

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**QUESTIONABLE BILLING FOR  
MEDICARE INDEPENDENT  
DIAGNOSTIC TESTING  
FACILITY SERVICES**



**Daniel R. Levinson**  
Inspector General

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**EXECUTIVE SUMMARY: QUESTIONABLE BILLING FOR MEDICARE  
INDEPENDENT DIAGNOSTIC TESTING FACILITY SERVICES  
OEI-09-09-00380**

**WHY WE DID THIS STUDY**

Independent Diagnostic Testing Facilities (IDTF), a type of Medicare provider, offer diagnostic services and are independent of physicians' offices or hospitals. IDTF services have historically been vulnerable to abuse. In 1997, the Office of Inspector General found that 20 percent of IDTFs were not at the locations on file with the Centers for Medicare & Medicaid Services (CMS). In 2007, CMS reported that in Los Angeles, it had denied \$163 million in IDTF charges and terminated Medicare billing privileges for 83 IDTFs.

**HOW WE DID THIS STUDY**

To describe IDTF billing patterns and identify questionable IDTF claims, we conducted a four-part review of such claims among geographic areas—specifically, Core Based Statistical Areas (CBSA). Based on an analysis of all Medicare Part B IDTF claims from 2009, we (1) identified the top 20 CBSAs with the highest average Medicare payments per beneficiary for IDTF services, terming these “high-utilization CBSAs”; (2) compared IDTF billing patterns in high-utilization CBSAs to such billing patterns in all other CBSAs nationally; (3) identified IDTF claims with questionable characteristics; and (4) compared the prevalence of IDTF claims with questionable characteristics in high-utilization CBSAs to the prevalence of such claims in all other CBSAs.

**WHAT WE FOUND**

Twenty high-utilization CBSAs accounted for 10.5 percent of Medicare Part B payments for IDTF services despite having only 2.2 percent of the total population of beneficiaries. Almost four times more beneficiaries in high-utilization CBSAs received IDTF services than beneficiaries in all other CBSAs. Nine percent of the IDTFs that served beneficiaries in high-utilization CBSAs provided 90.1 percent of IDTF services. Additionally, high-utilization CBSAs had twice as many claims with at least two questionable characteristics as all other CBSAs.

**WHAT WE RECOMMEND**

We recommend that CMS: (1) monitor IDTF claims for questionable characteristics, (2) take appropriate action when IDTFs submit a high number of questionable claims, and (3) assess whether to impose a temporary moratorium on new IDTF enrollments in CBSAs with high concentrations of IDTFs. CMS concurred with all of our recommendations.

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## OBJECTIVES

1. To compare the billing patterns of Independent Diagnostic Testing Facilities (IDTF) in high-utilization areas with the billing patterns of IDTFs in other geographic areas.
2. To identify IDTF claims with questionable characteristics.

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## BACKGROUND

### Independent Diagnostic Testing Facilities

Medicare covers inpatient and outpatient clinical and diagnostic services. These services can be provided in a number of settings, including physicians' offices, hospitals, and IDTFs. IDTFs, a type of Medicare provider, offer diagnostic services and are independent of physicians' offices or hospitals.<sup>1</sup> From 2002 to 2009, substantial growth occurred in the number of IDTFs and in Medicare-allowed charges to IDTFs. The number of Medicare-enrolled IDTFs during this time increased from 2,400 to 6,697, and Medicare-allowed charges for services from IDTFs increased from \$740 million to \$1 billion.<sup>2, 3</sup> Previous OIG work has also found that high geographic concentrations of providers or services may indicate weaknesses in Medicare's program safeguards.<sup>4</sup>

Services that may be provided by an IDTF include, but are not limited to, magnetic resonance imaging, ultrasound, x-rays, and sleep studies. Although some IDTF services can be performed remotely, such as pacemaker monitoring, most require a patient to be present at a facility.

### Historical Vulnerabilities

IDTF services have historically been vulnerable to fraud, waste, and abuse. IDTFs were originally known as Independent Physiological Laboratories (IPL). In 1997, after becoming concerned that IPL services were vulnerable to abuse—in particular, citing a lack of certification requirements and confusion about the type of services that IPLs should provide—CMS issued new standards to address these vulnerabilities.<sup>5, 6</sup>

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<sup>1</sup> 42 CFR § 410.33(a)(1).

<sup>2</sup> Medicare Payment Advisory Commission, *Public Meeting: Characteristics of IDTFs and ambulatory surgical centers*. Accessed at [http://www.medpac.gov/transcripts/0404\\_allcombined\\_transcripts.pdf](http://www.medpac.gov/transcripts/0404_allcombined_transcripts.pdf) on June 7, 2010.

<sup>3</sup> Office of Inspector General (OIG) analysis of 2009 Medicare Part B claims for IDTF services.

<sup>4</sup> OIG, *South Florida Suppliers' Compliance With Medicare Standards*, OEI-03-07-00150, March 2007, and OIG, *Aberrant Billing in South Florida for Beneficiaries With HIV/AIDS*, OEI-09-07-00030, September 2007.

<sup>5</sup> 62 Fed. Reg. 59048, 59071–72 (Oct. 31, 1997).

<sup>6</sup> 62 Fed. Reg. 59048, 59100–01 (Oct. 31, 1997) (adding 42 CFR § 410.33).

The new standards modified staffing, certification, and documentation requirements for IPLs. IPLs were also renamed IDTFs to help clarify their function.<sup>7</sup>

Also in 1997, OIG conducted site visits to IPLs. In an August 1998 report based on these visits, OIG reported that 20 percent of IPLs were not at the locations on file with CMS.<sup>8</sup> In the report, OIG also projected \$11.6 million in improper payments for IPL services and expressed concerns that the new standards that CMS had issued would not be sufficient to reduce the vulnerabilities that OIG had identified.<sup>9</sup>

Despite the new standards, problems with IDTF services persisted. In a 2001 review of IDTF services, OIG identified claims that were not reasonable, necessary, ordered by a physician, or sufficiently documented and projected \$71.5 million in improper payments.<sup>10</sup> In 2007, CMS reported that it had denied \$163 million in IDTF charges and terminated Medicare billing privileges for 83 IDTFs in Los Angeles.<sup>11</sup>

### **IDTF Enrollments**

An IDTF that wishes to enroll in Medicare must submit an application. The application collects a variety of information, including the procedure codes for which the applicant intends to bill, the names of supervising physicians and technicians, the location where medical records will be kept, and the address at which the IDTF will provide services.<sup>12</sup>

Before approving an IDTF's enrollment, CMS reviews the application and conducts an initial site visit, which may help to ensure that information on the application is correct.

