DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date DEC - 1 1995

From June Gibbs Brown
Inspector General

Subject Review of the Alabama Medicaid Agency's Reimbursement for Clinical Laboratory Services Under the Medicaid Program (A-04-95-01108)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on December 5, 1995 of our final audit report to the Alabama Medicaid Agency concerning reimbursement for clinical laboratory services under the Medicaid program for Calendar Years (CY) 1993 and 1994. A copy is attached.

This report is part of a nationwide review to determine the adequacy of procedures and controls at State Medicaid agencies over the payment of Medicaid claims which contain clinical laboratory services. 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.

Our review was limited to clinical laboratory services involving chemistry and hematology tests. Due to the immateriality of the amount of potential instances of overpayments in the laboratory services involving urinalysis tests. we excluded those tests from this review.

Our review disclosed that the State agency was reimbursing providers for laboratory services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. We found that 85 of the 100 sampled items were overpaid. This was due to the State agency not having adequate edits in place to prevent the payment of unbundled or duplicated claims for certain laboratory services.

Based on our audit, we estimate that $1,142,337 (Federal share $813,458) should be recovered for CY 1993 and 1994. In addition, if the State agency implements our recommendations, we estimate that approximately $580,000 (Federal share $400,000) could be saved annually or about $2.9 million (Federal share $2 million) over a 5-year period.

We are recommending that the State agency (1) install edits to detect and prevent payments for unbundled services and billings which contain duplicative tests, (2) recover overpayments for clinical laboratory services identified in this review, and

(3) make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to the Health Care Financing Administration.

The State agency officials concurred with our first recommendation and stated that they were in the process of developing additional claims payment edits which they expect to have in place shortly.

In response to our second and third recommendation, State agency officials requested that the report be modified to eliminate the recommendation that the State agency recover overpayments identified in the review. Instead, State agency officials requested a re-review be conducted in the future to confirm that the edits enacted had the desired effect. We do not agree with the State agency and we believe they should collect the noted overpayments.

For further information, contact:
Charles J. Curtis
Regional Inspector General
for Audit Services, Region IV
(404) 331-2446

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE ALABAMA MEDICAID AGENCY'S REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES UNDER THE MEDICAID PROGRAM

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1995
A-04-95-01108

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

REGION IV
P.O. BOX 2047
ATLANTA, GEORGIA 30301

CIN: A-04-95-01108

Ms. Gwen H. Williams, Commissioner
Alabama Medicaid Agency
501 Dexter Avenue
P.O. Box 5624
Montgomery, Alabama 36103-5624

Dear Ms. Williams:

This report presents the results of our review of the Alabama Medicaid Agency's (State agency) reimbursement for clinical laboratory services under the Medicaid program. The objective of our review was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers for clinical laboratory tests. Our review was limited to clinical laboratory services involving chemistry and hematology tests.

Our review disclosed that the State agency was reimbursing providers for laboratory services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. Specifically, we found that the State agency does not have adequate edits in place to prevent the payment of unbundled or duplicated claims for certain laboratory services.

We randomly selected 100 instances involving claims with potential payment errors from a sample population of Calendar Years (CY) 1993 and 1994 paid claims file valued at $2,537,432. We found that 85 of the 100 sampled items were overpaid. Each instance represents a potential payment error in which the State agency paid a provider for clinical laboratory tests (on behalf of the same recipient on the same date of service) on an individual test basis instead of as part of a group, or were duplicative of each other. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the State agency overpaid providers $1,142,337 (Federal share $813,458) for chemistry and hematology tests. At the 90 percent confidence level, the precision of this estimate is plus or minus 14.86 percent.

We are recommending that the State agency (1) install edits to detect and prevent payments for unbundled services and billings which contain duplicative tests, (2) recover overpayments for clinical laboratory services identified in this review, and (3) make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to the Health Care Financing Administration (HCFA).

Based on our audit, we estimate that $1,142,337 (Federal share $813,458) should be recovered for CY 1993 and 1994. In addition, if the State agency implements our recommendations, we estimate that approximately $580,000 (Federal share $400,000) could be saved annually or about $2.9 million (Federal share $2 million) over a 5-year period.

