

**Memorandum**

MAR 26 1996

Date

From

Michael Mangano
for June Gibbs Brown
Inspector General

Subject

Clinical Laboratory Services Provided Under the Missouri Medicaid Program
(A-07-95-01138)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This memorandum alerts you to the issuance on March 29, 1996 of our final audit report to the Missouri Department of Social Services 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, we evaluated claims for chemistry, hematology, and urinalysis tests to determine if the tests were appropriately grouped for payment (bundled) and whether payments included duplicate services.

Our review disclosed that the State agency did not have procedures to prevent paying for unbundled or duplicate laboratory services. We found that 121 of the 150 sampled claims were overpaid. Based on our audit, we estimate that providers received excess reimbursement of \$1,091,587 (Federal share \$653,315) during CYs 1993 and 1994 for clinical laboratory services that were unbundled or duplicated.

We are recommending that the State: (1) install edits to prevent payments for unbundled or duplicate services, (2) instruct providers on bundling requirements, (3) identify and recover CYs 1993 and 1994 overpayments from providers, and (4) return the Federal share of recovered overpayments to the Health Care Financing Administration (HCFA).

With regard to our first and second recommendations, the State is in partial agreement and is developing system editing capabilities that will more closely screen individual laboratory tests against panel tests. In addition, the State is notifying providers of the restriction against unbundling of laboratory tests.

The State did not concur with our recommendations three and four and requested our office to reconsider the recommendations to recover the overpayments for CYs 1993 and 1994 and to return the Federal share of the overpayments recovered. The State cited

that (1) laboratory reimbursement did not exceed Medicare reimbursement for specific laboratory procedures, (2) Medicaid rules did not require the State to follow Medicare rules regarding bundling of laboratory procedures for reimbursement purposes, and (3) post-payment review procedures result in lump-sum recoupments from providers that do not appear as adjustments to specific recipient claims and suggested that some of the overpayments in our review may have been recouped in this manner. However, the State plans to conduct a special review of the laboratory test providers included in our review as well as any others that may be identified by the State as billing inappropriately and recoup overpayments if inappropriate claims are found.

In response to the State's reasons for nonconcurrency: (1) our audit compared reimbursement for the State's unbundled versus bundled rates rather than comparing payment rates for specific laboratory tests; (2) Medicaid policy, promulgated by HCFA, requires States to observe Medicare rules governing reimbursement of clinical laboratory services, including schemes for bundling tests; and (3) we agree with the State approach to recover potential overpayments. Therefore, our recommendations should remain as originally reported.

In light of the error factor of unbundled/duplicated claims submitted to the State agency, we will be continuing our review to determine the possibility of questionable billing practices by providers. Our audit and investigative staffs will be working with HCFA staff and the State Medicaid Fraud Control Unit to identify instances of abuses.

Attachment

For further information, contact:
Barbara A. Bennett
Regional Inspector General
for Audit Services, Region VII
(816) 426-3591

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**CLINICAL LABORATORY SERVICES
PROVIDED UNDER THE
MISSOURI MEDICAID PROGRAM**



JUNE GIBBS BROWN
Inspector General

MARCH 1996
A-07-95-01138



Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

CIN: A-07-95-01138

Mr. Gary Stangler, Director
Missouri Department of Social Services
Broadway State Office Building
P.O. Box 1527
Jefferson City, Missouri 65102-1527

Dear Mr. Stangler:

This report provides you with the results of an Office of Inspector General (OIG), Office of Audit Services (OAS) review entitled, *Clinical Laboratory Services Provided Under The Missouri Medicaid Program*. Our objective was to determine the adequacy of procedures for payment of clinical laboratory claims. Specifically, we evaluated claims for chemistry, hematology, and urinalysis tests to determine if the tests were appropriately grouped for payment (bundled) and whether payments included duplicate services. In conducting the audit, we applied Medicaid rules which prohibit Federal matching funds for laboratory claims payments which exceed the amount Medicare commonly allows for such laboratory claims.

Medicaid providers received excess reimbursement estimated at \$1.1 million (Federal share \$653,315) during Calendar Years (CY) 1993 and 1994 for clinical laboratory services that were unbundled (not grouped for payment) or duplicated. The State did not have procedures to prevent paying for unbundled or duplicate laboratory services. We recommend the State (1) install edits to prevent payments for unbundled or duplicate services; (2) instruct providers on bundling requirements; (3) identify and recover 1993 and 1994 overpayments from providers; and (4) return the Federal share of recovered overpayments to the Health Care Financing Administration (HCFA).

The State did not concur with our findings and recommendations citing a number of issues such as that (1) laboratory reimbursement did not exceed Medicare reimbursement for specific laboratory procedures, (2) Medicaid rules did not require the State to follow Medicare rules regarding bundling of laboratory procedures for reimbursement purposes, and (3) post-payment review procedures resulted in lump-sum recoupments from providers that did not appear as adjustments to specific recipient claims suggesting that some of the overpayments in our review may have been recouped in this manner. The State also provided documentation showing that the Missouri Medicare carrier did not require bundling for four chemistry tests that were included in our analyses as tests which required bundling. As a result, we have

revised our estimate of excess reimbursement to exclude reimbursement involving the four chemistry tests. The State response is summarized in more detail following the recommendation section of this report along with our comments concerning the State response. The State response is included in its entirety as Appendix F.

INTRODUCTION

BACKGROUND

Medicaid is a federally-aided, State program that provides medical benefits to certain low income persons. Within broad Federal guidelines, HCFA provides general oversight and the States design and administer their individual Medicaid programs. The program, authorized by title XIX of the Social Security Act, requires States to provide certain medical services and permits them to provide other services, such as outpatient clinical laboratory services used to help diagnose and treat illness. Physician offices, hospital laboratories, or independent laboratories can provide clinical laboratory services.

Federal matching funds are not available to the extent a State pays more for outpatient clinical laboratory tests than the amount Medicare recognizes (State Medicaid Manual (SMM), sections 6300.1 and 6300.2). The Medicare organizations (carriers) that pay physicians and independent laboratories maintain the fee schedules that are provided to State Medicaid agencies. Medicare reimburses clinical laboratory services at the lower of fee schedule amounts or actual charges. Clinical laboratory services include chemistry, hematology, and urinalysis tests.

Reimbursement for chemistry tests frequently performed on automated equipment is limited to panel rates based on grouping individual tests together. Similar restrictions apply regarding organ panel rates, which involve combining chemistry tests under problem-oriented classifications. When testing includes doing all of the component tests, use of organ panel rates limits reimbursements. Many component tests of organ panels are also chemistry panel tests.

Hematology tests are performed and billed in groups or combinations of tests known as profiles of specific hematology tests. 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. Another situation which creates a duplicate billing is hematology indices that are billed with a hematology profile. Indices are measurements and ratios calculated 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.

Reimbursement for urinalysis tests depends on whether there is physical, chemical or microscopic analysis, or just examination of urine. A complete urinalysis includes testing for components and a microscopic examination. However, providers can perform and bill different levels of urinalysis testing including urinalysis with microscopic examination, urinalysis without microscopic examination or microscopic examination only. Based on the test performed and billed, unbundling or duplication of billing can occur.

SCOPE

We conducted our review in accordance with generally accepted government auditing standards. Our objective was to determine the adequacy of procedures for the payment of Medicaid claims involving clinical laboratory tests. Specifically, we reviewed payments for proper groupings and for duplicate services. The audit was limited to clinical laboratory services involving chemistry, hematology, and urinalysis tests listed in Appendix A.

In performing our review, we used the HCFA Medicaid Statistical Information System (MSIS). The HCFA operates the MSIS in collecting Medicaid eligibility and claims data from participating States. States participating in MSIS provide HCFA with quarterly eligibility and paid claims computer files. The eligibility file contains specified data for persons covered by Medicaid. The paid claims file contains adjudicated claims for medical services reimbursed by the program.

