

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE OFTEN MADE  
OVERPAYMENTS TO  
NEW ENGLAND HOME HEALTH  
AGENCIES FOR CLAIMS  
WITHOUT REQUIRED  
OUTCOME AND ASSESSMENT  
INFORMATION SET DATA**

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# ***Office of Inspector General***

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## EXECUTIVE SUMMARY

***We estimated that the regional home health intermediary for six New England States made approximately \$25.1 million in Medicare overpayments because it did not deny claims that home health agencies submitted without the required Outcome and Assessment Information Set data, which is a condition of payment.***

### WHY WE DID THIS REVIEW

In 2012, the Office of Inspector General issued a report that disclosed that home health agencies (HHAs) nationwide did not submit required Outcome and Assessment Information Set (OASIS) data for 6 percent of HHA claims in calendar year (CY) 2009, which represented over \$1 billion in Medicare payments. Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) began requiring HHAs to submit OASIS data as a Medicare condition of payment. In its response to our report, CMS stated that it cannot enforce this requirement because of limitations in the Medicare claims processing system. CMS stated that it is still working on building a systematic interface of the HHA claims and OASIS submission process. CMS contracts with four regional home health intermediaries (RHHIs) that use the Fiscal Intermediary Shared System (FISS) to process and pay HHA claims. As a followup to our review of CY 2009 claims taking into account the new condition of payment, we reviewed one RHHI that processes and pays HHA claims for six New England States to determine the extent to which it denied CY 2010 claims with missing OASIS data.

The objective of this review was to determine whether the RHHI made Medicare payments only for claims for which HHAs had submitted accepted OASIS data.

### BACKGROUND

OASIS data are a standard set of data elements used by HHA clinicians to assess the clinical needs, functional status, and service utilization of beneficiaries receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate case-mix groups (which are used to help determine payment rates), to monitor the effects on the patient care and outcome, and to determine whether adjustments to the case-mix groups are warranted. CMS requires an HHA to complete the OASIS data within 5 calendar days after the start of care, update and revise the assessment and the OASIS data at least 5 days before the next 60-day episode of care, and encode and transmit electronically OASIS data to its State survey agency within 30 days. The HHA submits an interim claim after completing the OASIS data at the start of care to receive 60 percent of the payment for that episode and further interim claims at the beginning of any additional episodes of care to receive 50 percent of those payments, but a final claim should be submitted and paid only after OASIS data are updated and accepted by the State survey agency. The State survey agency provides a final validation report, which informs the HHA whether the OASIS data have been accepted or rejected. The HHA must fill out the CMS form CMS-1450 for both the interim claim and for the final claim. During the OASIS process, RHHIs perform some limited periodic payment reviews and CMS maintains a Quality Improvement and Evaluation System that tracks accepted OASIS data.

Beginning January 1, 2010, CMS required HHAs to submit accepted OASIS data as a condition of payment and instructed RHHIs not to pay claims that lacked OASIS data. Our audit covered 16,582 HHA claims totaling \$42.8 million that were at a high risk of being overpaid because HHAs did not submit accepted OASIS data or submitted accepted OASIS data after RHHIs paid the claims.

## **WHAT WE FOUND**

The RHHI paid Medicare claims for which HHAs had not submitted the required OASIS data. Of the 100 claims that we sampled, the RHHI made payments totaling \$156,722 for 65 claims that should not have been paid. Specifically, 36 claims should not have been paid because the HHAs had not submitted accepted OASIS data at the time of payment, and 29 claims should not have been paid because HHAs had not submitted accepted OASIS data. We estimated that the RHHI made approximately \$25.1 million in Medicare overpayments because it did not deny claims that HHAs had submitted without the OASIS data, which is a condition of payment.

Overpayments occurred because HHAs often had inadequate controls for the submission of OASIS data. Furthermore, Medicare payment controls were inadequate to prevent or detect payments to HHAs for claims that were missing accepted OASIS data. Without adequate controls, CMS has a limited ability to prevent payments to HHAs that have not submitted accepted OASIS data.

