Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CONNECTICUT GENERALLY IMPLEMENTED RECOMMENDATIONS FROM PRIOR REVIEW OF MEDICAID PAYMENTS FOR CLINICAL LABORATORY SERVICES

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Office of Inspector General

https://oig.hhs.gov

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

EXECUTIVE SUMMARY

Connecticut generally implemented the recommendations from our prior review of Medicaid payments for clinical diagnostic laboratory services.

WHY WE DID THIS REVIEW

A prior Office of Inspector General review found that the State of Connecticut did not always claim Medicaid payments for clinical diagnostic laboratory services in accordance with Federal requirements. We conducted this followup audit to ensure that the Connecticut Department of Social Services (State agency) implemented the recommendations from our prior review.

The objective of this review was to determine whether the State agency had implemented our prior recommendations (1) to refund $1.4 million in Medicaid overpayments and (2) to ensure that amounts claimed for clinical diagnostic laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

BACKGROUND

Hospital outpatient and independent clinical diagnostic laboratory services provide information for the diagnosis, prevention, or treatment of disease or for the assessment of a medical condition. Tests are ordered by a physician or a qualified nonphysician practitioner who is treating the patient. Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount set in the Medicare Clinical Laboratory Fee Schedule (Medicare fee schedule) (the Centers for Medicare & Medicaid Services *State Medicaid Manual* § 6300.2).

We issued a report in 2001 to the State agency on the results of an audit of clinical diagnostic laboratory services for the period of January 1996 through December 1999. The audit identified hospital outpatient and independent laboratory claims totaling $2.8 million ($1.4 million Federal share) that exceeded the Medicare fee schedule payment amounts. These overpayments occurred because the State agency had not updated its clinical laboratory fee schedules for hospital outpatient laboratory services since 1993 and for independent laboratory services since 1994. Accordingly, we recommended that the State agency:

- make an adjustment on the next quarterly report of expenditures in the amount of $2,823,505 ($1,411,752 Federal share) and

- implement procedures to update 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**.**

The State agency agreed with our findings.

HOW WE CONDUCTED THIS REVIEW

We verified that the State agency implemented the recommendations from the prior report by (1) confirming that the State agency refunded $1.4 million to the Federal Government for Medicaid overpayments identified in our prior audit and (2) reviewing Medicaid hospital outpatient and independent clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency for Federal reimbursement on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The State agency claimed $60,686,313 ($34,284,881 Federal share) for Medicaid hospital outpatient and independent clinical laboratory services provided during calendar years 2006 through 2010.

WHAT WE FOUND

The State agency implemented the first recommendation from our prior audit. Specifically, the State agency made an adjustment on its next quarterly report of expenditures for $2.8 million ($1.4 million Federal share). In general, the State agency implemented our prior audit's second recommendation to ensure that amounts claimed for laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts. However, for some services (25,880 of the 6,333,931 services that we reviewed) the State agency paid providers more than the payment amounts in the Medicare fee schedule. As a result, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $564,069 ($334,610 Federal share).

The Medicaid overpayments occurred because the State agency occasionally did not follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services and submitted for Federal reimbursement did not exceed the Medicare fee schedule amounts.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $334,610 to the Federal Government and

- follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings.

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INTRODUCTION

WHY WE DID THIS REVIEW

A prior Office of Inspector General review found that the State of Connecticut did not always claim Medicaid payments for clinical diagnostic laboratory services in accordance with Federal requirements. We conducted this followup audit to ensure that the Connecticut Department of Social Services (State agency) implemented the recommendations from our prior review.

OBJECTIVE

Our objective was to determine whether the State agency had implemented our prior recommendations (1) to refund $1.4 million in Medicaid overpayments and (2) to ensure that amounts claimed for clinical diagnostic laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to certain low-income individuals and individuals with disabilities (the Social Security Act (the Act), Title XIX). The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In Connecticut, the State agency administers the State's Medicaid program.

Medicaid Coverage of Clinical Diagnostic Laboratory Services

Hospital outpatient and independent clinical diagnostic laboratory services provide information for the diagnosis, prevention, or treatment of disease or for the assessment of a medical condition. Tests are ordered by a physician or a qualified nonphysician practitioner who is treating the patient. Clinical laboratory services involve the following types of examination of materials derived from the human body: biological, microbiological, serological, chemical, immunohematological, hematological, biophysical, cytological, pathological, or other examinations of materials.

Providers use CMS's Health Care Common Procedural Coding System (HCPCS) codes to claim clinical laboratory costs for reimbursement from the State agency. The State agency seeks Federal reimbursement for amounts paid on behalf of Medicaid beneficiaries. The Federal Government pays its share of State Medicaid expenditures, including claims for clinical diagnostic laboratory services, according to a formula established in the Act § 1905(b). That share is known as the Federal medical assistance percentage (FMAP). The FMAP in Connecticut ranged from 50.00 percent to 61.59 percent during our audit period.

Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount set in the Medicare Clinical Laboratory Fee Schedule (Medicare fee schedule) (CMS *State Medicaid Manual* § 6300.2).

Prior Office of Inspector General Report

We issued a report in 2001 to the State agency on the results of an audit of clinical diagnostic laboratory services for the period of January 1996 through December 1999.[1] The audit identified hospital outpatient and independent laboratory claims totaling $2.8 million ($1.4 million Federal share) that exceeded the Medicare fee schedule payment amounts. These overpayments occurred because the State agency had not updated its clinical laboratory fee schedules for hospital outpatient laboratory services since 1993 and for independent laboratory services since 1994. Accordingly, we recommended that the State agency:

- make an adjustment on the next quarterly report of expenditures in the amount of $2,823,505 ($1,411,752 Federal share) and

- implement procedures to update 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**.**

The State agency agreed with our findings. Specifically, the State agency stated that it would adjust its next quarterly report of expenditures as recommended and that it took action to update its laboratory fee schedule annually by obtaining the relevant information from Medicare.

HOW WE CONDUCTED THIS REVIEW

We verified that the State agency implemented the recommendations from the prior report by (1) confirming the State agency refunded $1.4 million to the Federal Government for Medicaid overpayments identified in our prior audit and (2) reviewing Medicaid hospital outpatient and independent clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency for Federal reimbursement on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. The State agency claimed $60,686,313 ($34,284,881 Federal share) for Medicaid hospital outpatient and independent clinical laboratory services provided during calendar years (CY) 2006 through 2010.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology.

[1] *Review of Fee Schedules Used for Reimbursement of Clinical Laboratory Services – Connecticut Medicaid Program* (A-01-01-00003).

FINDINGS

The State agency implemented the first recommendation from our prior audit. Specifically, the State agency made an adjustment on its next quarterly report of expenditures for $2.8 million ($1.4 million Federal share). In general, the State agency implemented our prior audit's second recommendation to ensure that amounts claimed for laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts. However, for some services (25,880 of the 6,333,931 services that we reviewed) the State agency paid providers more than the payment amounts in the Medicare fee schedule. As a result, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $564,069 ($334,610 Federal share).

The Medicaid overpayments occurred because the State agency occasionally did not follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services and submitted for Federal reimbursement did not exceed the Medicare fee schedule amounts.

FEDERAL AND STATE REQUIREMENTS

No Federal financial participation would be available to any amounts expended for clinical diagnostic laboratory tests that exceeded the amount that would be recognized under the Medicare program (the Act § 1903(i)(7) and the CMS *State Medicaid Manual* § 6300).

The State agency reviews Medicare rate changes annually and any Medicaid fee that exceeds the applicable Medicare fee is reduced to 95 percent of the Medicare fee or the Medicare floor, whichever is higher (the Connecticut State Plan, Att. 4.19-B).

Clinical laboratory tests are reimbursed on the basis of the Medicare fee schedule published annually by CMS (CMS's *Medicare Claims Processing Manual*, chapter 16, § 20). For each HCPCS code, Medicare pays the lesser of (1) actual charges, (2) the national limitation amount on the CMS fee schedule, or (3) the CMS fee schedule amount for the State or local geographic area.

MEDICAID PAYMENTS EXCEEDED AMOUNTS ALLOWED BY MEDICARE

The State agency generally claimed Federal Medicaid reimbursement for hospital outpatient and independent clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 6,333,931 services that we reviewed, the Medicaid payments made by the State agency for 6,308,051 services did not exceed the Medicare fee schedule amounts. However, for the remaining 25,880 services the State agency paid providers more than would have been paid under the Medicare program. As a result, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $564,069 ($334,610 Federal share).

We determined whether the Medicaid payments for hospital outpatient and independent clinical diagnostic laboratory services were made in accordance with Federal and State requirements by

calculating the allowable and unallowable paid amounts for each individual service. For example, during CY 2009 a provider billed $43 to the State agency for one unit of service for HCPCS code 86901 (Blood typing; Rh (D)). The State agency paid $9.60 to the provider and claimed the same amount for Federal Medicaid reimbursement. On the Medicare fee schedule for 2009, both the national limit and the State limit for Connecticut was $4.35 per unit. Since the National limit and the State limit were lower than the actual charge, we determined that the allowable payment was $4.35 for one unit. As a result, we identified a Medicaid overpayment of $5.25 for this claim ($9.60 minus $4.35). In total, we identified Medicaid payments that exceeded the amounts allowed by Medicare for each CY as follows:

