MEDICARE REIMBURSEMENT FOR OUTPATIENT LABORATORY SERVICES

OFFICE OF INSPECTOR GENERAL

OFFICE OF ANALYSIS AND INSPECTIONS

MARCH 1989

MEDICARE REIMBURSEMENT FOR OUTPATIENT LABORATORY SERVICES

Richard P. Kusserow
INSPECTOR GENERAL

OAI-04-88-01080

MARCH 1989

EXECUTIVE SUMMARY

PURPOSE

This inspection assesses the effects on Medicare program costs of adopting a national fee schedule for the payment of outpatient lab services for Medicare beneficiaries.

BACKGROUND

Medicare paid nearly $1.3 billion for outpatient lab services in 1986 and nearly $1.6 billion in 1987 according to Part B Medicare Annual Data (B-MAD). Expenditures are expected to rise to $2.4 billion by 1990.

Payments are now made at the lowest of three rates: the amount indicated on a carrier-wide fee schedule (the "area rate"); the amount imposed by a national fee limitation; or the amount actually billed.

Under current law, starting in 1990 area rates will be discontinued and all reimbursement will be based on a national fee schedule.

FINDINGS

Conversion of the National Limitation to a National Fee Schedule Could be Costly

Area rates for reimbursement of lab services vary significantly among Medicare carriers. The Medicare program benefits from these variances in cases where the area rate is lower than the national limitation.

Implementation of a national fee schedule without these area rates could be costly. For example, using the current national fee limitation as the national fee schedule would increase Medicare costs by $82 million in 1990 for the 62 most frequently reimbursed tests. The total cost for all Medicare lab tests would be much higher.

RECOMMENDATION

The Health Care Financing Administration (HCFA) should request that Congress repeal the requirement to base lab reimbursement on a national fee schedule beginning in 1990.

Health Care Financing Administration Comments

The HCFA concurs with the OIG recommendation, noting the Office of Inspector General's (OIG) projected savings of $82 million for the 62 most frequently reimbursed lab tests. The HCFA suggests that the OIG could have projected savings of about $145 million if all tests were included instead of the 62 tests used in the calculation.

The HCFA itself estimates potential savings of $190 million, by a completely different method: basing a national fee schedule on Medicare's 1984 lab charge data. The HCFA suggests that OIG consider its methodology for calculating prospective savings or that the OIG extrapolate to the entire volume of Medicare lab tests.

Further, the HCFA suggests several related lab issues for future OIG program inspections. They particularly requested that we analyze the 60 lab tests which represent the greatest outpatient dollar volume under Medicare.

The HCFA also recommended replacement of the term "area rates" with "carrier-wide fee schedules" and the term "national fee limitation" with "median cap" or "ceiling amount." (See appendix E for the HCFA memo commenting on the draft report).

Office of Inspector General Response

The OIG appreciates HCFA's concurrence with the recommendation and its favorable comments on the report. The suggestions of related topics for future study are also appreciated.

We concur with HCFA that the $82 million savings documented in the report is conservative. However, the methodology employed by this inspection will not permit extrapolation to the full volume of Medicare reimbursed lab tests. We do acknowledge, however, that the total figure is much higher than $82 million (see page 9 of the report), and could well be as high as the $190 million HCFA supports.

We did not change the terms "area rates" and "national fee limitation" as suggested by HCFA. An important audience of this report is the general public. We have chosen to retain the more common terms to describe the lab reimbursement process because we believe these terms are more understandable to readers outside the Department.

As requested by HCFA, we are undertaking an analysis of the 60 lab tests representing the greatest outpatient dollar volume under Medicare.

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INTRODUCTION

BACKGROUND

What Are Outpatient Clinical Laboratory Services?

