DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date **MAR 171997**

From June Gibbs Brown
Inspector General

Subject Review of Clinical Laboratory Services Under West Virginia's Medicaid Program for Calendar Years 1993 and 1994 (A-03 -96-O0203)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on March 19, 1997 of our final audit report. A copy is attached.

The objective of our review was to evaluate the West Virginia Department of Health and Human Resources' (State agency) procedures and controls over the payment of Medicaid claims which contain clinical laboratory services. Clinical laboratory services include chemistry, hematology, and urinalysis tests. Our review was limited to clinical laboratory services involving chemistry tests. Due to the immateriality of the amount of potential instances of overpayments in the laboratory services involving hematology and urinalysis tests, we excluded those tests from this review.

Our review disclosed that the State agency lacked adequate procedures and controls to ensure that chemistry tests were reimbursed in accordance with the State Medicaid Manual which requires State agencies to ensure that Medicaid reimbursements for clinical laboratory tests do not exceed amounts recognized by the Medicare program. The Medicare regulations require that laboratory tests, which are available as part of a multichannel chemistry panel or an all-inclusive urinalysis test, be bundled into and reimbursed at a lesser panel or all-inclusive fee rather than being reimbursed at higher individual test fees. The State agency did not have adequate controls to ensure that chemistry tests are bundled for reimbursement purposes. We found that all 100 sampled claims were overpaid. Based on our audit, we estimate that the State agency overpaid providers $1,378,601 (Federal share $1,047,789) during Calendar Years 1993 and 1994.

We are recommending that the State agency: (1) implement a policy change that would clearly define and mandate the use of bundled services for chemistry tests, (2) install edits to detect and prevent payments for unbundled services, (3) recover overpayments for clinical laboratory services identified in this review, and (4) 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 generally agreed with three of our four recommendations. The State agency did not agree with our recommendation to recover overpayments identified through our review because it questioned certain aspects of our sample methodology and audit process.

We do not agree with the State agency. Our calculation of the potential amount of overpayment is based on sound statistical sampling and projection methodology. Our review identified overpayment errors in all 100 sampled claims. We believe that the State agency should pursue collection of the overpayments identified during our review and make the appropriate adjustments on its Quarterly Report of Expenditures.

Attachment

For information contact:

Thomas J. Robertson
Regional Inspector General
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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF CLINICAL LABORATORY SERVICES UNDER WEST VIRGINIA'S MEDICAID PROGRAM FOR CALENDAR YEARS 1993 AND 1994

JUNE **GIBBS BROWN**
Inspector General

MARCH 1997
A-03-96-O0203

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Our Reference: Common Identification Number A-03 -96-O0203

Gretchen O. Lewis, Secretary
Department of Health and Human Resources
State of West Virginia
Building 3, State Capital Complex
Charleston, West Virginia 25305

Dear Ms. Lewis:

This report presents the results of our review of the West Virginia Department of Health and Human Resources (State agency) reimbursements for outpatient 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 in Calendar Years (CY) 1993 and 1994 for outpatient clinical laboratory services involving chemistry tests.

Our review disclosed that the State agency lacked adequate procedures and controls to ensure that chemistry tests were reimbursed in accordance with Section 6300 of the State Medicaid Manual which requires State agencies to ensure that Medicaid reimbursements for clinical laboratory tests do not exceed amounts recognized by the Medicare program. The Medicare regulations require that laboratory tests, which are available as part of a multichannel chemistry panel, be bundled into and reimbursed at a lesser panel fee rather than being reimbursed at higher individual test fees. The State agency did not have adequate controls to ensure that chemistry tests are bundled for reimbursement purposes.

We selected a stratified sample of 100 chemistry claims for more than one individual test or panel, or for a panel and individual tests for the same recipient on the same date of service by the same provider. We considered these claims to be potential payment errors because the probability existed that the claims should have been reimbursed at a panel fee rather than at higher individual test fees.

We found that all 100 claims were overpaid since the chemistry tests were available as part of an automated multichannel chemistry panel. We also found that for 18 of the chemistry

claims the State agency paid providers higher fees than the West Virginia Medicare carrier (Nationwide Mutual Insurance Company) clinical laboratory fee schedule prices. [1]

In our opinion, the overpayments occurred because the State agency: (1) did not have adequate edits to detect chemistry tests that should have been bundled into a single automated multichannel panel chemistry test code for reimbursement purposes; (2)' did not consider for bundling purposes all chemistry tests identified by the local Medicare carrier as being suitable for bundling; and (3) reimbursed some chemistry tests at fees higher than those established by the local Medicare carrier.

