DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services
Region VI

Memorandum

Date July 9, 2002

From Gordon L. Sato
Regional Inspector General

Subject Office of Inspector General's Partnership Plan—Oklahoma Health Care Authority's Report on Oklahoma's Clinical Laboratory Services (A-06-01-00026)

To James R. Farris, M.D.
Regional Administrator
Centers for Medicare and Medicaid Services

We are transmitting for your information and use, the attached final report on an audit of Medicaid clinical laboratory services in Oklahoma for Calendar Years (CY) 1996 through 1999. The Oklahoma Health Care Authority Management & Audit Services Division (OHCAMASD), an internal audit organization of the Oklahoma Health Care Authority (OHCA), conducted this review.

The objective of the review was to determine the adequacy of procedures and controls over the payment of Medicaid claims that contain clinical laboratory tests. Specifically, the audit determined whether the Medicaid payment for certain chemistry, hematology and urinalysis tests did not exceed what Medicare would have paid for the same services.

This work was conducted as part of our partnership efforts with State audit organizations to expand audit coverage of the Medicaid program. As part of the review, the Office of Audit Services assisted the OHCAMASD by (1) providing guidance for identifying, through computer applications, a universe of potentially overpaid claims resulting from certain chemistry, hematology, and urinalysis tests that were improperly grouped or duplicative of each other; (2) providing training on identifying and calculating the potential overpayments; and (3) providing technical assistance during the course of the audit. In addition, we have performed sufficient work to satisfy ourselves that the attached OHCAMASD audit report can be relied upon and used by the Centers for Medicare and Medicaid Services (CMS) in meeting its program oversight responsibilities.

The OHCAMAS determined that the OHCA did not have adequate controls to ensure Medicaid reimbursements for clinical laboratory tests did not exceed amounts recognized by Medicare for the same tests. The OHCAMAS determined that OHCA made payments of $54,780 (Federal share of approximately $38,690) in excess of what Medicare recognizes for the same tests for CYs 1996 through 1999. The OHCAMAS further determined the overpayments occurred because the OHCA does not have adequate edit checks built into the computer programs to detect improper payments.

The OHCAMAS recommended that the OHCA: (1) implement edits in its claims processing system to identify and prevent inappropriate payments for unbundled and /or duplicative tests; (2) review its clinical laboratory fee schedules on a regular basis to ensure that amounts paid for clinical laboratory services do not exceed amounts that Medicare pays for the same services; and (3) adjust the next Quarterly Report of Title XIX expenditures in the amount of $54,780 (Federal share of approximately $38,690) which represents overpayments for CYs 1996 through 1999. As we do with all audit reports developed by nonfederal auditors, we provided as an attachment, a listing of the coded recommendations for your staff's use in working with the State to resolve findings and recommendations through our stewardship program. Attachment A provides a summary of the recommendations.

We plan to share this report with other States to encourage their participation in our partnership efforts. If you have any questions about this review, please let me know or have your staff contact Mark Ables, Audit Manager, at (214) 767-8414.

Gordon L. Sato

GORDON L. SATO

Attachment

cc: Andy Fredrickson, Chief
Medicaid Operations and Financial Management Branch
Ben Jackson, Director, CMSAD, OIG
John Fisher, NEAR, OIG

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

AUDIT OF MEDICAID CLINICAL LABORATORY SERVICES IN OKLAHOMA FOR CALENDAR YEARS 1996 THROUGH 1999

JANET REHNQUIST
INSPECTOR GENERAL

JULY 2002
A-06-01-00026

State of Oklahoma
Oklahoma Health Care Authority

Medicaid Program

Medicaid Payments for Clinical Laboratory Services January 1996 thru December 1999

An Internal Operational Review by the:
Oklahoma Health Care Authority
Management & Audit Services Division
Audit, Design & Evaluation Unit

Conducted in Partnership with:
Department of Health & Human Services –
Office of Inspector General's Office

REPORT CONTENTS

Federal / State Partnership Project

February 2002

Purpose

This audit was conducted as a joint Federal / State project under the Office of Inspectors General's (OIG) Partnership Plan with the Oklahoma Health Care Authority.

Objectives, Scope, and Methodology

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 payment of Medicaid claims which contain clinical laboratory tests. Specifically, the audit determined whether the Medicaid payment for certain chemistry, hematology and urinalysis tests did not exceed what Medicare would have paid for the same services.

To accomplish our objectives, we:

- Reviewed current State agency policies and procedures for processing Medicaid claims from providers for clinical laboratory services;
- Tested current payment policies by extracting paid claims for chemistry, hematology, and urinalysis tests performed in calendar years 1996-1999;
- Reviewed all instances of potential overpayments involving chemistry, hematology, and urinalysis tests performed in calendar years 1996-1999.

