



SEP 20 2005

REGION IV
61 Forsyth Street, S.W., Suite 3T41
Atlanta, Georgia 30303

Report Number: A-04-05-02000

Mr. Ron Arrington
President and Chief Executive Officer
Total Patient Care Home Health, LLC
6820 Southpoint Parkway, Suite #4
Jacksonville, Florida 32216

Dear Mr. Arrington:

Enclosed are two copies of the Office of Inspector General final report entitled "Review of Selected Paid Claims with Therapy Services Submitted to Medicare by Total Patient Care Home Health, LLC for the Period October 1, 2002, through September 30, 2003." A copy of this report will be forwarded to the Department of Health and Human Services (HHS) action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. 552, as amended by Public Law 104-231, Office of Inspector General reports are made available to members of the public to the extent the information is not subject to exemptions in the Act that the Department chooses to exercise (see 45 CFR Part 5).

Please refer to report number A-04-05-02000 in all correspondence.

Sincerely,

A handwritten signature in black ink, appearing to read "L. Pilcher", with a long horizontal line extending to the right.

Lori S. Pilcher
Regional Inspector General
for Audit Services, Region IV

Enclosures—as stated

Direct Reply to HHS Action Official:

Mr. Roger Perez, Acting Regional Administrator
Centers for Medicare & Medicaid Services, Region IV
Department of Health and Human Services
61 Forsyth Street, S.W., Suite 4T20
Atlanta, Georgia 30303

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF SELECTED PAID CLAIMS
WITH THERAPY SERVICES
SUBMITTED TO MEDICARE BY TOTAL
PATIENT CARE HOME HEALTH, LLC
FOR THE PERIOD OCTOBER 1, 2002,
THROUGH SEPTEMBER 30, 2003**



**Daniel R. Levinson
Inspector General**

**SEPTEMBER 2005
A-04-05-02000**

Office of Inspector General

<http://oig.hhs.gov>

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

Office of Audit Services

The Office of Audit Services (OAS) provides all auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations in order to reduce waste, abuse, and mismanagement and to promote economy and efficiency throughout HHS.

Office of Evaluation and Inspections

The Office of Evaluation and Inspections (OEI) conducts management and program evaluations (called inspections) that focus on issues of concern to HHS, Congress, and the public. The findings and recommendations contained in the inspections generate rapid, accurate, and up-to-date information on the efficiency, vulnerability, and effectiveness of departmental programs. OEI also oversees State Medicaid Fraud Control Units which investigate and prosecute fraud and patient abuse in the Medicaid program.

Office of Investigations

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of allegations of wrongdoing in HHS programs or to HHS beneficiaries and of unjust enrichment by providers. The investigative efforts of OI lead to criminal convictions, administrative sanctions, or civil monetary penalties.

Office of Counsel to the Inspector General

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support in OIG's internal operations. OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within HHS. OCIG also represents OIG in the global settlement of cases arising under the Civil False Claims Act, develops and monitors corporate integrity agreements, develops compliance program guidances, renders advisory opinions on OIG sanctions to the health care community, and issues fraud alerts and other industry guidance.

Notices

THIS REPORT IS AVAILABLE TO THE PUBLIC
at <http://oig.hhs.gov>

In accordance with the principles of the Freedom of Information Act (5 U.S.C. 552, as amended by Public Law 104-231), Office of Inspector General, Office of Audit Services reports are made available to members of the public to the extent the information is not subject to exemptions in the act. (See 45 CFR Part 5.)

OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.



EXECUTIVE SUMMARY

BACKGROUND

A home health agency (HHA) provides home visits for skilled nursing care; home health aide; occupational, physical and speech therapy; and medical social services.

Under the home health prospective payment system, Medicare pays for home health services based on a national standardized 60-day service period called an episode. The payment is based upon the beneficiary's health condition and level of care needed during the episode. To establish a level of care, including the expected therapy needs (i.e., physical, speech, or occupational), HHAs use an Outcome and Assessment Information Set (OASIS) instrument. The OASIS instrument is used to determine the appropriate Medicare reimbursement amount.

One item on the OASIS instrument indicates the need for home health therapies totaling 10 or more visits during the episode. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. When the 10-visit threshold is met, HHA receives a payment increase of about \$2,300 more than what HHA would have received for a similar claim with 9 or fewer therapy visits. To qualify for Medicare reimbursement, therapy services must be medically necessary, properly documented, and properly authorized by a physician.

