



MAR 17 2006

Washington, D.C. 20201

TO: Mark B. McClellan, M.D., Ph.D.
Administrator
Centers for Medicare & Medicaid Services

FROM: Daniel R. Levinson *Daniel R. Levinson*
Inspector General

SUBJECT: Review of Home Health Agencies' Billing for Services Preceded
by a Hospital Discharge (A-01-04-00527)

The attached final report provides the results of our nationwide review of home health agencies' (HHAs') billing for services preceded by an acute care hospital discharge. Our objective was to determine whether HHAs complied with Medicare requirements in billing for fiscal years 2002 and 2003 services that were preceded by discharges from both an acute care hospital and a postacute care facility.

Under the Medicare prospective payment system, HHAs use a data instrument called the Outcome and Assessment Information Set (OASIS) to measure the care that each beneficiary needs over a 60-day service period known as an episode. Various items reported on the OASIS determine the appropriate prospective payment. One item requires HHAs to identify all facilities that discharged the beneficiary in the 14 days preceding the home health episode. Medicare pays more for an episode preceded only by a discharge from a postacute care facility (a skilled nursing or rehabilitation facility) than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility.

Previous Office of Inspector General audits identified overpayments to HHAs that did not comply with Medicare requirements for billing services preceded by discharges from both an acute care hospital and a postacute care facility. On April 1, 2004, the Centers for Medicare & Medicaid Services (CMS) implemented controls to prevent and detect such overpayments.

Our current review found that HHAs did not comply with Medicare requirements in billing for services that were preceded within 14 days by discharges from both an acute care hospital and a postacute care facility. Specifically, HHAs improperly coded all 400 sampled claims as discharges from a postacute care facility only, rather than discharges from both an acute care hospital and a postacute care facility. Overpayments to HHAs for these claims totaled \$122,674.

The overpayments occurred because HHAs had not established the controls necessary to identify on the OASIS all facilities that discharged the beneficiary in the 14 days before the home health episode. In addition, during our audit period, Medicare had not established

sufficient controls to prevent or detect overpayments and initiate recovery. As a result, we estimate that Medicare overpaid HHAs approximately \$48.1 million for 142,469 claims during fiscal years 2002 and 2003.

We recommend that CMS:

- instruct its regional home health intermediaries to recover the \$122,674 in overpayments related to the 400 sampled claims,
- direct the intermediaries to use our files containing the remaining 142,069 paid claims with billing errors to recover additional overpayments estimated at \$48 million,
- emphasize to HHAs the need to strengthen billing controls by educating their staffs regarding the identification on the OASIS of all facilities that discharged the beneficiary within 14 days of the home health episode,
- monitor the effectiveness of the newly established prepayment edits and postpayment controls, and
- develop data analysis techniques to identify HHAs with significant numbers of claims rejected or adjusted by the newly implemented payment controls and subject those HHAs to appropriate corrective action.

In its comments on our draft report, CMS concurred with the recommendations.

Please send us your final management decision, including any action plan, as appropriate, within 60 days. If you have any questions or comments about this report, please do not hesitate to call me, or your staff may contact George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or through e-mail at george.reeb@oig.hhs.gov. Please refer to report number A-01-04-00527 in all correspondence.

Attachment

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HOME HEALTH
AGENCIES' BILLING FOR SERVICES
PRECEDED BY A HOSPITAL
DISCHARGE**



**Daniel R. Levinson
Inspector General**

**MARCH 2006
A-01-04-00527**

Office of Inspector General

<http://oig.hhs.gov>

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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

The Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system for home health agencies (HHAs) on October 1, 2000. CMS contracts with four regional home health intermediaries to assist in administering this payment system.

Under the prospective payment system, HHAs use a data instrument called the Outcome and Assessment Information Set (OASIS) to measure the care that each beneficiary needs over a 60-day service period known as an episode. Various items reported on the OASIS determine the appropriate prospective payment. One item requires HHAs to identify all facilities that discharged the beneficiary in the 14 days preceding the home health episode. Medicare pays more for an episode preceded only by a discharge from a postacute care facility (a skilled nursing or rehabilitation facility) than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility.