Our review of internal controls was limited to an evaluation of that part of the claims processing function related to the processing of claims for clinical laboratory services. Specifically, we reviewed the OHCA policies and procedures and instructions to providers related to the billing of clinical laboratory services. We limited our review to paid claims by the OHCA for chemistry, hematology, and urinalysis tests performed during the period of January 1996 through December 1999.

The potential overpayments identified in our review include claims for the same individual for the same date of service performed by the same provider in which one of following situations was claimed:

- More than one chemistry panel; a chemistry panel and at least one individual panel test; or two or more panel tests;
- More than one automated hematology profile; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or additional hematology indices and a profile; and
- A complete urinalysis test which includes microscopy; a urinalysis without microscopy; or a microscopy only.

Results in Brief

Our review indicated that the OHCA did not have adequate edits in its claim processing system to ensure that all reimbursement for clinical laboratory tests under Medicaid did not exceed amounts recognized by the Medicare program. Based on the results of our review for laboratory procedures performed during the period January 1996 through December 1999, we determined that the OHCA made payments of $54,780.33 (approximately $38,690.07 federal share) in excess of what Medicare recognizes for the same tests.

Background

Medicaid is a Federally aided, state program which provides medical assistance to certain individuals and families with low incomes and resources. Within broad Federal guidelines, states design and administer the Medicaid program under the general oversight of CMS. Medicaid, as established under Title XIX of the Social Security Act, requires states to provide certain medical and other services such as outpatient clinical laboratory tests. Laboratory tests are performed by providers on a patient's specimen to help physicians' diagnose and treat ailments. The testing may be performed in a physician's office, a hospital laboratory or by an independent laboratory. These providers submit claims for laboratory services performed on Medicaid recipients. Claims processing is the responsibility of a designated Medicaid agency in each state. In Oklahoma, the Oklahoma Health Care Authority is responsible for administrating the Medicaid program. The OHCA has contracted with Unisys to process medical service claims for reimbursement under the Medicaid program in Oklahoma.

The State Medicaid Manual 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. 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 the fee schedule to the state Medicaid agency in its locality. Blue Cross and Blue Shield is the Medicare Carrier for the State of Oklahoma. Guidelines for the processing of provider claims including the bundling of automated multichannel chemistry tests are contained in CMS's Medicare Carriers Manual.

Chemistry tests involve the measurement of various chemical levels in the blood. 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. This situation results in overlap between organ panels and automated chemistry panels.

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

results of hematology tests. Examples of indices are red blood cell width, red blood cell volume and platelet volume.

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

Findings and Recommendations

Reimbursement Requirements

Policy for the reimbursement of clinical laboratory services under the Medicaid program is based on provisions governing the Medicare program. Section 1903(i)(7) of the Social Security Act provides that:

> Payment under Medicaid shall not be made "...with respect to any amount expended for clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital, to the extent such amounts exceeds the amount that would be recognized under Section 1833 (h) for tests performed for an individual enrolled under part B of title XVIII [Medicare]..."

Section 6300.1 of the State Medicaid Manual further discusses Medicaid reimbursement requirements as follows:

> "...clinical laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules...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:

> "...Medicaid reimbursement for clinical laboratory tests may not exceed the amount that Medicare recognizes for such tests..."

The Medicare reimbursements for clinical laboratory tests are defined in Section 5114.1 of the Medicare Carriers Manual. Specifically, this Section lists tests which can be performed on automated equipment and are grouped or bundled together when more than one test is billed by the provider. Section 5114.1.L.2, has established reimbursement guidelines to indicate that if claims are received for such tests in which a provider separately billed for the tests, the tests should be bundled into the appropriate Health Care Common Procedure Coding System (HCPCS) panel code and the provider should be reimbursed at the lesser amount allowed for the panel code.

Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives. In addition, Section 7103.1B states that a provider is liable in situations when the error is due to overlapping or duplicate bills. For example, duplicate billings occur when a profile or comprehensive test is billed along with one or more components of these types of tests.

The Medicare payment principles described above have imposed limitations on reimbursement for tests that can be performed as part of an automated battery or panel. One way for a state to ensure that its Medicaid payments for laboratory services do not exceed the amounts recognized by Medicare for such tests is for the state to establish controls that bundle laboratory tests in accordance with Medicare principles and select the appropriate fee from the relevant fee schedule.

In addition to billing errors resulting from unbundling and/or duplicative payment of tests, prior OIG/OAS audits have determined that separate billing for additional hematology indices was not appropriate and also results in overpayments. In this regard, we noted that many Medicare contractor studies had determined that additional hematology indices were merely a by-product of the automated process that produces the hematology profile results that calculated and measured all indices simultaneously. Therefore, many Medicare contractors denied payment for separately billed additional hematology indices. Also, prior audits have found that most physicians did not order or use the additional hematology indices in the care and treatment of their patients but providers billed for the indices as a routine billing practice. It should be noted that, effective January 1999, CMS has indicated that additional hematology indices (HCPCS 85029 and 85030) are no longer valid services for Medicare reimbursement and eliminated the codes from the Medicare fee schedules. These codes were also eliminated from the 1999 CPT manual.

