Comparative Billing Report

July 23, 2018

Comparative Billing Report Program
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IDTFs Referring Providers
NPI#: 1111111111
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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 compares providers' billing or referral patterns to those of their peers in their state or specialty and nationwide. No reply is necessary as this report is for educational purposes.

Why did I get a CBR?

You received this CBR because your referral patterns differ from your peers' patterns within your specialty and/or across the nation. Receiving this CBR is not an indication or precursor to an audit for all recipients. Selected providers, however, may be referred for additional review and education. We hope the report assists you in identifying opportunities for improvement and helps you validate your current referring patterns.

Optional - Next Steps

- Contact your Medicare Administrative Contractor (MAC) for specific billing or coding questions
- Visit www.cbrinfo.net for additional resources
- Attend our free webinar August 22, 2018 from 3:00 p.m. – 4:00 p.m. ET. Space is limited so register early at www.cbrinfo.net/cbr201806-webinar
- If you are unable to attend the live webinar, a recording will be available within 5 business days following the event at www.cbrinfo.net/cbr201806-webinar

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

Enclosure

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Comparative Billing Report (CBR): NPI 1111111111
Independent Diagnostic Testing Facilities (IDTFs) Referring Providers

Introduction

CBR201806 focuses on the referring providers of Medicare Part B claims submitted by Independent Diagnostic Testing Facilities (IDTFs). Medicare covers diagnostic services provided in settings such as hospitals, physicians' offices, and IDTFs; however, research from the Office of Inspector General (OIG) suggests that many services rendered by IDTFs do not meet Medicare guidelines. Per Chapter 35 of the *Medicare Claims Processing Manual*, MACs should deny claims submitted without appropriate documentation and "demand refunds of any payments that have been made."

According to the *Medicare Fee-for-Service 2016 Improper Payments Report* (Appendix I), Medicare Part B IDTFs had an improper payment rate of 14.3 percent and projected improper payments of more than $142 million, with insufficient documentation listed as the top cause of errors at 95.3 percent. The report also lists the provider compliance improper payment rate at 20.0 percent.

The *2017 Medicare Fee-for-Service Supplemental Improper Payment Data* (Appendix I) report shows some improvement in errors for Medicare Part B IDTFs; however, the projected improper payments were still high at more than $29.7 million with the provider compliance improper payment rate listed at 9.5 percent. Per the 2017 report, "The dollars in error for the improper payment rate are based on the final allowed charges. The dollars in error for the provider compliance improper payment rate are based on the initial allowed charge, which is before MAC reductions and denials. The provider compliance rate is what the improper payment rate would be without MAC activities."

The most recent OIG information found on IDTFs is from a 2012 report titled **Questionable Billing for Medicare Independent Diagnostic Testing Facility Services**. The OIG found that 20 high-utilization Core Based Statistical Areas (CBSAs) had only two percent of the total population of beneficiaries; however, four times more beneficiaries received IDTF services in these CBSAs than beneficiaries in all of the other CBSAs. A CBSA is a geographic area defined as an urban center of 10,000 or more people, including the surrounding counties.

The OIG report listed these three questionable characteristics:

- "Claims involving a beneficiary linked to four or more IDTFs…may indicate that providers are inappropriately sharing beneficiary identifiers.
- Claims for which beneficiaries did not see their referring physicians within 90 days before or after receiving the IDTF service…may indicate that the referring physician is not the treating physician.
- IDTF claims on which the diagnosis category is not the same as the diagnosis category on any other corresponding provider claim for that beneficiary... may indicate that unnecessary services were provided."

Metrics

The metrics calculated for this report include the following:

- Percentage of IDTF services without a corresponding visit to the referring provider within 90 days prior to the IDTF service date
- Percentage of IDTF services without a corresponding claim with the same diagnosis category rendered within 90 days prior to the IDTF service date
- Average IDTF charges per beneficiary for the one-year period

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 MACs' Local Coverage Determinations (LCDs) and Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

According to Chapter 35 of the *Medicare Claims Processing Manual*, an IDTF can be a fixed location or mobile unit and "is one that is independent both of an attending or consulting physician's office and of a hospital. However, IDTF general coverage and payment policy rules apply when an IDTF furnishes diagnostic procedures in a physician's office." Payment for diagnostic procedures performed by an IDTF is made according to the physician fee schedule. Additionally, some monitoring service entities classified as IDTF may be performed without a physician actually seeing the patient. These include transtelephonic and electronic monitoring services (e.g., cardiac event detection, 24-hour ambulatory electrocardiogram monitoring, and pacemaker monitoring). These services also require a supervisory physician, and a site visit is

required prior to final enrollment of a transtelephonic or electronic monitoring service as an IDTF.

