Sec. 17-134d-50. Medicaid reimbursement clinical diagnostic laboratory services furnished by acute care hospitals

(a) **Definitions**

(1) This regulation defines the method of reimbursement of clinical diagnostic laboratory services provided by acute care hospitals to Connecticut Medical Assistance recipients.

(2) For the purposes of this regulation, "Clinical Diagnostic Laboratory Services" means those clinical diagnostic laboratory tests and related specimen collections subject to the statewide Clinical Diagnostic Laboratory Test Fee Schedule established by the State Medicare carrier for outpatient hospital-based laboratories effective July 1, 1984 in accordance with Section 2303 of Public Law 98-369. The procedures covered by this definition shall include or exclude any subsequent additions or deletions made by the State Medicare carrier for outpatient hospital-based laboratories. Each test covered is identified and described using the Health Care Financing Administration Common Procedures Coding System (HCPCS) five (5) digit procedure code and terminology or local codes and descriptions assigned by the State Medicare carrier.

(3) "Hospital Outpatient" means a person who has not been admitted by the hospital as an inpatient but is registered on the hospital records as an outpatient and is directly receiving outpatient hospital services (rather than supplies alone). Where the hospital uses the category "day patient," i.e., a person who directly 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.

(4) "Hospital Nonpatient" means a person who is not registered on the hospital records as an outpatient or is not directly receiving services from the hospital but the hospital provides all or part of the required testing.

(5) For the purposes of these regulations, "hospital" means acute care Connecticut-based or border hospital.

(6) "Department" means the Department of Income Maintenance.

(7) "Rate Year" means beginning January 1, 1987 the Medicaid rate year shall be concurrent with the Medicare rate year.

(b) **Services Covered**

Clinical Diagnostic Laboratory Services, as defined in these regulations, and Specimen Collection Fees, as provided in these regulations, are eligible for payment as set forth below provided the requirements set forth below are met.

(c) **Services Not Subject to the Fee Schedule**

Laboratory tests not subject to the fee schedule pursuant to this regulation include:

(1) Laboratory tests furnished to a hospital inpatient as defined in § 150.1B of the Department's Medical Services Policy Manual;

(2) Those laboratory tests furnished by hospital-based end-stage renal dialysis (ERSD) facilities the cost of which are included in the ERSD composite rate payment;

(3) Laboratory tests and services as identified by the State Medicare carrier to be performed by a physician; and

(4) Certain blood tests and test primarily associated with the provision of blood products as identified by the State Medicare carrier.

(d) **Need for Service**

In order to be eligible for reimbursement any clinical diagnostic laboratory service performed and for which payment is sought must be reasonable, necessary, and furnished under the direction of a physician for the diagnosis or treatment of a particular illness or injury of the patient upon whom the test was performed.

(e) **Payment Rate**

(1) Pursuant to Section 2303 (g) (2) and (j) (2) of Public Law 98-369 enacted effective July 18, 1984, clinical diagnostic laboratory services provided to hospital outpatients and nonpatients and performed on and after July 1, 1984 and paid on or after October 1, 1984 shall be reimbursed no more than the statewide fee schedule for clinical diagnostic laboratory tests, including amounts for specimen collections as permitted under these regulations, established by the State Medicare carrier for outpatient/nonpatient hospital-based laboratories; or the amount of the charges billed for the tests. Effective for outpatient clinical laboratory services rendered on or after July 1, 1986, the rate shall be the lesser of the amount determined under such Medicare fee schedule, the limitation amount for that test pursuant to Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986, or the amount of the charges billed for the tests;

(2) In order to remain in compliance with Section 2303 (g) (2) and (j) (2) of Public Law 98-369 for the rate period July 1, 1985 through June 30, 1986 and Section 9303 (b) of the Public Law 99-272 enacted effective July 1, 1986 for the rate period July 1, 1986 through December 31, 1986 and the current rate year, i.e., January 1, 1987 through December 31, 1987 and all subsequent Medicare rate years, the rates for clinical diagnostic laboratory services as defined in these regulations shall be reimbursed as follows:

(A) For the Medicare rate period July 1, 1985 through June 30, 1986, payments by the Department shall be made in accordance with the Medicare Fee Schedule as it existed on July 1, 1985. The rates established by the Department shall be the lesser of the Medicare Fee Schedule for such period or the amount of the charges billed for the tests;

(B) For the Medicare rate period July 1, 1986 through December 31, 1986, the rates established by the Department shall be the lesser of the Medicare Fee Schedule in effect on July 1, 1985, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 for the amount of the charges billed for the tests.

(C) For the Medicare rate period beginning on and after January 1, 1987, the rates of payment shall be based upon the lesser of the amount of the Medicare Fee Schedule, the limitation amount pursuant to Section 9303 (b) of the Public Law 99-272 or the amount of the charges billed for the tests;

(D) Any subsequent changes mandated by Congress or of the United States Department of Health and Human Services shall be implemented by the Department as soon as practicable retroactive to the effective date of said mandatory change.

