

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NATIONAL GOVERNMENT
SERVICES, INC.,
MADE MEDICARE PAYMENTS FOR
DIABETIC TEST STRIPS WHEN
BENEFICIARIES HAD NOT NEARLY
EXHAUSTED PREVIOUSLY
DISPENSED SUPPLIES**

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EXECUTIVE SUMMARY

National Government Services, Inc., made Medicare payments for 2013 to suppliers that dispensed diabetic test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers, resulting in potential overpayments of an estimated \$3.2 million.

WHY WE DID THIS REVIEW

In calendar year (CY) 2013, Medicare paid approximately \$489 million for home blood-glucose test strips (test strips) dispensed to Medicare beneficiaries nationwide. A previous Office of Inspector General review found that for CY 2007, National Government Services, Inc. (NGS), a Medicare contractor, made inappropriate payments to multiple suppliers that submitted claims with overlapping service dates for test strips and lancets dispensed to the same beneficiary. These payments were inappropriate because the suppliers dispensed test strips and lancets when the beneficiaries had not nearly exhausted the previously dispensed supplies. In response to one of the recommendations in our report, NGS stated that it was in the process of developing a system edit that would address the problem of overlapping dates of service on claims for individual beneficiaries. We conducted this followup review to determine whether this system edit had been implemented and was effective in preventing overpayments.

Our objective was to determine whether NGS made payments for CY 2013 to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers.

BACKGROUND

Medicare Part B covers test strips that physicians prescribe for diabetics, whether they are insulin-treated or non-insulin-treated. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a test strip, and inserts the strip into a home blood-glucose monitor to obtain a reading of the blood-sugar level. Medicare covers up to 100 test strips every month for insulin-treated diabetics and every 3 months for non-insulin-treated diabetics (utilization guidelines).

To be reimbursed for a claim for any quantity of test strips, the supplier is required to maintain (1) a physician order containing the items to be dispensed, the specific frequency of testing, and the physician's signature with the date and (2) proof of delivery. There are additional documentation requirements for reimbursement of a claim for a quantity of test strips that exceeds the utilization guidelines. In addition, the supplier may refill an order only when the beneficiary requests that the test strips be dispensed and has nearly exhausted the previous supply, which is no sooner than 10 calendar days before the end of usage for the current product.

Suppliers must submit claims to the durable medical equipment Medicare administrative contractor (contractor) that serves the State or territory in which the Medicare beneficiary permanently resides. The contractor's responsibilities include, but are not limited to, performing edits on these claims to determine whether they are complete and reimbursable, calculating

Medicare payment amounts and remitting payments to the appropriate parties, and educating suppliers on Medicare requirements and billing procedures. An edit is programming within the standard claim-processing system that selects certain claims; evaluates or compares information on the selected claims or another accessible source; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

HOW WE CONDUCTED THIS REVIEW

We obtained CY 2013 claim data consisting of 1.9 million line items for test strips for which NGS (the contractor for Jurisdiction B, which covers seven States) paid approximately \$112 million to suppliers. A line item represented a supply of test strips included on a claim with service beginning and ending dates (e.g., May 31, 2013, through August 28, 2013). We analyzed the claim data and identified 46,850 line items that each had service dates that overlapped service dates of a line item on a prior claim submitted by a different supplier for test strips dispensed to the same beneficiary. NGS paid approximately \$4.4 million to suppliers for the 46,850 line items. We reviewed a random sample of 100 of these line items.

We reviewed the claim data and supplier documentation to determine whether each line item of test strips on the prior claim was nearly exhausted when the new supply of test strips was dispensed (i.e., whether the test strips were dispensed sooner than 10 calendar days before the expected end of usage for the current product). We did not review the sampled line items for compliance with other Medicare requirements. Also, because we did not have a medical review contractor review the supplier documentation, the medical necessity of the test strips dispensed to the beneficiaries in our sample was not determined. Therefore, our determination of whether NGS made overpayments for the sampled line items was limited.

WHAT WE FOUND

NGS made payments for CY 2013 to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers. Of the 100 line items in our sample, 17 were allowable. We considered an additional 13 line items to be non-errors because the suppliers were no longer in business and the supporting documentation could not be obtained for review. The remaining 70 line items may not have been allowable because the suppliers dispensed test strips before the beneficiaries' existing supplies were nearly exhausted; i.e., sooner than 10 calendar days before the expected end of usage for the current product. For 37, or more than half, of the 70 line items, the suppliers dispensed test strips when there were more than 60 days remaining in the beneficiaries' existing supplies.

