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DEPARTMENT OF HEALTH & HUMAN SERVICES — Office of Inspector General

Memorandum

Date OCT 1 1996

From June Gibbs Brown
Inspector General

Subject Review of Separately Billable End Stage Renal Disease Laboratory Tests (A-01-96-005 13)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, *Review of Separately Billable ESRD Laboratory Tests*. The objective of our review was to determine whether laboratory tests (lab tests) billed separately under Medicare's end stage renal disease (ESRD) program were reimbursed in accordance with Medicare regulations and guidelines. We found that a significant control weakness exists in the Medicare payment system that allowed hospitals and independent laboratories to be reimbursed separately for lab tests even though payment for these tests was already included in each facility's composite rate. Based on a statistical sample, we estimate that $6.3 million out of $12.8 million was improperly paid to hospitals and independent laboratories for separately billed lab tests performed for ESRD beneficiaries during Calendar Year 1994.

We recommend **(1)** an education program for ESRD providers and independent laboratories explaining proper ESRD billing practices, (2) monitoring of providers' billing for lab tests outside the composite rate for possible post-payment reviews, and (3) recovery of the estimated overpayments.

When undertaking the overpayment recovery process, the Health Care Financing Administration (HCFA) should coordinate with the Office of Inspector General in the event the provider is under investigation. Also, the Office of Audit Services can provide the computer data necessary for the recovery effort.

In response to our draft report, HCFA officials concurred with our recommendations and have proposed and/or implemented corrective actions to address the issues.

Please advise us within 60 days on actions taken or planned on our recommendations. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-01-96-005 13 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF SEPARATELY BILLABLE END STAGE RENAL DISEASE LABORATORY TESTS

JUNE GIBBS BROWN
Inspector General

OCTOBER 1996
A-01-96-00513

Memorandum

Date · OCT 1 1996

From June Gibbs Brown
Inspector General

Subject Review of Separately Billable End Stage Renal Disease Laboratory Tests (A-01-96-00513)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of the subject review. The objective of our review was to determine whether laboratory tests (lab tests) billed separately under Medicare's end stage renal disease (ESRD) program were reimbursed in accordance with Medicare regulations and guidelines. We found that a significant control weakness exists in the Medicare payment system that allowed hospitals and independent laboratories to be reimbursed separately for lab tests even though payment for these tests was already included in each facility's composite rate. Based on a statistical sample, we estimate that $6.3 million out of $12.8 million was improperly paid to hospitals and independent laboratories for separately billed lab tests performed for ESRD beneficiaries during Calendar Year (CY) 1994. We are recommending (1) an education program for ESRD providers and independent laboratories explaining proper ESRD billing practices, (2) monitoring of providers' billing for lab tests outside the composite rate for possible post-payment reviews, and (3) recovery of the estimated overpayments.

In response to our draft report, Health Care Financing Administration (HCFA) officials concurred with our recommendations and have proposed and/or implemented corrective actions to address the issues. The HCFA comments to our draft report are included in their entirety in Appendix I.

INTRODUCTION

BACKGROUND

Health Insurance for the Aged and Disabled (Medicare), under title XVIII of the Social Security Act, as amended, is a broad health insurance program which includes coverage for ESRD services provided to eligible persons suffering renal failure. The HCFA, as the agency responsible for administering the Medicare program, utilizes a prospective payment method for dialysis services by reimbursing ESRD facilities through a composite rate per maintenance dialysis treatment. This composite rate is a comprehensive payment for dialysis related services provided to the patient and includes, among other services, payment for selected lab tests.

Sections 207.3 and 240.3D of the Renal Dialysis Facility Manual designate the lab tests that are included in a facility's composite rate and specify the frequencies at which these tests are included (weekly or monthly). When lab tests are performed at these frequencies, they cannot be billed separately. However, when any of these tests are performed at a frequency greater than specified, the additional tests are separately billable and are covered (assuming they are medically justified). In addition, lab tests not included as part of the facility's composite rate may be billed separately.