To accomplish our objective, we:

- o Reviewed State policies and procedures for payments regarding clinical laboratory services.
- o Extracted CYs 1993 and 1994 paid claims for clinical laboratory procedures listed in Appendix A from HCFA's MSIS. The extraction identified 186,447 instances of potential unbundling or duplication. Total reimbursement for the 186,447 procedures was \$3.3 million. We did not assess the accuracy of data in HCFA's MSIS files.
- o Selected 3 random statistical samples of 50 instances each involving chemistry claims, hematology claims, and urinalysis claims. Each instance represented a potential payment error in which the State paid providers for clinical laboratory tests (on behalf of the same recipient on the same date of service) on an individual test basis instead of as part of a group or for duplicate services. The 50 instances were selected from a universe of payments representing claims for more than one panel or for a panel and individual tests for the same recipient on the same date of service by the same provider.
- o Reviewed supporting documentation for the 150 randomly selected instances to determine the propriety of the payment.

- o Utilized a variable sample appraisal methodology in estimating overpayments for chemistry, hematology, and urinalysis tests.

Our review of internal controls was limited to evaluating the claims processing function related to clinical laboratory services. Specifically, we reviewed State policies, procedures, and instructions for the billing of clinical laboratory services. We also reviewed State documentation on edits involving the bundling of chemistry, hematology, and urinalysis tests. Appendix B contains details on the selection and appraising of our review sample.

We discussed the results of the audit with State officials. In addition, we provided copies of our worksheet analysis for each sample of unbundled and duplicate claims reviewed.

We performed our review in April and May 1995. During this period, we visited the State office in Jefferson City, Missouri.

RESULTS OF REVIEW

Medicaid providers received an estimated \$1.1 million in excess reimbursement during CYs 1993 and 1994, for chemistry, hematology, and urinalysis tests that were not grouped together for reimbursement or were claimed more than once. The excess reimbursement (which included chemistry tests of \$386,689, hematology tests of \$661,656, and urinalysis tests of \$43,242) occurred because the State had not established adequate procedures to identify unbundled laboratory service claims and duplicate billings which are not allowed for reimbursement under Medicaid.

Medicaid Requirements

Reimbursement for clinical laboratory tests under Medicaid cannot exceed the amount recognized by the Medicare program (section 6300.2 of the State Medicaid Manual). Medicare requires that the payment for separately billed laboratory tests, which are normally available as part of automated battery tests, should be based on the lesser amount of the battery tests. In addition, Medicare makes providers liable when payment errors are made due to overlapping or duplicate billings.

Chemistry Tests

State instructions to providers required chemistry tests to be bundled when three or more tests were administered. The State instructions should have required bundling when two or more test were involved. In addition, the State instructions to providers did not require bundling for four of the chemistry tests included in Medicare's list of chemistry tests to be bundled.

As a result, 21 of the 50 instances of unbundled chemistry tests that we reviewed contained overpayments. We estimate the State overpaid providers \$386,689 for unbundled or duplicated chemistry tests during CYs 1993 and 1994. Appendix C lists the frequency that

procedure code combinations occurred for the 21 instances of unbundled services in our sample of 50 that contained overpayments.

Hematology Profiles

For the hematology procedures included in our review, the State had not instructed providers of the reimbursement restrictions as established under Medicare. As a result, all 50 instances we reviewed involved hematology profiles that were duplicate charges. We estimate the State overpaid providers \$661,656 for duplicated hematology tests during CYs 1993 and 1994.

Of the 50 duplicate charges, 43 (86 percent) involved blood indices Physician's Current Procedure Terminology (CPT) code 85029 on the same day that blood profiles CPT codes 85022, 85023, 85024, and 85025 were billed. A complete listing of the duplicated procedure combinations is provided in Appendix D.

Urinalysis

For the urinalysis procedures included in our review, the State had not instructed providers of the reimbursement restrictions as established under Medicare. As a result, our review of 50 instances involving urinalysis claims showed that all 50 instances contained urinalysis tests which were unbundled for payment purposes or duplicated. We estimate the State overpaid providers \$43,242 for unbundled or duplicated urinalysis tests during CYs 1993 and 1994.

Of the 50 instances reviewed, 37 (74 percent) involved billings for urinalysis without microscopic examinations (CPT codes 81002 and 81003) and microscopic examinations only (CPT code 81015) on the same day. Section 5114.1 F of the Medicare Carriers Manual states that if a urinalysis examination which does not include microscopy (81002) and a urinalysis microscopy examination (81015) are both billed, payment should be as though the combined service (81000 - urinalysis with microscopy) had been billed. A complete listing of the duplicated procedure combinations is provided in Appendix E.

RECOMMENDATIONS

We recommend the State:

- (1) Install edits to prevent payments for unbundled or duplicate services.
- (2) Issue instructions and/or reminders to providers concerning bundling requirements.
- (3) Identify and recover the 1993 and 1994 overpayments to each provider for unbundled clinical laboratory services. Based on our audit, we estimate \$1.1 million (Federal share (\$653,315) should be recovered for CYs 1993 and 1994.

- (4) Return the Federal share of the overpayments to HCFA as the overpayments are recovered.

The State's response to our draft audit report addressed a number of issues. These issues are summarized below followed by our rebuttal comments. We have numbered the issues to facilitate identification. The State's response is included in its entirety as Appendix F.

State Response

1. The Missouri Medicaid program has edits to prevent unbundling or duplicate services for laboratory tests. The State provided documentation to show that the Medicaid policy for bundling chemistry tests conformed with the Missouri Medicare carrier's policy regarding chemistry test bundling.

OIG Comments

Four chemistry tests (Triglycerides - CPT 84478, creatinine phosphokinase - CPT 82550 and 82555, and glutamyltransferase - CPT 82977) that were included in our analyses as tests that were commonly included in chemistry panel tests were not included in either the Missouri Medicaid or Medicare carrier's policies for tests requiring bundling. To recognize this factor, we have revised our original estimate of unbundled or duplicated claims to exclude instances involving the four procedures.

However, Medicare carriers for most States require bundling of the four procedures. This indicates that, nationally at least, laboratory providers commonly include the four procedures in panel testing. The Missouri Medicaid program may not be achieving optimal cost savings by eliminating the four procedures from bundling consideration and may want to consider requiring the four procedures to be bundled in the future.

State Response

2. Section 6300 of the State Medicaid Manual does not require Medicaid agencies to follow bundling procedures established by Medicare carriers. Instead, the State concludes that section 6300 requires only that States not pay more than Medicare would pay for individual laboratory procedures. The State bases its opinion on a section 6300 statement which says, "The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program."

OIG Comments

In our opinion, Medicaid reimbursement exceeds Medicare reimbursement anytime the sum of the Medicaid reimbursement for unbundled claims exceeds the amount Medicare would reimburse providers for the same procedures under the bundling payment process. In

addition, we believe that efficient administration of the Medicaid program requires eliminating unnecessary costs whenever possible.

State Response

3. Laboratory fees paid by Medicaid were either the same, very close, or lower than the Medicare fee schedule. Also, Medicaid payments were adjusted when the State is notified of Medicare reimbursement changes that are effective retroactively.

OIG Comments

Our audit scope did not include comparing Medicaid payment rates with Medicare payment rates for specific laboratory tests. Rather, we reviewed the State procedures for establishing payment rates and compared reimbursement for the State's unbundled versus bundled rates. Consequently, we did not note any problems regarding rates paid for specific laboratory procedures.

State Response

4. The Missouri Medicaid policy did not require bundling when two individual chemistry tests were done by a provider. Instead, the policy permits providers to bill the tests separately and receive reimbursement for both tests. Providers were instructed to bundle tests only when three or more tests were involved.

OIG Comments

The Missouri Medicare carrier's policy requires bundling when two or more chemistry tests are done on the same day. More importantly, we cannot think of a good reason for allowing providers additional reimbursement just because two tests were unbundled rather than three or more tests being unbundled. Consequently, we recommend that the State revise the policy to require bundling when two or more tests are involved.

State Response

5. The State's post-payment review of certain providers (with exceptional billing practices) results in program recoupments that are not identifiable to specific recipient claims. The State said that it would conduct a special review of the laboratory test providers included in our audit as well as other providers that they identify as billing inappropriately. Recoupment will reportedly be made if inappropriate claims are found.

OIG Comments

We agree with the State's approach.

