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TO: Jackie Garner
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FROM: Stuart Wright /S/
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SUBJECT: Memorandum Report: "Potential Improper Medicaid Payments for Outpatient Clinical Diagnostic Laboratory Services for Dual-Eligible Beneficiaries,"
OEI-04-07-00340

This memorandum report provides information on potential improper Medicaid payments for outpatient clinical diagnostic laboratory services that were provided on an assignment-related basis during fiscal years (FY) 2005 and 2006 to dual eligibles who were Medicare Part B beneficiaries. Dual eligibles are beneficiaries who are enrolled in Medicare Part A and/or Part B and also entitled to some Medicaid benefits.¹ State Medicaid programs should not pay for any portion of outpatient clinical diagnostic laboratory services that were provided on an assignment-related basis to dual eligibles who are enrolled in Medicare Part B.² However, we found that Medicaid programs in 8 of 11 selected States spent a total of \$1.3 million in potential improper payments for these services in FYs 2005 and 2006. Over half of this amount corresponded to five Current Procedural Terminology (CPT) codes. One of these codes accounted for almost 30 percent of the potential improper payments we identified.

BACKGROUND

As of January 2006, there were over 6 million dual eligibles nationwide.³ Both Medicare and Medicaid have regulations to determine which program covers the cost of services provided for dual eligibles, as well as the payment rates for those services.

¹ The Centers for Medicare & Medicaid Services (CMS), "Dual Eligibility: Overview." Available online at http://www.cms.hhs.gov/dualeligible/01_overview.asp. Accessed March 1, 2008. Not all dual eligibles qualify for full Medicaid benefits (i.e., some dual eligibles receive Medicaid assistance only for paying some or all of the Medicare premiums, deductibles, and copayments).

² Pursuant to 42 U.S.C. §1395l(a)(1)(D), with respect to clinical laboratory services paid under the clinical laboratory fee schedule on an assignment-related basis, Medicare shall pay 100 percent of the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount.

³ Kaiser Family Foundation. "Resources on Dual Eligibles and Issues to Their Transition to the New Medicare Drug Benefit." Available online at <http://www.kff.org/medicaid/dualsrx.cfm>. Accessed October 28, 2008.

For a dual eligible, services that are covered by both Medicare and Medicaid will be paid first by Medicare. Any remaining balance for a service will be covered by Medicaid up to the State's payment limit.⁴

Outpatient Laboratory Services Provided for Dual Eligibles

Dual eligibles may receive clinical diagnostic laboratory services in different settings, such as independent laboratories, physicians' offices, hospitals, and clinics. After laboratory services are rendered, providers submit claims to Medicare for payment using CPT codes. These codes determine amounts that Medicare will pay for services. The 2005 and 2006 Medicare Clinical Laboratory Improvement Amendments fee schedules included approximately 1,080 CPT codes under the "Pathology and Laboratory" classification.⁵

Generally, Medicare payment for outpatient clinical laboratory tests may be made only on an assignment-related basis (i.e., the Medicare-paid amount is the payment in full).⁶ With respect to clinical laboratory services paid on an assignment-related basis, Medicare pays 100 percent of the lesser of the actual charge, the fee schedule amount, or the National Limitation Amount and no deductible or copay is required.⁷ Therefore, when Medicare Part B is liable for payment of 100 percent of a dual eligible's clinical laboratory services, no payment should be made by the recipient's State Medicaid program.

METHODOLOGY

Scope

We determined the extent to which Medicaid programs in 11 selected States made payments on an assignment-related basis for dual-eligible fee-for-service outpatient clinical diagnostic laboratory services during FYs 2005 and 2006.

Data Collection and Analysis

State Selection. We obtained FY 2005 Medicaid Statistical Information System (MSIS) eligibility and claims files from CMS. The MSIS is a CMS-maintained database and the only source of nationwide Medicaid data. We analyzed MSIS claims and eligibility data from all 39 States that had submitted this information to CMS as of July 2007.⁸ First, we identified payments associated with dual eligibles using the dual-eligible identifier in the MSIS eligibility file. Next, we totaled fee-for-service payments for all clinical diagnostic laboratory services provided to dual eligibles by State.⁹

⁴ CMS, "Dual Eligibility: Overview." Available online at http://www.cms.hhs.gov/dualeligible/01_overview.asp. Accessed October 28, 2008.

⁵ A fee schedule is a listing of codes with the corresponding maximum amounts that a provider may receive in payment for each code.

⁶ CMS, "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 16, § 30.1. Available online at <http://www.cms.hhs.gov/manuals/Downloads/clm104c16.pdf>. Accessed February 9, 2009. See 42 U.S.C. § 1395l(h)(5)(C) (excluding rural health clinics from this requirement).

⁷ 42 U.S.C. §§1395l(a)(1)(D) and (b)(3).

⁸ FY 2005 MSIS eligibility and claims files were the most current data available as of July 2007.

⁹ We identified these services using all clinical diagnostic laboratory CPT codes listed in the FY 2005 Medicare fee schedule.

