CBR201706:
Drugs of Abuse Testing
Webinar Handout
August 23, 2017
3:00 p.m. ET

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INTRODUCTION

Good afternoon everyone. Welcome to the Comparative Billing Report (CBR) webinar, CBR201706: Drugs of Abuse Testing. My name is Cheryl Bailey, and I work for eGlobalTech. We also have our subcontractor from Palmetto GBA on the webinar today. We’re contracted by the Centers for Medicare & Medicaid Services (CMS) to produce CBRs. Our teams conduct the data analyses; we develop and disseminate the reports, ensure data integrity and privacy, and provide customer service and educational outreach.

Before we get started, I just want to point out that we ensure the accuracy of the contents of the CBR at the time of publication; however, Medicare policy changes frequently. Some of the materials in the CBR may change without further notice. Please make sure you are staying up-to-date with Medicare Program requirements.

I’d also like to point out that the information in the CBR is intended to be a general summary. It doesn’t supersede or alter the coverage and documentation policies outlined in the Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs) for the A/B Medicare Administrative Contractors (MACs) or Durable Medical Equipment Medicare Administrative Contractors (DME MACs). If you have any specific questions about coverage, please contact the MAC for your region. All coverage and documentation policies can be accessed from the CMS website page titled Medicare Coverage Database (https://www.cms.gov/medicare-coverage-database/overview-and-quick-search.aspx).
Today, we’ll give you an overview of the Drugs of Abuse Testing CBR. We’ll discuss coverage policy and documentation requirements for items included in the topic, methods used to produce the report, source references, and additional resources available to you. We’ll be taking your questions at the end of the presentation. At the conclusion of the Question and Answer session, we’ll provide you with a brief survey to complete. We do welcome and value your feedback. To view the Q&A, please select the following web link: CBR201706 Webinar (http://www.cbrinfo.net/cbr201706-webinar).

Now that we’ve gone over the agenda for today’s webinar, we’d like to get your response to a poll question. During today’s presentation, we will be asking five poll questions, and we’ll give you about 30 seconds to respond to each question. We are now ready for our first poll question.

**POLL QUESTION**

*What is your role in the Medicare program for your facility?*

- Clinician
- Biller
- Compliance
- Administrator
- Other

Now that we have all of your answers, we will continue with our presentation. Thank you for your participation.

Please note that during the webinar, all attendee lines will be muted. All questions can be submitted at any time during the presentation via the chat function, which is currently open. We’ll provide responses during our Q&A session at the end of the webinar. Please keep in mind that we may not be able to answer all of your questions today; however, a Q&A document with answers to all webinar related questions submitted is available at the following link: CBR201706 Webinar (http://www.cbrinfo.net/cbr201706-webinar). For questions about individual claims, please contact your Medicare Administrative Contractor, or MAC with. To locate your MAC, please select the following link: Review Contractor Directory-Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).
By the end of this webinar, you should have a general understanding of this CBR and how the data was analyzed. You should also be able to locate policy references and resources.

If you did not receive a CBR and you’d like to reference one during this webinar, please log on to our website at CBR201706 Sample CBR (http://www.cbrinfo.net/cbr201706-sample-cbr). A sample CBR is produced for each topic, and you may find it beneficial to have a copy available to reference during the webinar.

**CBR PURPOSE & FOCUS**

The purpose of the CBR is to provide comparative data on how an individual health care provider’s billing and payment patterns compare to those of his/her peers. The CBR is solely for provider and supplier information, and gives providers the opportunity to compare themselves to their peers, check their records against data in CMS files, and review Medicare guidelines to ensure compliance.

CBR201706 focuses on Medicare providers who referred or ordered procedures for drug abuse testing with presumptive and/or definitive testing. The report examines:

- Percentage of definitive tests using HCPCS code G0483
- Percentage of services ordered too frequently
- Average number of services per beneficiary
- Average number of services per visit

The reports were sent to approximately 10,000 providers who had different billing patterns for these services as compared to their peers.
Links to all of the references and resources provided in the CBR and discussed today are currently available on the CBR website page at [CBR201706 Recommended Links](http://www.cbrinfo.net/cbr201706-recommended-links). The slides for today’s webinar are currently available on the CBR201706 webinar page, but do not contain any speaker’s notes. Within five business days of today, we’ll post the video recording of the entire webinar presentation. Additionally, all of the questions answered today, as well as those that we are not able to address this afternoon, will be answered and posted in a detailed Q&A document. This will be available on our website along with a handout of the presentation within 14 days of today (August 23, 2017). The webinar recording, handout, and Q&A document will all be posted, when available, at this link: [CBR201706 Webinar](http://www.cbrinfo.net/cbr201706-webinar).

