

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**NEW JERSEY IMPROPERLY CLAIMED
MEDICAID REIMBURSEMENT FOR
SOME HOME HEALTH CLAIMS
SUBMITTED BY HOME HEALTH
AGENCIES**

*Inquiries about this report may be addressed to the Office of Public Affairs at
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**James P. Edert
Regional Inspector General
for Audit Services**

**July 2015
A-02-12-01012**

Office of Inspector General

<http://oig.hhs.gov>

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

New Jersey claimed at least \$2.8 million in Federal Medicaid reimbursement for home health services claims that were unallowable.

WHY WE DID THIS REVIEW

We identified a potential vulnerability with New Jersey's Medicaid home health program. Specifically, some providers improperly billed for services that did not comply with all Federal and State requirements for Medicaid home health services. As a result, the New Jersey Department of Human Services (State agency) received unallowable payments for these home health services.

The objective of this review was to determine whether the State agency claimed Federal Medicaid reimbursement for home health services claims submitted by home health providers in accordance with Federal and State requirements.

BACKGROUND

Home health services are services provided to a beneficiary at the beneficiary's place of residence and must be provided under a physician's orders as part of a written plan of care that the physician reviews every 60 days. Many providers use Form CMS-485, Home Health Certification and Plan of Care, to document physicians' orders for home health services.

In New Jersey, home health providers must prepare an initial nursing assessment for each beneficiary and maintain clinical records for each patient admitted for care or accepted for service, including physician orders signed by the authorized practitioner. Home health aide services must be documented in the home health aide plan of care, provided by a certified aide who meets State agency training requirements and is supervised by a registered nurse from a certified home health provider.

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid claims for the following home health services: home health aide, skilled nursing, social services, occupational therapy, physical therapy, and speech therapy. From the 555,527 claims for these home health services with payments totaling \$69,631,484 (\$36,044,389 Federal share) that New Jersey claimed during the period of August 6, 2008, through March 30, 2011, we reviewed a simple random sample of 100 claims.

WHAT WE FOUND

The State agency claimed Federal Medicaid reimbursement for some home health services claims that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 75 claims complied with Federal and State requirements, but 25 claims did not. Of the 25 noncompliant claims, 2 contained more than 1 deficiency. Specifically, 12 claims

contained billing errors, aide in-service requirements were not met for 5 claims, nursing supervision requirements were not met for 4 claims, care plan requirements were not met for 3 claims, services were not documented or supported for 2 claims, and nursing assessment requirements were not met for 1 claim.

These deficiencies occurred because: (1) certain home health providers did not comply with Federal and State requirements, and (2) the State agency did not adequately monitor the home health providers. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$2,835,361 in Federal Medicaid reimbursement for home health services.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$2,835,361 to the Federal Government and
- improve its monitoring of home health providers to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS AND OUR RESPONSE

In written comments on our draft report, the State agency stated that it did not concur with all of our findings. The State agency stated that it has initiated the collection of overpayments associated with billing errors affected by a software programming error; therefore, these claims inaccurately influenced our sample results and estimated overpayment. The State agency also described actions it has taken and plans to take to address our second recommendation.

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We identified a total of 14 claims in our sample for which we identified billing issues; however, providers reported (and the State agency subsequently adjusted) 2 of these claims. We removed these two claims from our findings prior to issuing the draft report to the State agency. The State agency did not identify and adjust the remaining 12 claims; therefore, we included them in our findings.

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INTRODUCTION

WHY WE DID THIS REVIEW

We identified a potential vulnerability with New Jersey’s Medicaid home health program. Specifically, some providers improperly billed for services that did not comply with all Federal and State requirements for Medicaid home health services. As a result, the New Jersey Department of Human Services (State agency) received unallowable payments for these home health services.

OBJECTIVE

Our objective was to determine whether the State agency claimed Federal Medicaid reimbursement for home health services claims submitted by home health providers in accordance with Federal and State requirements.