## **WHAT WE RECOMMEND**

We recommend that CMS:

- adjust the 65 sampled claims for overpayments of \$156,722 to the extent allowed under the law;
- consider reopening the 16,482 nonsampled claims for which 3,819 claims were paid before OASIS data were accepted and 12,663 claims that did not match to OASIS data, review our information on these claims, and recover any overpayments to the extent allowed under the law;
- complete the process that would allow the FISS to interface with State survey agency systems to identify, on a prepayment basis, HHA claims without accepted OASIS data submissions, which could have resulted in savings totaling \$25.1 million during CY 2010 for claims paid by one RHHI; and
- encourage RHHIs to conduct periodic postpayment reviews of HHA claims, which would include ensuring OASIS data supports claims, until sufficient prepayment controls are established.

## **CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OUR RESPONSE**

In written comments on our draft report, CMS fully concurred with recommendations one and three, partially concurred with recommendation two, and did not concur with our fourth recommendation.

We disagree with CMS's partial nonconcurrence with our second recommendation and its nonconcurrence with our fourth recommendation.

**TABLE OF CONTENTS**

INTRODUCTION ..... 1

    Why We Did This Review ..... 1

    Objective ..... 1

    Background ..... 1

        Medicare ..... 1

        Outcome and Assessment Information Set Data ..... 1

        Data Required as a Condition of Payment ..... 2

    How We Conducted This Review ..... 2

FINDINGS ..... 3

    Program Requirements ..... 3

    Payments for Claims That Lacked Accepted Data ..... 3

        Claims Paid Before Data Were Accepted ..... 3

        Claims Paid Without Accepted Data ..... 4

    Inadequate Internal Controls ..... 4

        Home Health Agencies Did Not Ensure That Outcome and Assessment  
        Information Set Data Were Accepted Before Submitting Claims ..... 4

        Medicare Did Not Have Adequate Payment Controls ..... 4

    Overpayments Estimates ..... 4

RECOMMENDATIONS ..... 5

CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND  
OFFICE OF INSPECTOR GENERAL RESPONSE ..... 5

    Reopen Nonsampled Claims and Recover Overpayments ..... 5

        CMS Comments ..... 5

        Office of Inspector General Response ..... 6

    Encourage Regional Home Health Intermediaries To Conduct Periodic Postpayment  
    Reviews of Home Health Agencies’ Claims ..... 6

        CMS Comments ..... 6

        Office of Inspector General Response ..... 7

APPENDIXES

A: Audit Scope and Methodology .....8

B: Statistical Sampling Methodology.....10

C: Sample Results and Estimates .....12

D: Centers for Medicare & Medicaid Services Comments .....13

## INTRODUCTION

### WHY WE DID THIS REVIEW

In 2012, the Office of Inspector General issued a report<sup>1</sup> that disclosed that home health agencies (HHAs) nationwide did not submit required Outcome and Assessment Information Set (OASIS) data for 6 percent of HHA claims in calendar year (CY) 2009, which represented over \$1 billion in Medicare payments. Effective January 1, 2010, the Centers for Medicare & Medicaid Services (CMS) began requiring HHAs to submit OASIS data as a Medicare condition of payment. In its response to our report, CMS stated that it cannot enforce this requirement because of limitations in the Medicare claims processing system. CMS stated that it is still working on building a systematic interface of the HHA claims and OASIS submission process. CMS contracts with four regional home health intermediaries (RHHIs) that use the Fiscal Intermediary Shared System (FISS) to process and pay HHA claims. As a followup to our review of CY 2009 claims taking into account the new condition of payment, we reviewed one RHHI that processes and pays HHA claims for six New England States to determine the extent to which it denied CY 2010 claims with missing OASIS data.

### OBJECTIVE

Our objective was to determine whether the RHHI made Medicare payments only for claims for which HHAs had submitted accepted OASIS data.

### BACKGROUND

#### Medicare

Medicare provides health insurance coverage to people aged 65 and over, people with disabilities, and people with end-stage renal disease. Medicare Part A pays for certain inpatient services in hospitals, hospice care, skilled nursing facilities, and some home health care services. CMS administers Medicare.