State Response

6. Providers were instructed to bill the appropriate hematology profile codes (CPT codes 85021, 85022, 85023, 85024, 85025, 85027, or 85031) whenever providers billed for three or more hematology component tests (CPT codes 85007, 85014, 85018, 85041, 85048, or 85590) that are provided on the same day.

OIG Comments

Our review did not find billing of unbundled component tests on the same day to be a problem. Rather, we found six instances where component tests were provided on the same day as related profile tests. For example, the component test Manual Differential WBC (CPT code 85007) was provided on the same day as the profile test Hemogram and Manual Differential (CPT code 85022) was done. Since the profile test includes the component test, only the profile test should be reimbursed. Appendix C lists the other five instances (all instances that do not involve automated hemogram procedure codes 85029 or 85030 which are discussed later).

State Response

7. Providers were instructed to bill for the Urinalysis CPT 81000 when urinalysis with microscopy tests and urinalysis tests were performed on the same day.

OIG Comments

Our review of 50 randomly selected sample cases indicated that providers violated the instructions 100 percent of the time. Therefore, the State must not have adequate controls to ensure that the providers follow the instructions that the State provided.

State Response

8. Automated hemogram indices (CPT codes 85029 and 85030) would be performed in addition to the hemogram procedures if the physician was looking for certain types of anemia. The State advised the additional automated hemogram indices are done alone a few days after the hemogram profiles as a "check for certain types of anemia." The State further advised that some automated machines automatically do the indices but the provider would not bill unless they were looking for certain diagnoses.

OIG Comments

Providers billed and were reimbursed for automated hemogram indices (CPT codes 85029 and 85030) that were done on the same day as related profile tests in 43 of the 50 sample cases included in our review. As pointed out on page 2 of the report, indices are measurements and ratios calculated from the results of hematology tests. If the indices are done on the same day

as the profile tests, no additional testing is required to produce the additional indices. Consequently, no reimbursement should be made for additional automated hemogram indices that are provided on the same day as related hemogram profile tests. Our sample included only tests billed as automated indices, all of which were done on the same day (not a few days after as represented by the State response) as the related hemogram profiles.

State Response

9. Professional judgment of medical consultants concerning medical necessity was involved. The State's utilization review function resulted in recoupment of some of the payments. The audit looked at a "minute" sample of paid claims data. A more in-depth review by the State would probably result in proof of validity for many of the claims not already recouped by the utilization review function.

OIG Comments

In our opinion, professional judgment of medical consultants should not be involved regarding bundling of laboratory tests. Experience and review of laboratory tests have established which individual tests are commonly conducted as a part of laboratory profiles. Our sample was small. However, the sample was statistically valid. At the completion of our field work, we presented our findings to the State and asked for any additional information concerning the sample cases included in our audit. No additional information was provided. We would be interested in reviewing any proof that the State could produce concerning the validity of the sampled claims or information regarding recoupment of the claims included in our sample.

State Response

10. In concluding its response, the State indicated partial agreement with audit recommendations one and two saying that they were (1) developing a system to more closely screen individual laboratory tests to ensure bundling requirements are met and (2) notifying providers of restrictions against unbundling laboratory tests. The State requested that we reconsider our audit recommendations three and four concerning recovering overpayments due to unbundling and duplicated payments. The State cited its efforts to convert significant portions of the Medicaid population to managed care and other issues discussed previously as the reason for asking us to reconsider audit recommendations three and four. With implementation of managed care, the State said that the problems identified by our report would not occur in the future.

OIG Comments

The State indicated that it would conduct a special review (See 5. above) of the laboratory test providers included in our audit as well as other providers that they identify as billing

inappropriately. If the State identifies bundling problems and excess reimbursement using the same requirements that we used in our audit analyses, the results of State's review should further identify the need to do the review recommended by our audit. The State's special review would probably meet the intent of our recommended review so long as it covers the CYs 1993 and 1994.

We agree that changing to a managed care delivery system should reduce the incidence of unbundled laboratory test. However, the problem would not be entirely eliminated unless all Medicaid was provided under the managed care system. Some of the problems that we found involved policy imperfections and control problems that would continue for services provided to Medicaid recipients who do not obtain services under managed care. Consequently, changes to the State's policies and procedures continue to be necessary in our opinion.

INSTRUCTIONS FOR STATE RESPONSE

Final determinations as to actions to be taken on all matters reported will be made by the HHS action official identified below. We request that you respond to each of the recommendations in this report within 30 from the date of this report to the HHS action official, presenting any comments or additional information that you believe may have a bearing on final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), OIG, OAS 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.)

Sincerely,



Barbara A. Bennett
Regional Inspector General for Audit Services

Appendixes
HHS Action Official:
Mr. Joe Tilghman, Regional Administrator
Health Care Financing Administration
Richard Bolling Federal Building
601 East 12th Street, Room 235
Kansas City, Missouri 64106

APPENDICES

AUTOMATED MULTICHANNEL CHEMISTRY PANEL TEST HCPCS

Chemistry Panel CPT Codes

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

Chemistry Tests Subject to Panelling (35 CPT Codes)

Albumin	82040
Albumin/globulin ratio	84170
Bilirubin Total or Direct	82250
Bilirubin Total and Direct	82251
Calcium	82310, 82315, 82320, 82325
Carbon Dioxide Content	82374
Chloride	82425
Cholesterol	82465
Creatinine	82565
Globulin	82942
Glucose	82947
Lactate Dehydrogenase (LDH)	83610, 83615, 83620, 83624
Alkaline Phosphatase	84075, 84078
Phosphorus	84100
Potassium	84132
Total Protein	84155, 84160
Sodium	84295
Aspartate aminotransferase (AST, SGOT)	84450, 84455
Alanine aminotransferase (ALT, SGPT)	84460, 84465
Urea Nitrogen (BUN)	84520
Uric Acid	84550
Triglycerides	84478 <u>1/</u>
Creatinine Phosphokinase (CPK)	82550, 82555 <u>1/</u>
Glutamyltransferase, gamma (GGT)	82977 <u>1/</u>

1/ Medicare carriers for most States require these chemistry tests to be bundled for reimbursement. However, the Medicare carrier for Missouri does not require providers to bundle these tests. Consequently, our audit analyses excluded these tests from consideration during the conduct of the audit and resulting estimates of available cost savings.

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, (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

URINALYSIS TESTS

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

SAMPLE METHODOLOGY

From the Health Care Financing Administration's (HCFA) Medicaid Statistical Information System (MSIS) paid claims file for CYs 1993 and 1994, 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 (see Appendix A);
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 A); and
3. urinalysis and component tests listed in the CPT handbook (see Appendix A).

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

1. more than one 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; and
3. a complete urinalysis test and microscopy, a urinalysis without microscopy, or a microscopy only.

This extract resulted in a sample population totaling \$3.29 million consisting of three strata. The first strata consisted of 60,373 instances totaling \$1.43 million for potentially unbundled chemistry panel tests. The second strata consisted of 101,245 instances totaling \$1.73 million for potentially duplicate hematology profile tests. The third strata consisted of 24,829 instances totaling \$.13 million for urinalysis tests with potentially unbundled or duplicate tests. Each instance is a potential payment error in which the State paid providers for clinical laboratory tests (on behalf of the same beneficiary of date on the same date of service) which were billed individually instead of as part of a group, or were duplicative of each other.

On a scientific stratified selection basis, we examined 150 instances involving claims from three strata. The first stratum consisted of a randomly generated statistical sample of 50 potentially unbundled instances involving chemistry panel tests totaling \$922. The second stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving hematology profile or profile component tests totaling \$897. The third stratum consisted of a randomly generated statistical sample of 50 potentially duplicate instances involving urinalysis tests totaling \$297.

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

Stratum	Number of Items	Number Sampled	Examined Value	Number of Errors	Error in Sample	Estimated Recovery
Chemistry Tests	60,373	50	\$ 922	21	\$320	\$ 386,689
Hematology Tests	101,245	50	897	50	327	661,656
Urinalysis Tests	24,829	50	297	50	87	43,242
Totals	186,447	150	\$2,116	121	\$ 734	\$1,091,587

The results of the scientific sample of Stratum 1, chemistry tests, showed that 21 of 50 instances we reviewed represented overpayments for unbundled chemistry panel tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$386,689 paid for unbundled chemistry panel tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 34.38 percent.

