clinical laboratory claims submitted by independent laboratories and physicians and found similar inappropriate billing practices for additional hematology indices (A-01-96-00509). Also, a number of OIG/OAS audits of Medicaid State agencies have disclosed these same problems for billings under the Medicaid program. Of particular note, we found in one State, four hospital outpatient laboratories and four independent laboratories accounted for 99 percent and 95 percent, respectively, of the claims involving additional hematology indices billed in the entire State. With regard to this latter point, the Medicaid State agency performed follow-up reviews at some of the providers and found no support to indicate that physicians ordered the additional hematology indices that were reimbursed.

In addition to the evidence gathered during our audits on this issue, it should also be noted that we provided the results of the prior audit to OIG, Office of Investigations (OI). The OIG/OI, in cooperation with the U.S. Attorney's Offices of the Department of Justice (DOJ), has been involved in a number of investigations of the billing practices of some of the providers identified in our prior audit. In this regard, the frequency by which some of these providers billed for these services was far in excess of other providers and warranted further review to determine whether overpayments to these providers were the result of insufficient internal controls, adoption of aberrant marketing or billing practices, or some form of potentially fraudulent activity. The OIG/OI and DOJ activity recovered, or is in the process of recovering, overpayments related to additional hematology indices from a number of Medicare providers.

CONCLUSION

In summary, we believe that the results described above from our prior and current audits provide significant evidence to support our contention that additional hematology indices are merely by-products of the automated process used to produce hematology tests, are not used by most physicians in treating their patients, and are the result of a billing practice used by certain providers to maximize revenue. The actions taken by HCFA to eliminate the additional hematology indices from the Medicare fee schedules further substantiate our contention that additional hematology indices were not a routine medical service that should have been billed to Medicare. The HCFA's actions has eliminated the problem for future periods. However, we believe that HCFA should take action to recover the overpayments identified by our current review for the period January 1996 through December 1998.

RECOMMENDATION

We recommended that HCFA direct FIs to recover the estimated $14 million in overpayments made to providers for reimbursement of additional hematology indices for the period January 1996 through December 1998. We will make available to HCFA our computer files identifying the overpayments by provider for use in these recovery efforts. In addition, HCFA should coordinate all recovery efforts with applicable investigative agencies.

HCFA COMMENTS AND OIG RESPONSE

HCFA Comments

In its written comments on our draft report (See APPENDIX C), HCFA concurred with our recommendation. The HCFA indicated that once they receive the computer files identifying the potential overpayments "...we will ensure that the fiscal intermediaries (FIs) begin appropriate recovery efforts..."

OIG Response

We commend HCFA's actions to eliminate Medicare payments for additional hematology indices. We will work with HCFA staff to provide the data necessary for the FIs to collect the overpayments identified.

With respect to the technical comments, we made changes to the report as appropriate.

APPENDICES

APPENDIX A

DETAILED SCOPE OF AUDIT

(Fiscal Intermediaries Selected for Review and Sample Projections)

Fiscal Intermediary	Additional Hematology Indices Services Containing Potential Overpayments (Population)
Blue Cross of California	135,108
Health Care Service Corporation	337,237
Associated Hospital Service of Maine	36,848
Empire Medicare Services	188,968
Premera Blue Cross	62,984
United Government Services	95,128
Aetna - California	13,303
Mutual of Omaha	310,991
Total	1,180,567

APPENDIX B

NATIONWIDE ESTIMATE OF POTENTIAL OVERPAYMENTS

Includes Results of Services Sampled for the Period January 1996 Through December 1998

Fiscal Intermediary	Sample Size	Sample Error
00040 - Blue Cross of California	30	30
00123 - Health Care Service Corporation	30	30
00180 - Associated Hospital Service of Maine	30	30
00308 - Empire Medicare Services	30	30
00430 - Premera Blue Cross	30	30
00450 - United Government Services	30	30
51051 - Aetna - California	30	30
52280 - Mutual of Omaha	30	30
Totals	240	240

ESTIMATE OF POTENTIAL OVERPAYMENTS (point estimate)	LOWER LIMIT	UPPER LIMIT	PRECISION *
$13,977,526	$11,713,546	$16,241,506	+/- 16.20 percent

* Based on 90 percent confidence level

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrati

The Administrator
Washington, D.C. 20201

DATE: MAY 31 2000

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

SUBJECT: Office of the Inspector General (OIG) Draft Report: "Follow-up Audit of Medicare Reimbursements to Hospital Outpatient Department Laboratories for Additional Hematology Indices," (A-01-99-00521)

Thank you for the opportunity to comment on the above-referenced report. Medicare spent $3.5 billion on clinical laboratory services in 1998. I am pleased with our success in reducing the number of instances in which hematology indices were paid improperly from more than 2 million instances in 1996 to about 108,000 instances in 1998. This reduction of 95% is a significant improvement for the program. As your report points out, HCFA has already taken steps that will continue to improve our performance in this area.

Specific efforts taken by our Medicare contractors to effectuate the above reduction are just part of our broader strategy to protect Medicare today and into the future. Since 1993, the Clinton Administration has done more than any previous administration to fight waste, fraud, and abuse of the Medicare program, which pays more than $200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the federal government recovered nearly $500 million as a result of health-care prosecutions. Medicare has also reduced its improper payment rate sharply from 14 percent 4 years ago to less than 8 percent last year, and the Health Care Financing Administration (HCFA) is committed to achieving further reductions in the future.

We appreciate the effort that went into this report and the opportunity to review and comment on the issues raised. We concur with the OIG's recommendation. Our detailed comments on the audit report are attached.

Attachment

Attachment -- Response to OIG Report A-01-99-00521

OIG Recommendation

HCFA should direct fiscal intermediaries (FIs) to recover the estimated $14 million in overpayments made to providers for reimbursement of additional hematology indices for the period January 1996 through December 1998. OIG will make available to HCFA the computer files identifying the overpayments by provider for use in their recovery efforts. In addition, HCFA should coordinate all recovery efforts with applicable investigative agencies.

HCFA Response

We concur. While we agree with the OIG's findings, neither HCFA nor the OIG can determine the exact amount of the overpayment without additional review. We look forward to receiving the computer files identifying the potential overpayments by provider so that HCFA can begin this review. Upon receipt of those files, we will ensure that the fiscal intermediaries (FIs) begin appropriate recovery efforts. We will forward a copy of the draft audit report to the appropriate Regional Office (RO) with instructions to contact the OIG auditor for further instructions.

We also note that the results of prior audits were provided to the Department of Justice (DOJ) for additional investigation. Since it is the RO's responsibility to monitor the FI's role in the recoupment of overpayments, we will advise the RO to coordinate its efforts with the DOJ and the OIG's Office of Investigation.