Projecting the results of our statistical sample over the population of similar claims using standard statistical methods, we estimated that the State agency overpaid providers $1,378,601 (Federal share $1,047,789).

We recommended that the State agency: (1) implement a policy change that would clearly define and mandate the use of bundled services for chemistry tests, (2) install edits to detect and prevent payments for unbundled services, (3) recover overpayments for clinical laboratory services identified in this review, and (4) 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).

The State agency responded to a draft of this report and concurred with three of our four recommendations. The State agency did not agree to recover overpayments for clinical laboratory services identified by our review because it did not agree with our audit process. We have summarized the State agency's response along with our comments after the Conclusions and Recommendations section of this report. The State agency's written response is included as APPENDIX C.

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[1] Because many of the overpayments identified in this review were attributed to Medicaid fee schedule prices exceeding the local Medicare carrier's fee schedule prices, we intend to make a separate review of the State agency's Medicaid fee schedules and paid claims to determine the impact on the Medicaid program for all clinical laboratory services. The results of this expanded review will be reported separately.

INTRODUCTION

BACKGROUND

Medicaid, a Federally aided State program established under Title XIX of the Social Security Act, provides medical assistance to certain individuals and families with low income and resources. Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of HCFA. States are required to provide certain medical services and other services such as outpatient clinical laboratory tests. In West Virginia, the Department of Health and Human Resources is the State agency responsible for administering the Medicaid program.

Laboratory tests are performed by providers on a patient's specimen to help physicians diagnose and treat ailments. Chemistry tests involve the measurement of various chemical levels in 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.

Testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory. The providers submit claims for laboratory services performed on Medicaid recipients. Claims processing is the responsibility of a designated Medicaid agency in each State which may elect to use an outside fiscal agent to process claims.

The State Medicaid Manual limits Medicaid payments for outpatient clinical laboratory tests to the amount that Medicare pays. Specifically:

- 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.

- 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. The Medicare 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.

- Section 6300.5 allows a State agency to enter into agreements to purchase laboratory services. However, States may not pay more in the aggregate for clinical diagnostic laboratory tests than the amount that would be paid for the tests under the Medicare fee schedule.

SCOPE OF AUDIT

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 in CY 1993 and 1994 for clinical laboratory services for chemistry tests. We did not include in our detailed review urinalysis and hematology tests because our computer applications identified an insignificant amount of potential payment errors, $100,195.

To accomplish our objective, we reviewed State agency policies and procedures for processing Medicaid claims from providers for clinical laboratory services involving chemistry tests. We also reviewed the Medicare carrier's policies and procedures for processing Medicare claims from providers for clinical laboratory services.

We extracted from the State agency's CY 1993 and 1994 Medicaid paid claims files payments made under the American Medical Association Physician's Current Procedural Terminology (CPT) codes for chemistry tests. We identified 82,861 claims totaling $2,415,317 for more than one individual test *or* panel, or for a panel and individual tests for the same recipient on the same date of service by the same provider.

We considered these claims to be potential payment errors because the probability existed that the claims should have been reimbursed at a panel fee rather than at the higher individual test fee(s). From this extraction, we selected a stratified sample of 100 chemistry claims--50 from CY 1993 claims and 50 from CY 1994 claims--and reviewed their supporting documentation, including paid vouchers, from the State agency to determine the propriety of the payment.

We determined the overpayment amount for each claim. The overpayment is the difference between what the State agency paid and what should have been paid considering the single bundled code and the Medicare fee schedule. The bundled code we used in our overpayment calculation was the lesser of the provider's actual charge, or the Medicaid or Medicare fee schedule amount. We then used a stratified variable appraisal methodology to estimate the amount of overpayment for chemistry tests.

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 the paid claims files nor did we evaluate the adequacy of the input controls.

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 edits for bundling of chemistry tests.

Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report. APPENDIX B contains the CPT codes included in our review. Weperformed ourreview during August and September 1996. During this period we visited the State agency office in Charleston, West Virginia.

RESULTS OF REVIEW

Our review showed that all of the 100 selected claims were overpaid by the State agency. The overpayments occurred because the State agency reimbursed providers: (1) higher individual test fees rather than bundling the tests into an appropriate lower panel fee and (2) Medicaid fees that were higher than the Medicare fee schedule established by the Medicare carrier.