The results of the scientific sample of Stratum 2, hematology tests, showed that 50 of the instances we reviewed contained duplicate payments for hematology profiles and profile component tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$661,656 in duplicate payments for hematology profile tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 10.81 percent.

The results of the scientific sample of Stratum 3, urinalysis tests, showed that 50 of the instances we reviewed represented overpayments for unbundled and duplicate urinalysis tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that \$43,242 paid for unbundled and duplicate urinalysis tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 18.62 percent.

The combined results for the three strata, showed that 121 of the 150 instances we reviewed represented overpayments for unbundled and duplicate chemistry, hematology, and urinalysis tests. Projecting the results of the statistical sample over the population using standard statistical methods, we estimate that a total of \$1,091,587 paid for unbundled and duplicate tests can be recovered. At the 90 percent confidence level, the precision of this estimate is plus or minus 13.59 percent.

**LISTING OF PROCEDURE CODE GROUPS INVOLVED IN THE
AUDIT SAMPLE OF UNBUNDLED CHEMISTRY SERVICES
BY FREQUENCY OF OCCURRENCE**

<u>PROCEDURE CODE COMBINATIONS 1/</u>	<u>FREQUENCY OF OCCURRENCE</u>
80004, 80050	3
80004, 82565, 82947	2
80006, 80058	2
80007, 80058	1
80016, 82040, 84075, 84450	1
80018, 82465	1
80019, 80058	1
80019, 82565	1
80019, 82947	1
82565, 84132	1
82565, 84450	1
82565, 84520	4
84450, 84460	2

1/ The groups of procedures listed were provided to recipients on the same date by the same providers. The number of times the groups of procedures were provided to the same recipients by the same providers is shown in the frequency column. The total of the frequency column equals 21 (the number of unbundled chemistry instances in our sample that included overpayments).

**LISTING OF PROCEDURE CODE GROUPS INVOLVED IN THE
AUDIT SAMPLE OF UNBUNDLED HEMATOLOGY SERVICES
BY FREQUENCY OF OCCURRENCE**

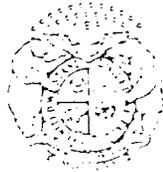
<u>PROCEDURE CODE COMBINATIONS 1/</u>	<u>FREQUENCY OF OCCURRENCE</u>
85007, 85022	1
85014, 85027	1
85018, 85021	1
85018, 85022	1
85022, 85029	1
85023, 85029	2
85024, 85029	18
85024, 85030	1
85024, 85048	1
85024, 85595	1
85025, 85029	20
85025, 85029, 85030	2

1/ The groups of procedures listed were provided to recipients on the same date by the same providers. The number of times the groups of procedures were provided to the same recipients by the same providers is shown in the frequency column. The total of the frequency column equals 50 (the number of unbundled/duplicated hematology instances in our sample that included overpayments).

LISTING OF PROCEDURE CODE GROUPS INVOLVED IN THE
AUDIT SAMPLE OF UNBUNDLED URINALYSIS SERVICES
BY FREQUENCY OF OCCURRENCE

<u>PROCEDURE CODE COMBINATIONS</u> ^{1/}	<u>FREQUENCY OF OCCURRENCE</u>
81000, 81002	4
81000, 81003	1
81000, 81015	8
81002, 81015	27
81003, 81015	10

^{1/} The groups of procedures listed were provided to recipients on the same date by the same providers. The number of times the groups of procedures were provided to the same recipients by the same providers is shown in the frequency column. The total of the frequency column equals 50 (the number of unbundled/duplicated urinalysis instances in our sample that included overpayments).



MISSOURI
DEPARTMENT OF SOCIAL SERVICES

P.O. BOX 1527
BROADWAY STATE OFFICE BUILDING
JEFFERSON CITY
65102-1527

TELEPHONE: 314-751-4815, FAX: 314-751-3203

MEL CARNAHAN
GOVERNOR
GARY J. STANGLER
DIRECTOR

RELAY MISSOURI
for hearing and speech impaired
TEXT TELEPHONE
1-800-735-2966
VOICE
1-800-735-2466

October 18, 1995

Barbara A. Bennett
Regional Inspector General
Department of Health and Human Services
Office of Audit Services, Region VII
601 East 12th Street
Room 284A
Kansas City, MO 64106

Re: CIN A-07-95-01138

Dear Ms. Bennett:

The purpose of this letter is to follow-up on my September 6, 1995, letter to you regarding our response to your draft report and audit results of certain clinical laboratory services provided under the Missouri Medicaid program. We appreciate your allowing us the additional time to respond.

The Missouri Medicaid program does have edits to prevent unbundling or duplicate services for automated, multichannel tests. The Division of Medical Services (DMS) has identified nineteen procedures to be billed as a multichannel when three or more individual procedures are performed. General American Part B Medicare Carrier has identified nineteen procedures that are to be billed as a multichannel (see attached). The State Medicaid Manual (SMM) Section 6300.1, states: . . . "The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program. . . ." Claims failing these edits are resolved by nurses either at our fiscal agent facility or by the DMS nurse consultant. Although guidelines have been established for them to follow in processing claims, they also have the flexibility to make medical judgments in the payment of claims. Due to the tremendous volume of claims processed by the Missouri Medicaid program, the potential for errors to occur does exist.

The majority of the claims in the audit sample were outpatient claims. The outpatient laboratory fee schedule is either the same or very close to the Medicare fee schedule. The physician fee schedule, in most cases, is lower than the Medicare fee schedule, and we did not increase the Medicaid fees to the Medicare fees. Upon notification of new Medicare fees, clinical diagnostic laboratory procedures that the

Barbara A. Bennett
Page 2

Missouri Medicaid program had reimbursed at a higher rate than Medicare, the fee was reduced to the Medicare fee.

Providers have been instructed in the Physician Manual to bill any combination of three or more of the identified nineteen procedure codes using the appropriate automated, multichannel test (80003-80019). The Missouri Medicaid policy for billing one or two tests is to bill the individual procedure codes rather than the provider billing 80002 (automated multichannel test; one or two clinical chemistry test[s]) and receive the same payment whether one or two tests had been performed.

The Surveillance, Utilization, and Review Unit (SURS) monitors providers that have exceptional billing practices post-payment which includes automated channel tests and hematology. SURS does recoupments of inappropriate payments when identified. When SURS initiates a recoupment, the provider is assessed a lump sum amount which reflects overpayments. These recoupments do not appear in the claims processing system as adjustments. The only way to verify these amounts were recouped would be to have a staff person identify the recipient and the billing provider, and then review their cases to determine if the validity for that particular claim was established. When the payment is not valid, the recoupment process, which includes a right of provider appeal, is put into place. The SURS unit will be directed to do a review of the providers identified in your sample as well as other providers that are later identified as inappropriately billing and initiate the recoupment process for those claims that fall outside of acceptable parameters.

Providers have been instructed when billing three or more of the following tests for the same recipient on the same date of services 85007, 85014, 85018, 85041, 85048, 85590, they are to bill the following blood count hemogram procedure codes: 85021, 85022, 85023, 85024, 85025, 85027, or 85031. Providers have also been instructed that when a microscopy and urinalysis are performed on the same date of service, they are to bill only procedure code 81000.

The automated hemogram indices (one to three indices) or (four or more indices) would be performed in addition to the hemogram procedure codes if the physician looking for certain types of anemia, etc. It is possible to do the indices alone a few days after doing the hemogram procedure code just as a check for certain types of anemia, etc. Some automated machines automatically do the indices but the provider would not bill this additionally if not looking for certain diagnoses, e.g. anemia, etc.

As with all medical claims, there is always the professional judgment of our medical consultants as to the final decision regarding whether or not a specific claim in suspense or under review is medically necessary. The SURS function has resulted in the recoupment of some of these payments. Your review looked at a minute sample of the paid claims data. A more in-depth review by DMS would probably result in proof of validity for many of the claims not already recouped by the SURS function. The language in the State Medicaid Manual clearly states in Sec-

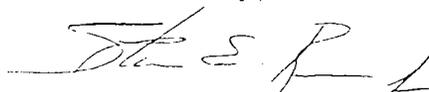
Barbara A. Bennett
Page 3

tion 6300.1 that the impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. We interpret that to mean that this applies to a specific HCPC code and the fee for that code, not an overpayment that would result from possible duplication or overlapping payments. In accordance with 6300.2, we pay the same or less than Medicare for each outpatient clinical laboratory test.

