

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE COMPLIANCE REVIEW
OF EXCELLENT HOME
CARE SERVICES, LLC**

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Office of Inspector General

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EXECUTIVE SUMMARY

Excellent Home Care Services, LLC, did not fully comply with Medicare requirements for billing home health services, resulting in overpayments of at least \$7.5 million over 2 years.

WHY WE DID THIS REVIEW

This review is part of a series of reviews of home health agencies (HHAs). Using computer matching, data mining, and data analysis techniques, we identified certain types of home health claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid HHAs about \$19 billion for home health services. The Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was approximately 51 percent, or about \$9.4 billion. Although Medicare spending for home health care accounts only for about 5 percent of fee-for-service spending, improper payments to HHAs account for over 20 percent of the total 2014 fee-for-service improper payments (\$46 billion).

The objective of this review was to determine whether Excellent Home Care Services, LLC, (the Agency) complied with Medicare requirements for billing home health services on selected types of claims.

BACKGROUND

Under the home health prospective payment system (PPS), CMS pays HHAs a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, covered therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. CMS adjusts the 60-day episode payment by a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcome and to determine whether adjustments to the case-mix groups are warranted.

The Agency is a home health care agency located in Brooklyn, New York. National Government Services, its Medicare contractor, paid the Agency approximately \$16 million for 6,472 claims for services provided to beneficiaries during CYs 2011 and 2012 based on CMS's National Claims History data.

Our audit covered \$16,027,484 in Medicare payments to the Agency for 3,578 beneficiary starts-of-care. A beneficiary start-of-care represents all contiguous home health episodes of care during the audit period for the same beneficiary. A home health agency submits a claim for Medicare payment for each episode of care. The 3,578 beneficiary starts-of-care included 6,472 claims for home health services that had dates of service in CY 2011 and/or CY 2012. We selected a stratified random sample of 124 beneficiary starts-of-care (including 555 claims) with payments totaling \$2,071,489 for review. We evaluated compliance with selected billing

requirements and subjected 248 of the 555 claims to focused medical review to determine whether the services met coverage, medical necessity, and coding requirements.

WHAT WE FOUND

The Agency did not comply with Medicare billing requirements for 96 of the 124 starts-of-care (156 of the 555 home health claims) we reviewed. Specifically, the 96 starts-of-care had billing errors resulting in net overpayments of \$497,608. The Agency incorrectly billed Medicare for (1) some beneficiaries who were not homebound, (2) some beneficiaries who did not require skilled services, and (3) some services for which the documentation from the certifying physician was missing or insufficient to support the services. These errors occurred primarily because the Agency did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that the Agency received net overpayments of at least \$7,549,283 for the audit period. Of the total estimated overpayments, at least \$6,382,323 have payment dates that are within the 3-year recovery period and, accordingly, as much as \$1,166,960 paid outside the 3-year recovery period. (The Patient Protection and Affordable Care Act established a 60-day repayment rule under which Medicare overpayments must be reported and returned within 60 days after being identified.)

WHAT WE RECOMMEND

We recommend that the Agency:

- refund to the Medicare contractor \$6,382,323 in estimated net overpayments for claims incorrectly billed that are within the 3-year claims recovery period;
- work with the Medicare contractor to refund net overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1,166,960 for our audit period, in accordance with the 60-day repayment rule;
- identify claims in subsequent years that did not meet Medicare payment requirements and refund any associated overpayments; and
- strengthen its procedures to ensure that:
 - the homebound status of a Medicare beneficiary is verified and the specific factors qualifying the beneficiary as homebound are documented,
 - beneficiaries are receiving only reasonable and necessary skilled services, and
 - the physicians' certification and plan of care comply with Medicare documentation requirements and support the services the Agency provided.

AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the Agency, through its attorneys, did not indicate concurrence or nonoccurrence with our recommendations. The Agency disagreed with our determinations for 113 of the 158 claims questioned in our draft report and, under separate cover, submitted documentation related to these claims. The Agency agreed with our findings for the remaining 45 claims.

The determinations for 107 of the 113 claims for which the Agency disagreed with our findings, were based on focused medical review by an independent medical review contractor. The medical reviewers determined whether the services billed met medical necessity and coding requirements. Determinations for the remaining six claims were based on our review of Agency billing records.

After reviewing the Agency's comments and documentation, we revised our determinations for two claims and revised our related findings and recommendations accordingly. We maintain that our remaining findings and recommendations are valid. For these findings, we determined that the Agency had previously provided all of the documentation included with its comments. The medical review contractor considered the information in these documents when it made its determinations. We will forward a copy of our final report to the CMS action official for review and any action deemed necessary. The Agency may appeal the determinations in our final report with the action official and thereafter, through the Medicare appeals process.

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INTRODUCTION

WHY WE DID THIS REVIEW

This review is part of a series of reviews of home health agencies (HHAs). Using computer matching, data mining, and data analysis techniques, we identified certain types of home health claims that are at risk for noncompliance with Medicare billing requirements. For calendar year (CY) 2014, Medicare paid HHAs about \$19 billion for home health services. The Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing (CERT) program determined that the 2014 improper payment error rate for home health claims was approximately 51 percent, or about \$9.4 billion. Although Medicare spending for home health care accounts only for about 5 percent of fee-for-service spending, improper payments to HHAs account for over 20 percent of the total 2014 fee-for-service improper payments (\$46 billion).

OBJECTIVE

Our objective was to determine whether Excellent Home Care Services, LLC, (the Agency) complied with Medicare requirements for billing home health services on selected types of claims.

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare (Parts A and B) covers eligible home health services under a prospective payment system (PPS) that covers intermittent skilled nursing care and home health aide visits, covered therapy (physical, speech-language pathology, occupational), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs a standardized payment for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments by a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups,¹ to monitor the effects of treatment on patient care and outcome and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the HIPPS rate codes and represent specific sets of patient characteristics. CMS requires the submission of OASIS data as a condition of payment.²

¹ CMS uses case-mix groups as the basis for the Health Insurance Prospective Payment System (HIPPS) rate codes in Medicare's prospective payment system. CMS designed case-mix groups to classify patients who are similar clinically in terms of resources used.