BACKGROUND

Medicaid Program

The Medicaid program provides medical assistance to low-income individuals and individuals with disabilities. The Federal and State Governments jointly fund and administer the Medicaid program. At the Federal level, the Centers for Medicare & Medicaid Services (CMS) administers the program. Each State administers its Medicaid program in accordance with a CMS-approved State plan. Although the State has considerable flexibility in designing and operating its Medicaid program, it must comply with applicable Federal requirements. In New Jersey, the State agency administers the Medicaid program.

New Jersey’s Medicaid Home Health Program

Under New Jersey’s Medicaid home health program, home health care agencies provide a variety of services to beneficiaries at the beneficiaries’ place of residence, including: homemaker-home health aide, skilled nursing, speech therapy, physical therapy, occupational therapy, medical social services, and dietary/nutritional needs. Medicaid reimbursement is available for home health services provided by providers licensed by the New Jersey Department of Health and Senior Services.

Federal Requirements

Home health services must be provided under a physician’s orders as part of a written plan of care that the physician reviews every 60 days.¹ Many providers use Form CMS-485, Home Health Certification and Plan of Care, to document physicians’ orders for home health services.²

¹ 42 CFR § 440.70(a).

² Although Federal requirements do not require the use of the Form CMS-485, State regulations (NJAC § 10:60-1.8(a)) require its use for home health services.

Line 3 of Form CMS-485, entitled “Certification Period,” includes spaces for providers to enter “From” and “To” dates for valid home health services. The certification period represents the 60-day period during which the plan of care is valid. Federal law also establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards.³ Specifically, to be allowable, costs must be authorized or not prohibited by State or local laws and regulations.⁴

State Requirements

State regulations require physicians to certify the need for home health care services (NJAC § 10:60-2.2). Providers must also provide an initial nursing assessment for each beneficiary (NJAC § 10:60-2.1(d)1). Home health agencies are also required to maintain clinical records for each patient admitted for care or accepted for service, including physician orders signed by the authorized practitioner (NJAC § 10:60-2.4(a)4).

Home health aide services must be documented in the home health aide plan of care, provided by a certified aide who meets State agency training requirements (NJAC § 10:60-1.2) and is supervised by a registered nurse from a certified home health agency (NJAC § 10:60-2.1(d)4).

HOW WE CONDUCTED THIS REVIEW

We limited our review to Medicaid claims for the following home health services: home health aide; skilled nursing; social services; occupational therapy; physical therapy and speech therapy. From the 555,527 claims for these home health services with payments totaling \$69,631,484 (\$36,044,389 Federal share) that the State claimed during the period of August 6, 2008, through March 30, 2011, we reviewed a simple random sample of 100 claims. Specifically, we reviewed provider documentation to determine whether services were provided in accordance with Federal and State requirements.

We conducted this performance 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.

Appendix A contains the details of our audit scope and methodology, Appendix B contains our statistical sampling methodology, and Appendix C contains our sample results and estimates. For details on Federal and State requirements related to home health services, see Appendix D.

³ Section 1905(a) (7) of the Act authorizes home health services under the Medicaid State plan.

⁴ 2 CFR pt. 225 (Office of Management and Budget Circular A-87, *Cost Principles for State, Local, and Indian Tribal Governments*).

FINDINGS

The State agency claimed Federal Medicaid reimbursement for some home health services claims that were not in accordance with Federal and State requirements. Of the 100 claims in our random sample, 75 claims complied with Federal and State requirements, but 25 claims did not. Of the 25 claims, 2 contained more than 1 deficiency. The table summarizes the deficiencies noted and the number of claims that contained each type of deficiency.