#### Outcome and Assessment Information Set Data

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups,<sup>2</sup> to monitor the effects of treatment on patient care and outcome, and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes and represent specific sets of patient characteristics.

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<sup>1</sup> *Limited Oversight of Home Health Agency OASIS Data* (OEI-01-10-00460), issued February 2012.

<sup>2</sup> Case-mix groups are used as the basis for the Health Insurance Prospective Payment System (HIPPS) rate codes used by Medicare in its prospective payment systems. Case-mix groups are designed to classify acute care inpatients who are similar clinically in terms of resources used.

HHAs use OASIS data to determine how much care on average beneficiaries with the same conditions need over a 60-day period known as an episode. CMS requires an HHA to complete a comprehensive assessment, including OASIS data items, within 5 calendar days after the start of care, update and revise the assessment and the OASIS data at least 5 days before the next 60-day episode, and encode and transmit electronically OASIS data to its State survey agency within 30 days of completing the comprehensive assessment.<sup>3</sup> The HHA submits an interim claim after completing the OASIS data at the start of the first episode of care to receive an initial payment of 60 percent of the rate for that episode, with the balance to be paid subsequently (42 CFR § 484.205(b)(1)). Initial payments of 50 percent are paid at the beginning of additional episodes of care, with the balance paid subsequently (42 CFR § 484.205(b)(2)). HHAs must fill out the CMS form CMS-1450 for both the interim claim and again for a final claim once the OASIS data are accepted. The State survey agency provides a final validation report, which informs the HHA whether the OASIS data have been accepted or rejected.<sup>4</sup> CMS maintains a Quality Improvement and Evaluation System (QIES) that tracks OASIS data that the State survey agency has accepted.

### **Data Required as a Condition of Payment**

Effective January 1, 2010, CMS required HHAs to submit OASIS data as a condition of payment and instructed RHHIs not to pay claims that lacked OASIS data.<sup>5</sup> CMS did not address whether HHAs could resubmit denied claims for payment once HHAs had submitted accepted OASIS data for those claims.

### **HOW WE CONDUCTED THIS REVIEW**

Medicare made payments to HHAs in six New England States for HHA claims totaling approximately \$1 billion with dates of service in CY 2010. We limited our review to 16,582 HHA claims totaling \$42.8 million that our data match showed (1) OASIS data was submitted and accepted but only after the RHHI paid the claims or (2) did not have a record that accepted OASIS data had been submitted. Our objective did not require an understanding or assessment of the complete internal control structures of HHAs, CMS, the RHHI, or the State survey agencies. Therefore, we limited our review at the HHAs to the controls related to submitting OASIS data and the corresponding claims. We limited our review at the RHHI and CMS to those controls relating to preventing and detecting Medicare overpayments and at the State survey agency to controls in processing HHA OASIS data.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit

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<sup>3</sup> 42 CFR § 484.55(b) and (d) and 42 CFR § 484.20(a).

<sup>4</sup> OASIS data are rejected for errors such as missing diagnoses or procedure codes.

<sup>5</sup> 42 CFR § 484.210(e); 74 Fed. Reg. 58110 (Nov. 10, 2009); CMS, *Program Integrity Manual*, chapter 3, § 3.2.3.1.

objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our audit scope and methodology, Appendix B contains the details of our statistical sampling methodology, and Appendix C contains the details of our sample results and estimates.

## **FINDINGS**

The RHHI paid Medicare claims for which HHAs had not submitted the required OASIS data. Of the 100 claims that we sampled, the RHHI made payments totaling \$156,722 for 65 claims that should not have been paid. Specifically, 36 claims should not have been paid because the HHAs had not submitted accepted OASIS data at the time of payment, and 29 claims should not have been paid because HHAs had not submitted accepted OASIS data. We estimated that the RHHI made approximately \$25.1 million in Medicare overpayments because it did not deny claims that HHAs had submitted without the OASIS data, which is a condition of payment.