In conclusion, with regard to recommendation numbers one and two, we are in partial agreement and are developing system editing capabilities that will more closely screen individual laboratory tests against panel tests. We are also notifying providers of the restriction against unbundling of laboratory tests accordingly. With regard to recommendation numbers three and four, for the reasons identified throughout this correspondence, we respectfully request your office to reconsider the recommendation to recover the 1993 and 1994 overpayments to each provider for unbundled clinical laboratory services and return the federal share of the overpayments to HCFA. Additionally, as you may know, the Missouri Medicaid program is in the process of converting a significant portion of the eligible population to managed care. As a result of this conversion, the areas of concern identified in your draft report will not occur in the future.

Thank you for the opportunity to respond to your draft, and if you have any questions, please feel free to contact Donna Checkett, Director, Division of Medical Services, at 314/751-6922.

Sincerely,



Gary J. Stangler
Director

GJS/jd

6300. PAYMENT FOR OUTPATIENT CLINICAL DIAGNOSTIC LABORATORY TESTS FOR CALENDAR QUARTERS BEGINNING ON OR AFTER OCTOBER 1, 1984.

6300.1. Introduction.—Pursuant to §2303 of the Deficit Reduction Act of 1984 for services rendered to Medicare beneficiaries on or after July 1, 1984, clinical diagnostic laboratory tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients are reimbursed on the basis of fee schedules. These fee schedules have been established on the Medicare carrier's service area (not exceeding a statewide basis). The Consolidated Omnibus Budget Reconciliation Act (COBRA) requires national limitation amounts to be applied to the Medicare payments for outpatient clinical diagnostic laboratory services.

For services rendered on or after July 1, 1986, the national limitation amount is 115 percent of the median of all the fee schedules established for a test for each laboratory setting (i.e., separately calculated for 60 and 62 percent fee schedules).

Effective with calendar quarters beginning on or after October 1, 1984 (for services rendered on or after July 1, 1984), Federal matching funds will not be available to the extent a State pays more for outpatient clinical diagnostic laboratory tests performed by a physician, independent laboratory, or hospital than the amount Medicare recognizes for such tests. If a Medicare fee has not been established for a particular test reimbursed by Medicaid, no such limitation applies to the test. If a State agency has a buy-in arrangement with Part B of the Medicare program, it should ensure that the combined amounts of the Medicaid payment and the Medicare payment do not exceed the allowable Medicare fee or national limitation amount.

For services rendered on or after July 1, 1984, a nominal fee may be allowed under Medicare for separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. (See §6300.3.)

These guidelines are designed to provide assistance to the State Medicaid agencies in implementing, where applicable, the limitations of the Medicare fee schedules and the specimen collection fees into payment procedures. The impact of the Medicare regulations on the Medicaid program is strictly with respect to the amount of payment. The applicable Medicare assignment and billing requirements are not necessarily to be incorporated into the State Medicaid program. The establishment and use of (1) fee schedules for payment of clinical diagnostic laboratory tests and (2) nominal fees for specimen collection are discussed. The treatment of anatomic pathology services is provided. Reimbursement options available to States are also described.

6300.2. Fee Schedules for Outpatient Clinical Laboratory Tests.—Outpatient clinical diagnostic laboratory tests encompass tests performed in a physician's office, by an independent laboratory, or by a hospital laboratory for its outpatients. Medicaid reimbursement for clinical diagnostic laboratory tests may not exceed the amount that Medicare recognizes for such tests.

A. Application.—Each Medicare carrier in a respective State will provide magnetic tapes of its fee schedules to the State agency. (See §6300.2.D.)

To determine the applicable fee schedule limitation for a test where more than one Medicare carrier operates within the State, the State agency may select one of the following options:

1. The lowest fee among the carriers within the State for this test. In this manner, the State may assure that its fee schedules for all tests are based upon the lowest Medicare fees within its State.
2. The average fee derived by combining the fee schedules of all Medicare carriers within the State.
3. The fee of the largest Medicare carrier within the State.
4. The fee of the Medicare carrier whose jurisdiction corresponds to the place of service.

B. Exceptions.—The fee schedule limitation applies to all clinical diagnostic laboratory tests, except:

1. laboratory tests furnished to an inpatient as part of a hospital or SNF benefit.
2. laboratory tests furnished to an inpatient of a hospital or SNF as part of a general diagnostic laboratory benefit and performed by the institution's laboratory.
3. laboratory tests that are included under the ESRD composite rate payment and that are furnished by hospital outpatient or free-standing ESRD dialysis facilities.
4. laboratory tests furnished by hospitals in Maryland and New Jersey. They have been granted waiver of Medicare reimbursement principles for outpatient services.
5. laboratory tests furnished to inpatients of a hospital with a waiver under §602(k) of the 1983 Amendments to the Social Security Act. This section of the Act provides that an outside supplier may bill under Part B for laboratory and other nonphysician services furnished to inpatients that would otherwise be reimbursed only through the hospital. Part B payment to the outside supplier for laboratory tests furnished to inpatients under the 602(k) waiver will be made at 80 percent of the reasonable charge if the claim is unassigned or at 100 percent of the reasonable charge if the claim is assigned. The fee schedule does apply to any tests furnished by the outside supplier to hospital outpatients and to nonhospital patients.
6. laboratory tests furnished to patients of rural health clinics under an all-inclusive rate.
7. laboratory tests provided by participating health maintenance organizations (HMO) or health care prepayment plans (HCPP) to an enrolled member of the plan.
8. laboratory tests furnished by a hospice.

C. Clinical Diagnostic Laboratory Services.—For purposes of the fee schedule, clinical diagnostic laboratory services include laboratory tests listed in codes 80002-89399 of the Current Procedural Terminology Fourth Edition, 1986 printing, (CPT-4). Certain tests, however, are required to be performed by a physician and are therefore exempt from the fee schedule. These tests include:

80500-80502	Clinical pathology consultation
85095-85109	Codes dealing with bone marrow smears and biopsies
86077-86079	Blood bank services
88000-88125	Certain cytopathology services
88160-88199	Certain cytopathology services
88300-88399	Surgical pathology services

Some CPT-4 codes in the 80000 series are not clinical diagnostic laboratory tests. Such codes include codes for blood products such as whole blood, various red blood cell products, platelets, plasma and cryoprecipitates. Other codes for tests primarily associated with the provision of blood products are also not considered to be clinical diagnostic tests. These codes include the various blood crossmatching techniques.

The following codes are never subject to fee schedule limitations:

86012	86068
86013	86069
86016-86019	86072-86076
86024	86100
86026	86120
86028	86128
86034	86265-86267

The following codes should not be subject to fee schedule limitations when they are submitted for payment on the same bill with charges for blood products:

86011	86082
86014	86090
86031-86033	86095
86035	86096
86080	86105

If no blood product is provided and billed on the same claim, these codes are subject to the fee schedule.

Please note that for purposes of the fee schedule, clinical diagnostic laboratory tests include some services described as anatomic pathology services in CPT-4 (i.e., certain cervical, vaginal, or peripheral blood smears). Services excluded from the fee schedule when billed by an independent laboratory are reimbursable under existing reasonable charge rules and assignment may be taken on a case-by-case basis unless the laboratory enrolls as a participating supplier in which event assignment is mandatory. Where a service is performed by a physician for a hospital inpatient or outpatient and meets the definition of a physician laboratory service, the service is subject to the Medicare Economic Index and the freeze on physician fees under §2306 of the DRA of 1984. Physician laboratory services are anatomic pathology services, consultative pathology services, or services performed by a physician in personal administration of test devices, isotopes, or other materials to an individual patient. Such service, however, when billed by an independent laboratory as a laboratory service for a nonhospital patient (e.g., surgical pathology) is not considered a physician service for purposes of the Medicare Economic Index or the physician fee freeze.

