DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

WASHINGTON, DC 20201

March 4, 2014

TO: Marilyn Tavenner
Administrator
Centers for Medicare & Medicaid Services

FROM: /Brian P. Ritchie/
Assistant Inspector General for Audit Services

SUBJECT: Memorandum Report: Results of Reviews at Three Suppliers of Diabetic Testing Supplies (A-09-13-02032)

This memorandum report summarizes the results of our reviews at three suppliers of mail-order diabetic testing supplies. The Senate Special Committee on Aging requested that we determine whether durable medical equipment suppliers correctly coded Medicare claims for diabetic testing supplies delivered by mail to beneficiaries. Medicare requires suppliers to use the KL modifier on all claims for mail-order diabetic testing supplies, which, from January 2009 through March 2013, were reimbursed using lower fee schedule amounts than supplies provided at local supplier storefronts (walk-in suppliers).

In response to the Senate committee's request, at each of three selected suppliers, we reviewed a random sample of 100 line items on claims for diabetic testing supplies to determine whether the supplier submitted claims without the KL modifier in accordance with Medicare requirements. The suppliers that we reviewed were Neighborhood Diabetes, Inc. (Neighborhood), MedEnvios Healthcare, Inc. (MedEnvios), and Advanced Diabetes Supply (Advanced).[1]

Further, the Centers for Medicare & Medicaid Services (CMS) requested that we determine whether suppliers were waiving beneficiaries' coinsurance to influence their choice of supplier for diabetic testing supplies. Medicare requires suppliers to collect unmet deductibles, coinsurance, and copayments from beneficiaries. In response to CMS's request, this report provides the results of our review of the coinsurance collected by the three selected suppliers.

An Office of Inspector General (OIG) evaluation report issued in 2012 addressed concerns about suppliers' use of the KL modifier and their waiving of beneficiary coinsurance. To provide a broader perspective on the use of the KL modifier and the collection of coinsurance for diabetic testing supplies, we have incorporated the results of that evaluation into this report.

[1] See the Appendix for the report titles, numbers, and issuance dates.

For calendar years 2010 and 2011, the three selected suppliers submitted claims for diabetic testing supplies without the KL modifier in accordance with Medicare requirements and did not routinely waive beneficiaries' coinsurance for these supplies.

SUMMARY

Of the 300 sampled line items, 298 were properly submitted without the KL modifier because the suppliers used company-owned vehicles to deliver diabetic testing supplies to Medicare beneficiaries. Under Medicare requirements in effect during calendar years (CYs) 2010 and 2011 (audit periods), supplies delivered by company-owned vehicles were not considered mail-order items. Therefore, claims for these supplies did not require use of the KL modifier. The remaining two sampled line items should have been submitted with the KL modifier because two of the suppliers had delivered the diabetic testing supplies by mail. The suppliers discovered these errors during our audits and resubmitted the claims with the KL modifier.

The three suppliers began delivering supplies in company-owned vehicles around the time that Medicare reimbursements for mail-order diabetic testing supplies were scheduled to decrease. The CMS definition of "mail-order item" allowed the suppliers to bill Medicare for non-mail-order supplies when they had delivered supplies in company-owned vehicles and to receive higher Medicare reimbursements.

During our audit periods, Medicare paid the three suppliers approximately $8.2 million for diabetic testing supplies that were claimed as non-mail-order supplies (i.e., without the KL modifier). If the definition of "mail-order item" had included supplies delivered in company-owned vehicles and required the suppliers to claim them as mail-order supplies (i.e., with the KL modifier), we determined that Medicare would have paid approximately $4.7 million for the supplies. The difference between the amount that Medicare paid and the amount it would have paid if the supplies had been claimed with the KL modifier is approximately $3.5 million.

In addition, we determined that the three suppliers did not routinely waive beneficiaries' coinsurance for diabetic testing supplies. These suppliers (1) billed or collected coinsurance from Medicare beneficiaries or the beneficiaries' secondary payers, if possible, or (2) provided coinsurance waivers to beneficiaries on the basis of financial need.

