Memorandum

Date DEC 21

From Thomas D. Roslewicz
Deputy Inspector General
for Audit Services

Subject Follow-Up Audit of Virginia Department of Medical Assistance Services Payments for Outpatient Clinical Laboratory Services (A-03-00-00204)

To Neil Donovan
Director, Audit Liaison Staff
Centers for Medicare & Medicaid Services

This memorandum is to alert you to the issuance on December 31, 2001, of our final report entitled, "Follow-Up Audit of Virginia Department of Medical Assistance Services Payments for Outpatient Clinical Laboratory Services." A copy of the report is attached. We suggest you share this report with components of the Centers for Medicare & Medicaid Services (CMS) involved with program integrity, provider issues, and State Medicaid agency oversight, particularly the Center for Medicaid and State Operations.

The objective of the audit was to determine if the Virginia Department of Medical Assistance Services (State agency) had controls to prevent claiming Federal financial participation (FFP) for clinical laboratory service payments in excess of the amounts Medicare pays. We found that controls did not exist to prevent the State agency from claiming FFP for clinical laboratory services paid in excess of Medicare amounts. As a result, the State agency was overpaid $445,948 in FFP for paid claims totaling $867,631 from Calendar Years (CY) 1996, 1997, and 1998. In addition, as of the start of our audit, the State agency had not refunded the Federal share of overpayments related to 1993 and 1994 totaling $723,463 as identified in our prior audit of Outpatient Clinical Laboratory Services (A-03-96-00202).

Therefore, we recommended that the State agency:

1) Install and revise edits to detect and prevent payments for unbundled and duplicate services.

2) Eliminate payments for additional hematology indices.

3) Recover overpayments for clinical laboratory services identified in this audit. Based on our audit, we estimated that $857,037 (Federal share $440,497) should be recovered for CYs 1996, 1997, and 1998.

4) Make an adjustment on its Quarterly Report of Expenditures to CMS (Form HCFA-64) for the FFP of $445,948 (unbundling and duplication overpayments $440,497, excess fees $5,451) related to Medicaid overpayments of $867,631 (unbundling and duplication overpayments of $857,037 and excess fees of $10,594).

5) Make an adjustment on its Quarterly Report of Expenditures to CMS for the Federal share totaling $723,463[1] for overpayments related to 1993 and 1994 unbundled claims as identified in our prior audit report (A-03-96-00202).

Any questions or comments on any aspect of this memorandum are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104 or David M. Long, Regional Inspector General for Audit Services, Region III, at (215) 861-4470.

Attachment

[1] According to the State agency response, this amount was offset against their draw of Federal money during the week of August 27, 2001, the week after we sent the State agency our draft report.

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

FOLLOW-UP AUDIT OF VIRGINIA DEPARTMENT OF MEDICAL ASSISTANCE SERVICES PAYMENTS FOR OUTPATIENT CLINICAL LABORATORY SERVICES

JANET REHNQUIST
Inspector General

DECEMBER 2001
A-03-00-00204

DEPARTMENT OF HEALTH & HUMAN SERVICES
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OFFICE OF AUDIT SERVICES
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Common Identification Number: A-03-00-00204

Eric S. Bell, Director
Virginia Department of Medical Assistance Services
Suite 1300
600 E. Broad Street
Richmond, Virginia 23219

Dear Mr. Bell:

Enclosed for your information and use are two copies of the Department of Health and Human Services (HHS), Office of Inspector General, Office of Audit Services (OIG/OAS), final audit report entitled, "Follow-Up Audit of Virginia Department of Medical Assistance Services Payments for Outpatient Clinical Laboratory Services." Your attention is invited to the audit findings and recommendations contained in the report.

Final determination as to actions to be taken on all matters reported will be made by the HHS action official. 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. Should you have any questions, please direct them to the HHS action official named below.

In accordance with the principals of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, OIG/OAS reports are made available to members of the public to the extent the information contained therein is not subject to exemptions in the Act. (See 45 CFR part 5). As such, within 10 business days after the report is issued, it will be posted on the world wide web at http://www.oig.hhs.gov.