We received a written response to our draft report from the State agency dated July 21, 1995. The State agency officials concurred with our first recommendation and stated that they were in the process of developing additional claims payment edits which they expect to have in place by October 1, 1995.

In response to our second and third recommendation, State agency officials requested that the report be modified to eliminate the recommendation that the State agency recover overpayments identified in the review. Instead, State agency officials requested a re-review be conducted in the future to confirm that the edits enacted had the desired effect. Their comments are summarized following the recommendations and the entire text is included as Appendix C.

INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry and hematology tests. Laboratory tests are performed on a patient's specimen to help physicians diagnose and treat ailments. The testing may be performed in a physicians 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 frequently performed on automated equipment are grouped together and reimbursed at a 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. Many 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.

Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of HCFA. Claims processing is the responsibility of a designated Medicaid agency in each State. Many States use outside fiscal agents to process claims. States may elect to participate in the HCFA Medicaid Statistical Information System (MSIS). The MSIS is operated by HCFA to collect Medicaid eligibility and claims data from participating States. States participating in MSIS provide HCFA with two quarterly computer files consisting of an eligibility and a paid claims file. The eligibility file contains specified data for persons covered by Medicaid and the paid claims file contains adjudicated claims for medical services reimbursed by title XIX funds.

The State Medicaid Manual, 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. In addition, section 6300.2 states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. Under Medicare, clinical laboratory services are reimbursed at the lower of the fee schedule amount or the actual charge. Under Medicare, the 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.

SCOPE

Our review was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers by the State agency for clinical laboratory services. Our review was limited to clinical laboratory services involving chemistry and hematology tests.

To accomplish our objective, we:

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

- extracted from HCFA's MSIS, CY 1993 and 1994 paid claims files, payments totaling $7,961,145 for chemistry and hematology tests. Of this amount, $2,537,432 represented instances involving claims that contained potentially unbundled or duplicate charges for chemistry and hematology tests (See Appendices A and B). We tested the reliability of computer generated output by comparing data to source documents for our sampled items. We did not, however, assess the completeness of data in HCFA's MSIS files, nor did we evaluate the adequacy of the input controls.

- selected a stratified random sample of 100 instances. The sample consisted of two strata--chemistry, and hematology. We selected 50 instances involving chemistry claims from a population of 69,848 instances containing chemistry tests valued at $1,560,919 and 50 instances involving hematology claims from a population of 66,286 instances containing hematology tests valued at $976,513. These instances were taken from a universe of payments representing claims for more than one panel or for a panel and individual tests for the same recipient on the same date of service by the same provider.

- reviewed the randomly selected instances and supporting documentation from the State agency to determine the propriety of the payment.

- utilized a variable sample appraisal methodology to estimate the amount of overpayment for chemistry and hematology tests.

Our review of internal controls was limited to an evaluation of that part of the claims processing function that related to the processing of 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 edits for bundling of chemistry tests and the detection of duplicate claims for hematology tests. We limited our review to claims paid by the State agency during CY 1993 and 1994. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the RESULTS OF REVIEW section of this report.

We performed our review between April and June 1995. During this period we visited the State agency office in Montgomery, Alabama.

RESULTS OF REVIEW

Our review disclosed that the State agency was reimbursing providers for laboratory services that were not properly grouped together (bundled into a panel) or were duplicated for payment purposes. Specifically, we found that the State agency does not have adequate edits in place to prevent the payment of unbundled or duplicated claims for certain laboratory services.

Using computer applications, we extracted applicable chemistry and hematology tests from HCFA's MSIS database for CY 1993 and 1994. This extract yielded a total of $2,537,432

in payments for chemistry panel tests and hematology profile tests. This total consisted of 69,848 chemistry panel tests with a value of $1,560,919 and 66,286 hematology tests valued at $976,513 (See Appendices A and B).

