Department of Health and Human Services
Office of Inspector General
Office of Audit Services

August 2026 | A-05-24-00007

Medicare Home Health Agency Provider Compliance Audit: Deistic Home Health Care, Inc.

REPORT HIGHLIGHTS

August 2026 | A-05-24-00007

Medicare Home Health Agency Provider Compliance Audit: Deistic Home Health Care, Inc.

Why OIG Did This Audit

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional fee-for-service Medicare. In that year, nearly 10,000 HHAs participated in Medicare.

- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.

- This audit report, part of a nationwide series of home health audits, examined whether Deistic Home Health Care, Inc. (Deistic), complied with Medicare requirements.

What OIG Found

For the audit period (January 1, 2021, through December 31, 2022), Deistic complied with Medicare billing requirements for 63 of the 100 sampled home health claims we reviewed. For the remaining 37 claims, Deistic incorrectly billed Medicare $8,332 in net overpayments. Specifically:

- Thirty-six claims did not meet billing and coding requirements.
- Five claims did not meet face-to-face encounter requirements.

The total number of errors exceeds 37 because 4 claims had errors in both error categories.

We determined that these errors occurred because Deistic did not always review medical record documentation to prevent the incorrect billing of Medicare claims.

Based on our sample results, we estimated that, of the $15,301,644 in Medicare payments covered by our audit, Deistic received net overpayments of at least $43,074 for the audit period. Deistic's provider agreement with the Medicare program was voluntarily terminated on August 1, 2025.

What OIG Recommends

We recommended that Deistic refund to the Federal Government $43,074 in estimated net overpayments.

Deistic elected not to provide comments on the draft report.

TABLE OF CONTENTS

INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional fee-for-service Medicare (enrollees). In that year, nearly 10,000 HHAs participated in Medicare. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims (which is calculated based on July 1, 2021 – June 30, 2022, payments) was 7.7 percent, or about $1.2 billion. This audit is part of a series of HHA compliance audits.[1] Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Deistic Home Health Care, Inc. (Deistic), was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Deistic complied with Medicare requirements for billing home health services on selected types of claims.[2]

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare (Parts A and B) covers eligible home health services such as intermittent skilled nursing and home aide visits, covered therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health Prospective Payment System (PPS), CMS pays HHAs a national, standardized 30-day period payment rate.[3] This standardized payment rate is adjusted by using variables in the Patient-Driven Groupings Model (PDGM) that account for the enrollee's condition and health care needs.[4] For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called Home Health Resource Groups (HHRGs).

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis),

[1] See Appendix B for a list of related Office of Inspector General reports on Medicare home health compliance. For more information, see Work Plan Summary, accessed on Feb. 12, 2026.

[2] We did not include the following types of claims in our audit that we judged as low risk for waste and abuse: Requests for Anticipated Payment, Notices of Admissions, Low Utilization Payment Adjustments, and Partial Episode Payments.

[3] Adjustments are made for geographic differences in wage levels.

[4] The PDGM became effective Jan. 1, 2020.

Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue to, receive home health services. CMS requires HHAs to submit OASIS data as a condition of payment.[5] CMS uses the HHRGs as the basis for the Health Insurance Prospective Payment System (HIPPS) codes, which determine payment.[6]

While home health PPS payment is made for each 30-day period, patient eligibility is determined based on a 60-day certification period. Medicare permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications as long as the enrollee meets eligibility requirements. Each 60-day certification can include two 30-day payment periods.

CMS administers the Medicare program and contracts with Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs in four jurisdictions.[7]

Medicare Requirements for Home Health Services and Claims

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)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR §§ 409.42 and 424.22 require, as a condition of payment for home health services, that a physician or other allowed practitioner[8] certify and recertify that the Medicare enrollee is:

- Confined to the home (homebound)
- In need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or has a continuing need for occupational therapy
- Under the care of a physician or allowed practitioner

[5] 42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

[6] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and HHAs. For more information, see CMS | HIPPS Codes, accessed on Feb. 12, 2026.

