Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Home Health Agency Provider Compliance Audit: Residential Home Health

Why OIG Did This Audit

Under the home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies.

Our prior audits of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

Our objective was to determine whether Residential Home Health (Residential) complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Audit

We selected a stratified random sample of 100 home health claims and submitted these claims to independent medical review.

What OIG Found

Residential did not comply with Medicare billing requirements for 11 of the 100 home health claims that we reviewed. For these claims, Residential received overpayments of $16,927 for services provided in calendar years (CYs) 2014 and 2015. Specifically, Residential incorrectly billed Medicare for beneficiaries who (1) were not homebound or (2) did not require skilled services. On the basis of our sample results, we estimated that Residential received overpayments of at least $2 million in CYs 2014 and 2015. All of the incorrectly billed claims are now outside of the Medicare reopening period.

What OIG Recommends

We recommend that Residential exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with our recommendations. We also recommend that Residential strengthen its procedures to ensure that (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented and (2) beneficiaries are receiving only reasonable and necessary skilled services.

In written comments on our draft report, Residential disagreed with our findings and recommendations and stated that it plans to contest our findings through the appeals process. After reviewing the response we received from Residential and further considering our medical review results, we maintain that our findings and recommendations are valid.