**ACRONYMS**

Please note some of the acronyms that we will be using today:

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>CERT</td>
<td>Comprehensive Error Rate Testing</td>
</tr>
<tr>
<td>CLIA</td>
<td>Clinical Laboratory Improvement Amendments</td>
</tr>
<tr>
<td>COT</td>
<td>Chronic Opioid Therapy</td>
</tr>
<tr>
<td>CPT®</td>
<td>Current Procedural Terminology</td>
</tr>
<tr>
<td>GC-MS</td>
<td>Gas Chromatography coupled with Mass Spectrometry</td>
</tr>
<tr>
<td>HCCPCS</td>
<td>Healthcare Common Procedure Coding System</td>
</tr>
<tr>
<td>IA</td>
<td>Imunoassay</td>
</tr>
<tr>
<td>LCA</td>
<td>Local Coverage Article</td>
</tr>
<tr>
<td>LCD</td>
<td>Local Coverage Determination</td>
</tr>
<tr>
<td>LC-MS/MS</td>
<td>Liquid Chromatography coupled with Mass Spectrometry</td>
</tr>
<tr>
<td>OLR</td>
<td>Office of Legislative Research</td>
</tr>
</tbody>
</table>

Level II HCPCS codes are maintained and distributed by the Centers for Medicare & Medicaid Services (CMS).
Now that you have some information on the purpose, objective, and focus of this CBR, we would like to get your response to our second poll question.

**POLL QUESTION**

*How do you plan to use the information in the CBR and the information presented today?*

- To better understand Medicare guidelines for drugs of abuse testing
- To educate our billing staff
- To locate references and resources
- To better comprehend CBR201706
- All of the above

Now that we have all of your answers, we will continue with our presentation. Thank you for your participation. And now, I will be turning it over to Tamara Canipe who will provide a coverage and documentation overview.

**COVERAGE & DOCUMENTATION OVERVIEW**

Thank you, Cheryl. My name is Tamara Canipe. I am a Registered Nurse with Palmetto GBA. My primary responsibility is to research policies and guidelines for our CBR letters and webinar presentations. Today, I will be providing an overview of the coverage criteria, billing and documentation requirements for drugs of abuse testing.
TOPIC SELECTION - CERT

The CBR team uses reports and investigations from other entities to get ideas for our comparative billing reports. Some of those agencies include the Office of Inspector General (OIG), the comprehensive error rate testing, or CERT contractor, and of course, the Medicare Administrative Contractors, or MACs. Based on the Medicare Fee-for-Service 2016 Improper Payments Reports, laboratory tests (which include urine drug screenings) had an improper payment rate of 36 percent and accounted for a projected $1.3 billion in Medicare FFS improper payments. Most of the improper payments were due to insufficient documentation. It appears that some providers are not adhering to Medicare guidelines and are testing their patients for substance abuse when it is not medically necessary.


An article by a health information technology company, XIFIN Connected Health, titled CERT Urine Drug Testing Errors states the “Comprehensive Error Rate Testing Program (CERT) discovered an increase in denials for urine drug testing (UDT) related to substance abuse monitoring and drug abuse testing.” Additionally, the Medicare Learning Network publication also provides information on urine drug screenings. To review these report, select the web links below:

Many reports detail billing and payment errors for Medicare claims associated with substance abuse testing. According to a Reuters Health News article titled **Exclusive: Medicare on Drugs: 24,000 Tests for 145 Patients**, three doctors in Connecticut billed almost 24,000 drug tests in 2012. The billing included only 145 beneficiaries and cost Medicare $1.4 million. These three physicians ordered three to four times more drug tests for each of their beneficiaries than all other providers in the country, averaging one almost every other day. Based on the article, prescription drug abuse in older Americans has increased, and “in 2011, the average number of older Americans misusing or dependent on prescription pain relievers grew to about 336,000, up from 132,000 a decade earlier.” This has led to a dramatic increase in both urine and blood tests for drugs of abuse. To view this article, select the following web link: [Exclusive: Medicare on Drugs: 24,000 Tests for 145 Patients](http://www.reuters.com/article/us-usa-healthcare-medicare-idUSKBN0E910X20140529?wb48617274=49FDFBE0).
Bloomberg BNA’s *Health Care Fraud Report* explains in the article titled *How Urine Drug Testing Fraud and Abuse is Impacting the Treatment Community* that urine drug testing (UDT) is an objective way to monitor compliance, to detect drug abuse and to discourage illicit or un-prescribed drug abuse. It is often difficult to detect drug abuse signs in behavior. Urine drug testing (UDT) assists clinicians by providing objective information in order to identify the presence or absence of drugs or drug classes in the body which facilitates making treatment decisions. The report cites two prominent cases involving a false claims case settled by the provider Millineum for $256 million and a pending case filed by Cigna in Florida against Sky Toxicology. The article states “these cases are the tip of the iceberg.” The *Bloomberg BNA* report is available to view at the following web link: [How Urine Drug Testing Fraud and Abuse is Impacting the Treatment Community](http://www.nelsonhardiman.com/media/NelsonArticlePDF.pdf?wb48617274=E61698FB).
**LEGISLATIVE RESEARCH**