[7] The MACs are National Government Services, Inc. (two jurisdictions); CGS Administrators, LLC (one jurisdiction); and Palmetto GBA, LLC (one jurisdiction).

[8] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

- Receiving services under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner

Furthermore, as a condition for payment, a practitioner must certify that a face-to-face (F2F) encounter occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)).[9] 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)).

The determination of whether care is reasonable and necessary is based on information provided on the forms and in the medical record (e.g., plan of care, certification or recertification statement, the OASIS, progress notes) concerning the unique medical condition of the individual. Coverage determination is not made solely on the basis of general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the enrollee's individual need for care (42 CFR § 409.44(a)).

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

Reopening of Claims

Medicare contractors may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[10] National Government Services, Inc. (NGS), Deistic's Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims.

Deistic Home Health Care, Inc.

Deistic was a for-profit HHA headquartered in La Crescenta, California.[11] National Government Services, its MAC, paid Deistic approximately $16 million for 7,073 claims for services provided to enrollees during CYs 2021 and 2022 (audit period), identified in CMS's Integrated Data Repository (IDR) data.[12]

[9] The F2F encounter can be performed by the certifying physician or allowed practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

[10] 42 CFR § 405.980(b)(2).

[11] Deistic's provider agreement with the Medicare program was voluntarily terminated on Aug. 1, 2025.

[12] This was the most recent timeframe for which claims data were available at the start of the audit.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $15,301,644 in Medicare payments to Deistic for 6,836 claims for services provided during the audit period.[13] We selected a simple random sample of 100 claims with payments totaling $212,579 for review. We evaluated these claims for compliance with selected billing requirements and submitted these claims to independent 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 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 A contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains the types of errors for each sample item.[14]

FINDINGS

Deistic complied with Medicare billing requirements for 63 of the 100 sampled home health claims that we reviewed. For the remaining 37 claims, Deistic incorrectly billed Medicare for services that did not meet billing and coding requirements (36 claims) and did not meet F2F encounter requirements (5 claims).[15] For 30 of these claims, the errors did not result in overpayments.[16] For seven claims, Deistic received net overpayments of $8,332.[17]

We determined that these errors occurred because Deistic did not always review medical record documentation to prevent the incorrect billing of Medicare claims. On the basis of our

[13] Our sampling frame included home health claim payments for 30-day billing periods with ending dates of service from Jan. 1, 2021, through Dec. 31, 2022, that had not been previously reviewed by a CMS contractor or were not identified as low risk for waste and abuse. We did not include Requests for Anticipated Payment (42 CFR § 484.205(i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[14] Sample items may have more than one type of error.

[15] Total exceeds 37 claims because 4 claims had more than 1 type of error.

[16] While these claim billing errors may not always result in overpayments, findings such as these can and do result in overpayments. Therefore, these findings are relevant to our objective of determining Deistic's compliance with Medicare requirements for billing home health services.

[17] Two of the seven claims qualified for partial Medicare reimbursement. For these two claims, we determined the difference between what was originally reimbursed and what was eligible for reimbursement. The remaining five claims were not eligible for any Medicare reimbursement.

sample results, we estimated that Deistic received net overpayments of at least $43,074 for the audit period.[18]

SERVICES DID NOT MEET BILLING AND CODING REQUIREMENTS

Effective January 1, 2020, Medicare pays HHAs for home health services under the Home Health PPS by means of a national, standardized 30-day payment rate calculated using the PDGM. Each 30-day billing period is categorized into 1 of 432 HHRGs for the purpose of adjusting payment under the PDGM.[19] In particular, 30-day billing periods are placed into different subgroups for each of the following broad categories: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses).[20]

CMS's home health PPS Grouper software automatically draws information from the home health claim and submitted OASIS assessment to group the 30-day billing period into a HHRG and assigns a corresponding HIPPS code. The HIPPS code is a five-position alphanumeric code that represents the case mix on which payment determinations are made.

