Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MAINE DID NOT ALWAYS CLAIM FEDERAL MEDICAID REIMBURSEMENT FOR CLINICAL DIAGNOSTIC LABORATORY SERVICES IN ACCORDANCE WITH REQUIREMENTS

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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

Maine did not always claim Medicaid payments for clinical diagnostic laboratory services in accordance with Federal and State requirements, resulting in overpayments of approximately $3.5 million ($2.5 million Federal share) over 4 years.

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews found that some States did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Specifically, the States submitted claims for Medicaid clinical diagnostic laboratory services that exceeded the allowed amounts. We conducted this audit to ensure that the Maine Department of Health and Human Services, Office of MaineCare Services (State agency), did not submit claims in excess of the amounts allowed by Federal and State requirements. We selected the State agency in part because we had not previously reviewed its laboratory claims.

The objective of this review was to determine whether the State agency claimed Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

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). State regulations further limit Medicaid reimbursement paid to in-State providers to 53 percent of the limit in the current Medicare fee schedule for Maine in effect at that time (Code of Maine Rules 10-144-101, chapter II, § 55.07, effective March 29, 2009).

HOW WE CONDUCTED THIS REVIEW

We determined whether the State agency claimed Federal reimbursement in accordance with Federal and State requirements by reviewing Medicaid hospital outpatient and independent clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. Specifically, we calculated the amount that should have been paid according to Federal and State requirements and compared it with the amount actually paid. The State agency claimed $30,366,515 ($21,526,813 Federal share) for Medicaid hospital outpatient and independent clinical laboratory services provided during calendar years 2007 through 2010.

WHAT WE FOUND

The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 1,151,170 services that we reviewed, the Medicaid payments that the State agency made for 795,812 services did not exceed the amounts allowed by Federal and State requirements. However, for 355,358 services, the State agency paid providers more than they would have been paid under Medicare or more than the amounts allowed by State regulations. As a result, the Federal reimbursement that the State agency claimed exceeded the rates allowed by Federal and State requirements by $3,492,829 ($2,538,406 Federal share).

The Medicaid overpayments occurred because the State agency did not always follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State regulations.

WHAT WE RECOMMEND

We recommend that the State agency:

- refund $2,538,406 to the Federal Government and

- follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services do not exceed the amounts that would be paid under the Medicare program (for out-of-State providers) or the amounts allowed by State regulations (for in-State providers).

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency neither agreed nor disagreed with our findings. Rather, the State agency stated that it will await the final disposition of future discussions between the Centers for Medicare & Medicaid Services (CMS) and OIG before returning any funds to CMS. In addition, the State agency stated that it will develop a corrective action plan to ensure that out-of-State payments for outpatient clinical laboratory tests do not exceed the amounts paid by Medicare.

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INTRODUCTION

WHY WE DID THIS REVIEW

Prior Office of Inspector General (OIG) reviews found that some States did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.[1] Specifically, the States submitted claims for Medicaid clinical diagnostic laboratory services that exceeded the allowed amounts. We conducted this audit to ensure that the Maine Department of Health and Human Services, Office of MaineCare Services (State agency), did not submit claims in excess of the amounts allowed by Federal and State requirements. We selected the State agency in part because we had not previously reviewed its laboratory claims.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements.

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 Maine, the State agency administers the 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.

[1] *Massachusetts Generally Implemented Recommendations From Prior Review of Claims for Hospital Outpatient Clinical Laboratory Services* (A-01-12-00005, issued November 30, 2012) and *Connecticut Generally Implemented Recommendations From Prior Review of Medicaid Payments for Clinical Laboratory Services* (A-01-12-00014, issued April 29, 2013).

Providers use CMS's Health Care Common Procedural Coding System (HCPCS) codes to claim clinical laboratory services for payment by 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, section 1905(b). That share is known as the Federal medical assistance percentage (FMAP). The FMAP in Maine ranged from 63.27 percent to 74.86 percent during our audit period.

HOW WE CONDUCTED THIS REVIEW

Our review covered the $30,366,515 ($21,526,813 Federal share) that the State agency claimed for Medicaid hospital outpatient and independent clinical laboratory services provided during calendar years (CYs) 2007 through 2010. We determined whether the State agency claimed Federal reimbursement in accordance with Federal and State requirements by reviewing Medicaid hospital outpatient and independent clinical diagnostic laboratory services that were submitted by providers and claimed by the State agency on Form CMS-64, Quarterly Medicaid Statement of Expenditures for the Medical Assistance Program. Specifically, we calculated the amount that should have been paid according to Federal and State requirements and compared it with the amount that actually was paid.

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.

FINDINGS

The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 1,151,170 services that we reviewed, the Medicaid payments that the State agency made for 795,812 services did not exceed the amounts allowed by Federal and State requirements. However, for 355,358 services, the State agency paid providers more than they would have been paid under the Medicare program or more than the amounts allowed by State regulations. As a result, the Federal reimbursement that the State agency claimed exceeded the rates allowed by Federal and State requirements by $3,492,829 ($2,538,406 Federal share).