Various policies have been implemented by states to prevent prescription drug abuse and deaths related to drug abuse. The Office of Legislative Research (OLR) report titled *State Strategies for Addressing Prescription Drug Abuse* states that “The federal Centers for Disease Control and Prevention (CDC) has classified prescription drug abuse as an epidemic in the United States. In 2012, prescription drug overdoses accounted for 53% of all U.S. drug overdose deaths. Of these deaths, 72% involved opioid analgesics...Additionally, in 2011, approximately 1.4 million emergency department visits involved the nonmedical use of prescription drugs and almost half of these visits were related to opioid analgesics.” All 50 states and the District of Columbia have a Prescription Drug Monitoring Program. Missouri became the final state after a bill was passed in April 2017. More information about the OLR report can be found at the link, *State Strategies for Addressing Prescription Drug Abuse* ([https://www.cga.ct.gov/2014/rpt/pdf/2014-R-0236.pdf](https://www.cga.ct.gov/2014/rpt/pdf/2014-R-0236.pdf)).
DEFINITIONS

Presumptive UDT is used when it is medically necessary to determine whether drugs are in someone’s system at a certain cutoff level. The results are reported as positive or negative. Definitive UDT is used to identify specific medications and/or illicit drugs. The results are analyzed using complex technology.

LCDs & LCAs

This slide shows the LCDs and LCAs for Drugs of Abuse for each MAC. To view your LCD, select the link to your MAC below:

<table>
<thead>
<tr>
<th>Medicare Administrative Contractor (MAC)</th>
<th>Current LCD</th>
<th>Current LCA</th>
<th>Retired</th>
</tr>
</thead>
<tbody>
<tr>
<td>CGS Administrators, LLC</td>
<td>L36029</td>
<td>A54314</td>
<td>A54315</td>
</tr>
<tr>
<td>First Coast Service Options</td>
<td>L36393</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>National Government Services</td>
<td>L36037</td>
<td>N/A</td>
<td>A54681</td>
</tr>
<tr>
<td>Noridian Healthcare Solutions</td>
<td>L36668</td>
<td>A55001 A54998 A55030 A55031</td>
<td>N/A</td>
</tr>
<tr>
<td>Novitas Solutions, Inc.</td>
<td>L35006</td>
<td>N/A</td>
<td>L32050</td>
</tr>
<tr>
<td>Palmetto GBA</td>
<td>L35724</td>
<td>A54799 A53953</td>
<td>L35105 A53952</td>
</tr>
</tbody>
</table>
DRUG TESTING METHODS

Presumptive UDT may be read by direct optical observation or with instrument assisted direct optical observation. This method should only be done if results are needed immediately, and uses dipsticks, cassettes, cups and cards, and is based on qualitative competitive immunoassay (IA) methodology. It is reported as negative if the drug is below the cutoff. Instrumented chemistry analyzers are also an IA UDT and can be used in both the office and a clinical lab setting. IA UDT using a chemistry analyzer is never considered as definitive testing. Definitive UDT uses gas and liquid chromatography coupled with mass spectrometry, and therefore, requires the competency of on-site highly trained experts to interpret the results. These types of tests provide the definitive absence or presence of specific drugs, metabolites, and most illicit substances and the results are most often reported in concentrations such as nanograms per milliliter (ng/ml). Gas chromatography with mass spectrometry (GC-MS) methodology allows for the testing of multiple substances. It requires multiple steps by trained experts. Liquid chromatography with mass spectrometry (LC-MS/MS) is about 100 times more selective and sensitive. It provides a much faster turn around time, uses less specimen volume, can test for many more substances simultaneously and needs less human involvement. For additional guidelines, select the following link: Palmetto GBA LCD L35724 (https://www.cms.gov/medicare-coverage-database/details/lcddetails.aspx?LCDId=35724&ver=30&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAA%3Ad%3d&).