Calendar Year	Claimed Services		Services Exceeding Medicare Fee Schedule	
	Number of Line Items	Paid Amount	Number of Line Items	Unallowable Amount
2006	1,220,448	$9,626,027	757	$16,805
2007	1,057,097	8,458,553	4,214	51,435
2008	1,139,419	11,587,372	5,732	128,767
2009	1,097,555	11,515,973	6,590	152,861
2010	1,819,412	19,498,388	8,587	214,201
TOTAL	**6,333,931**	**$60,686,313**	**25,880**	**$564,069**

CAUSE OF MEDICAID OVERPAYMENTS

The Medicaid overpayments occurred because the State agency occasionally did not follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services and submitted for Federal reimbursement did not exceed the Medicare fee schedule payment amounts.

RECOMMENDATIONS

We recommend that the State agency:

- refund $334,610 to the Federal Government and
- follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency agreed with our findings. The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed Medicaid hospital outpatient and independent clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency for Federal reimbursement on Form CMS-64. The State agency claimed $60,686,313 ($34,284,881 Federal share) for Medicaid hospital outpatient and independent clinical laboratory services provided during CYs 2006 through 2010.[2]

Our objective did not require an understanding or assessment of the complete internal control structures at the State agency. Rather, we limited our review to those controls that were significant to the objective of our audit.

We performed our fieldwork at the State agency in Hartford, Connecticut, from September 2012 through March 2013.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the CMS-approved State plan;
- reviewed our prior audit report on Connecticut clinical diagnostic laboratory services;
- interviewed officials from CMS, the Medicare carrier for Connecticut, and the State agency;
- verified that the State agency refunded $1.4 million to the Federal Government for Medicaid overpayments identified in our prior audit; and
- obtained a computer-generated file from the Connecticut Medicaid Management Information System containing all claims for Medicaid hospital outpatient and independent clinical laboratory services submitted by the State agency with HCPCS codes on the Medicare fee schedule and service dates during the period of January 1, 2006, through December 31, 2010, to:
    - evaluate the file to identify 6,333,931 Medicaid hospital outpatient and independent clinical laboratory services totaling $60,686,313 ($34,284,881 Federal share);

[2] We limited our review to HCPCS codes listed on the Medicare fee schedules for each CY. Our review did not include HCPCS codes without CMS-established payment limits.

- compute what the Medicare payment limit should be for each service by multiplying the Medicare fee schedule rate by the number of units billed, per HCPCS code;

- calculate the difference between the Medicaid amount claimed (paid amount) and the Medicare payment limit for each service; and

- total the differences to determine the amount that the State agency was reimbursed in excess of the Medicare fee schedule.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

STATE OF CONNECTICUT
DEPARTMENT OF SOCIAL SERVICES
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April 22, 2013

Michael J. Armstrong
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Re: OIG Audit performed on the Connecticut Department of Social Services
Report Number A-01-12-00014

Dear Mr. Armstrong:

The State of Connecticut Department of Social Services has reviewed the draft report issued by the Department of Health and Human Services (DHHS) Office of Inspector General (OIG) Audit Number A-01-12-00014. The audit objective was to determine whether the State agency implemented the OIG prior recommendations (1) to refund $1.4 million in Medicaid overpayments and (2) to ensure that amounts claimed for clinical laboratory services and submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts. Provided below is our written comments for each reecommendation.

OIG Recommendation:
We recommend that the State agency refund $334,610 to the Federal Government.

State of Connecticut Department of Social Services comments:
The state concurs with the recommendation that the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements. The state will recoup the overpayment from each specific medical provider noted in the OIG audit report and return the funds to CMS. The funds will be returned by reducing future expenditures claimed for Federal reimbursement on the Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program.

OIG Recommendation:
We recommend that the State agency follow its existing policies and procedures to ensure that the amounts claimed for hospital outpatient independent clinical laboratory services and submitted for federal reimbursement do not exceed the Medicare fee Schedule amounts.

State of Connecticut Department of Social Services comments:
The state concurs with the recommendation. The Department is working on a project that will implement the OIG recommendation to eliminate the number of overpayments. It is estimated that the change in claims processing will be implemented in the fall of 2013 or by the end of the calendar year at the latest.

The State of Connecticut Department of Social Services appreciates the opportunity to provide comments to the OIG audit findings. The department looks forward to improving the effectiveness for ensuring that clinical laboratory services fees submitted for Federal reimbursement do not exceed the Medicare fee schedule amounts.

Sincerely,

Kathleen M. Brennan
Deputy Commissioner
for
Roderick L. Bremby
Commissioner

c: Curtiss Roy, Audit Manager, DHHS, OIG
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