We selected a stratified random sample of 100 instances (50 instances involving claims with chemistry panel tests and 50 instances involving claims with hematology tests) valued at $1,648 from the sample population of CY 1993 and 1994 paid claims file valued at $2,537,432. Our review showed that 85 of the 100 claims were overpaid. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the State agency overpaid providers $1,142,337 (Federal share $813,458) for chemistry and hematology tests during the 2-year audit period. At the 90 percent confidence level, the precision of this estimate is plus or minus 14.86 percent.

We are recommending that the State agency (1) install edits to detect and prevent payments for unbundled services and billings which contain duplicative tests, (2) recover overpayments for clinical laboratory services identified in this review, and (3) make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to the HCFA. Based on our audit, we estimate that $1,142,337 should be recovered for CY 1993 and 1994. In addition, if the State agency implements our recommendations, we estimate that approximately $580,000 (Federal share $400,000) could be saved annually or about $2.9 million (Federal share $2 million) over a 5-year period.

Chemistry Panel Test

Our review of 50 instances involving claims containing unbundled charges for chemistry tests disclosed that 43 instances contained overpayments. These overpayments occur when providers submit claims for more than one different chemistry panel; a chemistry panel and at least one individual panel test; or two or more panel tests. The 50 instances were selected on a scientific random basis from a population of 69,848 instances involving claims containing potentially unbundled chemistry panel tests valued at $1,560,919. Based on our statistical sample, we estimate that the State agency overpaid providers $753,185 for unbundled or duplicated chemistry panel 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 judgment, 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 State agency's claims processing system did not contain adequate edits to prevent the payment of certain unbundled chemistry panel tests.

Hematology Profiles

Our review of 50 instances involving claims containing hematology profiles disclosed that 42 of these instances contain duplicate charges. These overpayments occur when providers submit claims for duplicate hematology profiles or for a profile and an individual test which is included in the profile. These 50 instances were selected on a scientific random basis from a population of 66,286 instances involving claims containing hematology tests valued at $976,513. Based on our statistical sample, we estimate that the State agency overpaid providers $389,152 for duplicated hematology tests.

Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives. In addition, section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

Hematology tests are performed and billed in groups or combinations of tests known as profiles. The hematology tests are grouped into profiles of specific hematology tests; however, hematology tests can also be performed individually. Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile which includes the individual test. Duplicate billings also occur when two hematology profiles are billed for the same patient and same date of service. Another situation which creates a duplicate billing is hematology indices billed with a hematology profile. Hematology indices are calculations and ratios calculated from the results of hematology tests. Since hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices results in a duplicate billing.

We noted that the State agency's claims processing system did not contain adequate edits to prevent duplicate payments for certain hematology profiles and profile component tests.

RECOMMENDATIONS

We are recommending that the State agency:

(1) install edits to detect bundling errors and billings which contain duplicative tests.

(2) recover Medicaid overpayments for clinical laboratory services identified in this review. Based on our audit, we estimate that $1,142,337 (Federal share $813,458) should be recovered for CY 1993 and 1994.

(3) make adjustments for the Federal share of amounts recovered by the State agency on its Quarterly Report of Expenditures to HCFA.

STATE AGENCY'S RESPONSE

In response to our draft report, the State agency officials concurred with one of our three recommendations. State agency officials responded to our first recommendation by stating that they were in the process of developing additional claims payment edits and expected to have them in place by October 1, 1995.

In response to our second and third recommendation, State agency officials requested that the report be modified to eliminate the recommendation that the State agency recover overpayments identified in the review. They believe that many of the proposed recoupments would be appealed and do not believe that recovering the overpayments would be cost effective. Instead, State agency officials requested a re-review be conducted in the future to confirm that the edits enacted had the desired effect.

Additionally, the State agency officials stated that:

(1) it appeared we had applied 1995 standards to services performed in 1993 and 1994,

(2) Medicare had no regulations or procedures requiring the bundling of laboratory tests cited in the report during our audit period, and

(3) the State Agency had no such requirements in 1993 or 1994.

The full text of the State agency's response is contained in Appendix C.