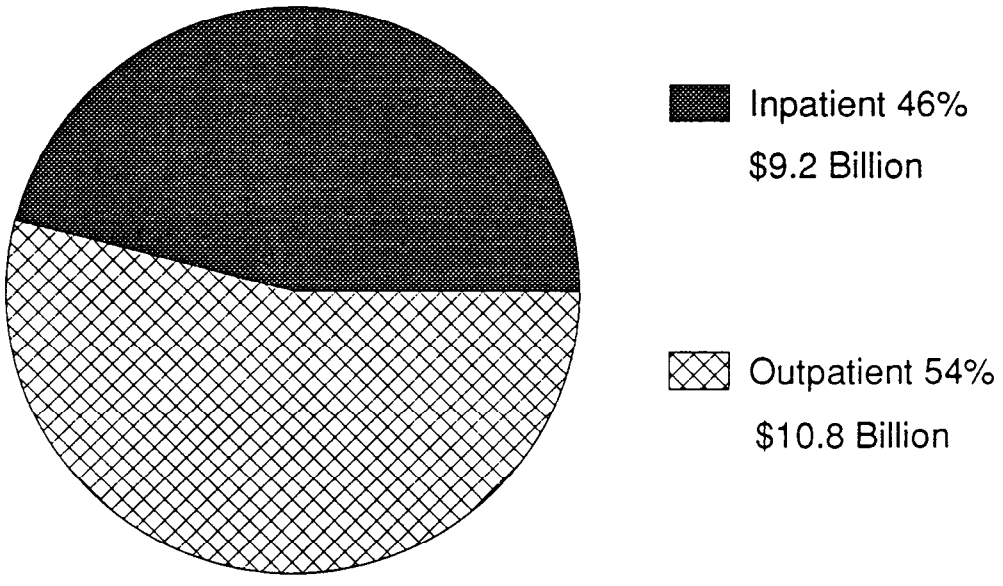
Clinical laboratory (lab) services include a wide range of chemical and other types of examinations of materials derived from the human body to assist in diagnosis, prevention, or treatment of illness. Medicare pays for more than 1,000 types of lab tests. Some of the most common are complete blood counts, urinalyses and glucose tolerance tests.

Outpatient clinical lab services are those provided outside the hospital inpatient setting. They are reimbursed through Part B of the Medicare program.

How Much Money Is Involved?

Payments for all lab services in the United States are estimated to be $20 billion annually. About $10.8 billion (54 percent) of that amount is spent on outpatient lab services. The following chart illustrates the size of the lab services market and the proportions attributable to inpatient and outpatient services.

Figure A
PAYMENT FOR LAB SERVICES
UNITED STATES - 1986



$ 20 BILLION

Medicare payments for outpatient lab services constitute about 12 percent of the total outpatient lab market. In 1986, those payments were nearly $1.3 billion, and in 1987, nearly $1.6 billion. The Health Care Financing Administration (HCFA) estimates that Medicare outpatient lab expenditures will reach $2.4 billion in 1990.

This report addresses only ***outpatient*** lab expenditures. ***Inpatient*** lab services, those provided to hospital and skilled nursing facility inpatients, are generally reimbursed through Medicare's Part A coverage. In the case of hospital inpatients, no separate Medicare payment is made for lab services. The diagnosis related group (DRG) payment to the hospital must cover lab costs along with all other costs of the patient's hospitalization.

Some outpatient lab testing for Medicare beneficiaries is performed by hospital-based or nursing home-based labs (8.2 percent), but most is done by physician office labs (50.6 percent) and freestanding or independent labs (41.2 percent).

The following charts illustrate Medicare's proportion of the outpatient lab market (figure B) and the proportion of Medicare lab payments going to independent labs, physician office labs and labs based in hospital and other settings (figure C).

Figure B
OUTPATIENT LAB SERVICES
1986

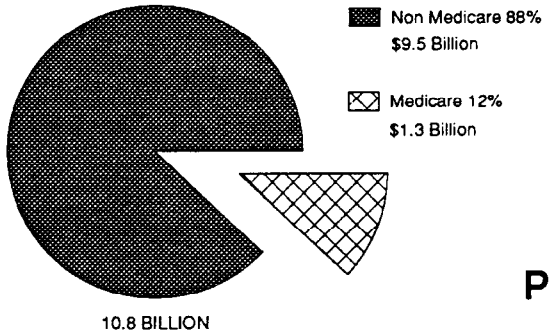
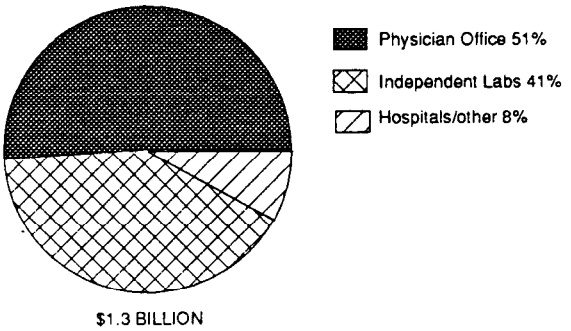


Figure C
PROVIDERS OF LAB SERVICES



How Does Medicare Reimburse for Lab Services?

The amount Medicare pays for specific outpatient lab services is the lowest of:

- the amount billed by the lab;
- the amount indicated on the area rate; or
- the national limitation for the billed service.