### **IDTF Billing Requirements**

Services from IDTFs must be ordered in writing by the physician treating the beneficiary, and the physician must also use the results of these services to manage the beneficiary's medical problem.<sup>13</sup> In addition, nonphysician practitioners may order tests under appropriate physician

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<sup>7</sup> 62 Fed. Reg. 59048, 59071–72 (Oct. 31, 1997).

<sup>8</sup> OIG, *Independent Physiological Laboratories: Vulnerabilities Confronting Medicare*, OEI-05-97-00240, August 1998.

<sup>9</sup> Ibid.

<sup>10</sup> OIG, *Review of Claims Billed by Independent Diagnostic Testing Facilities for Services Provided to Medicare Beneficiaries During Calendar Year 2001*, A-03-03-00002, June 2006.

<sup>11</sup> CMS, Testimony before the House Budget Committee, July 17, 2007. Accessed at <http://www.cms.hhs.gov> on October 5, 2009.

<sup>12</sup> Form CMS-855B. Accessed at <http://www.cms.hhs.gov> on October 13, 2009.

<sup>13</sup> 42 CFR § 410.33(d).

supervision.<sup>14</sup> The order must include the diagnosis or the basis for the service.

### **Postenrollment Site Visits**

According to the *Medicare Program Integrity Manual*, if an IDTF requests an expansion of services and if the new services are sufficiently different from those already provided, CMS must conduct a postenrollment site visit.<sup>15</sup> For example, if an IDTF that provides sleep studies submits a request to start providing ultrasound tests, CMS is required to conduct a site visit.

CMS may also conduct postenrollment site visits at its discretion.<sup>16</sup> CMS cites the use of unannounced site visits as a successful way to determine whether IDTFs are operational and at the locations on file with CMS.<sup>17</sup> According to the *Medicare Program Integrity Manual*, when CMS conducts a site visit to verify the operational status of an IDTF, CMS should attempt to make its determination using only an external review of the IDTF. CMS requires that reviewers document their visits using written observations of the facilities and photographs as appropriate.<sup>18</sup>

### **Temporary Moratoria**

In addition to taking administrative actions against individual IDTFs, CMS may also reduce the potential for fraud, waste, or abuse by instituting a temporary moratorium on IDTF enrollment. CMS's authority to do this for specific provider types, specific geographic areas, or both was established by the ACA and implemented in 2011.<sup>19</sup>

### **Related Work**

OIG conducted two concurrent evaluations of IDTFs to determine whether they complied with select Medicare standards.<sup>20</sup> The evaluations involved conducting unannounced site visits in areas with a high density of IDTFs that demonstrated questionable billing patterns.<sup>21</sup>

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<sup>14</sup> 42 CFR § 410.32(a)(2).

<sup>15</sup> CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 10, § 4.19.6(C). Accessed at <http://www.cms.hhs.gov> on February 3, 2011.

<sup>16</sup> 42 CFR § 410.33(g)(14).

<sup>17</sup> Preamble to final rule implementing sections of the Patient Protection and Affordable Care Act of 2010, P.L. 111-148 (ACA). 76 Fed. Reg. 5862, 5869. (Feb. 2, 2011).

<sup>18</sup> CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 15, § 20.1. Accessed at <http://www.cms.hhs.gov> on February 22, 2011.

<sup>19</sup> ACA, § 6401(a)(3) (adding section 1866(j)(6) of the Social Security Act, which was designated as 1866(j)(7) by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152, § 1304). Implementing regulations for moratoria on newly enrolling Medicare providers and suppliers are at 42 CFR § 424.570.

<sup>20</sup> The IDTF Medicare standards are at 42 CFR § 410.33.

<sup>21</sup> OIG, *Miami Independent Diagnostic Testing Facilities' Compliance With Medicare Standards*, OEI-05-09-00560; OIG, *Los Angeles Independent Diagnostic Testing Facilities' Compliance With Medicare Standards*, OEI-05-09-00561.

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## METHODOLOGY

### Scope

This evaluation is national in scope and is based on an analysis of all Medicare Part B IDTF claims from 2009. We focused the analysis on geographic areas with the highest average Medicare payment per fee-for-service beneficiary (beneficiary)<sup>22</sup> for IDTF services and on claims submitted by IDTFs. We define a geographic area as a Core Based Statistical Area (CBSA), which is a geographic area based around an urban center of at least 10,000 individuals.<sup>23</sup>

### Data Sources

Our data sources consist of the 2009 Part B National Claims History (NCH) file from CMS, the 2009 Medicare Part A data file, and the 2009 Denominator File from the Medicare Enrollment Database. The Part B NCH file contains claims submitted by noninstitutional providers, such as physicians, physician assistants, IDTF providers, and nurse practitioners. Claims information includes National Provider Identifiers (NPI),<sup>24</sup> Provider Identification Numbers (provider ID),<sup>25</sup> specialty codes, diagnosis and procedure codes, dates of service, the beneficiary's Health Insurance Claim Number (beneficiary identifier), and payment amounts. The CMS Denominator File contains enrollment information about each beneficiary enrolled in a given calendar year.<sup>26</sup> The Medicare Part A data file contains claims that were submitted by institutional providers, such as hospitals and skilled nursing facilities.

### Data Collection

CMS considers an IDTF to be a provider specialty rather than a place of service. We analyzed the 2009 Part B NCH file for IDTF claims from

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<sup>22</sup> The term "fee-for-service beneficiary" refers to a Medicare beneficiary enrolled in a payment system in which providers are paid for each service provided to a beneficiary.