D. Calculation of Fee Schedule Amounts.—Beginning January 1, 1987, Medicare fee schedules will be updated on January 1 each year. The Medicare fee schedules (adjusted for any applicable national limitation amounts) will be furnished to the State Medicaid agency on magnetic tape by the Medicare carriers within the respective State. (See §6300.6 for tape formats.)

Carriers initially set the fee schedule amounts at 60 percent of the prevailing charges for laboratory tests performed in physicians' offices and by independent laboratories. For hospital outpatient laboratory tests, the fee schedule amount was established at 62 percent of the prevailing charges. Subsequent updates are made on the basis of changes in the Consumer Price Index.

Where a hospital laboratory acts as an independent laboratory; i.e., performs tests for persons who are nonhospital patients, the services are reimbursed using the 60 percent of prevailing charge fee schedule. A hospital outpatient is a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and receives services (rather than supplies alone) from the hospital. Where a tissue sample, blood sample, or specimen is taken by personnel that are not employed by the hospital and is sent to the hospital for performance of tests, the tests are not outpatient hospital services since the patient does not directly receive services from the hospital. Where the hospital uses the category "day patient," i.e., an individual who receives hospital services during the day and is not expected to be lodged in the hospital at midnight, the individual is classified as an outpatient.

The codes and terminology of the Health Care Common Procedure Coding System (HCPCS) are used to establish the fee schedule for Medicare. State Medicaid agencies which have not yet converted their coding systems to HCPCS should identify the equivalent tests in their own systems and use the fees of corresponding HCPCS codes for those tests in reviewing their current reimbursement levels.

6300.3. Fee Schedules for Specimen Collection.—Medicare will recognize separate charges made by physicians, independent laboratories, or hospital laboratories for drawing or collecting specimens. States are not required to recognize this fee. However, since specimen collection fees will be taken into account in determining whether a State paid more for a laboratory test than would be paid under Medicare, States must take into account Medicare policies in this area.

State agencies may consult with regional offices concerning the implementation of the fee schedule and specimen collection provisions.

Presently, Medicare will recognize up to \$3 for a specimen collection whether or not the specimens are referred to physicians or other laboratories for testing. This fee will not be paid to anyone who has not actually extracted the specimen from the patient. Only one collection fee may be allowed for each patient encounter, regardless of the number of specimens drawn. A specimen collection fee may be allowed only in circumstances including, but not limited to: (1) drawing a blood sample through venipuncture (i.e., inserting into a vein a needle with syringe or vacutainer to draw the specimen) or (2) collecting a urine sample by catheterization. A specimen collection fee is not allowed for blood samples where the cost of collecting the sample is minimal, such as a throat culture or routine capillary puncture for clotting or bleeding time.

Medicare will recognize a specimen collection fee when it is medically necessary for a laboratory technician to draw a specimen from either a nursing home patient or homebound patient. The technician must personally draw the specimen, i.e., venipuncture or urine sample by catheterization. A specimen collection fee should not be allowed the visiting technician where a patient in a facility is not confined to the facility or the facility has on duty personnel qualified to perform the specimen collection. A specimen collection fee not exceeding \$5 may be allowed in drawing a specimen from one patient in a nursing home or a homebound patient. An amount not exceeding \$3 per patient may be allowed when specimens are drawn from more than one patient during the same nursing home visit. Exceptions to the above rules may be permitted under certain circumstances, such as allowing a travel expense in addition to the specimen collection fee where the patient is confined to a nursing home in a distant rural area.

When independent (free-standing) or hospital-based ESRD facilities are paid on a composite rate basis, no specimen fees should be paid since specimen collection costs are included in the composite rate except for Method II home dialysis patients. Where the State permits reimbursement under Method II, a separate specimen collection fee may be paid if the specimen is drawn by an ESRD facility or laboratory. The specimen collection fee is not allowed when a physician or one of a physician's employees draws a specimen from a dialysis patient because it is included in the Monthly Capitation Payment.

6300.4 Who Can Bill and Receive Payment for Clinical Laboratory Tests.—Payment for clinical laboratory tests subject to the fee schedule may only be made to the person or entity performing or supervising the performance of the tests. The general rules of 42 CFR 447.10(g)(2), (3), and (4) on reassignment are followed for clinical diagnostic laboratory tests as for all other services.

6300.5 Competitive Bidding or Other Arrangements.—42 CFR 431.54(d) allows a Medicaid agency to enter into arrangements to purchase laboratory services. Section 1903(i)(7) of the Act requires that States may not pay more in the aggregate for clinical diagnostic laboratory tests than the amount that would be paid for the tests under Medicare fee schedule. If a Medicaid agency, therefore, enters into arrangements to purchase laboratory services, the total payment for the clinical diagnostic laboratory tests may not exceed the amount recognized by Medicare.

6300.6

PAYMENT FOR SERVICES

09-86

6300.6. Magnetic Tape File and Record Specifications for HCPCS Pricing Detail

HEADER TAPE SPECIFICATIONS

<u>Field No.</u>	<u>Field Name</u>	<u>Size</u>	<u>Picture</u>	<u>Field Specification</u>	<u>Remarks</u>
1	Label	5	X(5)	L	"HCPCS"
2	Filler	1	X		
3	Carrier #	5	9(5)	L	
4	Filler	1			
5	Interm. #	5	9(5)	L	
6	Filler	1			
7	Date Prevailing Updated	6	X(6)	L	MMDDYY
8	Filler	30			
9	Date File Created	6	X(6)	L	MMDDYY

09-66

PAYMENT FOR SERVICES

6300.5(Cont.)

<u>Name</u>	<u>Positions</u>	<u>Picture</u>
HCPCS	5	X(5)
60% Fee Schedule*	7	9(5)V99
62% Fee Schedule*	7	9(5)V99

DETAIL RECORD

<u>Field No.</u>	<u>Field Name</u>	<u>Size</u>	<u>Picture</u>	<u>Field Specification</u>
1	HCPCS	5	X(5)	L
2	Filler	2	XX	L
3	Filler	2	XX	L
4	60% Fee Schedule*	7	9(5)V99	R
5	62% Fee Schedule*	7	9(5)V99	R
6	Filler	10	X(10)	L
7	Carrier #	5	X(5)	L
8	Filler	2	XX	
9	Carrier Name	20	X(20)	L

*Adjusted for national limitation amounts.

Rev. 5

6-47

Effective 2/15/90 (original)
4/15/93 (revision,
for dates of service)

Revision: Jan, 1993,
1/1/94

Automated Multi-Channel Chemistry Tests (#58)

Introduction

This policy addresses those tests that can be and are frequently done as groups and combinations on automated multi-channel equipment. These groupings enable physicians to more accurately diagnose their patients' medical problems. Groupings can vary from one laboratory or physician's office or clinic to another.

Composition:

The following blood tests are frequently found in these automated multi-channel tests:

<u>CPT Code</u>	<u>Test</u>
84460 ✓	Alanine Aminotransferase (ALT, SGPT)
82040 ✓	Albumin
84450 ✓	Aspartate Aminotransferase (AST, SGOT)
82250 ✓	Bilirubin, direct
82251 ✓	Bilirubin, total
82310 ✓	Calcium
32374 ✓	Carbon Dioxide Content
82435 ✓	Chloride
82465 ✓	Cholesterol
82565 ✓	Creatinine; blood
82947 ✓	Glucose
83615 ✓	Lactate Dehydrogenase (LDH)
84075 ✓	Phosphatase, Alkaline
84100 ✓	Phosphorus (inorganic phosphate)
84132 ✓	Potassium
84155 ✓	Protein, total
84295 ✓	Sodium
84520 ✓	Urea Nitrogen (BUN)
84550 ✓	Uric Acid; blood

HCPCS Benefit Category: Laboratory, diagnostic services

CPT Billing Codes

CPT Codes 80002-80019 are to used when two or more and up to 19 or more chemistry tests (see composition above) are grouped as automated multi-channel tests.

HCFA National Policy: MCM 5114.1L

Indications

1. This type testing is not covered when performed for routine screening purposes.
2. The disease states for which the testing is ordered must be correctly coded in appropriate ICD-9 format.
3. In order for a 'V' code to be used, at least one disease entity should also be coded with it.