² 42 CFR § 484.210(e), 74 Fed. Reg. 58110 (Nov. 10, 2009) and CMS's *Program Integrity Manual*, chapter 3, § 3.2.3.1.

CMS administers the Medicare program and contracts with four of its Medicare Administrative Contractors (MACs) to, among other things, process and pay claims submitted by HHAs.

Home Health Agency Claims at Risk for Incorrect Billing

In prior years, our reviews at other HHAs identified several areas at risk of noncompliance, including:

- beneficiary homebound status,
- beneficiary need for skilled services,
- timely submission of OASIS,
- home health visits overlapping an institutional stay, and
- adequate documentation to support billed services.

In this report, we refer to these areas at risk for incorrect billing as “risk areas.” We reviewed these and other risk areas as part of this review.

Medicare Requirements for Home Health Agency Claims and Payments

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (Social Security Act (the Act), § 1862(a)(1)(A)). Sections 1814(a)(2) and 1835(a)(2) of the Act establish, and regulations at 42 CFR part 409 implement, as a condition of payment for home health services the requirement that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis or physical, speech-language pathology, or have a continuing need for occupational therapy;
- under the care of a physician; and
- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Further, these sections require that the certification document a face-to-face encounter between the physician (or other allowable practitioner) and the Medicare beneficiary during the 6 months preceding the certification or at another reasonable timeframe as determined by the Secretary of

Health and Human Services.³ In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).⁴

The determination of whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR § 484.55, or a medical record of the individual patient (the Manual, chapter 7, § 20.1.2).

Appendix A contains the details of selected Medicare coverage and payment requirements for HHAs.

Excellent Home Care Services, LLC

The Agency is a for-profit HHA located in Brooklyn, New York and licensed in New York. National Government Services, its Medicare contractor, paid the Agency a total of approximately \$16 million for 6,472 claims for services provided to beneficiaries during calendar years (CYs)⁵ 2011 and 2012 (audit period) based on CMS's National Claims History data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered \$16,027,484 in Medicare payments to the Agency for 3,578 beneficiary starts-of-care.⁶ These beneficiary starts-of-care included 6,472 claims for home health services that had dates of service in CY 2011 and/or CY 2012. We selected a stratified random sample of 124 beneficiary starts-of-care (including 555 claims) with payments totaling \$2,071,489 for review. We evaluated compliance with selected billing requirements and subjected 248 of the 555 claims⁷ to focused medical review to determine whether the services met coverage, medical necessity, and coding requirements.

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

³ CMS's *Medicare Benefit Policy Manual* (the Manual), Pub. No. 100-02, chapter 7, § 30.5.1.1.3 requires the face-to-face encounter to occur no more than 90 days prior to the home health start of care date or within 30 days after the start of care.

⁴ Federal regulations at 42 CFR part 409 implement the conditions for payment in sections 1862(a)(1)(A), 1814(a)(2), and 1835(a)(2) of the Act. Federal regulations at 42 CFR part 424 implement additional conditions of payment specified in section 1833 of the Act.

⁵ CYs were determined by the home health agency claims' "through" date of service. The "through" date is the last day on the billing statement covering services rendered to the beneficiary.

⁶ A beneficiary start-of-care represents all contiguous home health episodes of care during the audit period for the same beneficiary. A beneficiary start-of-care series could range from one to several individual 60-day episodes of care. A home health agency submits a claim for Medicare payment for each episode of care.

⁷ The 307 claims not subjected to medical review were treated as having no medical necessity or coding errors.

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.

See Appendix B for the details of our scope and methodology.

FINDINGS

The Agency did not comply with Medicare billing requirements for 96 of the 124 starts-of-care⁸ (156 of the 555 home health claims) we reviewed. Specifically, the 96 starts-of-care had billing errors resulting in net overpayments of \$497,608. The Agency incorrectly billed Medicare for (1) some beneficiaries who were not homebound (37 starts-of care, including 57 claims), (2) some beneficiaries who did not require skilled services (36 starts-of-care, including 47 claims), and (3) some services for which the documentation from the certifying physician was missing or insufficient to support the services (29 starts of care, including 52 claims). These errors occurred primarily because the Agency did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that the Agency received net overpayments of at least \$7,549,283 for the audit period.⁹ Of the total estimated overpayments, at least \$6,382,323 have payment dates that are within the 3-year recovery period and, accordingly, as much as \$1,166,960 paid outside the 3-year recovery period.¹⁰ (The Patient Protection and Affordable Care Act established a 60-day repayment rule under which Medicare overpayments must be reported and returned within 60 days after being identified.)

See Appendix C for our statistical sampling methodology, Appendix D for our sample results and estimates, and Appendix E for types of errors by sample item.

AGENCY BILLING ERRORS

The Agency incorrectly billed Medicare for 96 of the 124 starts-of-care (156 of the 555 claims) which resulted in net overpayments of \$497,608.

⁸ Six of the 96 starts-of-care contained claims which had more than one type of error.

⁹ To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner will be less than the actual overpayment total at least 95 percent of the time.

¹⁰ Our audit report represents the results for all claims within our audit period. Section 1870(b) of the Act governs the recovery of excess payments. This section provides that excess payments identified are barred from recovery 3 years after the year in which the original payment was made. In addition, the Agency is responsible for reporting and returning overpayments it identified to its MAC.

The 2010 Patient Protection and Affordable Care Act requires the reporting and return of Medicare overpayments along with written notice of the reason for the overpayment within 60 days after the overpayment was identified (60-day repayment rule). Failure to meet this deadline subjects providers to potential False Claims Act and Civil Monetary Penalty Law liability.

