Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES UNDER THE MEDICAID PROGRAM

JUNE GIBBS BROWN
Inspector General

MARCH 1997
A-02-95-01009

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

March 10, 1997

Our Reference: Common Identification No. A-02-95-01009

Mr. William Waldman, Commissioner
New Jersey Department of Human Services
222 South Warren Street
CN 700
Trenton, New Jersey 08625

Dear Mr. Waldman:

This report provides you with the results of our "REVIEW OF THE NEW JERSEY DEPARTMENT OF HUMAN SERVICES REIMBURSEMENT FOR CLINICAL LABORATORY SERVICES UNDER THE MEDICAID PROGRAM." The objective of our audit was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers for clinical laboratory tests. Our review was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests.

Our review disclosed that the New Jersey Department of Human Services, Division of Medical Assistance and Health Services (State agency) did not have adequate procedures or controls to ensure that reimbursements for clinical laboratory tests under Medicaid did not exceed amounts recognized by the Medicare program, as required by Section 6300 of the State Medicaid Manual. In this regard, Medicare guidelines provide that claims for laboratory services in which a provider bills separately for tests that are available as part of an automated multichannel chemistry panel should be paid at the lesser amount for the panel. The Medicare guidelines also require that a provider be liable for overpayments it receives for overlapping or duplicate bills.

Using statistical sampling techniques, we estimate that $297,427 (Federal share $148,714) was overpaid to providers during calendar years 1993 and 1994 for chemistry, hematology and urinalysis tests that should have been grouped together (bundled into a panel, profile, or complete test) for payment at a lower rate. We found that the State agency established procedures and controls (including computer edits) for chemistry tests, but these were not fully effective in identifying and properly grouping together these tests into lower value chemistry panels. For hematology and urinalysis tests, the State agency did not establish

procedures or controls for identifying and properly grouping together these tests into lower value hematology profiles or complete urinalysis tests.

We are recommending that the State agency (1) improve its computer edits used to identify and properly pay charges for unbundled or duplicative chemistry panel tests, (2) establish procedures and controls including computer edits to identify and properly pay charges for unbundled or duplicative hematology profiles or complete urinalysis tests, (3) review the sampling universe to identify and recover Medicaid overpayments for improperly paid chemistry, hematology and urinalysis tests; we estimate the total overpayments to be $297,427 (Federal share $148,714), and (4) make adjustments for the Federal share of amounts recovered on the Quarterly Report of Expenditures to the Health Care Financing Administration (HCFA).

The State agency response to our draft report in effect provided full concurrence with our findings and recommendations, and included a corrective action plan to address each of the recommendations. In summary, State officials indicated that immediate corrective action has been taken to enhance the computer edits in the Medicaid Information Management System (MMIS) to identify and ensure proper payments for unbundled or duplicative chemistry panels, hematology profiles and complete urinalysis tests. In addition, new State regulations were put into effect that specifically addressed the reimbursement of unbundled Medicaid laboratory services. Furthermore, the State agency indicated that the potentially overpaid claims included in our audit universe will be reprocessed, and the Quarterly Report of Expenditures to HCFA would be adjusted accordingly. The full text of the State agency's response is included in Appendix C of this report.

INTRODUCTION

Background

Medicaid is a Federally aided state program which provides medical assistance to certain individuals and families with low incomes and resources. Within broad Federal guidelines, states design and administer the Medicaid program under the general oversight of HCFA. Medicaid, as established under Title XIX of the Social Security Act, requires states to provide certain medical services and other services such as outpatient clinical laboratory tests. Laboratory tests are performed by providers on a patient's specimen to help physicians diagnose and treat ailments. The testing may be performed in a physician office, a hospital laboratory, or by an independent laboratory. These providers submit claims for laboratory services performed on Medicaid beneficiaries. Claims processing is the responsibility of a designated Medicaid State agency in each state. In New Jersey, the State agency has contracted with an outside fiscal agent, UNISYS, to perform the claims processing function.

The State Medicaid Manual states that Federal matching funds will not be available to the extent a state pays more for outpatient clinical laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. In addition, payments 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 Part B contractor (carrier), which administers Medicare payments to physicians and independent laboratories, maintains the fee schedule and provides the fee schedule to the Medicaid State agency in its locality. Guidelines for the processing of provider claims including the bundling of automated multichannel chemistry panel tests are contained in the HCFA Medicare Carriers Manual.

While states generally cannot make payments for clinical laboratory tests under the Medicaid program which exceed the amount recognized by the Medicare program, the Medicaid Manual provides for an exception for laboratory tests furnished by hospitals in Maryland and New Jersey. Based on this waiver of Medicare fee schedule reimbursement principles, the New Jersey State agency used a Medicare cost principles methodology to reimburse hospital outpatient laboratory services provided to Medicaid recipients. However, effective September 1992, the State agency opted to use a fee schedule methodology for most outpatient laboratory services in order to reimburse hospitals for most outpatient laboratory services in an amount comparable to the amount reimbursed to independent clinical laboratories (an amount equal to or lower than the Medicare fee schedule).

Chemistry tests involve the measurement of various chemical levels in the blood. These tests, which are frequently performed on automated multichannel equipment, are grouped together and reimbursed at a panel rate which is a single payment for a group of tests. Chemistry panel tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and are used when all of the component tests are performed. Many of the component tests of organ panels are also chemistry panel tests.

