



Comparative Billing Report

June 20, 2016

CBR #: CBR201609
Topic: Diabetic Testing Supplies
NPI #: 1111111111
Fax #: (888)555-5555

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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 headquartered in Arlington, VA, to develop Comparative Billing Reports (CBRs). CBRs provide comparative data on how an individual health care provider's billing and payment patterns for selected topics compare to his/her peers. The CBRs give providers an opportunity to compare themselves to their peers, check their records against data in CMS' files, and review Medicare guidelines to ensure compliance. CBRs are for educational and comparison purposes and do not indicate the identification of overpayments. **Please note, no reply is necessary.**

Attached is a CBR that reflects your billing or referral patterns compared to peer providers' patterns for the same services in your state and nationwide. We recognize that practice patterns can vary by region, subspecialty, and patient acuity levels, which are elements that are not evident in the claims data reviewed for the CBR. We hope you find this CBR beneficial as an educational tool to assist you in identifying opportunities for improvement. If you have any questions regarding this CBR, or if you want to change the way you receive CBRs in the future, please contact the CBR Support Help Desk.

- Toll Free Number: 1-800-771-4430
- Email: CBRsupport@eglobaltech.com
- Website: <http://www.cbrinfo.net>

REMINDER: If you have changed your mailing address or contact information and have not notified the National Plan and Provider Enumeration System (NPPES) and/or CMS' provider enrollment contractor via the internet or the appropriate Medicare enrollment application, please take time to review and update the system.

You can update your National Provider Identifier (NPI) contact information in NPPES at <https://nppes.cms.hhs.gov/NPPES>. If you have forgotten your User ID and/or password or need assistance, contact the NPI Enumerator at 1-800-465-3203 or email customerservice@npienumerator.com.

We hope you find the attached report informative.

Sincerely,

Virna Elly
CBR Program Director
eGlobalTech
Enclosure

Comparative Billing Report (CBR): NPI 1111111111
Diabetic Testing Supplies

Introduction

This comparative billing report (CBR) focuses on suppliers who dispensed Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) for diabetic testing to Medicare beneficiaries. The report is an analysis of claims with Healthcare Common Procedural Coding System (HCPCS) codes A4253, blood glucose test or reagent strips for home blood glucose monitor, and A4259, lancets. The metrics reviewed in this report include:

- The percentage of beneficiaries with a KX modifier and those transitioning between KS and KX modifiers
- The average number of diabetic supplies per day per beneficiary by HCPCS code and KS/KX modifiers
- The average mileage between supplier and beneficiary and KL modifier use

Table 1 provides an abbreviated description for diabetic testing, HCPCS codes A4253 and A4259. The items per unit are assigned by HCPCS code and are also included.

Table 1: HCPCS Codes, Abbreviated Descriptions, and Items per Unit

HCPCS Code	Abbreviated Description	Items per Unit
A4253	Blood Glucose Test Strips	50
A4259	Lancets	100

The Office of Inspector General (OIG) has found in prior studies and recent investigations that diabetic testing supplies (DTS) is an area vulnerable to fraud, waste, and abuse. In its 2013 report titled, “Inappropriate and Questionable Medicare Billing for Diabetes Test Strips,” the OIG found Medicare inappropriately allowed \$6 million for DTS claims. They also found that \$425 million in Medicare-allowed claims made by 10 percent of DTS suppliers had characteristics of questionable billing. Suppliers in 10 geographic areas were responsible for 77 percent of the questionable claims.

In 2011, the OIG released a report titled, “Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets - Durable Medical Equipment Medicare Administrative Contractor (MAC) for Jurisdiction D.” During an audit of Noridian Healthcare Solutions (Jurisdiction D), the OIG reviewed a sample of 100 high utilization claims for Calendar Year 2007. After analyzing claim information, the OIG estimated that Noridian allowed \$76 million for claims identified as high utilization. Several deficiencies in documentation were identified by the audit, including either missing or incomplete physician’s orders, missing proof-of-delivery records and missing documentation to support refill requirements. Sixty-one of 100 claims reviewed lacked documentation to support the excess quantities billed. Approximately \$40.5 million of the \$76 million allowed for high utilization claims was inappropriate, of which \$30.9 million was paid to DMEPOS suppliers.