The area rate is based on the carrier's historical prevailing charge data. The national limitation is the median of all the area rates for each test. It is applied as a nationwide payment ceiling.

When Medicare is billed for a specific lab service, the carrier compares the billed amount to the area rate and the national limitation and reimburses at the lowest of these three figures.

How Has Lab Reimbursement Changed?

Over the past 8 years, the Congress has made a number of changes in Medicare lab reimbursement in order to stem the rising cost of lab services. The table on the following page summarizes those legislative actions. (See appendix A for a narrative summary of the legislation).

Recognizing that a system based on the amount labs charge for their services is inherently inflationary, the Congress imposed a national payment ceiling for each lab test in 1986. In January 1990, Medicare lab reimbursement is due for another major change. The Omnibus Budget Reconciliation Act of 1987 requires Medicare to begin in 1990 to pay for lab services according to a uniform national fee schedule, without using area rates.

Figure D

LEGISLATIVE HISTORY

	PRE - 1980	OBRA 1980	DEFRA 1984	COBRA 1986	OBRA 1987
Payment for Lab Services	• Reimbursement based on "usual, customary and reasonable" charges	• Eliminated physician markups for tests performed by other providers • Limited payment to lowest charge at which a physician could have secured the service	• Established area fee schedules at 60% of prevailing charges. Limited POL reimbursement to 80% of the fee schedule plus co-pay. • Built in automatic increases based on Consumer Price Index (CPI)		• Imposed a 3- month freeze on area rates • Effective April 1, 1988, imposed an 8.3 % reduction in area rates for most common tests
National Fee Limitation				• Imposed a national ceiling at 115 % of the median of all area rates effective July 1, 1986. On January 1, 1988, reduced ceiling to 110 %.	• Reduced national limitation amounts further, to 100% of the median as of April 1, 1988. • Eliminated CPI Increase
National Fee Schedule			• Required establishment of a national fee schedule by July 1, 1987	• Postponed establishment of a national fee schedule to January 1988	• Postponed establishment of a national fee schedule to January 1990
Medicare Assignment			• Required independent labs and hospitals to accept assignment; POLs exempt	• Required POLs to accept assignment	
Other			• Eliminated beneficiary deductible and 20% co-pay, except POLs		• Prohibited competitive bidding demonstrations until 1989. (Subsequently extended to 1990.)

PURPOSE

This inspection assesses the effects on Medicare program costs of adopting a national fee schedule for the payment of outpatient lab services.

Two major issues are addressed:

- What have been the effects of the present national limitation on Medicare outlays?

- What are the probable effects of Medicare adopting a national fee schedule?

METHODS

The inspection team analyzed existing statistical data, examined legislation and supporting documents, and reviewed other studies of lab reimbursement.

The HCFA data base (B-MAD) for 1986 and 1987 provided information on total Medicare expenditures for outpatient lab services, as well as billing frequencies and payments for individual lab services. These data were analyzed by type of test and by carrier, yielding the comparisons discussed in this report.

Other documents examined included the Medicare Carriers' Manual, the national fee limitation levels, current legislation and legislative proposals, and reports by the Office of Inspector General (OIG) and the General Accounting Office (GAO).

FINDINGS

National Limitation Reduces Medicare Costs

The current law requires that Medicare reimburse for outpatient lab services at the lowest of the area rate, the national limitation or the actual amount billed. Medicare saves money in every case where the national limitation is lower than the area rate, which would have been paid in the absence of a payment limitation.

Before July 1986, there was no national limitation. Medicare reimbursement was based on the lower of the actual charge or the area rate. Had the national limitations which were in effect in 1988 been applied to 1986 Medicare lab billings, Medicare would have saved nearly $71 million--9.6 percent--on the 62 most frequent outpatient lab tests. (See appendix B for a listing of those tests.) These 62 tests represent about 75 percent of all outpatient lab procedures reimbursed by Medicare, and about 57 percent of the total 1986 Medicare expenditures for outpatient lab services.