On the basis of our sample results, we estimated that just over \$3.2 million, or 74 percent, of the \$4.4 million that NGS paid to suppliers may have been unallowable for Medicare reimbursement. (Because a medical review of the sampled line items was not performed, we could not conclusively determine whether the \$3.2 million represented overpayments.) These potential overpayments occurred because NGS's system edit was not specifically designed to identify for review claims with overlapping service dates for test strips dispensed to the same

beneficiary. Rather, the system edit was designed to identify claims with a quantity of test strips that exceeded the utilization guidelines.

WHAT WE RECOMMEND

We recommend that NGS implement a system edit to identify for review claims submitted by multiple suppliers with overlapping service dates for test strips dispensed to the same beneficiary. Implementing this edit could have saved Medicare an estimated \$3.2 million for CY 2013.

AUDITEE COMMENTS AND OUR RESPONSE

In written comments on our draft report, NGS did not concur with our findings and stated that it disagreed with the methodology we used in the development of our data and the reported outcome. NGS officials stated that by not reviewing the medical necessity of the test strips, we potentially inflated both the identified overpayment and the claim error rate. NGS officials also stated that, in July 2015, CMS implemented an automated edit that would satisfy our recommendation.

After reviewing NGS's comments, we maintain that our findings and recommendation are valid. We acknowledge that conducting medical review is the only way to definitively establish the allowability of the sampled line items. For that reason, we stated in our report that because we did not conduct such a review, we could not conclusively determine whether the \$3.2 million represented overpayments. This amount represented claims that were likely to have been paid inappropriately.

We also acknowledge that CMS revised the *Medicare Claims Processing Manual* to describe an edit that could address our recommendation. However, we did not review the effectiveness of this edit because the change was effective after our audit period and occurred at the end of our fieldwork.

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INTRODUCTION

WHY WE DID THIS REVIEW

In calendar year (CY) 2013, Medicare paid approximately \$489 million for home blood-glucose test strips (test strips) dispensed to Medicare beneficiaries nationwide. A previous Office of Inspector General (OIG) review¹ found that for CY 2007, National Government Services, Inc. (NGS), a Medicare contractor, made inappropriate payments to multiple suppliers that submitted claims with overlapping service dates for test strips and lancets dispensed to the same beneficiary. These payments were inappropriate because the suppliers dispensed test strips and lancets when the beneficiaries had not nearly exhausted the previously dispensed supplies.

In response to one of the recommendations in our report, NGS stated that it was in the process of developing a system edit that would address the problem of overlapping dates of service on claims for individual beneficiaries.² We conducted this followup review to determine whether this system edit had been implemented and was effective in preventing overpayments. (We also recently conducted a review of another Medicare contractor, CGS Administrators, LLC, to evaluate the same issue.)³

OBJECTIVE

Our objective was to determine whether NGS made payments for CY 2013 to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers.

BACKGROUND

The Medicare Program

The Medicare program provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. The Centers for Medicare & Medicaid Services (CMS) administers the program. Medicare Part B provides supplementary medical insurance for medical and other health services.

¹ *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)*, issued February 17, 2011. This review included a medical review to determine the allowability of claims for test strips and lancets.

² An edit is programming within the standard claim-processing system that selects certain claims; evaluates or compares information on the selected claims or another accessible source; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, or suspending them for manual review.

³ *CGS Administrators, LLC, Made Medicare Payments for Diabetic Test Strips When Beneficiaries Had Not Nearly Exhausted Previously Dispensed Supplies (A-09-14-02015)*, issued July 29, 2015.

Medicare Coverage of Durable Medical Equipment, Prosthetics, Orthotics, and Supplies

Medicare Part B covers durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS).⁴ 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 test strips and lancets for patients for whom the glucose monitor is covered. To be paid by Medicare, a service or an item must be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member (the Act § 1862(a)(1)(A)).

CMS contracted with four durable medical equipment Medicare administrative contractors (contractors) to process and pay Medicare Part B claims for DMEPOS. Each contractor processes claims for one of four jurisdictions, which include specific States and territories. These jurisdictions are known as Jurisdictions A, B, C, and D. Suppliers must submit claims to the contractor that serves the State or territory in which the Medicare beneficiary permanently resides.

The contractors' responsibilities include, but are not limited to, (1) receiving Medicare Part B claims for DMEPOS suppliers and beneficiaries within their jurisdictions, (2) performing edits on these claims to determine whether they are complete and reimbursable, (3) calculating Medicare payment amounts and remitting payments to the appropriate parties, and (4) educating DMEPOS suppliers on Medicare requirements and billing procedures.

Home Blood-Glucose Test Strips

Medicare Part B covers test strips that physicians prescribe for diabetics, whether they are insulin-treated or non-insulin-treated. The patient, using a disposable sterile lancet, draws a drop of blood, places it on a test strip, and inserts the strip into a home blood-glucose monitor to obtain a reading of the blood-sugar level.

