Memorandum

Date DEC 24 1996

From June Gibbs Brown
Inspector General

Subject Clinical Laboratory Services Provided Under the Illinois Medicaid Program (A-05-95-00062)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum is to alert you to the issuance on December 27, 1996 of our final report to the Illinois Department of Public Aid (State agency) concerning reimbursement for clinical laboratory services under the Medicaid program for Calendar Years (CY) 1993 and 1994. This report is part of our nationwide review of Medicaid payments for laboratory services. A copy is attached.

The objective of our review was to determine the adequacy of procedures for payment of clinical laboratory claims. Specifically, the audit is designed to determine whether Medicaid payments for chemistry and hematology tests exceeded amounts recognized by Medicare for the same tests or were duplicated. In doing so, we identified tests that were not grouped together (bundled into a panel or profile) for payment purposes. Proper grouping of tests helps to ensure that Medicaid agencies do not reimburse medical providers more for clinical laboratory tests than the amounts Medicare recognizes for the same services.

Our review disclosed the State agency had a system of edits which included the majority of procedure codes reviewed; however, the absence of certain edits allowed improper payments to be made to providers. Our primary findings relate to two conditions: (1) the State agency's claims processing system did not edit for three chemistry procedures which Medicare carriers usually bundle into panels and (2) it did not deny payment for hemogram indices claimed with hemogram profiles, which include indices.

Our stratified sample of 100 instances involving chemistry and hematology claims with potential payment errors showed that 79 items were overpaid. Based on our audit results, we estimate the State agency overpaid providers $2,194,072 (Federal share $1,097,036) during CYs 1993 and 1994.

We are recommending that the State agency: (1) ensure that its edits detect and prevent payments for unbundled and duplicative tests by addressing the specific overpayment causes reported, (2) update and clarify its policies and instructions to providers to

include additional procedures which are subject to edits for unbundled and duplicate tests, (3) determine the amount of potential overpayments by provider and obtain recoveries of actual overpayments from those providers with the largest total potential overpayments, and (4) return the Federal share of the amounts recovered to the Health Care Financing Administration.

State agency officials do not agree the two primary findings resulted in overpayments during the audit period. State agency officials indicated (1) they do not allow more than Medicare for any individual lab tests, (2) they are not aware of any regulations that require the State agency follow Medicare bundling procedures, (3) the Physicians' Current Procedural Terminology (CPT) guidelines do not require the three chemistry procedures be bundled, (4) recent Illinois Medicare bulletins indicate Medicare did not bundle two of the three chemistry procedures until January 1, 1996, and (5) their physician consultants did not recommend denying hemogram indices when claimed with hemogram profiles.

In response to the State's comments, we believe the two primary findings resulted in overpayments based on Medicaid rules and CPT definitions which existed during the audit period. The State Medicaid Manual precludes paying more for laboratory tests than Medicare pays. The Illinois Medicare carrier determined that laboratories frequently perform the three chemistry procedures as part of a panel and, therefore, required these tests be bundled and reimbursed at the lower panel fee since at least 1987. When the State agency reimburses these tests individually rather than as a panel, it pays more than Medicare. By CPT definition, the two hemogram indices duplicate automated hemogram profiles and, thus, should not be reimbursed when claimed with a profile.

For further information, contact:

Paul P. Swanson
Regional Inspector General
for Audit Services, Region V
(312) 353-2618

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CLINICAL LABORATORY SERVICES PROVIDED UNDER THE ILLINOIS MEDICAID PROGRAM

JUNE GIBBS BROWN
Inspector General

DECEMBER 1996
A-05-95-00062

DEPARTMENT OF HEALTH AND HUMAN SERVICES

REGION V
105 W. ADAMS ST.
CHICAGO, ILLINOIS 60603-6201

OFFICE OF
INSPECTOR GENERAL

Common Identification Number: A-05-95-00062

Mr. Robert Wright, Director
Illinois Department of Public Aid
100 South Grand Avenue, East
Springfield, Illinois 62762

Dear Mr. Wright:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), Office of Audit Services' report entitled, "Review of Medicaid Clinical Laboratory Services." The audit covered calendar years 1993 and 1994. A copy of this report will be forwarded to the action official noted below for his review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any further 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), HHS/OIG Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent information contained therein is not subject to exemptions in the Act which the Department chooses to exercise. (See 45 CFR Part 5.)

To facilitate identification, please refer to Common Identification Number A-05-95-00062 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:
Mr. David Dupre
Associate Regional Administrator
Division of Medicaid
Health Care Financing Administration
105 West Adams Street, 14th Floor
Chicago, Illinois 60603

EXECUTIVE SUMMARY

OBJECTIVE

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 certain chemistry and hematology tests set forth in APPENDIX B.

