



MAY 11 2005

CIN: A-01-04-00507

Ms. Josephine Elliott, Director
Connecticut Home Health Care Inc.
2285 Reservoir Avenue
Trumbull, CT 06611

Dear Ms. Elliott:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, Office of Audit Services' report entitled "Review of Compliance With Billing Provisions Under The Prospective Payment System For Home Health Agencies' Therapy Services at Connecticut Home Health Care Inc."

Final determination as to actions taken on all matters will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should include 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 information contained therein is not subject to exemptions under the Act (See 45 CFR Part 5).

To facilitate identification, please refer to report number A-01-04-00507 in all correspondence.

Sincerely yours,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:

Charlotte S. Yeh, M.D.
Regional Administrator
Centers for Medicare & Medicaid Services – Region I
U.S. Department of Health and Human Services
J.F.K Federal Building, Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF COMPLIANCE WITH
BILLING PROVISIONS UNDER THE
PROSPECTIVE PAYMENT SYSTEM
FOR HOME HEALTH AGENCIES'
THERAPY SERVICES
CONNECTICUT HOME HEALTH
CARE, INC.**



May 2005
A-01-04-00507

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 OIG's 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 the department.

Office of Evaluation and Inspections

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

Office of Investigations

The OIG's 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. The OCIG imposes program exclusions and civil monetary penalties on health care providers and litigates those actions within the department. The 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.

EXECUTIVE SUMMARY

BACKGROUND

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

Under the home health prospective payment system (PPS), 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, the HHA receives a payment increase of about \$2,500 more than what the HHA would receive 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.

Connecticut Home Health Care Inc. (CHHC) is an HHA in Trumbull, CT. With the assistance of the Regional Home Health Intermediary (RHHI), we reviewed selected claims submitted by CHHC and paid by Medicare. The claims included selected for review included home health episode with 10, 11, or 12 therapy visits with dates of service from October 1, 2001, through September 30, 2002. For that period, there were 40 claims billed by CHHC with 10, 11, or 12 visits and paid by Medicare at the higher rate, totaling \$188,827.

OBJECTIVE

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

SUMMARY OF FINDINGS

We selected 40 claims submitted by CHHC where the number of therapy services provided was 10, 11, or 12 per claim. A medical record review performed by the RHHI determined that 19¹ of these claims contained therapy services that were not reasonable or medically necessary. CHHC did not have effective controls to ensure that the therapy visits were reasonable or medically necessary. Therefore, because these claims no longer met the 10-visit threshold and were not eligible for the higher payment, CHHC was overpaid \$41,940 for the 19 claims.

¹ Originally, the RHHI medical review determined that 20 claims did not meet the medical necessity requirements for therapy services and were overpaid \$44,508 for the therapy services. Upon Re-determination 1 of the disallowances was overturned.

RECOMMENDATIONS

We recommend that CHHC:

- work with the RHHI to reimburse the Medicare program \$41,940 for unallowable therapy services;
- identify and submit adjusted claims for Medicare overpayments received subsequent to our audit period; and
- strengthen controls to ensure that the therapy services provided are reasonable and medically necessary.

CONNECTICUT HOME HEALTH CARE'S COMMENTS

In written response to the draft report, CHHC stated it has reimbursed Medicare \$39,598¹ for overpaid claims, had identified and submitted any adjusted claims subsequent to our audit period, and continues to ensure all services provided are reasonable and necessary. CHHC noted that the RHHI performed a Re-determination and reversed the medical review decision on several claims that it initially down coded or disallowed. Only one of these claims included a Re-determination of therapy that was included in our audit. However, CHHC stands behind the number of therapy visits provided for all the claims and will appeal the Re-determination by the RHHI to the Administrative Law Judge level.

OFFICE OF INSPECTOR GENERAL RESPONSE

The RHHI reversed only one claim that its medical review initially determined to contain excessive therapy services. The Re-determination resulted in a reduction of \$2,568 of the \$44,508 initial overpayment related to excessive therapy services. Accordingly, we have revised our report, where applicable, to state CHHC was overpaid \$41,940 for 19 claims.