Bundling Requirements

If two or more of the above chemistry tests are billed separately on the same day, they will be grouped into one of the chemistry groupings or panels for reimbursement purposes. A payment allowance for a battery cannot exceed the payment allowance fee schedule for the sum of the individual tests.

Place of Service

These services may be performed in the office or independent laboratory and purchased from a supplier.

EDI Requirements for Documentation Submission

No special requirements are necessary with claims submission. If it is suspected that the claims will be denied, submit appropriate documentation (e.g., a cover letter explaining the reasons for the testing, what was done, the results and the frequency of testing) to: Electronic Data Interchange, P.O. Box 66844, St. Louis, MO (314) 525-5525.

Documentation Requirements

Medical records should clearly document the reason for the tests, the results and frequency and an appropriate history and physical exam.

Documentation on the medical record must support the need for processing medically necessary tests in all instances. A related disease or injury must be present or there must be a suspicion of disease with signs and symptoms not otherwise explainable to support the need for testing.

This information should be available and generally submitted on reconsideration only or with the claim(s) if the services are unusual or if a rejection is anticipated.

Utilization Guidelines

1. Tests which are performed other than those listed under composition (see introduction), may be billed separately.

2. Calculations which do not involve a separate lab procedure will not be allowed (e.g., A/G ratio).
3. Where at least one test of an initial automated battery of tests can be reasonably related to a specific complaint, symptom, disease or injury, the payment allowance for the complete initial battery of tests will be allowed. This same rule can apply for a yearly evaluation of a patient with a known disease or injury.
4. Where a battery of tests is repeated, however, only those individual tests in the battery which are required to follow the patient's progress and condition are covered (e.g., blood sugar for diabetes, BUN and/or creatinine for renal failure, etc.). In no event, however, may payment for covered individual tests exceed the payment allowance for a battery or panel containing the same test.
5. Follow-up testing performed at a frequency greater than is necessary for the reasonable medical management of the patient's condition is not covered. This frequency increases with new onset disease, when therapy changes, when conditions worsen or do not respond. Infrequent or lesser amounts of testing, on the other hand, will only be allowed when stability is reached.
6. Where no test in an automated battery of tests performed initially or as a follow-up measure can be reasonably related to a specific complaint or symptom, no payment is allowed for the battery.

Rationale for policy: To better define excessively used tests. Revised as result of FMR (FY-93).

Carrier Advisory Committee: Approved on 3/12/93 with minor wording changes.

This policy does not reflect the sole opinion of the carrier or carrier medical director. This policy was also developed in consultation with the medical community via the carrier advisory committee, which includes representation from all medical specialties.

References: MCM 4110.2, 4110.3, 5114, 5258 Common Diagnostic Tests, Harold C. Sox, M.D.; ACP, 1987; pp 277-329

Note: Changes to the original policy are shown by the presence of a vertical line in the left hand column.

1/1/94
Revision #2
(HCFA directed)

Start Date Comment Period: 1/1/93

Start Date Provider Notice: MN Nov/Dec '89, Jan/Feb '90; 1/93 (PN 93-01),
4/1/93 (PN 93-02)

<u>Type of Service (TOS)</u>	<u>Place of Service (POS)</u>	<u>Limitations and Requirements</u>
R - Professional Component, Laboratory	1 - Inpatient Hospital	o Services must be billed on HCFA-1500. (Professional component may not be billed for those specified "Clinical Diagnostic Laboratory Procedures").
	2 - Outpatient Hospital	o Services must be billed on HCFA-1500. (Professional component may not be billed for those specified "Clinical Diagnostic Laboratory Procedures").
	3 - Office	o Services must be billed on HCFA-1500. (Professional component may not be billed for those specified "Clinical Diagnostic Laboratory Procedures").
	A - Independent Lab	o Diagnosis required. o Services must be billed on HCFA-1500. (Professional Component may not be billed for those specified "Clinical Diagnostic Laboratory Procedures".) o Referring physician required.
	I*- Technical Component: Laboratory	1 - Inpatient Hospital

<u>Type of Service (TOS)</u>	<u>Place of Service (POS)</u>	<u>Limitations and Requirements</u>
	2 - Outpatient Hospital	o May never be billed by physician. Hospital must bill on UB-82. Type of Service I must be used for all "Clinical Diagnostic Laboratory Procedures".
	3 - Office/Clinics	o Services must be billed on HCFA-1500. May only be billed if the physician actually performs (processes) the service. Type of Service I must be used on all "Clinical Diagnostic Laboratory Procedures".
		o Diagnosis required.
	A - Independent Lab	o Services must be billed on HCFA-1500. May only be billed if independent lab actually performs the service. Type of Service I must be used on all "Clinical Diagnostic Laboratory Procedures".
		o Referring physician required.

*Clinical diagnostic lab tests must always be billed under TOS-I.

General Screening Panels

The following list contains tests performed as groups or combinations. For reporting one or two tests, use the appropriate single test code number(s). For any combination of three or more tests listed below, use the appropriate "profile" number 80003-80019 and indicate the tests performed.

12/87

SECTION 13

NOTE: Routine screening is not covered. The tests must be consistent with the patient's symptoms and diagnosis, and must have been requested by the patient's attending physician.

Albumin
 Albumin/globulin ratio
 Bilirubin, direct
 Bilirubin, total
 Calcium
 Carbon dioxide content
 Chlorides
 Cholesterol
 Creatinine
 Globulin
 Glucose (sugar)
 Lactic dehydrogenase (LDH)
 Phosphatase, alkaline
 Phosphorus (inorganic phosphate)
 Potassium
 Protein, total
 Sodium
 Transaminase, glutamic oxaloacetic (SGOT)
 Transaminase, glutamic pyruvic (SGPT)
 Urea Nitrogen (BUN)
 Uric Acid

80003	3 clinical chemistry tests
80004	4 clinical chemistry tests
80005	5 clinical chemistry tests
80006	6 clinical chemistry tests
80007	7 clinical chemistry tests
80008	8 clinical chemistry tests
80009	9 clinical chemistry tests
80010	10 clinical chemistry tests
80011	11 clinical chemistry tests
80012	12 clinical chemistry tests
80016	13-16 clinical chemistry tests
80018	17-18 clinical chemistry tests
80019	19 or more clinical chemistry tests (indicate instrument used and number of tests performed)

AIDS Testing

Procedure code 86312, "HTLV-III antibody detection; ELISA" is a covered service to help determine a diagnosis for symptomatic patients.

It is not covered when furnished as part of a screening program for asymptomatic persons.

When a test is reactive on initial testing, it should be repeated on the same specimen.

A more specific text procedure code 86314, "HTLV-III antibody detection; confirmatory test (eg. Western blot)" is usually performed following repeatedly reactive ELISA results.

Diagnosis codes for AIDS can be found in Section 18.

Feto-protein Testing

Procedure code 86244 "Feto-protein, alpha-1, RIA or EIA" is a covered screening test of maternal serum based on gestational age, to determine possible birth defects.

Chlamydia Testing

The procedure to be used for testing for Chlamydia, a sexually transmitted disease, is determined by the method used, eg, smear vs culture. Procedure codes 86277, 87081 or 87163 may be used for Chlamydia testing.

12/87

SECTION 13

Obstetric Profile (80055)

The provider performing three or more tests for the same recipient on the same date of service must bill the Obstetric Profile (Panel) code 80055 and list the tests, instead of billing separately for each individual test.