OIG'S COMMENTS

After reviewing the State agency's comments, we contacted HCFA officials concerning the regulations requiring bundling of laboratory tests. HCFA officials confirmed that regulations applied in our audit were in place during our audit period and assured us that Alabama had been provided the regulations in a timely manner.

After considering the State agency's response, we believe our recommendations should remain as reported.

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In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

Sincerely yours,

for/ Gerald R Dunham

Charles J. Curtis
Regional Inspector General
for Audit Services

SAMPLE METHODOLOGY

From the HCFA Medicaid Statistical Information System (MSIS) paid claims file for CY 1993 and 1994, we utilized computer applications to extract all claims containing:

1. automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physician's Current Procedural Terminology (CPT) handbook. (See APPENDIX B)

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

The above file extract yielded a total of $7,961,145 in payments for chemistry and hematology tests in CY 1993 and 1994. This total consisted of 399,521 records totaling $3,613,860 relating to chemistry panel tests, and 529,108 records totaling $4,347,285 relating to hematology profile tests.

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

1. more than one different chemistry panel; a chemistry panel and at least one individual panel tests; or two or more panel tests.

2. 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.

This extract resulted in a sample population totaling $2,537,432 consisting of two strata. The first strata consisted of 69,848 instances totaling $1,560,919 for potentially unbundled chemistry panel tests. The second strata consisted of 66,286 instances totaling $976,513 for potentially duplicate hematology profile tests. Each instance 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 duplicative of each other.

On a scientific stratified selection basis, we examined 100 instances involving claims from two strata. The first stratum consisted of a randomly generated statistical sample of 50 potentially unbundled instances involving chemistry panel tests totaling $944. The second

stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving hematology profile or profile component tests totaling $704.

For the sample items, we requested and reviewed supporting documentation from the State agency consisting of copies of physician, hospital or independent laboratory claims, electronic paid claims detail for claims submitted electronically, explanation of benefits paid, and related paid claims history.

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

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery	Precision at the 90% Confidence Level
Chemistry Tests	69,848	50	$944	43	$539	$ 753,185	+/- 21.98 %
Hematology Test	66,286	50	$704	42	$294	$ 389,152	+/- 12.95 %
Overall	136,134	100	$1,648	85	$833	$1,142,337	+/- 14.86 %

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCS

Chemistry Panel CPT Codes

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

Chemistry Tests Subject to Panelling (34 CPT Codes)

1.	Albumin	82040
2.	Albumin/globulin ratio	84170
3.	Bilirubin Total OR Direct	82250
4.	Bilirubin Total AND Direct	82251
5.	Calcium	82310, 82315, 82320, 82325
6.	Carbon Dioxide Content	82374
7.	Chlorides	82435
8.	Cholesterol	82465
9.	Creatinine	82565
10.	Globulin	82942
11.	Glucose	82947
12.	Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
13.	Alkaline Phosphatase	84075
14.	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.	Glutamyl transpetidase, gamma	82977

AUTOMATED HEMATOLOGY PROFILE AND COMPONENT TEST HCPCS

Hematology Component Test CPT Codes

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

Additional Hematology Component Tests - Indices

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

Hematology Profile CPT Codes

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

ALABAMA MEDICAID AGENCY
501 DEXTER AVENUE
P.O. BOX 5624
MONTGOMERY, ALABAMA 36103-5624

FOB JAMES, JR.
Governor

GWENDOLYN H. WILLIAMS
Commissioner

July 21, 1995

Mr. Joseph J. Green
Regional Inspector General
for Audit Services
Health Care Financing Administration
Region IV
P.O. Box 2047
Atlanta, Georgia 30301

Re: CIN A-04-95-01108

Dear Mr. Green:

Thank you for giving me the opportunity to review and comment on the draft review of the Alabama Medicaid Agency's reimbursement for clinical laboratory services. While I strongly support the intent and goals of this audit of laboratory payments, I have several concerns with the draft findings and recommendations.

