



JUL 26 2007

Office of Audit Services  
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Boston, MA 02203  
(617) 565-2684

Report Number: A-01-06-00514

Ms. Karen Green  
President and Chief Executive Officer  
VNA Care Network, Inc.  
120 Thomas Street  
Worcester, Massachusetts 01608

Dear Ms. Green:

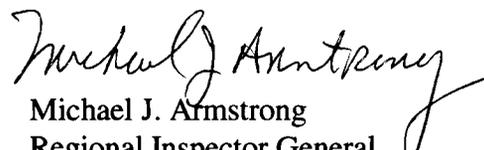
Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicare Payments to VNA Care Network, Inc., for Home Health Services Preceded by a Hospital Discharge." We will forward a copy of this report to the HHS action official noted on the following page for review and any action deemed necessary.

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

Pursuant to the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports are generally made available to members of the public to the extent information is not subject to exemptions in the Act (45 CFR part 5). Accordingly, within 10 business days after the final report is issued, it will be posted on the Internet at <http://oig.hhs.gov>.

If you have any questions or comments about this report, please do not hesitate to call me or Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at [Leah.Scott@oig.hhs.gov](mailto:Leah.Scott@oig.hhs.gov). Please refer to report number A-01-06-00514 in all correspondence.

Sincerely,

  
Michael J. Armstrong  
Regional Inspector General  
For Audit Services

Enclosures – as stated

Page 2 – Karen Green

**Direct Reply to HHS Action Official:**

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Consortium Administrator  
Consortium for Financial Management and Fee For Service Operations  
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Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**REVIEW OF MEDICARE  
PAYMENTS TO VNA CARE  
NETWORK, INC., FOR HOME  
HEALTH SERVICES PRECEDED  
BY A HOSPITAL DISCHARGE**



Daniel R. Levinson  
Inspector General

July 2007  
A-01-06-00514

# ***Office of Inspector General***

<http://oig.hhs.gov>

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## **OAS FINDINGS AND OPINIONS**

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



## **EXECUTIVE SUMMARY**

### **BACKGROUND**

The Centers for Medicare & Medicaid Services (CMS) implemented a Medicare prospective payment system for home health agencies (HHA) on October 1, 2000. Under the prospective payment system, CMS 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 or from only an acute care hospital.

On April 1, 2004, CMS implemented prepayment edits in its Common Working File to prevent overpayments to HHAs that bill incorrectly for services for beneficiaries who were recently discharged from acute care hospitals.

### **OBJECTIVE**

Our objective was to determine whether VNA Care Network, Inc., (the agency) complied with Medicare requirements in billing for fiscal years 2004 and 2005 services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days.

### **SUMMARY OF FINDINGS**

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days. Specifically, the agency improperly coded 161 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. These errors occurred because the agency had not established adequate controls to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged a beneficiary within the 14-day period. CMS's prepayment edit corrected 138 of the 161 claims. Overpayments for the 23 claims not identified by the edit totaled \$6,178.

### **RECOMMENDATIONS**

We recommend that the agency:

- return the \$6,178 overpayment to the appropriate regional home health intermediary and
- further educate its staff regarding the importance of identifying all facilities that had discharged the beneficiary within 14 days of the home health episode and determining which of these facilities were acute care (including long-term care) hospitals.

## **VNA CARE NETWORK, INC.'S, COMMENTS**

In its comments on our draft report, the agency agreed with our finding. We have included the agency's comments in the appendix.

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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 (HHA) on October 1, 2000. CMS contracts with four regional home health intermediaries to assist in administering this payment system.

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, including the beneficiary's use of inpatient services in the 14 days preceding admission to home care, determine the appropriate prospective payment.

According to CMS's research (65 Federal Register 41127, July 3, 2000), 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 or from only an acute care facility in the preceding 14 days. As a result, Medicare pays less for a home health episode of care preceded by a discharge from an acute care hospital. CMS requires that HHAs use specific codes to identify beneficiaries who were discharged from acute care facilities (including long-term care hospitals) in the 14 days preceding admission to home health care.