¹ In its response, CHHC reduced the overpayment by an additional \$2,342 that pertained to issues not related to the overpayment for the therapy issues included in our report. Accordingly, we recommend that CHHC repay \$41,940 to the Medicare Program.

TABLE OF CONTENTS

	<u>Page</u>
INTRODUCTION	1
BACKGROUND	1
Home Health Legislation	1
Home Health Resource Groups	1
Payment for Home Health Services.....	1
Regional Home Health Intermediary Responsibility	1
Connecticut Home Health Care Inc.....	2
OBJECTIVE, SCOPE, AND METHODOLOGY	2
Objective	2
Scope.....	2
Methodology.....	3
FINDING AND RECOMMENDATIONS	3
MEDICARE REQUIREMENTS FOR HOME HEALTH SERVICES.	4
Medical Necessity	4
SERVICES NOT REASONABLE OR MEDICALLY NECESSARY	4
LACK OF EFFECTIVE CONTROLS	4
RECOMMENDATIONS	4
CONNECTICUT HOME HEALTH CARE’S COMMENTS	5
OFFICE OF INSPECTOR GENERAL RESPONSE	5

INTRODUCTION

BACKGROUND

Home Health Agency

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

Home Health Legislation

The Centers for Medicare & Medicaid Services (CMS) was required to implement a 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 as soon as it notifies Medicare of an admission and a final percentage payment at the close of the 60-day episode. The HHA's final payment may increase or decrease in response to a difference between the projected services (i.e., therapy) at the start of care and the services received by the patient by the end of the 60-day episode.

The 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 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: clinical severity, functional status, and 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 categories are totaled, and a home health resource group is assigned.

HHAs submit claims for reimbursement using the designated Medicare payment codes. These codes match the reimbursement amount to the number of services required to treat the patient. 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 \$2,500 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.

Connecticut Home Health Care Inc.

CHHC, located in Trumbull, CT, provides home health services such as skilled nursing care, physical, occupational, and speech therapy. The RHHI for CHHC is Associated Hospital Service (AHS).

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed Associated Hospital Services' Medicare payments made to CHHC for home health claims that included therapy visits with dates of service from October 1, 2001, through September 30, 2002. For that period, CHHC submitted 40 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 40 paid claims, 20 claims included 10, 11, or 12 therapy visits, which totaled \$188,827.

We limited our review of internal controls at CHHC 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 CHHC.

We conducted audit work from February 2004 through May 2004, which included visits to CHHC's office in Trumbull, CT.

The CHHC's written comments to our draft report are appended in their entirety to this report (see Appendix) and are summarized and addressed on page 5.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;
- extracted all home health PPS paid claims from the National Claims History File with dates of service from October 1, 2001, through September 30, 2002, that included at least one therapy service;
- selected paid claims submitted by CHHC with 10, 11, or 12 therapy visits during the period October 1, 2001, through September 30, 2002;
- obtained CHHC 's medical records for each claim and provided them to AHS for medical review;
- reviewed CHHC's policies and procedures for physical therapy services;
- interviewed CHHC 's physical therapist and reviewed documentation supporting the therapist's time with the patients; and
- quantified the erroneously paid claims.

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

FINDINGS AND RECOMMENDATIONS

We selected 40 claims submitted by CHHC where the number of therapy services provided was 10, 11, or 12 per claim. A medical record review performed by the RHHI determined that 19¹ of these claims contained therapy services that were not reasonable or medically necessary. CHHC did not have effective controls to ensure that the therapy visits were reasonable or medically necessary. Therefore, because these claims no longer met the 10-visit threshold and were not eligible for the higher payment, CHHC was overpaid \$41,940 for the 19 claims.