Overpayments occurred because HHAs often had inadequate controls for the submission of OASIS data. Furthermore, Medicare payment controls were inadequate to prevent or detect payments to HHAs for claims that were missing accepted OASIS data. Without adequate controls, CMS has a limited ability to prevent payments to HHAs that have not submitted accepted OASIS data.

### **PROGRAM REQUIREMENTS**

CMS requires the submission of OASIS data for final claims as a condition of payment as of January 1, 2010.<sup>6</sup> Additionally, CMS stated that a “contractor shall not authorize payment if the provider fails to submit OASIS” data consistent with the HIPPS on the claim<sup>7</sup> and “shall deny the claim if providers do not meet this regulatory requirement.”<sup>8</sup>

### **PAYMENTS FOR CLAIMS THAT LACKED ACCEPTED DATA**

#### **Claims Paid Before Data Were Accepted**

The RHHI made Medicare overpayments to HHAs for 36 claims because it made those payments before the HHAs submitted accepted OASIS data. For these claims, the HHAs’ final validation reports showed that the OASIS data were submitted an average of 292 days after the RHHI made the payment. CMS’s QIES also confirmed that the HHAs had submitted the OASIS data after payment. For 3 of these 36 claims, the HHAs also submitted OASIS data with HIPPS codes that

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<sup>6</sup> 42 CFR 484.210(e); 74 Fed. Reg. 58110 (Nov. 10, 2009) and CMS, *Program Integrity Manual*, chapter 3, §, 3.2.3.1.

<sup>7</sup> CMS Transmittal 343, June 18, 2010.

<sup>8</sup> CMS, *Program Integrity Manual*, chapter 3, § 3.2.3.1.

did not match the HIPPS codes on the paid claims. Medicare overpaid HHAs \$94,425 for these 36 claims.

### **Claims Paid Without Accepted Data**

The RHHI made Medicare overpayments to HHAs for 29 claims because the HHAs had not submitted accepted OASIS data for those claims.<sup>9</sup> For each of these claims, the State survey agencies had rejected the OASIS data associated with the claims, and the HHAs had not resolved the issue and resubmitted the OASIS data. The RHHI made \$62,297 in Medicare overpayments to HHAs for these 29 claims.

## **INADEQUATE INTERNAL CONTROLS**

### **Home Health Agencies Did Not Ensure That Outcome and Assessment Information Set Data Were Accepted Before Submitting Claims**

HHAs often had inadequate controls for the submission, validation, and correction of the OASIS data they submitted to the State survey agencies. Specifically, HHAs did not always (1) process OASIS data in a timely manner, (2) develop procedures to obtain electronic copies of the final validation reports from the State survey agency, (3) review the final validation reports to identify rejected OASIS data, (3) reconcile the final validation reports to HHA system reports to verify acceptance of the OASIS data, and (5) confirm the payment rates.

### **Medicare Did Not Have Adequate Payment Controls**

Medicare payment controls were inadequate to prevent or detect payments to HHAs for claims that were missing accepted OASIS data. Specifically, CMS had not implemented a process that would allow the FISS to interface with State survey agencies to identify, on a prepayment basis, HHA claims without accepted OASIS data.<sup>10</sup> Further, CMS had not established a unique occurrence code to be recorded on the required CMS-1450 claim form to report the date that State survey agencies accepted the OASIS submission. Lastly, the controls at the RHHI were limited to postpayment reviews of a small percentage of claims to determine whether HHAs submitted accepted OASIS data before payment. However, we acknowledge that postpayment reviews can be costly and labor intensive and may not always ensure overpayment recoveries.

## **OVERPAYMENT ESTIMATES**

We estimated that the RHHI made approximately \$25.1 million in overpayments for claims that HHAs submitted before OASIS data were accepted or without accepted OASIS data.

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<sup>9</sup> HHAs had not submitted accepted OASIS data for these claims as of November 2012.

<sup>10</sup> Although we limited our review to claims processed and paid by one RHHI, the other three RHHIs also used the FISS to process and pay claims.