BACKGROUND

Diabetic Testing Supplies

According to sections 1832(a)(1), 1861(s)(6), and 1861(n) of the Social Security Act (the Act), Medicare Part B covers durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS). DMEPOS includes blood glucose monitors that physicians prescribe for diabetics, whether they are insulin-treated or non-insulin-treated. Part B also covers diabetic testing supplies, such as blood-testing strips (test strips), lancets, glucose control solutions, and spring-powered lancet devices for patients for whom the glucose monitor is covered.

Medicare Reimbursement of Diabetic Testing Supplies

Medicare's fee schedule for DMEPOS establishes the maximum amounts reimbursed to suppliers for diabetic testing supplies. The amount allowed by Medicare for payment for an individual item, such as a box of test strips, is equal to the lesser of the fee schedule amount or the amount charged by a supplier. Medicare pays the beneficiary or the supplier the amount allowed for payment, less the beneficiary share (i.e., deductibles and coinsurance). For a supplier to be reimbursed by Medicare for a claim for any quantity of diabetic testing supplies, the supplier is required to maintain supporting documentation, including but not limited to a physician order and proof of delivery.

Payment and Collection of Beneficiary Deductibles, Coinsurance, and Copayments for Diabetic Testing Supplies

CMS's *Medicare General Information, Eligibility, and Entitlement Manual* requires that in each calendar year, a beneficiary deductible must be met before Medicare pays for Part B items, including diabetic testing supplies (Pub. No. 100-01, chapter 3, § 20.2). After the deductible has been met, the beneficiary is responsible for a coinsurance amount equal to 20 percent of the amount allowed by Medicare. Medicare pays the supplier the remaining 80 percent (Pub. No. 100-01, chapter 3, § 20.3).

Suppliers are required to collect unmet deductibles, coinsurance, and copayments[2] from beneficiaries.[3] If a beneficiary is unable to pay these charges, he or she should sign a waiver that explains the financial hardship. If a waiver is not granted, the supplier's record should reflect normal and reasonable attempts to collect the charges before they are written off. Consistently waiving deductibles, coinsurance, and copayments may be interpreted as program abuse (CMS's *Fact Sheet: Medicare Claim Submission Guidelines*, issued June 2012).[4]

Walk-In and Mail-Order Suppliers

Beneficiaries may obtain diabetic testing supplies from a walk-in supplier or a mail-order supplier. A walk-in supplier has a physical location where beneficiaries or their caregivers can pick up diabetic testing supplies. As of July 1, 2013, a mail-order supplier is a supplier that ships or delivers the supplies to the beneficiary's home, regardless of the method of delivery. Before that date, a mail-order supplier was a supplier that received requests for supplies from beneficiaries remotely (e.g., by mail, phone, or email or through a Web site) and delivered the supplies through a common carrier (e.g., the U.S. Postal Service or FedEx). Therefore, supplies

[2] A copayment is usually a set amount, rather than a percentage, that the beneficiary may be required to pay as a share of the cost for the items.

[3] There are circumstances that may prevent a supplier from collecting deductibles, coinsurance, or copayments. For example, a supplier may not be authorized to bill the beneficiary's secondary payer because it was not a contracted provider.

[4] We reviewed only the coinsurance collected by the three suppliers.

delivered to a beneficiary without use of a common carrier, such as supplies delivered to a beneficiary's home in a company-owned vehicle, were not considered mail-order supplies.[5]

Required Use of the KL Modifier for Mail-Order Diabetic Testing Supplies

CMS's *Medicare Claims Processing Manual* requires that suppliers use the KL modifier[6] on all claims for diabetic testing supplies delivered by mail to Medicare beneficiaries (Pub. No. 100-04, chapter 36, § 20.5.4.1). When the KL modifier was introduced on July 1, 2007, it was used only as an informational modifier to identify mail-order supplies, with no impact on the Medicare reimbursement amount. However, the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA) required a 9.5-percent reduction in the fee schedule amounts for certain items, including diabetic testing supplies delivered by mail on or after January 1, 2009, in any geographical area (P.L. No. 110-275, § 154(a)(2)). Effective January 1, 2009, the KL modifier became a pricing modifier, reducing the reimbursement for diabetic testing supplies delivered by mail.