The *Medicare National Coverage Determinations Manual* (the Manual) specifies coverage of test strips for patients who meet certain conditions and use home blood-glucose monitors to better control their glucose levels by frequently checking those levels and contacting their attending physicians for advice and treatment.⁵ However, the Manual does not specify utilization guidelines and documentation requirements for test strips.

The Local Coverage Determinations (LCDs) implemented by the contractors establish utilization guidelines and documentation requirements for test strips. These LCDs state that the quantity of test strips that Medicare covers depends on the beneficiary's usual medical needs. The LCDs for the contractors further state that Medicare covers up to 100 test strips every month (i.e., the quantity for a testing frequency of approximately 3 times per day) for insulin-treated diabetics

⁴ The Social Security Act (the Act) §§ 1832(a)(1), 1861(s)(6), and 1861(n).

⁵ The Manual, Pub. No. 100-03, chapter 1, § 40.2, effective June 19, 2006.

and up to 100 test strips every 3 months (i.e., the quantity for a testing frequency of approximately 1 time per day) for non-insulin-treated diabetics.⁶

Medicare Reimbursement Requirements for Test Strips

To be reimbursed for a claim for any quantity of test strips, the supplier is required to maintain (1) a physician order containing the items to be dispensed, the specific frequency of testing, and the physician's signature with the date and (2) proof of delivery. There are additional documentation requirements for reimbursement of a claim for a quantity of test strips that exceeds the utilization guidelines (high-utilization claim).

The supplier must also document a request to refill an order for test strips. The supplier may refill an order only when the beneficiary requests that the supplies be dispensed. The supplier must contact the beneficiary before dispensing the refill to ensure that the test strips remain reasonable and necessary and that existing supplies are nearly exhausted and to confirm any changes to the order. The supplier must dispense the test strips no sooner than 10 calendar days before the end of usage for the current product.

National Government Services, Inc.

NGS is the contractor for Jurisdiction B. NGS processes and pays DMEPOS claims for Illinois, Indiana, Kentucky, Michigan, Minnesota, Ohio, and Wisconsin.

Previous Office of Inspector General Reviews of Diabetic Testing Supplies

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 all 4 jurisdictions, which included all 50 States, 5 territories, and the District of Columbia. We estimated that Medicare improperly paid suppliers approximately \$209 million for claims that we identified as high-utilization claims. Of this amount, \$42.2 million was improperly paid to suppliers for test strips and lancets dispensed to beneficiaries in Jurisdiction B. See Appendix A for related OIG reports on Medicare claims for diabetic testing supplies.

HOW WE CONDUCTED THIS REVIEW

We obtained CY 2013 claim data consisting of 1,921,381 line items for test strips for which NGS paid \$112,402,047 to suppliers. A line item represented a supply of test strips included on a claim with service beginning and ending dates (e.g., May 31, 2013, through August 28, 2013). We analyzed the claim data and identified 46,850 line items that each had service dates that overlapped service dates of a line item on a prior claim submitted by a different supplier for test

⁶ For a 1-year period, Medicare covers 1,200 test strips for insulin-treated beneficiaries and 400 test strips for non-insulin-treated beneficiaries.

strips dispensed to the same beneficiary.⁷ NGS paid \$4,357,396 to suppliers for the 46,850 line items. We reviewed a random sample of 100 of these line items.

We reviewed the claim data and supplier documentation to determine whether each line item of test strips on the prior claim was nearly exhausted when the new supply of test strips was dispensed (i.e., whether the test strips were dispensed sooner than 10 calendar days before the expected end of usage for the current product). We did not review the sampled line items for compliance with other Medicare requirements. Also, because we did not have a medical review contractor review the supplier documentation, the medical necessity of the test strips dispensed to the beneficiaries in our sample was not determined. Therefore, our determination of whether NGS made overpayments for the sampled line items was limited.

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.

Appendix B contains the details of our audit scope and methodology, Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

NGS made payments for CY 2013 to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers. Of the 100 line items in our sample, 17 were allowable. We considered an additional 13 line items to be non-errors because the suppliers were no longer in business and the supporting documentation could not be obtained for review. The remaining 70 line items may not have been allowable because the suppliers dispensed test strips before the beneficiaries' existing supplies were nearly exhausted; i.e., sooner than 10 calendar days before the expected end of usage for the current product. For 37, or more than half, of the 70 line items, the suppliers dispensed test strips when there were more than 60 days remaining in the beneficiaries' existing supplies.