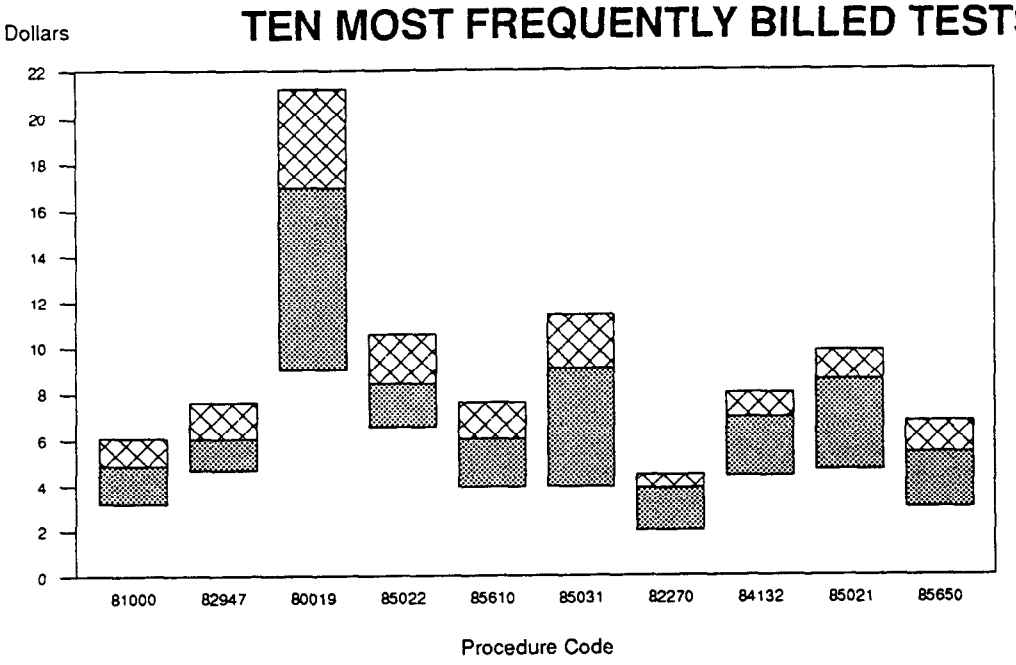
The $71 million in savings was calculated as follows:

Area rate for 62 tests X area frequency	= $739.7m
Lowest of the area rate or the national limitation X area frequency	= $668.8m
IMPACT OF NATIONAL LIMITATION	= $ 70.9m

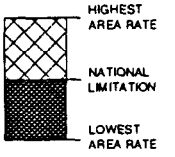
Area Rates Vary Greatly

Examination of the area rates for the 62 most frequently billed lab tests reveals significant variation among carriers. Figure E illustrates the extent of variance for the 10 tests most frequently billed to Medicare. (See appendix C for a listing of each test, its highest area rate, lowest area rate, and national limitation.)

Figure E
MEDICARE LAB REIMBURSEMENT - VARIANCE
TEN MOST FREQUENTLY BILLED TESTS



81000 - Urinalysis: routine w/microscopy
82947 - Glucose: except urine
80019 - Auto tests: 19 or more chemistries
85022 - Blood Count: Hemogram, auto, CBC, Dif
85610 - Prothrombin Time
85031 - Blood Count: Hemogram, manual, CBC
82270 - Blood: occult, feces screening
84132 - Potassium: Blood
85021 - Blood Count: Hemogram, auto
85650 - Sedimentation Rate: Wintrobe type