Competitive Bidding Program for Mail-Order Diabetic Testing Supplies

On January 1, 2011, CMS implemented the first phase of the DMEPOS Competitive Bidding Program (competitive bidding program). To become Medicare-contracted suppliers under the competitive bidding program, suppliers were required to submit bids to compete for contracts to furnish certain items in competitive bidding areas (CBAs).[7] CMS awarded contracts to 356 suppliers to provide certain DMEPOS items in CBAs. Beneficiaries who permanently resided in a CBA could choose to obtain diabetic testing supplies from either a Medicare-contracted mail-order supplier or a walk-in supplier. Medicare did not cover mail-order diabetic testing supplies delivered by noncontracted suppliers to Medicare beneficiaries residing in a CBA.[8] However, Medicare did cover diabetic testing supplies provided by noncontracted suppliers through non-mail-order methods, such as delivering supplies in company-owned vehicles or making supplies available to beneficiaries for pickup from a storefront.

On July 1, 2013, CMS implemented the national mail-order competitive bidding program for diabetic testing supplies, which was not limited to certain CBAs. For this competition, CMS

[5] *Facts about the DMEPOS Competitive Bidding Program Round 1 Rebid: Mail-Order Diabetic Supplies.* Issued September 25, 2009, by Palmetto GBA, Competitive Bidding Implementation Contractor.

[6] A modifier is either alphanumeric or two letters reported with a Healthcare Common Procedure Coding System (HCPCS) code and is designed to give Medicare and commercial payers additional information needed to process a claim. (HCPCS codes are used throughout the health care industry to standardize coding for medical procedures, services, products, and supplies.) Medicare requires use of the KL modifier for only the following mail-order diabetic testing supplies: test strips, glucose control solutions, lancet devices, lancets, and replacement batteries for blood glucose monitors.

[7] CBAs are defined by specific zip codes related to Metropolitan Statistical Areas, which include major cities and the surrounding suburbs.

[8] Mail-order diabetic testing supplies delivered by contracted suppliers to beneficiaries residing in a CBA were reimbursed at the single payment amounts, which replaced the fee schedule amounts for items included in the competitive bidding program.

awarded supplier contracts for delivery of diabetic testing supplies across the Nation to beneficiaries who elect to have these supplies delivered to them. Medicare will reimburse only contracted suppliers for mail-order diabetic testing supplies.

Office of Inspector General's Prior Reviews of Test Strips and Lancets

OIG has conducted other reviews of Medicare payments for diabetic testing supplies. For example, we reviewed high utilization claims for test strips and lancets for CY 2007 for Jurisdictions A through D, which included all 50 States, 5 territories, and the District of Columbia. (We defined a high utilization claim as a claim for a quantity of test strips and lancets that exceeds the Medicare utilization guidelines.)[9] We estimated that Medicare improperly paid suppliers approximately $209 million, in 1 year, for claims that we identified as high utilization claims. See the Appendix for related OIG reports on Medicare claims for diabetic testing supplies.

HOW WE CONDUCTED THIS REVIEW

We judgmentally selected Neighborhood, MedEnvios, and Advanced for review on the basis of analyses of Medicare claim data.[10] These analyses indicated that (1) in CY 2010, Neighborhood, which we considered a mail-order company, billed a high dollar amount for claims for non-mail-order diabetic testing supplies; (2) in CY 2011, MedEnvios stopped providing mail-order diabetic testing supplies to beneficiaries who had received mail-order diabetic testing supplies in CY 2010; and (3) in CY 2011, Advanced provided non-mail-order diabetic testing supplies to beneficiaries who lived more than 30 miles from its business location.