Medicare utilization guidelines allow up to 100 test strips and 100 lancets every month for insulin-treated diabetics, while non-insulin treated diabetics can receive 100 test strips and 100 lancets every three months. To be reimbursed for any quantity of test strips and/or lancets, the DMEPOS

supplier is required to maintain a physician order containing the items to be dispensed, the specific frequency of testing, and a dated physician's signature. The date and proof of delivery must also be part of the record. The supplier may refill an order only when the beneficiary has nearly exhausted the previous supply and specifically requests the supplies be dispensed. Additional requirements must be met for reimbursement of a claim that exceeds typical utilization. There must be documentation in the beneficiary's medical record to support the need for additional supplies.

According to "The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report", blood glucose reagent strips and lancets were found to have high rates of improper payment. Reagent strips were paid in error 43.7 percent of the time, resulting in a projected improper payment amount of \$116,663.821, based on 947 claims reviewed. Lancets had an error rate of 38.8 percent, with no projected improper payment amount included in the report.

Several MACs have ongoing service specific review of diabetic testing supplies. Noridian is currently performing a service specific prepayment review of HCPCS code A4253. The review for July 2015 through February 2016 showed an improper payment rate of 88 percent. Noridian found the following errors:

- Medical documentation was not received
- Documentation did not support the actual testing frequency that corroborated the quantities of supplies that were dispensed
- Documentation did not support that the beneficiary had been evaluated by the treating physician

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 Medicare Administrative Contractors (MACs), in Local Coverage Determinations (LCDs), or in Local Coverage Articles (LCAs).** Please refer any specific questions you may have to the MAC for your region.

Basic Coverage Criteria

LCD L33822 titled, "Glucose Monitors," covers all jurisdictions in the nation and is used by all four of the DMEPOS MACs to provide coverage indications and limitations for glucose meters and DTS. The LCD explains that DTS are only covered by Medicare when the beneficiary has been diagnosed with diabetes and the treating physician has provided a prescription or detailed written order (DWO) for supplies, with the determination that the beneficiary or caregiver has sufficient training to use the prescribed device. Suppliers can find information regarding prescription order requirements, dispensing orders, and medical record documentation in the LCD or in the article attached to the LCD.

Modifier KX is appended to claims when the beneficiary requires insulin for the treatment of his/her illness. Typically, 300 strips and lancets are covered by Medicare during a three month period for beneficiaries being treated with insulin, which equates to testing three times per day. Modifier KS is appended to claims when the beneficiary does not require insulin for the treatment of his/her illness. Typically, 100 strips and lancets are covered by Medicare during a three

month period for beneficiaries not being treated with insulin, which equates to testing once per day.

According to a Medicare Learning Network®(MLN®) publication titled “The Durable Medical Equipment, Prosthetics, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program Mail Order Diabetes Supplies” that was published in April of 2016, “Contract suppliers are required to use the KL modifier on each claim for diabetes testing supplies furnished on a mail-order basis.” The term “mail order” means items shipped or delivered to the beneficiary’s residence by any method.

When the number of supplies utilized exceeds the limits specified in the LCD, medical records must support the testing frequency and provide evidence that the beneficiary is using all the supplies being provided. Testing logs may be requested to support usage. The treating physician must see the beneficiary and evaluate the beneficiary’s diabetes control within six months prior to ordering quantities of strips and lancets when typical utilization is exceeded. Suppliers are required to keep supporting documentation for seven years.

According to the LCD, suppliers must contact the beneficiary prior to dispensing refills to ensure that the beneficiary’s current supply reserve is nearing exhaustion. Contact with the beneficiary should take place no sooner than 14 calendar days prior to the delivery/shipping date. Suppliers must not deliver refills without a refill request from the beneficiary and must not dispense a quantity of supplies exceeding a beneficiary’s expected utilization. Suppliers must never dispense more than a three-month supply of test strips and/or lancets at a time.