Beneficiaries Were Not Homebound

Sections 1814(a)(2) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 409.42) require for reimbursement of home health services that the beneficiary is “confined to the home.” Section 1814(a) states that a beneficiary qualifies as “confined to the home” if he or she:

has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.... Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.

For 57 claims associated with 37 starts-of-care, the Agency incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above criteria for being homebound.¹¹ For example, documentation for one beneficiary did not support that the patient was homebound, as the patient was able to walk with a cane, even on uneven surfaces and stairs, and was able to leave her residence. These errors occurred because the Agency did not have adequate oversight procedures to ensure that it verified the homebound status of Medicare beneficiaries and did not properly document the specific factors that qualify the beneficiaries as homebound.

As a result of these errors, the Agency received overpayments of \$156,242.

Beneficiaries Did Not Require Skilled Services

Pursuant to Section 1395 of the Act, Federal regulations (42 CFR § 409.42) require that the Medicare beneficiary be in need of skilled nursing care on an intermittent basis or physical, speech-language pathology, or have a continuing need for occupational therapy. In addition, Federal regulations (42 CFR § 409.44(b)) and the Manual (chapter 7, §40.1) state that skilled nursing services must require the skills of a registered nurse, or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient’s illness or injury and must be intermittent. Also, Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled therapy services must be reasonable and necessary to the treatment of the patient’s illness or injury or to the restoration or maintenance of function affected by the patient’s illness or injury within the context of the patient’s unique medical condition.

¹¹ Additionally, 48 of these claims had other errors. In the majority of cases, the beneficiary also did not require skilled services in addition to not being homebound. Appendix E provides detail on the extent of errors, if any, per sample item reviewed.

For 47 claims associated with 36 starts-of-care, the Agency incorrectly billed Medicare for an entire home health episode (43 claims) or part of the episode¹² (4 claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing and/or therapy services. For example, the Agency provided skilled nursing care to a beneficiary who was stable and had no significant changes in his treatment plan to warrant the skills of a licensed nursing professional. As a result, skilled nursing services on the entire claim were not considered reasonable and necessary. These errors occurred because the Agency did not always provide sufficient clinical review to verify that beneficiaries required skilled services.

As a result of these errors, the Agency received net overpayments of \$135,803.

Missing or Insufficient Documentation

Sections 1814(a)(2) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 424.22(a)) state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the coverage requirements specified in the statute and regulations. Prior to certifying a patient's eligibility for home health services, the certifying physician must document that he or she (or an allowed nonphysician practitioner) had a face-to-face patient encounter related to the primary reason the patient requires home health services. In addition, Federal regulations (42 CFR § 424.22(a)) and the Manual (chapter 7, § 30.5.1.1) state that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

The Manual (chapter 7, § 30.2.2) also states that the orders on the patient's plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services. Federal regulations (42 CFR § 409.43(e)) and the Manual (chapter 7, § 30.2.6) further state that the plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review.

Federal regulations (42 CFR § 484.210(e)) and CMS's *Program Integrity Manual*, (chapter 3, § 3.2.3.1) state that HHAs are required to submit OASIS data as a condition of payment and instructs Regional Home Health Intermediaries not to pay claims that lack OASIS data. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the HIPPS rate codes and represent specific sets of patient characteristics.

For 52 claims associated with 29 starts-of-care, the Agency incorrectly billed Medicare for home health episodes that did not meet the Medicare documentation requirements for the physician certification, plan of care and/or home health certification. These claims contained the following types of errors:

¹² For two claims for which the Agency incorrectly billed for part of the episode, the agency was underpaid for its services. We determined this through repricing the claims using the appropriate HIPPS rate code and reflected the underpayments in our estimates.

- The plan of care and/or physician orders were not dated or the date was illegible (five claims).
- The physician did not certify that the patient was homebound on the plan of care (one claim).
- The physician signature on the required face-to-face encounter form was undated (four claims).
- Documentation of services were not delivered in accordance with the plan of care and/or physician orders (eight claims).
- The OASIS was not submitted or was submitted after the claim receipt date (30 claims).
- The HIPPS code on the claim was incorrectly billed (four claims).

These errors occurred primarily because the Agency did not always have sufficient procedures to ensure that the physician's certification and plan of care complied with Medicare documentation requirements and supported the services the Agency provided.

As a result of these errors, the Agency received overpayments of \$205,562.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that the Agency received net overpayments of at least \$7,549,283 for the audit period. Of the total estimated overpayments, at least \$6,382,323 have payment dates that are within the 3-year recovery period and, accordingly, as much as \$1,166,960 paid outside the 3-year recovery period.

RECOMMENDATIONS

We recommend that the Agency:

- refund to the Medicare contractor \$6,382,323 in estimated net overpayments for claims incorrectly billed that are within the 3-year claims recovery period;
- work with the contractor to refund net overpayments outside of the 3-year recovery period, which we estimate to be as much as \$1,166,960 for our audit period, in accordance with the 60-day repayment rule;
- identify claims in subsequent years that did not meet Medicare payment requirements and refund any associated overpayments; and
- strengthen its procedures to ensure that:

- the homebound status of a Medicare beneficiary is verified and the specific factors qualifying the beneficiary as homebound are documented,
- beneficiaries are receiving only reasonable and necessary skilled services, and
- the physicians' certification and plan of care comply with Medicare documentation requirements and support the services the Agency provided.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, the Agency, through its attorneys, did not indicate concurrence or nonoccurrence with our recommendations. The Agency disagreed with our determinations for 113 of the 158 claims questioned in our draft report and, under separate cover, submitted documentation related to these claims.¹³ The Agency agreed with our findings for the remaining 45 claims.

After reviewing the Agency's comments and documentation, we revised our determinations for two claims and revised our related findings and recommendations accordingly. We maintain that our remaining findings and recommendations are valid. For these findings, we determined that the Agency had previously provided all of the documentation included with its comments. The medical review contractor considered the information in these documents when it made its determinations. We will forward a copy of our final report to the CMS action official for review and any action deemed necessary. The Agency may appeal the determinations in our final report with the action official and thereafter, through the Medicare appeals process.