We summarized the results of our reviews at the three selected suppliers. For each supplier, we reviewed Medicare Part B claims for line items without the KL modifier for test strips, glucose control solutions, lancet devices, and lancets provided to Medicare beneficiaries. A line item represented an individual type of diabetic testing supply included on a claim. We reviewed a random sample of 100 of these line items for each supplier, for a total of 300 line items, to determine whether the suppliers appropriately claimed diabetic testing supplies without the KL modifier. We also determined the amount that Medicare would have paid if the suppliers had used the KL modifier on the claims for supplies delivered in company-owned vehicles. Further, we reviewed documentation provided by the suppliers to determine whether the coinsurance for diabetic testing supplies was billed or collected or both.[11] Finally, we reviewed an evaluation report issued earlier by OIG to determine whether our findings were consistent with that report's findings and incorporated the results of that analysis into our report.

[9] In 2007, Medicare utilization guidelines allowed up to 100 test strips and 100 lancets every month for insulin-treated diabetics and every 3 months for non-insulin-treated diabetics.

[10] Neighborhood had offices in Woburn, Massachusetts; New York, New York; and Orlando, Florida. MedEnvios was located in Miami, Florida, and Advanced was located in Carlsbad, California.

[11] We did not sufficiently develop the finding related to the collection of coinsurance to make any recommendations.

For the individual reports issued to the three selected suppliers, we limited our review of internal controls to those that were significant to the objective of our audits. Because this report's information on the suppliers' collection of coinsurance was not part of the objective of our original audits of the suppliers, we did not review the internal controls over collecting coinsurance.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

RESULTS

The Three Suppliers Submitted Claims for Diabetic Testing Supplies Without the KL Modifier in Accordance With Medicare Requirements

The three suppliers submitted claims for diabetic testing supplies without the KL modifier in accordance with Medicare requirements. Of the 300 sampled line items that we reviewed, 298 were properly submitted without the KL modifier because the suppliers used company-owned vehicles to deliver diabetic testing supplies to Medicare beneficiaries. Under Medicare requirements in effect during CYs 2010 and 2011, supplies delivered by company-owned vehicles were not considered mail-order items. Therefore, claims for these supplies did not require use of the KL modifier.[12] The remaining two sampled line items should have been submitted with the KL modifier because two of the suppliers had delivered the diabetic testing supplies by mail. The suppliers discovered these errors during our audits and resubmitted the claims with the KL modifier.

The Three Suppliers Started Delivering Supplies in Company-Owned Vehicles Around the Time That Medicare Reimbursements for Mail-Order Diabetic Testing Supplies Were Scheduled To Decrease

The Three Suppliers Established Home Delivery Programs To Deliver Supplies in Company-Owned Vehicles

The three suppliers established home delivery programs around the time that Medicare reimbursements for mail-order diabetic testing supplies were scheduled to decrease. Through these programs, suppliers delivered supplies in company-owned vehicles rather than using a common carrier.

[12] Even though MedEnvios and Advanced were not contracted suppliers in the competitive bidding program, Medicare covered their claims because the diabetic testing supplies they delivered using company-owned vehicles were not considered mail-order items.

- MedEnvios established its home delivery program in April 2008, before the original start of the competitive bidding program.[13]