SUMMARY OF FINDING

Our audit disclosed that the Illinois Department of Public Aid (State agency) did not have certain controls in place to detect and prevent Medicaid payments for laboratory tests in excess of what program guidelines allow. According to the State Medicaid Manual, payment for clinical laboratory tests under the Medicaid program cannot exceed the amount recognized by Medicare. These excessive payments occurred because the State agency was paying a higher price for individual tests than they would have if the tests had been bundled into lower cost panels and profiles. Although the State agency established a system of edits which covered the majority of procedure codes included in our review, the absence of certain edits allowed some improper payments to be made to providers. Our findings are primarily related to two conditions. Specifically, the State agency's claims processing system did not edit for three chemistry procedure codes which the Illinois Medicare carrier bundles into a panel and it did not deny payment for hemogram indices claimed with hemogram profiles. In addition, the State agency's policies and its instructions to providers did not require that the three chemistry procedures in our finding be bundled or specify which hematology procedure codes were duplicative.

We randomly selected a stratified sample of 100 instances involving claims with potential payment errors from a population of 318,051 instances that were extracted from the State agency's Calendar Year (CY) 1993 and 1994 paid claims files. We found that 79 of the 100 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 beneficiary on the same date of service) on an individual test basis, instead of as part of a group, or for tests which were duplicative of each other. Projecting the results of our statistical sample to the population using standard statistical methods, we estimate the State agency overpaid providers $2,194,072 (Federal share $1,097,036) for chemistry and hematology tests. At the 90 percent confidence level, the precision of this estimate is plus or minus $463,671 (21.13 percent).

State agency officials indicated that the three chemistry procedures were not bundled because the tests are not listed as automated, multichannel tests for bundling according to the Physicians' Current Procedural Terminology (CPT) guidelines. With respect to hemogram indices claimed with hemogram profiles, the State agency relied on the CPT which defines these procedures as "additional" indices. We were advised that instructions to providers are being updated and will be issued in the next year.

RECOMMENDATIONS

We are recommending that the State agency: (1) ensure that its edits detect and prevent payments for unbundled tests and duplicative tests by addressing the specific overpayment causes enumerated in this report; (2) update and clarify its policies and instructions to providers to include additional procedures which are subject to edits for unbundled and duplicate tests; (3) determine the amount of potential overpayment by provider and obtain recoveries of actual overpayments from those providers with the largest total potential overpayments; and (4) make adjustments for the Federal share of the amounts recovered by the State agency on its Quarterly Report of Expenditures to the Health Care Financing Administration (HCFA). Based on our audit, we estimate that $2,194,072 (Federal share $1,097,036) could be recovered from all providers for CYs 1993 and 1994.

The audit results are presented in detail in the FINDING AND RECOMMENDATIONS section of this report and summarized in APPENDICES A and B. The State agency's written response to our draft report is summarized below and attached as APPENDIX C.

STATE AGENCY COMMENTS

State agency officials do not agree the two primary findings resulted in overpayments during the audit period. State agency officials do not intend to change their edits or policies for the three chemistry procedures because they believe Medicaid regulations, the CPT handbook, and recent Medicare guidance do not require these procedures to be bundled. For the audit period, the hemogram indices were not considered duplications of hemogram profiles based on recommendations from the State agency's physician consultants and the CPT handbook. Although the projected overpayments did not pertain to several chemistry procedures (see page 6), the State agency agreed it would identify overpayments related to these procedures and refund the Federal share, when recovered.

OIG RESPONSES

We believe the two primary findings resulted in overpayments based on Medicaid rules and CPT definitions which existed during the audit period. The State Medicaid Manual precludes paying more for laboratory tests than Medicare pays. The Illinois carrier determined that laboratories frequently perform the three chemistry procedures as part of a panel and, therefore, required these tests be bundled and reimbursed at the lower panel fee since at least 1987. When the State agency reimburses these tests individually rather than as a panel, it pays more than Medicare. By CPT definition, the two hemogram indices duplicate automated hemogram profiles and, thus, should not be reimbursed when claimed with a profile.

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INTRODUCTION

BACKGROUND

Clinical laboratory services include chemistry and hematology tests. Laboratory tests are performed on a patient's specimen to help physicians diagnose and treat ailments. The testing may be performed in a physician's office, a hospital laboratory, or by an independent laboratory.

Chemistry tests involve the measurement of various chemical levels in the blood while hematology tests are performed to count and measure blood cells and their content. Chemistry tests frequently performed on automated equipment are grouped together and reimbursed at a panel rate. Chemistry tests are also combined under problem-oriented classifications (referred to as organ panels). Organ panels were developed for coding purposes and are to be used when all of the component tests are performed. Many of the component tests of organ panels are also chemistry panel tests.

Hematology tests that 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.

Within broad Federal guidelines, States design and administer the Medicaid program under the general oversight of HCFA. Claims processing is the responsibility of a designated Medicaid agency in each State. Many States use outside fiscal agents to process claims; however, in Illinois, the State agency processes Medicaid claims.

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, clinical laboratory services are reimbursed at the lower of a fee schedule amount or the actual charge.

Each Medicare carrier (the contractor that administers Medicare payments to physicians and independent laboratories) maintains a fee schedule showing the maximum amount Medicare can pay for clinical laboratory services and provides it to the State Medicaid agency in its locality to allow comparison with Medicaid fees. To ensure compliance, we believe the State Medicaid agency should know not just the maximum Medicare fee for each procedure code but which procedure code and fee Medicare would reimburse when certain code combinations are claimed. The coding conventions used in the audit were primarily based on the Physicians' Current Procedural Terminology (CPT) guidelines for

bundling automated, multichannel chemistry tests; a HCFA memorandum, dated April 8, 1993, regarding laboratory coding changes; the CPT definitions for hematology procedure codes in our review; and edits used by the Illinois Medicare carrier.