Previous Office of Inspector General audits identified overpayments to HHAs that did not comply with Medicare requirements for billing services preceded by discharges from both an acute care hospital and a postacute care facility. CMS's home health intermediaries generally concurred with our recommendations to educate HHAs regarding proper billing and to conduct postpayment data analysis to detect and recover overpayments for improperly billed claims. On April 1, 2004, CMS implemented controls to prevent and detect overpayments to HHAs that bill improperly for services preceded by discharges from both an acute care hospital and a postacute care facility.

OBJECTIVE

Our objective was to determine whether HHAs complied with Medicare requirements in billing for fiscal years 2002 and 2003 services that were preceded by discharges from both an acute care hospital and a postacute care facility.

SUMMARY OF FINDING

HHAs did not comply with Medicare requirements in billing for services that were preceded within 14 days by discharges from both an acute care hospital and a postacute care facility. Specifically, HHAs improperly coded all 400 sampled claims as discharges from a postacute care facility only, rather than discharges from both an acute care hospital and a postacute care facility. Overpayments to HHAs for these claims totaled \$122,674.

The overpayments occurred because HHAs had not established the controls necessary to identify on the OASIS all facilities that discharged the beneficiary in the 14 days before the home health episode. In addition, during our audit period, Medicare had not established sufficient controls to prevent or detect overpayments and initiate recovery. As a result, we estimate that Medicare overpaid HHAs approximately \$48.1 million for 142,469 claims during fiscal years 2002 and 2003.

RECOMMENDATIONS

We recommend that CMS:

- instruct its regional home health intermediaries to recover the \$122,674 in overpayments related to the 400 sampled claims,
- direct the intermediaries to use our files containing the remaining 142,069 paid claims with billing errors to recover additional overpayments estimated at \$48 million,
- emphasize to HHAs the need to strengthen billing controls by educating their staffs regarding the identification on the OASIS of all facilities that discharged the beneficiary within 14 days of the home health episode,
- monitor the effectiveness of the newly established prepayment edits and postpayment controls, and
- develop data analysis techniques to identify HHAs with significant numbers of claims rejected or adjusted by the newly implemented payment controls and subject those HHAs to appropriate corrective action.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with the recommendations. We have included CMS's comments as Appendix D.

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INTRODUCTION

BACKGROUND

Home Health Prospective Payment System

The Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system for home health agencies (HHAs) on October 1, 2000. CMS contracts with four regional home health intermediaries to assist in administering this payment system.

The prospective payment system classifies home health services into payment groups called Home Health Resource Groups. HHAs use the Outcome and Assessment Information Set (OASIS), a lengthy set of standardized data elements, to measure the care a beneficiary needs over a 60-day service period known as an episode. Under the prospective payment system, HHAs receive a predetermined rate subject to several adjustments, including a case-mix adjustment (42 CFR §§ 484.205 and 484.215). Various items reported on the OASIS, including the beneficiary's use of inpatient services in the 14 days preceding admission to home care, determine the appropriate case-mix adjustment and the resulting Home Health Resource Group.

According to CMS's research, the cost of a home health episode is higher for beneficiaries discharged only from a postacute care facility (a skilled nursing or rehabilitation facility) than for beneficiaries discharged from both an acute care hospital and a postacute care facility in the preceding 14 days. As a result, Medicare pays more for an episode preceded only by a discharge from a postacute care facility. HHAs use specific codes to bill Medicare for claims preceded only by a discharge from a postacute care facility in the 14 days preceding admission to home care.

Prior Office of Inspector General Reports and Centers for Medicare & Medicaid Services Corrective Actions

Previous Office of Inspector General audits identified \$22.8 million in fiscal year (FY) 2001 overpayments to HHAs that did not comply with Medicare requirements for billing services preceded by discharges from both an acute care hospital and a postacute care facility. (See Appendix A.) Our recommendations in those reports called for CMS's regional home health intermediaries to educate HHAs regarding proper billing and to conduct postpayment data analysis to detect and recover overpayments for improperly billed claims. The intermediaries generally concurred with our recommendations.