The Agency's comments are included as Appendix F.

FACE-TO-FACE ENCOUNTER FORM NOT DATED

Agency Comments

The Agency stated that the narrative included on face-to-face encounter forms should not be relied upon to disallow otherwise valid claims. According to the Agency, some of the claims determined to be unallowable were based on auditors' claims that the physician's signature on the face-to-face encounter form was not genuine. The Agency further stated that, in cases for which the physician did not date the face-to-face encounter form, the claim should be allowed when extrinsic evidence can establish that the examination occurred within the appropriate period.

¹³ The determinations for 107 of these claims were based on focused medical review by an independent medical review contractor. The medical reviewers determined whether the services billed met medical necessity and coding requirements. Determinations for the remaining six claims were based on our review of Agency billing records.

Office of Inspector General Response

We maintain that our findings regarding face-to-face encounter forms are valid. In keeping with current Medicare guidance—although not in effect during our audit period—the medical review contractor did not determine claims to be in error based solely on the narrative included on the face-to-face encounter form. The medical review contractor reviewed the entire medical record to determine whether the encounter occurred and that it was within the required time frames.¹⁴ Federal regulations state that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification. We note that none of the determinations were based on whether the physician’s signature appeared to be genuine. Further, no claims were denied solely because documentation of the face-to-face encounter was insufficient. The claims for which we noted this deficiency also contained other deficiencies (e.g., the patient was not homebound or did not have a skilled need).

PLAN OF CARE NOT DATED

Agency Comments

The Agency stated that, in some instances for which the physician did not date the plan of care, extrinsic evidence could establish that the physician signed the plan of care at a certain time (e.g., looking at other dates on the form where other professionals attested to when certain events were accomplished). The Agency further stated that it stamps the “received date” of all documents and that this date is always prior to the billing date. The Agency also stated that some of our determinations were based on the physician not signing each page of the plan of care.

Office of Inspector General Response

After reviewing the additional documentation provided by the Agency, we revised our determinations for two claims for which the documentation indicated that the physician signed the plan of care on at least one of the pages.

We note that Federal regulations and guidance require that the plan of care be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days.¹⁵ A stamp indicating “received date” is not adequate evidence that a physician reviewed the plan of care.

¹⁴ The medical review contractor denied claims if the face-to-face encounter form was not signed and/or dated and there was no evidence in the medical record that the encounter occurred or of the date of the encounter.

¹⁵ 42 CFR § 409.43(e) and chapter 7, § 30.2.6 of the Manual.

BENEFICIARIES WERE NOT HOMEBOUND

Agency Comments

The Agency stated that, for certain beneficiaries, “home” was an adult care facility. The Agency further stated that our determinations were based on the fact that the adult care facility did not establish that the patients were homebound. The Agency also stated that the fact that the adult care facility is a home for a number of residents does not change the fact that a patient’s condition must be judged based on their ability to move throughout the facility.

Office of Inspector General Response

We maintain that our findings regarding beneficiaries who were not homebound are valid. We did not disallow these claims based on where the beneficiary resided. Rather, the medical review contractor determined that the beneficiary was not homebound. Home health services are reimbursable if the beneficiary is “confined to the home.”¹⁶

NO PHYSICIAN’S ORDER FOR SERVICES

Agency Comments

The Agency stated that there can be an order for therapy services on a beneficiary’s plan of care form. According to the Agency, if there is no order on the plan of care, the physician can verbally order services which can become an addendum to the plan of care. The Agency also stated that, in some cases, an interim order may be placed in the beneficiary’s record although it may not be noted in the beneficiary’s plan of care form.

Office of Inspector General Response

We maintain that our findings for claims for which there were no physician’s order for services are valid. The medical review contractor did not make any adverse determinations based on how therapy services were ordered—either on the plan of care form, in addendums, or through interim orders. Therapy services were disallowed because documentation conflicted with the referral and intake forms, and nursing assessments; therefore, the need for therapy services was not documented.

OUTCOME AND ASSESSMENT INFORMATION SET FORM NOT SUBMITTED OR SUBMITTED AFTER CLAIM RECEIPT DATE

Agency Comments

The Agency stated that it does not bill a claim prior to receiving a completed OASIS form. In addition, the Agency stated that Medicare allows billing up to 365 days after a service is provided; therefore, an OASIS cannot be “stale” because it was submitted later than 30 days from the date of service. The Agency further stated that its notebook in which it maintained

¹⁶ Sections 1814(a)(2) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42.

paper copies of completed OASIS forms was lost; however, its practice is to submit OASIS forms for validation in every case in advance of billing, and to only bill in circumstances for which the OASIS is validated. Finally, the Agency stated that Medicare records should indicate that the OASIS forms were submitted and validated prior to the date of billing.

Office of Inspector General Response

We maintain that our findings regarding claims for which the OASIS form was not submitted or submitted after the claim receipt date are valid. CMS requires the submission of OASIS data as a condition of payment.¹⁷ We disallowed claims only if the OASIS form was not submitted or was not submitted and accepted before the claim receipt date.¹⁸ We verified this information through CMS's Quality Improvement and Evaluation System.¹⁹

INCORRECT PAYMENT CODE

Agency Comments

The Agency stated that in some cases, we determined that the "level-of-care should be lower." The Agency further stated that the Medicare program generates payment codes based on information entered onto the OASIS form by providers.²⁰ The Agency stated that it is inappropriate to substitute our judgement for that of the computer program that selected the HIPPS codes.

The Agency also stated that a number of our disallowances were based on supplies, even though supplies in certain categories are paid for by the Medicare program. The Agency stated that, if supplies are called for within a category of service, they should be paid as a bundled unit by Medicare, regardless of whether it submitted invoices for the supplies.