#### **Centers for Medicare & Medicaid Services Actions to Prevent and Detect Overpayments**

On April 1, 2004, CMS implemented prepayment edits in its Common Working File to prevent overpayments to HHAs that bill incorrectly for services for beneficiaries who were recently discharged from acute care hospitals. The prepayment edit now compares incoming claims that contain codes indicating that the beneficiary was not discharged from an acute care hospital in the preceding 14 days with the beneficiary's hospital claims history. If the edit determines that an acute care hospital submitted a claim on behalf of the beneficiary within 14 days of the home health episode, the claims processing system corrects the codes and pays the claims appropriately.

In addition, on April 20, 2004, CMS issued a special-edition "Medlearns 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 describes how to accurately count the 14-day period.

## **VNA Care Network, Inc.**

VNA Care Network, Inc., (the agency) is a nonprofit home health agency with headquarters in Worcester, Massachusetts. It offers more than 70 home health care, palliative care, hospice, wellness, and community-based services through its several offices located in Eastern and Central Massachusetts.

## **OBJECTIVE, SCOPE, AND METHODOLOGY**

### **Objective**

Our objective was to determine whether the agency complied with Medicare requirements in billing for fiscal year (FY) 2004 and 2005 services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days.

### **Scope**

We reviewed 161 home health claims with discharge dates during FYs 2004 and 2005 for which Medicare paid the agency \$437,019. These claims were submitted with codes indicating that the beneficiary had not had an acute care hospital stay in the 14 days before the start of the HHA episode.

Our objective did not require an understanding or assessment of the complete internal control structure at CMS, the regional home health intermediaries, or the agency. We limited consideration of the internal control structure to the payment controls in place within the Common Working File and the regional home health intermediaries' claims processing systems. We also limited our consideration of the internal control structure at the agency to those controls pertaining to developing and submitting Medicare claims. We did not assess the completeness of data extracted from CMS's National Claims History file.

We conducted our fieldwork at the agency from November 2006 through March 2007.

### **Methodology**

To accomplish our objective, we:

- reviewed applicable Medicare laws, regulations, and other requirements;
- extracted the agency's paid claims data from the National Claims History file for FYs 2004 and 2005 and identified claims submitted with codes designating that the beneficiary had not been discharged from an acute care hospital within 14 days of the home health admission;
- compared data from those claims with acute care hospital data in the National Claims History file for the same beneficiaries and identified 161 claims made on behalf of

beneficiaries who had been discharged from hospitals within 14 days of the home health episode;

- obtained the Common Working File data for the sampled claims and for the corresponding acute care hospital claims;
- contacted the regional home health intermediary to determine how to identify claims that had been corrected by the newly implemented edit;
- obtained the agency's assistance in recalculating the payments to determine the overpayment amounts;
- discussed the results of our review with officials from the intermediary, the CMS regional and central offices, and the agency.

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

## **FINDING AND RECOMMENDATIONS**

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days. Specifically, the agency improperly coded 161 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. These errors occurred because the agency had not established adequate controls to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged the beneficiary within the 14-day period. CMS's prepayment edit corrected 138 of the 161 claims. Overpayments for the 23 claims not identified by the edit totaled \$6,178.

## **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. (See the "OASIS Implementation Manual.") 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 or from only an acute care hospital.

## **INCORRECTLY CODED CLAIMS**

The agency did not always comply with Medicare requirements in billing for services for beneficiaries who had been discharged from an acute care hospital in the preceding 14 days. Specifically, the agency incorrectly coded 161 claims as if the beneficiary had not been discharged from an acute care hospital in the 14 days before the home health episode.

## **HHA BILLING CONTROLS NOT ESTABLISHED**

The agency had not established the controls necessary to ensure identification of all acute care facilities (including long-term care hospitals) that had discharged the beneficiary in the 14 days preceding the home health episode. Although the agency had educated its staff about the significance of identifying on the OASIS all inpatient facilities that had discharged the beneficiary in the 14 days before the home health admission and correctly noting the type of facility, clinicians who completed the OASIS either:

- did not identify all facilities that had discharged the beneficiary in the 14 days before the home health episode or
- did not recognize some of the facilities as long-term care hospitals, which are subject to the payment limitation of the 14-day rule.