My greatest concern is that the audit appears to have applied 1995 standards to services performed in 1993 and 1994. The Medicare Medical Review Policy regarding bundling of laboratory tests (copy enclosed) did not take effect until March 1995. It does not appear that Medicare had regulations or procedures requiring the bundling of laboratory tests cited in the report prior to that time. Likewise, Alabama Medicaid had no such requirements in 1993 and 1994 Due to this lack of regulatory authority, my legal staff advises that we would face significant difficulties in successfully recovering many of the claims paid.

Obviously, we cannot use the sampling performed by the OIG, but would have to conduct a much more extensive review of paid claims. Given the lack of regulatory authority and the likelihood that many of the proposed recoupments would be appealed, it seems unlikely that such recoupment action would be cost effective.

Also, the audit report does not distinguish the "overpayments" that are attributable to procedures not being bundled as opposed to duplicative procedures performed on the same date of service. Given these considerations, I am concerned

with the use of the word "overpayments." I request instead that the report refer to "cost avoidance." It appears certain costs could have been avoided had more effective edits been in place, but it is not so clear that all of the amounts cited in the report can be considered overpayments under the rules and guidelines in effect in 1993 and 1994.

I believe the audit has been useful in identifying certain areas needing attention. The Alabama Medicaid Agency had begun examining some problem areas with lab payments and implementing additional claims payment edits prior to receipt of the draft report. We are already working with our fiscal agent to develop additional edits and expect to have them in place by October 1, 1995. We recognize the large potential for abuse in this area. However, in light of the above considerations, I request that the report be modified to eliminate the recommendation that Medicaid recover "overpayments" identified in the review. I would request instead that a re-review be conducted in the future to confirm that the edits enacted by the Medicaid Agency have had the desired effect.

Thank you for your consideration of these points. If you have any disagreements or need additional information, I would like to discuss these matters with you prior to finalization of the audit report.

Sincerely,

Gwendolyn H. Williams
Commissioner

GHW:wbw

Enclosure

Injectable Drug Allowance Changes

The 1995 allowance on the following injectable drugs has been changed. The new allowance is effective 1995 dates of service, processed on or after January 9, 1995.

HCPCS Code	Participating	Non Participating	Limiting Charge
J1760	$ 36.36	$ 34.54	$ 39.72
J1770	$ 90.90	$ 86.36	$ 99.31
J1780	$181.80	$172.71	$198.62
J1830	$ 72.00	$ 68.40	$ 78.66
J3364	$ 49.69	$ 47.21	$ 54.29
J3365	$402.95	$382.80	$440.22

♦ ♦ ♦

1995 Clinical Laboratory Fee Schedule

The following Health Care Financing Administration Common Procedure Coding System (HCPCS) codes were omitted from the clinical laboratory fee schedule that was published in the January 1995 issue of *Medicare Focus*:

HCPCS Code	Fee Schedule	HCPCS Code	Fee Schedule
G0001	$ 3.00	Q0115	$ 14.01
Q0111	$ 6.04	Q0116	$ 3.34
Q0112	$ 3.79	86003	$136.68
Q0113	$ 7.65	86005	$ 79.20
Q0114	$ 8.40		

♦ ♦ ♦

Item 29 of the HCFA-1500 Claim Form – Correction

The March 1994 issue of *Medicare Focus*, page 19, included instructions on how to complete items 28 and the HCFA-1500 claim form. Following is a correction to these instructions:

Payments Made by the Beneficiary

The amount in item 28 should be your submitted charge. However, the amount in item 29 should be based on Medicare's covered charge. Providers accepting assignment should enter the total amount paid by a beneficiary for the covered charges in item 29 (Amount Paid) of the HCFA- 1500 claim form. This practice allows Medicare to refund to the beneficiary any over collection of deductible and/or coinsurance. Do not include all money a beneficiary pays on his/her account, only the amount paid for the covered charges.

Note: Item 29 should not be completed with payment from another insurance company, only payment from the beneficiary.

Item 29: Enter the total amount paid by the patient on the covered charges.