To facilitate identification, please refer to the above identification number in correspondence pertaining to this report.

Sincerely yours,

David M. Long

David M. Long
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

Steven McAdoo
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150 S. Independence Mall West
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EXECUTIVE SUMMARY

This is our report on the "Follow-Up Audit of Virginia Department of Medical Assistance Services Payments for Clinical Laboratory Services." The objective of this audit was to determine if the Virginia Department of Medical Assistance Services (State agency) had controls to prevent claiming Federal financial participation (FFP)[1] for clinical laboratory service payments in excess of the amounts Medicare pays. We found that controls did not exist to prevent the State agency from claiming FFP for clinical laboratory services paid in excess of Medicare amounts. As a result, the State agency was overpaid $445,948. In addition, as of the start of our audit, we determined that the State agency did not refund the Federal overpayments found on our prior audit of Outpatient Clinical Laboratory Services (A-03-96-00202), totaling $723,463.

This audit was separated into two sections: an unbundling audit and an excess fees audit. Regarding the unbundling audit, we randomly selected 150 claims[2] involving chemistry, hematology, and urinalysis services with potential payment errors[3] from a population of Calendar Years (CY) 1996, 1997, and 1998 paid claims with 124,100 claims totaling $2,593,039. Our review showed that 133 of the 150 sampled claims were overpaid.

- We found that 39 of the 50 sampled chemistry claims involved tests that were available as part of an automated multichannel chemistry panel and should have been paid at the lesser amount for the panel rather than at the higher individual test amount.

- Additionally, we found that 44 of the 50 sampled hematology claims were overpaid due to duplication and billing for hematology indices.

- We also found that all 50 sampled urinalysis claims involved duplicate services.

We also found that a portion of these overpayments was caused by the fact that the State agency's clinical laboratory fees are above the Virginia Medicare carrier fees for these services (hereafter referred to as the excess fees). To avoid duplication, in the unbundling portion of this audit, we eliminated the excess fee overpayments by pricing the service that should be billed at the State agency fee. We examined the excess fees in a separate section of this audit.

Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the State agency overpaid providers $857,037 (Federal share $440,497).

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[1] Federal financial participation represents the Federal share.

[2] A claim is all laboratory services performed on the same day, for the same patient, by the same provider.

[3] A potential payment error is a claim on which the State agency paid a provider for clinical laboratory tests (on behalf of the same Medicaid recipient on the same date of service) on an individual test basis instead of as part of a panel, or for services that duplicate each other.

We also noted that as of April 1998, chemistry unbundling overpayments increased and none of the chemistry overpayments involved multichannel panel codes. At that time, the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration, instructed Medicare providers to eliminate these multichannel panel codes so that Medicare payers (carriers and intermediaries) could determine and pay the proper panel code utilizing claim edits. The providers also billed Medicaid the same as Medicare for unbundled services. However, the State agency did not pay the proper panel code which caused an increase in 1998 unbundling overpayments for chemistry. Officials from the State agency explained that they planned to eliminate these overpayments with claim edits. However, they did not implement these edits.

Additionally, as a result of our prior audit on excessive fees for clinical laboratory and pathology services, the State agency refunded $820,001 in 1999 resulting from excess fees of $1,593,553 in CYs 1997 and 1998. We examined the 1999 refund and determined that the State agency should have refunded $825,452, which is an additional Federal share of $5,451, resulting from excess fees totaling $1,604,147 in CYs 1997 and 1998.

We determined that the State agency did not make an adjustment on its Quarterly Report of Expenditures (Form HCFA-64) to CMS for the Federal share totaling $723,463 for overpayments related to 1993 and 1994 unbundled claims as identified in our prior audit report (A-03-96-00202).

We recommended that the State agency:

1) Install and revise edits to detect and prevent payments for unbundled and duplicate services.

2) Eliminate payments for additional hematology indices.

3) Recover overpayments for clinical laboratory services identified in this audit. Based on our audit, we estimated that $857,037 (Federal share $440,497) should be recovered for CYs 1996, 1997, and 1998.