On the basis of our sample results, we estimated that \$3,213,559, or 74 percent, of the \$4,357,396 that NGS paid to suppliers may have been unallowable for Medicare reimbursement. (Because a medical review of the sampled line items was not performed, we could not conclusively determine whether the \$3,213,559 represented overpayments.) These potential overpayments occurred because NGS's system edit was not specifically designed to identify for review claims with overlapping service dates for test strips dispensed to the same beneficiary.

⁷ We included only the line items for beneficiaries whose use of test strips exceeded the utilization guidelines during CY 2013 (i.e., non-insulin-treated beneficiaries who received more than 400 test strips and insulin-treated beneficiaries who received more than 1,200 test strips). In addition, we included only the line items whose service dates overlapped more than 10 calendar days with a line item on the immediately preceding claim (based on the service beginning dates), which was dispensed by a different supplier, for the same beneficiary. We did not include line items that had been reviewed by the recovery audit contractors.

Rather, the system edit was designed to identify claims with a quantity of test strips that exceeded the utilization guidelines.

FEDERAL REQUIREMENTS

The *Medicare Program Integrity Manual* states:

For DMEPOS products that are supplied as refills to the original order, suppliers must contact the beneficiary prior to dispensing the refill and not automatically ship on a pre-determined basis, even if authorized by the beneficiary. This shall be done to ensure that the refilled item remains reasonable and necessary, existing supplies are approaching exhaustion, and to confirm any changes/modifications to the order. . . . For delivery of refills, the supplier must deliver the DMEPOS product no sooner than 10 calendar days prior to the end of usage for the current product.⁸

NGS's LCD L27231⁹ states: "Suppliers must not dispense a quantity of supplies exceeding a beneficiary's expected utilization." The LCD also states that test strips are covered if the beneficiary has nearly exhausted the supply of test strips that had been previously dispensed; otherwise, the test strips will be denied as not reasonable or necessary.

NGS MADE PAYMENTS TO SUPPLIERS THAT DISPENSED TEST STRIPS BEFORE THE BENEFICIARIES' EXISTING SUPPLIES WERE NEARLY EXHAUSTED

NGS made payments for CY 2013 to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers. For 70 of the 100 line items in our sample, the suppliers dispensed test strips before the beneficiaries' existing supplies were nearly exhausted. Specifically, for each line item, the supply of test strips was dispensed sooner than 10 calendar days before the expected end of usage of the beneficiary's existing supply of test strips.

For example, a physician ordered a testing frequency of once a day for a non-insulin-treated beneficiary. One supplier submitted a claim with service dates from May 31, 2013, through August 28, 2013, for 200 test strips dispensed to this beneficiary.¹⁰ The supplier of the sampled line item dispensed 100 test strips to the same beneficiary on June 14, 2013, when the beneficiary would have used only 14 of the 200 test strips dispensed by the prior supplier, based on a testing frequency of once per day. This indicates that the supplier of the sampled line item dispensed the test strips when the beneficiary should have had a 186-day supply of test strips remaining from a different supplier.

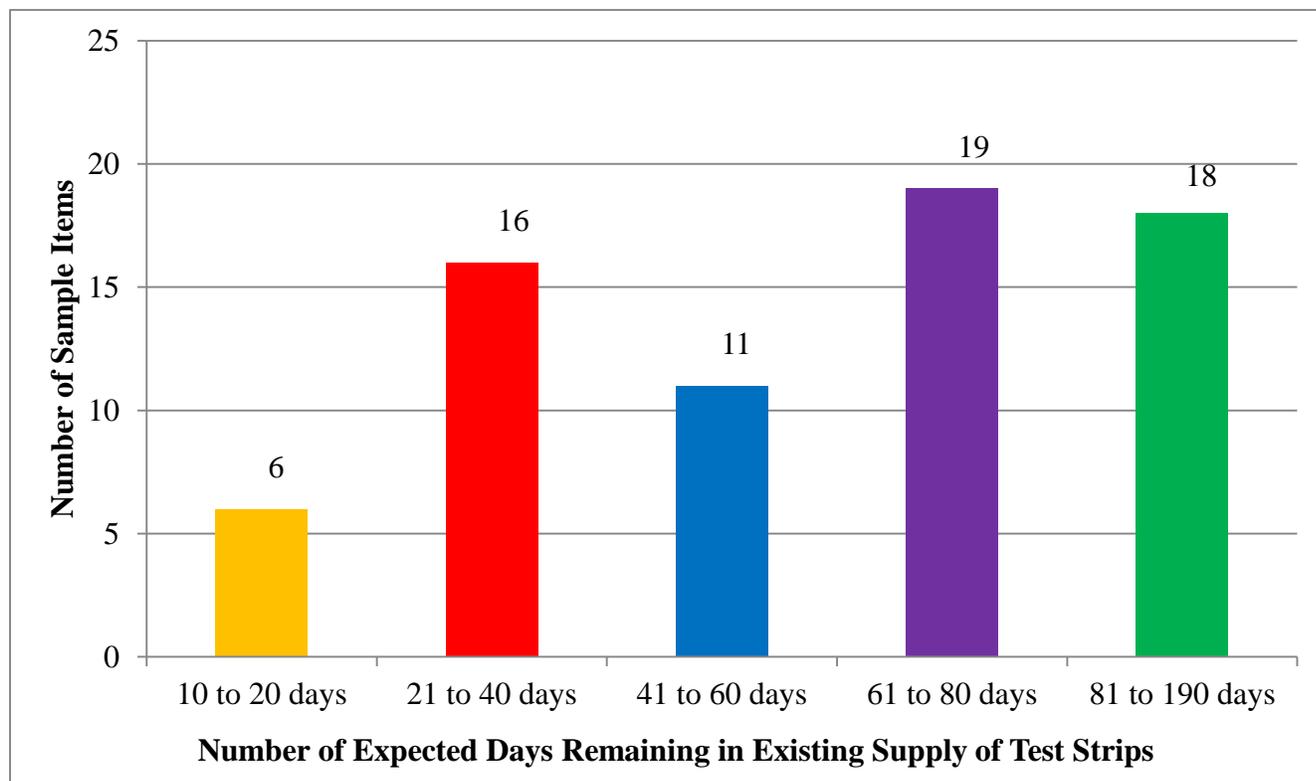
⁸ *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 5, § 5.2.6.

