

**Memorandum**

Date MAY 14 1999  
From June Gibbs Brown  
Inspector General *June Gibbs Brown*  
Subject Medicare Coverage of Glucose Monitoring Performed in Nursing Homes  
(OEI-05-99-00380)  
To Nancy-Ann Min DeParle  
Administrator  
Health Care Financing Administration

The purpose of this memorandum is to recommend that the Health Care Financing Administration (HCFA) institute a national policy stipulating that daily routine glucose testing services provided by nursing homes are routine care services covered under the per diem rate and not billable separately to the Medicare program.

Historically, residential nursing facilities have not attempted to submit claims to Medicare for reimbursement for blood glucose tests performed by their staff. Beginning in 1998, some nursing homes began submitting claims for glucose reimbursement to Medicare fiscal intermediaries. Nursing homes are being advised by a consultant that they are able to bill Medicare for glucose services provided to patients from as far back as 1992. The HCFA has left the decision as to whether to cover these tests to individual intermediaries.

During the typical glucose test in a nursing home, the patient's finger is pricked with a lancet and a drop of blood collected on a reagent test strip. The test strip is then inserted into a blood glucose monitor approved by the Food and Drug Administration (FDA) for home use. The monitors measure glucose (sugar) concentrations by reading the color changes produced by the specially treated reagent strips.

Millions of Americans perform this test each day in their own homes. Some patients check their blood glucose level before or after each meal. The FDA-approved glucose monitoring devices, lancets and reagent strips can be purchased over the counter at most pharmacies and other outlets. Medicare pays for the monitor and testing supplies as durable medical equipment and supplies for diabetic beneficiaries who self-test, but Medicare does not pay for the glucose results produced by such equipment unless the test is:

- ▶ Medically necessary,
- ▶ Ordered by a physician and used in the diagnosis and treatment of a patient, and,
- ▶ Performed at a laboratory site having either a certificate of waiver or certificate of registration as required by the Clinical Laboratory Improvement Act.

Many nursing homes hold a certificate of waiver. This certificate allows a nursing home to perform "waived tests" using equipment certified by FDA for home use. Waived tests are simple to perform and have an insignificant risk of error. They also pose no reasonable harm to the patient if performed incorrectly. Nearly all of the glucose tests performed by nursing home personnel are waived tests.

Examination of Medicare payment data indicates that in 1996 Medicare nursing homes billed about \$69,829 for glucose testing: \$36,010 for blood glucose tests performed using a reagent strip (HCFA Common Procedure Code 82948) and \$33,819 for blood glucose tests performed by monitoring devices (HCFA Common Procedure Code 82962). Random processing errors or a single contractor's coverage policy might account for all of the 1996 payments. Bills from nursing homes for these same glucose tests in 1998 totaled \$451,507. In contrast, a single Medicare intermediary received more than 9,000 claims for nursing home glucose testing in late 1998 and early 1999. This intermediary has chosen not to pay the claims. If paid, these claims could cost Medicare between \$3 and \$4 million. However, another fiscal intermediary is processing and will pay many of the 2,000 claims for glucose testing submitted by nursing homes. Payments range from \$100 to \$300 per claim. According to HCFA staff, nursing homes have submitted more than 75,000 claims for glucose reimbursement. Many of these claims seek retroactive payment for 12 or more months of testing.

Medicare policy does not specifically address glucose testing performed by nursing homes. Historically, nursing homes have not billed Medicare for these services. Medicare, Medicaid and facilities assumed that payment for glucose tests performed in acute care hospitals, SNFs and NHs was included in routine nursing care. Based on a consultant's advice, some nursing facilities have begun billing Medicare for glucose tests performed on their patients. What began as a trickle of claims is rapidly becoming a stream that could adversely affect intermediary systems and resources and potentially cost Medicare millions of dollars annually.

We believe that Medicare should not pay separately for glucose testing performed by nursing homes on a daily basis. Results from these tests are usually not reported to a physician for diagnostic or therapeutic intervention. The tests are performed by facility staff because patients residing in nursing homes may not be able to perform the test themselves.

A national policy prohibiting separate billing would be consistent with Medicare and Medicaid efforts to prevent unbundling of services and to establish prospective payment rates. Permitting nursing homes to bill for blood glucose tests invites abuse and risks substantial program losses.

We hope you will consider this policy recommendation. Please do not hesitate to call me or George Grob, Deputy Inspector General for Evaluation and Inspections, or have your staff call Mary Beth Clarke at (202) 619-2481 if you would like to discuss this issue further.