Chapter 27 of the Provider Reimbursement Manual (PRM) encompasses the payment instructions for outpatient maintenance dialysis services. Section 2711.1 of the PRM provides the payment instructions specific to separately billable ESRD lab tests. It not only provides when lab tests are separately billable but also provides limitations on all separately billable lab tests when they are performed as part of a panel of tests. Specifically, if 50 percent or more of the lab tests performed as a panel of tests are included in the composite rate, then the entire panel of tests is considered to be included in the composite rate (section 2711.1(B)(1)(c) of the PRM). In this instance, no separate payment is made for those lab tests outside the composite rate. We make reference to this throughout our report as the "50 percent rule."

All claims for separately billable lab tests performed by hospitals for ESRD beneficiaries are submitted to the Medicare fiscal intermediary (FI) for processing, whereas, lab tests performed by independent laboratories are submitted to the Medicare carrier.

SCOPE

We conducted our review in accordance with generally accepted government auditing standards. The objective of this review was to determine whether lab tests billed separately under Medicare's ESRD program were reimbursed in accordance with Medicare regulations and guidelines. Our review included CY 1994 paid claims for ESRD lab tests.

As part of our examination, we obtained an understanding of the internal control structure surrounding the processing of ESRD lab claims. We concluded, however, that our consideration of the internal control structure could be conducted more efficiently by expanding substantive audit tests, thereby placing limited reliance on the hospitals', independent laboratories', FIs', and carriers' internal control structure. We did not include as part of our review a determination of the medical necessity of separately billed ESRD lab claims.

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- performed a computer application using a database of CY 1994 ESRD paid claims compiled by HCFA to extract claims paid to hospital-based ESRD providers. We identified 3,645 hospitals that submitted 239,622 claims for ESRD lab tests[1] and were paid $3,369,847 for these tests. However, we limited our review to those hospitals that received 67 percent of the amount paid. Therefore, our population consisted of 190 hospital-based ESRD providers that submitted 171,463 claims for ESRD lab tests and were paid $2,262,372 for these tests;

- performed a computer application using a database of CY 1994 ESRD paid claims compiled by HCFA to extract claims paid to independent laboratories that performed lab testing for ESRD providers. We identified 6,007 laboratories that submitted 1,569,094 claims for ESRD lab tests[1] and were paid $15,054,199 for these tests. However, we limited our review to those independent laboratories that received 70 percent of the amount paid. Therefore, our population consisted of 35 independent laboratories that submitted 1,180,624 claims for ESRD lab tests and were paid $10,538,110 for these tests;

- employed a multistage statistical sampling approach (see Appendix II). Our primary sampling unit consisted of 8 hospital-based ESRD facilities from a population of 190 hospitals and 8 independent laboratories from a population of 35 laboratories. The secondary sampling unit consisted of 50 claims at each of the 8 hospitals (a total of 400 claims valued at $4,773.41) and 8 laboratories (a total of 400 claims valued at $4,282.41);

- for each of the 800 sampled claims, we extracted paid claims for ESRD services performed on the patient during the month under review to determine if a composite rate payment was made during the month;

- obtained from the hospitals and independent laboratories lab reports with results for all lab tests conducted during the month under review for each of the 800 claims randomly selected in our sample;

- used a variable appraisal program to estimate the dollar impact of improper payments in the total population;

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[1] We limited our review to panel tests (procedure codes 80002 through 80019), Blood Urea Nitrogen tests (procedure code 84520), and Uric Acid tests (procedure codes 84550/55).

- reviewed controls for processing ESRD lab claims at one FI; and
- discussed our results with HCFA officials in April 1996.

In completing our review of the sample, we established a reasonable assurance on the authenticity and accuracy of the data. Our audit, however, was not directed towards assessing the completeness of the file from which the data was obtained.

We conducted our work from October 1995 through April 1996 at the Office of Audit Services' (OAS) regional office in Boston, Massachusetts.

We issued our draft report on June 27, 1996. The HCFA's response to the draft report, dated September 3, 1996, is appended to this report (see Appendix I) and is addressed on page 8.