(f) **Payment Limitations**

(1) The amount paid by the Department for the clinical diagnostic laboratory services including amounts for specimen collections as permitted under these regulations constitutes payment in full to the provider hospital.

(2) There is no payment of Medicare coinsurance and deductible for clinical diagnostic laboratory tests subject to these regulations.

(3) When the hospital obtains laboratory tests for outpatients or nonpatients under

arrangements with independent laboratories or other hospital laboratories, either the originating hospital (or hospital laboratory) may receive payment for all tests, or the originating hospital and the reference laboratories may receive payment for the tests they perform. The hospital may not receive payment for tests under arrangement if it does not operate a laboratory.

(4) Pursuant to said Section 2303 (g) (2) and (j) (2) of Public Law 98-369, it will be necessary to verify that any amounts expended by the Department between October 1, 1984 and January 31, 1986 inclusive, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under the Social Security Act by Medicare. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(5) The methodology to be employed to accomplish this verification in subsection (f) (4) of these regulations will be one of the two methodologies set forth below at the election of the hospital. However, once a hospital has elected one methodology it may not wait for the results of that methodology and then request the other methodology. Each hospital must notify the Department of its election by March 31, 1986. Failure of a hospital to provide notification of said election or failure of a hospital to provide the necessary information required by whichever option the hospital has selected may result in the Department's deferral of payment for clinical diagnostic laboratory services of that hospital until said hospital has furnished the required information.

METHOD I

(6) The Department will take a random sample of claims paid for clinical diagnostic laboratory services under the applicable UB82 revenue codes for each hospital using the Department's claims payment history for each hospital. The sample will be randomly taken from all hospital claims paid using the summary, ratio-to-cost methodology and for which payment was made by the Department on or after October 1, 1984 for dates of service between July 1, 1984 and January 31, 1986 inclusive. The claims data base will be collected until the Department, at its sole discretion, determines that a sufficient number of clinical tests within said dates of service have been paid. The Department will provide each hospital with a record of each recipient claim payment included in the sample. The record will show the amount billed by the hospital, dates of service, the amount paid, and the date of payment by the Department for each applicable revenue code. This method will require the hospitals to provide to the Department a corresponding report indicating the details of each recipient claim in the sample. The detail report must include:

(A) the recipient's name and Medicaid identification number;

(B) the HCPCS for each test in the sample claim;

(C) the corresponding fee schedule rate, if available, and hospital charge for each test in the sample claim;

(D) date of service of each test and specimen collection;

(E) the total of the above details including the totals of the amounts that would have been billed and the amount that would have been paid using the Medicare Fee Schedule (if available);

(F) the hospital should report applicable specimen collection fees in the same manner

as described above as long as the collection fees are in conformance with the specimen collection section below;

(G) it is possible that some of the sample claims selected may represent a mixture of tests which are subject to, and tests which are not subject to, the Medicare Fee Schedule. The total charges for the tests which are not subject to the Medicare fee schedule must also be set forth on the hospital's detail report in order to reconcile the total of the charges on this report with the total charges on the Department's claims sample report sent to the hospital. Details for tests not subject to the fee schedule, as provided for in these regulations, need only show the aggregate amount billed.

(H) the Department will compare the ratio of the total amount billed by the hospital and paid by the Department with the ratio of the total amount billed by the hospital and paid using the Medicare Fee Schedule. The ratio of the amount paid to the amount billed is the percent of the amount billed to the amount paid. If the ratio resulting from the Department's sample claims is larger than the ratio resulting from the hospital's details of the sample claims using the fee schedule, an overpayment will exist. To determine the actual amount of the overpayment, the total amount billed by the hospital corresponding to the claims paid for the period beginning October 1, 1984 through January 31, 1986 will be multiplied by the ratio resulting from the total amounts calculated from the hospital's detailed report. If the total actually paid for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for the period October 1, 1984 through January 31, 1986. If the Department determines that the hospital has been overpaid, the Department shall notify the hospital. If payment arrangements satisfactory to the Department are not made by the hospital within thirty (30) days of said notification, the Department, in its sole discretion, may recoup the overpayment from the next payment or payments due from the Department to the hospital.

METHOD II

(7) At the election of the hospital, the Department will collect claims data for clinical diagnostic laboratory services from each hospital's record of payments for a sample period. The sample period will reflect claims paid at the current Medicare fee schedule including related specimen collection fees which meet the requirements of the specimen collection section below. The sample period shall include dates of service for a three month period beginning February 1, 1986 through April 30, 1986 which have been paid pursuant to the Medicare Fee Schedule.

(A) The Department will use its Medicaid Management Information System (MMIS) to collect the data necessary to determine any overpayment. The data will be collected until the Department, in its sole discretion, determines that a sufficient number of clinical tests with dates of services within the sample period have been paid.