Drug Testing Methods

Presumptive UDT may be read by:
- Direct optical observation or by instrument assisted direct optical observation
- Instrumented chemistry analyzers

Definitive UDT requires interpretation by trained experts:
- Gas chromatography coupled with mass spectrometry (GC-MS)
- Liquid chromatography coupled with mass spectrometry (LC-MS/MS)
**PRESUMPTIVE IA UDT**

Presumptive IA UDT screens for drug classes instead of specific drugs. It is often difficult to determine if a different drug in the same class is the reason for a positive result. It often times does not detect all drugs in a class, there can be cross-reactivity to other compounds or the cut off for the drug may be too high. Not all prescription drugs are detectable and some do not have assays available. Some drugs give false negative results due to low cross-reactivity or non-reactivity such as designer drugs that are manufactured to elude law enforcement. In these cases, it may be medically necessary to perform definitive testing. For more information on presumptive testing, select the following web link: [CGS Administrators LCD L36029](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36029&ver=13&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp>Title&KeyWordSearchType=And&bc=gAAAAACAAAAAAA%3d%3d&).
DEFINITIVE UDT

Per Noridian Healthcare Solutions’ LCD L36668: “Definitive UDT may be reasonable and necessary based on patient specific indications, including historical use, medication response, and clinical assessment, when accurate results are necessary to make clinical decisions. The clinician’s rationale for the definitive UDT and the tests ordered must be documented in the patient’s medical record.” Select the following web link for more information on definitive UDT: Noridian LCD L36668 (https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36668&ver=8&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAAAA%3d%3d).

DEFINITIVE TESTING FREQUENCY - SUD

This slide shows the expected frequency of definitive testing for SUD. For patients with 0 to 30 consecutive days of abstinence, definitive UDT is expected at a frequency not to exceed one physician-directed testing profile in one week. More than one physician-directed testing profile in one week is not reasonable and necessary and is not covered by Medicare.
For patients with 31 to 90 consecutive days of abstinence, definitive UDT is expected at a frequency of 1-3 physician-directed testing profiles in one month. More than 3 UDT in one month is not reasonable and necessary. For patients with consecutive abstinence greater than 90 days, definitive UDT is expected at a frequency of 1-3 physician-directed testing profiles in three months. More than 3 definitive UDT in 3 months is not 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. This information is outlined in the LCD L36029. For additional details on definitive testing frequency, select this web link: [CMS Administrators LCD L36029](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36029&ver=13&Cov…).

**PATIENT GROUPS**

Three patient groups are covered for UDT. Group A is for symptomatic patients taking multiple drugs. Group B patients have been diagnosed and are being treated for substance abuse or dependence. Group C patients are on chronic opioid therapy.
**GROUP A**

Group A patients are symptomatic patients that come to an urgent care setting with signs and symptoms of substance abuse toxicity or an unreliable history. A presumptive test should be done as part of the evaluation and management of the patient. Patients should be treated presumptively to stabilize them until the results of rapid definitive testing are completed and the cause or causes are determined.

**GROUP B**

Group B patients are in treatment for substance abuse or dependence, also known as substance use disorder (SUD). The testing frequency must meet medical necessity and be documented in the clinician’s medical record. Depending on the patient’s specific substance use history, definitive UDT is done to accurately determine the specific drugs in the patient’s system may be necessary. Definitive testing may be ordered when accurate and reliable results are necessary to integrate treatment decisions and clinical assessment. Physicians that are writing prescriptions to treat SUD need to know if the
patients are compliant with the medications or if they are taking medications that may interact with the prescribed medications. The maximum definitive UDT is expected at a frequency not to exceed 1 physician-directed testing profile in one week. Random UDT should be performed in order to assist the provider in decision making about the treatment and level of care. The tests and testing methods should match the stages in the treatment and recovery.

**GROUP C**

Group C are patients that are on chronic opioid therapy (COT). Testing must be based on clinician’s documented medical necessity 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 1-3 times every 3 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. Additional guidance can be found at this website: [Noridian LCD L36668](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=36668&ver=8&CoverageSelection=Both&ArticleType=All&PonyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAAACAAAAA%3d%3d&).
**CHRONIC OPIOID THERAPY TESTING**

This slide shows the expected testing of patients on COT. Testing for low, moderate and high risk patients is done on a random basis to check for non-prescribed medications and illicit substances that could interfere with prescribed medication and cause safety risks.

**BILLING GUIDELINES**

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 should 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. Please check with your MAC for 2017 billing instructions. To see an example of Palmetto GBA’s billing guidelines for 2017, select the following web link: [2017 Controlled Substance Monitoring and Drugs of Abuse Coding and Billing Guidelines (M001328, V5)](https://www.palmettogba.com/palmetto/moldx.nsf/docscat/MolDx%20Website~MolDx~Browse%20By%20Topic~Covered%20Tests~2017%20Controlled%20Substance%20Monitoring%20and%20Drugs%20of%20Abuse%20Coding%20and%20Billing%20Guidelines%20(M001328%20V5)).
**CLIA REGULATION**

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. Labs are not allowed to accept human samples for diagnostic testing until they have both certifications. For more details, select these web links:

- Clinical Laboratory Improvement Amendments (CLIA) ([https://wwwn.cdc.gov/clia/](https://wwwn.cdc.gov/clia/))