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

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

Objectives, Scope and Methodology

Our audit was conducted in accordance with generally accepted government auditing standards. The objective of our audit was to determine the adequacy of procedures and controls over the processing of Medicaid payments to providers by the State agency for clinical laboratory services. Our review was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests.

To accomplish our objective, we:

- reviewed State agency policies and procedures for processing Medicaid claims from providers for clinical laboratory services.

- extracted from the HCFA Medicaid Statistical Information System (MSIS) Calendar Year 1993 and 1994 Paid Claims Files payments totaling $13,344,996 for chemistry, hematology, and urinalysis tests. Of this amount, $1,806,831 represented instances involving claims that contained potentially unbundled or duplicate charges for chemistry, hematology, and urinalysis tests. Additional information on the results of the computer match is discussed in Appendix A. We also 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 HCFA MSIS files nor did we evaluate the adequacy of the input controls.

- selected a random statistical sample of 150 instances, which consisted of: 50 instances involving chemistry claims from a population of 68,936 instances containing chemistry tests valued at $887,325; 50 instances involving hematology claims from a population of 48,474 instances containing hematology tests valued at $890,385; and 50 instances involving urinalysis claims from a population of 5,552 instances containing urinalysis tests valued at $29,121. These instances were taken from a population of payments involving claims for more than one individual test, more than one bundled test, or for a bundled test and individual test for the same beneficiary on the same date of service by the same provider.

- reviewed the randomly selected instances and supporting documentation from the State agency to determine the propriety of the payment. In determining the error amount, we did not question the reimbursement of any outpatient hospital test subject to the HCFA waiver that was reimbursed under Medicare cost principles rather than fee schedule principles; however, we did consider and question any reimbursement amounts that were duplicative.

- utilized a variable sample appraisal methodology to estimate the amount of overpayment for chemistry, hematology and urinalysis tests.

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 limited our review to claims paid by the State agency during the 24-month period from January 1993 through December 1994.

We found that the items tested were in compliance with applicable laws and regulations except for the matters discussed in the FINDINGS AND RECOMMENDATIONS section of this report.

We performed our review between April 1995 and March 1996. During this period we visited the State agency office in Quakerbridge Plaza, Trenton, New Jersey.

FINDINGS AND RECOMMENDATIONS

Our review disclosed that the State agency did not have adequate procedures or controls to ensure that reimbursements for clinical laboratory tests under Medicaid did not exceed amounts recognized by the Medicare program. Specifically, we found that providers received excess reimbursements for chemistry, hematology and urinalysis tests that should have been grouped together (bundled into a panel, profile, or complete test) for payment at a lower rate.

The State Medicaid Manual, 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. In addition, 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, Section 5114.1.L.2 of the Medicare Carriers Manual provides that claims for laboratory services in which a provider bills separately for tests that are available as part of an automated multichannel chemistry panel should be paid at the lesser amount for the panel. For overpayments and duplicate bills, Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives. In addition, Section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

To implement these provisions for chemistry tests, the State agency established controls and procedures, including computer edits. We found that weaknesses in the computer edits allowed improper payments to be made to providers. For hematology and urinalysis tests, the State agency had not established controls and procedures to assure that these tests were appropriately bundled into a profile or complete test for payment at a lower rate.

To determine the extent of improper payments, on a randomly selected basis we examined 150 instances involving claims with potential payment errors from a sample population of calendar year 1993 and 1994 paid claims valued at $1,806,831. We found that 95 of the 150 sampled items were overpaid. Each instance represents a potential payment error in which the State agency paid a provider for clinical laboratory tests (on behalf of the same recipient on the same date of service) on an individual test basis instead of as part of a group, or that were duplicative. Projecting the results of our statistical sample over the population using standard statistical methods, we estimate that the State agency overpaid providers $297,427 (Federal share $148,714) for chemistry, hematology and urinalysis tests over the two-year audit period. At the 90 percent level of confidence, the sampling precision as a percentage of the midpoint is plus or minus 16.87. For a detailed breakdown of the results of our sample review, see Appendix B.

Chemistry Panel Tests

Our review disclosed that 25 of the 50 sampled instances contained overpayments for unbundled or duplicated charges for chemistry tests. We found that the State agency's edits to ensure that laboratory services are properly bundled were not sufficient to detect and prevent payment of chemistry tests that are not properly bundled or duplicated for payment. The 50 instances were statistically selected on a random basis from a population of 68,936 instances involving claims containing potentially unbundled chemistry panel tests valued at $887,325. Based on our statistical sample, we estimate that the State agency overpaid providers $165,115 for unbundled or duplicated chemistry panel tests.

The Medicaid State Manual states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. Section 5114.1.L.2 of the Medicare Carriers Manual provides that if the carrier receives claims for laboratory services in which the physician or laboratory has separately billed for tests that are available as part of an automated multichannel chemistry panel test, and, in the carrier's judgement, such panel tests are frequently performed and available for physicians' use, the carrier should make payment at the lesser amount for the panel. The limitation that payment for individual tests not exceed the payment allowance for the panel is applied whether a particular laboratory has or does not have the automated multichannel equipment.