## RECOMMENDATIONS

We recommend that CMS:

- adjust the 65 sampled claims for overpayments of \$156,722 to the extent allowed under the law;
- consider reopening the 16,482 nonsampled claims of which 3,819 claims were paid before OASIS data were accepted and 12,663 did not match to OASIS data,<sup>11</sup> review our information on these claims, and recover any overpayments to the extent allowed under the law;
- complete the process that would allow the FISS to interface with State survey agency systems to identify, on a prepayment basis, HHA claims without accepted OASIS data submissions, which could have resulted in savings totaling \$25.1 million during CY 2010 for claims paid by one RHHI; and
- encourage RHHIs to conduct periodic postpayment reviews of HHA claims, which would include ensuring OASIS data supports claims, until sufficient prepayment controls are established.

### CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, CMS fully concurred with our first and third recommendations, partially concurred with our second recommendation, and did not concur with our fourth recommendation. In addition, CMS did not concur with a recommendation included in our draft report that CMS should establish an occurrence code to be recorded on the CMS-1450 claim form for HHAs. We agreed with CMS's rationale for not concurring with that recommendation and have omitted it from this final report. CMS's comments, excluding a technical comment that we addressed, are included as Appendix D.

### REOPEN NONSAMPLED CLAIMS AND RECOVER OVERPAYMENTS

#### CMS Comments

CMS agreed to conduct an analysis of the 12,663 nonsampled claims that did not match to OASIS data to determine an appropriate number of claims to review. However, because our review showed OASIS data were submitted and accepted after the RHHI paid the 3,819 remaining nonsampled claims, CMS did not concur with reopening them and cited its *Program Integrity Manual*, which states that MACs may choose not to reopen claims when documentation is received past the deadline.

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<sup>11</sup> A Excel file of these transactions can be provided to support these nonsampled claims.

## Office of Inspector General Response

CMS's intention to make OASIS submission a condition of payment is clear through its regulations, rulemaking, and manual instructions.<sup>12</sup> As such, we do not agree with CMS's nonconcurrency regarding reopening the 3,819 claims in question. Section 3.2.3.9 of chapter 3 of the *Program Integrity Manual*, to which CMS cites, provides MACs with the discretion to reopen denied claims; however, it does so in the context of instructing MACs how to respond to the untimely submission of documents in a prepayment or postpayment review. By contrast, the 3,819 paid claims being questioned in this report are being questioned for failure to meet a condition of payment; that is, because of the belated submission of OASIS data, these claims have been determined by CMS in regulation to be ineligible for reimbursement. CMS stated in its Federal Register notice<sup>13</sup> that "providers will ensure that prior to submitting a final HH PPS [Home Health Prospective Payment System] episode claim, a provider will have submitted an OASIS" and "[a]s such, we are implementing the provision to require the submission of OASIS, for final claims, as a condition of payment." Indeed, the chapter of the *Program Integrity Manual* to which CMS cites to establish the MAC's flexibility in prepayment and postpayment reviews contains language in a separate paragraph that states clearly, "Beginning January 1, 2010, home health agencies (HHAs) are required to submit an OASIS as a condition for payment. The MACs shall deny the claim if providers do not meet this regulatory requirement."

In a subsequent discussion with officials from the CMS Office of Financial Management and the Center for Medicare regarding CMS's response to our report, the officials stated that if prepayment controls, such as the interface between the FISS and the OASIS assessment repository, were functioning at the time these HHA claims were submitted, the claims would not have been paid because no OASIS data had been accepted and no adjustment or subsequent claim payment would have been allowed. Therefore, we maintain that CMS should reopen the 3,819 claims that were paid before OASIS data were accepted and recover any overpayments associated with them.

## **ENCOURAGE REGIONAL HOME HEALTH INTERMEDIARIES TO CONDUCT PERIODIC POSTPAYMENT REVIEWS OF HOME HEALTH AGENCIES' CLAIMS**

### **CMS Comments**

CMS did not concur with our recommendation that it encourage RHHIs to conduct periodic postpayment reviews of HHA claims. CMS stated that MACs already review HHA claims on a prepayment basis. Furthermore, CMS stated that it is enhancing the Medicare Contractors Extract Systems, which will add more data fields to increase the probability of obtaining OASIS data.