Table: Summary of Deficiencies in Sampled Claims

| Type of Deficiency | Number of Unallowable Claims ^a |
|--|---|
| Billing errors | 12 |
| Aide in-service requirements not met | 5 |
| Nursing supervision requirements not met | 4 |
| Care plan requirements not met | 3 |
| Services not documented or supported | 2 |
| Nursing assessment requirements not met | 1 |

^a The total exceeds 25 because 2 claims contained more than 1 deficiency.

These deficiencies occurred because: (1) certain home health providers did not comply with Federal and State requirements, and (2) the State agency did not adequately monitor the home health providers. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$2,835,361 in Federal Medicaid reimbursement for home health services that did not meet Federal and State requirements.

BILLING ERRORS

Home health providers must bill the statewide Medicaid rate for each full 15-minute interval of a face-to-face service in which hands-on medical care is provided to a beneficiary (NJAC § 10:60-2.5(g)2).⁵

For 12 of the 100 sampled claims, the home health provider improperly billed for home health services.⁶ Specifically:

- For 10 claims, a software programming error resulted in the number of units billed being rounded up by an additional unit.

⁵ Providers are required to bill 1 unit of service for the initial contact through 29 minutes, 2 units for minutes 30 through 44, 3 units for minutes 45 through 59, and 1 additional unit for every 15 minutes thereafter.

⁶ We identified two additional claims in our sample for which the home health provider improperly billed for home health services. However, we did not report on these claims because the associated providers reported (and the State agency subsequently adjusted) the claims.

- For one claim, the provider billed for services not approved under the Medicaid home health program. Specifically, the provider billed for services approved under a Medicaid waiver program.⁷
- For one claim, a provider billed for a unit of service that was not performed.

AIDE IN-SERVICE REQUIREMENTS NOT MET

Home health aides are required to complete 12 hours of in-service training per year (NJAC § 10:60-1.2).

For 5 of the 100 sampled claims, the aide that provided direct patient care to the beneficiary did not complete 12 hours of in-service training during the calendar year in which the service was provided or during the preceding 12 months.

NURSING SUPERVISION REQUIREMENTS NOT MET

A registered nurse is required to visit each certified aide at least once every two weeks while the aide is performing Medicaid services. The aide is required to be under the direction and supervision of the nurse (NJAC § 10:60-2.1(d)4).

For 4 of the 100 sampled claims, nursing supervision requirements were not met for the aide providing Medicaid services.

CARE PLAN REQUIREMENTS NOT MET

Home health services are provided in a beneficiary's place of residence and on physician's orders as part of a care plan that the physician must review every 60 days.⁸ The care plan is developed by the attending physician in conjunction with the agency nursing staff (NJAC § 10:60-2.3(a)). When home health aide services are included on the care plan (Form CMS-485), a registered nurse is required to prepare a separate care plan specific to the beneficiary's needs for the home health aide to follow (NJAC § 10:60-2.1(d)4.ii).⁹

For 3 of the 100 sampled claims, there was no care plan prepared by a registered nurse for the home health aide to follow.

SERVICES NOT DOCUMENTED OR SUPPORTED

Services claimed for Federal Medicaid reimbursement must be documented (42 CFR § 433.32). Home health providers must maintain documentation such as clinical notes, which shall be written, signed and dated on each day a service is provided (NJAC § 10:60-2.4(a)4).

⁷ For this claim, we disallowed the difference between the Medicaid rate and the allowable waiver rate.

⁸ 42 CFR § 440.70(a). In New Jersey, providers used Form CMS-485 to document the beneficiary's plan of care.

⁹ A home health aide plan of care is required when aide services are on the Form CMS-485 plan of care.

For 2 of the 100 sampled claims, providers did not provide service documentation. Specifically:

- For one claim, the provider did not provide a clinical note for services.
- For one claim, the provider did not provide the beneficiary's medical record.

NURSING ASSESSMENT REQUIREMENTS NOT MET

Providers must provide comprehensive nursing services under the direction of a public health nurse supervisor as defined by the State (NJAC § 10:60-2.1(d)1). The services shall include, but not be limited to, identifying nursing needs of the beneficiary by an initial assessment and a periodic reassessment.