Projecting the results of our sample over the population using standard statistical methods, we estimate that the State agency overpaid providers during the 2-year audit period, $1,378,601 (Federal share $1,047,789). At the 90 percent confidence level, the precision of this estimate is plus or minus 14.8 percent.

CHEMISTRY TESTS

Our review of the 100 claims for chemistry tests showed that all were overpaid by the State agency. The claims were reimbursed at either the individual test fees or the individual test fee(s) and the individual panel fee(s) rather than being bundled into and reimbursed as one automated multichannel panel. Fifty-two of the claims included tests for triglycerides, creatinine phosphokinase (CPK), and/or glutamyltransferase gamma test (GGT). We also noted that the State agency paid higher fees than the West Virginia Medicare carrier for 18 of the claims. This violates Medicaid guidelines that state that Medicaid reimbursement for clinical laboratory tests may not exceed the amount that Medicare recognizes for such tests (Section 6300.2 of the State Medicaid Manual).

The unbundling of chemistry tests occurred primarily because the State agency did not have adequate edits to detect the unbundling of laboratory services. The State agency had edits to detect the same test performed on the same day. While these edits should prevent duplicate payments, they cannot detect different tests performed on the same day that should be bundled into a single billing code for reimbursement purposes.

We also noted that the State agency did not follow Medicare guidelines with regard to chemistry tests for triglycerides, CPK, and GGT. The Medicare carrier for West Virginia requires that these tests be bundled into a multichannel panel. The State agency requires providers to follow coding guidelines specified in CPT when billing for clinical laboratory services. The 1993 and 1994 CPT did not include the three tests as part of its automated multichannel codes.

The following chart illustrates two examples of the types of overpayments that we are reporting.

Sample No.	WVA Services Billed	WVA Medicaid Paid Amount	Audited Services	Audited Amount	Overpayment
K-18	84478 82465 80006 Total	$9.44 6.75 9.16 $25.35	80008	$12.29,	$13.06
L-1	82977 84478 80018 Total	$10.94 8.94 16.58 $36.46	80019	$16.44	$20.02

In the first example, inCY 1993 the provider was paid $25.35 for three services--84478 which is a triglycerides test; 82465 which is a cholesterol test; and 80006 which is a multichannel panel that includes six clinical chemistry tests. We concluded that the three services should have been bundled into code 80008 which is a multichannel panel that includes eight clinical chemistry tests. The provider should have been reimbursed $12.29, or $13.06 less that what the State agency paid.

In the second example, in CY 1994 the provider was paid $36.46 for the 3 services--82977 which is a GGT; 80018 which is a multichannel panel that includes 17-18 clinical chemistry tests; and 84478 which is described above. We concluded that the three services should have been bundled into code 80019. We noted that the State agency's fee for 80019 in CY 1994 was $17.21 or 77 cents higher than the Medicare fee schedule. We computed the overpayment to be $20.02 which is the difference between the amount reimbursed by the State agency and the amount allowed by Medicare for 80019.

CONCLUSIONS AND RECOMMENDATIONS

The State agency overpaid providers for chemistry tests because it did not have adequate procedures to prevent the unbundling of services or to ensure that its Medicaid fee schedule did not exceed the Medicare fee schedule established by the local Medicare carrier. We estimate that the State agency overpaid providers $1,378,601 (Federal share $1,047 ,789) for chemistry tests during CY 1993 and 1994. We recommend that the State agency:

1. Implement a policy change that would clearly define and mandate the use of bundled services for chemistry tests.

2. Install edits to detect and prevent payments for unbundled services.

3. Recover Medicaid overpayments for clinical laboratory services identified in this review. Based on our audit, we estimate that $1,378,601 should be recovered for CY 1993 and 1994.

4. Make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to HCFA.'

STATE AGENCY RESPONSE AND OIG COMMENTS

The State agency agreed with three of our four recommendations. It did not agree to recover $1,378,601 (Federal share $1,047,789) resulting from overpayments.

The State agency agreed with our first recommendation to implement a policy change to mandate the use of bundled services for chemistry tests. The State agency stated that within 90 days it will develop and disseminate a strong policy statement clarifying, defining, and mandating the use of bundled services in relation to chemistry tests performed on blood specimens.