Methods

This report is an analysis of Original Fee-for-Service DMEPOS claims with allowed services for the HCPCS codes A4253 and A4259, with dates of service from January 1, 2015 to December 31, 2015. This analysis was based on the latest version of claims available from the Integrated Data Repository, as of May 9, 2016. Your percentages and averages, denoted in Tables 3 through 5, are calculated from your data which is summarized in Table 2. Your values are compared to those of your state (GA) and national values, using either the chi-squared or t-test at the alpha value of 0.05. Due to some aberrancies found in the data, the following adjustments were made:

- Any claim line having a covered time of over one year was capped at 365 days
- Any claim line submitted with both the KS and the KX modifier was assumed to be KX
- Any claim line submitted with neither the KS or KX modifier was assumed to be KS

Percentage of Beneficiaries by Modifier Category

Beneficiaries are categorized by the use of the KS and KX modifiers. The “KS and KX” category is used when the beneficiary has allowed claim lines that include both KS and KX modifiers. These modifiers were identified on separate claim lines during the twelve-month period. The “KX” category is used if the beneficiary has allowed claim lines that only include the KX modifier. The percentage of beneficiaries by modifier category is calculated, as follows:

$$\frac{\text{Number of Beneficiaries by Modifier Category}}{\text{Total Number of Beneficiaries}} \times 100$$

Average Allowed Items per Beneficiary-Day by HCPCS Code and Modifier Type

The average allowed items per beneficiary-day is based on the combination of the HCPCS codes and KS/KX modifiers. The numerator, total allowed items, is the actual number of items contained in each unit of service. For HCPCS code A4253, the number of items is calculated as the number of services multiplied by 50 since there are 50 diabetic testing strips in each unit. For HCPCS code A4259, the number of items is calculated as the number services multiplied by 100 since there are 100 lancets in each unit.

The denominator, total number of beneficiary-days, is calculated by first finding the number of days covered on each claim line. This is done by subtracting the “from date” from the “through date” and adding one (through date - from date +1). The total number of days covered are summarized by beneficiary, and any overlapping time periods are removed. The sum of these allowed items and beneficiary-days are the components of the calculation of the average allowed items per beneficiary-days, as follows:

$$\frac{\text{Total Allowed Items}}{\text{Total Number of Beneficiary-Days}}$$

Average Distance from DMEPOS Supplier to Beneficiary

The distances between the DMEPOS supplier and the beneficiaries for claims submitted without the KL modifier are assessed. The lack of the KL modifier on the claim line indicates that the supplies were collected by the beneficiary or a designee at the supplier’s physical location. Distance is calculated as the mileage between the midpoint of the DMEPOS supplier’s location ZIP code and the midpoint of the beneficiary’s ZIP code. The average distance is based on the claim line, rather than the individual beneficiary. This allows beneficiaries with multiple claim lines to be weighted more heavily than those with fewer claim lines during this period. While there are occasions where a beneficiary purchases items in person from a distant supplier, significantly greater average distances may be an indicator that products are being delivered. Only DMEPOS suppliers on competitively-bid contracts are allowed to deliver supplies, and those claims must use the KL modifier. The average distance from the DMEPOS supplier to the beneficiary for you, your state, and the nation is calculated, as follows:

$$\frac{\text{Total Distance between Supplier and Beneficiary for each Claim Line}}{\text{Total Number of Claim Lines}}$$

Results

Table 2 provides a summary of your utilization of the HCPCS codes included in this CBR. The total allowed charges, allowed services, distinct beneficiary count, and the total number of beneficiary-days are included for each HCPCS code and modifier type. In addition, “Subtotal” rows are given for KS and KX modifiers, and an overall “Total” row is included. The number of beneficiary-days is included only at the HCPCS and modifier level. This calculation is not applicable at the subtotal and total levels and is, therefore, provided as “N/A”.

**Table 2: Summary of Your Utilization
January 1, 2015 - December 31, 2015**

HCPCS Code	Modifier	Allowed Charges	Allowed Services	Beneficiary Count	Beneficiary-Days
A4253	KS	\$1,446.99	139	35	4,805
A4253	KX	\$2,706.60	260	30	3,574
A4259	KS	\$61.05	37	15	2,051
A4259	KX	\$44.55	27	8	740
Subtotal	KS	\$1,508.04	176	37	N/A
Subtotal	KX	\$2,751.15	287	31	N/A
Total	-	\$4,259.19	463	67	N/A

Please note that the subtotal and total may not be equal to the sum of the rows. The number of beneficiaries is an unduplicated count for each HCPCS code, subtotal, and total row. It is likely that a supplier would submit multiple claims for a beneficiary for more than one HCPCS code and modifier combination. The number of beneficiaries are distinct counts and are therefore counted only once in the subtotals and total.