Office of Inspector General Response

We maintain that our findings regarding incorrect payment codes are valid. We did not make level-of-care determinations. The medical reviewers determined the appropriate level-of-care and needed medical supplies based on a review of the entire medical record, including information placed on the OASIS, and adjusted the level-of-care and related HIPPS code for individual claims if necessary.

¹⁷ 42 CFR § 484.210(e), 74 Fed. Reg. 58110 (Nov. 10, 2009) and CMS's *Program Integrity Manual*, chapter 3, § 3.2.3.1.

¹⁸ We note that we disallowed 30 claims based primarily on the OASIS form—not 31, as stated by the Agency.

¹⁹ This is a standard nationwide system for HHAs to submit assessment data. It maintains the receipt, storage, authentication and validation of OASIS assessment records received from HHAs.

²⁰ The Agency used the term "HHRG" (an acronym for Home Health Resource Group) in its comments. On Medicare claims, HHRGs are represented as HIPPS codes.

APPENDIX A: MEDICARE REQUIREMENTS FOR COVERAGE AND PAYMENT OF CLAIMS FOR HOME HEALTH SERVICES

GENERAL MEDICARE REQUIREMENTS

Medicare payments may not be made for items and services that “are not 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’s *Medicare Claims Processing Manual*, Pub. No. 100-04, states: “In order to be processed correctly and promptly, a bill must be completed accurately” (Chapter 1, § 80.3.2.2).

OUTCOME AND ASSESSMENT INFORMATION SET DATA

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcome, and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes used by Medicare in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify acute care inpatients who are similar clinically in terms of resources used.

CMS requires the submission of OASIS data as a condition of payment as of January 1, 2010 (42 CFR § 484.210(e), 74 Fed. Reg. 58110 (Nov. 10, 2009), and CMS’s *Medicare Program Integrity Manual*, chapter 3, § 3.2.3.1).

COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose of obtaining a blood sample) or physical, speech-language pathology, or occupational therapy;²¹ (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 CFR § 409.42 and the Manual, Chapter 7, § 30).

Per the Manual, Chapter 7, § 20.1.2, whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS set, or a medical record of the individual patient.

²¹ Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, physical therapy service, or speech language pathology service as required by law. Once that requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes).

The Act and Federal regulations state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the above coverage requirements (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), and 42 CFR § 424.22(a)).

The Affordable Care Act added an additional requirement to §§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Act requiring the physician to have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter.²²

Confined to the Home

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 409.42) require for reimbursement of home health services that the beneficiary is “confined to the home.” Section 1814(a) states that a beneficiary qualifies as “confined to the home” if he or she:

has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.... Any other absence of an individual from the home shall not so disqualify an individual if the absence is of infrequent or of relatively short duration.

Need for Skilled Services

Skilled Nursing Care

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR §§ 409.42(c) and 409.44(b) and the Manual, chapter 7, § 40.1).

Intermittent Skilled Nursing Care

The Act defines “part-time or intermittent services” as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case

²² See 42 CFR § 424.22(a) and the Manual, Ch. 7, § 30.5. The initial effective date for the face-to-face requirement was January 1, 2011. However, on December 23, 2010, CMS granted HHAs additional time to establish protocols for newly required face-to-face encounters. As such, documentation regarding these encounters must be present on certifications for patients with starts of care on or after April 1, 2011.

basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week) (the Act §1861(m) and the Manual, chapter 7, § 50.7).

Requiring Skills of a Licensed Nurse

Federal regulations (42 CFR § 409.44(b)) state that, in determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice. If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary's family or friends does not negate the skilled aspect of the service when performed by the nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service.

General Principles Governing Reasonable and Necessary Skilled Nursing Care

Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed practical (vocational) nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service although a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a nurse provides the service.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patient's whose condition is stable (the Manual, chapter 7, § 40.1.1).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, §40.2.1) state that skilled services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury, the therapy services must:

- be inherently complex, which means that they can be performed safely and/or effectively only by or under the general supervision of a skilled therapist;
- be consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and
- be considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

Documentation Requirements

Face-To-Face Encounter

Federal regulations (42 CFR § 424.22(a)) and the Manual (chapter 7, § 30.5.1) state that, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed non-physician practitioner, had a face-to-face encounter with the patient, which is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1.1) states that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

Plan of Care

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services (the Manual, chapter 7, § 30.2.2). The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

APPENDIX B: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$16,027,484 in Medicare payments to the Agency for 3,578 beneficiary starts-of-care. We selected for review a stratified random sample of 124 beneficiary starts-of-care²³ with payments totaling \$2,071,489. These beneficiary starts-of-care included a total of 555 claims for home health services that the Agency provided to Medicare beneficiaries during CYs²⁴ 2011 and 2012 (audit period).

We evaluated compliance with selected coverage and billing requirements and subjected 248 claims to focused medical review.

We limited our review of the Agency's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's National Claims History (NCH) file; however, we did not assess the completeness of the file.

We conducted our fieldwork at the Agency from December 2013 through December 2015.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted the Agency's paid claims data from CMS's NCH file for the audit period;
- used computer matching, data mining, and analysis techniques to identify claims potentially at risk for noncompliance with selected Medicare billing requirements;
- selected a stratified random sample of 124 beneficiary starts-of-care which included 555 claims totaling \$2,071,489 for detailed review (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- obtained and reviewed billing and medical record documentation provided by the Agency to support the claims contained in the sampled beneficiary starts-of-care;

²³ A beneficiary start-of-care may include more than one claim.

²⁴ Calendar years were determined by the home health agency claims' "through" date of service. The "through" date is the last day on the billing statement covering services rendered to the beneficiary.

