RELI Group
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CBR #: CBR202109
Drugs of Abuse Testing

September 30, 2021

NPI #: 1234567890
Fax #:

First Name Last Name Title
Address1
Addrees2
City, State, Zip

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 the RELI Group to develop this Comparative Billing Report (CBR) and to support providers with its use.

CMS routinely distributes an educational tool, known as a CBR, to the provider community in a variety of Medicare Fee-for-Service service areas. A CBR reflects a specific provider's billing and/or prescribing patterns as compared to his/her peers' patterns for the same services in his/her state or specialty, and nationwide. The CBR is intended to enhance accurate billing and/or prescribing practices and support providers' internal compliance activities. The report is not an indication of wrongdoing, and can support internal compliance review efforts, especially those related to coding and billing of code sets. Receiving a CBR is not an indication or precursor to an audit, and it requires no response on a provider's part. Selected providers, however, may be referred for additional review and education as a part of CMS' routine CBR Program.

This CBR provides data regarding your claims submission, as compared to other providers' claims submission within your state, and in the nation. The report is offered to facilitate an analysis of your billing submissions during a timeframe that includes the (Public Health Emergency) PHE. Please consider the changes that took place to your billing practices during the PHE when you review the data within this report.

Please carefully review this report. You may wish to check your records against data in CMS' files and review Medicare guidelines to ensure compliance. Contact your Medicare Administrative Contractor (MAC) with specific billing or coding questions. As appropriate, please share this CBR with others who may benefit from and/or assist with interpreting the data provided in the report.

To access an electronic copy of your CBR: Visit the secure CBR portal at https://cbrfile.cbrpepper.org/. Populate the fields, and in the "validation code" field, enter your unique validation code: SAMPLECD.

For more information: Please access a recorded webinar and additional resources at CBR.CBRPEPPER.org. Register for a live webinar on October 6, 2021, 3 p.m. ET.

To request assistance or submit questions: Contact the CBR Help Desk at https://cbr.cbrpepper.org/Help-Contact-Us.

Sincerely,

The CBR Team

REMINDER: Please ensure your email address and fax number are updated in the following systems:

- National Plan and Provider Enumeration System (NPPES): https://nppes.cms.hhs.gov/#/
- Provider Enrollment, Chain, and Ownership System (PECOS): https://pecos.cms.hhs.gov/pecos/login.do#headingLv1

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Comparative Billing Report (CBR) 202109
September 30, 2021

Drugs of Abuse Testing

Introduction

CBR202109 focuses on referring and rendering providers that submitted claims to Medicare Part B for drug testing or referred patients for drug testing. The analysis will focus on Current Procedural Terminology® (CPT®) codes 80305, 80306, and 80307, and Healthcare Common Procedure Coding System (HCPCS) codes G0480, G80481, G0482, G0483, and G0659. For the purposes of this document and analysis, these CPT® codes will be referred to as "presumptive and definitive drug testing," and "drug testing." Additionally, CPT® codes 80305, 80306, and 80307 will be referred to as "presumptive drug tests," and HCPCS codes G0480, G80481, G0482, G0483, and G0659 will be referred to as "definitive drug tests."

The CBR analysis was based on claims extracted from the Integrated Data Repository, based on the latest version of claims available on June 8, 2021. The analysis includes claims with dates of service from March 1, 2020, through Feb. 28, 2021. For the trend analysis presented in Figure 1 and Figure 2, claims represent dates of service between March 1, 2018, and Feb. 28, 2021.

The *2020 Medicare Fee-for-Service Supplemental Improper Payment Data* report reflects an improper payment rate of 42.7% for HCPCS code G0483, which represents $104,686,170 in improper payments. After review of and research into the improper payment rate, this CBR was created to analyze the possible threat associated with presumptive and definitive drug testing to the Medicare Trust Fund. The expectation is that providers that perform presumptive and definitive drug tests or refer patients for drug test at a higher rate than their peers will use the results of this report to support internal compliance and confirm accurate billing and coding practices.