⁹ LCD L27231 was revised during our audit period. However, the requirements listed were applicable throughout our audit period.

¹⁰ On the basis of the testing frequency shown on the physician's order, the supplier should have dispensed only 100 test strips to the beneficiary. Although this line item was not in our sample, we notified NGS of this potential error.

For 37, or more than half, of the 70 sampled line items, the suppliers dispensed test strips when there should have been more than 60 days remaining in the beneficiaries' existing supplies. The figure below shows the number of sampled line items associated with different ranges of days that should have been remaining in the beneficiaries' existing supplies of test strips when the suppliers dispensed test strips for the 70 sampled line items.

Figure: Number of Sampled Line Items Associated With Different Ranges of Expected Days Remaining in the Beneficiaries' Existing Supplies of Test Strips



For the 70 line items in our sample, NGS made \$6,859 in Medicare payments to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted test strips previously dispensed by different suppliers. On the basis of our sample results, we estimated that \$3,213,559, or 74 percent, of the \$4,357,396 that NGS paid to suppliers may have been unallowable for Medicare reimbursement. Because a medical review of the sampled line items was not performed, we could not conclusively determine whether the \$3,213,559 represented overpayments.

NGS'S SYSTEM EDIT WAS NOT DESIGNED TO IDENTIFY TEST STRIP CLAIMS WITH OVERLAPPING SERVICE DATES

In response to a recommendation in our previous report, NGS stated that it was in the process of developing a system edit that would address the problem of overlapping dates of service on claims for individual beneficiaries.

In July 2011, NGS implemented a system edit that was designed to target high-utilization claims for non-insulin-treated beneficiaries. When a supplier submitted a claim for test strips for a non-insulin-treated beneficiary, the edit looked back 80 days from the beginning date of service on the claim to determine whether NGS had paid for test strips dispensed to the same beneficiary during that 80-day period. If so, the system determined whether the total number of test strips dispensed for the 80-day period exceeded a predefined number of test strips.¹¹ If NGS paid for more than the predefined number of test strips during that 80-day period, the system generated a letter to the supplier requesting documentation to support the claim. The documentation provided by the supplier was then reviewed by NGS's medical review staff, who determined whether the claim was allowable. NGS did not have a similar edit for claims for test strips dispensed to insulin-treated beneficiaries.

According to NGS officials, this system edit was an overutilization edit that would also detect claims with overlapping service dates. However, the edit was not specifically designed to identify for review claims with overlapping service dates for test strips dispensed to the same beneficiary. Rather, the edit was designed to identify claims with a quantity of test strips that exceeded the utilization guidelines. Because the edit did not specifically target claims with overlapping service dates, unallowable claims with overlapping service dates might have bypassed the edit if the quantity of test strips dispensed to the beneficiary did not exceed the edit's threshold.

NGS could have saved Medicare an estimated \$3,213,559 for CY 2013 if its system edit had been designed to identify for review test strip claims submitted by multiple suppliers with overlapping service dates for non-insulin and insulin-treated beneficiaries.