- used an independent medical review contractor to determine whether 248 claims contained in the sample were reasonable and necessary and met Medicare coverage and coding requirements;
- reviewed the Agency's procedures for billing and submitting Medicare claims;
- discussed the incorrectly billed claims in our sample with Agency personnel to determine the underlying causes of noncompliance with Medicare requirements;
- verified State licensure information for selected nurses and therapists providing services to the patients in our sample;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample to estimate the total Medicare overpayments to the Agency for our audit period (Appendix D);
- used the results of the sample to estimate the Medicare overpayments to the Agency that are within the 3-year recovery period (Appendix D);
- calculated a non-statistical estimate of the overpayments that are outside the 3-year recovery period (Appendix D); and
- discussed the results of our review with Agency officials.

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 the Agency's claims that were for home health services that it provided to Medicare beneficiaries during CYs 2011 and 2012.

SAMPLING FRAME

We obtained a database of 6,472 home health claims from the CMS's NCH file. This database contained a higher-risk subset of the population. We grouped these claims by beneficiary Health Insurance Claim Number and the start-of-care date. We defined the grouping of claims or frame unit as a beneficiary start-of-care. The grouping resulted in 3,578 frame units (beneficiary starts-of-care) valued at \$16,027,484. All statistical estimates included in this report are restricted to the scope of this frame.

SAMPLE UNIT

The sample unit was a beneficiary start-of-care.

SAMPLE DESIGN

We used a stratified random sample. We stratified the sampling frame into four strata based on total payments for all claims within an individual beneficiary start-of-care.

Stratum	Dollar Range of Frame Units	Number of Frame Units	Dollar Value of Frame Units
1	\$126.32 to \$2,999.96	1,810	\$3,778,557
2	\$3,007.59 to \$5,292.72	995	3,882,912
3	\$5,300.94 to \$37,998.97	739	6,773,541
4 (100% review)	\$38,218.85 to \$61,657.52	34	1,592,474
Totals		3,578	\$16,027,484

SAMPLE SIZE

We randomly selected 30 beneficiary starts-of-care from stratum one, 30 from stratum two, and 30 from stratum three. We selected all 34 beneficiary starts-of-care in stratum four. Our total sample size was 124 beneficiary starts-of-care.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services, (OAS) statistical software random number generator.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units within strata one through three. After generating the random numbers for these strata, we selected the corresponding beneficiary starts-of-care in each stratum. We selected all beneficiary starts-of-care from stratum four.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of Medicare overpayments paid to the Agency during the audit period and the amount of the overpayments paid within the 3-year recovery period. We also calculated a non-statistical estimate of the overpayment amount outside the 3-year recovery period. To obtain this amount, we subtracted our estimate of the overpayments within the 3-year recovery period at the lower limit of the 90-percent confidence interval from our estimate of the total overpayments at the lower limit of the 90-percent confidence interval.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

OVERALL SAMPLE RESULTS²⁵

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Net Overpayments In Sample
1	1,810	\$3,778,557	30	\$64,437	23	\$47,740
2	995	3,882,912	30	120,262	21	67,491
3	739	6,773,541	30	294,316	25	137,914
4*	34	1,592,474	34	1,592,474	27	244,463
Total	3,578	\$16,027,484	124	\$2,071,489	96	\$497,608

* We reviewed all sample items in this stratum.

ESTIMATES

**Estimates of Net Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

Point Estimate	\$8,760,526
Lower Limit	\$7,549,283
Upper Limit	\$9,971,769

²⁵ The sample of 124 beneficiary starts-of-care included 555 claims. Ninety-six of the sample of 124 starts-of-care contained billing errors, which included 156 of 555 claims.

SAMPLE RESULTS WITHIN THE 3-YEAR RECOVERY PERIOD

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Net Overpayments In Sample
1	1,810	\$3,778,557	30	\$64,437	21	\$42,393
2	995	3,882,912	30	120,262	19	58,375
3	739	6,773,541	30	294,316	22	115,166
4*	34	1,592,474	34	1,592,474	24	195,908
Total	3,578	\$16,027,484	124	\$2,071,489	86	\$411,842

* We reviewed all sample items in this stratum.

ESTIMATES

**Estimates of Net Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

Point Estimate	\$7,526,643
Lower Limit	\$6,382,323
Upper Limit	\$8,670,963

MEDICARE NET OVERPAYMENTS OUTSIDE THE 3-YEAR RECOVERY PERIOD

ESTIMATES

**Non-statistical Estimates of Net Overpayments for the Audit Period
(Limits calculated for a 90-Percent Confidence Interval)**

Total Overall Lower Limit	\$7,549,283
Less: Lower Limit for the Net Overpayment for Claims Within 3-year Recovery Period	<u>\$6,382,323</u>
Difference: Estimated Net Overpayments for Claims Outside 3-year Recovery Period	\$1,166,960

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
1	2	-	-	-	\$0.00
2	1	-	-	1	2,669.97
3	1	1	-	-	1,820.91
4	1	1	-	-	2,291.89
5	1	1	-	-	2,769.31
6	1	-	1	-	2,677.56
7	1	-	1	-	1,582.45
8	1	1	-	-	2,226.76
9	1	-	1	-	(349.14)
10	1	1	-	-	1,485.67
11	1	-	-	-	0.00
12	1	-	-	-	0.00
13	1	1	-	-	1,820.91
14	1	-	-	1	2,693.07
15	1	1	-	-	1,988.29
16	1	-	-	-	0.00
17	1	-	1	-	2,346.47
18	1	-	1	-	2,677.56
19	1	-	-	1	2,902.83
20	1	1	-	-	2,677.56
21	1	-	1	-	2,728.63
22	1	1	-	-	256.32
23	1	-	1	-	1,820.91
24	1	-	1	-	2,803.72
25	1	-	1	-	663.74
26	2	-	-	-	0.00
27	1	-	1	-	2,769.31
28	1	-	1	-	2,415.87
29	2	-	-	-	0.00
30	1	-	-	-	\$0.00