The criteria for receiving a CBR are that a provider:

1. Is significantly higher compared to either state or national percentages in any of the three metric calculations (i.e., greater than or equal to the 90th percentile), and
2. Has at least 31 beneficiaries with claims and at least $24,240 in total allowed charges for Metric 1a, or at least 30 beneficiaries with claims and at least $31,870 in total allowed charges for Metric 1b, or at least 16 beneficiaries with claims and at least $6,090 in total allowed charges for Metric 2.

Coverage and Documentation Overview

Table 1 identifies the CPT® and HCPCS codes used in the CBR analysis.

Table 1: CPT® and HCPCS Code Descriptions

CPT®/HCPCS Codes	Description
80305	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; capable of being read by direct optical observation only, includes sample validation when performed, per date of service
80306	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; read by instrument assisted direct optical observation, includes sample validation when performed, per date of service

CPT®/HCPCS Codes	Description
80307	Drug test(s), presumptive, any number of drug classes, any number of devices or procedures; by instrument chemistry analyzers, chromatography, and mass spectrometry either with or without chromatography, includes sample validation when performed, per date of service
G0480	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers, including, but not limited to, GC/MS and LC/MS and excluding immunoassays and enzymatic methods, (2) stable isotope or other universally recognized internal standards in all samples, and (3) method or drug-specific calibration and matric-matched quality control material; qualitative or quantitative, all sources, includes specimen validity testing, per day; 1-7 drug class(es), including metabolite(s) if performed
G0481	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers including, but not limited to GC/MS and LC/MS and enzymatic methods, (2) stable isotope or other universally recognized internal standards in all samples, and (3) method or drug-specific calibration and matric-matched quality control material; qualitative or quantitative, all sources, includes specimen validity testing, per day; 8-14 drug class(es), including metabolite(s) if performed
G0482	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers including, but not limited to GC/MS and LC/MS and enzymatic methods, (2) stable isotope or other universally recognized internal standards in all samples, and (3) method or drug-specific calibration and matric-matched quality control material; qualitative or quantitative, all sources, includes specimen validity testing, per day; 15-21 drug class(es), including metabolite(s) if performed
G0483	Drug test(s), definitive, utilizing (1) drug identification methods able to identify individual drugs and distinguish between structural isomers including, but not limited to GC/MS and LC/MS and enzymatic methods, (2) stable isotope or other universally recognized internal standards in all samples, and (3) method or drug-specific calibration and matric-matched quality control material; qualitative or quantitative, all sources, includes specimen validity testing, per day; 22 or more drug class(es), including metabolite(s) if performed
G0659	Drug test(s), definitive, utilizing drug identification methods able to identify individual drugs and distinguish between structural isomers, including but not limited to GC/MS and LC/MS, excluding immunoassays and enzymatic methods, performed without method or drug-specific calibration, without matrix-matched quality control material, or without use of stable isotope or other universally recognized internal standard(s) for each drug, drug metabolite or drug class per specimen; qualitative or quantitative, all sources, includes specimen validity testing, per day, any number of drug classes

Table 2 provides summaries of your utilization of CPT® and HCPCS codes for drug testing.

Table 2: Summary of Your Utilization of CPT® and HCPCS Codes for Drug Tests Between March 1, 2020, and Feb. 28, 2021

CPT®/HCPCS Codes	Allowed Charges	Allowed Units	Beneficiary Count*
80305	$0	0	0

CPT®/HCPCS Codes	Allowed Charges	Allowed Units	Beneficiary Count*
80306	$0	0	0
80307	$267,016	4,297	545
G0480	$2,746	24	21
G0481	$25,368	162	75
G0482	$39,351	198	113
G0483	$956,321	3,873	535
G0659	$0	0	0
Total	$1,290,802	8,554	548

*A beneficiary is counted once per row of CPT®/HCPCS code level. The total "Beneficiary Count" is not the sum total; it represents unique beneficiaries for all the CPT®/HCPCS codes for the 12-month period.