FINDINGS AND RECOMMENDATIONS

Our assessment of the payment system for separately billable ESRD lab tests identified a control weakness with the reimbursement for these tests. Specifically, our analysis shows that hospitals and independent laboratories were reimbursed separately for lab tests even though these tests are included in each facility's composite rate. In addition, we found that, contrary to the 50 percent rule, separate payments were made for panel tests. Based on a statistical sample, we estimate that $6.3 million out of $12.8 million was improperly paid to hospitals ($1,006,644 out of $2,262,372) and independent laboratories ($5,295,097 out of $10,538,110) for separately billed lab tests performed on ESRD beneficiaries during CY 1994.

VALIDATION AND IDENTIFICATION OF IMPROPER PAYMENTS

Using a database of CY 1994 ESRD paid claims, which HCFA compiled from the National Claims History file, we identified over $18.4 million in Medicare payments for panel tests and other selected lab tests made to over 9,600 hospitals ($3.4 million) and independent laboratories ($15.0 million). For this review, we limited our population to 190 hospitals and 35 independent laboratories which received approximately 70 percent, or $12.8 million of these payments.

To determine whether lab tests billed separately under Medicare's ESRD program were reimbursed properly, we employed a multistage statistical sampling approach. In this regard, we included each facility that billed Medicare for an ESRD lab test in the primary sampling unit while each claim for an ESRD lab test represented the secondary sampling unit. We selected 8 hospital-based ESRD facilities from a population of 190 facilities and 8 independent laboratories from a population of 35 facilities. Further, we selected 50 claims from the population of claims at each of the 8 hospital-based ESRD facilities and 8 independent laboratories, or a total of 800 claims.

For each of the 800 claims, we obtained from the hospitals and independent laboratories lab reports with results for all lab tests conducted during the month under review in order to determine the frequency at which the lab tests were conducted. By doing this, we were able to determine whether a particular lab test was included in the facility's composite rate or if it was correctly billed outside the composite rate. Figure 1 presents the results of our analysis of the 800 claims.

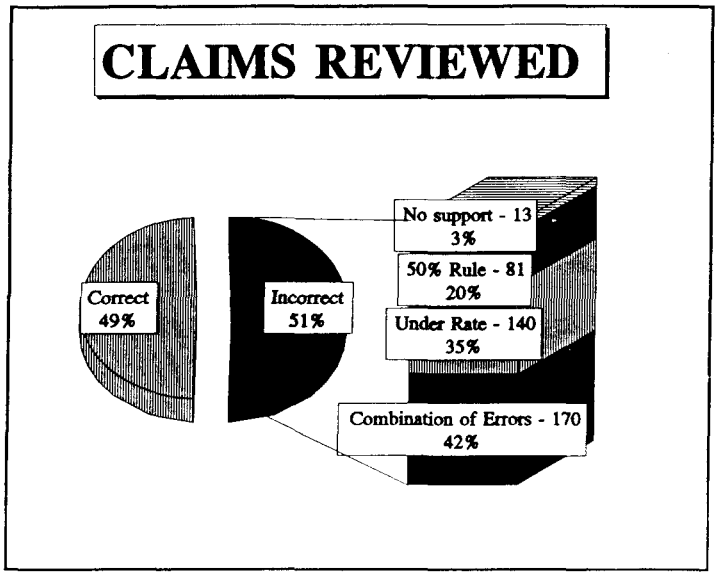

Figure 1

We found four types of conditions for which hospitals and independent laboratories were reimbursed for lab tests improperly. Specifically, we found that 405 out of 800 separately billed ESRD lab tests, or over 50 percent, were improperly reimbursed for the following types of conditions:

- A provider performed and billed one 19-panel test; however, 12 of the tests performed are included in the composite rate because the tests were not conducted above the frequency specified under the composite rate. Therefore, reimbursement for these 12 tests is duplicative of the composite rate payment. The remaining seven tests are nonbillable because of the 50 percent rule (in this case, 63 percent of the tests were in the composite rate). The combination of these types of errors accounted for 42 percent of the total claims in error.

- A provider performed one 19-panel test, did not bill for the 12 lab tests in the composite rate, but billed for the 7 tests not included in the composite rate. As explained above, these tests are nonbillable due to the 50 percent rule (in this case, 63 percent of the tests were in the composite rate). This type of error accounted for 20 percent of the total claims in error.