**CODING UPDATE**

HCPCS code G0659 and CPT® codes 80305, 80306 and 80307 became effective January 1, 2017. HCPCS codes G0477, G0478 and G0479 were deleted when the new codes became effective. Initially, there were issues with G0659 being accepted by the Medicare system. The system was updated to accept the code as of March 23, 2017. More detailed information can be found at this web link: Palmetto GBA ([https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35724&ver=30&Cov](https://www.cms.gov/medicare-coverage-database/details/lcd-details.aspx?LCDId=35724&ver=30&Cov)erageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAA%3d%3d&)).
**CODE DEFINITIONS**

This slide shows abbreviated definitions for the codes. Additional information may be found in the *CPT® Manual, HCPCS Manual* and on the Medicare Fee-for-Service-Payment Clinical Lab Fee schedule. Detailed coding information is available at the following web link: [Calendar Year (CY) 2017 Clinical Laboratory Fee Schedule (CLFS)](https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/ClinicalLabFeeSched/Downloads/CY2017-CLFS-Codes-Final-Determinations.pdf).

**NON-COVERED SERVICES**

Blanket orders, routine standing orders, IA testing to “confirm” a presumptive test, and specimen validity testing are a few of the non-covered services. A list can be found at the following web link: Noridian Healthcare’s LCD L36707.

This concludes the coverage and documentation portion of our presentation. Now we’ll have our third poll question.
POLL QUESTION

From the information presented today, do you have a better understanding of the documentation and coverage requirements for drugs of abuse testing?

- Yes
- Neutral
- No

Now, I will turn the presentation over to Steve Ash, who will go over the Methods & Results portion of the presentation.

METHODS & RESULTS

Good afternoon. My name is Steve Ash. I am a statistical analyst with Palmetto GBA. I will be explaining the data, statistical analysis and tables provided in this CBR. I will be using the data of a mock provider that are supplied in the sample CBR that you can locate from the CBR website, www.cbrinfo.net under CBR201706.
REPORT DATA

As mentioned earlier in this presentation, individualized reports were sent to about 10,000 fee-for-service Medicare Part B providers. These providers were identified by Referring NPI, as listed on the claim. Claims for Drugs of Abuse Testing procedures were pulled from the Integrated Data Repository (IDR) on June 7, 2017. The claim lines used in this analysis cover dates of service between January 1, 2016 and December 31, 2016. More information on the IDR is available at this link: CMS Integrated Data Repository (https://www.cms.gov/Research-Statistics-Data-and-Systems/Computer-Data-and-Systems/IDR/).

TABLE 1

Table 1 provides information for each procedure code included in this CBR. The first column lists the Type of the test, the second column lists the HCPCS Code, and the third column provides the Method/Number of Drug Classes.
**TABLE 2**

Table 2 lists the guidelines for **Definitive Testing for Substance Use Disorder**. As stated earlier, it is not considered medically reasonable to test patients more than the expected frequency listed on this slide.

For a patient with 0-30 days of abstinence, the expected frequency is 1 test per week. A patient with 31-90 days of abstinence should have no more than 1-3 tests per month. If the patient has more than 90 days of abstinence, the expected number of tests is 1-3 in 3 months.
**TABLE 3**

Table 3 shows data for the provider’s utilization of each procedure code. The first column lists the **HCPCS Code**, the second column shows **Allowed Charges**, the third column shows **Allowed Services**, and the last two columns provide the distinct **Visit Count** and distinct **Beneficiary Count** for each procedure code. A total row is also included. Please note that the total may not be equal to the sum of the rows. The number of visits and beneficiaries are unduplicated counts for each row and total. Since it is possible that a beneficiary would have billings for more than one procedure code, he/she would be counted in the visit and beneficiary counts in each applicable row; however, these both would be counted only once in the total rows.

**TABLE 3 - EXPLAINED**

In this example, the highlighted row for HCPCS Code G0482 shows the totals for that procedure. In this case, the total allowed charges are $11,622, total allowed services are 70, the total number of visits is 70 and the number of beneficiaries is 70. In addition, the highlighted **Total** row shows this provider across all of the procedure codes in the study. In this case, the total allowed charges are $54,098, total allowed services are 426, total number of visits is 156 and the total number of beneficiaries is 150.
**SELECTION OF CBR MEASURES**

There are four measurements for this CBR:

- Percentage of Definitive Tests using G0483
- Percentage of Services Ordered too Frequently
- Average Services per Beneficiary
- Average Services per Visit

**METRICS AND NATIONAL STATISTICS**

The national percentages and averages for the four measures are shown here:

- **Percentage of Definitive Tests using G0483:** 35 percent
- **Percentage of Services Ordered Too Frequently:** 3 percent
- **Average Services per Beneficiary:** 3.22
- **Average Services per Visit:** 1.48
**PEER GROUPS**