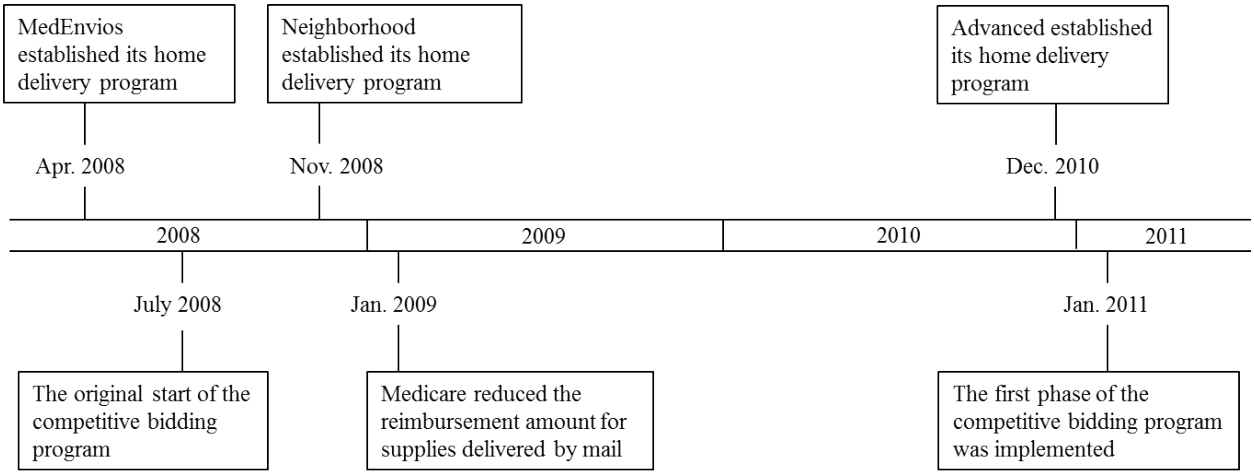
- Neighborhood established its home delivery program in November 2008, to prepare for home delivery services beginning in January 2009, when Medicare reduced the reimbursement amount for supplies delivered by mail.

- Advanced established its home delivery program in December 2010, to prepare for home delivery services beginning in January 2011, when the first phase of the competitive bidding program was implemented.

If these suppliers had provided mail-order diabetic testing supplies to beneficiaries who lived in a CBA after January 1, 2011, the suppliers would not have been paid by Medicare.

The figure below is a timeline that shows when the three suppliers established their home delivery programs and Medicare reimbursements for mail-order diabetic testing supplies decreased.

Figure: Timeline of the Establishment of Home Delivery Programs and Decreases in Medicare Reimbursement for Mail-Order Diabetic Testing Supplies



During our audit period of CY 2011 for MedEnvios and Advanced, they were not contracted suppliers under the first phase of the competitive bidding program but used company-owned vehicles to deliver diabetic testing supplies to Medicare beneficiaries who resided in a CBA. Because our audit period for Neighborhood was CY 2010, which was before the implementation of the competitive bidding program, we do not know whether Neighborhood used company-owned vehicles to deliver diabetic testing supplies to Medicare beneficiaries who resided in a CBA.

[13] CMS originally implemented the competitive bidding program on July 1, 2008, for 2 weeks, before MIPPA temporarily delayed the program and terminated the supplier contracts.

In September 2009, Advanced contracted with a membership warehouse club to deliver diabetic testing supplies to the club's stores for pickup by customers. Advanced paid a fixed fee to the membership warehouse club for its general and administrative expenses related to providing Advanced's diabetic testing supplies to customers. It used company-owned vehicles to deliver supplies to stores located in the Riverside CBA in California and billed these supplies as non-mail-order (i.e., without the KL modifier).[14] However, according to Advanced officials, Advanced mailed supplies to the stores that were not located in a CBA and billed these supplies as mail-order (i.e., with the KL modifier).

CMS Revised the Definition of "Mail-Order Item" Because It Discovered That Suppliers Adopted "… certain approaches to circumvent the mail order definition"

On July 13, 2010, CMS issued a notice of proposed rulemaking in the Federal Register to revise the definition of "mail-order item." The proposed rule states that CMS "discovered that suppliers … tried to adopt certain approaches to circumvent the mail order definition. … For example, some mail order suppliers considered purchasing a fleet of cars to deliver [diabetic testing supplies] to the beneficiary's home so as not to be considered a mail order supplier" (75 Fed. Reg. 40040, 40214). These suppliers would be able to increase their level of reimbursement because they would be paid the same amount as walk-in suppliers. CMS considered these practices to be inconsistent with the competitive bidding program statute and regulations in effect at that time and stated that such "arrangements prevent beneficiaries and the Medicare program from realizing savings afforded by the mail order DMEPOS [competitive bidding program] and is unfair to winning suppliers who bid in good faith for a contract for furnishing supplies to the home delivery market" (75 Fed. Reg. 40040, 40214).