OBJECTIVE, 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 the State agency's procedures and controls over the processing of Medicaid payments to providers for certain clinical laboratory services. Our review was limited to clinical laboratory services involving the chemistry and hematology tests shown in APPENDIX B.

To accomplish our objective, we:

- reviewed the State agency's procedures and controls relative to processing Medicaid claims for the clinical laboratory services included in our audit;

- extracted from the State agency's CY 1993 and 1994 paid claims files, all claims with payments for the chemistry and hematology procedures included in APPENDIX B. From this extract, we determined that claims totaling $3,235,319 represented instances involving claims that contained potentially unbundled or duplicate charges for chemistry and hematology tests (See Appendices A and B). We tested the reliability of computer generated output by comparing data to source documents for our sampled items. We did not, however, assess the completeness of data in the State agency's paid claims files nor did we evaluate the adequacy of the input controls;

- selected a stratified random sample of 100 instances (50 from a stratum of 228,093 instances involving chemistry tests and 50 from a stratum of 89,958 instances containing hematology tests). These instances were taken from a universe of payments representing claims for more than one chemistry panel or hematology profile, or for a panel or profile and individual tests, or for more than one 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;

- utilized a variable sample appraisal methodology to estimate the amount of overpayment for the chemistry and hematology tests in our audit.

Our review of internal controls was limited to an evaluation of the claims processing function related to Medicaid claims for the clinical laboratory services included in our audit. Specifically, we reviewed State agency policies and procedures and instructions to providers pertaining to the billing of clinical laboratory services. We also reviewed State agency documentation relating to automated and manual edits for bundling of chemistry

tests and the detection of duplicate claims for hematology tests. We limited our review to claims paid by the State agency during CYs 1993 and 1994. Details of the methodology used in selecting and appraising the sample are contained in APPENDIX A to this report.

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

We performed our audit between September 1995 and May 1996. We met with State agency officials at their office in Springfield, Illinois in September 1995 and June 1996. Audit fieldwork was conducted primarily at our office in Madison, Wisconsin using information obtained via mail from the State agency. We complied with the State agency's requirement that we submit our questions and requests for information to them in writing. We also provided State agency officials with lists of sampled claims and other finding details during the audit. In turn, State agency officials provided written responses to our questions, requests and findings. Their written response to our draft report is summarized in the STATE AGENCY COMMENTS AND OIG RESPONSES section of this report with the complete response attached as APPENDIX C.

FINDING AND RECOMMENDATIONS

Although the State agency established a system of edits which covered the majority of procedure codes included in our review, the absence of certain edits allowed some improper payments to be made to providers. Our examination of 100 instances of potential payment errors disclosed that the State agency's claims processing system did not edit for three chemistry procedure codes commonly bundled into panels (28 instances), chemistry procedures with more than one unit claimed (1 instance), hemogram indices claimed with hemogram profiles (49 instances), and a platelet count test claimed with a hemogram profile, including platelets (1 instance). Further, the State agency's policies and its instructions to medical providers did not include the three chemistry tests in our finding or enumerate which hematology procedure codes were duplicative.

The results of our audit were based on a statistical sample and projection of results. Using computer applications, we extracted claims data with applicable chemistry and hematology procedure codes from computer tapes of claims paid during CYs 1993 and 1994. This extract yielded a total of 1,215,120 chemistry tests and 1,463,007 hematology tests (See Appendices A and B for details). From this extract, we identified instances of potential payment errors made to providers for services rendered to the same beneficiary on the same date of service. The population of claims with potential payment errors totaled 318,051 instances (228,093 for chemistry tests and 89,958 for hematology tests) with a value of $3,235,319.

We randomly selected a sample of 100 instances (50 instances involving claims with chemistry panel tests and 50 instances involving claims with hematology tests) valued at $1,558 from the population of claims with potential payment errors totaling $3,235,319. Our review showed that 79 of the 100 claims were overpaid. Projecting the results of our statistical sample to the population using standard statistical methods, we estimate the State agency overpaid providers $2,194,072 (Federal share $1,097,036) for chemistry and hematology tests during the 2-year audit period. At the 90 percent confidence level, the precision of this estimate is plus or minus $463,671 (21.13 percent).

Chemistry Panel Tests

Our review of 50 instances involving paid claims containing potentially unbundled charges for chemistry tests disclosed that 29 instances contained overpayments. The sample of 50 instances were selected on a scientific random basis from a population of 228,093 instances involving claims containing potentially unbundled chemistry panel tests valued at $2,337,538. Based on our statistical sample, we estimate the State agency overpaid providers $1,880,946 (Federal share $940,473) for unbundled chemistry panel tests for the 2-year audit period.

The State agency properly bundled and reimbursed the chemistry procedures claimed in 21 of the 50 instances we reviewed. However, the State agency overpaid providers in the remaining 29 instances because the State agency's claims processing system did not:

1. bundle three procedure codes (82550, 82977 and 84478) which the Illinois Medicare carrier, like most carriers, normally bundles and reimburses as a chemistry panel (28 instances).