Regarding overpayments and duplicate bills, Section 7103 of the Medicare Carriers Manual states that a provider is liable for overpayments it receives. Section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

Our review of the 50 sampled items disclosed that 25 were overpaid, as illustrated below:

- 22 of the sampled items were overpaid because chemistry panels billed with other chemistry panels or chemistry panels billed with individual chemistry tests were not always grouped together and paid as one chemistry panel. Although a computer edit

was in place to group and price these tests, limitations in the computer edits allowed the inappropriate payments to be made.

For example, a laboratory submitted a claim for two panel tests, CPT code 80016 (13-16 clinical chemistry automated multichannel tests) and CPT code 80004 (4 clinical chemistry automated multichannel tests), performed for a patient on December 7, 1994. The existing computer edits did not suspend, group the procedures, and appropriately pay this claim as CPT code 80019 (19 or more clinical chemistry automated multichannel tests) valued at $11.00. Rather the laboratory was paid $13.40 ($7.50 for CPT code 80016 and $5.90 for CPT code 80004), an overpayment of $2.40.

- Three of the sampled items contained overpayments because organ panels (the hepatic function panel -- CPT code 80058, and the general health panel -- CPT code 80050) which include chemistry panel tests were not bundled when billed with additional chemistry panel tests.

  For example, a laboratory submitted a claim for a general health panel (CPT code 80050 -- which includes 12 to 19 automated chemistry panel tests)[1] and a chemistry panel (CPT code 80012 -- 12 clinical chemistry automated multichannel tests) performed for a patient on January 25, 1993. We found that there were no computer edits to suspend, group the procedures, and appropriately pay this claim as CPT code 80050 valued at $36.00. Rather the laboratory was paid $43.50 ($36.00 for CPT code 80050 and $7.50 for CPT code 80012), an overpayment of $7.50.

Hematology Profiles

Our review disclosed that 47 of the 50 sampled instances contained overpayments for unbundled or duplicated charges for hematology tests. We found that the State agency did not establish computer edits to detect and prevent payment of hematology tests that are not properly bundled or duplicated for payment. The 50 instances were statistically selected on a random basis from a population of 48,474 instances involving claims containing potentially unbundled hematology profile tests valued at $890,385. Based on our statistical sample, we estimate that the State agency overpaid providers $130,133 for unbundled or duplicated hematology profile tests.

The Medicaid State Manual states that payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by the Medicare program. For overpayments and duplicate bills, Section 7103 of the Medicare Carriers Manual states that

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[1] The general health panel includes automated chemistries (12 or more, CPT codes 80012-80019) and other non-chemistry tests including the Complete Blood Count (CBC; CPT code 85022 or 85025) and the thyroid stimulating hormone test (CPT code 84443).

a provider is liable for overpayments it receives. Section 7103.1 B states that the provider is liable in situations when the error is due to overlapping or duplicate bills.

Hematology tests are performed and billed in groups or combinations of tests known as profiles. The hematology tests can also be performed individually. Duplicate billings occur when individual hematology tests are billed for the same patient for the same date of service as a hematology profile which includes the individual test. Duplicate billings also occur when two hematology profiles are billed for the same patient and same date of service. Another situation which creates a duplicate billing is when hematology indices (calculations and ratios calculated from the results of hematology tests) are billed with a hematology profile.

Our review of the 50 sampled items disclosed that 47 were overpaid, as illustrated below:

- 21 of the sampled items were overpaid because individual hematology tests billed on the same claim as a hematology profile (which included those individual tests) were not grouped and priced as a single hematology profile.

- 15 of the sampled items were overpaid because two or more hematology profiles billed on the same claim were not grouped and priced as a single hematology profile.

- 11 of the sampled items were overpaid because hematology indices billed on the same claim as a hematology profile were not grouped and priced as a single hematology profile.

For each of the sampled items reviewed, we noted that computer edits were not in place to automatically assure that the hematology tests were appropriately grouped and priced.

An example of one of these hematology overpayments follows:

A laboratory submitted a claim for a CBC test (CPT code 85023 -- hemogram and platelet count, automated, and manual differential WBC count) and a differential WBC count (CPT code 85007 (blood count; manual differential count) performed for a patient on April 19, 1993. Since the CBC includes the manual differential count, no separate reimbursement should have been made for the manual differential count. However, we found that since there were no computer edits to suspend, group the procedures, and appropriately pay only the CBC valued at $14.68, the laboratory was overpaid $2.40 for the separately billed differential count.

Urinalysis

Our review disclosed that 23 of the 50 sampled instances contained overpayments for unbundled or duplicated charges for urinalysis tests. We found that the State agency did

not establish computer edits to detect and prevent payment of urinalysis tests that are not properly bundled or duplicated for payment. The 50 instances were statistically selected on a random basis from a population of 5,552 instances involving claims containing potentially unbundled complete urinalysis tests valued at $29,121. Based on our statistical sample, we estimate that the State agency overpaid providers $2,179 for unbundled or duplicated complete urinalysis tests.