Per the *Medicare Learning Network* publication titled **Independent Diagnostic Testing Facility (IDTF) Fact Sheet**, "An IDTF must have one or more supervising physicians who is responsible for the direct and ongoing oversight of the quality of the testing performed, the proper operation and calibration of equipment used to perform tests, and the qualifications of non-physician IDTF personnel who use the equipment." Each supervising physician does not have to be responsible for all of the functions, but "all the supervisory physician functions must be properly met at each location…they may have a different physician supervise the test at each location. The physicians used need only meet the proficiency standards for the tests they are supervising. Each supervising physician must be limited to providing general supervision at no more than three IDTF sites." Additionally, there is no requirement for an IDTF to have an interpreting physician. "If the IDTF does have such physicians, the IDTF interpreting physician must:

1. Be licensed to practice in the State(s) where the diagnostic tests he or she supervises will be performed
2. Be enrolled in Medicare
3. Not be currently excluded or barred
4. Be qualified to interpret the types of tests (codes) listed in the enrollment application"

Per the **IDTF Fact Sheet,** "With the exception of hospital-based and mobile IDTFs, a fixed-base IDTF does not:

1. Share a practice location with another Medicare-enrolled individual or organization
2. Lease or sublease its operations or its practice location to another Medicare enrolled individual organization
3. Share diagnostic testing equipment used in the initial diagnostic test with another Medicare enrolled individual or organization"

Specific rules regarding ordering IDTFs are outlined in the **Electronic Code of Federal Regulations (e-CFR) Title 42, 410.33(d)**: "The supervising physician for the IDTF may not order tests to be performed by the IDTF, unless the IDTF's supervising physician is in fact the beneficiary's treating physician. That is, the physician in question had a relationship with the beneficiary prior to the performance of the testing and is treating the beneficiary for a specific medical problem." The treating physician or non-physician practitioner must provide a written order for any service performed by the IDTF. The order must include the diagnosis and/or reason for the testing.

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 based on the latest version of claims as of May 16, 2018. The analysis includes claims with a rendering specialty of IDTF (specialty 47) and with dates of service from January 1, 2017 to December 31, 2017.

Table 1 provides a summary of your referrals to IDTFs.

Table 1: Mock Summary of Your Referrals to IDTFs
Dates of Service: January 1, 2017 – December 31, 2017

Services	285
Beneficiaries	134
Charges	$51,791

There are over 268,000 providers nationwide with referrals to IDTFs. Criteria for receiving the CBR are as follows:

- Provider is significantly higher than at least one of the peer groups on at least two of the metrics studied
- Provider is above the 75th percentile in allowed charges ($5,000) for the referrals
- Provider had referrals for at least 10 beneficiaries

Statistics were calculated for each provider and the two peer groups: all providers in the nation with referrals to IDTFs, and all providers in your specialty (e.g, Internal Medicine) with referrals to IDTFs. Each provider's values are compared to his/her peer group values. 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

Table 2 shows the percentage of services submitted without a visit to the referring provider within 90 days prior to the IDTF service.

Table 2: Mock Percentage of Services without a Visit to the Referring Provider within 90 Days Prior to the IDTF Service Date
Dates of Service: January 1, 2017 – December 31, 2017

Number of Services without a Visit	Total Number of Services	Your Percent	Your Specialty's Percent	Comparison with Specialty's Percent	National Percent	Comparison with National Percent
18	285	6%	15%	Does Not Exceed	21%	Does Not Exceed

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

Table 3 presents the percentage of services without a similar diagnosis within 90 days prior to the IDTF service date. A similar diagnosis was defined as the diagnosis category, or the first three characters of the ICD-10 diagnosis code. All diagnoses submitted on Medicare Part B claims, from all providers with service dates within 90 days prior to the IDTF service date, were compared to the line diagnosis on the IDTF claim. The referring provider or any other provider who does not have a specialty of IDTF could submit the corresponding claim with a similar diagnosis.

Table 3: Mock Percentage of Services without a Similar Diagnosis within 90 Days Prior to the IDTF Service Date
Dates of Service: January 1, 2017 – December 31, 2017

Number of Services without a Similar Diagnosis	Total Number of Services	Your Percent	Your Specialty's Percent	Comparison with Specialty's Percent	National Percent	Comparison with National Percent
200	285	70%	45%	Significantly Higher	39%	Significantly Higher

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

Table 4 shows the average allowed charges per beneficiary for the one-year period. This metric includes all services referred to one or more IDTFs.

Table 4: Mock Average Allowed Charges per Beneficiary
Dates of Service: January 1, 2017 – December 31, 2017

Total Charges	Total Number of Beneficiaries	Your Average	Your Specialty's Average	Comparison with Specialty's Average	National Average	Comparison with National Average
$51,791.10	134	$386.50	$320.46	Significantly Higher	$373.59	Higher

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

References & Resources

The coverage and documentation guidelines for IDTFs listed below are accurate as of the date of this CBR, but may change due to updates in Medicare policy. A complete list of web links is located at http://www.cbrinfo.net/cbr201806-recommended-links.

Centers for Medicare & Medicaid Services:

- *Medicare Fee-for-Service 2016 Improper Payments Report (Appendix G, Appendix I)*
- *2017 Medicare Fee-for-Service Supplemental Improper Payment Data*

Office of Inspector General:

- *Questionable Billing for Medicare Independent Diagnostic Testing Facility Services*

Medicare Manual:

- *Medicare Claims Processing Manual* (Chapter 35, Section 10)

Medicare Learning Network:

- *Independent Diagnostic Testing Facility (IDTF) Fact Sheet*

Electronic Code of Federal Regulations (e-CFR):

- Title 42, 410.33(d)