We then selected the 10 States with the highest Medicaid payments for all clinical diagnostic laboratory services for dual eligibles: California, Florida, Illinois, Ohio, Mississippi, New Jersey, New York, North Carolina, Tennessee, and Texas.¹⁰ We also selected Washington, based on discussions with CMS officials, for a total of 11 States.¹¹

Calculating Potential Improper Payments. Next, we obtained payment data from each of the 11 selected States' Medicaid Management Information Systems (MMIS). Specifically, we obtained information on FYs 2005 and 2006 Medicaid payments for dual eligibles for all clinical diagnostic laboratory CPT codes listed in the 2005 and 2006 Medicare fee schedules.^{12 13}

We then sorted the clinical diagnostic laboratory CPT codes included in the MMIS data that we obtained by service location and excluded services provided in inpatient settings. We also excluded outpatient laboratory services provided in rural health clinics and critical access hospitals.¹⁴ For all 11 selected States, Medicaid paid for 104,070 outpatient clinical diagnostic laboratory services that were provided to dual eligibles on an assignment-related basis. Finally, we calculated the amount each selected State Medicaid program paid for these services.

Limitations

The data obtained for Texas were from CYs 2005 and 2006; the data for Washington were from CY 2005 only.¹⁵ Therefore, the results for these two States do not reflect improper payments for the entire timeframe under review, i.e., FYs 2005 and 2006.

¹⁰ We excluded payments for services provided in inpatient settings.

¹¹ Meeting with CMS officials in June 2007.

¹² The data we obtained for Texas were from calendar years (CY) 2005 and 2006; CMS officials provided us with Washington MMIS data for CY 2005 only.

¹³ We requested States to provide payment information for dual eligibles only. We confirmed that these payments were for Medicaid recipients who were also enrolled in Medicare Part B as of July 2007 using the CMS Enterprise Cross Reference. The Enterprise Cross Reference matches beneficiary identification numbers from MMIS and the Medicare Enrollment Database.

¹⁴ Payments for outpatient clinical diagnostic laboratory services furnished to critical access hospitals are made on a reasonable cost basis. CMS, "Medicare Claims Processing Manual," Pub. No. 100-04, chapter 16, § 10.2. Available online at <http://www.cms.hhs.gov/manuals/Downloads/clm104c16.pdf>. Accessed February 9, 2009. Rural health clinics are not required to accept assignment. 42 U.S.C. § 1395l(h)(5)(C).

¹⁵ The 2006 data for Washington were unavailable from CMS.

Standards

This study was conducted in accordance with the “Quality Standards for Inspections” issued by the President’s Council on Integrity and Efficiency and the Executive Council on Integrity and Efficiency.

RESULTS

Eight of Eleven Selected State Medicaid Programs Spent a Total of \$1.3 Million in Potential Improper Payments During FYs 2005 and 2006 for Outpatient Clinical Diagnostic Laboratory Services for Dual Eligibles

Of the \$1.3 million in potential improper payments, \$722,906 was paid in FY 2005 by 8 of the 11 selected States. The remaining \$563,820 was paid in FY 2006 by 7 of 10 States.¹⁶

Table 1 shows potential improper Medicaid payments in FYs 2005 and 2006 for outpatient clinical diagnostic laboratory services for dual eligibles by State.

Table 1			
State	FY 2005 Potential Improper Medicaid Payments	FY 2006 Potential Improper Medicaid Payments	Total Potential Improper Medicaid Payments
California	\$1,401	\$4,081	\$5,482
Florida	\$21,967	\$12,981	\$34,948
Illinois	\$0	\$0	\$0
Mississippi	\$0	\$0	\$0
New Jersey	\$0	\$0	\$0
New York	\$63,160	\$66,052	\$129,212
North Carolina	\$4,137	\$5,123	\$9,260
Ohio	\$35,677	\$24,016	\$59,693
Tennessee	\$63,809	\$45,775	\$109,584
Texas*	\$388,787	\$405,793	\$794,580
Washington**	\$143,968	NA	\$143,968
TOTAL	\$722,906	\$563,820	\$1,286,726

Lines may not sum to totals because of rounding.

* CYs 2005 and 2006 data.

** CY 2005 data only.

Fifty-five Percent of Potential Improper Medicaid Payments Corresponded to Five CPT Codes

The following CPT codes represented the most frequently reimbursed services: 36415, 85025, 80053, 81000, and 87536. These five services represented 55 percent of all potential improper Medicaid payments that we identified. Code 36415 represented 29 percent of the total potential improper payments.

¹⁶ The 2006 data for Washington were unavailable and, therefore, were not included in the analysis.

Table 2 lists the top five CPT codes associated with improper Medicaid payments in FYs 2005 and 2006 for outpatient clinical diagnostic laboratory services for dual eligibles and the potential improper payments associated with each code.

Table 2			
CPT Code	Description	Total Potential Improper Medicaid Payments	Percentage of Total Potential Improper Medicaid Payments
36415	Collection of venous blood by venipuncture	\$379,065	29%
85025	Complete, automated, and automated differential white blood cell count	\$166,457	13%
80053	Comprehensive metabolic panel	\$57,981	5%
81000	Urinalysis, nonautomated with microscopy	\$50,884	4%
87536	HIV-1, quantification	\$49,771	4%
Others	All remaining procedure codes	\$582,568	45%
TOTAL		\$1,286,726	100%

CONCLUSION

In FYs 2005 and 2006, 8 of 11 selected State Medicaid programs paid a total of \$1.3 million in potential improper payments for outpatient clinical diagnostic laboratory services provided on assignment to dual eligibles. These results demonstrate that opportunities exist to educate State Medicaid programs that they should not pay for any portion of these services. To facilitate followup, we will provide a summary of these potential improper Medicaid payments under separate cover.

This memorandum report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this memorandum report, please provide them within 60 days. Please refer to memorandum report OEI-04-07-00340 in all correspondence.

cc: Jacquelyn White
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