<sup>23</sup> In 2003, the Office of Management and Budget (OMB) established CBSAs as a new geographic entity. OMB designated two categories of CBSAs: metropolitan statistical areas (based on populations of at least 50,000 people) and new micropolitan statistical areas (based on a population of 10,000–49,999). During our review period, there were 955 CBSAs in the United States and Puerto Rico. OMB, *OMB Bulletin 09-01: Update of Statistical Area Definitions and Guidance on Their Uses*, November 20, 2008. Accessed at <http://www.whitehouse.gov/sites/default/files/omb/assets/omb/bulletins/fy2009/09-01.pdf> on September 23, 2010.

<sup>24</sup> An NPI is the standard 10-digit unique health identifier for health care providers. CMS, Glossary. Accessed at <http://www.cms.gov/apps/glossary/search.asp?Term=npi&Language=English> on March 14, 2010.

<sup>25</sup> A provider ID is a provider identifier that local Medicare contractors assign for each provider practice setting. Thus, a single provider may have several provider IDs. National Plan & Provider Enumeration System, *NPI Application Help*. Accessed at <https://nppes.cms.hhs.gov/NPPES/Help.do?topic=OtherID> on September 27, 2010.

<sup>26</sup> CMS, *Denominator File Identifiable Data Files*. Accessed at [http://www.cms.gov/IdentifiableDataFiles/06\\_DenominatorFile.asp](http://www.cms.gov/IdentifiableDataFiles/06_DenominatorFile.asp) on October 1, 2010.

practice settings that used only specialty code 47—which indicates that a claim is for an IDTF service—to bill Medicare.<sup>27</sup>

Using specialty code 47 and provider ID fields in the 2009 Part B NCH file, we identified IDTFs that submitted claims in 2009. We counted each provider ID that had claims only with specialty code 47 as an IDTF. The final file included 5,974,969 claims representing \$798 million in Medicare payments for IDTF services from 6,697 IDTFs.

### **Analysis**

To describe IDTF billing patterns and identify questionable IDTF claims, we conducted a four-part review of such claims. First, we identified CBSAs with the highest average Medicare payments per beneficiary for IDTF services. Second, we compared IDTF billing patterns in those CBSAs to such billing patterns in all other CBSAs. Third, we identified IDTF claims with questionable characteristics. (We describe these characteristics in detail on pages 7 and 8 of this report.) Finally, we compared the prevalence of such IDTF claims in the two groups of CBSAs (i.e., CBSAs with the highest average Medicare payments per beneficiary for IDTF services and all other CBSAs).

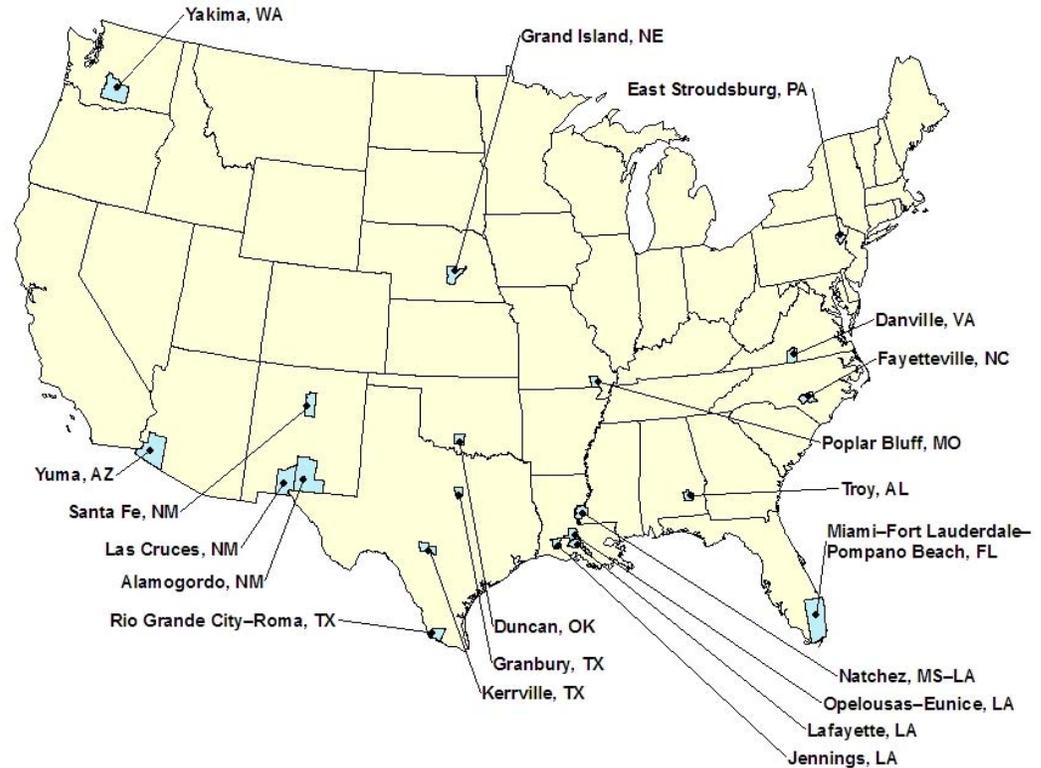
*Identification of high-utilization CBSAs.* Using the 2009 Part B NCH file and the 2009 Denominator File, we identified CBSAs with the highest average Medicare Part B payments per beneficiary for IDTF services in 2009. We determined the CBSA to which each beneficiary belonged by matching the ZIP Code field from the Part B NCH file and the Denominator File with the ZIP Codes corresponding to each CBSA. We used the 2009 Denominator File to count the number of beneficiaries in each CBSA. We then merged the 2009 Part B NCH file and the 2009 Medicare denominator file by CBSA. To calculate the average Medicare payments per beneficiary for IDTF services within each CBSA, we divided the total Medicare payments for IDTF services in 2009 by the number of all beneficiaries in each CBSA.

We analyzed this file to identify the CBSAs (among the total of 955 CBSAs) with the highest average IDTF payment per beneficiary. From this group, we selected the top 20 CBSAs, which we defined as high-utilization CBSAs. See Figure 1 for a map showing their locations.