The Medicaid overpayments occurred because the State agency did not always follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State regulations.

FEDERAL AND STATE REQUIREMENTS

No Federal financial participation is available for amounts expended for clinical diagnostic laboratory tests that exceed the amounts recognized under Medicare (the Act, § 1903(i)(7), and the CMS *State Medicaid Manual*, § 6300.2). Under Medicare, outpatient clinical laboratory services are paid on the basis of a fee schedule established by the Secretary of Health and Human Services (the Act, § 1833(h)(1)(A)).

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 Medicare fee schedule, or (3) the Medicare fee schedule limit for the State or local geographic area.[2]

The State agency posts the payment rates for hospital outpatient and independent clinical diagnostic laboratory services online. Prior to March 29, 2009, the rates for services performed by in-State providers were determined based on the lesser of (1) the Medicare fee schedule limit for Maine in effect at that time or (2) the provider's usual and customary charge. Effective March 29, 2009, the rates for services performed by in-State providers are determined based on the lesser of (1) 53 percent of the Medicare fee schedule limit for Maine in effect at that time or (2) the provider's usual and customary charge (Code of Maine Rules 10-144-101, chapter II, § 55.07).[3]

MEDICAID PAYMENTS EXCEEDED AMOUNTS ALLOWED BY FEDERAL AND STATE REQUIREMENTS

The State agency did not always claim Federal Medicaid reimbursement for hospital outpatient and independent clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 1,151,170 services that we reviewed, the Medicaid payments that the State agency made for 795,812 services did not exceed the amounts allowed by Federal and State requirements. However, for 355,358 services, the State agency paid providers more than would have been paid under the Medicare program or more than the amounts allowed by State regulations.

For example, during May 2009, an in-State provider billed $6.20 to the State agency for one unit of service for HCPCS code 86901 (blood typing; Rh (D)). The State agency paid $6.20 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 Maine were $4.35 per unit.

[2] CMS establishes a national payment limit for each HCPCS code on the Medicare fee schedule. CMS also establishes a State limit on the Medicare fee schedule, which varies by State and may be less than or equal to the national limit.

[3] Code of Maine Rules 10-144-101, chapter II, § 55.07 is not applicable to out-of-State providers. Therefore, out-of-State providers were not subject to the Code of Maine Rules amendment effective March 29, 2009, which further limited the rates for services to 53 percent of the Medicare fee schedule limit for Maine. However, out-of-State providers are subject to Federal requirements, which limit the rate to the amount on the Medicare fee schedule.

Because State regulations limit Medicaid reimbursement to in-State providers to 53 percent of the State limit in the current Medicare fee schedule, we determined that the allowable payment was $2.31 ($4.35 multiplied by 53 percent) for one unit. As a result, we identified a Medicaid overpayment of $3.89 for this claim ($6.20 minus $2.31).

In total, the Federal reimbursement claimed by the State agency exceeded the rates allowed by Federal and State requirements by $3,492,829 ($2,538,406 Federal share). The Medicaid overpayments that we identified for each CY are as follows:

Medicaid Overpayments by Calendar Year

	Claimed Services		Services Exceeding Federal or State Limits	
CY	**Number of Line Items**	**Paid Amount (Federal Share)**	**Number of Line Items**	**Unallowable Amount (Federal Share)**
2007	255,226	$3,184,239	39,520	$214,627
2008	266,363	4,321,520	35,318	289,315
2009	301,183	6,240,213	127,381	928,801
2010	328,398	7,780,841	153,139	1,105,663
Total	**1,151,170**	**$21,526,813**	**355,358**	**$2,538,406**

CAUSE OF MEDICAID OVERPAYMENTS

The Medicaid overpayments occurred because the State agency did not always follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State regulations.

RECOMMENDATIONS

We recommend that the State agency:

- refund $2,538,406 to the Federal Government and
- follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services do not exceed the amounts that would be paid under the Medicare program (for out-of-State providers) or the amounts allowed by State regulations (for in-State providers).

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency neither agreed nor disagreed with our findings. Rather, the State agency stated that it will await the final disposition of future discussions between CMS and OIG before returning any funds to CMS. In addition, the State

agency stated that it will develop a corrective action plan to ensure that out-of-State payments for outpatient clinical laboratory tests do not exceed the amounts paid by Medicare. The State agency's comments are included in their entirety as Appendix B.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

We reviewed claims for Medicaid hospital outpatient and independent clinical diagnostic laboratory services that providers submitted to the State agency and that the State agency claimed for Federal reimbursement on Form CMS-64. The State agency claimed $30,366,515 ($21,526,813 Federal share) for Medicaid hospital outpatient and independent clinical laboratory services provided during CYs 2007 through 2010.[4]

Our objective did not require an understanding or assessment of the complete internal control structure 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 Augusta, Maine, from May through September 2013.

