DEPARTMENT OF HEALTH AND HUMAN SERVICES

OFFICE OF INSPECTOR GENERAL

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/S/

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SUBJECT: Memorandum Report: *Supplier Billing for Diabetes Test Strips and Inappropriate Supplier Activities in Competitive Bidding Areas*, OEI-04-11-00760

This memorandum report responds to a written request from the Centers for Medicare & Medicaid Services (CMS) for the Office of Inspector General (OIG) to determine whether an increase in claims for non-mail order diabetes test strips (DTS) between 2010 and 2011 may be attributed to abusive supplier practices. These practices include (1) improperly billing mail order items as non-mail order and (2) inappropriately waiving beneficiaries' out-of-pocket expenses (i.e., copayments). Under Round 1 of CMS's Competitive Bidding Program, implemented in January 2011, non-mail order DTS in Competitive Bidding Areas (CBAs) are reimbursed at a rate more than double that of mail order DTS. This price difference provides a financial incentive for suppliers to bill for non-mail order rather than mail order DTS. In contrast, this price difference provides a financial disincentive for beneficiaries because they are responsible for a 20-percent Medicare copayment, and the higher price of non-mail order DTS thus makes the copayment higher. The Senate Special Committee on Aging also expressed written concerns to OIG regarding the price difference between mail order and non-mail order DTS.

In accordance with CMS's request, we determined the extent to which (1) claims in CBAs for the more expensive, non-mail order DTS increased between 2010 and 2011; (2) suppliers improperly billed Medicare for the more expensive, non-mail order DTS in 2011; (3) beneficiaries changed from mail order to non-mail order DTS between 2010 and 2011 because suppliers waived their copayments; and (4) suppliers conducted activities that we determined to be inappropriate (i.e., routinely waiving copayments, sending unsolicited DTS) in 2010 or 2011.

SUMMARY

We reviewed 2010 and 2011 Medicare claims data and conducted telephone interviews with 211 beneficiaries. We found that claims in CBAs for the more expensive, non-mail order DTS increased by 33 percent from 2010 to 2011, while claims for the less expensive, mail order DTS decreased by 71 percent. Further, for 20 percent of beneficiaries in our review, suppliers improperly billed Medicare for the more expensive, non-mail order DTS in 2011, but beneficiaries reported having instead received the less expensive, mail order DTS. This improper supplier billing contributed to the increase in claims for non-mail order DTS between 2010 and 2011. Of the beneficiaries in our review who reported changing from mail order to non-mail order DTS between 2010 and 2011, none reported suppliers' waiver of copayments as a reason for their change. Therefore, suppliers' inappropriate waiver of beneficiaries' copayments did not appear to contribute to the increase in non-mail order DTS claims between 2010 and 2011. However, 23 percent of beneficiaries in our review reported supplier activities (i.e., routinely waiving copayments, sending unsolicited DTS) that we determined to be inappropriate.

BACKGROUND

Diabetes is a chronic disease in which a person has a high blood sugar (i.e., glucose) level because either the body does not produce enough insulin or cells do not respond properly to the insulin that the body does produce.[1] If not properly managed, diabetes can lead to a number of complications, including increased risk for heart attack and stroke.[2] Monitoring blood sugar levels is one way that individuals with diabetes can manage their disease. Individuals with diabetes use DTS in small, hand-held blood glucose meters to test the concentration of glucose in their blood. This test, which may need to be performed several times a day, can assist individuals with diabetes in maintaining their blood glucose at the appropriate level.

DTS Reimbursement Under the Competitive Bidding Program

Title XVIII of the Social Security Act sets coverage requirements under Part B of the Medicare program. Part B covers durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS), including DTS and blood glucose monitors for individuals with diabetes.[3] Generally, Medicare pays 80 percent of the Medicare-allowed amount for DTS, and beneficiaries are responsible for the remaining 20 percent.[4]

Medicare covers up to 100 DTS (i.e., two 50-count boxes) per month for insulin-dependent beneficiaries and up to 100 DTS every 3 months for

[1] National Institutes of Health, *Diagnosis of Diabetes.* Accessed at http://diabetes.niddk.nih.gov/dm/pubs/diagnosis/ on June 20, 2012.

[2] National Center for Biotechnology Information, U.S. National Library of Medicine, *Diabetes Complications*. Accessed at http://www.ncbi.nlm.nih.gov/pubmedhealth/PMH0002194/ on February 1, 2012.

[3] Social Security Act, §§ 1832(a)(1), 1861(s)(6), and 1861(n), 42 U.S.C. §§ 1395k(a)(1), 1395x(s)(6), and 1395x(n).

[4] Social Security Act, §1834(a), 42 U.S.C. §1395m(a).

non-insulin-dependent beneficiaries.[5] Medicare covers DTS that exceed the utilization guidelines only if deemed medically necessary.[6] Until January 2011, CMS reimbursed DTS throughout the country using established fee schedule amounts based on payment amounts allowed under the previous reasonable-charge payment methodology.

In January 2011, CMS implemented Round 1 of its Competitive Bidding Program for selected DMEPOS, including mail order DTS, in nine CBAs.[7] The DMEPOS items that were selected for inclusion in the initial Competitive Bidding Program are generally high-cost and/or high-volume items with high cost-savings potential.[8] CMS estimates that the Competitive Bidding Program will save Medicare more than $17 billion over a 10-year period.[9] Under the Competitive Bidding Program, suppliers submit competing bids to become Medicare contract suppliers in CBAs.[10] In each CBA, the lower-cost single payment amount that results from the bidding process replaces the higher-cost fee schedule amount. Contracts to supply DMEPOS in CBAs are awarded to enough winning bidders to meet beneficiary demand in each CBA.[11]

The Competitive Bidding Program currently includes mail order DTS but not non-mail order DTS. Beneficiaries in CBAs must purchase mail order DTS from a winning contract supplier for their respective CBAs. However, any beneficiary—regardless of whether he or she lives in a CBA—can purchase non-mail order DTS from any enrolled Medicare supplier.

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[5] CMS, *Medicare Local Coverage Determinations (LCDs) for Glucose Monitors* (L11530, L27231, L11520, and L196). Insulin-dependent beneficiaries (i.e., beneficiaries with type 1 diabetes) depend on insulin injections to regulate their blood glucose levels. Non-insulin dependent beneficiaries (i.e., beneficiaries with type 2 diabetes) can manage their disease with lifestyle changes, such as special diets and exercise and do not require insulin injections to regulate their blood glucose levels. National Institute of Diabetes and Digestive and Kidney Diseases, *Your Guide to Diabetes: Type 1 and Type 2*. Accessed at http://diabetes.niddk.nih.gov/dm/pubs/type1and2/what.aspx on August 13, 2012.