CMS finalized the rule on November 29, 2010, to include the following definition of a mail-order item at 42 CFR § 414.402: " … any item (for example, diabetic testing supplies) shipped or delivered to the beneficiary's home, regardless of the method of delivery" (75 Fed. Reg. 73170, 73623). This definition became effective on July 1, 2013, when CMS implemented the national mail-order competitive bidding program for diabetic testing supplies.

Prior Evaluation Report Found That Claims for Non-Mail-Order Test Strips Increased, While Claims for Mail-Order Test Strips Decreased

In an evaluation report issued in November 2012, OIG reported that claims in CBAs for the more expensive, non-mail-order diabetes test strips increased from 2010 to 2011, while claims for the less expensive, mail-order diabetes test strips decreased.[15] OIG reported the following:

[14] The Riverside (Riverside–San Bernardino–Ontario, California) CBA is located in southern California.

[15] OIG evaluation report entitled *Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas* (OEI-04-11-00760), issued November 7, 2012.

> Overall, Medicare claims for [diabetes test strips] in CBAs decreased by 22 percent after CMS implemented [the first phase] of the DMEPOS Competitive Bidding Program in January 2011. Further, the number of claims for the more expensive, non-mail order [diabetes test strips] in CBAs increased by 33 percent, and the number of claims for the less expensive, mail order [diabetes test strips] in CBAs decreased by 71 percent.

The evaluation report's finding that claims for non-mail-order test strips increased while claims for mail-order test strips decreased is consistent with our finding that the three suppliers established home delivery programs around the time that Medicare reimbursements for mail-order diabetic testing supplies were scheduled to decrease. Through these programs, the suppliers delivered supplies in company-owned vehicles rather than using a common carrier. Medicare covered their claims because these supplies were not considered mail-order items.

Medicare Would Have Paid the Three Suppliers $4.7 Million Rather Than $8.2 Million if the Definition of "Mail-Order Item" Had Included Supplies Delivered in Company-Owned Vehicles

During our audit periods, Medicare paid the three suppliers $8,228,505 for diabetic testing supplies that were claimed as non-mail-order supplies (i.e., without the KL modifier). If the definition of "mail-order item" had included supplies delivered in company-owned vehicles and required the suppliers to claim them as mail-order supplies (i.e., with the KL modifier), we determined that Medicare would have paid $4,740,730 for the supplies.[16] The difference between the amount that Medicare paid and the amount it would have paid if the supplies had been claimed with the KL modifier is $3,487,775.

The table on the following page shows (1) the number of units of diabetic testing supplies that the suppliers claimed without the KL modifier, (2) the total Medicare Part B payment amount for these supplies, and (3) the amount that Medicare would have paid if the suppliers had used the KL modifier.

[16] For this calculation, we used the fee schedule amounts for supplies delivered to beneficiaries who did not reside in a CBA and a payment amount of zero for supplies delivered to beneficiaries who resided in a CBA. This calculation does not take into account supplies claimed without the KL modifier that may have been picked up by the beneficiary at the supplier's business location. Although the three suppliers did not have storefronts where they sold supplies, beneficiaries could pick up supplies at the suppliers' business locations. All three suppliers stated that it was uncommon for beneficiaries to walk in and pick up supplies, but it happened occasionally.