Metrics

This report is an analysis of the following metrics:

1. Average number of presumptive and definitive drug tests, per unique beneficiary
    a. Average number of presumptive drug tests, per unique beneficiary
    b. Average number of definitive drug tests, per unique beneficiary
2. Percentage of definitive drug test using HCPCS code G0483

The CBR analysis focuses on referring and rendering providers that submitted claims for drug testing or referred patients for drug testing. Statistics were calculated for each provider, all providers in the state, and all providers in the nation. The state and national peer groups are defined as follows:

- The state peer group is defined as all referring and rendering Medicare providers practicing in the individual provider's state or territory with allowed charges for the procedure codes included in this study.
- The national peer group is defined as all referring and rendering Medicare providers in the nation with allowed charges for the procedure codes included in this study.

Each provider's values are compared to his/her state peer group values and to the national values. Your metrics were compared to your state [State_Code] and the nation. There are four possible outcomes for the comparisons between the provider and his/her peer groups:

1. Significantly Higher — Provider's value is greater than or equal to the 90th percentile from the state or national mean.
2. Higher — Provider's value is greater than the state or national mean.
3. Does Not Exceed — Provider's value is less than or equal to the state or national mean.
4. Not Applicable (N/A) — Provider does not have sufficient data for comparison.

Methods and Results

There are 85,183 referring and rendering providers nationwide that have submitted claims for drug testing or referred patients for drug testing. The total allowed charges for these claims were over $629,799,046 during the analysis timeframe.

Metric 1: Average Number of Presumptive and Definitive Drug Tests, per Beneficiary

Metric 1a: Average Number of Presumptive Drug Tests, per Beneficiary

Metric 1a is calculated as follows:

- The total number of units for presumptive drug testing is divided by the total number of beneficiaries who received at least one presumptive drug test.

Table 3: Average Number of Presumptive Drug Tests, per Beneficiary

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
4,297	545	7.88	2.15	Significantly Higher	2.08	Significantly Higher

Metric 1b: Average Number of Definitive Drug Tests, per Beneficiary

Metric 1b is calculated as follows:

- The total number of units for definitive drug testing is divided by the total number of beneficiaries who received at least one definitive drug test.

Table 4: Average Number of Definitive Drug Tests, per Beneficiary

Numerator	Denominator	Your Average	Your State Average	Comparison with Your State	National Average	Comparison with National Average
4,257	547	7.78	1.97	Significantly Higher	2.01	Significantly Higher

Metric 2: Percentage of Definitive Drug Tests Using HCPCS Code G0483

Metric 2 is calculated as follows:

- The number of allowed units of HCPCS code G0483 is divided by the total number of allowed units for all definitive drug tests.

Table 5: Percentage of Definitive Drug Tests Using HCPCS Code G0483

Numerator	Denominator	Your Percent	Your State Percent	Comparison with Your State	National Percent	Comparison with National Percent
3,873	4,257	90.98%	22.18%	Significantly Higher	33.10%	Higher

Figures 1 and 2 illustrate the trend over time analysis for the total number of beneficiaries who had claims submitted for or were referred for drug tests. Year 1, Year 2, and Year 3 are defined as follows:

- **Year 1:** March 1, 2018 – Feb. 28, 2019
- **Year 2:** March 1, 2019 – Feb. 28, 2020
- **Year 3:** March 1, 2020 – Feb. 28, 2021

Figure 1: Total Number of Beneficiaries Who Had Claims Submitted or Were Referred for Presumptive Drug Testing