[6] CMS, *Medicare Local Coverage Determinations (LCDs) for Glucose Monitors* (L11530, L27231, L11520, and L196). See also, CMS, *MLN [Medicare Learning Network] Matters*, Number SE1008. Accessed at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMattersArticles/downloads//SE1008.pdf on April 24, 2012.

[7] CBAs are defined by specific ZIP Codes related to Metropolitan Statistical Areas. The nine CBAs included in Round 1 were Cincinnati-Middletown (Ohio, Kentucky, and Indiana); Charlotte-Gastonia-Concord (North Carolina and South Carolina); Cleveland-Elyria-Mentor (Ohio); Dallas-Fort Worth-Arlington (Texas); Kansas City (Missouri and Kansas); Miami-Fort Lauderdale-Pompano Beach (South Florida); Orlando-Kissimmee (Florida); Pittsburgh (Pennsylvania); and Riverside-San Bernardino-Ontario (California). Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/Fact_Sheet_Competitive_Bidding_Areas.pdf/$FIle/Fact_Sheet_Competitive_Bidding_Areas.pdf on June 20, 2012.

[8] CMS, *General Overview of the Final Rule for Competitive Acquisition for Certain Durable Medical Equipment, Prosthetics, Orthotics, and Supplies*. Accessed at https://www.cms.gov/DMEPOSCompetitiveBid/Downloads/DMEPOSRegSumm.pdf on February 1, 2012.

[9] CMS, *CMS' Implementation of Round 1 Rebid of DMEPOS Competitive Bidding Program*. April 5, 2011. Accessed at http://www.hhs.gov/asl/testify/2010/09/t20100915a.html on February 1, 2012.

[10] CMS, *DMEPOS Competitive Bidding—Overview*. Accessed at https://www.cms.gov/dmeposcompetitivebid/ on February 1, 2012.

[11] Ibid.

In 2010 and 2011, CMS defined mail order as items delivered by a common carrier, such as UPS, FedEx, or the U.S. Postal Service.[12] CMS intended for this definition to distinguish between mail order items and non-mail order items, i.e., items that a beneficiary or caregiver picks up in person at a local pharmacy or storefront.[13] However, some suppliers began using their own fleet of vehicles to deliver DTS to beneficiaries' homes, allowing the suppliers to bill Medicare for non-mail order DTS.[14]

In CBAs, Medicare payment for mail order DTS under the Competitive Bidding Program is lower than that for non-mail order DTS. Specifically, under Round 1 of the Competitive Bidding Program, the average per-box reimbursement for mail order DTS provided to beneficiaries in CBAs in 2011 was $14.62. In contrast, the average per-box fee schedule reimbursement for non-mail order DTS provided to beneficiaries in CBAs in 2011 was $37.67—more than double that of mail order. Therefore, suppliers have a financial incentive to bill for non-mail order DTS rather than mail order DTS for beneficiaries in CBAs. In contrast, this price difference provides a financial disincentive for beneficiaries because they are responsible for a 20-percent Medicare copayment, and the higher price of non-mail order DTS thus makes the copayment higher.[15]

To receive Medicare reimbursement for mail order DTS, suppliers must submit claims using the Healthcare Common Procedure Coding System (HCPCS) code A4253.[16] In addition, if the DTS were furnished on a mail order basis, the supplier must use HCPCS modifier KL on the claim.[17] For beneficiaries in CBAs, claims with the KL modifier are reimbursed at the lower Competitive Bidding Program amount. Claims without the KL modifier indicate that the DTS were non-mail order, and the claims are reimbursed at the higher fee schedule amount.

Suppliers may refill an order for mail order or non-mail order DTS only when beneficiaries have nearly exhausted the previous supply and specifically request that the DTS be dispensed.[18] Suppliers may not automatically dispense a quantity of DTS on a

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[12] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 36, § 10.2. Accessed at https://www.cms.gov/manuals/downloads/clm104c36.pdf on February 2, 2012. See also CMS, *Mail Order Diabetic Supplies Fact Sheet*. Accessed at https://www.cms.gov/MLNProducts/downloads/DME_Mail_Order_Factsheet_ICN900924.pdf on June 20, 2012.

[13] 75 Fed. Reg. 73170, 73569-70 (Nov. 29, 2010).

[14] Ibid. After Round 1 of the Competitive Bidding Program, CMS will expand the definition of mail order to include "any item (for example, diabetes testing supplies) shipped or delivered to the beneficiary's home regardless of the method of delivery." 75 Fed. Reg. 73170, 73570, and 73623 (Nov. 29, 2010) (revising the definition of "mail order item" in 42 CFR 414.402 and explaining why the new definition will not apply to Round 1). The new definition of "mail order" will include supplier delivery to beneficiary homes.

[15] 42 CFR 414.408(a).

[16] CMS, *Medicare Local Coverage Determinations (LCDs) for Glucose Monitors* (L11530, L27231, L11520, and L196).

[17] CMS, *Medicare Claims Processing Manual*, Pub. No. 100-04, ch. 36, §§ 20.5.4.1 and 50.6.

[18] CMS, *Medicare Program Integrity Manual.* Pub. 100-08, ch. 4, § 4.26.1. See also CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 5, § 5.2.6 (effective Aug. 8, 2011).

predetermined basis.[19] Instead, suppliers must contact the beneficiary prior to dispensing the refill.

CMS will implement a National Mail Order Competition for diabetes test supplies, including DTS. The National Mail Order Competition will take effect in 2013, concurrent with Round 2 of the Competitive Bidding Program.[20] The National Mail Order Competition will cover DTS that are delivered via any method (i.e., common carrier or supplier delivery) to beneficiaries in all parts of the U.S. As an alternative, beneficiaries may still choose to receive the more expensive, non-mail order DTS by picking them up in person from the supplier's storefront.