Automated Multichannel Tests; Organ or Disease Oriented Panels Medicare Part B – Local Medical Review Policy

Covered (X)	Non-Covered ( )
CPT Codes:	80002 – 80019; 80050 – 80092
CPT Category:	Pathology and Laboratory

Description

Automated Multichannel Tests (80002–80019)

The following list contains the tests that can be and are frequently done as groups and combinations on automated multichannel equipment. For Medicare payment purposes, these are the only tests that are consider automated profile tests. Future revisions to this list will be made through *Medicare Carriers Manual* revisions. For any combination of tests among those listed immediately below, use the appropriate Physicians' Current Procedural Terminology (CPT) Laboratory codes 80002 – 80019:

Alanine aminotransferase (ALT, SGPT) (84460)
Albumin (82040)
Aspartate aminotransferase (AST, SGOT) (84450)
Bilirubin, direct (82250)
Bilirubin, total (82251)
Calcium (82310)
Carbon dioxide content (82374)
Chloride (82435)
Cholesterol (82465)
Creatinine (82565)
Creatine Kinase (ck) (cpk); Total (82550)
Glucose (82947)
Glutamyl Transferase, Gamma (GGT) (82977)
Lactate dehydrogenase (LD) (83615)
Phosphatase, alkaline (84075)
Phosphorus (inorganic phosphate) (84100)
Potassium (84132)
Protein, total (84155)
Sodium (84295)
Triglycerides (84478)
UREA Nitrogen (BUN) (84520)
Uric acid (84550)

- 80002 Automated multichannel test; one or two clinical chemistry test(s)
- 80003 Three clinical chemistry tests
- 80004 Four clinical chemistry tests
- 80005 Five clinical chemistry
- 80006 Six clinical chemistry tests
- 80007 Seven clinical chemistry tests

(Continued on next page.

(Medical Review Policy— Continued from previous page)

- 80008 Eight clinical chemistry tests
- 80009 Nine clinical chemistry tests
- 80010 Ten clinical chemistry tests
- 80011 11 clinical chemistry tests
- 80012 12 clinical chemistry tests
- 80016 13–16 clinical chemistry tests
- 80018 17–18 clinical chemistry tests
- 80019 19 or more clinical chemistry tests

Organ or Disease Oriented Panels (80055-80092)

CPT-95 includes a grouping of organ or disease oriented panels developed for coding purposes only. These panel components are not intended to limit the performance of other tests. The organ or disease oriented panels and their components include:

- 80055 Obstetric panel
  Hemogram, automated, and manual differential white blood count (WBC) [complete blood count (CBC)] (85022)
  Hemogram and platelet count, automated and automated complete differential WBC count (CBC) (85025)
  Hepatitis B surface antigen (HBsAg) (86287)
  Antibody, rubella (86762)
  Syphilis test, qualitative (e.g., VDRL, RPR, ART) (86592)
  Antibody screen, red blood cell (RBC), each serum technique (86850)
  Blood typing, ABO (86900) and
  Blood typing, Rh (D) (86901)
- 80058 Hepatic function panel
  Albumin, serum (82040)
  Bilirubin, total or direct (82250)
  Phosphatase, alkaline (84075)
  Transferase, aspartate amino (AST) (SGOT) (84450)
  Transferase, alanine amino (ALT (SGPT) (84460)
- 80059 Hepatitis panel
  Hepatitis B surface antigen (HBsAg) (86287)
  Hepatitis B surface antibody (HBsAb) (86291)
  Hepatitis B core antibody (HBcAb), IgG and IgM (86289)
  Hepatitis A antibody (HAAb), IgG and IgM (86296)
  Hepatitis C antibody (86302)
- 80061 Lipid panel
  Cholesterol, serum, total (82465)
  Lipoprotein, direct measurement, high density cholesterol (HDL cholesterol) (83718)
  Triglycerides (84478)