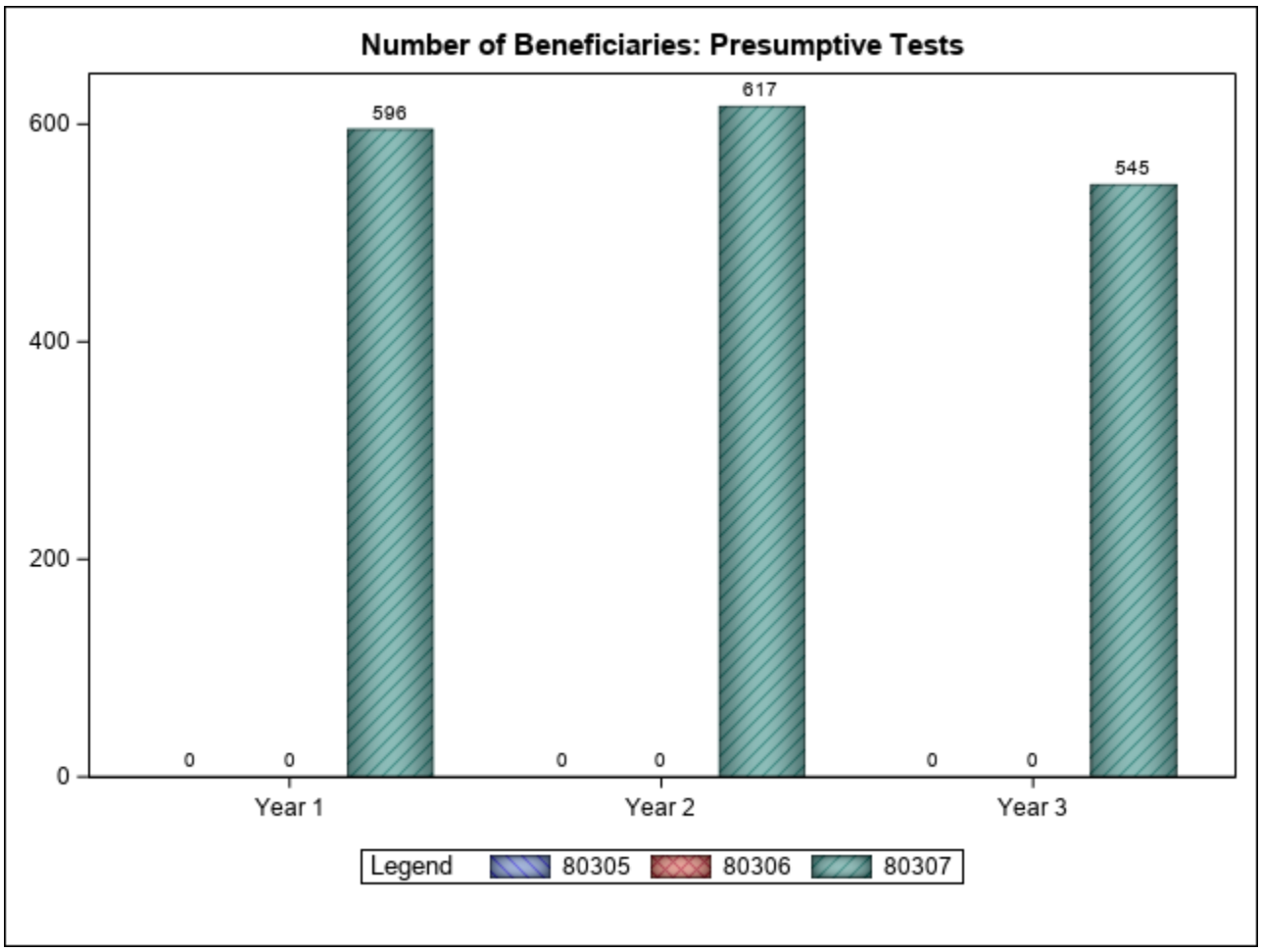
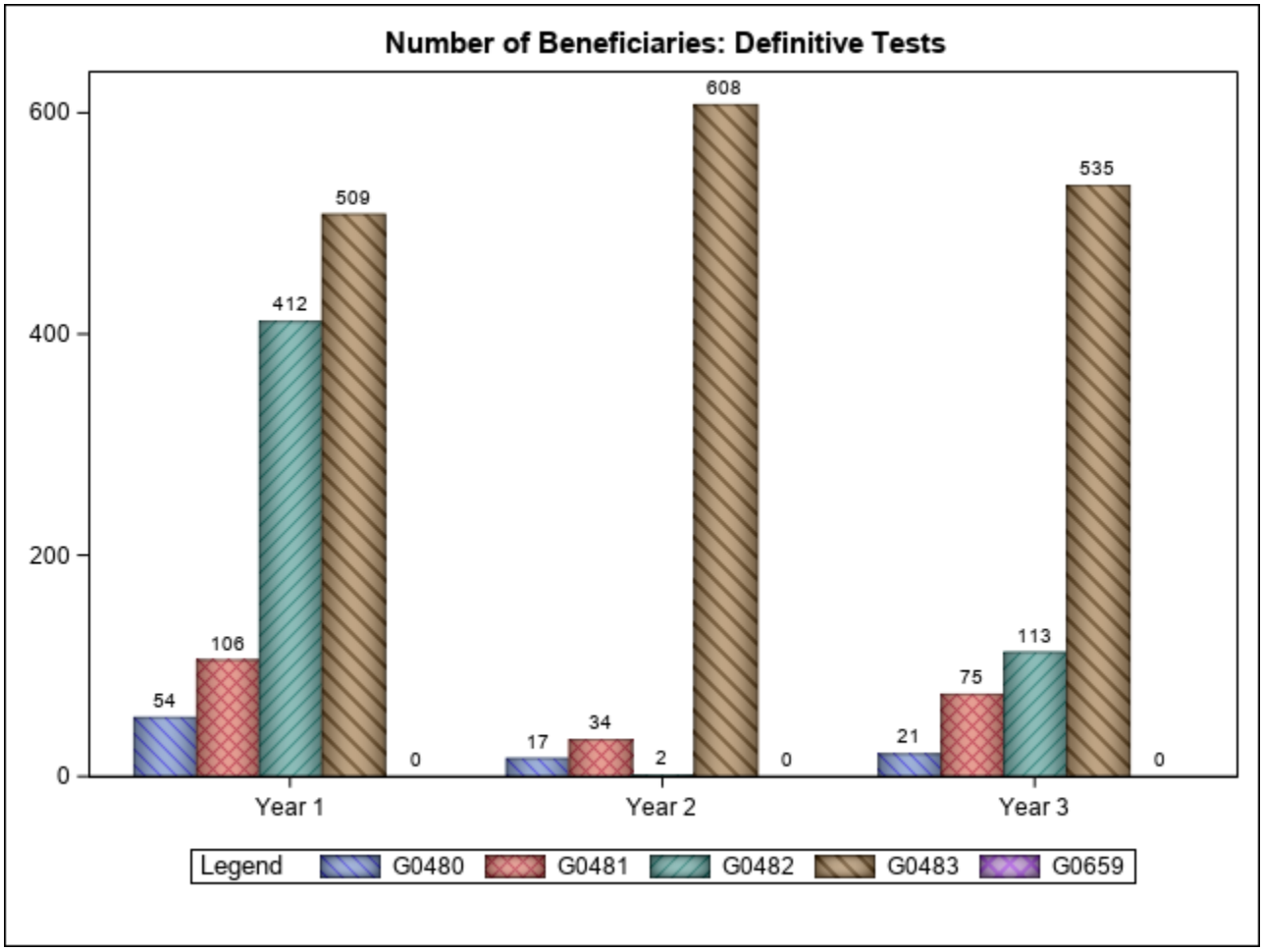


Figure 2: Total Number of Beneficiaries Who Had Claims Submitted or Were Referred for Definitive Drug Testing



References and Resources

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