Results

Our audit disclosed that the OHCA did not have adequate edits in place to identify and prevent overpayments for chemistry, hematology, and urinalysis laboratory tests that were unbundled, duplicative, or not normally ordered or needed. We determined that for the period of January 1996 through December 1999, the OHCA made payments totaling $54,780.33 (approximately $38,690.07 federal share) in excess of what the Medicare program recognizes for such tests. Audit results, by specific laboratory test, are identified below.

Chemistry Laboratory Services:

For the period of January 1996 through December 1999, we noted 3,177 instances in which the Oklahoma Health Care Authority paid providers more than the amount recognized by Medicare. These instances resulted in the OHCA making payments totaling $41,639.17 (approximately $29,431.75 federal share) in excess of what Medicare would have paid for the same services.

Chemistry Tests				
Calendar Year	# of Items Overpaid	Total Overpayment	Approx. FMAP Rate	Approx. Federal Share [1]
1996	194	$ 2,286.59	0.6989	$ 1,598.10
1997	164	$ 1,719.37	0.7001	$ 1,203.73
1998	638	$ 8,923.18	0.7051	$ 6,291.73
1999	2,181	$ 28,710.03	0.7084	$20,338.19
Totals	3,177	$ 41,639.17		$29,431.75

[1]It should be noted that FMAP rate is based on federal fiscal year and the overpayment is based on calendar year.

Hematology Laboratory Services:

For the period of January 1996 through December 1999, we noted 2,091 instances in which the Oklahoma Health Care Authority paid providers more than the amount recognized by Medicare. These instances resulted in the OHCA making payments totaling $9,074.40 (approximately $6,399.56 federal share) in excess of what Medicare would have paid for the same services.

Hematology Tests				
Calendar Year	# of Items Overpaid	Total Overpayment	Approx. FMAP Rate	Approx. Federal Share [1]
1996	0	$ -	0.6989	$ -
1997	0	$ -	0.7001	$ -
1998	2,043	$ 8,709.70	0.7051	$ 6,141.21
1999	48	$ 364.70	0.7084	$ 258.35
Totals	2,091	$ 9,074.40		$ 6,399.56

[1]It should be noted that FMAP rate is based on federal fiscal year and the overpayment is based on calendar year.

Urinalysis Laboratory Services:

For the period of January 1996 through December 1999, we noted 747 instances in which the Oklahoma Health Care Authority paid providers more than the amount recognized by Medicare. These instances resulted in the OHCA making payments totaling $4,066.76 (approximately $2,858.76 federal share) in excess of what Medicare would have paid for the same services.

Urinalysis Tests				
Calendar Year	# of Items Overpaid	Total Overpayment	Approx. FMAP Rate	Approx. Federal Share [1]
1996	188	$ 1.135.9	0.6989	$ 793.88
1997	125	$ 902.14	0.7001	$ 631.59
1998	155	$ 1,168.38	0.7051	$ 823.82
1999	279	$ 860.34	0.7084	$ 609.46
Totals	747	$ 4,066.76		$ 2,858.76

[1]It should be noted that FMAP rate is based on federal fiscal year and the overpayment is based on calendar year.

Recommendations
We recommend the OHCA:

- Implement edits in its claims processing system to identify and prevent inappropriate payments for unbundled and/or duplicative tests;
- Review its clinical laboratory fee schedules on a regular basis to ensure that amounts paid for clinical laboratory services do not exceed amounts that Medicare pays for the same services;
- Adjust the next Quarterly Report of Title XIX expenditures in the amount of $54,780.33 (Approximately $38,690.07) which represents the amount of overpayments for the period of January 1996 through December 1999.

Corrective Action
The following corrective action has or will be taken regarding the above recommendations:

- The McKesson HBOC ClaimCheck® And ClaimReview™ Claim Auditing System was implemented by OHCA in June of 2000. The ClaimCheck® and ClaimReview™ product is a fully automated claim auditing system that verifies the coding accuracy of professional claims. This allows for systematic identification of the appropriate coding of procedures eligible for reimbursement. During this process, ClaimCheck® and ClaimReview™ analyze the current and historical procedure codes billed on a single and/or multiple dates of service. In the past, detecting inaccuracies required manual review by OHCA staff. Automation expedites processing, enhances payment consistency and allows for more efficient monitoring;
- The OHCA will review its clinical laboratory fee schedules in the future to ensure that amounts paid for clinical laboratory services do not exceed that paid by Medicare;
- A total overpayment of $54,780.33 was identified during this review. The federal share was approximately $38,690.07. Of this amount, $28,517.12 has been refunded to Center for Medicare and Medicaid Services. The remaining $10,172.95 will be refunded on the 2nd Quarter CMS 64 report which will be submitted in April 2002.