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<sup>27</sup> We analyzed claims from practice settings that billed using specialty code 47 only. We did not include practice settings that bill using multiple specialty codes. We focused our study in this manner to analyze the same type of claims as OIG's two concurrent IDTF evaluations that conducted site visits to IDTFs. To best target their site visits, the evaluation teams that conducted the concurrent evaluations had to identify locations most likely to be IDTFs. They did this by selecting practice settings that billed using only IDTF specialty code 47.

**Figure 1: High-Utilization CBSAs, 2009**



Source: OIG analysis of 2009 Medicare Part B IDTF claims.

*Comparison of high-utilization CBSAs to all other CBSAs.* We compared IDTF billing patterns in these 20 high-utilization CBSAs to IDTF billing patterns in all other CBSAs. We did this by identifying the CBSAs corresponding to the claims in the 2009 Part B NCH file and the 2009 Medicare Denominator File, based on the beneficiary's CBSA.

First, we summarized the 2009 Part B NCH file by CBSA to generate totals of IDTF services, payments, and beneficiaries who received IDTF services in high-utilization CBSAs and in all other CBSAs. We used the 2009 Medicare Denominator File to obtain a count of beneficiaries in high-utilization CBSAs and in all other CBSAs. We merged these files to calculate utilization measures in high-utilization CBSAs and all other CBSAs and compared these utilization measures. Utilization measures that we calculated include:

- the percentage of beneficiaries who received at least one IDTF service;
- the average number of IDTF services received per beneficiary;

- the average Medicare payment per beneficiary who received IDTF services;
- the number of IDTFs per 10,000 beneficiaries;<sup>28</sup> and,
- the number of IDTF services those IDTFs provided.

Identification of questionable characteristics. We developed a list of three characteristics that may identify questionable IDTF claims. We based this list on IDTF requirements and previous OIG work that analyzed billing patterns.<sup>29</sup> The characteristics include:

1. Claims involving a beneficiary linked to four or more IDTFs. A beneficiary “linked to” four or more IDTFs is one who had claims submitted from four or more IDTFs in a 1-year period. The presence of claims for beneficiaries who are linked to four or more IDTFs may indicate that providers are inappropriately sharing beneficiary identifiers.<sup>30</sup>
2. Claims for which beneficiaries did not see their referring physicians within 90 days before or after receiving the IDTF service. We identified the referring physician listed on each IDTF claim and determined whether the physician had a claim for treating the beneficiary within 90 days before or after the beneficiary received the IDTF service. We looked at noninstitutional and institutional claims.<sup>31</sup> The absence of a claim within 90 days before or after the beneficiary received the IDTF service may indicate that the referring physician is not the treating physician.<sup>32</sup>
3. IDTF claims on which the diagnosis category<sup>33</sup> is not the same as the diagnosis category on any other corresponding provider claim for that beneficiary. We looked at noninstitutional and institutional claims 90 days before and after the beneficiary received the IDTF service.

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<sup>28</sup> For ease of reporting, our unit of analysis to measure the concentration of IDTFs in CBSAs is based on the number of IDTFs per 10,000 Medicare beneficiaries.

<sup>29</sup> OIG, *Medicare Part B Billing for Ultrasound*, OEI-01-08-00100, June 2009.

<sup>30</sup> This characteristic was based on OIG, *Medicare Part B Billing for Ultrasound*, OEI-01-08-00100, June 2009.

<sup>31</sup> Institutional claims under the Medicare Part A and B data files that we reviewed include claims from hospitals, nursing facilities, renal dialysis facilities, hospices, federally qualified health centers, and rural health clinics.

<sup>32</sup> This characteristic was based on OIG, *Medicare Part B Billing for Ultrasound*, OEI-01-08-00100, June 2009.

<sup>33</sup> We determined diagnosis categories based on the Clinical Classification Software system for International Classification of Diseases, 9<sup>th</sup> edition Clinical Modification developed by the Agency for Healthcare Research and Quality. Accessed at <http://www.hcup-us.ahrq.gov/toolsoftware/ccs/ccs.jsp> on September 29, 2010.

The difference in diagnosis categories may indicate that unnecessary services were provided.<sup>34</sup>

*Comparison of IDTF claims with questionable characteristics in high-utilization CBSAs and such claims in all other CBSAs.* We determined whether any of the three questionable characteristics were present on IDTF claims. We compared the presence of each characteristic on IDTF claims from high-utilization CBSAs and on IDTF claims from all other CBSAs. Next, we determined how often at least two of the three characteristics were present on IDTF claims. We compared how often at least two of the three questionable characteristics were present on IDTF claims from high-utilization CBSAs and on IDTF claims in all other CBSAs.

### **Limitations**

We did not conduct a medical review to determine whether services were provided, whether services were medically necessary, or whether claims were coded correctly.

The three characteristics that we used to identify questionable claims are not intended to be a comprehensive set of characteristics for identifying questionable billing. Further, while the presence of such characteristics raises questions about the appropriateness of a given IDTF claim, it does not necessarily mean that such claims are inappropriate or fraudulent.

Our 2009 Part B NCH file (5,974,969 IDTF claims) for IDTF services included 43,039 IDTF claims in which the IDTF listed its own NPI as that of the referring physician.<sup>35</sup> CMS instituted a temporary provision allowing billing providers to use their own NPIs in the required field for the referring physician's NPI if the billing provider cannot obtain the referring physician's NPI.<sup>36</sup> To be conservative, we counted these 43,039 claims as though the beneficiaries involved had all seen a referring physician within 90 days before or after receiving IDTF services. Therefore, our results may underestimate the number of beneficiaries who did not see a referring physician within that timeframe.

### **Standards**

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

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<sup>34</sup> We developed this characteristic based on the requirement that IDTF services be ordered in writing by the physician who is treating the beneficiary and that the order include the diagnosis or the basis for the service. 42 CFR § 410.33(d).

<sup>35</sup> There were 613 IDTFs that entered their own NPIs in the field for the referring physician's NPI at least once.

<sup>36</sup> CMS, *Medicare Program Integrity Manual*, Pub. No. 100-08, ch. 14, § 14.5. Accessed at <http://www.cms.hhs.gov/manuals/downloads/pim83c14.pdf> on March 23, 2011.

