

Report in Brief

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



Why OIG Did This Review

Under the Medicare 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 reviews 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.

The objective of this review was to determine whether Mederi Caretenders (the Agency) complied with Medicare requirements for billing home health services.

How OIG Did This Review

We selected a stratified random sample of 100 home health claims (29 of these claims were for services in calendar year (CY) 2013 that were outside of the 4-year claim-reopening period). We evaluated the sampled claims for compliance with selected billing requirements and sent the claims to an independent medical review contractor to determine whether the services met coverage, necessity, and coding requirements.

Mederi Caretenders Home Health Billed for Home Health Services That Did Not Comply With Medicare Billing Requirements

What OIG Found

The Agency did not comply with Medicare billing requirements for 21 of the 71 home health claims paid in CYs 2014 or 2015 that we reviewed. For these claims, the Agency received overpayments of \$31,428. Specifically, the Agency incorrectly billed Medicare because (1) beneficiaries were not homebound, (2) beneficiaries did not require skilled services, (3) one claim was assigned with an incorrect Health Insurance Prospective Payment System billing code, or (4) one claim was not adequately documented. On the basis of our sample results, we estimated that during CYs 2014 and 2015 the Agency received overpayments totaling at least \$1.26 million.

What OIG Recommends and Agency Comments

We recommended that the Agency (1) refund to the Medicare program the portion of the \$1.26 million in estimated overpayments received during CYs 2014 and 2015 for claims incorrectly billed that are within the reopening and recovery periods; (2) exercise reasonable diligence to identify and return any additional similar overpayments outside of the 4-year claim-reopening period, in accordance with the 60-day rule; and (3) strengthen its controls to ensure full compliance with Medicare requirements for billing home health services.

The Agency disagreed with our findings and did not concur with any of our recommendations, including our extrapolated overpayment. The Agency stated that the draft report was fundamentally flawed because the independent medical review contractor misconstrued the applicable Medicare requirements and failed to perform a complete review of the patients' entire medical records. The Agency disputed our statistical sampling methodology and denied that the controls it had in place were inadequate to prevent the incorrect billing of Medicare claims. The Agency separately provided additional documentation related to these claims.

After reviewing the Agency's comments, the additional documentation that it provided, and the results of additional medical review, we revised our determinations, reducing the total number of reportable error claims in our audit period from 42 to 21, and revised our related findings and recommendations accordingly. We maintain that all of our findings, as revised, and all of our recommendations remain valid.