STRATUM 2

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
31	1	1	-	-	\$4,146.13
32	1	1	-	-	3,093.70
33	1	-	1	-	3,962.16
34	1	1	-	-	4,189.18
35	1	-	1	-	3,962.16
36	1	-	1	-	3,732.17
37	1	-	-	-	0.00
38	3	-	-	-	0.00
39	1	-	1	-	730.40
40	4	-	-	-	0.00
41	3	-	-	-	0.00
42	3	1	-	-	2,226.76
43	3	-	-	-	0.00
44	3	-	-	-	0.00
45	1	-	1	-	3,253.02
46	1	-	1	-	3,022.37
47	1	-	-	-	0.00
48	2	1	-	-	2,238.88
49	1	-	-	-	0.00
50	1	-	-	-	0.00
51	3	-	-	1	450.80
52	1	1	-	-	3,458.78
53	3	-	1	-	2,677.56
54	2	2	-	-	4,374.40
55	1	1	-	-	541.79
56	1	1	-	-	3,458.78
57	2	2	-	-	4,532.10
58	1	1	-	-	4,046.01
59	2	-	2	-	4,583.78
60	1	1	-	-	\$4,809.70

STRATUM 3

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
61	4	4	-	-	\$13,682.63
62	3	3	-	-	7,411.94
63	5	1	-	-	2,677.56
64	4	1	-	-	3,511.08
65	1	1	-	-	3,544.78
66	6	1	-	-	2,226.76
67	6	1	1	-	5,093.43
68	4	-	1	1	9,302.94
69	5	4	1	-	13,287.84
70	2	-	-	-	0.00
71	2	-	1	-	3,159.50
72	4	1	-	-	555.26
73	2	-	-	-	0.00
74	4	-	1	-	2,226.76
75	4	-	1	-	2,769.31
76	2	-	2	-	5,538.62
77	3	-	3	-	8,039.54
78	2	-	2	-	6,070.58
79	5	5	-	-	12,767.25
80	5	-	2	-	4,271.04
81	10	-	-	-	0.00
82	2	-	-	-	0.00
83	2	2	-	-	5,355.12
84	3	-	1	-	5,028.74
85	11	-	-	-	0.00
86	2	2	-	-	6,456.31
87	4	1	-	-	2,135.52
88	2	-	2	-	532.42
89	4	-	4	-	9,779.84
90	5	-	1	-	\$2,489.03

STRATUM 4

Sample	No. of Claims	Not Homebound	Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
91	10	-	-	1	\$2,291.89
92	13	-	-	1	3,496.02
93	10	-	-	1	2,934.41
94	9	-	2	-	10,952.43
95	10	-	-	1	3,180.35
96	11	-	-	1	12,556.79
97	12	-	-	1	122.46
98	9	-	-	3	16,118.88
99	11	-	-	2	6,808.35
100	10	-	-	2	4,707.76
101	12	-	-	-	0.00
102	9	-	-	-	0.00
103	8	-	-	-	0.00
104	12	-	-	1	2,291.89
105	10	-	-	-	0.00
106	10	-	-	6	16,062.49
107	12	2	-	3	19,310.88
108	12	-	-	-	0
109	12	1	-	-	2,291.89
110	13	4	-	2	19,854.65
111	12	-	-	2	5,369.75
112	10	-	-	1	7,932.82
113	10	-	-	3	17,295.45
114	12	-	-	1	2,904.17
115	12	-	-	4	14,698.37
116	5	-	-	-	0.00
117	9	-	-	1	5,238.95
118	10	-	-	2	15,628.60
119	12	-	-	1	122.45
120	10	-	-	2	11,475.46
121	10	-	-	2	11,142.99
122	8	-	1	-	6,723.86
123	10	-	1	3	22,948.63
124	8	-	-	-	0.00
Total	555	57	47	52	\$497,607.64
Total	Start of Care	37	36	29	102*

* Six starts-of-care contained claims for which we determined that there were overpayments associated with more than 1 billing error category.

APPENDIX F: AGENCY COMMENTS

NEW YORK
LONDON
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SAN FRANCISCO
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ALLIANCE WITH
MIRANDA & ESTAVILLO
SRI LANKA
ALLIANCE WITH
GOWERS INTERNATIONAL

March 2, 2016

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Jacob K. Javits Federal Building
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New York, NY 10278

Re: Report No. A-02-14-01005 Excellent Home Care Services, LLC

Dear Mr. Edert:

I have been engaged by Excellent Home Care Services, LLC (the "Provider") to respond to your letter of December 11, 2015 enclosing the report of the draft audit of the subject Provider. The Provider has authorized me to set out its comments herein. Thank you for extending the time for response to and including March 2, 2016. We have a number of general comments as well as responses to the individual findings made with regard to specific encounters. We ask that these comments be reviewed and that your audit be adjusted accordingly.

General Comments: the following comments are applicable in general to all of the audit findings.

1. Use of Face to Face encounter forms:

- a. Often, the auditors seized upon comments in the face to face narrative that were inconsistent with other physician or professional staff documentation in the record to deny reimbursement which would otherwise be allowed. It is no secret that in this industry doctors document poorly. They are pressed with other duties and responsibilities, and derive no direct financial benefit from taking the time to

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complete the required reports fully and consistently. Therefore, often the face to face encounter narrative contains an "off the top of the head" assessment which may be inconsistent with the more formal documentation prepared and submitted in the plan of care and elsewhere and may not address the formal criteria needed to establish "home bound" or "skilled needs". The face to face narrative should not be relied upon to disallow otherwise valid claims. We understand that the National Homecare Association is suing HHS on the use of the face to face forms. That suit is not yet resolved. The form should not be used as a basis for disallowance if there is other appropriate assessment information in the record.

b. We note that in some of the cases, there are denials based on the auditors' claim that the physician's signature on the face to face narrative is not genuine. We do not believe the auditors should double as handwriting experts. These denials will be identified and rebutted in individual cases.

c. In some cases, there were disallowances because the physician did not date the form, others did. This is an unacceptable disallowance and must be reversed. If the physician signs the form the fact that (perhaps) another person may have indicated the date before the form was presented to the physician, does not invalidate the physician's signature, or the date for that matter. If the physician believes the date is incorrect he could cross it out. All disallowances in this category should be reversed.