Table: Amount Paid for Units Claimed Without KL Modifier and Paid Amount if KL Modifier Had Been Used

Supplier	CY	No. of Units Claimed Without KL Modifier	Amount Paid for Units Claimed Without KL Modifier	Paid Amount if KL Modifier Had Been Used
Neighborhood	2010	226,565	$5,482,752	$4,703,202
MedEnvios	2011	98,092	2,110,313	12,840
Advanced	2011	29,008	635,440	24,688
Total		**353,665**	**$8,228,505**	**$4,740,730**

The amounts that Medicare would have paid MedEnvios and Advanced are significantly lower than the amount that Medicare would have paid Neighborhood because our audit period for Neighborhood was CY 2010, which was before the implementation of the competitive bidding program. MedEnvios and Advanced were not contracted suppliers under the first phase of the competitive bidding program; therefore, their claims for mail-order diabetic testing supplies provided to beneficiaries in a CBA would not have been paid by Medicare. If MedEnvios and Advanced had been contracted suppliers, Medicare would have paid them $818,264 and $235,800, respectively, for these supplies.[17]

The Three Suppliers Did Not Routinely Waive Beneficiaries' Coinsurance

We determined that the three suppliers did not routinely waive beneficiaries' coinsurance for diabetic testing supplies. CMS guidance states that consistently waiving coinsurance may be interpreted as program abuse. These suppliers (1) billed or collected coinsurance from Medicare beneficiaries or the beneficiaries' secondary payers, if possible, or (2) provided coinsurance waivers to beneficiaries on the basis of financial need.

For 275 of the 300 sampled line items (approximately 92 percent), the beneficiaries had a secondary payer, such as Medicaid, which eliminated the beneficiaries' responsibility for paying the coinsurance. For the remaining 25 sampled line items, the beneficiaries either had to pay their coinsurance out-of-pocket or signed waivers on the basis of financial need.

The suppliers collected coinsurance for 173 of the 275 sampled line items for which the beneficiaries had secondary payers. The suppliers were unable to collect coinsurance for the remaining 102 sampled line items:

[17] For these calculations, we used the fee schedule amounts for supplies delivered to beneficiaries who did not reside in a CBA and the single payment amounts for supplies delivered to beneficiaries who resided in a CBA.

- For 89 line items, one supplier was not authorized to bill Medicaid because it was not an enrolled provider.[18]

- For six line items, the Medicaid fee schedule amount was lower than the Medicare paid amount; therefore, Medicaid did not cover the coinsurance.[19]

- For three line items, one supplier attempted to collect coinsurance from the secondary payer, but the claim was denied.

- For two line items, one supplier did not bill Medicaid. The supplier stated that the cost of billing these line items to Medicaid exceeded the coinsurance amount that Medicaid would have paid the supplier.

- For two line items, one supplier was not authorized to bill the beneficiaries' secondary payer because it was not a contracted provider.

For 94 percent of the sampled line items, the beneficiaries did not incur any out-of-pocket costs for coinsurance because they had a secondary payer or a signed waiver, which eliminated the beneficiaries' responsibility for paying the coinsurance. However, the suppliers collected the coinsurance for only 63 percent of the sampled items for which the beneficiaries had a secondary payer.

Prior Evaluation Report Found That No Beneficiaries Reported Changing From Mail-Order to Non-Mail-Order Test Strips Because of Suppliers Waiving Coinsurance

In an evaluation report issued in November 2012, OIG reported similar results in a study of beneficiaries who showed a pattern of receiving mail-order test strips in 2010 and non-mail-order test strips in 2011.[20] OIG interviewed randomly selected beneficiaries in CBAs to determine how they received test strips in 2010 and 2011. None of the beneficiaries reported that the suppliers' waiver of coinsurance was the reason for changing from mail-order to non-mail-order test strips. However, 79 percent of the beneficiaries in the study did not pay any coinsurance for test strips in 2011. Of these beneficiaries, 87 percent had supplemental insurance that paid the entire amount of their Medicare coinsurance, 10 percent had never paid Medicare coinsurance (the beneficiaries did not know why), and 3 percent had their Medicare coinsurance waived because of financial hardship.

[18] Section 1902(n)(3) of the Act states that the Medicare payment and the Medicaid payment, if any, are considered payment in full and that the beneficiary has no legal liability to pay a provider for cost sharing. Suppliers are not allowed to bill a dual-eligible beneficiary for the coinsurance that was not paid by Medicaid.