2. include the same three procedure codes in its policies and procedures for bundling or its instructions to providers (28 instances).

3. correctly bundle tests when multiple units of a panel or test were claimed until July 28, 1993 (1 instance).

As previously stated in the BACKGROUND section of this report, the Medicaid program may not pay more for laboratory tests than the amount Medicare recognizes for such tests. In addition, section 5114.1.L.2of the Medicare Carriers Manual states 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 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 equipment.

At the Medicare carrier's discretion, certain procedures that are available as part of an automated panel test are combined into a chemistry panel and paid at the lesser panel fee. Most Medicare carriers, including the Illinois carrier, bundle three chemistry procedure codes (82550, 82977 and 84478) into a panel when determining the amount of reimbursement allowed. In August 1993, the Medicare carrier provided its coding policies for bundling chemistry tests (including these three procedures) to the State agency in the form of a monthly provider bulletin.

State agency officials do not agree they have overpaid providers because they believe there is some discretion allowed when determining whether these three procedures should be bundled into a panel. They do not bundle these procedures because the CPT does not identify the procedures as automated, multichannel tests. Consequently, neither their claims processing edits nor their instructions to providers require these tests to be included in a panel for reimbursement. State agency officials maintain the Medicaid program is not required to follow Medicare payment procedures and pricing guidelines. They believe it is their responsibility to only ensure the Medicaid fees per test do not exceed Medicare fees for the same tests. As a result, the State agency does not plan to implement an edit to bundle these three procedures into a panel or modify their policies and instructions to providers.

We disagree, to ensure compliance with the requirement that Medicaid pay less than Medicare, we believe the State agency should know not just the Medicare fee for each procedure code but which procedure codes Medicare would bundle and reimburse at a lower panel fee.

Regarding the one instance in which multiple quantities of a test were not bundled, State agency officials agree that at the time this claim was processed, an overpayment was made. Initially, the chemistry pricing logic in their computer system had difficulty counting the number of tests when a quantity greater than one was claimed for a test. They informed us this weakness was corrected by July 28, 1993.

Other Matters. Our review of the State agency's claims processing edits and written instructions to providers disclosed other weaknesses which could result in overpayments. We could not readily quantify the effect of these weaknesses but the State agency is reportedly making improvements to correct these weaknesses.

Most significantly, the State agency did not bundle the hepatic function panel (80058) when claimed with any of 31 procedure codes in our review. This panel was not bundled because the CPT did not identify any of the 31 procedures as being among the 5 chemistry tests comprising the hepatic function panel. However, in a memorandum dated April 8, 1993, HCFA officials directed Medicare carriers to count the hepatic function panel as a five-test panel to be bundled into a larger panel, dependent on the number of other chemistry procedures claimed. The Medicare carriers were to advise Medicaid State agencies of this change in procedures. State agency officials indicated they did not receive the memorandum from the Medicare carrier and were unaware of the need to bundle the hepatic function panel with other chemistry tests. Beginning in March 1996, they implemented an edit to bundle this procedure into the appropriate chemistry panel for reimbursement.

The total protein test (84160) was not bundled for payment when claimed with any of the other chemistry procedures in our audit, except the general health panel (80050). Initially, the State agency's physician consultants advised against including this test in a panel. After we inquired about the nonbundling, their physician consultant agreed the test should be bundled and an edit has now been established.

There was no edit to bundle a phosphorus test (84100) when claimed with either the general health panel (80050) or the hepatic function panel (80058). State agency officials agreed to add the phosphorus test to its edit for both panels.

The State agency's instructions to providers could be improved. While the instructions to providers referred to the CPT manual for guidance, neither the physicians handbook nor the laboratory handbook cited specific procedure codes to bundle. The laboratory handbook, last issued in 1981, was outdated with respect to procedure codes, error code definitions, and references to CPT pages. It also omitted the requirement to bundle two or more chemistry tests as set forth in the physicians handbook. State agency officials plan to issue updated versions of the laboratory and physicians handbooks during fiscal year 1997.

Hematology Profiles

Our review of 50 instances involving paid claims for potentially duplicate hematology tests disclosed that all 50 instances contained paid duplicate tests. These 50 instances were selected on a scientific random basis from a population of 89,958 instances involving potentially duplicate hematology tests valued at $897,781. Based on our statistical sample, we estimate the State agency overpaid providers $313,126 (Federal share $156,563) for duplicated hematology tests for the 2-year audit period.

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.

Hematology tests are performed and billed in groups or combinations of tests known as profiles; however, 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. In addition, duplicate billings occur when hematology indices are billed with a hematology profile. Hematology indices are calculations from the results of hematology tests. Since hematology indices are calculated along with the performance of each hematology profile, a separate billing for hematology indices results in a duplicate billing.

The State agency did not detect all claimed duplicate hematology charges and, as a result, overpaid some claims. This condition occurred because the State agency did not:

1. deny payment for either of two automated hemogram indices (85029 or 85030) when claimed with at least one automated hemogram profile (85021, 85022, 85023, 85024, 85025 or 85027) (49 instances).