A complete urinalysis includes testing for components and a microscopic examination; however, providers can perform and bill different levels of urinalysis testing. In this regard, a urinalysis with microscopic examination, a urinalysis without microscopic examination or a microscopic examination only can be performed. Based on the test performed and billed, unbundling or duplication of billing can occur among these tests. More specifically, the Medicare Carriers Manual Section 5114.1 F states that if a urinalysis examination which does not include microscopy (81002) and a urinalysis microscopy examination (81015) are both billed, payment should be as though the combined service (81000 - urinalysis with microscopy) had been billed.

Our review of the 50 sampled items disclosed that 23 were overpaid because two components of a complete urinalysis test were billed and paid separately or a complete urinalysis and a component test were billed and paid separately. For each of the sampled items reviewed, we noted that computer edits were not in place to automatically assure that the urinalysis tests were appropriately grouped and priced.

RECOMMENDATIONS

We are recommending that the State agency:

(1) improve its computer edits used to identify and properly pay charges for unbundled or duplicative chemistry panel tests,

(2) establish procedures and controls including computer edits to identify and properly pay charges for unbundled or duplicative hematology profiles or complete urinalysis tests,

(3) review the sampling universe to identify and recover Medicaid overpayments for improperly paid chemistry, hematology and urinalysis tests -- we estimate the total overpayments to be $297,427 (Federal share $148,714)[2], and

(4) make adjustments for the Federal share of amounts recovered on the Quarterly Report of Expenditures to HCFA.

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[2] This estimate includes Medicaid overpayments of $274 (Federal share $137) identified in our sample review.

STATE AGENCY COMMENTS

In their comments dated February 20, 1997, State agency officials in effect provided full concurrence with our findings and recommendations, and included a corrective action plan to address each of the recommendations. In regards to our recommendations concerning enhancements to controls (including computer edits) over the payment of unbundled or duplicative chemistry, hematology and urinalysis tests, State officials described specific computer edits developed and included in the MMIS which the State agency believes appropriately identifies and ensures proper payment for unbundled or duplicative laboratory services. The State indicated that the improvements to the edits were completed on February 7, 1997. In addition, the officials responded that specific State regulations were put into effect on February 5, 1996 to address limitations of Medicaid coverage and reimbursement related to bundled laboratory services. Furthermore, the officials indicated that the State agency is preparing to reprocess those laboratory claims included in our audit universe that were potentially overpaid, and that the Quarterly Report of Expenditures to HCFA would be adjusted accordingly. The full text of the State agency's response is included in Appendix C of this report.

OIG RESPONSE

We are pleased to note that the State agency concurred with our findings and recommendations and outlined a corrective action plan to address these recommendations. Throughout the audit, State officials responsible for the payment of Medicaid laboratory services have worked closely with the OIG, particularly in regards to the implementation of timely corrective actions.

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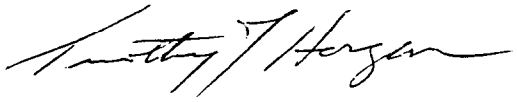
Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter report. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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.)

Please refer to Common Identification Number A-02-95-01009 in all correspondence relating to this report.

Sincerely yours,



Timothy J. Horgan
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Mr. Arthur J. O'Leary
Associate Regional Administrator
Division of Medicaid, HCFA, Region II
U.S. Department of Human Services
26 Federal Plaza, Room 38-130
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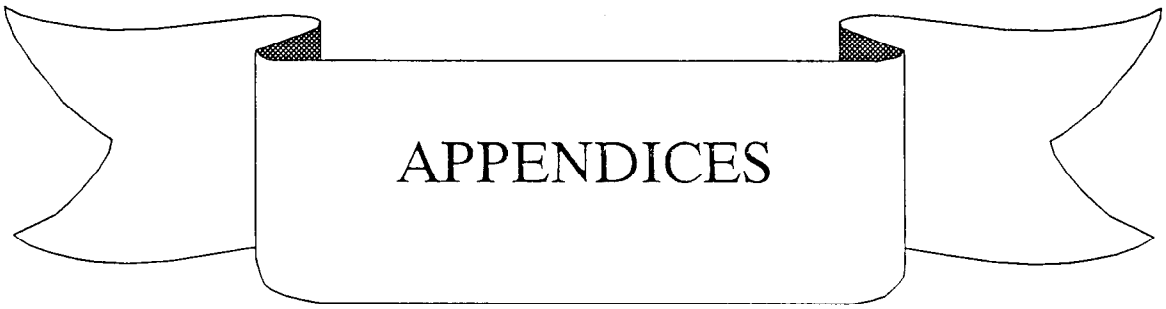
APPENDICES

RESULTS OF COMPUTER MATCH

We used specially designed computer applications to extract all records from the HCFA MSIS paid claims file which were for claims paid in calendar years 1993 and 1994 and which contained the following Physician's Current Procedural Terminology (CPT) handbook procedures codes for automated multichannel chemistry panels and individual panel tests, hematology profiles and component tests normally included as part of a hematology profile, and complete urinalysis and urinalysis component tests:

16 Chemistry Panel CPT Codes

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
19 or more clinical chemistry automated multichannel tests	80019
General Health Panel	80050
Hepatic Function Panel	80058

