Comparative Billing Report

July 24, 2017

Comparative Billing Report Program
7127 Ambassador Rd., Suite 150
Baltimore, MD 21244

CBR#: CBR201706
Drugs of Abuse Testing
NPI#: 1111111111
Fax#: (888)555-5555

Questions: Contact CBR Support
www.cbrinfo.net
(800) 771-4430 / M-F 9 am – 5 pm ET
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Write to the return address above

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Dear Medicare Provider:

The Centers for Medicare & Medicaid Services (CMS) strives to protect the Medicare Trust Fund and effectively manage Medicare resources. To support these goals, CMS has contracted with eGlobalTech, a professional services firm, to develop Comparative Billing Reports (CBRs).

What is a CBR?

- A CBR is an educational tool that reflects your billing patterns compared to peer patterns for the same services in your state and nationwide.

Why did I get a CBR?

- You received this CBR because your billing patterns differ from your peers in your state or across the nation. Receiving this CBR is not an indication or precursor to an audit.

What should I do with this CBR?

- Read the report in its entirety. We hope the report assists you in identifying opportunities for improvement, or helps you validate your current billing patterns.
- Contact your Medicare Administrative Contractor for specific billing or coding questions, and to ensure you are meeting Medicare standards for your jurisdiction.

Do I need to reply to explain my utilization?

- No reply is necessary, as this report is for educational purposes.

REMINDER: If you have changed your mailing address or contact information, please take time to review and update the appropriate Medicare provider enrollment system.

Sincerely,

Frank Gorton
CBR-Program Director
eGlobalTech

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Drugs of Abuse Testing

Introduction

CBR201706 focuses on Medicare Part B providers who referred or ordered procedures for drug abuse testing with presumptive and/or definitive testing for dates of service January 1, 2016-December 31, 2016. The presumptive tests for Healthcare Common Procedure Coding System (HCPCS) codes G0477 - G0479 are drug tests used to determine the presence for any number of drug classes and any number of devices or procedures (eg, immunoassay) per date of service. The difference in the HCPCS codes for the presumptive tests indicates the method by which the test is read. The definitive tests for HCPCS codes G0480 – G0483 are drug tests that utilize drug identification methods capable of identifying individual drugs and to distinguish between structural isomers of all sources, qualitative or quantitative, including specimen validity testing, per date of service. The difference in the HCPCS codes for the definitive tests indicate the number of drug classes tested, including metabolites. Table 1 describes the type of drug testing and the method or number of drug classes tested for each HCPCS code. A summary of these codes is given in Table 1:

Table 1: Summary of HCPCS Codes for Drugs of Abuse Testing

Type	HCPCS Code	Method/Number of Drug Classes
Presumptive	G0477	Read by direct optical observation only
Presumptive	G0478	Read by instrument-assisted direct optical observation
Presumptive	G0479	Read by instrument chemistry analyzers
Definitive	G0480	Testing of 1-7 drug classes
Definitive	G0481	Testing of 8-14 drug classes
Definitive	G0482	Testing of 15-21 drug classes
Definitive	G0483	Testing of 22 or more drug classes

Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS)

The metrics included in this report are:

- The percentage of definitive tests using HCPCS code G0483
- The percentage of services ordered too frequently
- The average number of services per beneficiary
- The average number of services per visit

This report is based on the HCPCS codes for presumptive and definitive drug testing services that were effective through December 31, 2016. Beginning January 1, 2017 several of these

codes have been deleted or changed. Additional information can be found in the Current Procedural Terminology (CPT®) and HCPCS manuals and on the Medicare Fee-for-Service-Payment Clinical Lab Fee schedule.

According to the *Supplementary Appendices for the Medicare Fee-for-Service 2016 Improper Payments Report*, laboratory tests (which include urine drug screenings) were included in the list of **Top 20 Service Types with Highest Improper Payments: Part B**. These tests had an improper payment rate of 36 percent with a projected $1.3 billion in improper payments. The goal of this CBR is to educate providers on proper billing of drugs of abuse testing.

Coverage and Documentation Overview

This portion of the CBR offers a broad look at the coverage and documentation requirements to ensure compliance with Medicare guidelines**. The information provided does not supersede or alter the coverage and documentation policies, as outlined by the Medicare Administrative Contractors' (MACs) Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

Urine drug testing (UDT) assists clinicians by providing objective information that can be used to identify the presence or absence of drugs or drug classes in the body. This facilitates making treatment decisions.

These three patient groups are covered for UDT:

- Group A is for symptomatic patients with multiple drug ingestion and/or patients with an unreliable history. Treatment is usually in an urgent care setting and a presumptive test should be done as part of the evaluation and management of the patient. Patients should be treated based on the presumptive results in order to stabilize them until the results of rapid definitive testing are completed and the cause or causes are determined.