The Obstetric Profile includes the following tests:

- o Hematology Panel (85022 or 85031)
- o ABO Group and Rh Type (D) (86082)
- o RPR (86592)
- o Rubella Screen (86280)
- o Antibody Screen (86016)
- o Urinalysis (81000)

Thyroid Panel (80070)

- o T₃ Uptake
- o T₄ by RIA
- o Free Thyroxine Index (FTI)

80071

One of the following tests may be included with Thyroid Panel (80070):

- o Thyrotropin releasing hormone (TRH)
- o Thyroid stimulating hormone (TSH)
- o T₃ by RIA

Complete Blood Count

Three or more of the following tests when performed for the same recipient on the same date of service must be billed as one of the blood count hemograms (codes 85021, 85022, 85023, 85024, 85025, 85027, or 85031):

- 85007 Differential (WBC) Count
- 85014 Hematocrit (Hct.)
- 85018 Hemoglobin (Hgb.)
- 85041 Red Cell Count (RBC)
- 85048 White Cell Count (WBC)
- 85580 Platelet Count

8 5599

12/87

SECTION 13

Hemostasis

Prothrombin time, prothrombin consumption, thrombin time, clotting time, bleeding time, thromboplastin (PTT), platelet count, etc., are covered for the diagnostic and/or therapeutic approach to disorders of hemostasis. Anticoagulation therapy (Heparin, Coumadin) must be documented in the diagnosis box of the claim form "on anti-coagulant".

NOTE: Tests are non-covered for pre-admission screening prior to outpatient surgery.

Serology Testing

Serology testing (procedure codes 86592 and 86593) is a Medicaid covered service. Type of Service "I" must be used.

Wasserman test used in venereal disease testing is non-covered.

Skin TestingTuberculosis (TB) Tine Test

Procedure code 86585, Skin Test; tuberculosis tine test, is a Medicaid covered service. Type of Service "I" (Technical Component Only) should be used.

Allergy Testing

When performing allergy skin testing (procedure codes 95000-95051 or 95080-95082) it is appropriate to bill only one procedure code within a group which is indicative of the number and type of tests performed. For example, if eleven intradermal skin tests are performed, the appropriate procedure code indicating "11-15" tests would be the only code billed. Place a "1" in the "Days or Units" field (24F) of the HCFA-1500.

Smears and Cultures

- o Covered for the diagnosis and treatment of acute infection.

12/87

SECTION 13

- o Bacterial, fungi, microplasma, endotoxin, tissue, virus, tubercle cultures, etc., are covered.
- o Bacterial smear and culture of the same area on the same date of service are non-covered. Only the culture is payable.
- o Sensitivity studies are covered.
- o Wet and dry mount smears are covered.
- o Thayer-Martin used in venereal disease testing is non-covered.

Carcinoembryonic Antigens (C.E.A. Tests)

- o These tests are payable only for cancer of the colon, stomach, pancreas, or lungs.
- o The test employing the reagent must be used with other tests that are acceptable for diagnosing cancer or a test for tumor growth reoccurrence in patients who have had a tumor radiated or removed surgically.

Urinalysis

Clinical pathology urinalysis codes 81000 - 81099 must be consistent with the diagnosis (disease, procedure).

Clean catch kit to collect a clean-voided midstream specimen for culture is covered in the physician's office by billing procedure code 99070. Specify the supply provided.

Routine urinalysis is non-covered except for monthly prenatal visits and new patient examinations (when applicable). When billing the global delivery code (59400), the fee for this procedure includes all urinalysis testing during the prenatal period.

Simple catheterization of the urethra to collect a urine specimen is included in the fee for the office visit and is not separately covered.

Culture media (e.g., agar, broth egg base, Thayer-Martin, culturette, etc.) is part of a culture and is not paid separately.

12/87

SECTION 13

When a microscopy and urinalysis are performed on the same date of service, use urinalysis procedure code 81000 only. Do not bill separately.

Supplies such as dextrostik, ketodiastik or clini-test/acetest, or multistick (for qualitative, simple specimen, urine for glucose) are included in the office visit fee and are not paid separately.

Pap Smears

Pelvic examinations and obtaining the specimen for a pap smear are included in the reimbursement for the office visit. Processing and interpreting the pap smear (88150) are only payable to a facility employing a pathologist (cytologist). However, procedure code 88151 may be billed for those abnormal pap smears requiring interpretation by a physician.

Surgical Pathology

According to the Physicians' Current Procedural Terminology (CPT), procedures 88300 through 88399 include accession, handling, and reporting.

Providers should be very specific in describing certain procedures. Procedure codes 88311, 88312 and 88313 require manual pricing by the State Medical Consultant. The fee determination is based on the number of slides tested and what particular stain was used in the analysis.

Only one of the procedure codes 88300-88309 should be used in reporting specimens (single or multiple) which are removed from a single anatomic site. However, additional procedure codes within this range may be used for specimens removed from more than one anatomic site requiring examination and report (e.g., hysterectomy and biopsy of lung).

Determination of anatomical site(s) by the consultant is impossible without a diagnosis or pathology report. Therefore, in order to expedite claims processing and reduce claim resubmissions, providers are requested to include the diagnosis(es) on the claim form and/or attach a pathology report which identifies the location of each anatomical site.

For purposes of uniformity, the following outline is offered to help categorize surgical pathology procedures 88300 - 88309.

88300 Surgical pathology, gross examination only.

88300 is used when any specimen which in the opinion of the examining pathologist can be satisfactorily handled without microscopic examination.

88302 Surgical pathology, gross and microscopic examination of presumptively normal tissue(s), for identification and record purposes.

88302 is used for specimens ordinarily requiring relatively little time, effort, and professional responsibility. This descriptor will ordinarily include tissue determined by the surgeon to be "normal". If it is necessary to make several slides or perform extra studies, coding under a higher number may be justified.

88304 Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); uncomplicated specimen.

88304 includes tissues thought to be abnormal that require more professional responsibility and effort than those described under 88302, and in which the number of slides is small. Usually, if two tissues are combined on one slide this number is used. Lesions requiring several slides to assess margins and larger organs requiring several slides to evaluate all areas would ordinarily be coded under a higher number.

88305 Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); single complicated or multiple uncomplicated specimen(s), without complex dissection.

88305 includes those specimens that carry substantial professional responsibility and/or effort. Entire 181organs, with or without adjacent tissue, but without complex dissection, might ordinarily be coded here.

88307 Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); single complicated specimen requiring complex dissection or multiple complicated specimens.

88307 would include more complicated and/or larger specimens requiring more physician effort for dissection and/or description. Tissues with limited node dissections or more complex tumors or specimens might be included here.

88309 Surgical pathology, gross and microscopic examination of presumptively abnormal tissue(s); complex diagnostic problem with or without extensive dissection.

88309 would include the most complicated and largest specimens with extensive dissection and/or complex diagnostic problems. Most specimens with regional node dissections would be included here.

Lab Services for Outpatient Surgeries

Covered Services

- o Complete blood count and urinalysis for surgery requiring local anesthesia.
- o Complete blood count, urinalysis and chest x-ray (one view) for surgery requiring general anesthesia.

Non-Covered Services

- o Routine SMA 6 or 12, electrocardiogram, prothrombin time, thrombin time, thromboplastin time, bleeding time, clotting time, prothrombin consumption test, platelet count, cholinesterase, VDRL or RPR, and tourniquet test.
- o Sickle cell screen (surgery requiring local anesthesia).

Therapeutic Apheresis (Plasma and/or Cell Exchange)

Therapeutic Apheresis (Plasma and/or Cell Exchange), procedure code 36520 is covered by Medicaid but must be prior authorized by the State Medical Consultant. The following supplies may be billed; however procedure code J7030 also requires prior authorization.

J7040 IV Fluids (per 500 ml unit)
J7030 Infusion Normal Saline Solution, 1000 cc (see Page 13-31).

Non-Covered Services

The following services are not covered by Medicaid:

- o Handling and/or conveyance of specimen for transfer from physician's office to a laboratory.
- o Handling and/or conveyance of specimen for transfer from the patient in other than a physician's office to a laboratory.

- o Postage
- o Telephone calls for consultations.
- o Drawing fees, as these are included in the reimbursement for the office visit. Drawing fees may not be billed to the recipient.

Clinical Diagnostic Laboratory Procedures

Section 2303 of the Deficit Reduction Act of 1984 (P.L. 98-369) contains guidelines for reimbursement for certain clinical diagnostic laboratory services and is applicable to physicians (individual or group practice), independent laboratories and outpatient hospitals. These guidelines contain a requirement that Medicaid reimbursement may not exceed the national limitation amount.

The following procedures have been identified as clinical diagnostic laboratory procedures. The appropriate Type of Service to be billed for these procedures is Type of Service "I" (Technical Component - Laboratory).