DTS Supplier Practices That Are Inappropriate Under the Federal False Claims Act and the Federal Anti-Kickback Statute

A supplier that knowingly presents to the Federal Government a false or fraudulent claim for payment faces liability under the Federal False Claims Act.[21, 22] For example, a claim for mail order DTS that is submitted without the KL modifier (i.e., indicating incorrectly that non-mail order DTS were supplied) would be a "false claim" under the Federal False Claims Act.[23] Further, a claim containing a total charge that includes the beneficiary's copayment can also be a false claim if the supplier routinely waives the beneficiary's copayment.[24]

Under the Federal Anti-Kickback Statute, it is illegal to knowingly and willfully solicit, offer, pay, or receive any remuneration to induce or reward referrals of items or services reimbursable by a Federal health care program, such as Medicare.[25] Suppliers must not

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[19] CMS, *Medicare Program Integrity Manual.* Pub. 100-08, ch. 4, § 4.26.1. See also CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 5, § 5.2.6 (effective Aug. 8, 2011).

[20] CMS, *National Mail-Order Competition for Diabetic Testing Supplies*. Accessed at http://www.dmecompetitivebid.com/Palmetto/Cbic.nsf/files/R2_Fact_Sheet_Mail-Order_Diabetic_Supplies.pdf/$FIle/R2_Fact_Sheet_Mail-Order_Diabetic_Supplies.pdf on January 30, 2012.

[21] 31 U.S.C. § 3729(a)(1).

[22] In fiscal year 2009, $2.4 billion was recovered for Federal False Claims Act cases. Health care-related cases accounted for two-thirds ($1.6 billion) of the money recovered. Medicare and Medicaid-related cases composed the bulk of health care-related cases. Department of Justice, Office of Public Affairs, *Justice Department Recovers $2.4 Billion in False Claims Cases in Fiscal Year 2009; More Than $24 Billion Since 1986*. November 19, 2009. Accessed at http://www.justice.gov/opa/pr/2009/November/09-civ-1253.html on February 1, 2012.

[23] The supplier does not have to deliberately intend to defraud the Federal Government to be liable under the Federal False Claims Act; instead, the supplier only needs to "knowingly" present the false or fraudulent claim. The definition of "knowingly" includes: (1) having actual knowledge that the information on the claim is false; (2) acting in deliberate ignorance of the truth or falsity of the information on the claim; or (3) acting in reckless disregard of the truth or falsity of the information on the claim. 31 U.S.C. § 3729(b)(1).

[24] The Department of Health and Human Services (HHS), *OIG Special Fraud Alert*, 59 Fed. Reg. 6532 (December 19, 1994). Accessed at http://oig.hhs.gov/fraud/docs/alertsandbulletins/121994.html on February 1, 2012.

[25] 42 U.S.C. §§ 1320a–7b(b).

offer beneficiaries incentives, such as routinely waiving copayments, as a means of generating Medicare business.[26]

Medicare Fraud in South Florida

In recent years, South Florida has been a focus area of efforts to combat Medicare fraud, waste, and abuse. Additionally, in 2007, HHS and the Department of Justice (DOJ) established a joint Medicare Fraud Strike Force (Strike Force) in South Florida to combat Medicare fraud. Strike Forces are teams of Federal, State, and local investigators that combat fraud in certain areas of the country by analyzing current Medicare claims data.[27] In July 2010, the Strike Force in South Florida charged 24 defendants in Miami for allegedly participating in various schemes that resulted in approximately $103 million in false claims.[28] OIG has published reports indicating that South Florida is a fraud-prone area for Medicare, including home health services, community mental health services, and retail pharmacies' billing for prescription drugs.[29]

METHODOLOGY

Scope of Inspection

We reviewed 2010 and 2011 Medicare claims data and conducted beneficiary telephone interviews to determine the extent to which claims in CBAs for non-mail order DTS increased between 2010 and 2011. We also determined the extent to which: (1) suppliers improperly billed Medicare for non-mail order DTS in 2011, (2) beneficiaries changed from mail order DTS in 2010 to non-mail order DTS in 2011 because suppliers waived their copayments, and (3) suppliers conducted activities that were inappropriate (i.e., routinely waiving copayments, sending unsolicited DTS) in 2010 or 2011.

Data Collection and Analysis

We analyzed 2010 and 2011 DTS claims from CMS's Durable Medical Equipment 100 Percent Standard Analytic File to identify beneficiaries who received DTS in 2010

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[26] In addition, Federal law provides for the imposition of civil monetary penalties against any supplier who offers or transfers remuneration (which includes waiver of copayments and deductibles) that the person knows or should know is likely to influence the individual to order or receive Medicare items or services from a particular supplier. Social Security Act, 1128A(a)(5) and 1128A(i)(6), 42 U.S.C. §§ 1320a-7a(a)(5) and 1320a-7a(i)(6). Suppliers may waive copayments on a case-by-case basis if three criteria are met: (1) the copayments are not waived in connection with any advertisement or solicitation; (2) the copayments are not routinely waived; and (3) the suppliers have made a good faith determination that the beneficiary has a financial hardship, or reasonable collection efforts to collect the beneficiary's copayment have failed. Social Security Act, 1128A(i)(6)(A), 42 U.S.C. § 1320a-7a(i)(6)(A).

[27] HHS News Release, *Strike Force Formed To Target Fraudulent Billing of Medicare Program by Health Care Companies*. Accessed at http://www.hhs.gov/news/press/2007pres/05/20070509c.html on February 1, 2012.

[28] Nationwide Strike Force operations in July 2010 resulted in charges against 94 doctors and over $251 million in alleged false billing. HHS and DOJ, *Medicare Fraud Strike Force Charges 94 Doctors, Health Care Company Owners, Executives and Others for More Than $251 Million in Alleged False Billing*. Accessed at http://www.hhs.gov/news/press/2007pres/05/20070509c.html on February 1, 2012.

[29] HHS OIG, *Inappropriate and Questionable Billing by Medicare Home Health Agencies*, OEI-04-11-00240, August 2012; HHS OIG, *Questionable Billing by Community Mental Health Centers*, OEI-04-11-00100, August 2012; and HHS OIG, *Retail Pharmacies With Questionable Part D Billing*, OEI-02-09-00600, May 2012.

and/or 2011. From these data, we calculated the number of claims, Medicare-allowed amounts, and the number of beneficiaries who received mail order or non-mail order DTS.

We then identified beneficiaries in CBAs who, according to Medicare claims data, received DTS in both 2010 and 2011 (174,243 beneficiaries). From this, we identified 3,633 beneficiaries in CBAs who showed a pattern of receiving both mail order DTS in 2010 and non-mail order DTS in 2011. We identified beneficiaries as having this pattern if they had at least two mail order DTS claims in the last 6 months of 2010 and at least two non-mail order DTS claims in the first 6 months of 2011. We did not include beneficiaries who, according to Medicare claims data, received only mail order DTS or only non-mail order DTS in 2010 and 2011.