The State agency generally concurred with our second recommendation to install edits to detect and prevent payments for unbundled services. The State agency is currently reviewing the option of adopting edits to detect and bundle laboratory procedure codes. If the edits prove to be not efficient, the State will contract with a third-party to initiate retroactive review and seek recoupment of improperly unbundled services.

The State agency did not agree with our third recommendation to recover $1,378,601 in overpayments. It agreed, however, with our fourth recommendation to make an adjustment for the Federal share of any amounts recovered.

The State agency expressed concern with several issues related to our audit process. First, it disagreed with our sample selection and projection methodology. The State agency stated that the sample size of 100 claims was insufficient to extrapolate the data to the population of 82,861. Second, the State agency was uncertain whether the supporting documentation we reviewed corresponded to the sample claims given the initial confusion over the service dates and recipient numbers in the original sample. It also questioned whether the proper Medicare rates were applied during our analysis because there is a time lag between the period that the Medicare fee schedule becomes effective and when the fees were available for implementation by the State agency. The State agency was concerned that we did not review medical records given that emergency services may require repeating the same tests and would not, in its view, be subject to bundling requirements. Lastly, the State agency stated that it could not adequately assess our analysis without reviewing all 100 sample items. The draft report provided only two examples of how we calculated overpayments.

We are pleased that the State agency agreed with three of the four recommendations. We disagree with the State agency's position regarding the remaining recommendation to recover

Medicaid overpayments. Our calculation of the potential amount of overpayment is based on sound statistical sampling and projection methodology which we described in APPENDIX A of this report. Significantly, our review identified overpayment errors in all 100 sampled claims. As stated in this report, we considered Medicare pricing which was confirmed by the State's Medicare carrier and was based on the fees as of the date of service. Also, our recommendation does not require the State agency to recover exactly $1,378,601. This figure is an estimate of overpayments based on our review of the sampled claims. Actual recoveries may be more or less and would require review of all 82,861 instances of potential overpayments. Finally, we disagree with the State agency's contention that it was unable to independently assess the accuracy of our overpayment calculations. We have provided the State agency with our computerized data base files which contain (1) the population of 82,861 potentially overpaid claims and (2) the 100 sampled claims that we reviewed. We continue to believe that the State agency should pursue collection of the overpayments identified during our review and make the appropriate adjustments on its Quarterly Report of Expenditures.

*** *** ***

Final determination as to actions to be taken on all matters will be made by the Department of Health and Human Services (HHS) official named on the next page. The HHS action official will contact you to resolve the issues in the audit report. Any additional comments or information that you believe may have a bearing on the resolution of this audit may be presented at that time. Should you have any questions please direct them to the HHS official.

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).

To facilitate identification, please refer to the referenced common identification number in all correspondence relating to this report.

Sincerely yours,

Thomas J. Robertson
Regional Inspector General
for Audit Services

SAMPLE METHODOLOGY

From the State agency paid claims file for CY 1993 and 1994, we utilized computer applications to extract all claims containing automated multichannel chemistry panels and panel tests for chemistry procedure codes listed in the CPT handbook (See APPENDIX B). We then performed computer applications to extract all records for the same Medicaid recipient for the same date of service with:

- CPT line item charges for more than one chemistry test or panel;
- a chemistry panel and at least one individual panel test; or
- two or more panel tests.

The extract resulted in a sample population of 82,861 claims totaling $2,415,317 consisting of 2 strata. The first stratum of 1993 chemistry data consisted of 40,143 claims totaling $1,186,294 for potentially unbundled chemistry panel tests. The second stratum of 1994 chemistry data consisted of 42,718 claims totaling $1,229,023 for potentially unbundled chemistry panel tests. Each claim is a potential payment error in that the State agency may have paid providers for clinical laboratory tests (on behalf of the same recipient on the same date of service) that were billed individually instead of as part of a group.

On a scientific stratified selection basis, we examined 100 claims from the 2 strata. The first stratum consisted of a randomly generated statistical sample of 50 CY 1993 chemistry claims with a potential error totaling $976.62. The second stratum consisted of a randomly generated statistical sample of 50 CY 1994 chemistry claims with a potential error totaling $917.62.

For the sample claims, 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 or duplicate chemistry panel tests as shown on the following page.