33 CPT Codes for Chemistry Tests Subject to Paneling

Albumin	82040
Albumin/globulin ratio	84170
Bilirubin Total OR Direct	82250
Bilirubin Total AND Direct	82251
Calcium	82310, 82315, 82320, 82325
Carbon Dioxide Content	82374
Chlorides	82435
Cholesterol	82465
Creatinine	82565
Globulin	82942
Glucose	82947

Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
Phosphorus	84100
Potassium	84132
Total Protein	84155, 84160
Sodium	84295
Transaminase (SGOT)	84450, 84455
Transaminase (SGPT)	84460, 84465
Blood Urea Nitrogen (BUN)	84520
Uric Acid	84550
Triglycerides	84478
Creatinine Phosphokinase (CPK)	82550, 82555
Glutamyltransferase, gamma (GGT)	82977

Six Hematology Component Tests CPT Codes

Red Blood Cell Count (RBC) only	85041
White Blood Cell Count (WBC) only	85048
Hemoglobin, Calorimetric (Hgb)	85018
Hematocrit (Hct)	85014
Manual Differential WBC count	85007
Platelet Count (Electronic Technique)	85595

Two Additional Hematology Component Tests - Indices

Automated Hemogram Indices (one to three)	85029
Automated Hemogram Indices (four or more)	85030

Six Hematology Profiles CPT Codes

Hemogram (RBC, WBC, Hgb, Hct and Indices)	85021
Hemogram and Manual Differential	85022
Hemogram and Platelet and Manual Differential	85023
Hemogram and Platelet and Partial Automated Differential	85024
Hemogram and Platelet and Complete Automated Differential	85025
Hemogram and Platelet	85027

Four Urinalysis Tests

Urinalysis	81000
Urinalysis without microscopy	81002, 81003
Urinalysis microscopic only	81015

Our extract identified calendar year 1993 and 1994 payments of $13,344,996 for chemistry, hematology and urinalysis tests contained on 1,980,402 records, as detailed below:

	Number	Dollars
Chemistry tests	603,623	$ 5,201,285
Hematology tests	943,057	7,517,557
Urinalysis tests	433,722	626,154
Total	1,980,402	$13,344,996

We then performed computer applications to extract all records for the same individual for the same date of service with HCFA's Common Procedure Coding System (HCPCS) line item charges for:

1. more than one different chemistry panel; a chemistry panel and at least one individual panel tests; or two or more panel tests.

2. more than one automated hematology profile under different profile codes; more than one unit of the same profile; a component normally included as part of a profile in addition to the profile; or hematology indices and a profile.

3. a complete urinalysis test and microscopy; a urinalysis without microscopy; or a microscopy only.

This extract resulted in a sample population of 122,962 instances totaling $1,806,831, which consisted of the following three strata:

	Number	Dollars
Chemistry tests	68,936	$ 887,325
Hematology tests	48,474	890,385
Urinalysis tests	5,552	29,121
Total	122,962	$1,806,831

Each instance is a potential payment error in which the State agency paid providers for clinical laboratory tests (on behalf of the same beneficiary on the same date of service) which were billed individually instead of as part of a group, or that were duplicative.

Appendix B

RESULTS OF SAMPLE REVIEW

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
Chemistry Tests	68,936	50	$512.50	25	$119.76	$165,115
Hematology Tests	48,474	50	$824.37	47	$134.23	$130,133
Urinalysis Tests	5,552	50	$182.96	23	$19.62	$2,179

State of New Jersey

DEPARTMENT OF HUMAN SERVICES
DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

CHRISTINE TODD WHITMAN
Governor

WILLIAM WALDMAN
Commissioner

February 20, 1997

Timothy J. Horgan
Regional Inspector General
for Audit Services
Department of Health and Human Services
Office of Inspector General
Office of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

Dear Mr. Horgan:

This is in response to your letter of January 2, 1997, to Commissioner Waldman concerning the results of a "Review of the New Jersey Department of Human Services Reimbursement for Clinical Laboratory Services Under the Medicaid Program," conducted between April 1, 1995 and March 31, 1996.

The purpose of my letter is to provide, on behalf of the Department, the response of the New Jersey Division of Medical Assistance and Health Services (DMAHS) to findings reported for this audit, including a plan of correction.

Background

The audit focused on outpatient laboratory services for three categories of clinical laboratory services, including chemistry, hematology and urinalysis tests. Sample claims included paid claims with payment dates between January 1, 1993 and December 31, 1994, totaling $13,344,996, including $1,806,831 for claims reflecting potentially unbundled or duplicate charges. The audit was intended to test the reliability of, or challenges to edits incorporated by the New Jersey Medicaid Management Information System (NJMMIS) to minimize potential overpayments for freestanding laboratory tests provided by the same laboratory, to the same Medicaid beneficiary, on the same service date as bundled or paneled laboratory services which include the same laboratory test.

The audit included a random statistical sample of 150 challenges to NJMMIS edits, involving 50 chemistry testing occurrences out of a population of 68,936, valued at $887,325; 50 hematology testing occurrences out of a population of 48,474, valued at $890,385; and 50 urinalysis testing occurrences out of a

population of 5,552, valued at $29,121. These occurrences included claim payments for one individual test, more than one bundled test, or a bundled test and individual test for the same beneficiary, on the same service date, provided by the same laboratory.