Under the PDGM, the first 30-day period is classified as early. All subsequent 30-day periods in the sequence (second or later) are classified as late.[21]

The primary and secondary diagnoses reported on the home health claim, which are used to determine the HHRG and resulting HIPPS code, must be supported by information in the certifying practitioner's and/or the acute or post-acute facility's medical record (83 Fed. Reg. 56406, 56461 (Nov. 13, 2018); ICD-10-CM *Official Guidelines for Coding and Reporting*, section I.B.14; Medicare Program Integrity Manual, ch. 6, § 6.2.4).

For 36 of the sampled claims, Deistic submitted claims for services that did not meet billing and coding requirements. Of the 36 claims, 30 claims did not result in overpayments because the HIPPS code did not change: 3 claims with unsupported primary diagnoses, 26 with unsupported secondary diagnoses, and 1 claim with an unsupported primary and secondary diagnosis. For 2 of the 36 claims in error, Deistic submitted claims that were not supported by the timing of the episode or by the primary diagnosis code. Specifically, for one claim, Deistic submitted a late episode code, but the supporting documentation did not support a late episode. The

[18] To be conservative, we recommend recovery of net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[19] Adjustments are also made for geographic differences in wage levels.

[20] 84 Fed. Reg. 60478, 60485-60495 (Nov. 8, 2019); 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); CMS | Home Health PPS, accessed on Feb. 12, 2026.

[21] 84 Fed. Reg. 60478, 60485-60495 (Nov. 8, 2019); 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); CMS | Home Health PPS, accessed on Feb. 12, 2026.

documentation showed that it was an early episode, which changed the resulting HIPPS code. For the other claim, Deistic submitted an unsupported primary diagnosis code that changed the clinical grouping portion of the HIPPS code. The change of the HIPPS code in both claims resulted in underpayments totaling $1,716. For each of the remaining four claims, there were multiple errors identified on the claims, and the overpayments were assigned to another error category.

SERVICES BILLED DID NOT MEET FACE-TO-FACE ENCOUNTER REQUIREMENTS

As a condition for payment of home health services under Medicare, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and be related to the primary reason the patient requires home health services (42 CFR § 424.22(a)(1)(v)).

For five of the sampled claims, Deistic submitted claims that did not meet F2F encounter requirements, resulting in overpayments totaling $10,048. Specifically, for three claims, the F2F encounter documented in the records was not related to the primary reason for home health services. For the remaining two claims, there was no F2F encounter documentation in the medical record.

Example: Face-to-Face Encounter Not Related to Primary Reason for Home Health Services

Deistic submitted a claim for an enrollee whose F2F encounter note did not support the primary reason for home health services, which was gastritis without bleeding. Our medical review contractor determined that the F2F encounter instead addressed the enrollee's pain, mobility issues, and need for physical therapy; therefore, Deistic should not have received payment.

CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

We determined that these errors occurred because Deistic did not always review medical records from the certifying practitioner or the inpatient facility to verify that all codes billed were supported by documentation. Since Deistic has voluntarily terminated its provider agreement with the Medicare program, we did not recommend that Deistic address the cause identified in this report by improving processes to verify claims have necessary supporting documentation. However, we do make one recommendation to refund estimated net overpayments owed to the Federal Government.

OVERALL ESTIMATE OF NET OVERPAYMENTS

On the basis of our sample results, we estimated that Deistic received at least $43,074 in net overpayments for the audit period.

RECOMMENDATION

We recommend that Deistic refund the $43,074 in estimated net overpayments to the Medicare program.[22]

DEISTIC HOME HEALTH CARE, INC., COMMENTS

Deistic elected not to provide comments on the draft report.

[22] OIG audit recommendations do not represent final determinations. CMS, acting through a Medicare contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $15,301,644 in Medicare payments to Deistic for 6,836 home health claims with service dates in CYs 2021 and 2022.[23, 24] From this sampling frame, we selected for review a simple random sample of 100 home health claims with payments totaling $212,579.

We evaluated compliance with selected coverage and billing requirements and submitted the sampled claims to an independent medical review contractor to determine whether services met those requirements, including medical necessity and coding requirements.