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
1993 Chemistry Tests	40,143	50	$976.62	50	$854.92	$686,381
1994 Chemistry Tests	42,718	50	$917.62	50	$810.22	$692,220
Total	82,861	100	$1,894.24	100	$1,665.14	$1,378,601

The results of the scientific sample of stratum 1, 1993 chemistry tests, disclosed that all 50 claims we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $686,381 paid for unbundled chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 24.23 percent.

The results of the scientific sample of stratum 2, 1994 chemistry tests, disclosed that all 50 claims we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $692,220 paid for unbundled chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 18.02 percent.

The results of the total sample of chemistry tests disclosed that all 100 claims reviewed contained overpayments. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that $1,378,601 in duplicate payments for chemistry tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 14.80 percent.

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TESTS

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

24 Chemistry Tests Subject to Panels (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.	Transarninase (SGPT)	84460, 84465
20.	Blood Urea Nitrogen (BUN)	84520
21	Uric Acid	84550
22.	Triglycerides	84478
23.	Creatinine Phosphokinase (CPK)	82550, 82555
24.	Glutamyltransferase, gamma (GGT)	82977

STATE OF WEST VIRGINIA
DEPARTMENT OF HEALTH AND HUMAN RESOURCES

Gaston Caperton
Governor

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Gretchen O. Lewis
Secretary

January 13, 1997

Thomas J. Robertson
Regional Inspector General for Audit Services
Department of Health and **Human Services**
Region III
P.O. **Box 13716, Mail Stop 9**
Philadelphia, PA I9104

RE: *Common Identification Number A-03-96-O0203*

Dear Mr. Robertson:

The West Virginia Department of Health and Human Resources, Bureau for Medical Services, has carefully reviewed the draft of the Review of Clinical Laboratory Services Under West Virginia's Medicaid Program for Calendar Years 1993 and 1994. In your letter, you asked that we prepare comments to include: 1) a statement of concurrence or nonconcurrence, 2) in the event of concurrence, a statement describing the nature of the corrective action planned or taken, and 3) in the event of nonconcurrence, specific reasons for nonconcurrence and a statement of any alternative corrective action planned or taken for each recommendation in the report. The following are the responses for the Bureau for Medical Services, the state agency.

RECOMMENDATION NUMBER ONE:

> **The State agency implement a policy change that would clearly define and mandate the use of bundled services for chemistry tests.**

The Bureau for Medical Services concurs with this recommendation and within ninety (90) days will develop and will disseminate a strong policy statement clarifying, defining and mandating the use of bundled services in relation to chemistry tests performed on blood specimens. The Bureau has previously issued verbal instructions and referred to wording contained in the CPT code book. Additionally, this issue will be addressed in a subsequent reissuance of the Laboratory manual.

RECOMMENDATION NUMBER TWO:

> **The state agency shall install edits to detect and prevent payments for unbundled services.**

The Bureau for Medical Services concurs in part with this recommendation. The Bureau is currently reviewing the option of entering combination edits into our MMIS system to detect and bundle laboratory procedure codes. If this doesn't prove efficient, the Bureau will negotiate with our third party liability (TPL) contractor to initiate retroactive review and seek recoupment from laboratory providers who improperly unbundle laboratory services.

RECOMMENDATION NUMBER THREE:

> **The State agency will recover overpayment for clinical laboratory services identified in this review.**

The agency does not concur with the recommendation that the Bureau should recover $1,3768,601 in overpayments from providers based on the findings made by the OIG audit. The Bureau feels that there are a number of issues related to the process of the audit that make this recommendation questionable.

1. Sample Methodology
   The Bureau contends that the method of sampling and the sample size do not support the extrapolation. A review of 100 claims out of 82,861 is insufficient to extrapolate the data to the population. Moreover, a 90 % confidence level, with a plus or minus precision level of 24.23°/0, 18.020/0 and 14,80°/0 is statistically unacceptable.