[19] Section 1902(n)(2) of the Act provides that States are not required to pay for deductibles, coinsurance, or copayments if the amount paid by Medicare exceeds the Medicaid fee schedule amount for the same service provided to any other Medicaid enrollee.

[20] OIG evaluation report entitled *Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas* (OEI-04-11-00760), issued November 7, 2012. The report refers to coinsurance as "copayment."

The evaluation's finding that no beneficiaries reported that the suppliers' waiver of coinsurance was the reason for changing from mail-order to non-mail-order test strips and that 79 percent of beneficiaries did not pay any coinsurance is consistent with our finding that for 94 percent of the sampled line items we reviewed, the beneficiaries did not incur any out-of-pocket costs for coinsurance.

CONCLUSION

The three suppliers submitted claims for diabetic testing supplies without the KL modifier in accordance with Medicare requirements because they delivered the supplies in company-owned vehicles. The three suppliers began delivering supplies in company-owned vehicles around the time that Medicare reimbursements for mail-order diabetic testing supplies were scheduled to decrease. The CMS definition of "mail-order item" in effect during our audit periods allowed the suppliers to bill Medicare for non-mail-order supplies when they had delivered supplies in company-owned vehicles and to receive higher Medicare reimbursements.

Because CMS has changed the definition of "mail-order item," suppliers may no longer receive higher Medicare reimbursement for claims for diabetic testing supplies that are delivered to beneficiaries in company-owned vehicles. During our audit periods, Medicare paid the three suppliers approximately $8.2 million for diabetic testing supplies that were claimed as non-mail-order supplies (i.e., without the KL modifier). If the definition of "mail-order item" had included supplies delivered in company-owned vehicles and required the suppliers to claim them as mail-order supplies (i.e., with the KL modifier), we determined that Medicare would have paid approximately $4.7 million for the supplies. The difference between the amount that Medicare paid and the amount it would have paid if the supplies had been claimed with the KL modifier is approximately $3.5 million.

Further, we determined that the three suppliers did not routinely waive beneficiaries' coinsurance for diabetic testing supplies.

We hope that CMS finds this report useful when it continues to provide oversight and revises policies on diabetic testing supplies in the future. The information in this report can also be useful in educating beneficiaries about their Medicare benefits, their cost sharing (e.g., coinsurance), and the cost savings that mail-order diabetic testing supplies can provide to beneficiaries. Further, we are providing this report so that CMS will have information to consider when assessing the national mail-order competitive bidding program for diabetic testing supplies.

This report is being issued directly in final form because it contains no recommendations. If you have comments or questions about this report, please provide them within 60 days. Please refer to report number A-09-13-02032 in all correspondence.

APPENDIX: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Inappropriate and Questionable Medicare Billing for Diabetes Test Strips	OEI-04-11-00330	8/26/13
MedEnvios Healthcare, Inc., Submitted Claims for Diabetic Testing Supplies Without the KL Modifier in Accordance With Medicare Billing Requirements	A-09-12-02053	4/24/13
Advanced Diabetes Supply Submitted Claims for Diabetic Testing Supplies Without the KL Modifier in Accordance With Medicare Billing Requirements	A-09-12-02035	3/08/13
Neighborhood Diabetes, Inc., Submitted Claims for Diabetic Testing Supplies Without the KL Modifier in Accordance With Medicare Billing Requirements	A-09-11-02073	1/16/13
Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas	OEI-04-11-00760	11/07/12
Medicare Contractors Lacked Controls To Prevent Millions in Improper Payments for High Utilization Claims for Home Blood-Glucose Test Strips and Lancets	A-09-11-02027	6/13/12
Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets – Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction B	A-09-08-00044	2/17/11
Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets – Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction D	A-09-08-00046	2/04/11
Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets – Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction C	A-09-08-00045	1/21/11
Medicare Market Shares of Mail Order Diabetic Testing Strips	OEI-04-10-00130	12/02/10
Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets – Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction A	A-09-08-00043	8/30/10