On April 1, 2004, CMS implemented prepayment edits in its Common Working File and postpayment claims data analysis to prevent and detect overpayments to HHAs that bill improperly for services preceded by discharges from both an acute care hospital and a postacute care facility. Also, on April 20, 2004, CMS issued a special-edition "Medlearn Matters," number SE0410, which presents an overview of resources available to HHAs for researching inpatient discharges within 14 days of a home health admission and which describes how to accurately count the 14-day period.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether HHAs complied with Medicare requirements in billing for FYs 2002 and 2003 services that were preceded by discharges from both an acute care hospital and a postacute care facility.

Scope

Our review included nationwide payments by regional home health intermediaries for claims with dates of service during FYs 2002 and 2003. We identified 142,469 claims for which payments totaled \$440,545,304 and for which both an acute care hospital discharge and a postacute care facility discharge occurred in the 14 days before the home care.

We limited our internal control reviews at the intermediaries to obtaining an understanding of their claims processing system edits and procedures for detecting improperly billed home health claims and identifying and recovering overpayments. We also limited our consideration of the internal control structures at 87 selected HHAs to those controls for developing and submitting Medicare claims because our review objective did not require an understanding or assessment of the complete internal control structures.

We performed our fieldwork from October 2004 through March 2005. Our fieldwork included visiting or telephoning the 87 selected HHAs and 30 postacute care facilities nationwide. We also performed work at one home health intermediary, Anthem Health Plans of Maine, Inc.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and other requirements;
- extracted the HHAs' paid claims data from the National Claims History file for FYs 2002 and 2003 and identified claims submitted with codes designating a discharge only from a postacute care facility within 14 days of the home health admission (Appendix B);
- performed a computer match of those data to the beneficiaries' acute care hospital data in the National Claims History file and identified 142,469 claims made on behalf of beneficiaries who were discharged from hospitals within 14 days of the home health episode;
- selected a stratified random sample of 200 paid claims nationwide for each of FYs 2002 and 2003, for a total of 400 sampled claims (Appendix B);

- obtained the Common Working File data for the sampled claims and for the corresponding acute care hospital claims and recalculated the payments to determine the overpayment amounts;
- contacted representatives from the 87 HHAs that billed for 100 claims randomly selected from our sample of 400 claims to validate the billing errors and determine the underlying causes of noncompliance with Medicare requirements;
- contacted representatives from 30 postacute care facilities that discharged beneficiaries to HHAs for the 400 sampled claims to determine whether the facilities could readily provide the acute care hospital discharge information that HHAs need to bill services in compliance with Medicare requirements;
- used a stratified variable appraisal program to estimate nationwide overpayments to HHAs (Appendix C); and
- discussed the results of our review with officials from the respective intermediaries and the CMS central office.

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

FINDING AND RECOMMENDATIONS

HHAs did not comply with Medicare requirements in billing for services that were preceded within 14 days by discharges from both an acute care hospital and a postacute care facility. Specifically, HHAs improperly coded all 400 sampled claims as discharges from a postacute care facility only, rather than discharges from both an acute care hospital and a postacute care facility. Overpayments to HHAs for these claims totaled \$122,674.

The overpayments occurred because HHAs had not established the controls necessary to identify on the OASIS all facilities that discharged the beneficiary within the 14 days before the home health episode. In addition, during our audit period, Medicare had not established sufficient controls to prevent or detect overpayments and initiate recovery. Based on our sample results, we estimate that Medicare overpaid HHAs approximately \$48.1 million for 142,469 claims during FYs 2002 and 2003.

PROSPECTIVE PAYMENT SYSTEM REQUIREMENTS

Pursuant to 42 CFR § 484.55, HHAs must complete, for each beneficiary, a comprehensive assessment that accurately reflects the beneficiary's current health status. HHAs use the OASIS to assess the beneficiary's home care needs. Medicare prospective payments to HHAs are based, in part, on a home health case-mix system that uses selected information from the OASIS (42 CFR § 484.210(e)).