2. deny payment for a platelet count (85595) when claimed with a hemogram profile that included platelets (85024) until August 27, 1993 (1 instance).

3. include hematology procedure code combinations subject to duplication in its policies and procedures or its instructions to providers (50 instances).

State agency officials do not agree they overpaid providers for hemogram indices during the audit period. The State agency did not bundle automated hemogram indices claimed with automated hemogram profiles because their physician consultant advised that codes 85029 and 85030 represent indices which are in addition to the indices included in hemograms. Separate payment was allowed for codes 85029 and 85030 based on the CPT description "Additional automated hemogram indices" for these codes. After we inquired about this condition, State agency officials agreed to deny the two indices in the future because they duplicate indices included in hemogram profiles.

Regarding the payment for a platelet count claimed with a hemogram that includes platelets, State agency officials indicated they did not have an edit in place to detect this condition at the time they processed this claim. They subsequently implemented an edit on August 27, 1993 to deny payment of this coding combination.

With respect to policies and procedures, we noted the Pricing Unit Procedures Manual, issued in October 1989, only provides for rejecting or reducing the allowable amount for any component of a complete blood count (CBC) that is billed with a CBC. The Manual does not enumerate the specific procedure code combinations from 85000 to 85999 subject to such adjustments. In addition, the instructions to providers did not identify the specific hematology procedures that would represent duplicated services. State agency officials commented that, due to the large number of codes, it is not possible to identify every situation of duplication in its procedures or the provider handbooks. Rather than identify procedure codes, the State agency plans to refer to tests by name when issuing its updated instructions to providers in FY 1997.

In summary, the State agency's claims processing system had edits in place for most of the procedure codes in our audit. In addition, they have taken some corrective action during the audit period and plan further changes thereafter. We believe that the remaining conditions reported represent opportunities for improvement in claims processing and that recoveries from providers which received large overpayments should be pursued.

RECOMMENDATIONS

We recommend that the State agency:

(1) Ensure its edits detect and prevent payments for unbundled tests and duplicative tests by addressing the specific overpayment causes enumerated in this report.

(2) Update and clarify its policies and instructions to providers to include additional procedure codes which are subject to edits for unbundled and duplicative tests.

(3) Determine the amount of potential overpayment by provider and obtain recoveries of actual overpayments from those providers with the largest total potential overpayments. We estimate overpayments amounting to $2,194,072 (Federal share $1,097,036) could be recovered from all providers for CYs 1993 and 1994.

(4) Make adjustments to its Quarterly Report of Expenditures for the Federal share of amounts recovered by the State agency.

STATE AGENCY COMMENTS AND OIG RESPONSES

During the audit fieldwork, State agency officials provided comments on our findings which are included in the FINDING AND RECOMMENDATIONS section of the report. In addition, the State agency commented on our draft report in a letter dated September 5, 1996 (see APPENDIX C). The comments pertain to each of the four recommendations. We summarized the State agency's written comments and our responses in the following paragraphs.

STATE AGENCY COMMENTS

With respect to our recommendation for edits, State agency officials indicated they do not allow more than the Medicare amount for any individual lab test; however, the Medicaid payment for various combinations of tests may deviate from the Medicare reimbursement because the State agency does not bundle procedures exactly the same as Medicare. They are not aware of any regulation that requires the State agency to mirror Medicare's bundling procedures.

Regarding recommended changes to policies and instructions to providers, the State agency will not bundle three chemistry procedures (82550, 82977 and 84478) that comprise nearly all of the reported chemistry findings. The State agency claims that it consistently followed CPT guidelines which did not include these tests among procedures that should be bundled into panels. They also stated that, according to recent Illinois Part B Bulletins, Medicare did not bundle procedures 82977 and 84478 until January 1, 1996. Therefore, the State agency believes it should not be held accountable for not bundling these chemistry procedures during the audit period.

The projected overpayments and recommendation for recoveries primarily relate to three chemistry procedures (listed above) and three hematology procedures (85029, 85030 and 85595). As described in the prior paragraph, the State agency does not agree that overpayments were made for the chemistry procedures. The State agency also disagrees that overpayments were made during the audit period for the three hematology procedures based on their physician consultants' recommendations and CPT definitions.

The projected overpayments were not directly attributable to four chemistry procedures (80050, 80058, 84100 and 84160) reported in Other Matters (page 6). However, the State agency responded that they now apply edits to bundle these procedures and have agreed to determine the amount overpaid, bill the providers for recoveries, and make the appropriate adjustment for the Federal share on the Quarterly Report of Expenditures.

OIG RESPONSES

Regarding the two most significant findings, we believe the Medicaid rules require the three chemistry procedures be bundled into panels for reimbursement and that, by CPT definitions, the two hemogram indices (85029 and 85030) duplicate automated hemogram

profiles. Because the Medicaid rules and CPT definitions existed during the audit period, we believe the conditions we found represent overpayments.

Chemistry. Section 6300 of the State Medicaid Manual mandates that the State agency ensure the Medicaid program does not pay more than Medicare for laboratory procedures. If the State agency reimburses the three chemistry tests as individual tests under Medicaid rather than at the lower panel fee, it pays more than Medicare. The excess reimbursement represents an overpayment for which the State agency cannot claim Federal matching funds.