2. Sampling Process
   The audit team's selection of the sample prior to the review had multiple' problems that call into question the validity of the sample. The original request for records was received by the Bureau on July 19, 1996. The review was to be conducted on invoices paid in 1993 and 1994. The selected sample included records from early 1992 and for 1995. The field names on the data were reversed on the recipient identification and the ICN, some of the recipient numbers had twelve (12) digits instead of the eleven (1 1) assigned by the agency and the provider identification numbers had only six (6) digits while West Virginia provider numbers have seven digits. We were told there had been a problem in how the

data was collapsed and a sample would be redrawn. We asked if it could include the activity date because this would be necessary to pull the claims trom the micro fiche files. The second sample was received on July 26, 1996. The recipient's ID and the ICN field names had been corrected and the inappropriate year data dropped, but the activity date was not included, the provider field still had only six (6) digits and there were still extra digits on the recipient's ID number. Several phone conversations were held with and regarding including the required information. On August 1, 1996, we received the actual sample that was used in the audit. The listing included the activity date and corrected provider numbers; however, some recipient number still contained twelve (12) digits. Our staff indicated that several of these numbers ended in zero and this is not a common last digit for recipients numbers. We volunteered that we could ignore those and look up the claim using the first eleven (1 1) digits; however, when the extra digit was not a zero there was no way to identify the correct recipients. indicated that he did not know the computer system wel I but said he would check. The final direction given to the Bureau staff was to drop the last number in the recipient number.

During the onsite portion of the audit our Office of Surveillance and Utilization Review asked for the tools being used by the audit team so they might be applied in future reviews conducted by the Bureau. demurred and said they had no tools but could just tell by looking whether the billing was appropriate. From this discussion it appears that the audit team had no formal guidelines that were utilized in the decision making process. This draft report shows that the team reviewed the 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.

In order to fully assess the validity of the billing it would also be necessary to review the patient records. In instances that include emergency department services, it could be expected to see that laboratory tests had been requested more than once in a dav. In emergency situations, the physician may request initial iab work on entry into the emergency department and request additional iab work as treatment progresses to assess the patient's response to treatment or to

more accurately diagnose the client's condition. In these instances, this test would not be part of a panel but an independent test that is appropriately billed by the individual procedure code. There is no indication in this report that the audit team made any attempt to verify the validity of the claims by reviewing client records. It is impossible for us to actually determine how the decisions were made since we have no individual claim data attached to this report.

3. **Absence of Work** Papers

On page 5 of this report, there is a table used to illustrate how overpayments were calcu **lated, The table refers to sample number K-18 and L-1. There is nothing attached to the report to identify which claims these sample numbers represent and make it impossible for the Bureau to respond about the accuracy of the calculations of the over payments based on the methodology defined in this table.** Also **this table indicated that the data is for services billed in Virginia instead of West Virginia. Without a summary showing the calculations made to identify the overpayment calculated by the review team for each individual client in the review sample we cannot adequately assess the process applied.**

4 . Apparent Erroneous Data

The audit assumes that the Medicare fee schedule was implemented on January 1 of each year. Due to delay in receiving the tape from the Medicare intermediary and loading it into our system there is often a delay of several months. Additionally in 1993, Medicare sent several laboratory fee schedules with revisions through out the year. There is no way to ascertain if the auditors used the correct schedule during this review. Extrapolations for each year should be adjusted to reflect the fees in effect at the time the service was provided, not the fee as defined by Medicare since there is a time lag between the figures being prepared by the Medicare intermediary and when the fees were available for implementation by the Bureau. Attached is a table that shows the dates of fee changes that should be used in calculation of the extrapolation once the individual charges are found to be an overpayment.

5. Faulty Assureption

The sample consisted of claims for more than one individual test or panel for the same recipient on the same date of service with the assumption that they are duplicates. As mentioned earlier, there are situations where an individual may be under observation in a hospital emergency room or a doctor's office and the tests may be ordered repeatedly to monitor an emergency situation. Without a clinical review of records there is no way to know when this occurred in the sample.

RECOMMENDATION NUMBER FOUR:

Make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to HCFA.

The State Agency concurs that it will 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), to the extent that the contractor named in recommendation number 2 above is successful in its efforts. For reasons previously cited, the State does not concur that $1,378,601 is an accurate amount.

In fact, the Bureau has recently run laboratory chemistry test procedure codes identical to those run in the OIG sample. For state fiscal year 1995, the total paid laboratory claim amount was $935,786.15, and for state fiscal year 1996 the amount was $899,631.30. Based on these years, it can be assumed that the results of the OIG sample of years 1993 and 1994 of $2,415,317 is not an accurate amount for laboratory claims in those years.

The Bureau for Medical Services (state agency) reserves the right to submit additional comments and/or expand these comments after the formal exit conference.

Sincerely,

R. Philip Shimer
Acting Commissioner

RPS:lc
Attachment

cc: Gretchen O. Lewis, Secretary
Department of Health and Human Resources