4) Make an adjustment on its Quarterly Report of Expenditures to CMS for the FFP of $445,948 (unbundling and duplication overpayments of $440,497, excess fees of $5,451) related to Medicaid overpayments of $867,631 (unbundling and duplication overpayments of $857,037 and excess fees of $10,594).

5) Make an adjustment on its Quarterly Report of Expenditures to CMS for the Federal share totaling $723,463 for overpayments related to 1993 and 1994 unbundled claims as identified in our prior audit report (A-03-96-00202).

By letter dated September 24, 2001, the State agency responded to a draft of this report. The State agency generally agreed with all of our recommendations and agreed to refund FFP associated with payments for Outpatient Clinical Laboratory Services paid in excess of Medicare amounts, for the period from 1996 through 1998. However, the State agency explained that it completed an offset against the draw of Federal funds for the $723,463 found in our prior audit (A-03-96-00202) as of the week of August 27, 2001, the week after we sent the State agency our draft report. We considered the State agency's response and incorporated its comments into our final report. A complete copy of the State agency's comments can be found as **APPENDIX C** of this report. Subsequent to the issuance of our draft report, we made a minor adjustment to the universe size from which we drew our sample for claims analysis. The effect of the adjustment was to lower the universe size, with a corresponding reduction in the questioned costs of $2,504. Accordingly, the State agency concurred with an amount of questioned costs that is actually slightly higher than our current recommendation. We considered the amount to be immaterial, and the methodology and principles used to conduct the audit were unchanged. As a result, we did not consider it necessary to re-issue our draft report.

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INTRODUCTION

BACKGROUND

Medicaid, a federally-aided State program established under title XIX of the Social Security Act, provides medical assistance to certain individuals and families with low income and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of the Centers for Medicare & Medicaid Services (CMS), formerly the Health Care Financing Administration. States are required to pay for certain medical services such as outpatient clinical laboratory tests.

Laboratory tests are performed by providers on patients' specimens to help physicians diagnose and treat ailments. Chemistry tests are laboratory tests involving the measurement of various chemical levels in blood. Because the tests are frequently performed by automated equipment, Medicare requires that they be reimbursed at a pre-determined panel reimbursement rate. The panel rates reflect the fact that these services are performed in a group on multichannel equipment. Therefore, the panel rates are less than the total for each service, if paid individually. 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. Many of the component tests of organ panels are also chemistry panel tests.

The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory. Providers submit claims for laboratory services performed for Medicaid recipients. Claims processing is the responsibility of a designated Medicaid agency in each State.

The State Medicaid Manual essentially limits Medicaid payments for outpatient clinical laboratory tests to the amount that Medicare pays. Specifically:

- Section 6300.1 states that Federal matching funds will not be available to the extent a State pays more for outpatient clinical laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests.

- Section 6300.2 states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. The Medicare carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains the fee schedule and provides it to the State Medicaid agency in its locality.

K Section 6300.5 allows a State agency to enter into agreements to purchase laboratory services. However, States may not pay more in the aggregate for clinical diagnostic laboratory tests than the amount that would be paid for the tests under the Medicare fee schedule.

Under Medicare, clinical laboratory services are reimbursed at the lower of the fee schedule amount or the actual charge.

OBJECTIVE, SCOPE, AND METHODOLOGY

Our audit was conducted in accordance with generally accepted government auditing standards. The objective of our audit was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers in Calendar Years (CY) 1996, 1997, and 1998 for clinical laboratory services involving chemistry, hematology, and urinalysis tests. To accomplish our objective, we:

- reviewed State agency policies and procedures for processing Medicaid claims from providers for clinical laboratory services;

- reviewed State agency controls and edits regarding unbundled and or duplicated laboratory services;

- reviewed the Virginia Medicare carrier and intermediary policies for processing Medicare claims from providers for clinical laboratory services during our audit period;

- extracted 124,100 claims from the Virginia Department of Medical Assistance Services CYs 1996 through 1998 paid claims for 3 strata: chemistry, hematology, and urinalysis, totaling $2,593,039;

- selected a random statistical sample of 50 claims from a population of 63,433 claims containing chemistry services valued at $1,768,416; 50 claims from a population of 40,853 hematology claims totaling $650,363; and 50 claims from 19,814 urinalysis claims totaling $174,260;

- reviewed the randomly selected claims and supporting documentation, including remittance advices from the State agency, to determine if the services were paid or adjusted. We tested the reliability of computer generated output by comparing data to supporting documents for our sampled items. We did not, however, assess the completeness of data in the paid claims files, nor did we evaluate the adequacy of the input controls; and

- utilized a stratified variable sample appraisal methodology to estimate the amount of overpayments for laboratory tests.