Question M0175 on the OASIS requires HHAs to identify all facilities that discharged the beneficiary in the 14 days before the home health episode. The response to this question directly affects the amount of Medicare reimbursement. Medicare pays more for an episode preceded only by a discharge from a postacute care facility than for the same episode preceded by discharges from both an acute care hospital and a postacute care facility.

CLAIMS INCORRECTLY CODED AS POSTACUTE CARE FACILITY DISCHARGES ONLY

For all 400 sampled claims, HHAs identified on the OASIS only the most recent discharge from a postacute care facility, rather than all inpatient facilities that discharged the beneficiary in the 14 days preceding the home health episode. HHAs then improperly billed Medicare by coding the claims as if the beneficiary had not been discharged from an acute care hospital in the 14 days before the home health episode.

We calculated the amounts that Medicare would have paid if HHAs had correctly coded the claims to indicate acute care hospital discharges. Based on our calculations, we determined that Medicare overpaid HHAs for each of the 400 sampled claims.

BILLING AND PAYMENT CONTROLS NOT ESTABLISHED

Home Health Agency Billing Controls Not Established

The 87 HHAs that we contacted had not established the controls necessary to ensure identification of all inpatient facility discharges in the 14 days preceding the home health episode. Those HHAs identified on the OASIS only the most recent postacute care facility discharge because:

- They did not contact postacute care facilities to confirm hospital discharge dates provided by such sources as beneficiaries and family members. Those sources could not always be depended upon for accurate hospital discharge dates.
- They did not educate their staffs about the significance of identifying on the OASIS all inpatient facilities from which the beneficiary had been discharged in the 14 days before home health admission. For instance:
 - Medical records available to HHAs often showed that hospital discharges occurred within 14 days of home health admission; however, HHAs did not check the medical records before completing OASIS question M0175.
 - HHA clinicians who completed the OASIS did not use hospital discharge information provided by HHA admissions staff.

In addition, all 30 postacute care facilities that we contacted informed us that they were able to readily access hospital discharge dates through various documents included in the beneficiaries' medical records. Furthermore, according to the facilities, the patient care

referral information that they provide to HHAs often includes hospital discharge dates. Therefore, in our opinion, postacute care facilities are the most reliable source of the information that HHAs need to complete question M0175 on the OASIS.

Medicare Payment Controls Not Established

During our audit period, CMS had not established the payment controls necessary to prevent and detect overpayments to HHAs and to initiate recovery. Specifically, CMS had not established controls to identify incorrectly billed claims, and its home health intermediaries had not initiated effective postpayment data analysis to detect claims vulnerable to billing error.

On April 1, 2004, CMS implemented prepayment edits in its Common Working File and postpayment controls to identify incorrect HHA billing and to detect and recover overpayments. On a prepayment basis, Medicare claims processing systems now compare incoming claims that contain codes representing a discharge from a postacute care facility (and no acute care hospital discharge) with the beneficiary's hospital claims history to determine whether an acute care hospital submitted a claim on behalf of the beneficiary within 14 days of the home health episode. If so, the claims processing systems correct the codes and pay the claims appropriately. On a postpayment basis, CMS uses its National Claims History file to identify all home health claims with those same codes (i.e., discharge only from a postacute care facility) for which related acute care hospital claims were received after the home health claims had already been paid.

Although CMS has established prepayment edits and postpayment controls, further actions are necessary at the HHA level because HHAs can bill incorrectly and receive Medicare payments before hospitals submit their claims. In other words, when hospitals submit their claims after HHAs submit theirs, CMS will not identify the HHA billing errors until the postpayment review. The resulting overpayments will need to be recovered through offset or collection activities.

MEDICARE OVERPAYMENTS

The billing errors for the 400 sampled claims resulted in overpayments totaling \$122,674. Projecting the sample results to the 142,469 claims with an acute care hospital discharge within 14 days of the home health episode, we estimate that Medicare made about \$48.1 million in overpayments to HHAs for services during FYs 2002 and 2003.