From our population of 3,633 beneficiaries with this pattern, we selected a stratified random sample of 500 beneficiaries. Because prior OIG work has demonstrated that South Florida is a fraud-prone area for Medicare, we stratified our sample to include 250 of the 863 beneficiaries in the South Florida CBA and 250 of the 2,771 beneficiaries in the remaining eight CBAs. This sample represented 14 percent of beneficiaries, 22 percent of Medicare-allowed amounts, and 19 percent of claims in our population. Table 1 provides information about the two strata in our sample compared to the population from which we selected the sample.

Table 1: Sample Compared to Population, Overall and for Two Strata

Sample Versus Population	Number of Beneficiaries Receiving DTS in 2010 and 2011	Medicare-Allowed Amounts in 2010 and 2011	Number of DTS Claims in 2010 and 2011
Sample	500	$589,324**	4,324
South Florida CBA	*250*	*$313,408*	*2,111*
Remaining Eight CBAs	*250*	*$275,917*	*2,213*
Population	3,633*	$2,643,370	22,565
South Florida CBA	*862*	*$645,009*	*4,898*
Remaining Eight CBAs	*2,771*	*$1,998,361*	*17,667*

* Sum of beneficiaries in the two strata exceeds the population of beneficiaries because one beneficiary moved from the South Florida CBA to one of the remaining eight CBAs within our timeframe and is counted in both strata.
** Sum of Medicare-allowed amounts in 2010 and 2011 is less than the sum of the two strata due to rounding.
Source: OIG analysis of the 18-month updates of the 2010 and 2011 CMS Durable Medical Equipment 100 Percent Standard Analytic Files, 2012.

One week prior to conducting our March 2012 telephone interviews, we sent letters in English and Spanish to beneficiaries notifying them that an OIG representative would be calling to request their participation in this study.[30] We searched online and used a

[30] Although 12 letters were undeliverable and marked "unable to forward" or "unidentifiable as addressed," we attempted to contact these beneficiaries via telephone to conduct the interview.

comprehensive database to obtain telephone numbers for the sampled beneficiaries.[31] For the 405 beneficiaries for whom we could locate telephone numbers, we attempted to contact them at least three times to ask them to participate in our interview. We conducted interviews in English or Spanish, depending on each beneficiary's preference. We completed telephone interviews with 104 beneficiaries in the South Florida CBA and 107 beneficiaries in the remaining eight CBAs, yielding a total of 211 interviews and a 42-percent response rate.[32, 33]

We compared interview respondents to nonrespondents on three variables: age, gender, and the number of Medicare DTS claims for the beneficiaries in 2010 and 2011.[34] We did not find differences on any of the variables that were significant at the 95-percent confidence level. See Appendix A for beneficiary information on these three variables for respondents and nonrespondents in the South Florida CBA, the remaining eight CBAs, and all CBAs combined.

We conducted telephone interviews with beneficiaries in our sample to determine how they received DTS in 2010 and 2011. We then determined whether their suppliers properly billed Medicare for mail order DTS in 2010 and non-mail order DTS in 2011. We determined that supplier billing was proper if beneficiaries reported obtaining DTS (1) in 2010 by having the DTS delivered to their homes by a common carrier (i.e., via mail order) and (2) in 2011 through beneficiary storefront pickup or supplier delivery to their homes (i.e., via non-mail order). If beneficiaries reported receiving DTS in 2010 only through non-mail order or in 2011 only through mail order, we determined that their suppliers improperly billed Medicare.

If beneficiaries told us that their suppliers provided mail order DTS in 2010 and non-mail order DTS in 2011, we asked beneficiaries why their method for receiving DTS changed. We also asked these beneficiaries if they were aware of the potential cost savings associated with mail order DTS and if they would be willing to switch back to mail order DTS to save themselves and/or the Medicare program money.

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[31] We used *CLEAR For Law Enforcement & Government Investigators* to obtain sampled beneficiaries' telephone numbers. *CLEAR* provides access to a vast collection of public and proprietary records, including landline phone and cell phone data. Accessed at https://clear.thomsonreuters.com/clear_home/government.htm on June 20, 2012.

[32] The response rate is calculated out of a total of 498 beneficiaries. Two beneficiaries out of the original 500 sampled beneficiaries were not located in either the South Florida CBA or the remaining 8 CBAs.

[33] For the remaining beneficiaries, one of the following situations applied: the telephone numbers that we had were disconnected (80 beneficiaries), we did not have telephone numbers (74 beneficiaries), we had functional telephone numbers but could not reach the beneficiaries after at least three attempts (73 beneficiaries), the beneficiaries declined to participate in the interview (36 beneficiaries), or the beneficiaries were deceased (24 beneficiaries).

[34] Although we also had access to demographic information regarding beneficiary race, this data tends to be unreliable. Therefore, we did not compare respondents and nonrespondents based on race. For example, see CMS, *Accuracy and Bias of Race/Ethnicity Codes in the Medicare Enrollment Database*. Accessed at https://www.cms.gov/Research-Statistics-Data-and-Systems/Research/HealthCareFinancingReview/downloads/04-05Winterpg61.pdf on June 20, 2012.

Finally, we asked beneficiaries whether suppliers waived their Medicare copayments and/or sent them DTS that they did not order (i.e., unsolicited DTS) in 2010 or 2011. We then determined if these actions were inappropriate based on beneficiaries' interview responses, as described below:

Determining whether suppliers inappropriately waived copayments. We asked beneficiaries how often, in 2010 or 2011, they paid a copayment when they purchased DTS. If beneficiaries responded that they sometimes or never paid a copayment, we asked if they had supplemental insurance to Medicare that paid their copayment or if they had a financial hardship. If beneficiaries did not have supplemental insurance or a financial hardship, we determined that their suppliers were waiving their copayments inappropriately.

Determining whether suppliers inappropriately sent unsolicited DTS. We asked beneficiaries whether, in 2010 or 2011, they received DTS that they did not order. If beneficiaries received DTS that they did not order, we asked them how often this occurred and how many unsolicited DTS boxes they received. We determined that suppliers inappropriately sent unsolicited DTS if the beneficiaries reported receiving DTS that they did not order.

For the results of our beneficiary interviews, we provide sample statistics, combined, for the two strata in our review. These combined statistics are weighted by each stratum's proportion of the population from which our sample was selected. Further, we did not find significant differences between the two strata in our review. Appendix B shows the sample sizes and weighted point estimates for all statistics in this report, both overall and for the two strata in our review. We do not project these sample statistics to the population from which our sample was selected.