For 1 of the 100 sampled claims, the provider did not provide an assessment of the beneficiary's nursing needs.

CONCLUSION

These deficiencies occurred because (1) certain home health providers did not comply with Federal and State requirements, and (2) the State agency did not adequately monitor the home health providers. On the basis of our sample results, we estimated that the State agency improperly claimed at least \$2,835,361 in Federal Medicaid reimbursement for home health services that did not comply with Federal and State requirements.

RECOMMENDATIONS

We recommend that the State agency:

- refund \$2,835,361 to the Federal Government and
- improve its monitoring of home health providers to ensure compliance with Federal and State requirements.

STATE AGENCY COMMENTS

In written comments on our draft report, the State agency stated that it did not concur with all of our findings. The State agency stated that it has initiated the collection of overpayments associated with billing errors affected by a software programming error; therefore, according to the State agency, these claims inaccurately influenced our sample results and estimated overpayment.¹⁰ The State agency also described actions it has taken and plans to take to address our second recommendation. The State agency's comments are included in their entirety as Appendix E.

¹⁰ The State agency also indicated that it is working to notify the providers associated with other claims we determined to be unallowable and recover all outstanding funds associated with these claims.

OFFICE OF INSPECTOR GENERAL RESPONSE

After reviewing the State agency's comments, we maintain that our findings and recommendations are valid. We identified a total of 14 claims in our sample for which we identified billing issues; however, providers reported (and the State agency subsequently adjusted) 2 of these claims. We removed these two claims from our findings prior to issuing the draft report to the State agency. The State agency did not identify and adjust the remaining 12 claims; therefore, we included them in our findings.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered the period August 6, 2008, through March 30, 2011. Our review covered 555,527 home health services claim lines, totaling \$69,631,484 (\$36,044,389 Federal share), submitted by 50 home health providers in the State. (In this report, we refer to these lines as claims.) We reviewed claims for the following home health services: home health aide services, skilled nursing, social services, occupational therapy services, physical therapy, and speech therapy services.

During our audit, we did not review the overall internal control structure of the State agency or the Medicaid program. Rather, we reviewed only the internal controls that pertained directly to our objective.

We performed fieldwork at the State agency's offices in Trenton, New Jersey, and at 35 home health providers throughout New Jersey.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal and State laws, regulations and guidelines related to home health care services;
- held discussions with State agency officials to gain an understanding of the Medicaid home health program;
- obtained from the State agency's contractor a sampling frame of 555,527 home health services claims, totaling \$69,631,484 (\$36,044,389 Federal share), made by 50 home health providers for the period August 6, 2008, through March 30, 2011;
- selected a simple random sample of 100 claims from the sampling frame of 555,527 claims; and for each of the 100¹¹ claims we:
 - reviewed the providers' documentation supporting the claim including clinical records and agency licensure and
 - reviewed the personnel file of the corresponding healthcare professional or home health aide for licensure or certification and training documentation;
- estimated the unallowable Federal Medicaid reimbursement paid in the sampling frame of 555,527 claims; and

¹¹ The 100 sampled claims comprised 41 skilled nursing claims, 22 home health aide claims, 17 physical therapy claims, 13 speech therapy claims and 7 occupational therapy claims.

- discussed our results with State agency officials.

We conducted this performance 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.

APPENDIX B: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population was Medicaid home health service claim lines (claims) submitted for selected procedure codes, submitted by home health agencies during our August 6, 2008, through March 30, 2011, audit period that were claimed for Federal Medicaid reimbursement by New Jersey.

SAMPLING FRAME

The sampling frame was a computer file containing 555,527 detailed claim lines for selected home health services delivered by 50 home health agencies in New Jersey during our audit period.¹² The total Medicaid reimbursement for the 555,527 claim lines was \$69,631,484 (Federal share \$36,044,389). The claims were extracted from the State's Medicaid payment files provided to us by staff of the State's Medicaid Management Information System fiscal agent.