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- 80072 Arthritis panel
  Uric acid, blood, chemical (84550)
  Sedimentation rate, erythrocyte, non-automated (85651)
  Fluorescent antibody, screen, each antibody (86255)
  Rheumatoid factor, qualitative (86430)
- 80090 TORCH antibody panel
  Antibody, cytomegalovirus (CMV) (86644)
  Antibody, herpes simplex, non-specific type test (86694)
  Antibody, rubella (86762)
  Antibody, toxoplasma (86777)
- 80091 Thyroid panel
  Thyroxine, total (84436)
  Triiodothyronine (T-3), resin uptake (84479)
- 80092 with thyroid stimulating hormone (TSH) (84443)

Sources of Information

1. *Medicare Carriers Manual*, Sections 2070, 5114
2. American Medical Association CPT-94.
3. October 1986 *ProviderFax*

Rationale

Laboratory work constitutes a significant cost to Medicare. Review of billing practices in some areas has revealed possible duplicate billing and medically unnecessary services.

Diagnosis Codes for Coverage

The following CPT codes will be reimbursed based on medical necessity and/or the listed International Classification of Diseases 9th Revision Clinical Modification (ICD-9-CM) codes:

80058 – 80059	Hepatic function and Hepatitis panels will be covered for ICD-9-CM codes 042.0 – 044.9, 130.5, 155.0 – 156.9, 570.0 – 571.9, 070.0 – 070.9, and pregnancy.
80072	Arthritis panel: coverage policy suspended pending American College of Rheumatology recommendations to the CPT editorial panel.
80090	TORCH antibody panel may be referred for medical review.
80091– 80092	Thyroid panel/with TSH will be covered for ICD-9-CM codes 240.0 – 279.9, 780.7, and pregnancy.
80061	Lipid panel will be covered for ICD-9-CM codes 272.0 – 272.9.

Reasons for Non-Coverage

CPT code 80050 (general health panel) will be denied, as it is predominately a screening panel and does not qualify for Medicare coverage.

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Documentation Required

The medical record should contain documentation to support the medical necessity of all billed laboratory services, including the automated multichannel tests and organ or disease oriented panels. Providers billing for these laboratory services at a higher frequency than their peers may be audited using Medicare's post-payment audit procedures.

Comments

The Medicare Carrier received many constructive and critical comments about the policy. Many helpful comments were incorporated into the policy.

The Health Care Financing Administration (HCFA) and the Medicare Carrier received a substantial proposal for modifying the coding and payment system for multichannel automated testing. The main considerations of the proposal were:

- Establish a single standardized list of tests to be included in the codes for automated multichannel chemistries.
- Develop new CPT codes to cover new tests.
- Establish new fee schedule amounts for additional codes.
- Establish a process to reflect future changes in technology.
- Consider a more comprehensive review of laboratory reimbursement.

The above proposals will have to be considered by HCFA and the National CPT Coding Panel [American Medical Association (AMA)]. HCFA has recently developed draft manual (*Medicare Carriers Manual*) instructions on clinical laboratory automated profile testing. The Medicare Carrier feels that the present local medical review policy will not impede any constructive modification of the coding or payment systems developed by HCFA. Therefore, notwithstanding future HCFA policy directives, the Medicare Carrier will implement the terms of this policy.

Coding Technique

The *Medicare Carriers Manual* requires that laboratory allowances be made based on the most economical method in Alabama. Therefore, if the components of an organ or disease oriented laboratory panel can be found under the automated multichannel tests list, then CPT codes 80002 – 80019 should be billed. For instance, if a Chemistry – 19 profile contains the individual elements of a hepatic function panel, bill CPT code 80019 or 80053. Do NOT bill CPT code 80019 and 80053.

Approvals

This policy does not reflect the sole opinion of the Medicare Carrier or Carrier Medical Director. Conversely, this policy was developed in consultation with the State's Practicing Physicians and the medical community via the Carrier Advisory Committee, which includes representatives from The Medical Association of The State of Alabama. The Medicare Carrier also received comments from the American Clinical Laboratory Association.

Dates

Date of Notice on Comment:	October 5, 1994
Carrier Approval Date:	November 18, 1994
Date Policy Becomes Effective:	March 1995
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