Although the CPT guidelines did not specifically list the three chemistry procedures among the automated, multichannel tests to be bundled, most Medicare carriers bundle these procedures into a panel for reimbursement. The Medicare Carriers Manual [section 5114.1.L.2] states carriers are to exercise judgement in deciding whether to bundle individual tests into a panel by considering whether the individual tests are frequently performed as part of an automated panel test. We conclude that, since the Illinois carrier has bundled these three procedures for many years, they determined Illinois laboratories frequently perform the tests as part of an automated panel. Therefore, when any of these tests is performed as part of a group of tests, the group should be reimbursed at the lesser panel amount based on the common practice of laboratories in the State.

The State agency referred to recent Illinois carrier bulletins which stated that Medicare required two (82977 and 84478) of the three chemistry tests in question be bundled starting in January 1996. Actually, the Illinois carrier has required the three tests be bundled into chemistry panels since 1987. Further, in an August 1993 Medicare bulletin, the Illinois carrier listed the three tests among chemistry tests which should be bundled and reimbursed at the lower panel fee. We were told these bulletins have been routinely provided to State agency personnel. The more recent carrier bulletins referred to by the State agency were based on HCFA instructions to add the three chemistry tests to the list of automated tests which should be bundled.

Hematology. We believe the CPT definitions show that reimbursement of either hemogram indices with any of the six hemogram profiles (see APPENDIX B) duplicates reimbursement. Indices are measurements and ratios calculated from the hematology test results. Procedure code 85029 is defined as one to three indices and procedure code 85030 is defined as four or more indices. The CPT guidelines, however, also define an automated hemogram profile as including indices. Therefore, reimbursing both a hemogram indices and a hemogram profile, which includes indices, is a duplication which results in an overpayment. Even though State agency officials did not agree that overpayments were made during the audit period, they did agree to implement edits for hematology indices claimed with profiles after the audit period.

APPENDICES

SAMPLE METHODOLOGY

At our request, the Illinois Department of Public Aid provided us with its computer tapes of claims paid during calendar years (CY) 1993 and 1994. From these paid claims tapes, we utilized computer applications to extract all claims containing:

1. automated, multichannel chemistry panels and panel tests for chemistry procedure codes listed in the Physician's Current Procedural Terminology (CPT) handbook and other chemistry panel tests bundled by most Medicare carriers. (See APPENDIX B)

2. hematology profiles and component tests normally included as part of a hematology profile for hematology procedure codes listed in the CPT handbook. (See APPENDIX B)

The resulting file extract consisted of 1,215,120 records for chemistry panel tests and 1,463,007 records for hematology component and profile tests.

We then performed computer applications to match 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 test; 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.

This matching application resulted in a population totaling $3,235,319 consisting of two strata. The first stratum consisted of 228,093 instances totaling $2,337,538 for potentially unbundled chemistry panel tests. The second stratum consisted of 89,958 instances totaling $897,781 for potentially duplicate hematology profile tests. 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 were duplicative of each other.

Using a stratified random selection basis, we examined 100 instances involving claims from the two strata. The first stratum consisted of a sample of 50 instances of potentially unbundled chemistry panel tests totaling $1,059. The second stratum consisted of a sample of 50 instances of potentially duplicate hematology profile or profile component tests totaling $499.

For the sample items, we reviewed supporting documentation from the State agency consisting of copies of physician, hospital or independent laboratory claims, State agency payment vouchers, and paid claims histories.

We utilized a standard scientific estimation process to quantify overpayments for unbundled chemistry panel tests and duplicate hematology profile tests as shown in the following schedule.

Stratum	Number of Instances	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
Chemistry Tests	228,093	50	$1,059	29	$412	$1,880,946
Hematology Tests	89,958	50	$499	50	$174	$313,126
Totals	318,051	100	$1,558	79	$586	$2,194,072

The results of the scientific sample disclosed that 79 of 100 instances we reviewed represented overpayments for unbundled chemistry panel tests or contained a duplicate payment for a hematology profile component test. Projecting the results of the statistical sample to the population using standard statistical methods, we estimate that $2,194,072 (Federal share $1,097,036) paid for unbundled chemistry panel tests and duplicate hematology profile tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus $463,671 (21.13 percent).

CLINICAL LABORATORY PROCEDURES REVIEWED
AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCS

Chemistry Panel CPT Codes

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

Chemistry Tests Subject to Panelling (34 CPT Codes)

1.	Albumin	82040
2.	Albumin/globulin ratio	84170
3.	Bilirubin Total OR Direct	82250
4.	Bilirubin Total AND Direct	82251
5.	Calcium	82310, 82315, 82320, 82325
6.	Carbon Dioxide Content	82374
7.	Chlorides	82435
8.	Cholesterol	82465
9.	Creatinine	82565
10.	Globulin	82942
11.	Glucose	82947
12.	Lactic Dehydrogenase (LDH)	83610, 83615, 83620, 83624
13.	Alkaline Phosphatase	84075
14.	Phosphorus	84100
15.	Potassium	84132
16.	Total Protein	84155, 84160
17.	Sodium	84295
18.	Transaminase (SGOT)	84450, 84455
19.	Transaminase (SGPT)	84460, 84465
20.	Blood Urea Nitrogen (BUN)	84520
21	Uric Acid	84550
22.	Triglycerides	84478
23.	Creatinine Phosphokinase (CPK)	82550, 82555
24.	Glutamyl transpetidase, gamma	82977