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<sup>12</sup> 42 CFR 484.210(e); 74 Fed. Reg. 58110 (Nov 10, 2009); and CMS, *Program Integrity Manual*, chapter 3, § 3.2.3.1.

<sup>13</sup> 74 Fed. Reg. 58110 (Nov. 10, 2009).

## **Office of Inspector General Response**

The RHHI paid over 16,000 Medicare claims for which HHAs had not submitted the required OASIS data. Until CMS establishes the interface between the FISS and the OASIS assessment repositories, we maintain that RHHIs should augment prepayment reviews with postpayment reviews of HHA claims.

## **APPENDIX A: AUDIT SCOPE AND METHODOLOGY**

### **SCOPE**

We limited our review to Medicare payments made by HHAs in the six New England States (Massachusetts, Connecticut, Maine, Vermont, Rhode Island, and New Hampshire) totaling \$1 billion with dates of service in CY 2010. Our audit covered 16,582 HHA claims totaling \$42.8 million that were at high risk of overpayments because our data match showed that OASIS data were not submitted or were submitted and accepted but only after the RHHI paid the claims.

Our objective did not require an understanding or assessment of the complete internal control structures of HHAs, CMS, the RHHI, or the State survey agencies. Therefore, we limited our review at the HHAs to the controls related to submitting OASIS data and the corresponding claims. We limited our review to one RHHI, one State survey agency, and CMS to those controls relating to preventing and detecting Medicare overpayments.

Our fieldwork consisted of contacting selected HHAs in New England. We also contacted one RHHI, the Massachusetts State survey agency, and the CMS regional office in Boston, Massachusetts. We conducted our fieldwork from June through November 2012.

### **METHODOLOGY**

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted specific types of HHA final action claims from CMS's National Claims History file for CY 2010;
- obtained OASIS data submissions from CMS's QIES for CY 2010;
- developed computer matches that compared the HHA claims and the OASIS data submissions and identified 12,733 claims with no OASIS data and 3,849 claims where the OASIS data were submitted after the claim was paid;
- selected a stratified random sample of 100 claims from the 16,582 claims (Appendix B);
- reviewed data from CMS's Common Working File for the 100 claims to (1) validate claim information extracted from the National Claims History file, (2) verify that the HHAs were paid for claims that lacked accepted OASIS data, and (3) determine whether any of the selected claims had been canceled or adjusted;
- removed 35 claims from our sample (our match did not account for 14 claims for which HHAs submitted accepted OASIS data in CY 2011 for CY 2010 services; for 11 claims,

HHAs submitted accepted OASIS data more than 5 calendar days after the start of care;<sup>14</sup> 4 claims were under investigation by OIG; 3 claims had accepted OASIS data with missing social security numbers; and for 3 claims, we incorrectly identified that HHAs had not submitted accepted OASIS data);

- interviewed officials from CMS, the RHHI, and the Massachusetts State survey agency to better understand the OASIS data submission process and requirements;
- contacted officials from 39 HHAs that submitted the 100 claims to request supporting documentation for the OASIS data submission;
- reviewed the supporting documentation (i.e., final validation reports) obtained from the HHAs for their OASIS data submissions;
- worked with the CMS regional office to verify OASIS data submissions;
- estimated the total value of overpayments on the basis of our sample results (Appendix C); and
- discussed the results of our review with RHHI and CMS officials.

We conducted this audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

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<sup>14</sup> The HHAs that submitted these OASIS data did not comply with the timeframe for which HHAs must complete the OASIS data as a condition of participation under § 484.55(b). However, these HHAs did comply with the condition of payment which requires that HHAs submit accepted OASIS data before their claims are paid.

## APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

### POPULATION

The population consisted of Medicare HHA claims processed by National Heritage Insurance Corporation (NHIC) for services provided to beneficiaries in CY 2010.

### SAMPLING FRAME

The sample frame was an Access file containing 16,582 HHA claims for which (1) 3,849 were matched to OASIS data that were submitted after the claims were already paid and (2) 12,733 did not have OASIS data that matched. The value of the sampling frame is \$42,780,651.