Regarding excess fees, our prior report on excess State agency clinical laboratory and pathology fees resulted in CMS requiring the State agency to correct its laboratory fee schedules to agree with Medicare and to refund the Federal share of laboratory overpayments for 1997 and 1998 totaling $1,593,553 (Federal share $820,001). Because the 1997 and 1998 excess fees were refunded, we performed a detail examination of the refund.

This included:

- determining which State agency fees were paid above Medicare rates during 1997 and 1998.

- examining on a judgmental sample basis, the Virginia Medicaid paid claims tape for any State agency laboratory fees that were paid above Medicare rates and not refunded.

- verifying the refund amount. Specifically, we determined which State agency fees exceeded Medicare fees and the amount of the excess. We multiplied units refunded by the excess fee amount. For any discrepancies between the amount refunded and the audited excess amount, we examined supporting documentation.

- examining our prior years' extracts from the paid claims tapes to assure that quantities that were refunded are in line with prior years.

- verifying the refund transactions with CMS officials.

Our review of internal controls was limited to an evaluation of claims processing for clinical laboratory services. Specifically, we reviewed the State agency's policies and procedures and instructions to providers related to the billing of clinical laboratory services. We also reviewed the State agency's documentation relating to manual and automated edits for bundling of chemistry tests. We limited our review to claims paid by the State agency during CYs 1996 through 1998.

Details of the methodology used in selecting and appraising the sample are contained in **APPENDIX A** to this report. We performed our audit between August 2000 and January 2001. During this period, we visited the State agency office in Richmond, Virginia.

By letter dated September 24, 2001, the State agency responded to a draft of this report. We reviewed the State agency's response and included it as **APPENDIX C** to this report. We have also presented a summary of their comments after the **CONCLUSIONS AND RECOMMENDATIONS** section of this report.

RESULTS OF AUDIT

Contrary to the State Medicaid Manual, section 6300, the State agency paid providers more for laboratory tests than would have been paid under the Medicare program. As a result, the State agency overpaid providers $867,631 and over-claimed the Federal share of $445,948 for laboratory services from CY 1996 through CY 1998. This is comprised of unbundling overpayments totaling $857,037 (Federal share $440,497) and excess fee overpayments of $10,594 (Federal share $5,451). Therefore, the State agency should refund the Federal share of $445,948 related to overpaid laboratory services from 1996 through 1998.

CHEMISTRY

Contrary to the State Medicaid Manual, section 6300, the State agency paid providers more for chemistry tests than would have been paid under the Medicare program. Specifically, the State agency reimbursed Medicaid providers for chemistry tests that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. These improper payments were caused by the State agency's lack of policies requiring providers to bill for bundled services and by the lack of edits to eliminate payments for unbundled services. State agency officials told us that they have proposed changes to their claims edits. However, they have not yet implemented these changes.

We randomly selected and reviewed 50 claims totaling $1,316 from the population of CYs 1996, 1997, and 1998 paid claims files with 63,433 chemistry services valued at $1,768,416. Our audit showed that 39 of the 50 claims totaling $591 were overpaid. We projected the results of our statistical sample of laboratory services over the population using standard statistical methods.

Overall, we estimated at least $857,037 was overpaid based on our statistical analysis of laboratory claims. In order to determine the amount of overpayments attributable to chemistry claims, we used an accounting allocation based on the point estimate of the chemistry strata compared to the overall point estimate. We determined that the State agency overpaid providers $638,848 (Federal share $328,412) for chemistry claims during the 3-year audit period.

