



SEP 10 2007

Office of Audit Services
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Report Number: A-01-07-00501

Ms. Marion Donahue
President
Connecticut VNA, Inc.
33 North Plains Industrial Road
Wallingford, Connecticut 06492

Dear Ms. Donahue:

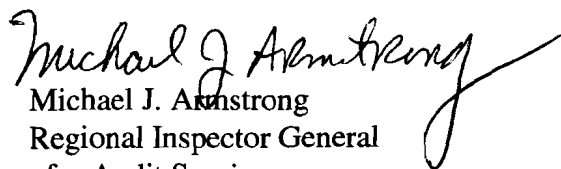
Enclosed is the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG), final report entitled "Review of Medicare Payments to Connecticut VNA, Inc., for Home Health Services Preceded by a Hospital Discharge." We will forward a copy of this report to the HHS action official 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 the public to the extent the 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 contact Leah Scott, Audit Manager, at (617) 565-2679 or through e-mail at Leah.Scott@oig.hhs.gov. Please refer to report number A-01-07-00501 in all correspondence.

Sincerely,


Michael J. Armstrong
Regional Inspector General
for Audit Services

Enclosure

Direct Reply to HHS Action Official:

James Bryant
Associate Regional Administrator for Medicare Financial Management
Division of Financial Management and Fee for Service Operations
Centers for Medicare and Medicaid Services, Region I
JFK Federal Building, Room 2325
Boston, Massachusetts 02203

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

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



Daniel R. Levinson
Inspector General

September 2007
A-01-07-00501

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 Connecticut VNA, Inc., (the agency) complied with Medicare requirements in billing for fiscal year 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 35 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. Medicare paid the agency \$113,615 for these claims. 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 27 of the 35 claims. Overpayments for the eight claims not identified by the edit totaled \$3,683.

RECOMMENDATION

We recommend that the agency:

- ensure that its adjustments to reimburse Medicare for the \$3,683 in overpayments that our audit identified were processed by the regional home health intermediary and
- further educate its staff regarding the importance of identifying all facilities that discharged the beneficiary within 14 days of the home health episode and determining which of these facilities are acute care (including long-term care) hospitals.

CONNECTICUT VNA, INC.'S, COMMENTS

In its response to our draft report, the agency agreed with our finding. However, the agency noted that one of the eight claims that we determined to be an overpayment was billed incorrectly but paid at the correct amount because of an unrelated payment adjustment. The agency also stated that it had returned the \$3,683 overpayment identified during this review to the regional home health intermediary. We have included the agency's comments in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree with the provider's assertion that one of the eight error claims, although billed incorrectly, ultimately resulted in no overpayment to the provider. We have revised the overpayment amount for the eight claims billed incorrectly from \$4,616 to \$3,683 to properly reflect that this claim did not result in an overpayment. We have modified our first recommendation to reflect the agency's comment that it had reimbursed Medicare for the \$3,683 overpayment.

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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.

Connecticut VNA, Inc.

Connecticut VNA, Inc. (the agency) is a nonprofit home health and hospice agency located in Wallingford, Connecticut. It has 11 patient service offices that serve the entire Connecticut population.

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 home health claims with discharge dates during FYs 2004 and 2005 that the agency 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 May 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 35 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; and
- 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 35 claims as if the beneficiaries had not been discharged from an acute care hospital within the 14-day period preceding the home health admission. Medicare paid the agency \$113,615 for these claims. 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 27 of the 35 claims. Overpayments for the eight claims not identified by the edit totaled \$3,683.

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 35 claims as if the beneficiary had not been discharged from an acute care hospital in the 14 days before the home health episode.

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 35 incorrectly coded claims during FYs 2004 and 2005. The prepayment edit detected 27 of these claims, and the claims processing system corrected the codes and paid the claims appropriately.

The prepayment edit could not detect the remaining eight 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 \$3,683.

RECOMMENDATION

We recommend that the agency:

- ensure that its adjustments to reimburse Medicare for the \$3,683 in overpayments that our audit identified were processed by the 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.

CONNECTICUT VNA, INC.'S, COMMENTS

In its response to our draft report, the agency agreed with our finding. However, the agency noted that one of the eight claims that we determined to be an overpayment was billed incorrectly but paid at the correct amount because of an unrelated payment adjustment. The agency also stated that it had returned the \$3,683 overpayment identified during this review to the regional home health intermediary. We have included the agency's comments in the Appendix.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We agree with the provider's assertion that one of the eight error claims, although billed incorrectly, ultimately resulted in no overpayment to the provider. We have revised the overpayment amount for the eight claims billed incorrectly from \$4,616 to \$3,683 to properly reflect that this claim did not result in an overpayment. We have modified our first recommendation to reflect the agency's comment that it had reimbursed Medicare for the \$3,683 overpayment.

APPENDIX



FEDERAL EXPRESS

July 26, 2007

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Mr. Michael J. Armstrong
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RE: Report Number A-01-07-00501

Dear Mr. Armstrong:

This letter is in response to your letter of June 29, 2007 concerning the draft report entitled "Review of Medicare Payments to Connecticut VNA, Inc. for Home Health Services Preceded by a Hospital Discharge".

We have reviewed the report and agree with the findings.

With regard to the recommendations:

1. As a result of discussion between CT VNA and OIG staff in the Boston Office, the overpayment amount for the eight claims has been reduced to \$3,683 from \$4,616. The reduction was necessary to accurately reflect that the billing correction for one of the eight claims did not result in a change to the reimbursement amount. The overpayment amount of \$3,683 has been returned to the regional home health intermediary.
2. Policies and procedures have been revised and the staff and clinicians responsible for completing section MO175 of the OASIS have been instructed on how to properly identify all facilities that had discharged a beneficiary within 14 days of a home care episode and how to determine which facilities were acute (including long-term care) hospitals. In addition, all new clinicians receive training on the policy and procedure during their orientation to CT VNA.

Thank you for the opportunity to comment on the report.

Very truly yours,

Marion R. Donahue

Marion R. Donahue, RN, MS
President