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## FINDINGS

### **Twenty high-utilization CBSAs accounted for 11 percent of Medicare Part B payments for IDTF services despite having only 2 percent of the total population of Medicare beneficiaries**

High-utilization CBSAs accounted for 10.5 percent (\$75.8 million of \$797.9 million) of the Medicare Part B payments for IDTF services in 2009. However, only 2.2 percent (828,834 of 37.2 million) of beneficiaries reside in the high-utilization CBSAs.

### **Almost four times more beneficiaries in high-utilization CBSAs received IDTF services than beneficiaries in all other CBSAs**

Beneficiaries in high-utilization CBSAs received more IDTF services than beneficiaries in all other CBSAs. In 2009, 22.9 percent of beneficiaries in high-utilization CBSAs received IDTF services, compared to 6.2 percent of beneficiaries in all other CBSAs. The percentage of beneficiaries who received IDTF services in high-utilization CBSAs ranged from 15.2 percent in Troy, Alabama, to 38.8 percent in Jennings, Louisiana. The CBSAs with the next-highest percentages of beneficiaries who received IDTF services were Poplar Bluff, Missouri (35.0 percent), and Las Cruces, New Mexico (30.4 percent). See Appendix A, Table A-1, for details on use of IDTF services in high-utilization CBSAs and all other CBSAs.

### **On average, beneficiaries in high-utilization CBSAs received more IDTF services than beneficiaries in all other CBSAs**

On average, beneficiaries who received IDTF services in high-utilization CBSAs received slightly more such services than beneficiaries in all other CBSAs. Beneficiaries who received IDTF services in high-utilization CBSAs received an average of 3.5 such services, compared to 2.4 such services in all other CBSAs. The number of IDTF services per beneficiary who received such a service in high-utilization CBSAs ranged from 2.5 in Yuma, Arizona, to 4.5 in Kerrville, Texas. The CBSAs with the next-highest number of IDTF services per beneficiary were Granbury, Texas (4.3), and Duncan, Oklahoma (4.1).

### **The average Medicare payment per beneficiary who received an IDTF service in high-utilization CBSAs was almost 25 percent higher than in all other CBSAs**

The average Medicare payment per beneficiary receiving IDTF services in high-utilization CBSAs was \$399.90, compared to \$321.33 in all other CBSAs. The average Medicare payment per beneficiary receiving such

services in high-utilization CBSAs ranged from \$229.56 in Santa Fe, New Mexico, to \$484.90 in Troy, Alabama. The CBSAs with the next-highest average payment per beneficiary were Miami–Fort Lauderdale–Pompano Beach, Florida (\$457.75), and Kerrville, Texas (\$414.87).

### **Nine percent of IDTFs provided 90 percent of IDTF services in high-utilization CBSAs**

A small number of IDTFs provided most of the IDTF services in high-utilization CBSAs. Although 1,676 IDTFs provided at least 1 such service to beneficiaries in high-utilization CBSAs, 90.1 percent (601,933 of 668,252) of the services were provided by only 9.0 percent (151) of those IDTFs. In all other CBSAs, 6,620 IDTFs provided at least 1 such service to beneficiaries; however, 90.0 percent (4,769,358 of 5,306,717) of the services were provided by 24.1 percent (1,593) of those IDTFs.<sup>37</sup> Billing patterns in each high-utilization CBSA were consistent with the collective IDTF billing patterns among high-utilization CBSAs. For example, in Yakima, Washington, although 66 IDTFs provided at least 1 IDTF service to beneficiaries in that CBSA, 2 IDTFs provided 89.5 percent of such services to beneficiaries. Similarly, in Danville, Virginia, 45 IDTFs provided at least 1 IDTF service to beneficiaries, and a single IDTF provided 93.4 percent of such services to beneficiaries.

Even though a small number of IDTFs provided most of the IDTF services to beneficiaries in high-utilization CBSAs, there was a higher concentration of IDTFs in those CBSAs than in all others. There was an average of 88.3 IDTFs per 10,000 beneficiaries in high-utilization CBSAs, compared to an average of 29.5 per 10,000 beneficiaries in all others.

### **Seventy-one percent of IDTFs providing services to beneficiaries in high-utilization CBSAs were in the Miami–Fort Lauderdale–Pompano Beach, Florida, CBSA**

Of the 9.0 percent (151 of 1,676) of IDTFs that provided 90.1 percent of IDTF services to beneficiaries in high-utilization CBSAs, 70.8 percent (107 of 151) were in the Miami–Fort Lauderdale–Pompano Beach, Florida, CBSA (see Table 1). These 107 IDTFs accounted for 5.2 percent (\$41.1 million) of the Medicare payments for all IDTF services in 2009. However, only 1.4 percent (518,837 of 37.2 million) of beneficiaries resided in that CBSA. In addition, the average Medicare payment per beneficiary who received an IDTF service from these 107 IDTFs was

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<sup>37</sup> The percentage of IDTFs that provided 90 percent of IDTF services is based on IDTFs that submitted claims to Medicare for reimbursement, not on the percentage of Medicare-enrolled IDTFs.

\$438.98, compared to \$294.14 among the remaining 44 IDTFs in this group. These 107 IDTFs provided an average of 4.1 IDTF services to beneficiaries in high-utilization CBSAs, compared to 2.9 IDTF services among the remaining 44 IDTFs in this group.

**Table 1. Billing Patterns From IDTFs That Provided 90 Percent of IDTF Services to Medicare Beneficiaries in High-Utilization CBSAs**

CBSA Where the IDTFs Were Located	Number of IDTFs That Provided IDTF Services to Beneficiaries in High-Utilization CBSAs	Number of IDTF Services Provided to Beneficiaries in High-Utilization CBSAs	Number of Beneficiaries Who Received Services in High-Utilization CBSAs	Total Medicare Payments for IDTF Services	Average Number of IDTF Services per Beneficiary Who Received Such Services in High-Utilization CBSAs	Average Medicare Payment per Beneficiary Who Received IDTF Services in High-Utilization CBSAs
Miami–Fort Lauderdale–Pompano Beach, FL	107	379,748	93,708	\$41,135,779.96	4.1	\$438.98
Other High-Utilization CBSAs	44	222,185	75,766	\$22,285,647.37	2.9	\$294.14
<b>Total</b>	<b>151</b>	<b>601,933</b>	<b>168,059</b>	<b>\$63,421,427.33</b>	<b>3.6</b>	<b>\$377.38</b>

Source: OIG analysis of 2009 Medicare Part B IDTF claims.

