

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

OPERATION RESTORE TRUST

**REVIEW OF COSTS CLAIMED BY
HOME HEALTH CARE INC.**



JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1996
A-04-95-01107



SEP 30 1996

Memorandum

Date

From June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Home Health Care Inc. (A-04-95-01107)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Home Health Care Services Inc. (HHC) in Hialeah, Florida.

OBJECTIVE

The audit objective was to determine whether the home health care services claimed by HHC met Medicare reimbursement guidelines.

SUMMARY OF FINDINGS

We randomly selected for review 100 claims submitted by HHC for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,686 home health services. Our review showed that 44 claims or 44 percent of our sample contained 392 services (23 percent of the total services) that did not meet Medicare guidelines, as follows:

- ▶ 25 percent of the claims were for 285 services which, in the opinion of medical experts, were not reasonable or necessary;
- ▶ 14 percent of the claims were for 100 services provided to beneficiaries who, in their own opinion, or in the opinion of medical experts were not homebound;
- ▶ 3 percent of the claims were for 3 services which physicians did not authorize; and
- ▶ 2 percent of the claims were for 4 services not provided.

Cases in the latter two categories concern us and should be closely reviewed by the Medicare fiscal intermediary (FI).

During the FY ended December 31, 1993, HHC claimed \$6.7 million in 4,550 claims representing 80,439 services. Based on our review, we estimate that at least \$1.2 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between \$1.2 million and \$2 million.

Although we found documentation that indicated HHC monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as HHC, responsible for the actions of their subcontractors.

We recommend that the Health Care Financing Administration (HCFA) require the FI to instruct HHC on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FI and HHC to ensure that corrective actions are effectively implemented, direct the FI to investigate all cases of possible fraud and refer them as necessary to the Office of Inspector General's (OIG) Office of Investigations (OI), and recover all overpayments.

In its written response to our report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

BACKGROUND

Home Health Care Inc.

The HHC is a Medicare certified home health agency (HHA) with a principal place of business in Hialeah, Florida. The HHC is a proprietary Florida corporation owned and managed by South Eastern Health Management Associates Inc. The HHC directly and indirectly employs nurses, aides, therapists, and administrative personnel in Dade County.

A Medicare certified HHA, such as HHC, can either provide home health services itself or make arrangements with other certified or non-certified providers for home health services. Most of the services claimed by HHC were provided under contract with non-Medicare certified nursing groups.

During FY 1993, HHC was reimbursed under the periodic interim payment (PIP) method. Payments under PIP approximate the cost of covered services rendered by the provider. Interim reimbursement from Medicare totaled \$6.4 million. Interim payments are adjusted to actual costs based on annual cost reports. The HHC submitted a cost report for FY 1993 claiming costs totaling \$6.7 million.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in sections 1814, 1835, and 1861 of the Social Security Act; governing regulations are found in title 42 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Medicare HHA Manual.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the home health benefits program. The FI for HHC is Aetna Life and Casualty. The FI is responsible for:

- ▶ processing claims for HHA services,
- ▶ performing liaison activities between HCFA and the HHAs,
- ▶ making interim payments to HHAs, and
- ▶ conducting audits of cost reports submitted by HHAs.

SCOPE

The objective of the audit was to determine whether the home health care services claimed by HHC met Medicare reimbursement guidelines. The audit was performed under the auspice of Operation Restore Trust and was initiated by a request from HCFA's Atlanta Regional Office and its regional home health intermediary. The individuals who participated in this audit are shown on Appendix D.

The HHC claimed 80,439 services on 4,550 claims for FY 1993. We reviewed a statistical sample of 100 claims totaling 1,686 services for 94 different individuals (6 individuals appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims were submitted by HHC during the period January 1, 1993 through December 31, 1993. Appendix A contains the details on our sampling methodology. Appendix C contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by HHC met the reimbursement guidelines.

In addition to using the sample to determine the amount of overpayment, we used the sample to determine the percentage of certain characteristics. Appendix B contains the details of the results of these projections.