RECOMMENDATIONS

We recommend that CMS:

- instruct its regional home health intermediaries to recover the \$122,674 in overpayments related to the 400 sampled claims,

- direct the intermediaries to use our files containing the remaining 142,069 paid claims with billing errors to recover additional overpayments estimated at \$48 million,
- emphasize to HHAs the need to strengthen billing controls by educating their staffs regarding the identification on the OASIS of all facilities that discharged the beneficiary within 14 days of the home health episode,
- monitor the effectiveness of the newly established prepayment edits and postpayment controls, and
- develop data analysis techniques to identify HHAs with significant numbers of claims rejected or adjusted by the newly implemented payment controls and subject those HHAs to appropriate corrective action.

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

In written comments on our draft report, CMS agreed with the recommendations. We have included CMS's comments as Appendix D.

APPENDIXES

PREVIOUS OFFICE OF INSPECTOR GENERAL REPORTS

Report Title and Number	Issue Date
“Review of Payments Made by Associated Hospital Service for Home Health Services Preceded by a Hospital Discharge” (A-01-03-00500)	July 8, 2003
“Review of Controls Over Home Health Payments at Palmetto Government Benefit Administrators” (A-04-03-00018)	February 20, 2004
“Review of Payments Made by Cahaba Government Benefit Administrators for Home Health Services Preceded by a Hospital Discharge” (A-07-03-04021)	March 17, 2004
“Review of Payments Made by United Government Services for Home Health Services Preceded by a Hospital Discharge” (A-09-03-00042)	February 27, 2004

These reports are available at <http://oig.hhs.gov>.

SAMPLING METHODOLOGY

OBJECTIVE

Our objective was to determine whether home health agencies (HHAs) complied with Medicare requirements in billing for fiscal years (FYs) 2002 and 2003 services that were preceded by discharges from both an acute care hospital and a postacute care facility.

POPULATION

The population consisted of HHA K and M claims with dates of service during FYs 2002 and 2003 that were paid by Medicare and that were preceded by an inpatient acute care hospital discharge within 14 days of the home health episode.¹

Stratum	Number of Claims	Payment Amount
FY 2002:		
1–K claims	29,386	\$60,543,534
2–M claims	44,308	171,768,297
FY 2003:		
1–K claims	25,409	49,202,047
2–M claims	43,366	159,031,426
Total	142,469	\$440,545,304

SAMPLE DESIGN

The audit used a stratified random sample consisting of four strata, one for paid K claims and one for paid M claims for each of FYs 2002 and 2003. We determined error amounts by subtracting our calculated correct payment amounts from the original Medicare reimbursement to the provider.

SAMPLE SIZE

The sample consisted of 400 paid claims, 100 from each of the 4 strata in our identified population.

¹HHAs code claims as K or M to designate a discharge only from a postacute care facility in the 14 days preceding the home health episode. K claims represent HHA claims with fewer than 10 physical, speech, or occupational therapy visits during the episode, and M claims represent HHA claims with at least 10 therapy visits during the episode.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

The following table presents our sample results.

Stratum	Sample Size	Value of Sample	Number of Errors	Value of Errors
FY 2002:				
1-K claims	100	\$207,453	100	\$18,540
2-M claims	100	389,399	100	45,113
FY 2003:				
1-K claims	100	196,059	100 ¹	16,130
2-M claims	<u>100</u>	<u>367,305</u>	<u>100</u>	<u>42,891</u>
Total	400	\$1,160,216	400	\$122,674

VARIABLE PROJECTIONS

The point estimate of the sample was \$25,436,761 with a precision of plus or minus \$893,920 at the 90-percent confidence level for FY 2002 claims and \$22,698,634 with a precision of plus or minus \$785,390 at the 90-percent confidence level for FY 2003 claims. Thus, the total point estimate for both FYs was \$48,135,395.

¹For one of the sampled items in this stratum, the regional home health intermediary had previously identified the overpayment. We did not include the overpayment amount in our projection.



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

JAN -6 2006

Administrator
Washington, DC 20201

TO: Daniel R. Levinson
Inspector General
Office of Inspector General

FROM: Mark B. McClellan, M.D., Ph.D. 
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Home Health Agencies' Billing for Services Preceded by a Hospital Discharge," (A-01-04-00527)

REC'D
2006 JAN 10 PM 3:05
OFFICE OF INSPECTOR
GENERAL

Thank you for the opportunity to review and comment on the subject OIG draft report.