The 39 payment errors are summarized as follows:

- ✓ Eight claim payments for two or more chemistry tests, which are components of a panel (component chemistries) and not bundled into a panel.

- ✓ Twenty-three claim payments for panel tests billed with components of these panel tests.

- ✓ Five claim payments for multichannel panel tests billed with other multichannel panel tests.

- ✓ Three claim payments for multichannel panel tests billed with other multichannel panel tests and component chemistries tests.

Section 5114.1.L.2 of the Medicare Carriers Manual states that if the carrier:

> *"receives claims for laboratory services in which the physician or laboratory has separately billed for tests that are available as part of an automated battery test, and, in the carrier's judgement, such battery tests are frequently performed and available for physicians' use, the carrier should make payment at the lesser amount for the battery. 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."*

The chemistry unbundling overpayment in our sample increased in 1998. This increase is also reflected in the population of potential chemistry errors as illustrated in the table below:

POTENTIAL CHEMISTRY ERRORS BY YEAR		
1996	1997	1998
25,981	15,397	22,055

The 1998 increase took place when CMS instructed providers to bill unbundled Medicare services and eliminate multichannel panel codes, so Medicare payers (carriers and intermediaries) could determine and pay the proper panel code, utilizing claim edits. Providers followed these instructions for Medicaid claims, as well as Medicare claims. However, unlike the Medicare payers, the State agency did not have the edits in place to pay the proper panel code. This caused a 43 percent increase in unbundling overpayments for chemistry during 1998. Most of this increase took place in the last 9 months of 1998, which coincided with the Medicare change. Therefore, because the State agency did not implement edits, the escalation in unbundling overpayments could have continued after 1998.

HEMATOLOGY

We determined that State agency controls regarding hematology tests were not sufficient to eliminate overpayments for duplicate services or additional hematology indices.[1] Therefore, the State agency paid more for hematology tests than the Medicare carrier and intermediary allowed, which violated section 6300.1 of the State Medicaid Manual.

[1] Indices are measurements and ratios calculated from the results of hematology tests. Examples of indices performed as part of a hematology profile are red blood cell width, red blood cell volume, and platelet volume.

We randomly selected and reviewed 50 claims with hematology tests valued at $789 from the population of CYs 1996, 1997, and 1998 paid claims files. The 40,853 hematology population claims were valued at $650,363. We determined that 44 of the 50 claims totaling $217 were overpaid. We projected the results of our statistical sample of laboratory services over the population using standard statistical methods.

Overall, we estimated at least $857,037 was overpaid based on our statistical analysis of laboratory claims. In order to determine the amount of overpayments attributable to hematology claims, we used an accounting allocation based on the point estimate of the hematology strata compared to the overall point estimate. We determined that the State agency overpaid providers $150,817 (Federal share $77,435) for hematology tests during the 3-year audit period.

The 44 payment errors are summarized as follows:

- ✓ Thirty-nine claim payments for additional hematology indices that were billed along with a hematology panel. Medicare contractor studies have determined that the additional indices are an automatic bi-product of the hematology panels and not a separate service;

- ✓ Five claim payments for hematology services that duplicate other hematology services.

URINALYSIS

We determined that State agency controls regarding urinalysis claims were not sufficient to eliminate overpayments for duplicate services. Therefore, the State agency paid more for urinalysis tests than the Medicare carrier and intermediary allowed, which violated section 6300.1 of the State Medicaid Manual described above.

Regarding urinalysis billing, the Medicare Carriers Manual at section 5114 requires that, if the "non-automated urinalysis, without microscopy" and the "urinalysis, microscopy only" services are billed, it should be paid as if the all-inclusive urinalysis was billed. The all-inclusive urinalysis is described under CPT code 81000 as:

> *"Urinalysis by dip stick or table reagent for bilirubin, glucose, hemaglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy"*

We randomly selected and reviewed 50 urinalysis claims with payments totaling $439 from the Medicaid paid claims tapes with 19,814 potential urinalysis overpayments totaling $174,260.

We found that all 50 claims for urinalysis services included at least 1 duplicated service and 1 allowable service. The duplicate overpayments on these 50 claims totaled $200. We projected the results of our statistical sample laboratory services over the population using standard statistical methods.