SAMPLE UNIT

The sample unit was an individual Federal Medicaid claim for home health service.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We selected a sample of 100 claims.

SOURCE OF THE RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in the sampling frame. After generating 100 random numbers, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OAS statistical software to appraise the sample results. We estimated the overpayment associated with the unallowable claims at the lower limit of the 90-percent confidence interval.

¹² Specifically, we reviewed Medicaid claims for the following home health services: home health aide, skilled nursing, social services, occupational therapy, physical therapy, and speech therapy.

APPENDIX C: SAMPLE RESULTS AND ESTIMATES

Sample Details and Results

| Claims in Frame | Value of Frame (Federal Share) | Sample Size | Value of Sample (Federal Share) | Number of Unallowable Claims | Value of Unallowable Claims (Federal Share) |
|------------------------|---------------------------------------|--------------------|--|-------------------------------------|--|
| 555,527 | \$36,044,389 | 100 | \$5,967 | 25 | \$758 |

Estimated Unallowable Costs *(Limits Calculated for a 90-Percent Confidence Interval)*

| | |
|----------------|-------------|
| Point Estimate | \$4,211,200 |
| Lower Limit | \$2,835,361 |
| Upper Limit | \$5,587,039 |

APPENDIX D: FEDERAL AND STATE REQUIREMENTS RELATED TO HOME HEALTH SERVICES

Section 1905(a)(7) of the Social Security Act and implementing Federal regulations (42 CFR § 440.70(a)) permit States to elect, as an optional Medicaid benefit, home health care services furnished to an individual who is not an inpatient or resident of a hospital, nursing facility, intermediate care facility for persons with mental retardation, or institution for mental disease. The statute specifies that home health services must be: (1) authorized for an individual by a physician within a plan of care and reviewed every 60 days, (2) provided by an individual who is qualified to provide such services, and (3) furnished in a home or other location.

2 CFR pt. 225 (Office of Management and Budget Circular A-87) establishes principles and standards for determining allowable costs incurred by State and local governments under Federal awards. App. A, C.1.c. provides that to be allowable, costs must be authorized or not prohibited by State or local laws or regulations.

NJAC § 10:60-2.2 specifies that home health services must be authorized by a physician. The plan of care is developed by the attending physician with agency personnel and reevaluated by the nursing staff at least every two months and revised as necessary (NJAC § 10:60-2.3(a)).

The home health agency provides comprehensive nursing services under the direction of a public health nurse supervisor/director as defined by the Department of Health and Senior Services. Services include performing an initial assessment and periodic reassessments to identify the nursing needs of the beneficiary (NJAC § 10:60-2.1(d)1).

A registered nurse must prepare an assignment sheet for the aide to follow based on the nursing assessment of the beneficiary's needs and list the aide's duties as required in the plan of care (NJAC § 10:60-2.1(d)4.ii).

A registered nurse must supervise the homemaker home health aide at a minimum of one visit every two weeks when in conjunction with skilled nursing, physical or occupational therapy or speech-language pathology services at the beneficiary's residence when the homemaker home health aide is present or absent to assess relationships and determine whether goals are being met. (NJAC § 10:60-2.1(d)4.ii). The homemaker home health aide must successfully complete a minimum of 12 hours in-service education per year offered by the provider agency (NJAC § 10:60-1.2).

Clinical notes by nurses, social workers, and special therapists are required to be written, signed, and dated on the day each service is provided (NJAC § 10:60-2.4(a)4).

Providers are required to keep such records as are necessary to fully disclose the extent of services provided (NJAC § 10:49-9.8(b)1). Where such records do not document the extent of services billed, payment adjustments are necessary (NJAC § 10:49-9.8(b)3).