MEDICARE REQUIREMENTS FOR HOME HEALTH SERVICES

Medical Necessity

Section 205.2 of the HHA Manual states, "The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's

¹ Originally, the RHHI medical review determined that 20 claims did not meet the medical necessity requirements for therapy services and were overpaid \$44,508 for the therapy services. Upon Re-determination 1 of the disallowances was overturned.

unique medical condition.” In addition, “...the amount, frequency and duration of the services must be reasonable.”

SERVICES NOT REASONABLE OR MEDICALLY NECESSARY

The RHHI medical reviewers determined that 19 claims contained therapy services that were not reasonable or medically necessary for improving the condition of the beneficiary.

For example, for 7 of the 19 claims reviewed, medical review indicated that a brief period of physical therapy would have been reasonable to assess safety and to set-up a home exercise program for reconditioning the patient. As a result, they reduced the allowed number of visits to less than the ten-visit threshold because the unique skills of a physical therapist were not necessary to assist the patient in performing the exercise program. Consequently, medical review adjusted the claims to lower service utilization levels and reduced the allowable Medicare reimbursement to CHHC.

Overall, the medical reviewers concluded that a significant number of the services provided by CHHC were not reasonable or medically necessary for the beneficiaries’ conditions. As a result, CHHC was overpaid \$41,940 for the 19 claims.

LACK OF EFFECTIVE CONTROLS

These overpayments occurred because CHHC did not have effective controls to identify whether the therapy visits were reasonable or medically necessary for the beneficiaries’ conditions.

RECOMMENDATIONS

We recommend that CHHC:

- work with the RHHI to reimburse the Medicare program \$41,940 for unallowable therapy services;
- identify and submit adjusted claims for Medicare overpayments received subsequent to our audit period; and
- strengthen controls to ensure that the therapy services provided are reasonable and medically necessary.

CONNECTICUT HOME HEALTH CARE'S COMMENTS

In written response to the draft report, CHHC stated it has reimbursed Medicare \$39,598¹ for overpaid claims, had identified and submitted any adjusted claims subsequent to our audit period, and continues to ensure all services provided are reasonable and necessary. CHHC noted that the RHHI performed a Re-determination and reversed the medical review decision on several claims that it initially down coded or disallowed. Only one of these claims included a Re-determination of therapy that was included in our audit. However, CHHC stands behind the number of therapy visits provided for all the claims and will appeal the Re-determination by the RHHI to the Administrative Law Judge level.

OFFICE OF INSPECTOR GENERAL RESPONSE

The RHHI reversed only one claim that its medical review initially determined to contain excessive therapy services. The Re-determination resulted in a reduction of \$2,568 of the \$44,508 initial overpayment related to excessive therapy services. Accordingly, we have revised our report, where applicable, to state CHHC was overpaid \$41,940 for 19 claims.

¹ In its response, CHHC reduced the overpayment by an additional \$2,342 that pertained to issues not related to the overpayment for the therapy issues included in our report. Accordingly, we recommend that CHHC repay \$41,940 to the Medicare Program.

APPENDIX

CONNECTICUT HOME HEALTH CARE, INC.
2285 RESERVOIR AVENUE
TRUMBULL, CT 06611

TEL. (203) 374-4555

FAX (203) 374-9392

April 11, 2005

Mr. Michael J. Armstrong
Regional Inspector General
for Audit Services, Region I
John F. Kennedy Federal Building, Rm 2425
Boston, MA 02203

Re: Report Number: A-01-04-00507

Dear Mr. Armstrong,

I have reviewed your draft report entitled, "Review of Compliance With Billing Provisions Under the Prospective Payment System For Home Health Agencies' Therapy Services at Connecticut Home Health Care Inc." and have enclosed written comments in response to this report.

Please contact me if you should have any questions or need additional information.