### **High-utilization CBSAs had twice as many IDTF claims with at least two questionable characteristics as all other CBSAs**

In 2009, 17.5 percent of IDTF claims in high-utilization CBSAs had at least two questionable characteristics, compared to 8.0 percent of IDTF claims in all other CBSAs. These IDTF claims accounted for \$10.0 million (12.5 percent) of the Medicare payments for IDTF services in high-utilization CBSAs. See Appendix B, Table B-1, for a list of high-utilization CBSAs with the corresponding percentages of claims with at least two questionable characteristics.

### **Five times more IDTF claims in high-utilization CBSAs than in all other CBSAs involve a beneficiary linked to four or more IDTFs**

In high-utilization CBSAs, 15.4 percent (103,220 of 668,252) of IDTF claims involve a beneficiary linked to four or more IDTFs, compared to 2.7 percent of such claims in all other CBSAs. The presence of claims for

beneficiaries linked to four or more IDTFs may indicate that providers are inappropriately sharing beneficiary identifiers. The percentage of IDTF claims for which the beneficiary was linked to four or more IDTFs ranged from 0.2 percent in Duncan, Oklahoma, to 21.7 percent in Miami–Fort Lauderdale–Pompano Beach, Florida. The high-utilization CBSAs with the next-highest percentages were Lafayette, Louisiana (9.1 percent), and Fayetteville, North Carolina (6.1 percent).

**Seventeen percent of IDTF claims in high-utilization CBSAs had no corresponding claim by the referring physician**

In high-utilization CBSAs, 17.3 percent (115,669 of 668,252) of IDTF claims had no corresponding claim by the referring physician within 90 days before or after the beneficiary received the IDTF service, compared to 14.2 percent of IDTF claims in all other CBSAs. The absence of a claim 90 days before or after receiving the IDTF service may indicate that the referring physician is not the treating physician. The percentage of IDTF claims that had no corresponding claim by the referring physician ranged from 5.4 percent in Rio Grande City–Roma, Texas, to 21.8 percent in Santa Fe, New Mexico. The high-utilization CBSAs with the next-highest percentages were Fayetteville, North Carolina (21.7 percent), and Miami–Fort Lauderdale–Pompano Beach, Florida (19.5 percent).

**More than 46 percent of claims in high-utilization CBSAs did not have the same diagnosis categories as any other corresponding provider claims**

In high-utilization CBSAs, 46.7 percent (311,910 of 668,252) of IDTF claims did not have the same diagnosis categories as any other corresponding provider claims 90 days before or after the beneficiary received an IDTF service, compared to 35.4 percent of IDTF claims in all other CBSAs. If the diagnosis category on the IDTF claim is not the same as that on any other corresponding provider claim within 90 days before or after the beneficiary received the IDTF service, it may indicate that the IDTF provided unnecessary services. The percentage of IDTF claims on which the diagnosis categories did not match any other provider claims ranged from 2.7 percent in Grand Island, Nebraska, to 61.5 percent in Santa Fe, New Mexico. The high-utilization CBSAs with the next-highest percentages were East Stroudsburg, Pennsylvania (55.1 percent), and Miami–Fort Lauderdale–Pompano Beach, Florida (52.2 percent).

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## RECOMMENDATIONS

This report found that high-utilization CBSAs accounted for 10.5 percent of Medicare Part B payments for IDTF services despite having only 2.2 percent of the total population of beneficiaries. Almost four times more beneficiaries in high-utilization CBSAs received IDTF services than beneficiaries in all other CBSAs. Nine percent of the IDTFs that served beneficiaries in high-utilization CBSAs provided 90.1 percent of IDTF services. Additionally, high-utilization CBSAs had twice as many claims with at least two questionable characteristics as all other CBSAs.

Another OIG review of IDTFs—*Los Angeles Independent Diagnostic Testing Facilities’ Compliance With Medicare Standards* (OEI-05-09-00561)—recommended that CMS impose a moratorium on new IDTF enrollments in the Los Angeles area while CMS develops additional safeguards for IDTFs in the area. Because services provided by IDTFs are also available at physicians’ offices and hospitals, an enrollment moratorium on IDTFs is unlikely to have a negative impact on beneficiaries’ access to these services.

We recommend that CMS:

### **Monitor IDTF claims for questionable characteristics**

CMS should monitor IDTF claims for questionable characteristics to identify vulnerabilities. Claims exhibiting readily identifiable questionable characteristics may include those on which the beneficiaries were linked to four or more IDTFs; claims that lacked corresponding claims by the referring physicians; and claims for which the diagnosis categories were not the same as those on any other provider claims for those beneficiaries.

### **Take appropriate action when IDTFs submit a high number of questionable claims**

When IDTFs are found to have a high rate of questionable billing characteristics, CMS should review those claims before payment to ensure that they are appropriate. If CMS determines that inappropriate claims have been submitted, it should take steps to suspend payments for these providers and/or recover inappropriate payments made to them.

### **Assess whether to impose a temporary moratorium on new IDTF enrollments in CBSAs with high concentrations of IDTFs**

Given that a small number of IDTFs provide most IDTF services in high-utilization CBSAs, CMS should assess whether to impose a temporary moratorium on new IDTF enrollments in those CBSAs. Such a moratorium would prevent new enrollments while CMS develops program safeguards, such as more frequent in-depth reviews of IDTFs. In the

report entitled *Los Angeles Independent Diagnostic Testing Facilities' Compliance With Medicare Standards* (OEI-05-09-00561), OIG recommended that CMS impose a moratorium on new IDTF enrollments in the Los Angeles area.

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## AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its written comments on our draft report, CMS concurred with all of our recommendations. CMS stated that it is using predictive modeling technology to detect and generate alerts for suspicious billing by IDTFs. CMS indicated that it is using authorities granted in the ACA to address potential vulnerabilities in the enrollment and claims payments processes for IDTFs.