The sampling frame was the same as the target population.

### SAMPLE UNIT

The sample unit was an HHA claim.

### SAMPLE DESIGN

We used a stratified random sample with the following two strata:

**Table 1: Stratified Random Sample**

<b>Stratum</b>	<b>HHA Claim Categories</b>	<b>Number of HHA Claims</b>	<b>Dollar Value of HHA Claims</b>
1	Claim Matched to OASIS	3,849	\$9,992,867
2	Claim Not Matched to OASIS	12,733	\$32,787,784
<b>Total</b>		<b>16,582</b>	<b>\$42,780,651</b>

### SAMPLE SIZE

We randomly selected 30 claims from stratum 1 and 70 from stratum 2. Our total sample size was 100 claims.

### SOURCE OF RANDOM NUMBERS

We generated the random numbers with the Office of Inspector General (OIG), Office of Audit Services (OAS), statistical software.

## **METHOD OF SELECTING SAMPLE UNITS**

We consecutively numbered the sample units in the frame for each of the two strata. After generating 30 random numbers for stratum 1 and 70 random numbers for stratum 2, we selected the corresponding frame items.

## **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the dollar value of overpayments made to HHAs for services provided to beneficiaries.

**APPENDIX C: SAMPLE RESULTS AND ESTIMATES**

**Table 2: Sample Results**

<b>Stratum</b>	<b>Frame Size</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>HHA Claims in Error</b>	<b>Value of Overpayments</b>
1	3,849	\$9,992,867	30	\$76,230	25	\$62,740
2	12,733	32,787,784	70	154,953	40	93,982
<b>Total</b>	<b>16,582</b>	<b>\$42,780,651</b>	<b>100</b>	<b>\$231,183</b>	<b>65</b>	<b>\$156,722</b>

**Table 3: Estimated Overpayments**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	\$25,144,922
Lower limit	20,445,315
Upper limit	29,844,530

Notice: This section recorded our results by stratum and it will not match precisely with the categories discussed in this report's findings.



## APPENDIX D: CENTERS FOR MEDICARE & MEDICAID SERVICES COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

*Administrator*  
Washington, DC 20201

**DATE:** DEC - 9 2013

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

**FROM:** Marilyn Tavenner   
Administrator

**SUBJECT:** Office of Inspector General (OIG) Draft Report: "Medicare Often Made Overpayments to New England Home Health Agencies for Claims Without Required Outcome and Assessment Information Set Data" (A-01-12-00508)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the above subject OIG draft report. This report is a follow-up to OIG's review, issued in 2012, which disclosed that home health agencies (HHAs) nationwide did not submit required Outcome and Assessment Information Set (OASIS) data for six percent of HHA claims in calendar year (CY) 2009, which represented over \$1 billion in Medicare payments. In this follow-up report, OIG reviewed one regional home health intermediary (RHHI) that processes and pays HHA claims for six New England states to determine the extent to which it denied CY 2010 claims with missing OASIS data. The objective of this review was to determine whether the RHHI made Medicare payments only for claims for which HHAs had submitted accepted OASIS data.

The CMS appreciates the time and resources OIG has invested to review this issue. CMS has reviewed the report and responded to the recommendations below.

### **OIG Recommendation**

Adjust the 65 sampled claims for overpayments of \$156,722 to the extent allowed under the law.

### **CMS Response**

The CMS concurs with this recommendation. CMS has reviewed the OIG overpayment data for the 65 sample claims that should not have been paid and plans to recover the identified overpayments consistent with the agency's policies and procedures.

### **OIG Recommendation**

Consider re-opening the 16,482 non-sampled claims for which 3,819 claims were paid before OASIS data were accepted and 12,663 claims that did not match to OASIS data, review our information on these claims, and recover any overpayments to the extent allowed under the law.