Findings

These findings determined that the New Jersey Medicaid program had inadequate procedures and controls in place to limit excessive payments for chemistry, hematology and urinalysis tests for laboratory services bundled in a panel, profile, or complete test to ensure payments at a lower rate.

Specifically, the audit determined, based on requirements defined under Section 5114.1.L.2 of the Medicare Carriers Manual, that claims for laboratory services in which a provider billed separately for chemistry tests, available as a component of an automated multichannel chemistry panel; hematology tests, available as a component of a profile; and urinalysis tests, available as a component of a complete test, should have been paid at the lesser amount for the bundled service.

Overpayments were based on Section 6300.1 of the State Medicaid Manual, which states that federal matching funds will not be available to the extent that 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. Based on this requirement, total overpayments of $297,427 ($148,714 federal share) were determined for the review period, consisting of the following components:

- $165,115 for unbundled or duplicated chemistry panel tests;
- $130,133 for unbundled or duplicated hematology profile tests; and
- $2,179 for unbundled or duplicated complete urinalysis tests.

Corrective Action Plan

Recommendations from this review include (1) enhancements to the New Jersey Medicaid Information System (NJMMIS) to identify and ensure proper payments for unbundled or duplicative chemistry panel, hematology profiles and complete urinalysis tests; and (2) recovery of Medicaid overpayments for improperly paid chemistry, hematology and urinalysis tests provided during the review period. It is our understanding that the Office of the Inspector General (OIG) is recommending that claim adjustments be performed, and that these adjustments be reported on the Quarterly Report of Expenditures to HCFA or the HCFA-64.

As discussed during the exit conference and our meeting on February 10, 1997, the New Jersey Administrative Code (N.J.A.C.) 10:61, adopted February 5, 1996 (see enclosure), currently includes regulations which address limitations of Medicaid coverage and reimbursement related to bundled laboratory services. In addition, the claims processing system currently includes a hard-coded "table" which collapses multiple freestanding laboratory tests billed for the same beneficiary, on the same service date, by the same provider into the "800" CPT laboratory series to ensure lesser payments for bundled laboratory services.

Edit 726, "Individual test exceeds panel allowance - reduce payment," reduces the sum of potential payments for billed, freestanding laboratory services for the same beneficiary, for the same service date, by the same provider to an amount which does not exceed the lesser fee allowance for the panel. Any payment reflects the difference between this sum and the panel fee, provided the fee exceeds this sum. Edit 727, "Individual test allowance exceeds panel allowance (no payment)" accomplishes the same, reporting the absence of payment to providers when the maximum fee allowance of the panel is exceeded.

In addition, the Division will further enhance the NJMMIS by developing a laboratory-specific edit. Edit 700, "Conflicting same laboratory service," will ensure that further challenges by freestanding laboratory tests to panel, profile, or complete testing payments, such as those identified by this review, are appropriately denied. The following conflicts will govern Edit 700:

NJMMIS EDIT	DESCRIPTION	CPT CODE
741	Urinalysis	81000
742	Urinalysis	81005
743	Hemogram	85029
744	Hemogram	85030
745	Hematology	85014 85018 05041 85048
746	Hemogram	85021 85022 85023 85024 85025 85027
747	Hematology	85007
748	Hematology Profiles	85021 to 85027
749	Platelet	85590 85595

NJMMIS EDIT	DESCRIPTION	CPT CODE
750	Hemogram Platelet	85023 to 85027
751	Sweat Collection	84295
752	Sodium	89360
753	Hepatic Function Panel	80058
754	Auto Chemistry Panel	80005
755	General Health Panel	80050
756	Hepatic Function Panel	80058
757	TSH	84443
758	Thyroid w/ Stimulant	80092
759	Thyroid Panel	80091
760	Thyroid w/ Stimulant	80092
761	Thyroxin	84439
762	Thyroid Panel	80091

It is important to note that Edit 700 for laboratory services was activated on February 7, 1997. The Division is preparing to reprocess those laboratory claims potentially overpaid based on these service conflicts. The Quarterly Report of Expenditures to HCFA (HCFA-64) will be adjusted accordingly, based on the outcome of this reprocessing effort.

I am hopeful that this information provides an adequate response to this review. If you have any questions, please do not hesitate to contact me at (609) 588-2600.

Sincerely,

Karen I. Squarrell
Acting Director

KIS:EJV:v
Enclosure
c: William Waldman
Velvet G. Miller

	89050	.90
	89051	.90
	89060	8.50
	89100	20.00
	89105	6.00
	89125	.60
	89130	6.00
	89132	6.00
	89135	6.00
	89136	6.00
	89140	12.00
	89141	12.00
	89160	2.10
	89190	2.20
	89300	2.40
	89310	4.80
	89320	3.00
	89325	13.00
F	89329	31.00
F	89330	8.00
	89350	20.00
	89355	4.00
N	89360	9.00
	89399	B.R.

10:61-3.3 HCPCS procedure codes, procedure description and maximum fee allowance schedule for Level 2.