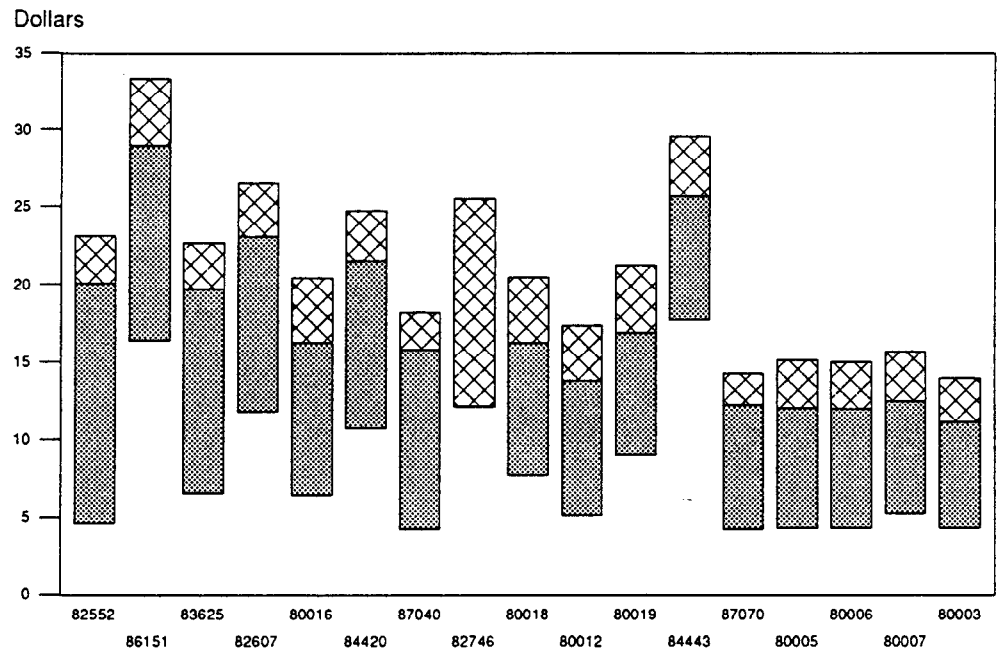


The chart above shows the complete range of rates. The dividing line between the dark and the light sections of each bar is the national limitation. The light portion of the bar shows the difference between the national limitation and the highest area rate. The dark portion shows the difference between the national limitation and the lowest area rate.

Since area rates are based on historical charges in the carrier service area, assumptions cannot be made about the reasons for the variations without examining the basis for individual labs' charges. Those charges may reflect the costs of laboratory operations, competitiveness of the local marketplace, or the labs' own decisions on acceptable profit levels. They may be based on factors which are not discernible by Medicare or other payers.

Figure F illustrates the 17 tests for which the variation in area rates is the greatest. (See appendix D for a listing of each test, its highest area rate, lowest area rate, and national limitation.)

Figure F
GREATEST VARIATION AMONG CARRIERS



82552 - Blood Crestine Phos.: Isoenzymes
86151 - Carcinoembryonic antigen: RIA
83625 - Blood LDH: Isoenzymes electrophoresis
82607 - Cyanocobalamin, RIA
80016 - Auto tests: 13-16 chemistries
84420 - Theophylline, Blood or Saliva
87040 - Def. Bacterial Culture, aerobic, blood
82746 - Blood Folic Acid: RIA
80018 - Auto tests: 17-18 chemistries
80012 - Auto tests: 12 chemistries
80019 - Auto tests: 19 or more chemistries
84443 - Thyroid Stimulating Hormone, RIA
87070 - Bacteria Culture, aerobic, other source
80005 - Auto tests: 5 chemistries
80006 - Auto tests: 6 chemistries
80007 - Auto tests: 7 chemistries
80003 - Auto tests: 3 chemistries

(Note that for test 82746 the difference between the national limitation and the combined area rate is too small to show in the chart.)

As in the prior illustration, the dividing line between the dark and light sections is the national limitation. The dark portion of each bar represents area rates below the national limitation and the light portion represents area rates exceeding the national limitation.

Variation in Area Rates Saves Medicare Money

The variations illustrated in figures E and F are advantageous to Medicare. Because the program reimburses at the lowest of the billed amount, the area rate or the national limitation, Medicare benefits from charges and area rates which fall below the national limitation. At the same time, Medicare is not adversely affected by area rates which exceed the national limitation.

Concerning the 62 most frequently billed lab procedures, if Medicare had paid the national limitation in all cases rather than paying the area rate when it was lower, the cost of laboratory services would have been $40 million higher in 1986.

This amount is based on the following calculation:

National limitation for 62 tests X area frequency	= $709m
Lowest of the area rate or national limitation X area frequency	= $668.9m
IMPACT OF VARIATION IN AREA RATES	= $ 40.1m

National Fee Schedule Could Be Costly

The HCFA is presently required to implement a national fee schedule for lab services by 1990. The effect on Medicare costs will depend on where that schedule sets reimbursement rates. For the purpose of illustrating this point, this analysis hypothetically assumes that the national fee schedule is set at the rates now indicated on the national limitation. Under this scenario, Medicare costs would be significantly higher in 1990.

The $40 million above is 6 percent more than Medicare would have paid under the current reimbursement system, which uses both area rates and the national limitation. If the same 6 percent factor is applied to estimated 1990 Medicare expenditures for these 62 tests, the result would be $82 million in increased Medicare costs.

The 62 lab procedures from which this $82 million cost is derived represent 75 percent of Medicare outpatient lab volume and 57 percent of the total Medicare expenditure for all lab services. If all the tests were examined, the cost would be even higher.

RECOMMENDATION

Recommendation

The HCFA should request that Congress repeal the requirement to base lab reimbursement on a national fee schedule beginning in 1990.