Home health services allow people with limited mobility to live independently while still receiving professional health care services. A Home Health Agency (HHA) is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis.

The Centers for Medicare & Medicaid Services (CMS) pays for home health services under a Prospective Payment System (PPS) based on payment groups which are weighted relative to a national standard per episode amount. Payments are impacted by the presence or absence of hospital stays.

Medicare systems compare incoming home health (HH) PPS Requests for Anticipated Payment (RAPs) and claims with Health Insurance Prospective Payment System (HIPPS) codes. Medicare systems will determine whether an inpatient hospital claim has been received for dates of service within 14 days of the start of care. If an inpatient hospital claim is found, Medicare systems take action on the RAP or claim. RAPs are returned to the provider to alert them to the hospital stay and allow them to correct the HIPPS code. Claims are automatically adjusted to correct the HIPPS code and pay at the correct payment level.

Further, CMS reviews its National Claims History (NCH) database to compare HH PPS claims with HIPPS codes representing no hospital discharge against inpatient hospital claims received with dates of service within 14 days of the start of care. These would occur when inpatient hospital claims were received after the HH PPS claim had already been paid. This post-payment identification is necessary because under Medicare timely

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filing guidelines, hospital claims may not be received for 15-27 months from the end of the hospital stay.

OIG Recommendation

The OIG recommends that CMS instruct its regional home health intermediaries to recover the \$122,674 in overpayments related to the 400 sampled claims.

CMS Response

The CMS agrees that the overpayments (subject to verification by the Medicare contractors) should be recovered as soon as possible.

OIG Recommendation

The OIG recommends that CMS direct the fiscal intermediaries to use the OIG's files containing the remaining 142,069 paid claims with billing errors to recover additional overpayments estimated at \$48 million.

CMS Response

The CMS agrees that the overpayments resulting from a review of the OIG files containing the remaining 142,069 paid claims with billing errors should be recovered.

The CMS will review these files and, when appropriate, determine overpayments.

OIG Recommendation

The OIG recommends that CMS emphasize to HHAs the need to strengthen billing controls by educating their staffs regarding the identification on the Outcomes and Assessments Information Set (OASIS) of all facilities that discharged the beneficiary within 14 days of the home health episode.

CMS Response

The CMS agrees that HHAs need to strengthen their billing controls. We appreciate OIG's recognition of our April 2004 "Medlearn Matters" article directing HHAs to information sources regarding prior inpatient stays. Our provider outreach and education and local provider education and training (LPET) programs provide opportunities to underscore this message.

In addition, CMS plans to monitor the effectiveness of our contractors' educational efforts and, if necessary, CMS will further improve these efforts.

OIG Recommendation

The OIG recommends that CMS monitor the effectiveness of the newly established prepayment edits and post payment controls.

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CMS Response

The CMS currently has instructions in place for all contractors to monitor the effectiveness of prepayment edits. The Program Integrity Manual, Chapter 3, Section 5.5.1.1.B – Evaluation of Prepayment Edits states:

Development or retention of edits should be based on data analysis, identification, and prioritization of identified problems. The contractor must evaluate all service specific and provider specific prepayment edits as follows:

- o Automated edits must be evaluated annually; and
- o All routine or complex edits must be evaluated quarterly.

We monitor the contractors' compliance with these instructions through the annual contractor review process.

OIG Recommendation

The OIG recommends that CMS develop data analysis techniques to identify HHAs with significant numbers of claims rejected or adjusted by the newly implemented payment controls and subject those HHAs to appropriate corrective action.

CMS Response

The CMS will monitor the impact of these new payment controls to assure that providers are submitting claims correctly. If certain HHAs continue to submit claims improperly, contractors will follow the Progressive Corrective Action plan and take appropriate action to ensure that claims are submitted appropriately.

The CMS appreciates the level of effort that the OIG expended in drafting this report. We look forward to working collaboratively with the OIG to protect the Medicare Trust Funds in the future.