In our draft report, we recommended that CMS monitor IDTF claims for questionable characteristics. In response, CMS stated that it is streaming every Medicare fee-for-service claim before payment through its predictive modeling technology, known as FPS. The FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations. CMS is intent on building reliable models in the FPS that can detect and generate alerts for suspicious billing by all major provider types, including IDTFs. Furthermore, IDTFs have been and will remain a key focus for CMS's program integrity operations. OIG supports CMS's continued development of FPS and its predictive modeling efforts to identify fraudulent claims and prevent payments.

We recommended that CMS take appropriate action when IDTFs submit a high number of questionable claims. In response, CMS stated that it is taking a variety of administrative actions against many provider types around the Nation, including IDTFs. Administrative actions may include, but are not limited to, verification of operational status, prepayment review, auto-deny edits, payment suspensions, and revocations. OIG supports CMS's administrative action efforts and agrees that they may help address IDTFs that submit a high number of questionable claims.

In our draft report, we recommended that CMS assess whether to impose a temporary moratorium on new IDTF enrollments in CBSAs with high concentrations of IDTFs. In response, CMS stated that in developing its approach for implementing the new temporary moratorium authority, it will assess whether moratoria are appropriate for a variety of provider types, including IDTFs. OIG supports CMS's use of a variety of data and information, including factors such as high concentration of IDTFs and high IDTF utilization, to determine whether a moratorium would be appropriate. For the full text of CMS's comments, see Appendix C.

## APPENDIX A

**Table A-1. Comparison of High-Utilization Core Based Statistical Areas to All Other Core Based Statistical Areas**

	<b>Core Based Statistical Areas (CBSA) (Alphabetical Order)</b>	<b>Percentage of Medicare Beneficiaries Who Received Independent Diagnostic Testing Facility (IDTF) Services</b>	<b>Average Number of IDTF Services per Medicare Beneficiary</b>	<b>Average Payment per Medicare Beneficiary Who Received IDTF Services</b>
1	Alamogordo, New Mexico	22.0%	2.7	\$358.67
2	Danville, Virginia	30.3%	2.6	\$266.83
3	Duncan, Oklahoma	28.3%	4.1	\$273.91
4	East Stroudsburg, Pennsylvania	26.4%	2.7	\$337.11
5	Fayetteville, North Carolina	26.5%	2.6	\$258.87
6	Granbury, Texas	24.8%	4.3	\$327.96
7	Grand Island, Nebraska	23.8%	2.9	\$354.14
8	Jennings, Louisiana	38.8%	2.8	\$284.63
9	Kerrville, Texas	16.4%	4.5	\$414.87
10	Lafayette, Louisiana	22.0%	3.0	\$354.75
11	Las Cruces, New Mexico	30.4%	3.2	\$325.72
12	Miami–Fort Lauderdale–Pompano Beach, Florida	21.5%	3.9	\$457.75
13	Natchez, Mississippi–Louisiana	28.9%	3.0	\$344.38
14	Opelousas–Eunice, Louisiana	19.0%	3.0	\$354.71
15	Poplar Bluff, Missouri	35.0%	3.4	\$338.13
16	Rio Grande City–Roma, Texas	20.4%	2.7	\$339.44
17	Santa Fe, New Mexico	29.4%	3.1	\$229.56
18	Troy, Alabama	15.2%	3.1	\$484.90
19	Yakima, Washington	21.8%	2.6	\$308.70
20	Yuma, Arizona	22.4%	2.5	\$387.65
	<b>All High-Utilization CBSAs Combined</b>	<b>22.9%</b>	<b>3.5</b>	<b>\$399.90</b>
	<b>All Other CBSAs</b>	<b>6.2%</b>	<b>2.4</b>	<b>\$321.33</b>

## APPENDIX B

**Table B-1. Independent Diagnostic Testing Facility Claims With Questionable Characteristics: Comparison of High-Utilization Core Based Statistical Areas to All Other Core Based Statistical Areas**

	Core Based Statistical Areas (CBSA) (Alphabetical Order)	Total Number of Independent Diagnostic Testing Facility (IDTF) Claims	Percentage of IDTF Claims With Two or More Questionable Characteristics	Percentage of IDTF Claims on Which the Medicare Beneficiary Is Linked to Four or More IDTFs	Percentage of IDTF Claims That Lacked a Claim by the Referring Physician	Percentage of IDTF Claims With Unmatched Diagnosis Categories
1	Alamogordo, New Mexico	5,336	2.6%	2.0%	14.1%	10.0%
2	Danville, Virginia	15,717	9.5%	0.3%	13.4%	49.7%
3	Duncan, Oklahoma	10,012	3.6%	0.2%	6.3%	43.5%
4	East Stroudsburg, Pennsylvania	16,382	12.0%	1.8%	15.4%	55.1%
5	Fayetteville, North Carolina	25,874	10.1%	6.1%	21.7%	36.1%
6	Granbury, Texas	12,248	5.9%	2.6%	9.6%	38.6%
7	Grand Island, Nebraska	7,169	0.8%	2.6%	6.4%	2.7%
8	Jennings, Louisiana	5,582	1.8%	3.1%	8.4%	5.8%
9	Kerrville, Texas	9,715	1.4%	1.8%	9.7%	10.3%
10	Lafayette, Louisiana	21,807	11.0%	9.1%	12.3%	46.2%
11	Las Cruces, New Mexico	23,242	7.5%	5.7%	12.8%	39.0%
12	Miami–Fort Lauderdale–Pompano Beach, Florida	435,781	22.7%	21.7%	19.5%	52.2%
13	Natchez, Mississippi–Louisiana	8,886	5.4%	5.5%	14.8%	21.1%
14	Opelousas–Eunice, Louisiana	8,811	9.0%	3.7%	11.7%	46.3%
15	Poplar Bluff, Missouri	10,164	5.3%	3.7%	11.5%	26.1%
16	Rio Grande City–Roma, Texas	4,072	3.0%	3.3%	5.4%	23.0%
17	Santa Fe, New Mexico	16,704	16.8%	2.5%	21.8%	61.5%
18	Troy, Alabama	2,247	6.8%	1.6%	8.7%	45.3%
19	Yakima, Washington	16,160	2.7%	1.7%	8.3%	11.4%
20	Yuma, Arizona	12,343	7.5%	3.5%	11.1%	43.0%
	<b>All High-Utilization CBSAs Combined</b>	<b>668,252</b>	<b>17.5%</b>	<b>15.4%</b>	<b>17.3%</b>	<b>46.7%</b>
	<b>All Other CBSAs</b>	<b>5,306,717</b>	<b>8.0%</b>	<b>2.7%</b>	<b>14.2%</b>	<b>35.4%</b>