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
N	G0001		Routine Venipuncture	$ 1.80
	Q0111		Wet mount, including preparations of vaginal, cervical or skin specimens	2.40
	Q0112		All potassium hydroxide (KOH) preparations	2.40
	Q0113		Pinworm examination	5.10
	Q0114		Fern test	9.60
	Q0115		Post-coital direct, qualitative examinations of vaginal or cervical mucous	12.33
	Q0116		Hemoglobin by single analyte instruments with self-contained or component features to perform specimen/reagent interaction, providing direct measurements and read-out	2.00

10:61-3.4 HCPCS procedure codes, procedure description and maximum fee allowance schedule for Level 3

IND	HCPCS Code	MOD	Procedure Description	Maximum Fee Allowance
N	W8200		Glucose, serum (separate tube, grey top)	$ 2.00
	W8260		Haldol (haloperidol) serum, confirmation test	33.00
	W8265		Serentil, serum mesoridazine, quantitative, confirmation test	33.00
	W8730		Gonozyme, Gonococcal antigen	11.00
N	W8900		Visits to homebound beneficiaries, residential health care facility, group home, or boarding home for purpose of obtaining blood by venous or arterial puncture	10.00
	W8920		Visit to obtain blood specimens by venous or arterial puncture for the first person in a nursing facility or Intermediate Care Facility/Mental Retardation (ICF/MR)	1.80
	W8925		Each additional person in nursing facility or Intermediate Care Facility/Mental Retardation (ICF/MR)	.60

10:61-3.5 Pathology and Laboratory HCPCS Codes—Qualifiers

(a) Qualifiers for pathology and laboratory services are summarized below:

1. Chemistry Automated, Multichannel Tests

Applies to CPT Codes: 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019. The following list contains those tests which can be and are frequently performed as groups and combinations (profiles) on automated multichannel equipment: Apply this methodology to the above CPT Codes. For reporting one test, regardless of method of testing, use appropriate single test code number. For any combination of tests among those listed below use the appropriate number 80002-80019. Groups of the tests listed here are distinguished from multiple tests performed individually for immediate or "stat" reporting. Laboratory chemistry tests performed on your automated equipment in addition to laboratory chemistry tests listed must be billed as 80002-80019 as part of the automated multichannel test listing.

Acid—Phosphatase	Creatinine
Albumin	Gamma Glutamyl Transpeptidase (GGTP)
Alkaline Phosphatase	Glucose (Sugar)
(ALT, SGPT) Aspartate Aminotransferase	Iron
(AST, SGOT) Aspartate Aminotransferase	Iron Binding Capacity
Amylase	Lactic Dehydrogenase (LD)
Bilirubin, Total	Lipoprotein (HDL Cholesterol)
Bilirubin, Direct	Magnesium
Blood Urea Nitrogen (BUN)	Phosphorus
Calcium	Potassium (K)
Carbon Dioxide (CO_2)	Protein, Total
Clorides (Cl)	Sodium (NA)
Cholesterol	Triglycerides
Creatine Kinase (CK, CPK)	Uric Acid

Note 1: If any two of the following HCPCS procedure codes are performed on the same day by automated equipment and the total reimbursement of the two chemistry tests would have exceeded $5.00, the maximum reimbursement will not be more than $5.00: 82040, 82150, 82250, 82251, 82310, 82374, 82435, 82465, 82550, 82565, 82947, 82977, 83540, 83550, 83615, 83718, 83735, 84060, 84075, 84100, 84132, 84155, 84295, 84450, 84460, 84478, 84520, 84550.

Note 2: The following calculations and ratios are not eligible for separate or additional reimbursement. Mathematical calculations listed below are not reimbursable.

A/G Ratio	Globulin
BUN/Creatinine Ratio	FTI (T7)
Free Calcium	Free Thyroxine

Note 3: Any additional automated multichannel chemistry tests performed on same date as Codes 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018, and 80019 will not be reimbursed at the current allowable fee for each added test when performed on automated multichannel equipment.

Note 4: Code (W8200)—Glucose (separate tube, gray top) performed on the same date as the following chemistry profiles 80002, 80003, 80004, 80005, 80006, 80007, 80008, 80009, 80010, 80011, 80012, 80016, 80018 and 80019 will be paid an additional $2.00.

Codes 80050, 80055, 80058, 80059, 80061, 80072, 80090, 80091, 092.—The panels listed must include the laboratory tests assigned by e CPT-4 as the components of the panel. The tests listed with each of ne panels identify the defined components of that panel. If any three laboratory tests included in the panel are billed a la carte, the tests must be billed as the panel. The laboratory provider may not charge Medicaid more than the lowest charge level offered to another provider. The lowest charges for the laboratory test comprising the panel must aggregate as equivalent to or greater than the listed panel fee.

Note 1: Code 80091—Thyroid panel

Reimbursement not eligible for 84439 when billed in conjunction with 80091 on same day.

Note 2: Code 80092—Thyroid panel with TSH

Code 84443—TSH will not be paid a separate reimbursement when performed in conjunction with 80091 or 80092.

3. Codes 82487, 82488, and 82489—Chromatography—must list substance (compound) tested for in block 34 (REMARKS) of the claim form.

4. Code 82728—Ferritin

When the procedure for ferritin is performed in combination with Vitamin B12 or Folate or any of the chemistry analytes listed on codes 80002-80019, the maximum reimbursable fee for code 82728 is $5.00.