### **CMS Response**

The CMS partially concurs with this recommendation. CMS does not agree with re-opening the 3,819 claims that were paid before OASIS data was accepted since OIG's report showed OASIS data was submitted and accepted after the RHHI paid the claims. The CMS Program Integrity Manual (PIM) (Pub. 100-08) Ch. 3 §3.2.3.9 states that a Medicare Administrative Contractor (MAC) can choose not to re-open claims when documentation is received past the deadline. CMS requests that OIG furnish the necessary data (e.g., Medicare contractor numbers, provider number, claims information including the paid date, claim number, Health Insurance Claim Number, overpaid amount, etc.) to follow-up on the 12,663 claims that did not match the OASIS data referenced in the draft report. In addition, CMS requests that current Medicare contractor-specific data be sent through a secure portal to better facilitate the transfer of information to the appropriate contractor.

Upon receipt of the files from OIG, CMS will conduct an analysis based on contractor resources to determine an appropriate number of claims to review. CMS will instruct the contractor to review the claims and take appropriate action.

### **OIG Recommendation**

Complete the process that would allow the Fiscal Intermediary Shared System (FISS) to interface with state survey agency systems to identify, on a prepayment basis, HHA claims without accepted OASIS data submissions, which could have resulted in savings totaling \$25.1 million during CY 2010 for claims paid by one RHHI.

### **CMS Response**

The CMS concurs with this recommendation. Change Request 7760 was issued April 27, 2012 to require Medicare contractors to create the claims/assessment interface:

<http://www.cms.gov/Regulations-and-Guidance/Guidance/Transmittals/Downloads/R2458CP.pdf>

The initial implementation is to link inpatient rehabilitation facility (IRF) claims and assessments, consistent with other OIG recommendations. System programming to include home health (HH) claims in the interface was part of this implementation, but was not activated. Since this interface is a new and unique process for Medicare systems, Medicare is using an incremental activation schedule to manage risk of unintended consequences.

All changes to Medicare's FISS were completed timely on October 1, 2012. However, the full IRF interface was delayed due to electronic file transfer problems. Medicare worked through 2013 to resolve all systems issues and the process is nearly complete. Activation of the IRF interface is expected in November 2013.

The CMS expects to activate the interface between the Medicare claims processing system and assessment repositories for HH claims in April 2014. Initially, the interface will be used to validate the accuracy of payment group codes billed on HH claims. The interface will be enhanced to include denial of HH claims if OASIS assessments were not submitted in full compliance with conditions of payment as soon as possible thereafter. Claim denials are being implemented separately, again to manage risk and also to allow for appropriate provider notification.

### **OIG Recommendation**

Establish an occurrence code to be recorded on the CMS-1450 claim form for HHAs which would include the date the OASIS data submission was accepted.

### **CMS Response**

The CMS does not concur with this recommendation. Precedent for an assessment-related occurrence code was established in 2011 when the National Uniform Billing Committee (NUBC) created occurrence code 50 – “Assessment Date.” The long descriptor for occurrence code 50 reads “Code indicating an assessment date as defined by the assessment instrument applicable to this provider type (e.g. Minimum Data Set (MDS) for skilled nursing).” This code could not be used for this recommendation since the date the OASIS assessment was accepted is not part of the assessment itself.

While CMS could approach NUBC for a similar code for the date the OASIS assessment was accepted, we do not believe this would be the best approach. Requiring HHAs to report this information on claims when the receipt date is on the OASIS assessment in CMS’ assessment repositories would create an unnecessary provider reporting burden to supply duplicative data. The assessment submission date is part of the response returned from the Quality Improvement Evaluation System in the claims-assessment interface created by Change Request 7760. CMS believes enforcement of assessment submissions based on this date can serve the same purposes as an occurrence code.

### **OIG Recommendation**

Encourage RHHIs to conduct periodic postpayment reviews of HHA claims, which would include ensuring OASIS data supports claims, until sufficient prepayment controls are established.

### **CMS Response**

The CMS does not concur with this recommendation. MACs are already reviewing HHA claims on a prepayment basis at this time. Furthermore, enhancements are being made to the Medicare Contractors Extract Systems, such as adding more data fields to increase the probability of locating the OASIS.

This will support the contractors' compliance reviews by increasing functional data or combination of data to substantiate that an assessment was appropriated and timely submitted.