For each measure in the CBR, the provider’s billing history and patterns are compared to their peers. These comparisons are given so that each provider is aware of where they stand among their peers and to allow them to see how their billing is different than their peers on the key measurements. For this CBR, each provider is compared to two peer groups:

- **STATE** peer group is defined as all Medicare providers who are located in the provider’s state as determined by PECOS, with allowed charges for the procedure codes included in this CBR

- **NATIONAL** peer group is defined as all Medicare providers in the nation with allowed charges for the procedure codes included in this CBR

**COMPARISON OUTCOMES**

In each analysis, there are four possible outcomes for the comparisons between the provider and the peer groups:

- **Significantly Higher** is displayed if the provider’s value is higher than the peer value and the statistical test confirms significance

- **Higher** is displayed if the provider’s value is higher than the peer value, but the statistical test does not confirm significance

- **Does Not Exceed** is displayed if the provider’s value is not higher than the peer value

- **N/A** is displayed if the provider did not have sufficient data for comparison
PERCENTAGE OF DEFINITIVE TEST USING G0483

The first analysis in this CBR is Percentage of Definitive Tests using G0483. It is calculated as the Number of Definitive Services using G0483 divided by the Total Number of Definitive Test Services for the one year time period, multiplied by 100.

Each provider’s percentage is compared to his/her state and the nation, using the chi-square test at the alpha value of 0.05. These results are shown in Table 4 of this CBR.

TABLE 4

In this example, this provider’s value is 29 percent. The state’s percentage is 44 percent, and the national percentage is 35 percent. This provider’s value Does Not Exceed the state’s value or the national peer group’s value.

These comparisons are based on statistical tests that take into account the differences between the individual and the peer group and also the quantity of claim lines reviewed. A lower number of claim lines will generally require a bigger difference between the provider and the peer group in order to claim significance. Because of this, we also use the result Higher to indicate when the provider’s value is higher than the peer, but not high enough to claim significance based on the statistical test. To view the percentages for each state and the nation, select the following link: CBR201706 Statistical Debriefing (https://www.cbrinfo.net/cbr201706-statistical-debriefing).
CALCULATION OF PERCENTAGE OF DEFINITIVE TESTS USING CODE G0483

To calculate the percentage, we use the data shown in Table 4: the number of services from definitive tests is 83, as shown by arrow 1, and the total number of services is 287, as shown by arrow 2. If we take the 83 and divide by 287, this gives us 29 percent of definitive test services using HCPCS code G0483.

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 by taking the Number of Services Billed Too Frequently and dividing by the Total Number of Services, and then we multiply by 100. Each provider’s percentage is compared to his/her state and the nation, using the chi-square test at the alpha value of 0.05. These results are shown in Table 5.
TABLE 5

In this example, this provider’s value is 31 percent. The state’s value is six percent, and the national value is 3 percent. This provider’s percentage is **Significantly Higher** than the state percentage and also **Significantly Higher** than the national peer group.

CALCULATION OF PERCENTAGE OF SERVICES ORDERED TOO FREQUENTLY

To calculate this percentage, take the **Total Number of Services Ordered Too Frequently** (indicated by the arrow 1) and divide by the **Total Number of Services** (indicated by arrow 2). Here, the calculation results in a value of 31 percent. To view the percentages for each state and the nation, select the following link: [CBR201706 Statistical Debriefing](https://www.cbrinfo.net/cbr201706-statistical-debriefing).
**AVERAGE SERVICES PER BENEFICIARY**

The next analysis is the **Average Services per Beneficiary**. It is calculated as the **Total Number of Services** divided by the **Total Number of Beneficiaries** for the one-year period.

Each provider’s average is compared to his/her state and the nation, using the t-test at the alpha value of 0.05. These results are shown in Table 6.

### TABLE 6

In this example, this provider’s **Average Services per Beneficiary** is 2.84. The state’s value is 2.88 and the national value is 3.22. This provider’s value **Does Not Exceed** that of the state and also **Does Not Exceed** the national peer group.

To view the percentages for each state and the nation, select the following link: CBR201706 Statistical Debriefing ([https://www.cbrinfo.net/cbr201706-statistical-debriefing](https://www.cbrinfo.net/cbr201706-statistical-debriefing)).
**TABLE 6 CALCULATION**

To calculate this value, our formula takes **Total Number of Services** (indicated by the arrow 1) divided by the **Total Number of Beneficiaries** (indicated by arrow 2). Here, the calculation results in a value of 2.84.

![Table 6 Calculation](image)

**AVERAGE SERVICES PER VISIT**

The next analysis is the **Average Services per Visit**. It is calculated as the **Total Number of Services** divided by the **Total Number of Visits** for the one year time period.