HCFA Comment

The HCFA response to the report's recommendation is: "We concur with the OIG recommendation. The recommendation is consistent with the Administration's Fiscal Year (FY) 1990 legislative proposal to eliminate the statutory requirement that the Secretary establish a national fee schedule by January 1, 1990."

APPENDIX A

SUMMARY OF LAB REIMBURSEMENT LEGISLATION

Prior to the 1980 Medicare and Medicaid Amendments, Medicare made payments to physicians, to independent labs or to patients for clinical lab services. Physicians could receive payment whether they actually performed the lab procedures or sent the specimen to an independent lab which then billed the physicians for the work. The General Accounting Office documented that physicians sometimes billed Medicare, or their patients, at rates which greatly exceeded what independent labs charged the physicians for the same tests. This common practice set the stage for the first of several legislative changes.

Omnibus Budget Reconciliation Act of 1980

The 1980 amendments addressed the problem of substantial physician markups on bills for lab services actually performed by third party labs. In such cases, the amendments required physicians to identify the lab which performed the services and the amount which it billed the physician. The legislation authorized Medicare carriers to limit payment to the lowest charge at which a physician could have secured the services from a lab serving the applicable locality. On the other hand, when physicians did provide the required information, the allowed payment was the lower of that lab's "reasonable charge," or the amount actually billed the physician. The "reasonable charge" is described as the lowest of: (1) the physician's or lab provider's customary charge for a given service; (2) the prevailing charge for similar services in the locality; (3) the actual charge submitted for the given service; or (4) the carrier's usual amount of reimbursement for comparable services to its own policyholders under comparable circumstances.

Deficit Reduction Act of 1984 (DEFRA)

Under DEFRA, area rates were set for outpatient lab tests. The rates applied to lab services furnished by physicians, independent labs, and hospitals on an outpatient basis. The goals were to save dollars for Medicare and its beneficiaries and to standardize payments for similar services within a geographic area. The DEFRA provided that Medicare pay 100 percent of the area rate amount and eliminated all co-payment requirements for beneficiaries. The DEFRA also required that hospital and independent labs accept assignment (which means that they agree to accept the Medicare schedule fee as full payment.)

The rate for each Medicare carrier was set at 60 percent of the prevailing charge level (i.e., 60 percent of the amount calculated as the 75th percentile of the customary charges, weighted by frequency). The rates were to be adjusted annually to reflect changes in the Consumer Price Index (CPI). Another key provision of DEFRA required the Secretary to establish a nationwide fee schedule by January 1, 1987; however, the Congress has postponed implementation of this requirement until January 1, 1990.

The Comptroller General was required to report to the Congress by January 1, 1987 on the appropriateness of the area rates and the potential impact of a national fee schedule. The Comptroller General found DEFRA saved beneficiaries substantial amounts of money, but increased Medicare costs somewhat. Beneficiary savings resulted from elimination of deductibles and co-payments, the responsibility for which was assumed by Medicare.

Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA)

This law imposed a ceiling on the amount that may be paid for each test under an area rate. The limitation was established as 115 percent of the median of all area rates for a particular test in a particular lab setting (e.g., physician office labs or independent labs). The limitation was to be in effect from July 1, 1986 through December 31, 1987. After December 31, 1987, the limitation was to be reduced to 110 percent of the median. The COBRA also required that physician office labs accept assignment.

Omnibus Budget Reconciliation Act of 1987 (OBRA)

The OBRA of 1987 imposed a 3-month freeze on area rates from January 1, 1988 through March 31, 1988. This provision rescinded the inflation (CPI) increase scheduled by DEFRA for January 1, 1988. Further, effective April 1, 1988, it provided for an 8.3 percent reduction in the area rates for certain automated tests and other widely available tests such as cholesterol blood tests and white blood cell counts. Finally, it provided for the 1987 national limitation amounts to be in effect through March 31, 1988. After that date, the national limitation amounts were reduced from 115 percent to 100 percent of the median established by the area rates.