RECOMMENDATION

We recommend that NGS implement a system edit to identify for review claims submitted by multiple suppliers with overlapping service dates for test strips dispensed to the same beneficiary. Implementing this edit could have saved Medicare an estimated \$3,213,559 for CY 2013.

AUDITEE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, NGS did not concur with our findings and stated that it disagreed with the methodology we used in the development of our data and the reported outcome. NGS officials stated that, in July 2015, CMS implemented an automated edit that would satisfy our recommendation. NGS's comments are included in their entirety as Appendix E.

AUDITEE COMMENTS

NGS officials stated that because our review was based on the "application of an analytical approach" and not based on a medical review of the claims, this audit approach did not account for medical justification for the increased utilization of test strips. NGS officials stated that by

¹¹ In CY 2013, the system edit's threshold exceeded the utilization guidelines.

not reviewing the medical necessity of the test strips, we potentially inflated both the identified overpayment and the claim error rate.

NGS officials stated that the system edit we identified related to identification of overutilization and assessment of proper payments for test strips was just one of several edits that NGS had implemented. The officials commented that “this type of approach was selected based on contributing factors including, but not limited to 1) claims processing requirements, 2) system functionality and 3) resources available to complete the ... manual medical review workload.”

NGS officials stated that NGS had worked jointly with CMS in pursuit of an automated solution to “eliminate overlapping glucose services” and that this edit would deny services when submitted by multiple suppliers with overlapping service dates for test strips dispensed to the same beneficiary. NGS officials also stated that NGS continues to search for methods to reduce inappropriate payment for diabetic testing supplies and to collaborate with CMS and the other contractors to coordinate reviews of suppliers that bill diabetic testing supplies.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing NGS’s comments, we maintain that our findings and recommendation are valid. We acknowledge that conducting medical review is the only way to definitively establish the allowability of the sampled line items. For that reason, we stated in our report that because we did not conduct such a review, we could not conclusively determine whether the \$3.2 million represented overpayments. Our methodology was designed to determine whether NGS’s system edit was effective in identifying for review claims that were submitted by multiple suppliers with overlapping service dates. The \$3.2 million represented claims that were likely to have been paid inappropriately.

We also acknowledge that CMS revised the *Medicare Claims Processing Manual* to describe an edit that could address our recommendation. This manual stated that effective July 1, 2015, claims for diabetic testing supplies (including test strips) with service dates that overlap the service dates of a paid claim that was submitted by a different supplier for the same type of diabetic testing supply dispensed to the same beneficiary will be denied as a duplicate claim. However, we did not review the effectiveness of this edit because the change was effective after our audit period and occurred at the end of our fieldwork.

APPENDIX A: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
<i>CGS Administrators, LLC, Made Medicare Payments for Diabetic Test Strips When Beneficiaries Had Not Nearly Exhausted Previously Dispensed Supplies</i>	<u>A-09-14-02015</u>	7/29/2015
<i>Medicare Market Shares of Mail Order Diabetes Test Strips 3–6 Months After the Start of the National Mail Order Program</i>	<u>OEI-04-13-00682</u>	11/25/2014
<i>Medicare Market Shares of Mail Order Diabetes Test Strips Immediately Prior to the National Mail Order Program</i>	<u>OEI-04-13-00681</u>	6/20/2014
<i>Results of Reviews at Three Suppliers of Diabetic Testing Supplies</i>	<u>A-09-13-02032</u>	3/4/2014
<i>Inappropriate and Questionable Medicare Billing for Diabetes Test Strips</i>	<u>OEI-04-11-00330</u>	8/26/2013
<i>Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas</i>	<u>OEI-04-11-00760</u>	11/7/2012
<i>Medicare Contractors Lacked Controls To Prevent Millions in Improper Payments for High Utilization Claims for Home Blood-Glucose Test Strips and Lancets</i>	<u>A-09-11-02027</u>	6/13/2012
<i>Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets—Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction B</i>	<u>A-09-08-00044</u>	2/17/2011
<i>Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets—Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction D</i>	<u>A-09-08-00046</u>	2/4/2011
<i>Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets—Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction C</i>	<u>A-09-08-00045</u>	1/21/2011
<i>Review of Medicare Claims for Home Blood-Glucose Test Strips and Lancets—Durable Medical Equipment Medicare Administrative Contractor for Jurisdiction A</i>	<u>A-09-08-00043</u>	8/30/2010

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

We obtained CY 2013 claim data consisting of 1,921,381 line items for test strips for which NGS paid \$112,402,047 to suppliers. A line item represented a supply of test strips included on a claim with service beginning and ending dates (e.g., May 31, 2013, through August 28, 2013). We analyzed the claim data and identified 46,850 line items that each had service dates that overlapped service dates of a line item on a prior claim submitted by a different supplier for test strips dispensed to the same beneficiary. NGS paid \$4,357,396 to suppliers for the 46,850 line items. We reviewed a random sample of 100 of these line items.