- Group B is for diagnosis and treatment for substance abuse or dependence, also known as substance use disorder (SUD). Definitive testing may be ordered when accurate and reliable results are necessary to integrate treatment decisions and clinical assessment. The frequency and the rationale for definitive UDT must be documented in the patient's medical record. Presumptive UDT for SUD is expected at a frequency of one to three times per week. Testing more than three times in one week is not considered reasonable and necessary. The testing frequency must meet medical necessity and be documented in the medical record. The results of the testing should also be included in the medical record.

- Group C includes patients that are on chronic opioid therapy (COT). Testing must be documented as medically necessary and reviewed by the clinician in the management of prescribing/renewing a controlled substance for every risk group. These patients are categorized as low, moderate and high risk. If they are high risk prior to initiation of COT, random, presumptive testing can be performed one to three times every three months. It is expected to be less frequent for low and moderate risk patients. These screenings would assist a physician with monitoring medication adherence, possible abuse or misuse of medication, side effects and possible drug interactions with undisclosed substances.

The following table outlines the guidelines for definitive testing for SUD:

Table 2: Definitive Testing for Substance Use Disorder

Consecutive Days of Abstinence	Expected Frequency	Not Reasonable and Necessary
0-30	1 per week	> 1 per week
31-90	1-3 per month	> 3 per month
>90	1-3 in 3 months	> 3 in 3 months

The date of service is the date of the sample collection, not the date the test was performed. Only one presumptive and one definitive test may be billed per patient per date of service. All subsequent claims are likely to be denied. In addition, the service reported on the claim must match the service that was ordered by the physician. If a presumptive test is negative for a patient on a prescribed medication, a definitive test may be performed. It would not be expected that a provider would bill both a presumptive and definitive test on every patient that is tested or every time a patient is tested. It would also not be expected that the higher codes of the definitive codes would be billed on most patients.

Laboratory testing is regulated by the Clinical Laboratory Improvement Amendments (CLIA). This amendment requires clinical labs to be certified by their state and by CMS. Clinical labs are not allowed to accept human samples for diagnostic testing until they have both certifications.

Methods & Results

This report is an analysis of providers submitted as the “Referring NPI” on Medicare Part B claims extracted from the Integrated Data Repository (IDR) based on the latest version of the claim as of June 7, 2017. The analysis includes claims with dates of service from January 1, 2016 to December 31, 2016.

There are over 140,000 providers nationwide who are indicated as referring NPI's on claims with allowed charges for the HCPCS codes (G0477-G0483) that are included in this study. Those who received the CBR were significantly higher than one of their peer groups on at least one of the measurements studied and also were above the 85th percentile in allowed charges ($5,000), with at least 20 beneficiaries during this one-year period.

Table 3 provides a summary of your utilization of the procedure codes included in this CBR. The total allowed charges, allowed services, and distinct visit and distinct beneficiary counts are included for each HCPCS code. In addition an overall "Total" row is included. Your percentages and averages, denoted in Tables 4 through 7, are calculated from your utilization of the procedure codes summarized in Table 3, using the formulas that follow.

Table 3: Summary of Your Referrals of Presumptive and Definitive Tests
Dates of Service: January 1, 2016 – December 31, 2016

HCPCS Code	Allowed Charges	Allowed Services	Visit Count	Beneficiary Count
G0477	$0	0	0	0
G0478	$0	0	0	0
G0479	$11,016	139	139	135
G0480	$5,356	67	67	67
G0481	$8,240	67	67	67
G0482	$11,622	70	70	70
G0483	$17,864	83	83	82
Total	**$54,098**	**426**	**156**	**150**

Please note that the totals may not be equal to the sum of the rows due to rounding. Also, the visit count and beneficiary count are unduplicated counts for each row and the total. For example, a beneficiary receiving multiple HCPCS codes within this time period would be counted in the beneficiary count in each applicable row; however, this beneficiary would be counted only once in the total row.

Metrics were calculated from your utilization and for each of the following peer groups:

- The **state** peer group is defined as all referring Medicare providers practicing in the individual provider's state who were indicated as the referring NPI on claims with allowed charges for the procedure codes included in this study

- The **national** peer group is defined as all referring Medicare providers in the nation who

were indicated as the referring NPI on claims with allowed charges for the procedure codes included in this study

Your metrics were compared to your state (CA) and the nation using statistical analysis. There are four possible outcomes for the comparisons between the provider and the peer groups:

- Significantly Higher - Provider's value is higher than the peer value and the statistical test confirms significance
- Higher - Provider's value is higher than the peer value, but the statistical test does not confirm significance
- Does Not Exceed - Provider's value is not higher than the peer value
- N/A - Provider does not have sufficient data for comparison

It is important to note that significance is based on the total number of charges, services, visits, or beneficiaries and the variability of those values.