Overall, we estimated at least $857,037 was overpaid based on our statistical analysis of laboratory claims. In order to determine the amount of overpayments attributable to urinalysis claims, we used an accounting allocation based on the point estimate of the urinalysis strata compared to the overall point estimate. We determined that the State agency overpaid providers $67,372 (Federal share $34,650) for urinalysis tests during the 3-year audit period.

EXCESS FEES

As part of our current audit of the State agency laboratory services, we performed a follow-up audit on excessive laboratory and pathology fees for CYs 1997 through 1998.

We found that as a result of our prior audit, CMS required the State agency to correct its laboratory fee schedules to agree with Medicare and to refund the Federal share of similar laboratory fee overpayments for 1997 and 1998 totaling $1,593,553 (Federal share $820,001). Because the 1997 and 1998 fee differences were refunded, we performed a detailed examination of the refund as described in the **OBJECTIVE**, **SCOPE**, **AND METHODOLOGY** section of this report. We determined that the Federal share of the refund was understated by $5,451 and should have been $825,452.

Specifically, we determined that the State agency under-refunded four excessive laboratory fees as listed below:

CPT CODE	AMOUNT REFUNDED	AUDITED REFUND	AMOUNT NOT REFUNDED	FEDERAL SHARE OF AMOUNT NOT REFUNDED
83890	$29,627	$33,159	$ 3,532	$1,817
83894	$21,862	$25,479	$ 3,617	$1,862
86003	$ 8,722	$11,338	$ 2,616	$1,346
88230	$13,607	$14,436	$ 829	$ 426
TOTAL	$73,818	$84,412	$10,594	$5,451

Other than the four excess fees listed above, we determined that the refund amounts were correct. Additionally, we determined that the State agency corrected its fee schedule during March and April 1998 to agree with Medicare.

FOLLOW-UP OF PRIOR AUDIT REPORT

In our prior audit report (A-03-96-00202), which covered clinical laboratory claims paid in 1993 and 1994, we concluded that the State agency did not have adequate edits in its claims processing system to ensure that all reimbursements for clinical laboratory tests paid under Medicaid did not exceed amounts recognized by Medicare. We found that providers received excess reimbursement for chemistry tests that should have been bundled at a lower panel rate. Based on the lower limit of our sample of paid claims, we estimated that the State agency overpaid providers $1,446,925 and recommended that it adjust the Federal share of $723,463.

In response to our prior report, the State agency generally disagreed with all of our recommendations. It stated that the overpayments we identified were based on Medicare guidelines, which the State was not required to follow. Our current audit showed that the State agency did not implement edits to detect unbundled or duplicated services. State agency officials stated that they did not refund any overpayments. With regard to recoveries of overpayments made to providers, 42 CFR 433.300 states:

> "...quarterly Federal payments to the States under title XIX...are to be reduced...a State has 60 days from discovery of an overpayment for Medicaid services to recover or attempt to recover the overpayment from the provider before adjustment in the Federal Medicaid payment to the State is made; and that adjustment will be made at the end of the 60 days, whether or not recovery is made..."

The above citation requires the State agency to make adjustments for the balance of prior overpayments not refunded to CMS. As a result, the State agency should credit CMS for $723,463 as recommended in our prior report.

CONCLUSIONS AND RECOMMENDATIONS

We found that controls did not exist to prevent the State agency from claiming FFP for laboratory payments in excess of the amount Medicare pays. The State agency has proposed changes to its reimbursement policies and edits that should bring Medicaid reimbursements in line with Medicare reimbursements for laboratory services. However, they had not implemented these changes at the conclusion of our fieldwork.

The State agency reimbursed providers for laboratory services for chemistry, hematology, and urinalysis tests that were not grouped together (bundled into a panel) or duplicated other paid services. We estimated that the State agency overpaid providers $857,037 (Federal share $440,497) for laboratory services during CYs 1996, 1997, and 1998. Additionally, we determined that the State agency under-refunded the Federal share by a total of $5,451 for CYs 1997 and 1998 laboratory and pathology service fees in excess of the Medicare fee.