## **MEDICARE OVERPAYMENTS**

The agency submitted 161 incorrectly coded claims during FYs 2004 and 2005. The prepayment edit detected 138 of these claims, and the claims processing system corrected the codes and paid the claims appropriately.

The prepayment edit could not detect the remaining 23 claims because the agency received payment for each of these incorrectly coded claims before the discharge hospital submitted its claim. These incorrect billings resulted in an overpayment to the agency of \$6,178.

## **RECOMMENDATIONS**

We recommend that the agency:

- return the \$6,178 overpayment to the appropriate regional home health intermediary and
- further educate its staff regarding the importance of identifying all facilities that had discharged the beneficiary within 14 days of the home health episode and determining which of these facilities were acute care (including long-term care) hospitals.

## **VNA CARE NETWORK, INC.'S, COMMENTS**

The agency agreed with our finding. However, the agency noted that the amount of claim errors represented approximately one tenth of one percent of its total Medicare claims for that period and about one hundredth of one percent of its Medicare revenue for the same period. The agency also stated that it had encountered difficulties in obtaining accurate and timely information needed to properly answer M0175 of the OASIS questionnaire, particularly with respect to the proper classifications of the discharge facilities. We have included the agency's comments in the appendix.

# **APPENDIX**



June 29, 2007

Mr. Michael Armstrong  
Office of the Inspector General  
Office of Audit Services  
Region I, Room 2425  
JFK Federal Building  
15 New Sudbury Street  
Boston, MA 02203

Re: Report Number A-01-06-00514

Dear Mr. Armstrong:

This letter is in response to the draft copy of U.S. Department of Health and Human Services, Office of Inspector General (OIG) draft report entitled "Review of Medicare Payments to VNA Care Network, Inc. for Home Health Services Preceded by a Hospital Discharge." First, I would kindly like to request that the name of our agency as used in the title of the report and throughout the report be changed to our official name: **VNA Care Network, Inc.** In addition, at the top of page two of the report, our agency is a nonprofit home health agency with headquarters in Worcester, Massachusetts. We would appreciate your assistance in making these changes. We have several office locations throughout central and eastern Massachusetts.

We agree with the findings as outlined in the report. Twenty-three (23) claims were identified as overpayments amounting to \$6,178 in the two year period covering fiscal 2004 and 2005. We would like to point out that this represents approximately one-tenth of one percent of our total Medicare claims for that period and about one-hundredth of one percent of our Medicare revenue for the same period.

We would also like to comment on the difficulties encountered in trying to obtain the information needed to properly answer MO175 of the OASIS questionnaire.

- Many rehab facilities in Massachusetts reclassified themselves as "Long Term Acute Care Hospitals" (LTACH) and continue to use the term "Rehabilitation" in their name making it difficult for us to determine the type of facility.
- Some facilities have more than one level of care within their facility and even when we call them for clarification on whether the patient was in a SNF bed or a rehab unit we are not always given the proper information.



- Referrals received from Rehab or SNF facilities don't always specify, even when asked, if the patient came to them from a LTACH within the 14-day period preceding the home health episode.
- The CMS common working file (CWF) only reflects claims that have been filed. Our agency tries to be efficient in filing claims timely. Other facilities' claims are not always in the CWF at the time we submit our claims. Therefore, they do not always show up when we check to see if the patient was in a facility 14 days prior to the home health episode.
- When patients are asked about their prior hospital stays, they don't always know the proper information and are sometimes confused as to when and where they were treated.

We have implemented controls and procedures to capture information on the prior facility stays within the 14 days preceding the home health episode to the best of our ability but the information is not always accessible to us at the time we submit our claim. We are pleased that the edit implemented by CMS on April 1, 2004 was able to catch and correct over 85% of the claims in question and that we were not overpaid on those claims.

In conclusion we agree with the findings of this study and would like to thank the OIG auditors for their time and effort in addressing this issue.

Sincerely,

*Karen H. Green*

Karen H. Green  
President and CEO