Total Patient Care Home Health, LLC (Total Patient Care) is an HHA in Jacksonville, FL. With the assistance of medical professionals, we reviewed selected claims submitted by Total Patient Care and paid by Medicare. The claims selected for review included home health episodes with 10, 11, or 12 therapy visits with dates of service from October 1, 2002, through September 30, 2003. For that period, there were 192 claims billed by Total Patient Care with 10, 11, or 12 therapy visits and paid by Medicare at the higher rate, totaling \$759,892.

OBJECTIVE

Our objective was to determine whether selected home health claims that included therapy services provided by Total Patient Care to Medicare beneficiaries met Federal requirements and were appropriately paid.

SUMMARY OF FINDINGS

Palmetto Government Benefits Administrator's medical reviewers determined that 22 of 100 sampled claims for therapy services submitted by Total Patient Care were not appropriately paid. While the medical reviewers determined the therapy services were medically necessary, they found that these 22¹ claims did not meet one or more of the other Federal requirements:

- therapy services not properly authorized,
- therapy services not provided as ordered,

¹Some claims had more than one type of error; therefore, some claims are included in more than one error category. As a result, the number of claims in the listing of errors exceeds 22 claims.

- payment codes inaccurate, and
- medical records incomplete.

The provider received \$43,088 in overpayments from Medicare for the sampled claims that did not meet the Federal requirements. Projecting the results of the overpayments in our random sample to the universe, the provider received an estimated \$63,425 in overpayments for claims billed to Medicare. Based on the results of the medical review, we concluded that Total Patient Care did not have adequate billing procedures in place to ensure claims submitted were in compliance with Federal requirements.

RECOMMENDATIONS

We recommend that Total Patient Care:

- refund to the Medicare program the \$63,425 in unallowable payments made for services provided from October 1, 2002, to September 30, 2003;
- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and
- strengthen billing controls to ensure that, prior to submitting a claim for final payment, the claims are accurately completed, and all therapy services are properly authorized and provided as ordered by a physician.

TOTAL PATIENT CARE'S COMMENTS

In its comments on the draft report, Total Patient Care agreed with our findings related to the claims for services provided from October 1, 2002, to September 30, 2003. Total Patient Care also agreed with our recommendation to strengthen billing controls, stating that, subsequent to our audit, it tightened controls for pre-billing audits and re-vamped personnel to preclude a continuation of similar results. We included the full text of Total Patient Care's comments as Appendix C to this report.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Home Health Agency.....	1
Home Health Legislation	1
Home Health Prospective Payment System.....	1
Regional Home Health Intermediary Responsibility	2
Total Patient Care Home Health, LLC	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective.....	2
Scope.....	2
Methodology.....	3
FINDINGS AND RECOMMENDATIONS	4
SERVICES NOT PROPERLY AUTHORIZED	4
SERVICES NOT PROVIDED AS ORDERED	5
INACCURATE PAYMENT CODES	6
INCOMPLETE MEDICAL RECORDS	6
EFFECT OF IMPROPER BILLINGS.....	6
LACK OF EFFECTIVE CONTROLS	7
RECOMMENDATIONS.....	7
TOTAL PATIENT CARE’S COMMENTS	7
APPENDIXES	
A - SAMPLING METHODOLOGY	
B - STATISTICAL SAMPLE INFORMATION	
C – TOTAL PATIENT CARE’S COMMENTS ON DRAFT REPORT	

INTRODUCTION

BACKGROUND

Home Health Agency

A home health agency (HHA) provides home visits for skilled nursing care; home health aide; occupational, physical and speech therapy; and medical social services.

Home Health Legislation

The Centers for Medicare & Medicaid Services (CMS) was required to implement a prospective payment system (PPS) for Medicare HHA services pursuant to the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Accordingly, CMS implemented a PPS for HHAs effective October 1, 2000.

Home Health Prospective Payment System

The home health PPS classifies home health services into 80 mutually exclusive groups called home health resource groups. Each home health resource group is assigned a five-character Health Insurance PPS code (payment code), which represents the beneficiary's needs over a 60-day service period, called an episode.

CMS established a split percentage billing for each 60-day episode. Under this system, an HHA receives a partial episode payment, usually 60 percent, as soon as it notifies Medicare of an admission and a final payment at the close of the 60-day episode. The HHA's final payment may increase or decrease in response to the difference between the projected services (e.g., therapy) at the start of care and the services received by the patient by the end of the 60-day episode.