- A provider billed Medicare for lab tests which were performed at or below the frequency specified under the composite rate. Because these tests were not conducted above the frequency specified under the composite rate, separate reimbursement is improper. This type of error accounted for 35 percent of the total claims in error.

- The remaining 3 percent of the claims in error relate to lab tests billed by providers for which they could not document support.

As a result of reviewing the 800 claims, 400 claims by hospital-based providers with a dollar value of $4,773.41 and 400 claims by independent laboratories with a dollar value

of $4,282.41, and extrapolating the result of the statistical sample over the population using standard statistical methods, we found the following:

- for hospital-based ESRD facilities, a total of 229 claims valued at $2,458.16 were improperly paid. The estimated dollar impact of improper payments in the population is $1,006,644 with a precision of this estimate at the 90 percent confidence level of +/- 24.08 percent.

- for independent laboratories, a total of 176 claims valued at $1,862.94 were improperly paid. The estimated dollar impact of improper payments in the population is $5,295,097 with a precision of this estimate at the 90 percent confidence level of +/- 27.16 percent.

REASONS FOR IMPROPER PAYMENTS

We believe that these improper payments occurred because the hospitals and independent laboratories did not follow Medicare billing guidelines. In this regard, we believe that most hospitals and several independent laboratories either did not have procedures in place or did not follow their procedures to determine whether lab tests performed were included in the composite rate or whether these tests were, in fact, separately billable.

Another reason for the overpayments surrounds the control procedures in place at the Medicare FI and carrier level which are responsible for processing lab claims. Specifically, control procedures to identify potential improper lab claims are not possible on a prepayment basis and, therefore, are limited to post-payment review procedures because of the nature of the ESRD billing system. In this regard, the current claim form used to bill Medicare for services rendered:

(1) only indicates what procedure was performed by using an identifying procedure code, e.g., procedure code 80019 indicating that 19 or more tests in a panel were conducted, but does not indicate the make-up of this panel test. Because the claim does not indicate the make-up of the panel test, the FI/carrier is unable to ascertain whether the tests are included in the composite rate; and

(2) only indicates the tests for which the provider is billing. However, the FI/carrier needs to know the frequency at which the tests were performed during the month in order to make a determination as to whether the tests are included in the composite rate or are, in fact, separately billable.

Because of these weaknesses, only a post-payment review of lab reports could determine whether the lab tests are included in the composite rate, meet the 50 percent rule, or are

indeed separately billable. This was verified in discussions with officials from one FI who indicated that an automated edit process to identify these conditions would not be feasible since data submitted on a claim does not identify all tests performed during the month.

RECOMMENDATIONS

We recommend that HCFA require all FIs and carriers to:

(1) provide education to ESRD providers and independent laboratories explaining proper ESRD billing practices, including which lab tests are included in the composite rate, the frequencies at which these tests are included, and the 50 percent rule;

(2) monitor providers' billing for lab tests outside the composite rate and, if cost-effective, conduct detailed post-payment reviews to determine if reimbursement was proper; and

(3) recover the overpayments which we estimate to be $6.3 million in CY 1994.

When undertaking the recovery process, HCFA should coordinate overpayment recovery with the Office of the Inspector General in the event the provider is under investigation. Also, the OAS can provide the computer data necessary for the recovery effort.

AUDITEE'S COMMENTS

In its comments to our draft report, HCFA concurred with our recommendations and has taken the following actions:

(1) developed new billing instructions to better explain proper ESRD billing practices and is in the process of developing Common Working File cross-over edits to eliminate duplicate processing of claims by carriers and FIs that process lab tests included in the composite rate;

(2) will incorporate specific outreach efforts into its ongoing provider education activities;

(3) believes that data analysis and post-payment review are the best tools for detecting and correcting inappropriate billings for lab tests outside the composite rate; and

(4) will issue a memorandum to all Associate Regional Administrators advising them to instruct their contractors to comply with our recommendations.