Generally, for each of the 100 claims, we interviewed:

- ▶ the beneficiary or a knowledgeable acquaintance,
- ▶ the physician who certified the plan of care, and
- ▶ the beneficiary's personal physician.

Our interviews included validation of beneficiaries' and physicians' signatures when necessary.

We interviewed 64 of the 94 beneficiaries. We were unable to interview 30 of the beneficiaries or a close acquaintance because they were either deceased or had moved out of the area. We were not able to interview one physician because he had moved out of the area. This physician certified the plan of care for one beneficiary who appeared twice in the sample.

We reviewed supporting medical records maintained by HHC for all of the claims in our sample. The records were also reviewed by the FI's medical personnel to determine whether the medical records for the claimed services met the reimbursement requirements.

We did not conduct a review of HHC's internal controls. Specifically, we did not review HHC's policies and procedures to monitor the work performed either by their own staff or subcontractors. However, during our review of medical records, we found documentation that indicated HHC did monitor its own employees and subcontractors.

Our field work was performed at HHC's administrative office in Hialeah, Florida, and the FI's office in Clearwater, Florida. Interviews were conducted in the beneficiaries' residences and the physicians' offices. Our field work was started in January 1995 and completed in December 1995. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

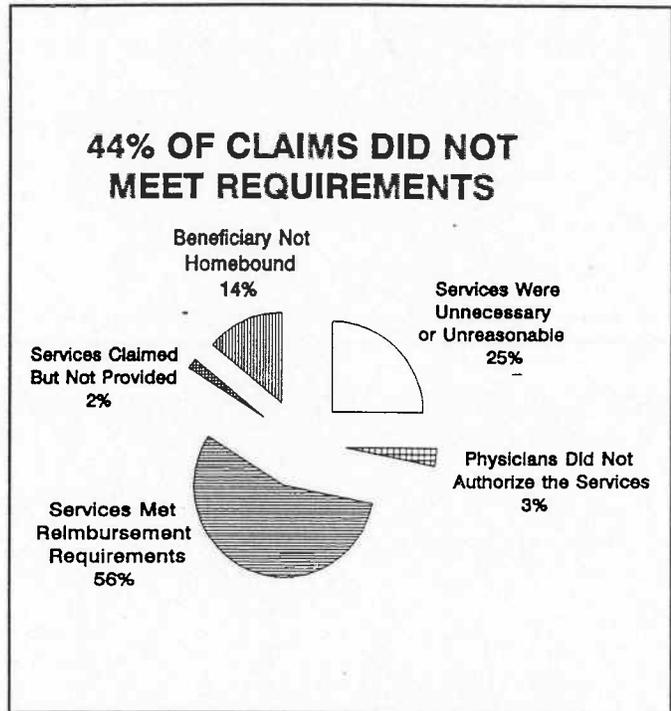
Our audit showed that 44 percent of the claims submitted by HHC during FY 1993 did not meet the Medicare reimbursement requirements.

Based on a statistical sample, we estimate that HHC received overpayments totaling at least \$1.2 million and using the 90 percent confidence interval, we believe the overpayment is between \$1.2 million and \$2 million. Although we found documentation that HHC monitored its employees and subcontractors, this monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement guidelines.

The regulations and guidelines clearly hold the HHA responsible for payments made for services performed by either their own staff or by subcontractors.

Criteria for Services Provided By Subcontractors

Section 409.42(g) of title 42 CFR states that "...home health services must be furnished by, or under arrangements made by a participating HHA." Section 200.2 of the Medicare HHA Manual states that "In permitting home health agencies to furnish services under arrangements it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the agency must exercise professional responsibility over the arranged-for services." In addition, the Medicare HHA conditions of participation at 42 CFR 484.14(h) set forth the requirements governing home health services furnished under arrangements.



Services That Were Not Reasonable or Necessary

Our review showed that 25 of the 100 claims were for 285 services which were not considered reasonable or necessary by the intermediary's medical review personnel.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy...." Section 203.1 of the Medicare HHA Manual states that the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary; and section 205.1.B.1 states that "Observation and assessment of the beneficiary's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the beneficiary's treatment regime is essentially stabilized."