The Outcome and Assessment Information Set (OASIS) instrument, which includes a group of standardized data elements, is used to assess the level of care needed by each home health patient. The OASIS instrument is, in large part, the basis for determining which home health resource group a particular claim falls into and, as a result, what payment is made for the services provided. Data elements on the OASIS instrument are organized into three categories: (1) clinical severity, (2) functional status, and (3) service utilization. One item under the service utilization category indicates the need for home health therapies totaling 10 or more visits during the episode. A patient's "scores" for the three categories are totaled, and a home health resource group, also known as a payment code, is assigned.

HHAs submit claims for reimbursement using the designated Medicare payment codes. These codes determine the reimbursement amount. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. Episodes with fewer than 10 therapy visits are referred to as below the therapy threshold. When the 10-visit threshold is met, the

HHA receives a payment increase of about \$2,300 more than what the HHA would have received for a similar claim with 9 or fewer therapy visits.

Regional Home Health Intermediary Responsibility

CMS contracts with four regional home health intermediaries nationwide to process claims, assist in applying safeguards against unnecessary utilization of services, resolve disputes, and audit cost reports submitted by HHAs.

Total Patient Care Home Health, LLC

Total Patient Care Home Health, LLC (Total Patient Care) is a Medicare-certified HHA located in Jacksonville, FL. Total Patient Care changed its corporation status under the State of Delaware from a C Corporation (standard business corporation) to a limited liability company on December 31, 2004. The intermediary for Total Patient Care is Palmetto Government Benefits Administrator (Palmetto GBA).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether selected home health claims that included therapy services provided by Total Patient Care to Medicare beneficiaries met Federal requirements and were appropriately paid.

Scope

We reviewed Palmetto GBA's Medicare final payments to Total Patient Care for home health claims that included therapy visits with dates of service from October 1, 2002, through September 30, 2003. For that period, Total Patient Care submitted 407 home health claims that included one or more therapy visits provided to beneficiaries and paid by Medicare. Based on a risk analysis, we limited our review to claims that included 10, 11, or 12 therapy visits. Of the 407 paid claims, 200 claims included 10, 11, or 12 therapy visits, which totaled \$770,275. Of those claims, 8 were excluded from review because the claims were originally paid at lower service utilization amounts (i.e., as if there were fewer than 10 therapy visits). To accomplish our objective, we selected a random sample of 100 claims totaling \$392,773 from a population of 192 claims.

We limited our review of internal controls at Total Patient Care to those controls over the preparation and submission of Medicare HHA claims. Our objective did not require us to review the complete internal control structure at Total Patient Care. We conducted audit work from November 2004 through April 2005, which included visits to Total Patient Care's office in Jacksonville, FL.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- identified Total Patient Care's home health PPS paid claims from the Medicare National Claims History File with dates of service from October 1, 2002, through September 30, 2003, that included episodes with at least one therapy service;
- selected a random sample of 100 claims from a universe of 192 paid claims submitted by Total Patient Care to Medicare for home health episodes with 10, 11, or 12 therapy services during the period October 1, 2002, through September 30, 2003;
- obtained Total Patient Care's medical records for each claim selected and provided those records to Palmetto GBA for medical review;
- obtained medical review data, which included a determination by medical reviewers of reasonableness, of medical necessity, and of adequate support and proper authorization of services billed, and summarized the results;
- reviewed Total Patient Care's policies and procedures for providing and billing Medicare for home health episodes with therapy services;
- interviewed a Total Patient Care's physical therapist and reviewed documentation supporting a therapist's time with selected patients;
- determined, with the assistance of medical reviewers, what the appropriate payment code and amount would have been for claims with unallowable services; and
- quantified the Medicare overpayment for identified unallowable services billed by Total Patient Care.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Palmetto GBA's medical reviewers determined that 22 of 100 sampled claims for therapy services submitted by Total Patient Care were not appropriately paid. While the medical reviewers determined the therapy services were medically necessary, they found that these 22 claims did not meet one or more of the other Federal requirements:

- therapy services not properly authorized,
- therapy services not provided as ordered,
- payment codes inaccurate, and
- medical records incomplete.

The provider received \$43,088 in overpayments from Medicare for the sampled claims that did not meet the Federal requirements. Projecting the results of the overpayments in our random sample to the universe, the provider received an estimated \$63,425 in overpayments for claims billed to Medicare. Based on the results of the medical review, we concluded that Total Patient Care did not have adequate billing procedures in place to ensure claims submitted were in compliance with Federal requirements.