APPENDIX B

LIST OF 62 MOST FREQUENTLY REIMBURSED LAB TESTS

Outpatient Clinical Lab Tests

HCPCS*	
80003	Automated Multichannel Test: 3 Clinical Chemistry Tests
80004	Automated Multichannel Test: 4 Clinical Chemistry Tests
80005	Automated Multichannel Test: 5 Clinical Chemistry Tests
80006	Automated Multichannel Test: 6 Clinical Chemical Tests
80007	Automated Multichannel Test: 7 Clinical Chemistry Tests
80012	Automated Multichannel Test: 12 Clinic Chemistry Tests
80016	Automated Multichannel Test: 13-16 Clinical Chemistry Tests
80018	Automated Multichannel Test: 17-18 Clinical Chemistry Tests
80019	Automated Multichannel Test: 19 or more Clinical Chemistry Tests (indicate instrument and number of tests performed)
81000	Urinalysis: Routine, with Microscopy
81002	Urinalysis; Routine, without Microscopy
82150	Amylase, Serum;

* *HCFA Common Procedure Coding System*

82270	Blood: Occult, Feces, Screening
82435	Chlorides; Blood (Specify chemical or electrometric)
82465	Cholesterol, Serum; Total
82550	Creatine Phosphokinase (CPK), Blood; Timed Kinetic Ultraviolet Method
82552	Creatine Phosphokinase (CPK), Blood; Isoenzyme
82565	Creatinine; Blood
82607	Cyanocobalamin (Vitamin B-l2); RIA Immunoassay
82643	Digoxin, RIA-Immunoassay
82644	Digoxin, emit
82746	Folic Acid (Folate), Blood; RIA-Immunoassay
82947	Glucose; Except Urine (EG, Blood, Spinal Fluid, Joint Fluid)
82948	Glucose; Blood, Stick test
83615	Lactic Dehydrogenase (LDH), Blood; Kinetic Ultraviolet Method
83625	Lactic Dehydrogenase (LDH), Blood; Isoenzyme, Electrophoretic separation and quantitation
84065	Phosphatase, acid; Prostatic fraction
84066	Phosphatase, acid; Prostatic Fraction, RIA-Immunoassay
84132	Potassium; Blood

84295	Sodium; Blood
84420	Theophylline, Blood
84435	Thyroxine, (T-4), CPB or resin uptake
84443	Thyroid Stimulating Hormone (TSH), RIA Immunoassay
84450	Transaminase, Glutamic Oxaloacetic (SGOT), Blood; Timed Kinetic Ultraviolet Method
84460	Transminas, Glutamic Pyruvic (SGPT), Blood, Time Kinetic Ultraviolet Method
84478	Triglycerides, Blood
84479	Triiodothyronine (T-3), Resin Uptake
84520	Urea Nitrogen, Blood (Bun); Quantitative
84550	Uric Acid; Blood, Chemical
85007	Blood count Differential WBC count (includes RBC Microphology and platelet estimation)
85014	Blood count; Hematocrit
85018	Blood count Hemoglobin, Calorimetric
85021	Blood count Hemogram, Automated (RBC, WBC, HGB, HCI, and indicates only)
85022	Blood count Hemogram, Automated, and differential WBC count (CBC)
85028	Blood count Hemogram, Automated and differential WBC count (CBC) with platelet count
85031	Blood count Hemogram, Manual, Complete CBC (RBC, WBC, HGB, HCI, differential and indices)

85044	Blood count; Reticulocyte Count
85048	Blood count White blood cell (WBC)
85580	Platelet; Count (Rees-Ecker)
85595	Platelet; Electronic Technique
85610	Prothrombin time;
85650	Sedimentation Rate (ESR); Wintrobe type
85651	Sedimentation Rate (ESR); Westergren type
85730	Thromboplastin time, partial (PTT); Plasma or whole blood
86151	Carcinoembryonic Antigen (CEA); RIA-Immunoassay
86592	Syphilis, precipitation or flocculation tests, Qualitative VDRL, RPR, DRT
87040	Culture Bacterial, Definitive Aerobic; Blood (May include anaerobic screen)
87070	Culture, Bacterial, Definitive, Aerobic; and other sources
87086	Culture, Bacterial, Urine Quantitative, Colony Count
87101	Culture, Fungi, Isolation; Skin
87184	Sensitivity studies, Antibiotic; Disc method, per plate (12 or less discs)
87205	Smear, Primary Source, with Interpretation Routine Stain For Bacteria, Fungi, or Cell Types
88150	Cytopathology, Smears, Cervical or Vaginal (EG, Papanicolaou), Screening and interpretation, Up to three Smears

APPENDIX C

TEN MOST COMMON LAB TESTS
VARIATION IN PAYMENT AMOUNTS IN 1986

PROCEDURE CODE	HIGHEST AREA RATE	LOWEST AREA RATE	NATIONAL LIMITATION
81000	$ 6.06	$ 3.16	$ 4.83
82947	7.57	4.64	6.03
80019	21.22	9.01	16.92
85022	10.55	6.53	8.41
85610	7.57	3.92	6.03
85031	11.36	3.90	9.06
82270	4.43	1.96	3.85
84132	7.99	4.36	6.96
85021	9.82	4.64	8.54
85650	6.79	2.95	5.41