We reviewed the claim data and supplier documentation to determine whether each line item of test strips on the prior claim was nearly exhausted when the new supply of test strips was dispensed (i.e., whether the test strips were dispensed sooner than 10 calendar days before the expected end of usage for the current product). We did not review the sampled line items for compliance with other Medicare requirements. Also, because we did not have a medical review contractor review the supplier documentation, the medical necessity of the test strips dispensed to the beneficiaries in our sample was not determined. Therefore, our determination of whether NGS made overpayments for the sampled line items was limited.

We did not review the overall internal control structure of NGS. Rather, we limited our review of internal controls to those that were significant to the objective of our audit.

We conducted our audit from October 2014 to July 2015 and performed fieldwork at NGS's office in Indianapolis, Indiana.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- interviewed NGS officials to obtain an understanding of Medicare reimbursement requirements and claim-processing procedures for test strips;
- obtained from CMS's National Claims History file the Medicare Part B claims for test strips;
- created a sampling frame that consisted of 46,850 line items for test strips dispensed in CY 2013 that each had service dates that overlapped service dates of a line item on a prior claim (submitted by a different supplier) by more than 10 calendar days for test strips dispensed to the same beneficiary;
- selected a simple random sample of 100 line items;

- requested supporting documentation from the supplier of each sampled line item and from the supplier that submitted the prior claim for test strips that had service dates that overlapped the service dates for the sampled line item;
- reviewed claim data and supplier documentation to determine whether the beneficiary's existing supply of test strips was nearly exhausted when the sampled line item was dispensed by:¹²
 - determining the number of days between the beginning dates on the 2 claims (i.e., the claim with the sampled line item and the prior claim),
 - multiplying the number of days between the 2 claims by the testing frequency on the physician's order to determine how many test strips the beneficiary would have been expected to use during that time period,¹³
 - subtracting the number of test strips expected to have been used from the number of test strips dispensed prior to our sampled line item to determine the number of test strips that the beneficiary would have been expected to have when the sampled line item was dispensed,
 - multiplying the testing frequency by 10 to determine the maximum number of test strips that the beneficiary should have had when the sampled line item was dispensed, and
 - comparing the number of test strips that the beneficiary would have been expected to have when the sampled line item was dispensed with the maximum number of test strips that the beneficiary should have had when the sampled line item was dispensed;
- estimated the amount of unallowable payments that may have been made to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted the supplies previously dispensed by different suppliers; and
- shared the results of our review with NGS officials.

Appendix C contains our statistical sampling methodology, and Appendix D contains our sample results and estimates.

¹² To determine whether the beneficiary's existing supply of test strips was nearly exhausted, we assumed that the beneficiary used test strips at the frequency prescribed by the ordering physician.

¹³ If the testing frequency shown on the physician's order provided by the supplier of the sampled line item was different from the testing frequency on the physician's order provided by the supplier of the prior supply of test strips, we used the higher testing frequency. If either of the orders was missing, we used the testing frequency on the physician's order that we had or the testing frequency in the utilization guidelines (i.e., one time per day for non-insulin-treated beneficiaries or three times per day for insulin-treated beneficiaries), whichever was greater.

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.

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of line items paid by NGS with overlapping service dates for test strips dispensed to the same beneficiary by multiple suppliers.

SAMPLING FRAME

The sampling frame consisted of 46,850 line items for test strips dispensed in CY 2013 that each had service dates that overlapped service dates of a line item on a prior claim submitted by a different supplier for test strips dispensed to the same beneficiary.¹⁴ NGS paid \$4,357,396 for these line items.

SAMPLE UNIT

The sample unit was a line item on a claim for test strips.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

The sample size was 100 line items.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG, Office of Audit Services (OAS), statistical software.

METHOD FOR SELECTING SAMPLE UNITS

We consecutively numbered the sample units in the sampling frame from 1 to 46,850. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the amount of the unallowable payments that may have been made to suppliers that dispensed test strips when the beneficiaries had not nearly exhausted the test strips previously dispensed by different suppliers.