In total, the State agency was overpaid $445,948 for CY 1996 through CY 1998 laboratory services. We also determined that the State agency did not refund the Federal overpayments from 1993 and 1994 found on our prior audit of outpatient clinical laboratory services (A-03-96-00202), totaling $723,463. Therefore, we recommended that the State agency:

1) Install and revise edits to detect and prevent payments for unbundled and duplicate services.

2) Eliminate payments for additional hematology indices.

3) Recover overpayments for clinical laboratory services identified in this audit. Based on our audit, we estimated that $857,037 (Federal share $440,497) should be recovered for CYs 1996, 1997, and 1998.

4) Make an adjustment on its Quarterly Report of Expenditures to CMS (Form HCFA-64) for the FFP of $445,948 (unbundling and duplication overpayments of $440,497, excess fees of $5,451) related to Medicaid overpayments of $867,631 (unbundling and duplication overpayments of $857,037 and excess fees of $10,594).

5) Make an adjustment on its Quarterly Report of Expenditures to CMS for the Federal share of overpayments related to 1993 and 1994 unbundling overpayments totaling $723,463 as identified in our prior audit report (A-03-96-00202).

STATE AGENCY'S COMMENTS

The State agency generally agreed with all of our recommendations and agreed to refund FFP associated with payments for outpatient clinical laboratory services paid in excess of Medicare amounts, for the period from CY 1996 through CY 1998. However, they explained that they completed an offset against the draw of Federal funds for the $723,463 found on our prior audit (A-03-96-00202) as of the week of August 27, 2001, the week after we sent the State agency our draft report. A complete copy of the State agency's comments can be found as **APPENDIX C** of this report.

SAMPLE METHODOLOGY

From the State Agency's paid claims file for CYs 1996, 1997, and 1998, we utilized computer applications to extract all claims containing laboratory services listed in **APPENDIX B** which are described in the Physician's Current Procedural Terminology (CPT) handbook. We then performed computer applications to extract all chemistry services for the same provider for the same patient for the same date of service with:

- CPT line item charges for more than one chemistry test that are components of a panel;
- a chemistry panel and at least one component of the panel tests; or
- two or more chemistry panel tests.

Regarding hematology services, we extracted:

- a hematology service billed with another service that duplicates at least one or more components of the service; or
- a hematology service billed with hematology indices.

Regarding urinalysis services, we extracted:

- a urinalysis service billed with another service that duplicates at least one or more components of the service.

The extract resulted in a population of 124,100 claims totaling $2,593,039 consisting of 3 strata. The first stratum of chemistry services consisted of 63,433 claims totaling $1,768,416 for potentially unbundled chemistry panel tests. The second stratum of hematology services consisted of 40,853 claims totaling $650,363 for potentially duplicate hematology services. The third strata included 19,814 claims of potentially duplicate urinalysis services valued at $174,260. Each claim is a potential payment error in which the State agency paid providers for clinical laboratory tests (on behalf of the same beneficiary on the same date of service) which were billed individually instead of as part of a group, or were duplicate of each other. On a scientific stratified selection basis, we examined 150 claims involving claims from the 3 stratum. The 3 stratum consisted of a randomly generated statistical sample of 50 potentially unbundled or duplicated claims from each stratum involving chemistry, hematology, and urinalysis services with potential errors as listed below:

- Stratum 1 - Chemistry tests sample of 50 totaling $1,316
- Stratum 2 - Hematology services sample of 50 totaling $789
- Stratum 3 - Urinalysis services sample of 50 totaling $439.

For the sample items, we requested and reviewed supporting documentation from the State agency consisting of copies of physician, hospital, or independent laboratory claim remittances, explanation of benefits paid, and related paid claims histories.

We utilized a standard scientific estimation process to quantify overpayments as shown below.