CLINICAL LABORATORY PROCEDURES REVIEWED
AUTOMATED HEMATOLOGY PROFILE AND COMPONENT TEST HCPCS

Hematology Component Test CPT Codes

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

Additional Hematology Component Tests - Indices

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

Hematology Profile 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

Robert W. Wright
Director

Illinois Department of Public Aid

Jesse B. Harris Building
100 South Grand Avenue East
Springfield, Illinois 62762-0001

September 5, 1996

Mr. Paul Swanson
Regional Inspector General for Audit Services
Office of Inspector General
Department of Health and Human Services
Region V, 105 West Adams Street
Chicago, IL 60603-6201

RE: CIN: A-05-95-00062

Dear Mr. Swanson:

Attached is our response to your report on the Review of Medicaid Clinical Laboratory Services for Calendar Years 1993 and 1994. I am responding for Robert W. Wright, Director.

We have reviewed the report and addressed each recommendation. Details are included in the attachment.

If your staff have any questions, please have them contact Eappen Thomas or Mary Fritz at (217) 782-1156.

Sincerely,

James R. Donkin, CIA
Chief Internal Auditor

JRD:ew
Attachments

Attachment

**Review of Medicaid Clinical Laboratory Services
for Calendar Years 1993 and 1994**

Agency Response

Recommendation 1:

Ensure State agency's edits detect and prevent payments for unbundled tests and duplicative tests by addressing the specific overpayment causes enumerated in this report.

IDPA Response:

Currently, IDPA does not exceed the Medicare Allowable Amount for any individual lab test. However, we do not bundle procedure codes in every situation exactly as Medicare; therefore, IDPA payment, for various combinations of lab tests, will deviate from Medicare's payments.

We are not aware of any rules/regulations that mandates IDPA to mirror Medicare's bundling procedures.

Recommendation 2:

Update and clarify State agency's policies and instructions to providers to include additional procedure codes which are subject to edits for unbundled and duplicative tests.

IDPA Response:

IDPA will not bundle codes 85550, 82977 and 84478 with panel codes because we have consistently utilized the Physicians' Current Procedural Terminology (CPT) guidelines for bundling. These three (3) codes are not included in the panels according to the CPT.

Not only do we disagree with the citing of overpayments but furthermore, we disagree with the methodology by which these overpayments have been determined since Medicare began bundling two of the three codes (82977 and 84478) for service dates of January 1996 and after. Therefore, the Department cannot be held accountable for not bundling these services for this audit period. Please reference the attached December 1995 and January 1996 pages from the Medicare B Bulletin for Illinois.

Recommendation 3:

Determine the amount of potential overpayment by provider and obtain recoveries of actual overpayments from these providers with the largest total potential overpayments. We estimate overpayments amounting to $2,194,072 (Federal share $1,097,036) could be recovered from all providers for CY 1993 and 1994.

**Review of Medicaid Clinical Laboratory Services
for Calendar Years 1993 and 1994**

Agency Response

IDPA Response:

We agree that overpayments were made for the chemistry procedure codes of 80050, 80058, 84100 and 84160. Edits have now been applied to these codes for bundling purposes. We will determine the potential amount of overpayment that were made for the procedure codes 80050, 80058, 84100 and 84160 and bill the providers for recoveries.

We disagree that overpayments were made for the hematology procedure codes of 85029, 85030 and 85595 because IDPA did not bundle these services, for the dates of service in question, based upon IDPA's Physician Consultants recommendations and the fact that the CPT does not depict bundling for these services.

We also disagree that overpayments were made for the chemistry procedure codes of 82550, 82977 and 84478 for the same reasons as depicted in response to Recommendation 2.

Recommendation 4:

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

IDPA Response:

Once the overpayments are recovered from the providers for procedural codes 80050, 80058, 84100 and 84160, then IDPA will make the appropriate adjustments to the Quarterly Report of Expenditures for the Federal share of amounts recovered by IDPA.

The following new temporary codes are to be used when a glucose tolerance test is performed on a device that is approved by FDA for quantitative determination of glucose for use in the diagnosis and treatment of the diabetic patient. **NOTE:** The typical home glucose monitoring devices are not approved for diagnosis. They are only approved for monitoring.

G0055 Glucose post dose (includes glucose), direct measurement by a glucose testing device approved by FDA for use in the home. (CLIA waived test).

G0056 Glucose tolerance test (GTT), by direct measurement by a glucose testing device approved by the FDA for use also in the home, three specimens (including glucose) (CLIA waived test).

G0057 Glucose tolerance test (GTT), by direct measure by a glucose testing device approved by the FDA for use also in the home, each additional beyond three specimens (including glucose) (CLIA waived test).

Previously, code 80019 referenced automated multichannel tests; 19 or more clinical chemistry tests. This code is revised and is now only used to bill for automated multichannel tests; 19 clinical chemistry tests.