The AEtna medical review personnel reviewed the records for the 25 beneficiaries and concluded that the medical records did not support the reasonableness or necessity of the services. The records for 19 of the beneficiaries did not show any instabilities, physician intervention, or changes in the plan of treatment which would require skilled nursing services. The records for four of the beneficiaries did not show objective comparative data to establish that the condition of the beneficiary will improve, or that the services were necessary to the establishment of a maintenance program. Two of the beneficiaries received psychiatric care from nurses who did not have the proper credentials to provide psychiatric care.

Services to Beneficiaries Who Were Not Homebound

Our review showed that 14 of the 100 claims were for 100 services to beneficiaries who were not homebound at the time the services were provided. The interviews of the beneficiary or a close acquaintance of the beneficiary, and the certifying physician indicated that the beneficiaries, by their own assessment, or that of the physicians, were not homebound at the time the services were provided. In all cases, HHC had documentation, such as the plan of care that indicated the individual needed skilled care and was homebound.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "... confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." Title 42 CFR 424.22 states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA manual at section 204.1 contains guidance regarding the "homebound" requirement.

The AEtna medical review personnel reviewed the records for the 14 beneficiaries that we determined did not meet the homebound requirement. They concluded that the medical records did not support a homebound determination for 12 of the beneficiaries, and did not support the need or reasonableness of the services for 2 of the beneficiaries.

We did not interview the personal physicians because the 14 beneficiaries did not have a personal physician different from the physician who signed the plan of treatment. We concluded that the 14 beneficiaries did not meet the homebound criteria. Our conclusion is based on the opinion of medical professionals, as well as the results of beneficiary interviews which included a description of their daily activities at the time of the services.

Physicians Did Not Authorize the Services

Our review showed that 3 of the 100 claims were for 3 services not authorized by a physician. In the three cases, the provider rendered and claimed one service in excess of the services authorized by the physician in the plan of care.

The laws, regulations, and guidelines recognize that the physician plays an important role in determining the utilization of services. The legislation specifies that payment for services may be made only if a physician certifies the services were required because the individual was homebound and needed skilled nursing care. The regulations (42 CFR 424.22) state that Medicare pays only if a physician certifies the services were needed. In addition, the regulations at 42 CFR 424.22 require all care to follow a physician's plan of care.

We discussed these cases with Aetna officials and they advised that claims not duly authorized should be denied.

Services Claimed but Not Provided

Our review showed that 2 of the 100 claims were for 4 services that were not provided. In the two cases, the medical records maintained by HHC contained the required documentation including nurses' notes and signatures of the beneficiaries indicating that the services provided were less than those claimed. In one case, four aide services were claimed; however, only one service was documented. In the other case, eight skilled nursing services were claimed but only seven were documented.

Effect

Our audit showed that 44 percent of the FY 1993 claims submitted by HHC were overstated. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval is \$1,179,157 to \$2,032,423 with a midpoint of \$1,605,790. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that HHC was overpaid by at least \$1,179,157 for unallowed home health services.

HHC Did Not Properly Monitor Subcontractors

Although documentation found in the files indicated that monitoring was being done to ensure that beneficiaries met the homebound and medical necessity criteria to receive HHA services, it failed to disclose the problems that we found.

The HHA coverage guidelines issued by HCFA provide that the HHA has essentially the same responsibilities for services provided by subcontractors as for services provided by their salaried employees. During reviews of the beneficiaries' medical records maintained

by the HHA, we found documentation that showed HHC did monitor subcontractors. However, in several instances the documentation showed that the beneficiaries were stable after an initial period of covered care, usually 3 weeks, yet no action was taken to discharge them until the certification period was over. We also found several instances where the services claimed were either more than those actually provided, or more than what was ordered by the physician, and the monitoring visits did not explain the discrepancies.

- RECOMMENDATIONS

We recommend that HCFA:

- o Require the FI to instruct HHC on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations and HCFA guidelines.
- o Monitor the FI and HHC to ensure that corrective actions are effectively implemented.
- o Direct the FI to investigate all cases of possible fraud and refer them as necessary to the OIG's OI.
- o Recover all overpayments.

In its written response to our report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