Stratum	Number of Population Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Point Estimate of the Projection
Chemistry Services	63,433	50	$1,316	39	$591	$749,892
Hematology Services	40,853	50	$789	44	$217	$177,032
Urinalysis Services	19,814	50	$439	50	$200	$79,082
Total	124,100	150	$ 2,544	133	$1,008	$ 1,006,006

Using standard statistical methods, we estimate that at least $857,037 ($440,497 Federal share), representing the lower limit, was paid for unbundled and duplicated laboratory services. At the 90 percent two-sided confidence level, the precision of this estimate is plus or minus 14.82 percent. To determine the overpayments for the three strata, we apportioned the lower limit of $857,037 based on the percentage of the point estimate in each of the stratum.

The following three sample items exemplify the three types of chemistry sample overpayments found:

Sample No.	Services Billed	State Agency Paid Amount	Audited Service	Audited Amount	Overpayment
11	80007, 84100	$20.07	80008	$13.09	$6.98
16	80007, 80016	$29.16	G0060	$17.22	$11.94
22	82310, 84100, 84155	$10.56	80003	$ 9.18	$1.38

The following two sample items exemplify the types of hematology sample overpayments found:

Sample No.	Services Billed	State Agency Paid Amount	Audited Service	Audited Amount	Overpayment
2	85025, 85029	$14.53	85025	$10.53	$4.00
6	85025, 85014	$14.17	85025	$10.53	$3.64

The following two sample items exemplify the urinalysis sample overpayments:

Sample No.	Services Billed	State Agency Paid Amount	Audited Service	Audited Amount	Overpayment
1	81001, 81002	$7.92	81000	$4.92	$3.00
34	81002 and 81015	$8.83	81000	$4.92	$3.91

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TESTS

Chemistry Panels	CPT Code
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 multi-channel clinical chemistry tests	80019
20 multi-channel clinical chemistry tests	G0058
21 multi-channel clinical chemistry tests	G0059
22 multi-channel clinical chemistry tests	G0060
Basic Metabolic Panel	80049
General Health Panel	80050
Hepatic Function Panel	80058

24 Chemistry Tests (Descriptions) that are Panels Components (Includes 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.	Phosphorus	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.	Glutamyltransferase, gamma (GGT)	82977

HEMATOLOGY SERVICES

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Colorirnetric (Hgb)	85018
Hematocrit (Hct)	85013
Manual Differential WBC count	85007

Hematology Indices

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

Hematolum 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

URINALYSIS SERVICES

Urinalysis by dip stick or table reagent for bilirubin, glucose, hemaglobin, ketones, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; non-automated, with microscopy	81000
Urinalysis - automated, with microscopy	81001
Urinalysis- Non Automated, without microscopy	81002
Urinalysis - Automated, without microscopy	81003
Urinalysis - Microscopic only	81015

COMMONWEALTH of VIRGINIA

Department of Medical Assistance Services

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September 24, 2001

Mr. David M. Long
Regional Inspector General for Audit Services
OIG/OAG
150 South Independence Mall West, Suite 316
Philadelphia, PA 19106-3499

Re: A-03-00-00204

Dear Mr. Long:

The purpose of this letter is to respond to the draft report entitled "Follow Up Audit of Virginia Department of Medical Assistance Services Payments for Outpatient Clinical Laboratory Services." The Department of Medical Assistance Services (DMAS) appreciates the work of your staff involved in the audit.

In your letter you request that we comment on the report. I will respond in the same order as your list of recommendations on page 9 of the report.

1. ClaimCheck, a nationally recognized automated claims edit system, became operational September 14, 2001. The ClaimCheck system will detect and prevent payments for unbundled and duplicate services.

2. ClaimCheck edits will prevent payments for additional hematology indices.

3. Staff from the Department will run the necessary programs to identify and recover overpayments for the period 1996-1998.

4. The Department of Medical Assistance Services agrees to refund to the Federal Government $448,452 FFP associated with overpayments for laboratory services for calendar years 1996, 1997 and 1998. This refund will be generated upon receipt of the final report from the United States Department of Health and Human Services, Office of Inspector General.

5. An offset of the draw of Federal money in the amount of $723,463 was completed the week of August 27, 2001. This represents a refund by DMAS of overpayments related to 1993 and 1994 unbundling of laboratory services.

Thank you for the opportunity to respond to the draft report.

Sincerely,

Eric S. Bell

ESB:jc