5. Code 84081—Phosphatidylglycerol—test done on newborn or amniotic fluid to determine fetal lung maturity.

6. Code 84202—Protoporphyrin, RBC; quantitative—Utilize only for testing of anemia. Utilize code 84203—Protoporphyrin, RBC; screen when testing for anemia. Code 84203 will not be reimbursed when billed in conjunction with code 83655—Blood lead determination (quantitative).

7. Code 84620—Xylose absorption tests, blood and/or urine (D-xylose tolerance test), includes serum and urine levels, up to five hourly specimens.

8. Codes 85023 and 85025—Hematology

Note: For purpose of reimbursement based on this schedule, a complete blood count (CBC) includes a hematocrit, hemoglobin determination, RBC count, RBC indices, WBC count and differential WBC count (see codes 85021 and 85022), for a platelet count with a CBC (see codes 85023-85025).

Hematology codes 85014, 85018, 85041 and 85048 will not be reimbursed in conjunction with codes for blood count with hemogram (85021, 85022, 85023, 85024, 85025, and 85027).

The code for manual differential WBC count (85007) will not be reimbursed in conjunction with codes 85021, 85022, 85023, 85024, 85025, and 85027.

Codes for platelet count (85590 and 85595) will not be reimbursed in conjunction with codes 85023-85027.

Code 85044 may be reimbursed in conjunction with codes 85023 and 85025, when a complete hemogram is ordered.

9. Codes 87040, 87045, 87060, 87070, 87184—Cultures

Note: These codes may only be billed when a pathogenic microorganism is reported. A culture that indicates no growth or normal flora must be billed as a presumptive culture, 87081 or 87082.

10. Code 88155—Pap smear

Note: Obtaining specimen is not a separate eligible service.

11. Codes 88348 and 88349—Electron microscopy; diagnostic and scanning are not reimbursable when used as a research tool.

Note: For reimbursement purposes, Medicaid will pay for the above diagnostic scanning procedure when it pertains to x-ray microanalysis for identification of asbestos particles and heavy metals, that is, gold, mercury, etc. and also when examining tissue specimens in occasional cases of malabsorption.

12. Code 89360—Sweat (without iontophoresis) test

Note: Reimbursement not eligible for qualitative tests. For reimbursement purposes, 84295 will not be reimbursed at any additional charge. Do not bill 84295 in conjunction 89360.

13. Code 36415—Utilize this code only for finger/heel/ear stick for collection of specimen(s). This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Finger/heel/ear stick is not reimbursable when billed by the independent clinical laboratory.

14. Code G0001—This service is reimbursable in the physician office laboratory (POL) when the specimen is not referred out to an independent clinical laboratory for testing. Venipuncture is not reimbursable when billed by the independent clinical laboratory. It is considered all inclusive as part of the laboratory test.

15. Code W8200—This code is reimbursable when submitted on same claim, and performed on same date as chemistry profiles.

16. Code W8900—This code may be used only once per trip regardless of the number of beneficiaries seen and requires a distance in excess of 20 miles per round trip.

Appendix A
Fiscal Agent Billing Supplement

AGENCY NOTE: The Fiscal Agent Billing Supplement is appended as a part of this chapter but is not reproduced in the New Jersey Administrative Code. When revisions are made to the Fiscal Agent Billing Supplement, replacement pages will be distributed to providers and copies will be filed with the Office of Administrative Law. For a copy of the Fiscal Agent Billing Supplement, write to:

UNISYS
P.O. Box 4801
Trenton, New Jersey 08619-4801

or contact:

Office of Administrative Law
Quakerbridge Plaza, Building 9
CN 049
Trenton, New Jersey 08625-0049

(a)

DIVISION OF MEDICAL ASSISTANCE AND HEALTH SERVICES

Psychological Services

Adopted Repeal and New Rules: N.J.A.C. 10:67

Proposed: November 6, 1995 at 27 N.J.R. 4261(a).
Adopted: January 4, 1996 by William Waldman, Commissioner, Department of Human Services.
Filed: January 9, 1996 as R.1996 d.61, with technical changes not requiring additional public notice and comments (see N.J.A.C. 1:30-4.3).

Authority: N.J.S.A. 30:4D-6b(10), and 30:4D-7, 7a, b and c.
Agency Control Number: 95-A-27.
Effective Date: February 5, 1996.
Expiration Date: February 5, 2001.

Summary of Public Comments and Agency Responses:

Two written comments were received. One comment was received from James S. Wulach, Ph.D., J.D., President of the New Jersey Psychological Association and one comment was received from Herman Huber, Ph.D., Randolph, New Jersey.

COMMENT: Both commenters addressed the same basic issues and offered the same solutions to the issues. They indicated that the change of payment from fee-for-service to fee-per-hour for psychological testing will result in an underpayment for testing compared to other services, such as individual psychotherapy as a result of the costs for materials and scoring some tests. Psychotherapy pays $37.00 for 45 minutes of face-to-face involvement and psychological testing pays $37.00, the same dollar amount, for 60 minutes of involvement.

It was stated that psychologists cannot afford to administer psychological testing at the proposed Medicaid fee and that, conservatively, many who require testing, particularly children, will either be deprived of these services or have the provision of these services delayed.

RESPONSE: The Division recognizes the training, expertise, time and effort required of the psychologist to provide the specialized service of psychological testing to Medicaid beneficiaries.