APPENDICES

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administra

The Administrator
Washington, D.C. 20201

DATE: SEP 3 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Separately Billable End Stage Renal Disease Laboratory Tests," (A-01-96-00513)

We reviewed the above-referenced report that examines whether laboratory tests billed separately under Medicare's end stage renal disease program were paid according to Medicare regulations and guidelines.

Our detailed comments on the report recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Health Care Financing Administration (HCFA) Comments on Office of Inspector General (OIG) Draft Report: "Review of Separately Billable End Stage Renal Disease (ESRD) Laboratory Test," (A-01-96-00513)

OIG Recommendation

HCFA should require all fiscal intermediaries (FIs) and carriers to provide education to ESRD providers and independent laboratories explaining proper ESRD billing practices, including which lab tests are included in the composite rate, the frequencies at which these tests are included, and the 50 percent rule.

HCFA Response

We concur. HCFA has already taken action to comply with this recommendation. We have developed new billing instructions to better explain proper ESRD billing practices. We are also developing Common Working File cross-over edits to eliminate duplicate processing of claims by carriers and FIs that process laboratory tests included in the composite rate. These instructions will be implemented by January 1, 1997.

Prior to implementation of the new billing instructions, HCFA will incorporate specific outreach efforts into our ongoing provider education activities. Educational activities, targeting providers and their billing staff, will focus on explaining proper ESRD billing practices, including lab tests included in the composite rate and the 50 percent rule. Activities will include articles published in provider bulletins and newsletters, alerts on provider bulletin boards, and discussions at provider meetings.

OIG Recommendation

HCFA should monitor providers' billing for lab tests outside the composite rate and, if cost-effective, conduct detailed post-payment reviews to determine if reimbursement was proper.

HCFA Response

We concur. HCFA believes that data analysis and post-payment review are the best tools for detecting and correcting this kind of abuse. Therefore, we are requesting that the OIG send a copy of the report "Review of Separately Billable End Stage Renal Disease Laboratory Tests" to each of our carriers and FIs. We will instruct our carriers and intermediaries to analyze claims data to determine if further investigation, such as a detailed post-payment review, is warranted.

OIG Recommendation

HCFA should recover the overpayments which we estimate to be $6.3 million in calendar year 1994.

HCFA Response

We concur. HCFA will issue a memorandum to all Medicare Associate Regional Administrators advising them to instruct their contractors to comply with the OIG's recommendations. We will work with the Office of Audit Services to identify and record the overpayments incurred by the providers and will instruct contractors to take immediate steps to recover provider overpayments. HCFA will coordinate this recovery action with the OIG in the event the provider is under investigation.

APPENDIX II

METHODOLOGY OF STATISTICAL SAMPLE SELECTION

To select a sample for validating our data and estimating the potential improper payments for ESRD related laboratory services, we employed a multistage sample based on probability-proportional-to-size weighted by dollar value at each provider. Our review focused on the following selected laboratory tests: panel tests (procedure codes 80002 - 80019), Blood Urea Nitrogen tests (procedure code 84520), and Uric Acid tests (procedure codes 84550 and 84555)).

Hospital Based ESRD Facilities

The sample was drawn from 190 hospitals with 171,463 claims for lab tests valued at $2,262,372. Thus, the primary sampling units consisted of 8 hospitals and our secondary units consisted of 50 claims for lab tests at each hospital (a total of 400 claims).

Independent Laboratories

The sample was drawn from 35 laboratories with 1,180,624 claims for laboratory tests valued at $10,538,110. Thus, the primary sampling units consisted of 8 laboratories and our secondary units consisted of 50 claims for lab tests at each laboratory (a total of 400 claims).

To select our primary sample units, the following steps were conducted:

- the number of claims and the total paid amount for the selected lab tests in these claims were determined,
- the primary units were randomly assigned to eight groups, and
- one provider was then selected from each of the eight groups with chance of selection proportional to their respective dollar value within that group.

The selection of secondary units was by a simple random sample of claims for lab tests. Fifty claims were selected from the population of claims at each of the 8 hospitals and 8 independent laboratories.

Claims for which we have not received supporting documentation were considered an error.

All random selections and estimations were made using the Office of Audit Services' Statistical Software dated February 1995.