Sincerely,



Josephine Elliott, RN, MS
President



MAR 17 2005

Office of Audit Services
Region I
John F. Kennedy Federal Building, Rm 2425
Boston, MA 02203
(617) 565-2684

APPENDIX

Page 2 of 4

Report Number: A-01-04-00507

Ms. Josephine Elliot, Director
Connecticut Home Health Care Inc.
2285 Reservoir Avenue
Trumbull, CT 06611

Dear Ms. Elliott:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General, draft report entitled, "Review of Compliance With Billing Provisions Under the Prospective Payment System For Home Health Agencies' Therapy Services at Connecticut Home Health Care Inc."

This draft is not to be considered final, as it is subject to further review and revision. Please safeguard it against unauthorized use. To properly consider and present your views relative to the validity of the facts and reasonableness of the recommendations presented, we request that you provide us with written comments within 30 days from the date of this letter. We would also appreciate the status of any action taken or contemplated on our recommendations.

Your formal response to the report will be summarized in the body of our report, and included in its entirety as an appendix. 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 information contained therein is not subject to exemptions in the Act. (See 45 CFR Part 5.) As such, within ten business days after the final report is issued, it will be posted on the world wide web at <http://oig.hhs.gov>.

To facilitate identification, please refer to Report Number A-01-04-00507 in all correspondence relating to this report. Any questions on any aspect of the report are welcome. Please address them to Mr. David Lamir, Audit Manager, at (617) 565-2704.

Sincerely yours,

A handwritten signature in black ink that reads "Michael J. Armstrong".

Michael J. Armstrong
Regional Inspector General
for Audit Services, Region I

Connecticut Home Health Care, Inc.
2285 Reservoir Avenue
Trumbull, Connecticut 06611

DATE: April 12, 2005 REFERENCE #: A-01-04-00507

AGENCY COMMENTS IN RESPONSE TO THE FOLLOWING REPORT:

“REVIEW OF COMPLIANCE WITH BILLING PROVISIONS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH AGENCIES’ THERAPY SERVICES AT CONNECTICUT HOME HEALTH CARE”

<u>Period Reviewed:</u>	10/01/2001 – 09/30/2002
<u>Claims Reviewed:</u>	40
<u>Claims Down Coded:</u>	20
<u>Denied Charges:</u>	\$39,597.74
<u>Medicare Program reimbursed:</u>	\$39,597.74

SUMMARY:

Connecticut Home Health Care supplies skilled services (SN, PT, OT, ST, HHA) under the Medicare Program ensuring strict compliance with Federal and State regulations.

All skilled services, for the forty claims referenced above, were provided as ordered by the patient’s primary physician. Documentation by each discipline providing services, was complete and in accordance with regulatory guidelines. The documentation was billed appropriately with no discrepancies between services provided and services billed.

The Office of the Inspector General thoroughly reviewed all forty medical records and corresponding bills. The claims were, then, sent to the RHHI (Associated Hospital Services of Maine) to receive a focused Medicare Medical Review. As a result of this review, several claims were found to be fully covered and the remaining were down coded and only partially covered. Connecticut Home Health Care (CHHC) appealed this decision and the disputed claims received a second Medicare Medical Review. The Re-determination Decision by the RHHI reversed the original decision on several more claims finding them either partially or fully covered and payable under the Medicare Program. The claims that were found only partially covered were determined by the RHHI to have received more than the number of therapy visits they felt to be reasonable and necessary.

Connecticut Home Health Care (CHHC) stands behind the number of therapy visits provided as ordered by the physician and has appealed the Re-determination Decisions by the RHHI to the Administrative Law Judge level. The service was ordered by the patient's primary physician in accordance with patient needs and therapy goals. CHHC believes that these patients would not have met their goals with less than the number of therapy visits provided and, as a result, would have been underserved.

Response to the recommendations made by the Office of the Inspector General:

1. CHHC will reimburse the Medicare Program for all overpaid claims. The current overpayment amount is \$39,597.74, which has already been paid.
2. CHHC will identify and submit any adjusted claims received subsequent to this audit period.
3. CHHC will continue to ensure that all services provided are reasonable and necessary, adhering strictly to Federal and State regulatory guidelines.