Each provider’s average is compared to his/her state and the nation, using the t-test at the alpha value of 0.05. These results are shown in Table 7.
In this example, shown in Table 7, this provider’s **Average Services per Visit** is 2.73. The state’s value is 1.58 and the national value is 1.48. This provider’s value is **Significantly Higher** than the state and also **Significantly Higher** than the national peer group.

**TABLE 7**

<table>
<thead>
<tr>
<th>Total Number of Services</th>
<th>Total Number of Visits</th>
<th>Your Average</th>
<th>Your State’s Average</th>
<th>Comparison with Your State</th>
<th>National Average</th>
<th>Comparison with National Average</th>
</tr>
</thead>
<tbody>
<tr>
<td>426</td>
<td>156</td>
<td>2.73</td>
<td>1.58</td>
<td>Significantly Higher</td>
<td>1.48</td>
<td>Significantly Higher</td>
</tr>
</tbody>
</table>

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

**TABLE 7 CALCULATION**

For this calculation, our formula takes **Total Number of Services** (indicated by the arrow 1) divided by the **Total Number of Visits** (indicated by arrow 2). Here, the calculation results in a value of 2.73. To view the results for each state and the nation, select this web link: [CBR201706 Statistical Debriefing](https://www.cbrinfo.net/cbr201706-statistical-debriefing)

\[
\frac{426}{156} = 2.73
\]
**WHO RECEIVED THIS REPORT?**

Why did you receive the CBR? After analyzing the data for each individual provider, we chose providers that were Significantly Higher than their peers in at least one of the metrics that I just described. Additionally, each of these providers met certain thresholds of allowed charges and beneficiary counts. For this CBR, recipients had at least $5,000 in allowed charges and at least 20 beneficiaries. These thresholds were chosen to ensure that the providers had sufficient information to compare to the peer groups, and that they could benefit from the educational material supplied in this letter.

Again, please note that this CBR letter does not indicate any wrongdoing. This report is meant for educational purposes based on the literature included in the references and resources section of this CBR. Also, all statistics supplied in this analysis are based only on the information obtained from the claims. No additional documentation was reviewed, nor special circumstances considered when making these calculations. We encourage you to keep sufficient documentation to justify your billings, especially in the areas where you are different than your peers.

This concludes the Methods & Results portion of our webinar. Now, time for another poll question.
**POLL QUESTION**

*Did the calculations help with understanding the CBR measures?*

- Yes
- Neutral
- No

It seems all your answers are in. Thank you for your responses. This concludes the Methods & Results portion of the webinar. Now, back to Cheryl Bailey for the References & Resources.

**REFERENCES & RESOURCES**

Thank you, Steve. As I mentioned previously, we provide links to all of the resources referenced in this webinar on our website page at the link, [CBR201706 Recommended Links](http://www.cbrinfo.net/cbr201706-recommended-links).
**CBR WEBSITE**

Again, our website is located at the link, [Comparative Billing Reports](http://www.cbrinfo.net/). The website includes a great deal of information for the provider and supplier community. On this site, you will find more information on:

- eGlobalTech and Palmetto GBA
- The most current CBR release, as well as previous releases
- Education information to include material on the most current CBR webinar, as well as all previous outreach events
- Recommended Links
- FAQs
- CBR support material that is created to give providers and suppliers various tools they can utilize when reading their CBRs
- And contact information for our help desk

**CBR201706 WEB PAGE**

Please be sure to visit the [CBR201706: Drugs of Abuse Testing](http://www.cbrinfo.net/) web page. Here, you will find the webinar materials for today’s presentation, which will be available by next Wednesday. You’ll also find the Sample CBR, the Statistical Debriefing, which shows comparison data for state and national analysis, and you’ll find Recommended Links and Frequently Asked questions. To visit our website, select the following web link: [Comparative Billing Reports](https://www.cbrinfo.net/).

**PROVIDER SELF-AUDIT**

After receiving a CBR, there are some additional steps that you may choose to take. For example, we encourage you to perform a self-audit. Providers and suppliers have an obligation to ensure claims are submitted to Medicare correctly. Self-audits help providers and suppliers identify coverage and coding errors. To aid in this effort, we recommend you use the Coverage and Documentation Overview and References discussed earlier and supplied in each CBR as a guide. We also have a [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html) page with links to high-level instruction and advice on how to begin the self-audit process located at the following web link: [Self-Audit Help](http://www.cbrinfo.net/self-audit-help.html).
**CBR SUPPORT HELP DESK**

If you have any questions regarding the CBR program, we encourage you to contact us. The CBR Support Help Desk is available from 9:00 a.m. to 5:00 p.m. ET Monday through Friday. The toll-free number which is 1-800-771-4430, and our email address is [cbrsupport@eglobaltech.com](mailto:cbrsupport@eglobaltech.com). Both the telephone number and the email address are on the actual CBR letter. The contact information is also on the CBR website page at [Comparative Billing Reports](http://www.cbrinfo.net/).

**CONTACTING MACS**

Providers should contact the MAC for their geographic areas for assistance with questions about specific claims, documentation requirements, and billing and coding questions. We encourage you to check with your MAC to ensure you are meeting the standards for all services that you are providing. MAC contact information is easily accessible on the CMS website at the link, [Review Contractor Directory – Interactive Map](https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

**PECOS**

eGlobalTech receives all contact information used in producing and disseminating the CBRs from the information providers and suppliers add to the Provider Enrollment, Chain, and Ownership System, or PECOS. Fax is the default dissemination method, but if a provider does not have a fax number listed in the system, or if more than five CBRs are scheduled to go to the same fax number, we mail the reports instead. If your CBR lists an incorrect address or was sent to an incorrect fax number, you are advised to update this information in PECOS. The link is provided here for your convenience: [PECOS](https://pecos.cms.hhs.gov/pecos/login.do). If no fax number is found in PECOS, fax numbers are pulled from the National Plan and Provider Enumeration System (NPPES), which can be viewed by selecting this link: [NPPES](https://nppes.cms.hhs.gov/NPPES/Welcome.do).

So this concludes the references and resources portion, and before we move on to the Q&A session, we have one last poll question:
**POLL QUESTION**

*Do you feel the CBR provided educational benefit?*

- Yes
- Neutral
- No
- Did not receive a CBR

It looks like we have gotten everyone’s responses. Thank you all for your participation.

**QUESTIONS & ANSWERS**

In a few minutes, we will respond to some of your questions submitted during the presentation. If you joined late or have more questions, the chat function is still open; but as I mentioned earlier, we may not be able to respond to all or your questions. Please feel free to email your questions to us at cbrsupport@eglobaltech.com. We'll be sure to get back to you.

As a reminder, the questions we answer today as well as those we can't get to will be addressed in a detailed Q&A document. The Q&A and a handout of the presentation will be posted to the CBR website within 14 days of today (August 23, 2017). To view these documents, select the following web link: [CBR201706 Webinar](http://www.cbrinfo.net/cbr201706-webinar).
Lastly, please note that we make every effort to address all questions submitted during our webinars; however, we cannot provide responses related to coding issues or specific claims and scenarios. Since your MAC makes the determination to pay or deny a claim based on the procedure codes, medical documentation, and description of the circumstances, and we do not have access to this documentation, we cannot respond to these types of questions. Please contact your MAC with questions that we do not address or if you identify any claims discrepancies while reviewing your CBR. Contact information for your MAC can be accessed from the CMS website link at Review Contractor Directory – Interactive Map (https://www.cms.gov/Research-Statistics-Data-and-Systems/Monitoring-Programs/Medicare-FFS-Compliance-Programs/Review-Contractor-Directory-Interactive-Map/).

Now, I’ll turn it over to Debra who will facilitate the Q&A session. Thank you all for your time.
RECOMMENDED LINKS

The below reference and resource website links have been added to the webinar transcript of CBR201706: Drugs of Abuse Testing to optimize your browsing experience while reading and/or listening to the webinar. All web links are accurate as of the date of the webinar (August 23, 2017), but may change due to frequent changes in Medicare policy or movement or change of online content by external publishers.


**CBR201706 Webinar** (http://www.cbrinfo.net/cbr201706-webinar)


**CBR201706 Sample CBR** (http://www.cbrinfo.net/cbr201706-sample-cbr)

**CBR201706 Recommended Links** (http://www.cbrinfo.net/cbr201706-recommended-links)


**CERT Urine Drug Testing Errors** (https://www.xifin.com/resources/industry-news/201703/cert-urine-drug-testing-errors)


**Exclusive: Medicare on Drugs: 24,000 Tests for 145 Patients** (http://www.reuters.com/article/us-usa-healthcare-medicare-idUSKBN0E910X20140529?wb48617274=49DFBE0)

**How Urine Drug Testing Fraud and Abuse is Impacting the Treatment Community** (http://www.nelsonhardiman.com/media/NelsonArticlePDF.pdf?wb48617274=E61698FB)


**Palmetto GBA LCD L35724** (https://www.cms.gov/medicarecoveredatabase/details/lcddetails.aspx?LCDId=35724&ver=30&CoverageSelection=Both&ArticleType=All&PolicyType=Final&s=All&KeyWord=controlled&KeyWordLookUp=Title&KeyWordSearchType=And&bc=gAAAACAAAAAAAA%3d%3d&)

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CGS Administrators LCD L36029

Noridian LCD L36668

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

National Government Services LCD L36037

Clinical Laboratory Improvement Amendments (CLIA)

Palmetto GBA

Calendar Year (CY) 2017 Clinical Laboratory Fee Schedule (CLFS)

CMS Integrated Data Repository