Why OIG Did This Audit

Drug testing is generally used to detect the presence or absence of drugs in patients undergoing treatment for pain management or substance use disorders. Medicare payments for definitive drug testing services increase based on the number of drug classes tested. The Centers for Medicare & Medicaid Services (CMS) identified overpayments for the definitive drug testing service with the highest reimbursement amount (procedure code G0483, definitive drug testing for 22 or more drug classes) due to noncompliance with Medicare requirements. In addition, a prior OIG report on drug testing services identified that payments for G0483 were at risk for overpayments.

Our objective was to identify Medicare Part B payments for definitive drug testing services that were at risk for noncompliance with Medicare requirements.

How OIG Did This Audit

Our audit covered $3 billion in Medicare Part B payments for definitive drug testing services with dates of service from January 2016 through December 2020 (audit period). These payments were made to 1,062 "at-risk providers," which routinely billed procedure code G0483 (for 75 percent or more of their definitive drug testing services), and 4,227 "other providers," which did not routinely bill this service. We compared characteristics of the at-risk providers and other providers.

Medicare Could Have Saved up to $216 Million Over 5 Years if Program Safeguards Had Prevented At-Risk Payments for Definitive Drug Testing Services

What OIG Found

For the 5-year audit period, Medicare paid $704.2 million for definitive drug testing services that were at risk for noncompliance with Medicare requirements. Specifically, these payments were for the definitive drug testing service with the highest reimbursement amount (procedure code G0483). These payments were made to 1,062 at-risk providers that routinely billed this procedure code and may not have been reasonable and necessary. We determined that presumptive drug testing preceded most definitive drug testing services billed by both the at-risk and other providers. However, the at-risk providers may not have always used presumptive testing to determine the number of drug classes that needed to be tested using definitive drug testing, because they routinely billed for testing 22 or more drug classes using G0483 and the other providers did not. Although the at-risk providers billed a significantly higher percentage of definitive drug testing services using G0483 than the other providers, the at-risk and other providers had similar characteristics (such as the types of patients they tested and the frequency of testing). This suggests that the at-risk providers may have been able to bill for definitive drug testing services using primarily procedure codes with lower reimbursement amounts, as the other providers did.

If CMS's program safeguards had focused on at-risk payments to at-risk providers for procedure code G0483, Medicare could have saved up to $215.8 million for our audit period.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) expand program safeguards to prevent and detect at-risk payments to at-risk providers for procedure code G0483; (2) review at-risk payments made to at-risk providers during and after our audit period and recover any overpayments; (3) notify appropriate providers to exercise reasonable diligence to identify, report, and return any overpayments; and (4) educate providers that received payments that did not comply with Medicare requirements.

CMS concurred with our first recommendation and provided information on corrective actions it had taken or planned to take, did not concur with our second and third recommendations, and did not state whether it concurred with our fourth recommendation but provided information on corrective actions it had taken or planned to take. After reviewing CMS's comments, we maintain that our second and third recommendations are valid.

The full report can be found at https://oig.hhs.gov/oas/reports/region9/92103006.asp.