Percentage of Definitive Tests using G0483

For definitive tests, it is important for the clinician to individualize his/her ordering practice to reflect the needs of the patient. In some cases, the most costly code is chosen too often. For definitive tests, the highest cost option is G0483. The percentage of definitive tests using HCPCS code G0483 is calculated as follows:

$$\left(\frac{\textbf{Number of G0483 Services}}{\textbf{Number of Definitive Test Services}} \right) \textbf{x } 100$$

Table 4 provides a statistical analysis of the percentage of definitive tests using G0483. Your percentage is compared to that of your state and the nation.

Table 4: Percentage of Definitive Tests using G0483
Dates of Service: January 1, 2016 – December 31, 2016

Number of G0483 Services	Total Number of Definitive Test Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
83	287	29%	44%	Does Not Exceed	35%	Does Not Exceed

A chi-square test was used in this analysis, alpha = 0.05.

Percentage of Services Ordered Too Frequently

As detailed above, there are cases that limit the amount of time between tests of the same type. In some cases, the frequency of the testing does not meet established guidelines. For this measure services ordered too frequently is defined as presumptive test services performed within three days of the previous presumptive test and/or definitive test services performed within seven days of the previous definitive test. The percentage of services ordered too frequently is calculated as follows:

$$\left(\frac{\textbf{Number of Services Ordered Too Frequently}}{\textbf{Total Number of Services}} \right) \textbf{x 100}$$

Table 5 provides a statistical analysis of the percentage of services ordered too frequently. Your percentage is compared to that of your state and the nation.

Table 5: Percentage of Services Ordered Too Frequently
Dates of Service: January 1, 2016 – December 31, 2016

Services Ordered Too Frequently	Total Services	Your Percent	Your State's Percent	Comparison with Your State	National Percent	Comparison with National Percent
134	426	31%	6%	Significantly Higher	3%	Significantly Higher

A chi-square test was used in this analysis, alpha = 0.05.

Average Services per Beneficiary

The average allowed services per beneficiary was calculated for each referring provider of drug testing services to identify potential overutilization of these items. This measure considers all allowed services for the beneficiary with dates of service in 2016. The average number of services per beneficiary is calculated as follows:

$$\frac{\textbf{Total Number of Services}}{\textbf{Total Number of Beneficiaries}}$$

Table 6 provides a statistical analysis of the average services per beneficiary. Your average is compared to that of your state and the nation.

Table 6: Average Services per Beneficiary
Dates of Service: January 1, 2016 – December 31, 2016

Total Number of Services	Total Number of Beneficiaries	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
426	150	2.84	2.88	Does Not Exceed	3.22	Does Not Exceed

A t-test was used in this analysis, alpha = 0.05.

Average Services per Visit

The average allowed services per visit was calculated for each referring provider of drug testing services. This measure focuses on the number of actual units (or services) that were allowed on a specific date of service for a beneficiary. This measure differs from the previous measure in that it focuses on the single date of service rather than the total number of services for the entire year. The average number of services per visit is calculated as follows:

$$\frac{\textbf{Total Number of Services}}{\textbf{Total Number of Visits}}$$

Table 7 provides a statistical analysis of the average services per visit. Your average is compared to that of your state and the nation.

Table 7: Average Services per Visit
Dates of Service: January 1, 2016 – December 31, 2016

Total Number Services	Total Number Visits	Your Average	Your State's Average	Comparison with Your State	National Average	Comparison with National Average
426	156	2.73	1.58	Significantly Higher	1.48	Significantly Higher

A t-test was used in this analysis, alpha = 0.05.

References & Resources

The coverage and documentation guidelines for Drugs of Abuse Testing are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at http://www.cbrinfo.net/cbr201706-recommended-links.

LCDs:

- CGS Administrators – LCD L36029
- First Coast Service Options – LCD L36393

Centers for Medicare & Medicaid Services:

- *Medicare Fee-for-Service 2016 Improper Payments Report*

Palmetto GBA MolDX:

- 2017 Controlled Substance Monitoring and Drugs of Abuse Coding and Billing Guidelines (M00128, V5)

Electronic Code of Federal Regulations (e-CFR):

- Title 42, Chapter IV, Section 410.32

University of Connecticut

- For background on the statistical tests used in this CBR, the University of Connecticut provides resources for the t-test and the chi-square test at: http://researchbasics.education.uconn.edu/

The Next Steps

We encourage you to check with your MAC to ensure that you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201706 webinar on August 23, 2017 from 3:00-4:00 PM ET. Space is limited, so please register early. Register online at http://www.cbrinfo.net/cbr201706-webinar.

If you are unable to attend, you may access a recording of the CBR201706 webinar five business days following the event at http://www.cbrinfo.net/cbr201706-webinar.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at CBRsupport@eglobaltech.com or via telephone at (800) 771-4430.

For written correspondence, postal mail can be sent to the following address:

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