METHODOLOGY

To accomplish our audit objective, we:

- reviewed applicable Federal and State laws, regulations, and guidance and the CMS-approved State plan;
- interviewed officials from CMS and the State agency;
- obtained a computer-generated file from the Maine Medicaid Management Information System (MMIS) containing all claims for Medicaid hospital outpatient and independent clinical laboratory services that the State agency submitted to CMS with HCPCS codes on the Medicare fee schedule and service dates during the period January 1, 2007, through December 31, 2010;
- evaluated the file to identify 1,151,170 Medicaid hospital outpatient and independent clinical laboratory services totaling $30,366,515 ($21,526,813 Federal share);
- reconciled the clinical laboratory services that the State agency claimed during CYs 2007 through 2010 on Form CMS-64 to the MMIS data; and
- determined the amount that the State agency was reimbursed in excess of the amounts allowed by State regulations and the amounts that would be paid under the Medicare program by:

[4] 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.

- computing what the State payment limit should be for each service provided by all providers prior to March 29, 2009, and out-of-State providers on or after March 29, 2009, by multiplying the Medicare fee schedule rate by the number of units billed, per HCPCS code;

- computing what the State payment limit should be for each service provided by in-State providers on or after March 29, 2009, by multiplying 53 percent of the Medicare fee schedule rate by the number of units billed, per HCPCS code;

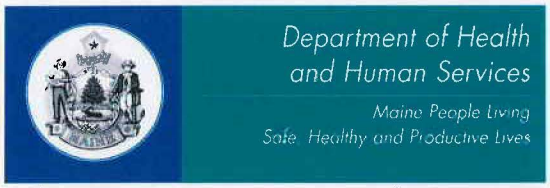
- computing what the Medicare payment limit should be for each service by multiplying the Medicare fee schedule rate by the number of units billed, per HCPCS code;

- calculating the difference between the Medicaid amount claimed (paid amount) and the lower of the provider's actual charge and the State and Medicare payment limit for each service; and

- totaling the differences.

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 B: STATE AGENCY COMMENTS



Paul R. LePage, Governor Mary C. Mayhew, Commissioner

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January 7, 2014

David Lamir, Regional Inspector General for Audit Services
DHHS -- Office of Inspector General
Office of Audit Services, Region 1
JFK Federal Building
15 New Sudbury Street, Room 2425
Boston, Massachusetts 02203

Re: *Maine Did Not Always Claim Federal Medicaid Reimbursement for Clinical Diagnostic Laboratory Services In Accordance With Requirements*. Report Number A-01-13-00005.

Dear Mr. Lamir:

The Department of Health and Human Services (DHHS) appreciates the opportunity to respond to the above mentioned draft audit report. We offer the following comments in relation to the recommendations on Page 4 of this report.

For your convenience, we include the summary finding and recommendation followed by our response. The response includes the State's proposed corrective action plan which we believe will bring the State into compliance with Federal requirements.

Finding:

The State agency did not always claim Federal Medicaid reimbursement for clinical diagnostic laboratory services in accordance with Federal and State requirements. Of the 1,151,170 services that we reviewed, the Medicaid payments that the State agency made for 795,812 services did not exceed the amounts allowed by Federal and State requirements. However, for 355,358 services, the State agency paid providers more than they would have been paid under the Medicare program or more than the amounts allowed by State regulations. As a result, the Federal reimbursement that the State agency claimed exceeded the rates allowed by Federal and State requirements by $3,492,829 ($2,538,406 Federal share).

The Medicaid overpayments occurred because the State agency did not always follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services did not exceed the amounts that would have been paid under the Medicare program or the amounts allowed by State regulations.

Recommendation:
We recommend that the State agency:

- refund $2,538,406 to the Federal Government and
- follow its policies and procedures to ensure that the amounts claimed for hospital outpatient and independent clinical laboratory services do not exceed the amounts that would be paid under the Medicare program (for out-of-State providers) or the amounts allowed by State regulations (for in-State providers).

Response:
DHHS will await the final disposition of future discussions between CMS and the Office of Inspector General, referred to in Rudolph Naples email of November 26, 2013, concerning findings in their respective audit reports before returning any funds to CMS.

This review was conducted on claims paid through the MeCMS system. The MIHMS system uses a variety of processes, payment terms and fee schedules to determine appropriate allowed amounts, as well as edits to ensure accurate payments.

Currently, instate payments for outpatient clinical laboratory tests do not exceed amounts paid by Medicare. DHHS will work with its fiscal agent, Molina, to develop a corrective action plan to ensure that out of state payments for outpatient clinical laboratory tests do not exceed amounts paid by Medicare.

We appreciate the time spent in Maine by OIG's staff reviewing Maine's compliance with the requirements for clinical diagnostic laboratory services. We believe this effort will enable us to perform this function more accurately in the future.

Sincerely,

Mary C. Mayhew
Commissioner

MCM/klv