APPENDIX D

OUTPATIENT LAB PROCEDURES WITH GREATEST VARIATION IN PAYMENT AMOUNT--1986

PROCEDURE CODE	HIGHEST AREA RATE	LOWEST AREA RATE	CEILING AMOUNT
82552	$ 23.09	$ 4.64	$ 20.08
86151	33.34	16.44	28.99
83625	22.67	6.54	19.71
82607	26.55	11.81	23.08
80016	20.43	6.39	16.29
84420	24.73	10.75	21.50
87040	18.18	4.24	15.82
82746	25.52	12.12	12.19
80018	20.46	7.72	16.31
80012	17.34	5.12	13.82
80019	21.22	9.01	16.92
84443	29.58	17.77	25.72
87070	15.16	4.24	13.18
80005	15.16	4.30	12.09
80006	15.03	4.30	11.99
80007	15.69	5.27	12.52
80003	14.01	4.30	11.17

DEPARTMENT OF HEALTH & HUMAN SERVICES

Financing Administration

Memorandum

Date FEB 1 1989

From William L. Roper, M.D. WLR
Administrator

Subject OIG Draft Report: Medicare Reimbursement for Outpatient Laboratory Services - OAI-04-88-01080

To The Inspector General
Office of the Secretary

We have reviewed your draft report which recommends that Congress be requested to remove the requirement for a laboratory reimbursement system based on a national fee schedule. The current laboratory reimbursement system requires payment at the lowest of the carrier fee schedule amount, the national median fee schedule amount, or the amount actually billed. Current law requires that, starting in 1990, reimbursement be based on a national fee schedule, rather than a carrier fee schedule.

We concur with the OIG recommendation. The recommendation is consistent with the Administration's Fiscal Year (FY) 1990 legislative proposal to eliminate the statutory requirement that the Secretary establish a national fee schedule by January 1, 1990. By extrapolating the savings cited in the report to the entire population, it appears the OIG is assuming a total savings of about $145 million. This is $45 million less than the $190 million savings attributed to this proposal in the President's Budget for FY 1990. The source of this discrepancy seems to be a differing interpretation of the law by HCFA and the OIG. While OIG makes the assumption that a national fee schedule would be set at the level of the current national limitation amount (resulting in a 6 percent savings if the current system is maintained), the HCFA interpretation is that the national fee schedule would be built from 1984 charge data (the last year without payment caps). This would result in savings equivalent to 17.4 percent of total expenditures without any behavioral effect being taken into account. When provider behavior is factored in, savings are reduced by 35 percent, resulting in net savings equal to approximately 11.3 percent (or $190 million in FY 1990). We recommend that the OIG take into account these factors in calculating prospective savings related to the position advocated by the report.

We have included in an attachment some suggestions as to how the report could be strengthened and made more useful.

Thank you for giving us the opportunity to comment on this draft report.

Attachment

Additional HCFA Comments on the OIG Draft Report
Medicare Reimbursement for Outpatient Laboratory Services
OAI-04-88-01080

The following changes to the report would be useful:

- The degree of variation in fee schedule amounts for tests that are highly or completely automated is of particular interest. Some discussion of the extent of variation found for different kinds of tests (more vs. less automated) would be very useful to the translation of the findings into future policy options.

- A list of the 62 tests included in the analysis should be attached as an appendix.

- We found the introduction of new terminology, like "area rates," distracting and confusing.

  + "Area rates" should be replaced by "carrier-wide fee schedules" or "carrier-wide fee schedule amounts."

  + Similarly, the term "national fee limitation" should be replaced. We suggest that the report initially define the limitation (as 100 percent of the median of all the carrier fee schedule amounts) and, thereafter, refer to the "median cap" or ceiling amount."

- The report provides an estimate of the impact the national fee schedule requirement on payments for the 62 tests most commonly provided. Could the same analysis be performed for the 60 tests that have the greatest dollar volume? Also, any data on the distribution of these high volume or high dollar volume tests by setting (i.e., the percentage of each done in physicians' office laboratories, independent laboratories and hospital outpatient laboratories) would be very useful.

- The carriers with the lowest and highest fee schedule amounts for specified tests (or overall, if meaningful) could be identified. Likewise, the tables in Appendices B and C would be of greater interest if all the carriers' fee schedule amounts were shown with the highest and lowest value for each test highlighted.