The service-specific Medicaid statewide rates are billed for each full 15 minute interval of face-to-face service in which hands-on medical care is provided to the beneficiary. One unit of

service is billed for services provided from the initial minute through 29 minutes, the second unit from 30 through 44 minutes, the third unit from 45 through 59 minutes, and the fourth unit from 60 through 74 minutes. A home health agency should not bill when a Medicaid/NJ Family Care fee-for-service beneficiary is not home or cannot be found, and hands-on medical care was not provided (NJAC § 10:60-2.5(g)).

APPENDIX E: STATE AGENCY COMMENTS



State of New Jersey

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May 27, 2015

Audit Report Number: A-02-12-01012

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Regional Inspector General for Audit Services
Department of Health and Human Services
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Jacob K. Javits Federal Building
26 Federal Plaza – Room 3900
New York, NY 10278

Dear Mr. Edert:

This correspondence is in response to the Department of Health and Human Services' Office of the Inspector General's (OIG) draft report entitled New Jersey Improperly Claimed Medicaid Reimbursement for Some Home Health Claims.

The draft audit report suggested that certain claims by the New Jersey Division of Medical Assistance & Health Services' (DMAHS) for federal Medicaid reimbursement related to home health services to fee-for-service beneficiaries did not comply with federal and state requirements.

Of the 100 random sample beneficiary claims reviewed during the audit period (August 6, 2008 through March 30, 2011), 75% were in compliance. According to the audit report, deficiencies occurred because DMAHS did not adequately monitor the business activities of the home health providers.

Following are the auditors' recommendations and DMAHS' responses:

New Jersey Is An Equal Opportunity Employer

Recommendation 1:

The OIG recommends that DMAHS refund \$2,835,361 to the Federal Government:

The State does not concur with all of the findings concerning claims for home health services. The audit report summarizes several deficiencies in the claims sample, specifically:

- Billing errors
- Aid in-service requirements not met
- Nursing supervision requirements not met
- Care plan requirements not met
- Services not documented or supported
- Nursing assessment requirements not met

DMAHS already has initiated collections of overpayments associated with home health billing errors affected by a software programming error. These claims, for which the number of units was being incorrectly calculated, already have been adjusted or are in the process of being adjusted and associated overpayments have been, or are being, refunded accordingly.

DMAHS believes that the claims categorized as billing errors in the audit sample are inaccurately influencing the calculation of the extrapolated refund amount. These claims, and others not identified in the audit sample, already have been addressed and corrected since the audit was completed. Furthermore, DMAHS currently is working to locate all other claims identified by the OIG in the audit report within the MMIS, notify the associated providers of the deficiencies found, and recover all outstanding funds associated with any claims not yet recovered.

Recommendation 2:

The OIG recommends that DMAHS improve its monitoring of home health providers to ensure compliance with Federal and State requirements:

Since the audit period, DMAHS has taken steps to enhance and improve the home health monitoring process. Specifically, an effective model for post-payment review of home health provider claims has been developed. The review parameters include, at minimum, the following verifications:

- Services are provided in accordance with the plan of care;
- The plan of care is reviewed and updated in a timely manner, as specified by the plan of care, at least every sixty days by the attending physician in conjunction with the agency nursing staff; and,

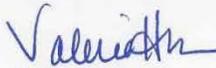
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- Home health aides employed by the home health agency have successfully completed a minimum of 12 hours in-service education per year offered by the agency and are supervised by a registered professional nurse employed by a DMAHS-approved home health and/or hospice agency provider.

DMAHS anticipates that these improvements will be fully implemented mid to late-summer 2015.

Thank you for providing the DMAHS an opportunity to provide written comments on the recommendations included in the draft audit report. If you have any questions, please do not hesitate to contact me or Richard Hurd at 609-588-2550.

Sincerely,



Valerie Harr
Director

VH:H
c: Elizabeth Connolly, Acting Commissioner
Richard Hurd, Chief of Staff