Table 3 provides a statistical comparison of your percentage of beneficiaries by modifier category to that of your peers.

**Table 3: Percentage of Beneficiaries by Modifier Category
January 1, 2015 - December 31, 2015**

Modifier Category	Your Percentage of Beneficiaries	Your State’s Percentage of Beneficiaries	Comparison with Your State’s Percentage	National Percentage of Beneficiaries	Comparison with the National Percentage
KS and KX	1%	11%	Does Not Exceed	7%	Does Not Exceed
KX Only	45%	32%	Significantly Higher	36%	Higher

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

Table 4 provides a statistical comparison of your average allowed items per beneficiary-days to that of your peers.

**Table 4: Average Allowed Items per of Beneficiary-Day by HCPCS Code and Modifier Type
January 1, 2015 - December 31, 2015**

HCPCS Code and Modifier Type	Your Average Allowed Items per Beneficiary-Day	Your State's Average Allowed Items per Beneficiary-Day	Comparison with Your State's Percentage	National Average Allowed Items per Beneficiary-Day	Comparison with the National Percentage
A4253KS	1.45	1.73	Does Not Exceed	1.62	Does Not Exceed
A4253KX	3.64	3.09	Significantly Higher	3.26	Significantly Higher
A4259KS	1.80	1.66	Higher	1.62	Higher
A4259KX	3.65	2.95	Significantly Higher	3.19	Higher

A t-test was used in this analysis, alpha=0.05. Beneficiary-days for line items are capped at a maximum of 365.

Table 5 provides a statistical comparison of your average distance from DMEPOS supplier to beneficiaries to that of your peers.

**Table 5: Average Distance from DMEPOS Supplier to Beneficiary
January 1, 2015 - December 31, 2015**

	Your Average Distance from Beneficiary	Your State's Average Distance from Beneficiary	Comparison with Your State's Percentage	National Average Distance from Beneficiary	Comparison with the National Percentage
Distance in Miles	3.29	17.21	Does Not Exceed	32.52	Does Not Exceed

A t-test was used in this analysis, alpha=0.05. Distance calculation is weighted by the number of claim lines.

Resources and References

The coverage and documentation guidelines for Diabetic Testing Supplies are listed below. Please follow the guidelines pertinent to your region. A complete list of web links is located at <http://www.cbrinfo.net/cbr201609-recommended-links.html>.

LCD L3822 Glucose Monitors

Office of Inspector General (OIG)

- Inappropriate and Questionable Medicare Billing for Diabetes Test Strips
- 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)

Comprehensive Error Rate Testing (CERT)

- *The Supplementary Appendices for the Medicare Fee-for-Service 2015 Improper Payments Report*

Noridian

- Blood Glucose Test or Reagent Strips (HCPCS A4253) Final Edit Effectiveness Results of Service Specific Prepayment Review

The Durable Medical Equipment, Prosthetic, Orthotics, and Supplies (DMEPOS) Competitive Bidding Program, Mail-Order Diabetes Supplies

The Next Steps

We encourage you to check with your MAC to ensure you are meeting the Medicare standards for your jurisdiction. Please use the above references and resources as a guide.

You are invited to join us for the CBR201609 webinar on July 27, 2016 from 3:00 - 4:30 PM ET. Space is limited, so please register early. Register online at <http://www.cbrinfo.net/cbr201609-webinar.html>.

If you are unable to attend, you may access a recording of the CBR201609 webinar five business days following the event at <http://www.cbrinfo.net/cbr201609-webinar.html>.

For detailed links to information listed in the references and resources section, visit <http://www.cbrinfo.net/cbr201609-recommended-links.html>.

If you have any questions or suggestions related to this CBR, please contact the CBR Support Help Desk via email at CBRsupport@eglobaltech.com or via telephone at (800) 771-4430.

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