¹⁴ We included only the line items for beneficiaries whose use of test strips exceeded the utilization guidelines during CY 2013 (i.e., non-insulin-treated beneficiaries who received more than 400 test strips and insulin-treated beneficiaries who received more than 1,200 test strips). In addition, we included only the line items whose service dates overlapped more than 10 calendar days with a line item on the immediately preceding claim (based on the service beginning dates), which was dispensed by a different supplier, for the same beneficiary. We did not include line items that had been reviewed by the recovery audit contractors.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Results

No. of Line Items in Sampling Frame	Value of Line Items in Sampling Frame	Sample Size	Value of Sample	No. of Potentially Unallowable Sampled Line Items	Value of Potentially Unallowable Sampled Line Items
46,850	\$4,357,396	100	\$9,697	70	\$6,859

Table 2: Estimated Value of Potentially Unallowable Payments
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	\$3,213,559
Lower limit	2,660,085
Upper limit	3,767,032

APPENDIX E: AUDITEE COMMENTS



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October 20, 2015

Report Number: A-09-15-02001

Lori A. Ahlstrand
Regional Inspector General for Audit Services
Office of Audit Services, Region IX
90-7th Street, Suite 3-650
San Francisco, CA 94103

Dear Ms. Ahlstrand:

National Government Services (NGS) appreciates the opportunity to provide the following comments and the assessment of concurrence in response to the review of the Office of Inspector General's (OIG) draft report "*National Government Services, Inc., Made Medicare Payments for Diabetic Test Strips When Beneficiaries Had Not Nearly Exhausted Previously Dispensed Supplies.*"

OIG Recommendation:

The OIG recommendation was for NGS to implement a system edit to identify claims for review that were submitted by multiple suppliers with overlapping service dates for test strips dispensed to the same beneficiary. Implementing this edit could have saved Medicare an estimated \$3,213,559 for CY2013.

NGS Response:

After reviewing the recommendations and the entirety of the report, NGS disagrees with the methodology used by the OIG in the development of their data and the reported outcome. As indicated in the report, the clinical assessment of the claims to determine if the supplies provided met medical need was not conducted. To conduct a review based on strict data analytics on a policy that provides language pertaining to "usual utilization" and "high utilization" is difficult because the application of an analytical approach does not account for medical justification for the increased utilization. The Local Coverage Determination (LCD) states that excess supplies are warranted when: "ordering quantities of strips and lancets that exceed the utilization guidelines and the beneficiary's medical record documents the specific reason for the additional materials..." As a result of this requirement and approach, NGS does not concur with the findings of the report, as not reviewing the medical necessity of the requested supplies potentially inflates both the identified overpayment amount and the claim error rate.

In the report, the OIG identified one NGS edit relating to the identification of over utilization and the assessment of proper payment for glucose services. This is just one of several edits NGS has implemented to assess proper utilization. The editing is for claims submitted for units of service over normal utilization parameters to identify if the quantities billed were medically necessary. This one particular edit was implemented within the current functionality of the claims processing system and aggregated units of





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service over time. Specifically, once the units of service exceeded a set threshold, the claims would suspend for manual review, which is the critical component of determining the validity of the claim. This type of approach was selected based on contributing factors including, but not limited to 1) claims processing requirements, 2) system functionality and 3) resources available to complete the aforementioned manual medical review workload.

During calendar years 2013 and 2014, NGS conducted medical reviews for over 150,000 glucose claims resulting in over \$31 million in estimated savings. This approach has changed supplier behavior as well as assisted in significantly lowering the associated Comprehensive Error Rate Testing (CERT) for glucose services within Jurisdiction B.

Another effective solution implemented to eliminate overlapping glucose services consisted of changes to the claim processing guidelines and system functionality that would allow for automated processing of claims and deny services when submitted by multiple suppliers with overlapping service dates for test strips dispensed to the same beneficiary. NGS worked jointly with CMS in pursuit of an automated solution and has submitted multiple proposals to further strengthen automated processing relating to glucose supplies. In July 2015, CMS implemented an automated edit in a uniform fashion by all DME MACs to limit the exposure of overlapping services for glucose supplies.

As a supplemental approach, NGS continues to search for methods to reduce inappropriate payment for diabetic testing supplies and continues to collaborate with CMS and the other DME MACs to coordinate reviews of suppliers billing diabetic testing supplies. This collaborative effort is structured to divide the workload for auditing activities enabling the contractors to maximize the effectiveness of the reviews while minimizing the burden for any single supplier. NGS and the other DME MACs monitor this activity closely to anticipate future impacts to a supplier's business operations.

In conclusion, NGS has actively worked to support the automated solution by CMS that will satisfy the recommendation outlined in the OIG report. This activity coupled with a multi-pronged approach within our medical review strategy to review claims for validation of medical necessity, provides a redundancy of support afforded within funding levels to mitigate improper payment. Should you have any additional questions, please contact Tim Fickle at 317.595.4305 or Timothy.Fickle@anthem.com.

Sincerely,

David Barnett
Jurisdiction B DME MAC Program Director