SERVICES NOT PROPERLY AUTHORIZED

Federal regulations (42 CFR § 424.22(a)(2)) state, "The certification of need for home health services must be obtained at the time the plan of treatment is established or as soon thereafter as possible and must be signed by the physician who establishes the plan." In addition, § 424.22(b)(1) states, "Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan of care."

Also, 42 CFR § 409.43(c)(3) states, "The plan of care must be signed and dated (i) By a physician as described who meets the certification and recertification requirements...and (ii) Before the claim for each episode for services is submitted for the final percentage prospective payment." In addition, CMS Transmittal A-00-71 provides clarification on orders for services, "The physician must specify the frequency and the expected duration of the visits for each discipline."

Based on a review of medical records for selected home health claims, the medical reviewers determined that 10 claims did not have a proper physician authorization as required. As a result, the provider received \$21,651 in overpayments. The 10 claims without proper authorization included:

- six claims with plans of care or orders not dated by the physician,
- two claims with orders dated after final bill submitted to Medicare,

- one claim with orders not signed by the physician, and
- one claim with orders neither dated nor specifying frequency or duration.

Examples of therapy services not properly authorized among the 10 claims include the following:

- One claim that included only therapy services had a plan of care that was not dated by the physician, and the HHA provided therapy services beyond the weeks indicated. Because all the therapy visits were denied, the medical reviewer determined the entire claim was unallowable and denied the \$3,963 paid by Medicare.
- Another claim had 10 therapy services and other services provided. The physician did not sign the orders for nine therapy services. As a result, the medical reviewers determined that the therapy threshold had not been met and the claim payment code was changed to a lower utilization level, which reduced the allowable Medicare reimbursement by \$1,944.

SERVICES NOT PROVIDED AS ORDERED

Federal regulations (42 CFR § 409.43(b)) state, “The physician’s orders for services in the plan of care must specify ... at what frequency the services will be furnished.... If a range of visits is ordered, the upper limit of the range is considered the specific frequency.” As previously stated, CMS Transmittal A-00-71 provides clarification on orders for services, “The physician must specify the frequency and the expected duration of the visits for each discipline.”

Reviewers determined that 11 claims had therapy services that were not provided as ordered on the physician’s plan of care or additional orders (i.e., the frequency or duration for a particular week was exceeded). As a result, the provider received \$23,409 in overpayments. Examples of the unapproved services among the 11 claims include the following:

- One claim billed a total of 11 physical and occupational therapy services. During the HHA episode, the patient was admitted to the hospital for 2 weeks. The occupational therapy was resumed after the patient returned home. The medical reviewers denied the two occupational therapy services provided at the later date because the duration of the orders was exceeded. As a result, only nine therapy services were approved; therefore, the therapy threshold was not met, and the allowable reimbursement to Total Patient Care was reduced by \$2,291.
- Another claim that billed 11 therapy visits had orders indicating that 2 visits had been provided at the time specified in the orders. In addition, the orders specified two therapy visits for one of the weeks; however, therapy was provided three times in that week. As a result of the three denied visits, only eight therapy visits were approved. Consequently, the medical reviewers determined the therapy threshold was not met and the claim payment code was changed to a lower utilization level, which reduced the allowable Medicare reimbursement to Total Patient Care by \$1,944.

INACCURATE PAYMENT CODES

The CMS Home Health Agency Manual for billing procedures classifies home health services into 80 home health resource groups. Each home health resource group is assigned a five-character payment code, which represents the case mix as defined by Federal regulation 42 CFR § 484.202. The OASIS instrument is used to assess the level of care needed by each home health patient, and is the basis for determining which home health resource group a particular claim falls into and, as a result, what payment is made for the services provided.

Payment codes on three claims were not accurately reflected in the billing. As a result, the provider received \$3,828 in overpayments. The medical reviewers recalculated the OASIS instrument for each sampled claim and determined that three had been miscalculated based on the medical records provided. For each error, the new payment code resulted in a reduced payment from Medicare.

On one claim, Total Patient Care had selected the wrong category when completing the OASIS, which resulted in an incorrect payment code on the bill. Medical reviewers changed the payment code from HDGM1 to HCGM1, which reduced the reimbursement amount by \$813.