(B) The data to be collected will be the total of the amounts billed by each hospital during the sample period and the total amount paid by the Department to each hospital covering dates of service in the same period. The amount billed should represent the hospital's usual and customary charges for clinical laboratory services and the Department's payment will be the amounts allowed in accordance with the current Medicare Fee Schedule.

(i) For the retroactive period covered by dates of service commencing July 1, 1984 (and paid by the Department on or after October 1, 1984) through June 30, 1985, the total amount billed in the sample period shall be adjusted for any across-the-board changes in the hospital's usual and customary charges set for clinical diagnostic laboratory services subject to the Medicare Fee Schedule and occurring on and after July 1, 1985. If such increases occurred, the hospital will be required to furnish the Department with the following information regarding its usual and customary charge history for clinical diagnostic laboratory services and specimen collection fees as defined in these regulations during the period July 1, 1985 through April 30, 1986:

(aa) the date(s) the across-the-board charge rate change(s) became effective between July 1, 1985 and April 30, 1986;

(bb) the amount of across-the-board change, e.g., percent or dollar amount.

The total amount paid for the sample period will be adjusted by the amount of the Medicare Fee Schedule rate increase which became effective July 1, 1985. The ratio of the adjusted amounts billed to the adjusted amount paid during the sample period shall represent the ratio of the total amount that should have been billed and paid during the aforementioned retroactive period for clinical laboratory services. Said ratio will be applied to the total amount actually billed by the hospital for the aforementioned retroactive period. The resulting amount shall represent the total amount which the Department should have paid to the hospital in said period. If the total amount which was actually paid to the hospital for said period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(ii) For the retroactive period beginning with dates of service July 1, 1985 through January 31, 1986, the unadjusted ratio calculated from the actual amount billed and paid for the sample period shall be applied to the total amount billed for said retroactive period. If the total amount which was actually paid to the hospital for said retroactive period is greater than the amount calculated to be the amount the Department should have paid, the resulting difference between said amounts shall be the total amount of the overpayment for clinical diagnostic laboratory services paid to the hospital for said retroactive period.

(iii) The Department shall notify the hospital of the overpayment resulting from either or both retroactive periods. If payment arrangements are not made by the hospital within thirty (30) days of said notification satisfactory to the Department, the Department in its sole discretion, may recoup said overpayment(s) from the next payment or payments due from the Department to the hospital.

(iv) If the amount of difference for either retroactive period utilizing Method I or Method II reveals that the Department paid less than would have been paid pursuant to Medicare, no payment shall be made by the Department to the hospital.

(8) Should any claims for clinical diagnostic laboratory services rendered prior to February 1, 1986 be submitted after the date that any overpayment has been calculated, the ratio used in determining the overpayment using either Method I or Method II shall be applied in calculating the amount of reimbursement for said services.

(9) Pursuant to said Section 9303 (b) of the Public Law 99-272, it will be necessary to

verify that any amounts expended by the Department for dates of service on and after July 1, 1986 and received for payment on or before November 30, 1986, for clinical diagnostic laboratory tests did not exceed the amount that would be recognized under said Section. If any such payments are found to exceed the amount permitted by Federal law, said amounts shall be adjusted so as not to exceed the maximum amount permitted by Federal law.

(10) Such amount of overpayment found pursuant to subsection (f) (9) of these regulations will be recouped from the next payment or payments due from the Department to the hospital.

(g) **Specimen Collections**

(1) Payment for drawing or collecting specimens is allowed for those hospitals who have an established rate and routinely charge for specimen collections.

(2) The payment of specimen collections is the lower of:

(A) the Medicare rate;

(B) the Medicaid prevailing rate; and

(C) the hospital's usual and customary charge.

(3) Payment will be made only in those cases in which the hospital has drawn or collected the specimen from the patient.

(4) Only one (1) collection fee is allowed for each type of specimen (e.g., blood, urine, etc.) for the same patient encounter regardless of the number of specimens drawn or collected.

(5) Payment is allowed in circumstances such as drawing blood samples through venipuncture (i.e., inserting into vein a needle with syringe or vacutainer to draw the specimen) or collecting a urine sample by catheterization.

(6) When a series of specimens is required to complete a single test (e.g., glucose tolerance test), the series is treated as a single encounter.

(7) A specimen collection fee is not allowed for samples where the cost of collecting the specimen is minimal (such as a throat culture, a routine capillary puncture for clotting, or bleeding time).

(8) A specimen collection fee is allowed 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, e.g., venipuncture or sample by catheterization. A specimen collection fee is not 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. It must be indicated in the SNF patient record that no staff is available to draw the sample.

(9) The amount allowed by the Department for drawing or collecting a specimen at the laboratory facility covers the specimen drawing service and materials and supplies used.

(10) The amount allowed for drawings done in the recipient's home or in a nursing home covers the travel expenses of the technician, specimen drawing service, and materials and supplies used.

(Effective August 5, 1989)