## APPENDIX C

### Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services  
Office of Strategic Operations  
and Regulatory Affairs

200 Independence Avenue SW  
Washington, DC 20201

**DATE:** DEC 23 2011

**TO:** Daniel R. Levinson  
Inspector General

**FROM:** Marilyn Tavenner *ISI*  
Acting Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Questionable Billing for Medicare Independent Diagnostic Testing Facility Services" (OEI-09-09-00380)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General (OIG) draft report entitled, "Questionable Billing for Medicare Independent Diagnostic Testing Facility Services." The purpose of this report was to compare the billing patterns of Independent Diagnostic Testing Facilities (IDTFs) in high-utilization areas with billing patterns of IDTFs in other geographic areas and to identify IDTF claims with questionable characteristics.

IDTFs offer diagnostic services and are independent of a physician's office or hospital. According to OIG's report, the number of Medicare-enrolled IDTFs from 2002 to 2009 substantially grew, as did the Medicare-allowed charges for IDTFs.

IDTF services have historically been vulnerable to abuse. CMS is currently streaming every Medicare fee-for-service claim in real-time through its predictive modeling technology, known as the Fraud Prevention System (FPS). The FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, and billing patterns. Using these profiles, CMS estimates a claim's likelihood of fraud and prioritizes providers with billing behavior that seem to pose an elevated risk to Medicare for a closer review. CMS will explore opportunities to build reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by IDTFs.

In addition, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group using the authorities granted under the Affordable Care Act. Under the new screening provisions of CMS 6028-FC<sup>1</sup> all IDTFs are

<sup>1</sup> CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

considered a moderate-risk provider/supplier and are, therefore, subject to unannounced site visits.

We appreciate OIG's efforts in working with CMS to help ensure that IDTFs do not continue to be vulnerable to abuse. Our response to each of the OIG recommendations follows.

**OIG Recommendation**

The CMS should monitor IDTF claims for questionable characteristics.

**CMS Response**

The CMS concurs with this recommendation. In addition to routine monitoring of a variety of providers and claims, CMS is currently streaming every Medicare fee-for-service claim prior to payment through its predictive modeling technology, known as the FPS. The FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, and billing patterns. Using these profiles, CMS estimates a claim's likelihood of fraud and prioritizes providers with billing behavior that seem to pose an elevated risk to Medicare for a closer review.

The CMS is intent on building reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by all major provider types, including IDTFs. In addition, CMS' Medicare-oriented field offices in Southern California, Miami, and New York are continuing to work on understanding the IDTF situations in those areas at the ground level, and feeding that information back to CMS' central office to inform our IDTF strategies. IDTFs have been, and will remain, a key focus for CMS' program integrity operations.

**OIG Recommendation**

The CMS should take appropriate action when IDTFs submit a high number of questionable claims for IDTF services.

**CMS Response**

The CMS concurs with this recommendation. CMS has taken and will continue to take administrative actions as appropriate, in specific cases. Administrative actions may include, but are not limited to, verification of operational status, prepayment review, auto-deny edits, payment suspensions, and revocations. In addition, CMS is currently exploring options to use payment suspensions in conjunction with revocation actions for providers/suppliers determined to be non-operational. In fact, CMS is actively taking a variety of administrative actions against many provider types around the nation, including IDTFs. The recommendation focuses on the need to take actions against IDTFs generally when high numbers of questionable claims are submitted, and CMS agrees. As stated in the response to the previous recommendation, CMS is currently focusing on IDTFs in several ways, and will continue to do so.

**OIG Recommendation**

The CMS should assess whether to impose a temporary moratorium on new IDTF enrollments in Core Based Statistical Areas (CBSAs) with high concentrations of IDTFs.

**CMS Response**

The CMS concurs with this recommendation. CMS, in developing our approach for implementing the new temporary moratorium authority effectively and thoughtfully, will assess whether moratoria are appropriate for a variety of provider types, including IDTFs. However, we would like to comment on one of the premises of the recommendation. While the recommendation suggests an enrollment moratorium on new IDTFs in CBSAs with a high *concentration* of IDTFs (that is, a high number of IDTFs), the rationale for the recommendation instead suggests moratoria for those CBSAs with high IDTF *utilization* (that is, disproportionate use per capita of IDTF services). Concentration and utilization are distinct concepts and need to be weighed as independent factors supporting a moratorium.

While factors such as a high concentration of providers, or a high rate of service utilization, may be pertinent to the decision whether or not to impose a moratorium, they may not be sufficient (either alone or together) to support a moratorium decision. In assessing whether or not there is a risk of fraud sufficient to support a moratorium, CMS anticipates that it will often be necessary to take into account a wide range of data and information, including the impact on beneficiary access to care. We anticipate that each situation may be different, and CMS will need to tailor its decisions appropriately to the circumstances of each case. In some instances, we expect that the moratorium will be the right tool, while in others, CMS may rely on other administrative tools.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

Attachment

## **Acknowledgments**

This report was prepared under the direction of Timothy S. Brady, Regional Inspector General for Evaluation and Inspections in the San Francisco regional office, and Michael Henry, Deputy Regional Inspector General.

Veronica Gonzalez served as the team leader for this study, and Loul Alvarez served as lead analyst. Other principal Office of Evaluation and Inspections staff from the San Francisco regional office who contributed to the report include Christina Lester; central office staff who contributed include Robert Gibbons, Scott Horning, Scott Hutchison, and Kevin Manley.

# Office of Inspector General

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