Three tests are added to the list of tests which are considered automated tests. The additional tests are: cholesterol (83721), gammaglutamyltransferase (GGT) (82977), and triglyceride (84478). The following new temporary codes are used when more than 19 automated tests are performed:

G0058 Automated multichannel test; 20 clinical chemistry tests
G0059 Automated multichannel test; 21 clinical chemistry tests
G0060 Automated multichannel test; 22 clinical chemistry tests

This is a reminder that the only acceptable Medicare definition for the component tests included in the CPT-4 codes for organ or disease oriented panels is the AMA definition of component tests. All of the tests in the definition must be performed in order to bill using those codes. If a laboratory uses a custom panel definition that includes other tests in addition to those in the CPT definition, the additional tests are to be billed separately in addition to the CPT panel code if the CPT panel code is billed.

Code 80055, obstetric panel, is not considered a valid billing code for Medicare purposes. If code 80055 is billed, it is treated as a G status code. This means code 80055 is not subject to the grace period and payment amounts have not been provided. Code 80055 must be recoded into its individual tests and paid on the basis of the individual component tests that are included in the panel. Code 85025 is assumed to be the CBC test performed.

A fee schedule amount did not appear in the 1995 file for code 80061, lipid panel. The 1996 fee schedule amount for code 80061 was derived by adding codes 83718 and 80002.

Previously, code 80410 was used for a calcitonin calcium pentagastrin stimulation panel. This code is revised for 1996 and now references a calcitonin stimulation panel (e.g., calcium, pentagastrin).

In 1995, code 81000 referenced urinalysis, by dipstick or tablet reagent for bilirubin, glucose, hemoglobin, ketone, leukocytes, nitrate, pH, protein, specific gravity, urobilinogen, any number of these constituents; with microscopy. Code 81000 denoted both non-automated and automated urinalyses, with microscopy. For 1996, code 81000 now references a non-automated urinalysis, with microscopy and new code 81001 references an automated urinalysis, with microscopy. In 1995, code 85651 was used for a non-automated sedimentation rate: erthyrocyte. There was no automated erthyrocyte sedimentation rate. For 1996, new code 85652 now references an automated sedimentation rate; erthyrocyte.

(crossover companies continued)
First Providian Life and Health of New York (formerly National Home Life of New York)
Providian Life and Health Assurance Company (formerly National Home Life Assurance)
Union Labor Life
CUNA Mutual
Standard Life
Torchmark Companies:
United American Life and Accident Insurance Company
Globe Life Insurance Company
J.C. Penney
1st United American Life Insurance
Union Bankers Insurance Company
United Commercial Travelers
USAA Life Insurance Company
Wausau

CLINICAL LABORATORY: CORRECTION

Information regarding the addition of three automated tests was originally given in the 1995 December Bulletin (page 13). One of the tests, cholesterol, CPT code 83721, *Lippoprotein, direct measurement; high density cholesterol (LDL cholesterol)* was incorrectly listed as an added service. Cholesterol - CPT 83271 was already considered a covered automated test. Beginning with dates of service on and after January 1, 1996, the three tests to be added to the list of tests which are to be considered automated are creatine kinase (CK, CPK), gamma glutamyl transferase (GGT), and Trigliceride.

Also, on January 1, 1996, a revision occurs in the terminology for CPT- 4 code 80019. Currently, CPT code 80019 references *automated multichannel test; 19 or more clinical chemistry tests*, but on the effective date, CPT- 4 80019 will reference *automated multichannel test; 19 clinical chemistry tests.*

OPTICAL CHARACTER RECOGNITION: TIP OF THE MONTH

Medicare B requests that providers submitting paper claims bill the actual number of services that were provided to the beneficiary. This information should be placed in box 24G on the HCFA 1500 claim form. For example, if the number of services provided was 1, bill 1, if the number of services provided was 15, bill 15, and so on.

UPDATED ICD-9-CM COVERAGE

(This information was originally published in the October 1995 Medicare B Bulletin for Illinois (page 11). However, the month indicating what Bulletin to reference for original policy were inadvertently omitted. Below is the information with the Bulletin referenced to the correct month.)

Effective for claims processed on and after November 15, 1995, Medicare will cover the following CPT codes when billed with the ICD-9-CM codes listed.

CPT Code	ICD-9-CM Code
80091, 80092	427.31 Atrial fibrillation 427.32 Atrial flutter These codes are in addition to the policy published in the April 1995 Medicare B Bulletin for Illinois (page 12)

UPDATED ICD-9-CM COVERAGE

Beginning with new claims processed on and after February 15, 1996, Medicare will cover the CPT codes below when billed with the additional ICD-9-CM codes listed:

CODE(S)	ICD-9-CM CODE(S)	ORIGINALLY PUBLISHED
72192-72194, 74150-74170, 72196, 74181	V10.05, V10.52	JULY 1995 BULLETIN
J9213	183.2-183.8, 203.00-203.81	OCT 1994 BULLETIN
J9214	183.2-183.8, 191.0-191.8, 203.30-203.31, 203.80-203.81	OCT 1994 BULLETIN
J9265	188.8	–