INCOMPLETE MEDICAL RECORDS

Federal regulations (42 CFR § 484.48) require that:

A clinical record...[be] maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician, drug, dietary, treatment, and activity orders, signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

The medical reviewers determined that four claims did not include all the documentation required, resulting in overpayments of \$9,030. The four claims without the required documentation were missing therapy visit notes and physician orders. For example, 1 claim for a home health episode included 10 physical therapy services of which 1 was not documented in Total Patient Care's medical records as required by Medicare PPS regulations. The billed claim listed two physical therapy visits on the same day. The medical records contained only one note, and no other documents indicated that the physical therapy services were provided twice on that day. Consequently, the medical reviewers denied one billed physical therapy service and changed the claim's payment code to a lower service utilization level, reducing the allowable Medicare reimbursement to Total Patient Care by \$2,398.

EFFECT OF IMPROPER BILLINGS

The sum of overpayments for all four findings equals \$57,918. However, six of the claims had duplicate errors totaling \$14,830. The net result is a \$43,088 overpayment the provider received from Medicare for the sampled claims that did not meet the Federal requirements. Projecting the results of the overpayments in our random sample to the universe, the provider received an

estimated \$63,425 in overpayments for claims billed to Medicare. The sampling methodology is included in Appendix A.

LACK OF EFFECTIVE CONTROLS

Based on the results of the medical review, we concluded that Total Patient Care did not have adequate billing procedures in place to ensure claims submitted for final payment were in compliance with Federal requirements.

RECOMMENDATIONS

We recommend that Total Patient Care:

- refund to the Medicare program the \$63,425 in unallowable payments made for services provided from October 1, 2002, to September 30, 2003;
- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and
- strengthen billing controls to ensure that, prior to submitting a claim for final payment, the claims are accurately completed and all therapy services are properly authorized and provided as ordered by a physician.

TOTAL PATIENT CARE'S COMMENTS

In its comments on the draft report, Total Patient Care agreed with our findings related to the claims for services provided from October 1, 2002, to September 30, 2003. Total Patient Care also agreed with our recommendation to strengthen billing controls, stating that, subsequent to our audit, it tightened controls for pre-billing audits and re-vamped personnel to preclude a continuation of similar results. We included the full text of Total Patient Care's comments as Appendix C to this report.

APPENDIXES

APPENDIX A

SAMPLING METHODOLOGY

OBJECTIVE

The audit objective was to determine whether selected home health claims that included therapy services provided by Total Patient Care to Medicare beneficiaries met Federal requirements and were appropriately paid. To achieve our objective, we selected an unrestricted, random sample of Palmetto GBA's Medicare claims from the universe of claims paid to Total Patient Care for services provided October 1, 2002, through September 30, 2003.

POPULATION

The universe consisted of 192 claims with 10, 11 or 12 therapy services from October 1, 2002, through September 30, 2003, for which Total Patient Care received an enhanced payment for therapy. Total Patient Care received \$759,892 in Medicare reimbursement for these 192 claims.

SAMPLING UNIT

The sampling unit was a claim with 10, 11, or 12 therapy visits performed from October 1, 2002, through September 30, 2003.

SAMPLING DESIGN

An unrestricted random sample of Palmetto GBA's Medicare paid claims.

SAMPLE SIZE

A sample of 100 claims.

APPENDIX B

STATISTICAL SAMPLE INFORMATION

<u>POPULATION</u>	<u>SAMPLE</u>	<u>ERRORS</u>
Items: 192 Claims Dollars: \$759,892	Items: 100 Claims Dollars: \$392,773	Items: 22 Claims Dollars: \$43,088

The sample projection was obtained using the RAT-STATS unrestricted variable appraisal program. We reported the lower limit of the 90 percent confidence interval. Details of our projection appear below:

Projection of Sample Results
90 Percent Confidence Interval

Point Estimate:	\$82,730
Precision Amount:	\$19,305
Lower Limit:	\$63,425
Upper Limit:	\$102,034

TPC

Total Patient Care Home Health, Inc.

"Home is the best place to be...with TPC"

*Lori S. Pilcher
Regional Inspector General for Audit Services, Region IV
61 Forsyth Street, S.W. Suite 3T41
Atlanta, Georgia 30303*

Ms. Pilcher:

We have researched the claims against Total Patient Care as identified in your report attached to your letter of July 19, 2005. Although we are disappointed in our lack of billing controls that led to this result, we cannot disagree with your findings. The period included in your study pertained to a period shortly following our acquisition of Total Patient Care and we were dissatisfied with our audit controls prior to billing.

Total Patient Care has since tightened our controls for pre-billing audits and re-vamped our personnel to preclude a continuation of similar results.

We do appreciate the professional manner in which you conducted your audit.

Sincerely Yours,



Ronald R. Arrington
President and Administrator