We assessed Deistic's internal controls and compliance with laws and regulations to the extent necessary to satisfy the audit objective. Our review of internal controls focused on Deistic's procedures when providing and billing home health services. Specifically, we assessed whether Deistic had a robust control environment that included establishing and overseeing an internal control system, and control activities that included policies for complying with Medicare regulations. Our internal control review was limited to these areas and may not have disclosed internal control deficiencies that could have existed at the time of this audit.

To assess the reliability of the data obtained from CMS's IDR, we: (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 home health claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from March 2024 through June 2026.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Extracted Deistic's paid claim data from CMS's IDR for the audit period

[23] We did not include Requests for Anticipated Payment (42 CFR § 484.205(i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[24] Service dates were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the enrollee. We selected claims with "through" dates falling within the period Jan. 1, 2021, through Dec. 31, 2022; therefore, claims subjected to audit could include services that began prior to Jan. 1, 2021.

- Identified a sampling frame of 6,836 claims totaling $15,301,644[25]

- Selected a simple random sample of 100 claims for detailed review (Appendix D)

- Reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted

- Obtained and reviewed billing and medical record documentation provided by Deistic to support the claims sampled

- Used an independent medical review contractor to determine whether the 100 claims in the sample were reasonable and necessary and met Medicare coverage and coding requirements

- Reviewed Deistic's procedures for billing and submitting Medicare claims

- Verified State licensure information for selected medical personnel providing services to the patients in our sample

- Verified that claims were billed with the appropriate Core Based Statistical Area (CBSA) and Federal Information Processing Standards (FIPS) codes according to the address where the home health services were provided[26]

- Calculated the correct payments for those claims requiring adjustments

- Used the results of the sample to estimate the total Medicare net overpayments to Deistic for our audit period (Appendix E)

- Discussed the results of our audit with Deistic 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.

[25] Our sampling frame included home health claim payments for 30-day billing periods with ending dates of service from Jan. 1, 2021, through Dec. 31, 2022, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[26] CMS requires that claims for home health services include the CBSA and FIPS codes to indicate where the services were provided.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Home Health Agency Provider Compliance Audit: VNS Health	A-02-22-01023	3/26/2026
Medicare Home Health Agency Provider Compliance Audit: Alternate Solutions Homecare of Dayton	A-05-24-00014	2/19/2026
Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC	A-07-24-05146	12/15/2025
Medicare Home Health Agency Provider Compliance Audit: VNA Care Network	A-05-22-00016	10/23/2025
Medicare Home Health Agency Provider Compliance Audit: Sunflower Home Health	A-05-23-00002	7/9/2025
Medicare Home Health Agency Provider Compliance Audit: HRS Home Health	A-05-22-00017	6/30/2025
Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health	A-05-23-00017	12/19/2024

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

GENERAL MEDICARE BILLING 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, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue, to receive home health services. CMS requires the submission of OASIS data as a condition of payment (42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019)).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Under the home health PPS, CMS pays HHAs a national, standardized 30-day period payment rate.[27] This standardized payment rate is adjusted by using variables in the PDGM that account for the enrollee's condition and health care needs. For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called HHRGs.

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the OASIS. CMS uses the HHRGs as the basis for the HIPPS codes, which determine payment.[28]

HOME HEALTH COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare enrollees must: (1) be confined to the home; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose

[27] Adjustments are made for geographic differences in wage levels.

[28] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and HHAs. For more information, see CMS | HIPPS Codes, accessed on Feb. 12, 2026.

of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy;[29] (3) be under the care of a physician or allowed practitioner; and (4) be under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; and 42 CFR § 409.42).[30]

Whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual patient (42 CFR § 409.44(a)).

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

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)(1)(v) state that the certifying physician or allowed practitioner; or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health; must have a F2F encounter with the enrollee. In addition, the practitioner responsible for the initial certification must document the date of the F2F patient encounter and that the encounter, which is related to the primary reason the patient requires home health services, 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 (42 CFR § 424.22(a)(1)(v)).