In those cases where the physician did not date, and there is no date on the form, the claim should be allowed in the event that extrinsic evidence can establish that the examination occurred within the appropriate period.

2. Disallowances Based on 485 Form (Plan of Care)

- a. There are some instances where the physician did not date the 485 Form. In these cases as well if it can be established by extrinsic evidence that the physician signed the 485 at a certain time (for example there are other dates on the form where other professionals attested to when certain things were accomplished) then there should be no disallowance. The fact that a busy physician does not date his signature should not disqualify payment if the date of the signature can be established by outside evidence. Moreover, it is the Provider's practice that all its documents are stamped indicating "Received Date", and such "Received Date" is always prior to the billing date. Documentation must be complete prior to billing.
- b. There were some disallowances because the physician did not sign each and every page of the form 485. We are aware of no specific requirement that the physician sign each page. Moreover there are times that there is

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no place for the doctor's signature on each page. Since it is clear signature on each page is not required, all of the denials based on a failure of a doctor to sign all pages should be reversed. Chapter 7 of the Medicare Beneficiary Policy Manual at Section 30.2.6 states that each review must contain a physician signature. Nothing is stated about signing every page of the form.

3. Adult Care Facility Cases: Some of these involve wound care or insulin delivery. The auditors stated that the facility did not establish that the patients were homebound. Home in this case is the Adult Care Facility. The fact the patients are in an Adult Care Facility does not mean that they are not confined to "home". In New York State, Adult Care Facilities are precluded from providing skilled nursing services. In these circumstances, the resident's needs must be met by homecare. The fact that the home is a home for a number of residents does not change the fact that the patient's condition must be judged on the basis of their ability to ambulate or their ability to understand and negotiate their surroundings.
4. Therapy Issues: Sometimes there can be an order for therapy on the 485 Form. If there is no order for therapy on the 485 Form the physician can give a verbal order, which can become an addendum to the 485. This is customary done orally with subsequent transcription to a signed written order. There should be no disallowance merely because there is no order for therapy on the 485. The physician is required to countersign a verbal order including a telephone order. If he has done that, it becomes an addendum to the 485, and there should be no disallowance. In addition, there are cases when during the course of care, it is determined that therapy is appropriate. In that case, there will be an interim order which will be placed in the record. In these cases, therapy is appropriate where there is no notation on the 485 Form. No disallowance should occur in this circumstance.
5. Disallowance based on Oasis Form submitted later than 30 days from the time of care. The Provider never billed prior to receiving a completed Oasis form. Medicare allows billing up to 365 days after the service is rendered. Given this extensive period for the submission of claims, an Oasis cannot be "stale" because it was submitted later than 30 days from the institution of service.
6. Oasis Form "not submitted". There were 31 episodes that the auditors have denied due to "Oasis not submitted", or "Oasis was submitted after the claim receipt date". Unfortunately, the Provider's notebook in which the paper copies of the completed Oasis forms were maintained has been lost. The agency maintains that its invariable practice is to have its personnel submit the Oasis for validation in every case in advance of billing, and only to bill in circumstances where the Oasis came back "validated". The Provider has lost its hard copies of

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the documents, but we submit that the Medicare records should show electronically in almost every case that these Oasis forms were submitted and validated prior to the date of billing. We ask that OIG review the appropriate Medicare records to identify these submitted documents.

7. Changes in HHRG level. In some cases the auditors reviewed the level of care, and determined the HHRG level of care should be lower. They then recalculated the amount of benefit payable. The auditors did not inform the Provider of the reasons for lowering the HHRG level. In fact in several cases the auditors stated "we cannot pinpoint the discrepancy". In those cases therefore it is impossible to appropriately contest the reduction in level. It is important to remember that the Provider does not generate the HHRG score. This is done by the Medicare program based upon the information placed on the Oasis by the Provider. It is therefore inappropriate for the auditors to substitute their judgment for that of the computer program which has selected the appropriate HHRG.
8. Denial of payment for supplies: There were a number of disallowances for lack of supplies, even though in certain diagnostic categories supplies are paid for by the Medicare program. In some cases the HHRG category includes supplies. The auditors inexplicably "cross walked" these cases to HHRG's where supplies were not included. The agency never submitted invoices for supplies. At most the auditors should deduct the cost of the supplies, not the total cost of care.

We believe that if supplies are called for within a category of service, they should be paid as a bundled unit by Medicare whether or not invoices were submitted. The instructions were not clear that separate invoices for supplies should be submitted.

In conclusion, the workers employed by the Provider showed up at the homes of the patients, they gave care, and the outcomes are what one would expect from an aged infirm population. Documentation in the form of face to face encounters, 485's, addenda thereto, and evidence both of homebound status and necessity for care are present in almost all cases reviewed by the auditors. There is no allegation here that care was not given. What the auditors have done is identify a series of mostly technical areas where in their view the letter of the requirements were not fully satisfied. The projection of these disallowances over the entire universe of patients seen results in a catastrophic demand for repayment, which threatens the viability and continued life of this agency. The audit should be adjusted to eliminate doubtful disallowances and provide Excellent Home Care with the opportunity to continue to provide excellent home care.

Attached are rebuttals to the individual claims. You will note that not every claim is contested. The Provider concurred with some of the disallowances made by the auditors.

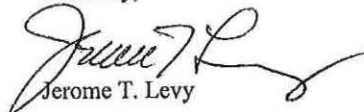
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Again, thank you for your courtesy in extending the time for response.

We would appreciate the opportunity to discuss this case with you and appropriate staff.

Sincerely,



Jerome T. Levy

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