We will forward to our investigators and/or CMS all instances of suppliers' improper billing and inappropriate activities that we identified, so that they may determine the appropriate course of action.

Limitations

Our results are based on self-reported data from beneficiaries and were not independently verified by a review of supplier or physician medical records. Beneficiaries' ability to recall events, particularly over a span of 2 years, may affect our data.

Standards

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

RESULTS

Claims in CBAs for the more expensive, non-mail order DTS increased from 2010 to 2011, while claims for the less expensive, mail order DTS decreased

Overall, Medicare claims for DTS in CBAs decreased by 22 percent after CMS implemented Round 1 of the DMEPOS Competitive Bidding Program in January 2011. Further, the number of claims for the more expensive, non-mail order DTS in CBAs increased by 33 percent, and the number of claims for the less expensive, mail order DTS in CBAs decreased by 71 percent. Similarly, Medicare-allowed amounts for non-mail order DTS and the number of beneficiaries receiving such DTS in CBAs increased between 2010 and 2011, whereas those for mail order DTS decreased. In contrast, there was not a similar pattern in the number of claims, Medicare-allowed amounts, or the number of beneficiaries in non-CBA areas between 2010 and 2011.[35]

Table 2 shows the percentage change in the number of claims, Medicare-allowed amounts, and the number of beneficiaries receiving non-mail order and mail order DTS in CBAs between 2010 and 2011. Table 2 provides these data for the South Florida CBA, the remaining eight CBAs, and overall. Appendix C provides the number of claims, Medicare-allowed amounts, and number of beneficiaries, as well as the percentage change for each of these categories.

Table 2: Percentage Change in the Number of Claims, Medicare-Allowed Amounts, and the Number of Beneficiaries Receiving Non-Mail Order and Mail Order DTS in CBAs Between 2010 and 2011

Paid Medicare Claims	Change in Number of Claims Between 2010 and 2011*	Change in Medicare-Allowed Amounts Between 2010 and 2011*	Change in Number of Beneficiaries Between 2010 and 2011*
Non-Mail Order	+ 33%	+ 49%	+ 46%
South Florida CBA	*+ 19%*	*+ 37%*	*+ 45%*
Remaining Eight CBAs	*+ 40%*	*+ 55%*	*+ 48%*
Mail Order	- 71%	- 84%	- 61%
South Florida CBA	*- 83%*	*- 89%*	*- 74%*
Remaining Eight CBAs	*- 68%*	*- 82%*	*- 59%*
Total	- 22%	- 36%	- 18%
South Florida CBA	*- 18%*	*- 23%*	*- 14%*
Remaining Eight CBAs	*- 24%*	*- 40%*	*- 21%*

* Percentage change includes beneficiaries who switched from mail order to non-mail order DTS, beneficiaries who were new to receiving DTS through Medicare in 2011, and beneficiaries who no longer received DTS through Medicare in 2011.
Source: OIG analysis of the 18-month updates of the 2010 and 2011 CMS Durable Medical Equipment 100 Percent Standard Analytic Files, 2012.

[35] The number of non-mail order DTS claims in non-CBA areas decreased by 3 percent, and the number of mail order DTS claims increased by 4 percent. Medicare-allowed amounts for non-mail order DTS in non-CBA areas decreased by 4 percent, and allowed amounts for mail order DTS increased by 1 percent. The number of beneficiaries receiving non-mail order DTS in non-CBA areas decreased by 2 percent, and the number of beneficiaries receiving mail order DTS increased by 4 percent.

For 20 percent of beneficiaries in our review, suppliers improperly billed Medicare for the more expensive, non-mail order DTS in 2011, but beneficiaries reported receiving the less expensive, mail order DTS

For all 500 beneficiaries in our sample, Medicare claims data documented that suppliers billed at least two orders of the more expensive, non-mail order DTS in 2011. However, 20 percent of the 211 beneficiaries we interviewed told us they received the less expensive, mail order DTS in 2011. Specifically, these beneficiaries received their mail order DTS through common carrier delivery to their homes. For example, one beneficiary in our review from the South Florida CBA stated that he has always had DTS delivered to his house through a mail carrier. He has "never had to sign anything and [has] never seen a supplier van."

Further, our analysis of beneficiaries' interview responses shows that the suppliers that provided DTS to these beneficiaries improperly billed Medicare for the more expensive, non-mail order DTS and received a higher Medicare reimbursement than they should have received. The average reimbursement rate for non-mail order DTS in 2011 was $23 per box more than for mail order DTS.[36]

The remaining beneficiaries in our review fell into four additional categories:

1. *Beneficiaries whose suppliers properly billed Medicare for mail order DTS in 2010 and non-mail order DTS in 2011*. For 42 percent of beneficiaries in our review, we determined that suppliers properly billed Medicare for mail order DTS in 2010 and non-mail order DTS in 2011.[37] That is, these beneficiaries received DTS in 2010 and 2011 in a manner that was consistent with their Medicare claims data.
2. *Beneficiaries whose suppliers improperly billed Medicare for the less expensive, mail order DTS in 2010 while providing the more expensive, non-mail order DTS.* For 29 percent of beneficiaries in our review, we determined that the suppliers received less Medicare reimbursement than they could have received.[38] In 2010, prior to the implementation of the Competitive Bidding Program, the average reimbursement rate for mail order DTS was $5 per box less than for non-mail order DTS.
3. *Beneficiaries who could not be classified as receiving mail order DTS in 2010 or non-mail order DTS in 2011.* Eight percent of beneficiaries in our review reported that they either received both mail order and non-mail order DTS within the same year (i.e., 2010 or 2011) or they could not recall how they received DTS in 2010 or 2011.
4. *Beneficiaries did not have diabetes*. One percent of beneficiaries in our review reported that they did not have diabetes, although Medicare paid suppliers for at least two mail order DTS claims in 2010 and at least two non-mail order DTS claims in

[36] The 20 percent of beneficiaries with improper supplier billing had a total of 133 non-mail order claims in 2011, resulting in $22,278 in improper Medicare-allowed amounts to suppliers. In comparison, Medicare allowed a total of $113,058 for non-mail order DTS in 2011 for the 211 beneficiaries in our review.

[37] Fifty-three percent of these beneficiaries began picking up non-mail order DTS in person in 2011. The remaining 47 percent received non-mail order DTS through supplier delivery to their homes.

[38] Sixty percent of these beneficiaries had suppliers deliver the non-mail order DTS to their homes in 2010, and the remaining 40 percent of beneficiaries picked up non-mail order DTS from the supplier's storefront.

2011 for these beneficiaries. These two beneficiaries did not use DTS, did not receive DTS, and were not aware that Medicare paid for DTS for them.

Beneficiaries in our review cited several reasons for changing from mail order to non-mail order DTS between 2010 and 2011, but no beneficiaries reported suppliers' waiver of copayments as a reason for their change

The 42 percent of the 211 beneficiaries in our review who changed from mail order to non-mail order DTS between 2010 and 2011 reported changing for four primary reasons. Of the beneficiaries who changed methods for receiving DTS, most beneficiaries (81 percent) reported doing so because the suppliers they used in 2010 were not selected as winning bidders under the Competitive Bidding Program. Therefore, these suppliers could not continue to provide mail order DTS to beneficiaries in CBAs in 2011. The remaining beneficiaries who reported changing from mail order to non-mail order DTS between 2010 and 2011 did so for other reasons. Eight percent of beneficiaries who changed methods did so because they were dissatisfied with the suppliers they used in 2010. Seven percent changed methods because the brand of DTS that worked with their monitors was no longer available through the suppliers they had used in 2010, and 2 percent changed methods because they did not like receiving DTS through mail order. An additional 2 percent changed methods but reported that they did not know why they had done so.

None of the beneficiaries in our review reported changing from mail order DTS in 2010 to non-mail order DTS in 2011 because their suppliers waived their copayments. However, 79 percent of beneficiaries in our review who received mail order DTS in 2010 and non-mail order DTS in 2011 did not pay any copayment for DTS in 2011. Of these beneficiaries, 87 percent had supplemental insurance that paid their entire Medicare copayment, and 10 percent of beneficiaries never paid a Medicare copayment for DTS in 2011 and did not know why. The remaining 3 percent had their Medicare copayment waived due to financial hardship.

Further, of the 42 percent of beneficiaries in our review who received mail order DTS in 2010 and non-mail order DTS in 2011, 71 percent were not aware of the potential cost savings to themselves or the Medicare program associated with mail order DTS. That is, these beneficiaries did not know that the average reimbursement for non-mail order DTS in 2011 was more than double that of mail order. Further, the majority of this group (67 percent) reported that they would be willing to switch back to mail order DTS to save themselves and/or the Medicare program money.

Twenty-three percent of beneficiaries in our review reported supplier activities that were inappropriate

Based on beneficiaries' interview responses, we determined that for 23 percent of the 211 beneficiaries in our review, suppliers inappropriately waived copayments and/or sent unsolicited DTS to beneficiaries in 2010 and/or 2011. For 1 percent of beneficiaries in our review, suppliers conducted both of these inappropriate activities. DTS suppliers who inappropriately waive beneficiaries' copayments or send unsolicited DTS to

beneficiaries may be in violation of the Federal False Claims Act or the Federal Anti-Kickback Statute.

For 20 percent of beneficiaries in our review, DTS suppliers inappropriately waived beneficiaries' copayments in 2010 or 2011. These beneficiaries did not know why they did not have to pay a copayment for DTS, and they did not have supplemental insurance or a financial hardship. Of the beneficiaries whose copayments were inappropriately waived in 2010 or 2011, most (89 percent) reported that their copayments were always waived. The remaining 11 percent of beneficiaries reported that they did not pay a copayment half or more than half of the time, but not always.

One beneficiary in our review from the California CBA reported that she never paid a copayment for her DTS in 2010 or 2011 and believed Medicare covered the full amount. She was not aware that she is responsible for a 20-percent copayment for her DTS. Further, she stated that she did not choose her DTS supplier; she reported attending a diabetes class and was "given this company to get supplies from."

Five percent of beneficiaries in our review received unsolicited DTS from suppliers in 2010 or 2011. On average, beneficiaries in our review reported receiving unsolicited DTS two times in 2010 and/or 2011. Beneficiaries in our review also reported receiving an average of five unsolicited boxes of DTS in 2010 and/or 2011.

For example, one beneficiary in our review from the Orlando-Kissimmee, Florida, CBA did not know that she is supposed to call her DTS supplier and request a refill for DTS. She said: "[A]bout every 3 months, DTS strips that I did not order arrive. The supplier just sends strips." She said that she did not choose her current DTS supplier: "[T]hey picked me, I guess."

A second beneficiary in our review from the South Florida CBA reported receiving a total of eight unsolicited DTS boxes from a supplier that is not her current DTS supplier. She indicated that she saved the DTS and tested extra times when she felt that she needed to. In some cases, she returned the DTS to the supplier and called CMS to make sure Medicare was not billed for the DTS she returned.

CONCLUSION

In response to a CMS request, we are providing information about the extent to which (1) claims in CBAs for the more expensive, non-mail order DTS increased between 2010 and 2011; (2) suppliers improperly billed Medicare for the more expensive, non-mail order DTS in 2011; (3) beneficiaries changed from mail order to non-mail order DTS between 2010 and 2011 because suppliers waived their copayments; and (4) suppliers conducted activities that we determined to be inappropriate (i.e., waiving copayments, sending unsolicited DTS) in 2010 or 2011. We found that claims in CBAs for the more expensive, non-mail order DTS increased by 33 percent from 2010 to 2011, while claims for the less expensive, mail order DTS decreased by 71 percent. Further, for 20 percent of beneficiaries in our review, suppliers improperly billed Medicare for the more

expensive, non-mail order DTS in 2011, but beneficiaries reported receiving the less expensive, mail order DTS. This improper supplier billing contributed to the increase in non-mail order DTS claims between 2010 and 2011. For the beneficiaries in our review who reported changing from mail order to non-mail order DTS between 2010 and 2011, none reported suppliers' waiver of copayments as a reason for their change. Therefore, suppliers' inappropriate waiver of beneficiaries' copayments did not appear to contribute to the increase in non-mail order DTS claims between 2010 and 2011. However, 23 percent of beneficiaries in our review reported supplier activities (e.g., routinely waiving copayments, sending unsolicited DTS) that we determined to be inappropriate.

CMS may find this information useful as it prepares to implement the DMEPOS Competitive Bidding Program National Mail Order Competition, projected to begin in 2013. Further, CMS may also find this information useful in implementing additional safeguards to prevent fraud, waste, and abuse in the Medicare program and in educating beneficiaries about their Medicare benefits and the cost savings of mail order DTS to themselves and/or the Medicare program.

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 OEI-04-11-00760 in all correspondence.

APPENDIX A

Table A-1 provides beneficiary information for respondents and nonrespondents in the South Florida Competitive Bidding Area (CBA) and the remaining eight CBAs.

Table A-1: Beneficiary Information for Respondents and Nonrespondents in the South Florida CBA and the Remaining Eight CBAs

Beneficiary Information	South Florida CBA		Remaining Eight CBAs		All CBAs	
	Respondents	Nonrespondents	Respondents	Nonrespondents	Respondents	Nonrespondents
Age						
Less than 65	39%	61%	32%	68%	35%	65%
65-74	49%	51%	50%	50%	50%	50%
75-84	40%	60%	45%	55%	43%	57%
85-94	38%	62%	41%	59%	39%	61%
95+	43%	57%	0%	100%	33%	67%
Sex						
Female	40%	60%	39%	61%	39%	61%
Male	44%	56%	50%	51%	47%	53%
Diabetes Test Strips Claims in 2010 and 2011	852	1,259	907	1,306	1,759	2,565

Note: Sum of percentages may exceed 100 percent due to rounding.
Source: Office of Inspector General analysis of beneficiary data, 2012.

APPENDIX B

Table B-1 provides, for each estimate description, the combined sample statistic for beneficiaries from two strata (i.e., the South Florida Competitive Bidding Area (CBA) and the remaining eight CBAs), as well as the sample statistic for each of the two strata. Each sample statistic is weighted by the size of each stratum's population from which our sample was selected.

Table B-1: Estimate Descriptions, Sample Sizes, and Weighted Point Estimates

Estimate Description	Sample Size	Weighted Point Estimate
Beneficiaries whose suppliers improperly billed Medicare for non-mail order diabetes test strips (DTS) in 2011 but provided mail order DTS in 2011	211	20%
South Florida CBA	*104*	*21%*
Remaining Eight CBAs	*107*	*20%*
Non-mail order DTS claims in 2011 for beneficiaries whose suppliers improperly billed Medicare for non-mail order DTS in 2011	43	133
South Florida CBA	*22*	*38*
Remaining Eight CBAs	*21*	*95*
Medicare-allowed amount for non-mail order DTS claims in 2011 for beneficiaries whose suppliers improperly billed Medicare in 2011	43	$22,278
South Florida CBA	*22*	*$6,182*
Remaining Eight CBAs	*21*	*$16,095*
Beneficiaries whose suppliers properly billed Medicare for mail order DTS in 2010 and non-mail order DTS in 2011	211	42%
South Florida CBA	*104*	*38%*
Remaining Eight CBAs	*107*	*43%*
Beneficiaries whose suppliers properly billed Medicare and who had DTS delivered to their homes in 2010 but picked up DTS from the suppliers' storefronts in 2011	85	53%
South Florida CBA	*39*	*8%*
Remaining Eight CBAs	*46*	*65%*
Beneficiaries whose suppliers properly billed Medicare and who had DTS delivered to their homes in both 2010 and 2011	85	47%
South Florida CBA	*39*	*92%*
Remaining Eight CBAs	*46*	*35%*
Beneficiaries whose suppliers improperly billed Medicare for mail order DTS in 2010 but provided non-mail order DTS in 2010	211	29%
South Florida CBA	*104*	*30%*
Remaining Eight CBAs	*107*	*29%*
Beneficiaries whose suppliers improperly billed Medicare for mail order DTS in 2010 but delivered DTS to beneficiaries' homes in 2010	62	60%
South Florida CBA	*31*	*77%*
Remaining Eight CBAs	*31*	*55%*
Beneficiaries whose suppliers improperly billed Medicare for mail order DTS in 2010 and who picked up DTS from the suppliers' storefronts in 2010	62	40%
South Florida CBA	*31*	*23%*
Remaining Eight CBAs	*31*	*45%*

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Table B-1: Estimate Descriptions, Sample Sizes, and Weighted Point Estimates (Continued)

Estimate Description	Sample Size	Weighted Point Estimate
Beneficiaries who could not be classified as receiving mail order DTS in 2010 or non-mail order DTS in 2011	211	8%
South Florida CBA	*104*	*12%*
Remaining Eight CBAs	*107*	*7%*
Beneficiaries who did not have diabetes in 2010 or 2011	211	1%
South Florida CBA	*104*	*0%*
Remaining Eight CBAs	*107*	*2%*
Beneficiaries who changed from mail order DTS in 2010 to non-mail order DTS in 2011 because their suppliers no longer provided DTS via mail order	85	81%
South Florida CBA	*39*	*82%*
Remaining Eight CBAs	*46*	*80%*
Beneficiaries who changed from mail order DTS in 2010 to non-mail order DTS in 2011 because they were dissatisfied with their suppliers	85	8%
South Florida CBA	*39*	*15%*
Remaining Eight CBAs	*46*	*7%*
Beneficiaries who changed from mail order DTS in 2010 to non-mail order DTS in 2011 because the brand of DTS that worked with their monitors was no longer available through the suppliers they used in 2010	85	7%
South Florida CBA	*39*	*0%*
Remaining Eight CBAs	*46*	*9%*
Beneficiaries who changed from mail order DTS in 2010 to non-mail order DTS in 2011 because they did not like receiving DTS through mail order	85	2%
South Florida CBA	*39*	*3%*
Remaining Eight CBAs	*46*	*2%*
Beneficiaries who changed from mail order DTS in 2010 to non-mail order DTS in 2011 and did not know why	85	2%
South Florida CBA	*39*	*0%*
Remaining Eight CBAs	*46*	*2%*
Beneficiaries who received mail order DTS in 2010 and non-mail order DTS in 2011 and did not pay any copayment in 2011	85	79%
South Florida CBA	*39*	*92%*
Remaining Eight CBAs	*46*	*76%*
Beneficiaries who did not pay a copayment for DTS in 2011 because they had supplemental insurance	71	87%
South Florida CBA	*36*	*75%*
Remaining Eight CBAs	*35*	*91%*
Beneficiaries who did not pay a copayment for DTS in 2011 and did not know why	71	10%
South Florida CBA	*36*	*22%*
Remaining Eight CBAs	*35*	*6%*
Beneficiaries who did not pay a copayment for DTS in 2011 because they had financial hardships	71	3%
South Florida CBA	*36*	*3%*
Remaining Eight CBAs	*35*	*3%*
Beneficiaries not aware of the potential cost savings for mail order DTS	85	71%
South Florida CBA	*39*	*77%*
Remaining Eight CBAs	*46*	*70%*

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Table B-1: Estimate Descriptions, Sample Sizes, and Weighted Point Estimates (Continued)

Estimate Description	Sample Size	Weighted Point Estimate
Beneficiaries not aware of the potential cost savings for mail order DTS who would be willing to switch back to mail order DTS	62	67%
South Florida CBA	*30*	*73%*
Remaining Eight CBAs	*32*	*66%*
Beneficiaries for whom suppliers inappropriately waived copayments or to whom suppliers sent unsolicited DTS in 2010 or 2011	211	23%
South Florida CBA	*104*	*32%*
Remaining Eight CBAs	*107*	*21%*
Beneficiaries for whom suppliers conducted both inappropriate activities	211	1%
South Florida CBA	*104*	*0%*
Remaining Eight CBAs	*107*	*2%*
Beneficiaries for whom suppliers inappropriately waived copayments	211	20%
South Florida CBA	*104*	*24%*
Remaining Eight CBAs	*107*	*19%*
Beneficiaries for whom suppliers always inappropriately waived copayments	45	89%
South Florida CBA	*25*	*100%*
Remaining Eight CBAs	*20*	*85%*
Beneficiaries for whom suppliers inappropriately waived copayments half or more than half of the time, but not always	45	11%
South Florida CBA	*25*	*0%*
Remaining Eight CBAs	*20*	*15%*
Beneficiaries to whom suppliers sent unsolicited DTS	211	5%
South Florida CBA	*104*	*8%*
Remaining Eight CBAs	*107*	*4%*
Average times beneficiaries received unsolicited DTS in 2010 and/or 2011	12	2
South Florida CBA	*8*	*1*
Remaining Eight CBAs	*4*	*3*
Average number of unsolicited DTS boxes that beneficiaries received in 2010 and/or 2011	12	5
South Florida CBA	*8*	*2*
Remaining Eight CBAs	*4*	*8*

Source: Office of Inspector General analysis of beneficiary interview data, 2012.

APPENDIX C

Tables C-1 through C-3 show the percentage change in the number of claims, Medicare-allowed amounts, and the number of beneficiaries receiving non-mail order and mail order diabetes test strips (DTS) in Competitive Bidding Areas (CBA) between 2010 and 2011. Each table provides these data for the South Florida CBA, the remaining eight CBAs, and overall.

Table C-1: Number of Claims in CBAs for Non-Mail Order and Mail Order DTS in 2010 and 2011

Paid Medicare Claims	Number of Claims in 2010	Number of Claims in 2011	Change Between 2010 and 2011*
Non-Mail Order	399,338	532,056	+ 33%
South Florida CBA	*131,112*	*155,946*	*+ 19%*
Remaining Eight CBAs	*268,226*	*376,110*	*+ 40%*
Mail Order	459,602	135,541	- 71%
South Florida CBA	*74,921*	*12,996*	*- 83%*
Remaining Eight CBAs	*384,681*	*122,545*	*- 68%*
Total	858,940	667,597	- 22%
South Florida CBA	*206,033*	*168,942*	*- 18%*
Remaining Eight CBAs	*652,907*	*498,655*	*- 24%*

* Percentage change includes beneficiaries who switched from mail order to non-mail order DTS, beneficiaries who were new to receiving DTS through Medicare in 2011, and beneficiaries who no longer received DTS through Medicare in 2011.
Source: OIG analysis of the 18-month updates of the 2010 and 2011 CMS Durable Medical Equipment 100 Percent Standard Analytic Files, 2012.

Table C-2: Medicare-Allowed Amounts for Claims in CBAs for Non-Mail Order and Mail Order DTS in 2010 and 2011

Paid Medicare Claims	Medicare-Allowed Amounts in 2010*	Medicare-Allowed Amounts in 2011*	Change Between 2010 and 2011**
Non-Mail Order	$33,151,723	$49,433,348	+ 49%
South Florida CBA	*$11,374,886*	*$15,614,447*	*+ 37%*
Remaining Eight CBAs	*21,776,837*	*33,818,901*	*+ 55%*
Mail Order	$58,742,124	$ 9,642,623	- 84%
South Florida CBA	*$10,406,444*	*$1,137,212*	*- 89%*
Remaining Eight CBAs	*48,335,681*	*8,505,411*	*- 82%*
Total	$91,893,848	$59,075,971	- 36%
South Florida CBA	*$21,781,331*	*$16,751,659*	*- 23%*
Remaining Eight CBAs	*70,112,518*	*42,324,312*	*- 40%*

* Sum of column may exceed total due to rounding.
** Percentage change includes beneficiaries who switched from mail order to non-mail order DTS, beneficiaries who were new to receiving DTS through Medicare in 2011, and beneficiaries who no longer receive DTS through Medicare in 2011.
Source: OIG analysis of the 18-month updates of the 2010 and 2011 CMS Durable Medical Equipment 100 Percent Standard Analytic Files, 2012.

Table C-3: Number of Beneficiaries in CBAs With Non-Mail Order and Mail Order DTS in 2010 and 2011

Paid Medicare Claims	Number of Beneficiaries in 2010*	Number of Beneficiaries in 2011*	Change Between 2010 and 2011**
Non-Mail Order	124,991	182,502	+ 46%
South Florida CBA	*33,769*	*47,833*	*+ 42%*
Remaining Eight CBAs	*91,244*	*134,689*	*+ 48%*
Mail Order	183,217	70,803	- 61%
South Florida CBA	*30,970*	*8,130*	*- 74%*
Remaining Eight CBAs	*152,271*	*62,679*	*- 59%*
Total	292,006	238,748	- 18%
South Florida CBA	*60,777*	*52,884*	*- 14%*
Remaining Eight CBAs	*231,275*	*185,893*	*- 21%*

* Sum of column may exceed total due to various factors (e.g., rounding, beneficiaries being counted more than once because they received both mail order and non-mail order DTS within a year and/or because they resided in both the South Florida CBA and at least one of the remaining eight CBAs within the same year).
** Percentage change includes beneficiaries who switched from mail order to non-mail order DTS, beneficiaries who were new to receiving DTS through Medicare in 2011, and beneficiaries who no longer receive DTS through Medicare in 2011.
Source: OIG analysis of the 18-month updates of the 2010 and 2011 CMS Durable Medical Equipment 100 Percent Standard Analytic Files, 2012.