Confined to the Home

For the reimbursement of home health services, the enrollee must be "confined to his home" (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). Additionally, the law requires that a practitioner certify in all cases that the patient is confined to his or her home (42 CFR § 424.22(a)(1)(ii)). For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

[29] Effective Jan. 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 the 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) (76 Fed. Reg. 68526, 68590 (Nov. 4, 2011)).

[30] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

Criterion One

The patient must either:

- Because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence or

- Have a condition such that leaving his or her home is medically contraindicated

If the patient meets one of the Criterion One conditions, then the patient must also meet two additional requirements defined in Criterion Two below.

Criterion Two

There must exist a normal inability to leave home, and leaving home must require a considerable and taxing effort.

Need for Skilled Services

Intermittent 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 § 409.44(b)).

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

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 enrollee, 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 enrollee or to the enrollee'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.

The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time (42 CFR § 409.44(b)(3)(iii)).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) state that skilled services must require the skills of a qualified physical therapist or a qualified physical therapy assistant under the supervision of a qualified physical therapist, a qualified speech-language pathologist, or a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist and must be reasonable and necessary. 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 effectively only by or under the general supervision of a skilled therapist

- 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

- Considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice

Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel (42 CFR § 409.44).[31]

[31] For additional information, see CMS | Jimmo Settlement, accessed on Feb. 12, 2026.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)(1)(v)) state that, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- Be related to the primary reason the patient requires home health services
- Occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date
- Be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health

Plan of Care

The practitioner's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the services and at what frequency the services will be furnished (42 CFR § 409.43(b)). The plan of care must be reviewed and signed by the practitioner 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 practitioner and the date of review (42 CFR § 409.43(e)).

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 6,836 claims for home health services provided by Deistic with ending dates of service from January 1, 2021, through December 31, 2022. Medicare payments for those claims totaled $15,301,644.

SAMPLE UNIT

The sample unit was a Medicare home health claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We randomly selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG/Office of Audit Services (OAS) Statistical Software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in the sampling frame by IDR_LINK_NUM[32] and then consecutively numbered the items in the sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of net overpayments made to Deistic in the sampling frame. To be conservative, we recommended recovery of net overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[32] This field uniquely identifies claims in CMS's IDR.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Claims in Sample	Value of Net Overpayments in Sample
6,836	$15,301,644	100	$212,579	37[33]	$8,332

Table 2: Estimated Net Overpayments in the Sampling Frame for the Audit Period

(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$569,559
Lower limit	43,074
Upper limit	1,096,045

[33] For 30 of these claims, the errors did not result in overpayments.

APPENDIX F: TYPES OF ERRORS BY SAMPLE ITEM

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Overpayment/ (Underpayment)
1			-
2			-
3			-
4			-
5			-
6			-
7			-
8			-
9			-
10			-
11	**X**		-
12			-
13			-
14	**X**		-
15			-
16			-
17			-
18	**X**		-
19			-
20	**X**		$(981)
21	**X**		-
22	**X**		(735)
23	**X**		-
24			-
25			-
26			-
27			-
28	**X**		-
29			-
30	**X**		-
31		**X**	2,332
32			
33			-
34			-
35			-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Overpayment/ (Underpayment)
36			-
37			-
38			-
39			-
40			-
41			-
42	X		-
43	X	X	1,590
44	X		-
45	X	X	2,235
46			-
47			-
48			-
49	X		-
50			-
51			-
52			-
53			-
54	X		-
55			-
56	X		-
57	X		-
58			-
59	X		
60	X		-
61	X		-
62			-
63			-
64	X	X	2,317
65			-
66	X		-
67			-
68			-
69	X		-
70			-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Overpayment/ (Underpayment)
71	X		-
72	X		-
73			-
74	X		-
75			-
76			-
77	X	X	1,574
78			-
79			-
80			-
81			-
82			-
83			-
84			-
85			-
86			-
87	X		-
88	X		-
89	X		-
90			-
91	X		-
92	X		-
93	X		-
94			-
95	X		-
96	X		-
97			-
98			
99			-
100	X		-
Totals	**36**	**5**	**$8,332**

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

Who Is Protected?

Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov