

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**INAPPROPRIATE AND
QUESTIONABLE BILLING BY
MEDICARE HOME HEALTH
AGENCIES**



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August 2012
OEI-04-11-00240

EXECUTIVE SUMMARY: INAPPROPRIATE AND QUESTIONABLE BILLING BY MEDICARE HOME HEALTH AGENCIES OEI-04-11-00240

WHY WE DID THIS STUDY

In 2010, Medicare paid \$19.5 billion to 11,203 home health agencies (HHA) for services provided to 3.4 million beneficiaries. Recent investigations and prior Office of Inspector General studies have found that home health services are vulnerable to fraud, waste, and abuse.

HOW WE DID THIS STUDY

We analyzed data from home health, inpatient hospital, and skilled nursing facility claims from 2010 to identify inappropriate home health payments. In addition, we identified HHAs that billed unusually high amounts according to at least one of our six measures of questionable billing. Although these six measures indicate potential fraud, there may be legitimate reasons for an HHA to exceed the threshold for unusually high billing on any of the six measures. We also determined the geographic locations of HHAs that had questionable billing.

WHAT WE FOUND

In 2010, Medicare inappropriately paid \$5 million for home health claims with three specific errors: overlapping with claims for inpatient hospital stays, overlapping with claims for skilled nursing facility stays, or billing for services on dates after beneficiaries' deaths. Further, we found that approximately one in every four HHAs exceeded the threshold that indicated unusually high billing for at least one of our six measures of questionable billing. Overall, HHAs with questionable billing were located mostly in Texas, Florida, California, and Michigan.

WHAT WE RECOMMEND

We recommend that the Centers for Medicare & Medicaid Services (CMS) (1) implement claims processing edits or improve existing edits to prevent inappropriate payments for the three specific errors we reviewed, (2) increase monitoring of billing for home health services, (3) enforce and consider lowering the 10-percent cap on the total outlier payments an HHA may receive annually, (4) consider imposing a temporary moratorium on new HHA enrollments in Florida and Texas, and (5) take appropriate action regarding the inappropriate payments we identified and HHAs with questionable billing. CMS concurred with all five recommendations; however, it disagreed with our estimate of the inappropriate payments for home health claims overlapping with claims for inpatient hospital stays and skilled nursing facility stays.

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OBJECTIVES

1. To determine the extent to which home health agencies (HHA) submitted Medicare claims that inappropriately overlapped with claims for inpatient hospital stays, overlapped with claims for skilled nursing facility stays, or were billed for services on dates after beneficiaries' deaths.
2. To identify and describe HHAs that exhibited questionable billing.

BACKGROUND

Medicare Parts A and B cover home health services furnished by HHAs to Medicare beneficiaries.^{1,2} In 2010, Medicare paid \$19.5 billion to 11,203 HHAs for home health services provided to 3.4 million beneficiaries.³ Home health services include part-time or intermittent skilled nursing services, physical therapy, occupational therapy, speech-language pathology services, part-time or intermittent home health aide services, medical social services, and medical supplies and durable medical equipment.^{4,5}

Home health services are vulnerable to fraud, waste, and abuse. In past years, OIG has raised concerns about HHAs and the billing of home health services.⁶ Additionally, recent investigations have illustrated a variety of fraud schemes involving HHAs. For example, a Texas physician was

¹ Social Security Act, §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 U.S.C. §§ 1395f(a)(2)(C) and 1395n(a)(2)(A).

² Part A covers home health services beginning within 14 days of a discharge from a hospital or skilled nursing facility. Social Security Act, § 1861(tt), 42 U.S.C. § 1395x(tt), and the Centers for Medicare & Medicaid Services (CMS), *Medicare Benefit Policy Manual*, Pub. 100-02, ch.7, § 60.1. Part B covers home health services not related to an inpatient stay. Social Security Act, § 1832(a), 42 U.S.C. § 1395f(a), and CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 60.3.

³ Office of Inspector General (OIG) analysis of 2010 National Claims History Part A Standard Analytical File.

⁴ Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

⁵ Part-time or intermittent skilled nursing or home health aide services are services furnished for a total of fewer than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, fewer than 8 hours each day and 35 or fewer hours per week). Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

⁶ OIG, *Review of Compliance with Billing Provisions Under the Prospective Payment System for Home Health Agencies' Therapy Services at Connecticut Home Health Care, Inc.*, A-01-04-00507, May 2005. See also OIG, *Review of Selected Paid Claims With Therapy Services Submitted to Medicare by Red Oak Home Health Services for the Period October 1, 2002, Through September 30, 2003*, A-09-04-00050, July 2005, and OIG, *Review of Selected Paid Claims with Therapy Services Submitted to Medicare by Total Patient Care Home Health, LLC for the Period October 1, 2002, Through September 30, 2003*, A-04-05-02000, September 2005.

indicted in February 2012 for allegedly certifying or directing the certification of beneficiaries' plans of care so that HHAs were able to bill Medicare for home health services that were not medically necessary or were not provided.⁷ This physician also allegedly performed unnecessary home visits and ordered unnecessary medical services. This is the largest alleged home health fraud scheme in U.S. history; HHAs allegedly fraudulently billed more than \$350 million to Medicare. Another alleged home health fraud scheme involved “beneficiary sharing”—a situation in which multiple HHAs fraudulently bill Medicare for the same beneficiaries. According to a September 2011 indictment, an individual allegedly sold beneficiary information to 100 different HHAs in Houston, Texas.⁸ These HHAs then allegedly used this beneficiary information to bill Medicare for services that were unnecessary or were never provided.

Medicare Home Health Services

To qualify for home health services, Medicare beneficiaries must (1) be confined to the home (i.e., homebound); (2) be in need of intermittent skilled nursing care or physical, speech, or continuing occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care established and periodically reviewed by a physician.^{9, 10, 11} For home health care starting on or after January 1, 2011, the certifying physician must document—prior to certifying the beneficiary’s eligibility—that he or she (or an allowed nonphysician practitioner) had a face-to-face

⁷ Department of Justice (DOJ) news release, *Dallas Doctor Arrested for Alleged Role in Nearly \$375 Million Health Care Fraud Scheme*, February 28, 2012. Accessed at <http://www.justice.gov/opa/pr/2012/February/12-crm-260.html> on March 12, 2012. Additionally, these certifications allegedly resulted in the fraudulent billing of more than \$24 million to Medicaid.

⁸ OIG news release, *Medicare Fraud Strike Force Charges 91 Individuals for Approximately \$295 Million in False Billing*, September 7, 2011. Accessed at <http://www.hhs.gov/news/press/2011pres/09/20110907c.html> on September 7, 2011.

⁹ Social Security Act, §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 U.S.C. §§ 1395f(a)(2)(C) and 1395n(a)(2)(A).

¹⁰ A beneficiary is considered to be confined to the home (or “homebound”) when he or she has a condition due to an illness or injury that restricts his or her ability to leave his or her residence except with the aid of supportive devices, the use of special transportation, or the assistance of another person or if leaving home is medically contraindicated. CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 30.1.1.

¹¹ For purposes of benefit eligibility, “intermittent skilled nursing care” means care that is provided or needed fewer than 7 days each week, or less than 8 hours of each day for periods of 21 days or less (with extensions in exceptional circumstances when the need for additional care is finite and predictable). Social Security Act, § 1861(m), 42 U.S.C. § 1395x(m).

encounter with the beneficiary.¹² This documentation must include a brief narrative explaining how the patient's clinical condition during that encounter supports the patient's homebound status and need for skilled services.¹³

A beneficiary cannot simultaneously receive home health services and care at an inpatient hospital or skilled nursing facility.^{14, 15} However, an HHA may arrange with a hospital, skilled nursing facility, or rehabilitation center to provide home health services on an outpatient basis if the services require use of equipment that cannot be made available in the home.¹⁶

Medicare Payment System for Home Health Services

CMS uses a prospective payment system that establishes a predetermined rate for each 60-day episode of home health care.¹⁷ The payment rate is adjusted for beneficiaries' health conditions and care needs, as well as for the geographical region.¹⁸ HHAs with beneficiaries who require a greater number of services receive a higher payment rate per 60-day episode.¹⁹ There are no limits to the number of 60-day episodes that eligible beneficiaries may receive; however, the home health services provided

¹² CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 30.5.1. For home health care starting on or after January 1, 2012, for patients admitted to home health agencies immediately after an acute or postacute stay, a physician who cared for the patient in an acute or postacute facility can inform the certifying physician regarding his or her face-to-face encounters with the patient. 42 CFR § 424.22(a)(1)(v), as amended by final rule "Medicare Program; Home Health Prospective Payment System Rate Update for Calendar Year 2012" (76 Fed. Reg. 68526 (Nov. 4, 2011)), effective January 1, 2012.

¹³ CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 30.5.1.1. This encounter must occur no more than 90 days prior to the start of home health care or within 30 days after the start of care.

¹⁴ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 10, § 30.9.

¹⁵ *Ibid.* A beneficiary can receive home health services on the day of admission to or on the day of discharge from an inpatient hospital or skilled nursing facility. However, Medicare systems will reject a home health claim containing dates for services provided during a beneficiary's inpatient hospital stay or skilled nursing facility stay. If a beneficiary has a leave of absence from an inpatient stay, then he or she can receive home health services during that leave of absence. CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 3, § 40.2.6, and ch. 6, § 40.3.5.2.

¹⁶ CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 30.1.1.

¹⁷ Social Security Act, § 1895(a), 42 U.S.C. § 1395fff(a).

¹⁸ Social Security Act, §§ 1895(b)(4)(B) and 1895(b)(4)(C), 42 U.S.C. §§ 1395fff(b)(4)(B) and 1395fff(b)(4)(C).

¹⁹ Medicare Payment Advisory Commission (MedPAC), *Home Health Care Services Payment System*, October 2011.

must be reasonable and necessary.^{20, 21} Beneficiaries generally do not make copayments for home health services.²²

Under the Medicare prospective payment system, at the time that the CMS contractor servicing an HHA's area receives the HHA's claim for a 60-day episode of care, the HHA receives an initial partial payment of the estimated rate for the full episode.²³ The HHA receives the remaining payment at the end of the 60-day episode. The total payment is the sum of the initial and remaining payments, unless there is an adjustment.²⁴ An example of a payment adjustment is a partial episode payment that occurs when a beneficiary transfers to another home health provider during a 60-day episode.

Medicare makes additional payments, known as outlier payments, to HHAs that provide services to beneficiaries who incur unusually high costs.²⁵ Beginning in January 2010, CMS implemented an agency-level outlier cap limiting total outlier payments for an individual HHA to a maximum of 10 percent of the HHA's annual total Medicare home health payments.²⁶

Additionally, Medicare adjusts the 60-day episode payment rate depending on whether the episode is an early episode (i.e., first or second) or a late episode (i.e., third or subsequent) in a sequence of episodes.²⁷ For episodes to be considered sequential, the next episode must begin within

²⁰ CMS, *Home Health PPS: Overview*. Accessed at <http://www.cms.gov/HomeHealthPPS/> on July 21, 2011.

²¹ Social Security Act, § 1862(a)(1)(A), 42 U.S.C. § 1395y(a)(1)(A).

²² CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, § 60.4. There is no coinsurance, copayment, or deductible for home health services and supplies other than (1) coinsurance for durable medical equipment (DME) covered as a home health service and (2) deductible and coinsurance for osteoporosis drugs, which are part of the home health benefit paid only under Part B. The coinsurance amount for DME and osteoporosis drugs furnished as home health services is 20 percent of the fee schedule amount for the services.

²³ CMS, *Home Health PPS: Overview*. Accessed at <http://www.cms.gov/HomeHealthPPS/> on July 21, 2011.

²⁴ *Ibid.*

²⁵ Social Security Act, § 1895(b)(5), 42 U.S.C. § 1395fff(b)(5).

²⁶ 74 Fed. Reg. 58078 and 58080-58087 (Nov. 10, 2009). See also CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 10, § 10.1.21. The Patient Protection and Affordable Care Act (Affordable Care Act) made the 10-percent agency-level cap a permanent statutory requirement beginning with 2011 by adding a new paragraph (B) to section 1895(b)(5) of the Social Security Act. Affordable Care Act, P.L. 111-148, § 3131(b)(2)(C) (adding Social Security Act, § 1895(b)(5)(B), 42 U.S.C. 1395fff(b)(5)(B)).

²⁷ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 10, § 10.1.19.2.

60 days of the previous episode's end date.²⁸ Late episodes have higher payment rates than early episodes.²⁹

Certificate of Need for Home Health Agencies

In order to participate in Medicare, HHAs must be licensed pursuant to applicable State or local law.³⁰ Some States require an HHA to obtain a Certificate of Need to be eligible to seek State licensure.³¹ Generally, a Certificate of Need program is intended to ensure that new health care facilities (e.g., HHAs) in the State (1) are developed as needed, (2) are the most cost effective approach to meeting identified needs, (3) are geographically accessible, (4) are financially viable, and (5) will not have a significant negative impact on the viability of other health care facilities or the quality and cost of the health care services that these other facilities provide. In addition, a Certificate of Need program is intended to ensure that services in the State (1) are of high quality and (2) are affordable by patients.

As of January 2012, 17 States and the District of Columbia have Certificate of Need policies that limit the number of HHAs in operation. The remaining 33 States do not require Certificates of Need for HHAs.

Detecting and Deterring Medicare Fraud and Abuse

CMS relies partly on contractors to safeguard the Medicare program from fraud and abuse. CMS requires these contractors to conduct activities to prevent improper payments and identify fraud and abuse. Specifically, CMS contracts with Home Health and Hospice Medicare Administrative Contractors (MAC) and Zone Program Integrity Contractors (ZPIC) to perform these activities for home health services.³²

MACs' primary responsibility is to process and pay Medicare home health and hospice claims. These contractors are also responsible for conducting prepayment and postpayment claim review and targeted provider education.³³ MACs create local coverage determinations and associated

²⁸ CMS, *Medicare Benefit Policy Manual*, Pub. 100-02, ch. 7, §§ 10.3 and 10.4.

²⁹ MedPAC, *Home Health Care Services Payment System*, October 2011. Assuming that other factors affecting payment, such as the beneficiary's health condition and care needs, remain the same.

³⁰ Social Security Act § 1861(o)(4), 42 U.S.C. § 1395x. See also 42 CFR § 484.12(a). If State or local law provides for licensure of HHAs, an HHA not subject to such licensure must be approved by the State or local licensing agency as meeting the licensure standards.

³¹ Certificate of Need is a State-specific issue, decided by each State through the health planning process. CMS does not participate in States' health planning processes.

³² The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, P.L. 108-173 § 911, required CMS to replace its current claims processing contractors (fiscal intermediaries and carriers) with Medicare Administrative Contractors. Also, CMS is replacing the legacy benefit integrity contractors, Program Safeguard Contractors, with ZPICs.

³³ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch.1, § 1.3.1.

articles and use proactive data analysis to monitor areas of vulnerability.^{34, 35} CMS and these contractors also implement and use claims processing edits (i.e., system processes) to prevent improper payments. For example, one such edit is intended to prevent payment of claims with dates of service after a beneficiary's death.

ZPICs identify cases of suspected fraud, develop them thoroughly and in a timely manner, take immediate action to ensure that Medicare funds are not inappropriately paid and that inappropriate payments are identified, and refer cases of potential fraud to law enforcement.³⁶ On occasion, CMS also contracts with ZPICs for special demonstration projects that combat fraud and abuse in a specific Medicare program and/or geographic area.

Additionally, CMS safeguards the Medicare program through its predictive analytics system and its authority to impose a temporary enrollment moratorium. As of June 2011, CMS implemented a predictive analytics system that analyzes all Medicare Part A and B claims to identify potential fraud.³⁷ This system builds profiles of Medicare providers (e.g., HHAs) that enable CMS to create risk scores.³⁸ These risk scores estimate the likelihood of fraud and identify potentially fraudulent claims and billing patterns.

CMS may also impose a temporary moratorium on the enrollment of new Medicare providers of a particular type (e.g., HHAs) and/or in a particular geographic location to safeguard Medicare payments.³⁹ For example, CMS may impose this moratorium if—in consultation with OIG (and/or DOJ) and with the approval of the CMS Administrator—it identifies a particular provider type and/or any particular geographic area as having a

³⁴ Local coverage determinations are decisions made by claims processing contractors (e.g., MACs) on a contractorwide basis regarding whether a particular item or service is considered “reasonable and necessary.” Any additional information that a contractor wants to communicate to providers—for example, information regarding billing or coding—would be placed in an associated article, known as a local coverage article.

³⁵ Proactive data analysis includes identifying patterns of potential billing errors through data analysis and evaluation of other information.

³⁶ CMS, *Medicare Program Integrity Manual*, Pub. 100-08, ch. 1, § 1.7.B.

³⁷ CMS, *Predictive Modeling Analysis of Medicare Claims*, MLN Network, November 2011. Accessed at <https://www.cms.gov/MLN/MattersArticles/Downloads/SE1133.pdf> on February 27, 2012.

³⁸ The predictive analytics system also builds profiles on networks, billing patterns, and beneficiary utilization.

³⁹ 42 CFR § 424.570 (a)(1). CMS may also impose a temporary enrollment moratorium on new Medicare suppliers.

significant potential for Medicare fraud, waste, or abuse.⁴⁰ A temporary moratorium may be imposed for 6 months, with the option to extend.

Related Office of Inspector General Work

In 2012, OIG found that 98 percent of medical records document that Medicare beneficiaries met coverage requirements for home health services.⁴¹ However, HHAs submitted 22 percent of claims in error because services were unnecessary or claims were coded inaccurately, resulting in \$432 million in improper payments. This review assessed HHAs' medical records for beneficiaries but did not determine whether those records accurately reflected beneficiaries' medical conditions. This review did not involve visiting beneficiaries to confirm their homebound status, nor did it determine whether the care provided was medically necessary.

In 2009, OIG found aberrant billing patterns in home health outlier payments in 24 counties nationwide.⁴² One county in Florida—Miami-Dade County—accounted for more home health outlier payments in 2008 than the rest of the Nation combined.

In 2006, OIG found that HHAs improperly coded claims to overstate the severity of the beneficiaries' conditions, resulting in overpayments.⁴³ OIG also found that contractors did not perform prepayment edits or postpayment analyses of claims data to prevent and detect overpayments.

Currently, OIG is conducting a companion study on Medicare contractor activities to identify and address improper payments and potential fraud and abuse in home health, as well as CMS's oversight of these contractors.⁴⁴

⁴⁰ 42 CFR § 424.570 (a)(2)(iv). Other reasons why CMS may impose a temporary enrollment moratorium include: (1) CMS determines that there is a significant potential for fraud, waste, or abuse with respect to a particular provider or supplier type and/or particular geographic area; (2) a State Medicaid program has imposed a moratorium on a group of Medicaid providers or suppliers that are also eligible to enroll in the Medicare program; and (3) a State has imposed a moratorium on enrollment in a particular geographic area and/or on a particular provider or supplier type. 42 CFR § 424.570(a)(2)(i)-(a)(2)(iii).

⁴¹ OIG, *Coverage Requirements and Payment Accuracy for Medicare Home Health Claims*, OEI-01-08-00390, March 2012.

⁴² OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, November 2009.

⁴³ OIG, *Review of Home Health Agencies' Billing for Services Preceded by a Hospital Discharge*, A-01-04-00527, March 2006.

⁴⁴ OEI-04-11-00220, in progress.

METHODOLOGY

This study is based on our analysis of home health claims from 100-percent paid claims data from CMS's National Claims History Part A Standard Analytical File for 2010.⁴⁵ Our analysis included both full and partial episode claims.

We also analyzed paid inpatient claims from hospitals and skilled nursing facilities for home health beneficiaries from the Part A Standard Analytical File. We used the beneficiary's Health Insurance Claim Number to link these inpatient hospital and skilled nursing facility claims to the home health claims. Additionally, we used CMS's Enrollment Data Base to identify beneficiaries with dates of death.

Identification of Inappropriate Medicare Payments for Home Health Claims

We analyzed the home health claims data to determine the number of home health claims that (1) inappropriately overlapped with claims for inpatient hospital stays, (2) inappropriately overlapped with claims for skilled nursing facility stays, or (3) were billed for services on dates after beneficiaries' deaths. We also calculated the total inappropriate Medicare payments for these home health services.

First, we identified home health claims that overlapped with claims for inpatient hospital stays or skilled nursing facility stays. According to CMS policy, institutional claims for inpatient hospital stays and skilled nursing facility stays have priority over claims for home health services.⁴⁶ When a home health claim contains dates of service that overlap with dates of an inpatient hospital stay or a skilled nursing facility stay, that home health claim is rejected regardless of whether it is received before or after the institutional claim.

We excluded appropriate instances of overlap, which are instances when beneficiaries receive home health services on the dates of admission to or on the dates of discharge from inpatient hospitals or skilled nursing facilities or when beneficiaries receive home health services during leaves of absence from inpatient stays. We considered the home health claim to have an inappropriate instance of overlap if a home health service was provided during an inpatient hospital stay or skilled nursing facility stay and a leave of absence did not occur. For home health claims inappropriately overlapping with claims for inpatient hospital stays or skilled nursing facility stays, we summed the payment amounts to

⁴⁵ We excluded all claims with a reimbursement amount of zero.

⁴⁶ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 10, § 30.9.

calculate the overall amount that Medicare inappropriately paid for these claims.

Next, we identified home health episodes that started after beneficiaries' deaths. A beneficiary's death during an episode results in a full payment for that episode.⁴⁷ However, a Medicare payment for a home health episode that starts *after* a beneficiary's death is an inappropriate payment. After identifying beneficiaries for whom HHAs billed Medicare for home health services in 2010, we used CMS's Enrollment Data Base to identify those beneficiaries who died before or during 2010. For home health claims in which beneficiaries' dates of death preceded the episodes' start dates, we summed the payment amounts to calculate the overall amount that Medicare inappropriately paid for these services.

Identification of HHAs That Had Questionable Billing

We first identified all home health claims with dates of service ending in 2010. In total, we identified approximately 6.96 million Medicare claims for both full and partial home health episodes billed by 11,203 HHAs. To identify HHAs that had questionable billing, we first identified those HHAs that submitted at least 20 claims in 2010.⁴⁸ These included 92 percent (10,341) of the 11,203 HHAs and accounted for 6.88 million claims.

We next identified HHAs that had questionable billing. We developed six measures of questionable billing based on the results of past OIG analyses and fraud investigations related to home health services, as well as on input from CMS staff and contractors. We considered an HHA's billing to be unusually high, or questionable, on each of the six measures if it was greater than the 75th percentile plus 1.5 times the interquartile range.⁴⁹ The six measures of questionable billing we developed were:

- *High average outlier payment amount per beneficiary.* Medicare makes outlier payments to HHAs that provide services to beneficiaries who incur unusually high costs. We based this measure on the total outlier payments each HHA was paid in 2010 relative to the number of beneficiaries for whom the HHA billed Medicare in 2010. We also calculated each HHA's total outlier payments relative to total Medicare payments in 2010.

⁴⁷ CMS, *Medicare Claims Processing Manual*, Pub. 100-04, ch. 10, § 10.1.16.

⁴⁸ HHAs that submitted fewer than 20 claims represented 8 percent of all HHAs and approximately \$18 million (or 0.1 percent) of Medicare payments for home health services in 2010.

⁴⁹ This is a standard exploratory method for identifying members of a population with unusually high values on a given statistic compared to the rest of the population when no established benchmarks exist. See J.W. Tukey, *Exploratory Data Analysis*, Addison-Wesley, 1977.

- High average number of visits per beneficiary. We based this measure on the total number of visits each HHA billed in 2010 relative to the number of beneficiaries for whom the HHA billed Medicare in 2010.
- High percentage of beneficiaries for whom other HHAs billed Medicare. When multiple HHAs bill for services provided to the same beneficiary in a given period, there is potential for fraud (i.e., beneficiary sharing). We based this measure on the percentage of each HHA's beneficiaries for whom at least one other HHA billed Medicare in 2010.
- High average number of late episodes per beneficiary. In a sequence of episodes, late (i.e., third and subsequent) episodes have higher payment rates than early episodes. We based this measure on the total number of late episodes each HHA billed in 2010 relative to the number of beneficiaries for whom the HHA billed Medicare in 2010.
- High average number of therapy visits per beneficiary. Beneficiaries who require a greater number of therapy services have episodes with higher payment rates. We based this measure on the total number of therapy visits each HHA billed in 2010 relative to the number of beneficiaries for whom the HHA billed Medicare in 2010.
- High average Medicare payment amount per beneficiary. We based this measure on the total payment for home health services that each HHA received in 2010 relative to the number of beneficiaries for whom the HHA billed Medicare in 2010.⁵⁰

These six measures of questionable billing indicate potential fraud. There may be legitimate reasons for an HHA to have unusually high billing on any of our six measures. For example, a beneficiary receiving home health services may live in a State with a colder climate most of the year and spend the winter in a warmer State. If this beneficiary receives home health services throughout the year, then at least two different HHAs would legitimately bill Medicare for services provided to this beneficiary. On the other hand, there are schemes in which multiple HHAs fraudulently bill Medicare for services provided to the same beneficiaries. Acknowledging legitimate instances of unusually high billing is necessary, but it is equally necessary to examine HHAs that bill unusually high amounts relative to other HHAs to determine whether such billing is inappropriate or fraudulent.

Geographic Analysis of HHAs With Questionable Billing

We compared the geographic locations of HHAs with questionable billing to those of other HHAs. Specifically, we determined for each State the

⁵⁰ We did not account for wage adjustments based on geographical areas in this analysis.

total number of HHAs and the number of HHAs with questionable billing.⁵¹ We then calculated the percentage of HHAs with questionable billing in each State. Additionally, we determined whether States had Certificate of Need policies for HHAs. We then analyzed the total number of HHAs and the number of HHAs with questionable billing by States with or without Certificate of Need policies.

Limitations

We did not independently verify the accuracy of the data we used for this study. Further, our findings are based on an analysis of claims data, rather than medical documentation; we did not determine whether the services billed were inappropriate or fraudulent. For example, we did not analyze the health status of beneficiaries to determine whether home health services billed by HHAs with questionable billing were appropriate. In addition, the measures included in our analysis are not intended to be a comprehensive set of measures for identifying questionable billing.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

⁵¹ HHAs were located in all 50 States; the District of Columbia; and certain U.S. territories, such as Puerto Rico and the U.S. Virgin Islands.

FINDINGS

In 2010, Medicare inappropriately paid \$5 million for home health claims with three specific errors

CMS has claims processing edits in place to prevent payment for home health claims with services that inappropriately overlap with claims for inpatient hospital stays or skilled nursing facility stays or that are billed for services on dates after beneficiaries' deaths. However, Medicare inappropriately paid \$5 million (out of \$19.5 billion total for home health services) in 2010 for home health claims that had at least one of these three errors. The \$5 million figure is based solely on our analysis of claims data for these three specific errors. It does not include any additional inappropriate payments that a medical record review or other claims analysis might find to be unreasonable or unnecessary.

In 2010, 1,285 HHAs had claims with at least 1 of the 3 errors. Table 1 shows the inappropriate payment amount, number of services, number of claims, and number of HHAs by the three types of errors.

Table 1: Inappropriate Medicare Payments for Home Health Services, 2010

Error Type	Inappropriate Payment Amount	Number of Services	Number of Claims	Number of HHAs*
Overlap between inpatient hospital stay and home health service	\$3,506,429	1,722	1,309	956
Overlap between skilled nursing facility stay and home health service	\$1,268,433	1,180	469	414
Home health service date after a beneficiary's date of death	\$208,311	1,007	82	51
Total	\$4,983,173	3,909	1,857	1,285

*Column sum exceeds total because some HHAs had multiple types of inappropriate payments.

Source: OIG analysis of Part A data for home health services, hospitals, and skilled nursing facilities, 2012.

Medicare inappropriately paid approximately \$4.8 million for home health claims that overlapped with claims for stays in inpatient hospitals or skilled nursing facilities

In 2010, Medicare inappropriately paid \$3.5 million for home health claims that overlapped with claims for inpatient hospital stays and \$1.3 million for home health claims that overlapped with claims for skilled nursing facility stays, for a total of \$4.8 million. Nationwide, Medicare paid 956 HHAs when home health claims and claims for inpatient hospital stays inappropriately overlapped and paid 414 HHAs when home health claims and claims for skilled nursing facility stays inappropriately overlapped.

Medicare inappropriately paid \$208,311 for home health services billed on dates after beneficiaries' deaths

In 2010, Medicare inappropriately paid \$208,311 for home health services on dates after beneficiaries' deaths. Overall, Medicare paid 82 claims for 50 beneficiaries for services on dates after their deaths. Two beneficiaries for whom HHAs billed Medicare had been deceased for more than 10 years. Table 2 shows the year of death of beneficiaries for whom HHAs billed for services on dates after their deaths, the total number and percentage of deceased beneficiaries by year, and the inappropriate payment amount by year.

Table 2: Beneficiaries for Whom HHAs Billed Medicare for Home Health Services After Death, 2010

Year of Death	Number of Deceased Beneficiaries	Percentage of Total Deceased Beneficiaries	Inappropriate Payment Amount
1995	1	2%	\$11,220
1999	1	2%	\$6,507
2001	5	10%	\$20,082
2002	1	2%	\$12,630
2005	3	6%	\$14,900
2006	1	2%	\$13,331
2007	2	4%	\$15,144
2008	4	8%	\$19,987
2009	4	8%	\$16,344
2010	28	56%	\$78,166
Total	50	100%	\$208,311

Source: OIG analysis of Part A data for home health services, 2012.

About half of deceased beneficiaries for whom HHAs billed Medicare for services on dates after their deaths died in 2010. On average, HHAs billed Medicare for such beneficiaries for services on dates about 2 months after their deaths. The service date on a claim for 1 beneficiary, who died in January 2010, was 275 days later, in October 2010.

Approximately one in every four HHAs had questionable billing

In 2010, 25 percent (2,594 of 10,341) of HHAs exceeded the threshold that indicated unusually high billing for at least 1 of our 6 measures of questionable billing.^{52, 53}

More than one-third (36 percent) of the HHAs with questionable billing exceeded the thresholds for multiple measures of questionable billing. Specifically, 925 HHAs exceeded the thresholds for 2 or more measures, and 6 HHAs exceeded the thresholds for 5 measures. Table 3 shows the number and percentage of HHAs by the number of measures of questionable billing for which HHAs exceeded thresholds.

Table 3: Number and Percentage of HHAs by Number of Measures of Questionable Billing for Which HHAs Exceeded Thresholds, 2010

Number of Measures of Questionable Billing for Which HHAs Exceeded Thresholds	Number of HHAs	Percentage of HHAs*
0	7,747	75%
1	1,669	16%
2	680	7%
3	199	2%
4	40	<1%
5	6	<1%
6	0	0%
Total	10,341	100%

*The percentages do not sum to 100 percent because of rounding.
Source: OIG analysis of Part A data for home health services, 2012.

For each measure of questionable billing, Table 4 shows the median among all HHAs, the threshold that indicated unusually high billing, the range of unusually high billing, and the number of HHAs with unusually high billing.

⁵² Of these 2,594 HHAs with questionable billing, 299 also had at least 1 inappropriately paid home health claim in 2010.

⁵³ A Texas physician was indicted in February 2012 for allegedly certifying or directing the certification of beneficiaries' plans of care so that HHAs were able to bill Medicare for home health services that were not medically necessary or were not provided. Of the HHAs affiliated with this physician, 60 percent (288 of 484) had questionable billing.

Table 4: HHAs With Unusually High Billing by Measure of Questionable Billing, 2010

Measure of Questionable Billing	Median Among All HHAs*	HHAs With Unusually High Billing**		
		Threshold	Range of Billing	Number of HHAs
Average outlier payment amount per beneficiary	\$13	\$403	\$404 to \$5,793	1,684
Average number of visits per beneficiary	32	91	91 to 629	658
Percentage of beneficiaries for whom other HHAs billed Medicare	20%	61%	61% to 100%	618
Average number of late episodes per beneficiary	<1	2	2 to 4	426
Average number of therapy visits per beneficiary	9	24	24 to 70	257
Average Medicare payment amount per beneficiary	\$5,112	\$11,653	\$11,669 to \$24,463	173
Total				2,594***

*The median (i.e., the 50th percentile) indicates that half of all HHAs fell below this value.

**We considered an HHA's billing to be unusually high if it was greater than the 75th percentile plus 1.5 times the interquartile range.

***Column sum exceeds total because some HHAs exceeded thresholds for multiple measures of questionable billing.

Source: OIG analysis of Part A data for home health services, 2012.

In 2010, 1,684 HHAs had unusually high outlier payments per beneficiary

Overall, 74 percent (or 7,636) of HHAs had at least 1 outlier payment in 2010. Of those HHAs, 1,684 HHAs had outlier payments above \$403 per beneficiary, our threshold for unusually high outlier payments. Fifty percent of all HHAs had average outlier payment amounts per beneficiary of less than \$13. One HHA received an average of \$5,793 per beneficiary in outlier payments. Ten HHAs' average outlier payment amounts per beneficiary exceeded \$3,000.

Beginning in January 2010, total outlier payments for an HHA should not have exceeded 10 percent of the HHA's annual projected total Medicare home health payments. For 72 percent (5,514 of 7,636) of HHAs with outlier payments, total outlier payments were 5 percent or less of total Medicare payments. However, 434 HHAs exceeded the 10-percent cap. In particular, one HHA's total outlier payments represented approximately 74 percent of its total Medicare payments in 2010. Almost all (429 of 434) of those HHAs that exceeded the 10-percent cap also exceeded our unusually high threshold for this questionable billing measure.

Additionally, of those HHAs with outlier payments representing 5 to 10 percent of their total Medicare payments, 72 percent exceeded our threshold for unusually high outlier payments.

In 2010, 658 HHAs billed unusually high numbers of visits per beneficiary

Six hundred fifty-eight HHAs exceeded our unusually high threshold of 91 visits per beneficiary in 2010. Fifty percent of HHAs billed for fewer than 32 visits per beneficiary. One HHA billed for an average 629 visits per beneficiary. Thirteen (out of 10,341) HHAs billed for over 300 visits per beneficiary, on average.

In 2010, 618 HHAs had an unusually high percentage of beneficiaries for whom other HHAs billed Medicare

In 2010, 618 HHAs had a high percentage of beneficiaries for whom other HHAs billed Medicare, exceeding our threshold—61 percent—for an unusually high percentage of such beneficiaries. For 50 percent of HHAs, other HHAs billed for 20 percent or less of their beneficiaries. When multiple HHAs bill for services provided to the same beneficiary, there is potential for fraud (i.e., beneficiary sharing). For six HHAs, other HHAs billed for 100 percent of their beneficiaries.

In 2010, for over 90 percent of beneficiaries, a single HHA billed Medicare. For about 9 percent of beneficiaries, two HHAs billed Medicare. For the remaining 1 percent of beneficiaries, three or more HHAs billed Medicare. In the case of one beneficiary, nine different HHAs billed Medicare.

In 2010, 426 HHAs billed for unusually high numbers of late episodes per beneficiary

Overall, 99 percent (or 10,195) of HHAs billed Medicare for at least 1 late episode—i.e., a third or subsequent episode—in 2010, meaning that such HHAs billed for 3 or more consecutive episodes for at least 1 beneficiary. However, 426 HHAs billed for unusually high numbers of late episodes, exceeding our threshold of 2 late episodes per beneficiary. Fifty percent of all HHAs billed for less than one late episode per beneficiary. Late episodes have higher payment rates than early (i.e., first or second) ones. Two HHAs substantially exceeded the threshold for this measure by billing for an average of four late episodes per beneficiary.

In 2010, 257 HHAs billed for unusually high numbers of therapy visits per beneficiary

Two-hundred fifty-seven HHAs exceeded our threshold for unusually high numbers of therapy visits—24 therapy visits per beneficiary—in 2010. Fifty percent of HHAs billed for fewer than nine therapy visits per beneficiary. As the number of therapy visits provided during an episode increases, the payment rate for the episode also increases. One HHA billed for an average of 70 therapy visits per beneficiary, almost 8 times the median.

In 2010, 173 HHAs had unusually high payments per beneficiary

One hundred seventy-three HHAs were paid above our threshold for unusually high payments per beneficiary—\$11,653 per beneficiary—for services provided in 2010. Fifty percent of all HHAs had average Medicare payment amounts per beneficiary of less than \$5,112. High-dollar per-beneficiary billing amounts may indicate that HHAs were billing for services that were not medically necessary or were never provided. Medicare paid one HHA an average of \$24,463 per beneficiary, almost five times the median. Fourteen HHAs' average Medicare payment amounts per beneficiary exceeded \$15,000, almost three times the median.

Eighty percent of HHAs with questionable billing were located in four States

In 2010, 80 percent (2,063 of 2,594) of HHAs that exceeded the threshold that indicated unusually high billing for at least 1 of our 6 measures of questionable billing were located in Texas, Florida, California, and Michigan. Overall, these 4 States represented 47 percent of the total number of HHAs (4,863 of 10,341) in 2010.

These 4 States all had more than 100 HHAs with questionable billing in 2010. Thirty-nine percent of HHAs with questionable billing (1,000) were located in Texas. Similarly, 25 percent of HHAs with questionable billing (652) were located in Florida. Table 5 shows the number of HHAs with questionable billing and the percentage of the total number of such HHAs for these four States. The remaining 531 HHAs with questionable billing were dispersed among 37 other States. Nine States did not have any HHAs with questionable billing in 2010.⁵⁴

⁵⁴ Additionally, no HHAs with questionable billing were located in the District of Columbia, Puerto Rico, the U.S. Virgin Islands, Guam, or Saipan. Saipan is the largest island of the Northern Mariana Islands, a U.S. territory.

Table 5: States With More Than 100 HHAs With Questionable Billing, 2010

State	Number of HHAs With Questionable Billing in State	Percentage of Total Number of HHAs With Questionable Billing
Texas	1,000	39%
Florida	652	25%
California	281	11%
Michigan	130	5%
Total	2,063	80%

Note: The remaining 531 HHAs with questionable billing are located in 37 other States.
Source: OIG analysis of Part A data for home health services, 2012.

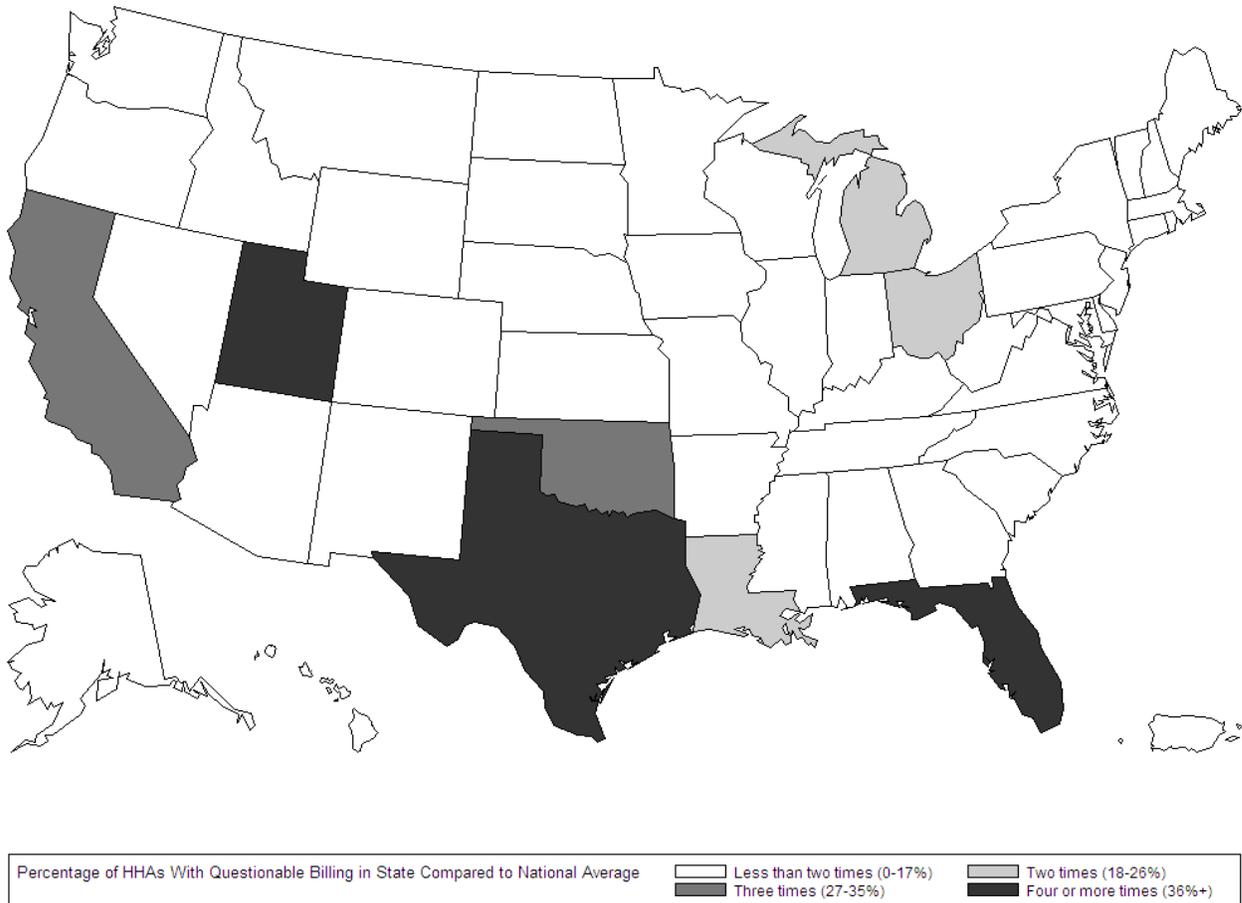
Texas, Florida, California, and Michigan also do not have Certificate of Need policies that limit the number of HHAs in operation. Overall, 97 percent (2,529 of 2,594) of HHAs with questionable billing that we identified were located in States that did not have Certificate of Need policies in 2010.

Eight States had high percentages of HHAs with questionable billing

In 2010, eight States had high percentages, or at least two times the national average of 9 percent, of HHAs with questionable billing (i.e., at least 18 percent of each State's total number of HHAs).⁵⁵ Figure 1 highlights these eight States. Appendix A corresponds to Figure 1 and shows the number and percentage of HHAs with questionable billing for each State and the amount by which each State exceeded the national average.

⁵⁵ Nine percent is the unweighted national average, which is calculated by summing all States' percentages of HHAs with questionable billing and dividing by the total number of States. The weighted national average is 25 percent and is calculated by dividing the total number of HHAs with questionable billing nationwide by the total number of HHAs nationwide.

Figure 1: States With High Percentages of HHAs with Questionable Billing, 2010



Source: OIG analysis of Part A data for home health services, 2012.

Five States far exceeded the national average, having at least three times as many HHAs with questionable billing as other States. For example, Florida had the largest representation of HHAs with questionable billing. In Florida, 652 HHAs (or 52 percent) of the 1,251 HHAs operating in the State had questionable billing in 2010. The percentage of HHAs with questionable billing in Florida was nearly six times the national average. Texas had the second-largest representation of HHAs with questionable billing. Forty-five percent, or 5 times the national average, of the 2,212 HHAs in Texas had questionable billing.

CONCLUSION AND RECOMMENDATIONS

In 2010, Medicare paid \$19.5 billion to 11,203 HHAs for services provided to 3.4 million beneficiaries. Recent investigations and prior OIG studies have found that home health services are vulnerable to fraud, waste, and abuse.

In 2010, Medicare inappropriately paid approximately \$5 million for home health claims that overlapped with claims for inpatient hospital stays, overlapped with claims for skilled nursing facility stays, or were billed for services on dates after beneficiaries' deaths. Further, in 2010, approximately one in every four HHAs exceeded the threshold that indicated unusually high billing for at least one of our six measures of questionable billing. Additionally, HHAs with questionable billing were located mostly in four States. Two of these—Florida and Texas—also each had a high number of HHAs with questionable billing relative to the total number of HHAs in the State.

Collectively, these findings identify specific issues with Medicare payments for home health services that need to be addressed to properly safeguard the Medicare program. However, our review is based solely on an analysis of claims data and does not include payments that a medical record review, site visits, interviews with physicians and beneficiaries, or additional data analysis may find to be unreasonable or unnecessary. Similarly, the measures of questionable billing used in this review are indicators of potential fraud. Although there may be legitimate reasons for an HHA to have unusually high billing on any of our six measures of questionable billing, it is important to examine HHAs that bill such unusually high amounts relative to other HHAs to determine whether such billing is inappropriate or fraudulent. CMS must use all of the tools at its disposal to more effectively review, identify, and eliminate fraud, waste, and abuse in home health services.

We recommend that CMS:

Implement claims processing edits or improve existing edits to prevent inappropriate payments

CMS should instruct MACs that process and pay home health claims to implement claims processing edits or improve existing edits to prevent inappropriate payments. These edits should identify home health claims that overlap with claims for inpatient hospital stays or skilled nursing facility stays and flag them for further review to ensure the overlap is appropriate (i.e., the service was provided on the date of admission or discharge or during a leave of absence). CMS should also ensure that Medicare does not pay for services on dates after beneficiaries' deaths.

Increase monitoring of billing for home health services

CMS should instruct MACs and ZPICs to monitor the billing of home health services by HHAs by using measures of questionable billing similar to those in this report. CMS should develop thresholds for these measures and instruct its contractors to conduct additional review of HHAs that exceed them. CMS should also consider including these measures of questionable billing in its predictive analytic work.

Enforce and consider lowering the 10-percent cap on the total outlier payments an HHA may receive annually

In January 2010, CMS began capping outlier payments to individual HHAs at 10 percent of total projected Medicare payments. Although this cap is a first step to mitigating potential fraud and inappropriate billing of outlier payments, we identified 434 HHAs that exceeded the cap in 2010. CMS should properly enforce the cap on the total outlier payments that an HHA may receive annually.

Additionally, 78 percent of HHAs with total outlier payments greater than 5 percent of total Medicare payments also exceeded the threshold for our measure of questionable billing specific to outlier payments, indicating potential fraud. CMS should reevaluate the 10-percent cap and consider lowering it, if appropriate, to better prevent fraud and inappropriate billing of outlier payments.

Consider imposing a temporary moratorium on new HHA enrollments in Florida and Texas

Florida and Texas each had a high number of HHAs with questionable billing in 2010. Additionally, the percentage of HHAs with questionable billing relative to the State's total number of HHAs exceeded the national average by six times in Florida and by five times in Texas. CMS should consider imposing a temporary enrollment moratorium on HHAs in these States.

CMS should determine whether this moratorium should be imposed Statewide or imposed in specific counties and/or metropolitan areas. CMS should also assess and consider beneficiary access to home health services when determining the geographic areas to which the moratorium would apply.

Take appropriate action regarding inappropriate payments and HHAs with questionable billing

In a separate memorandum, we will refer to CMS for appropriate action the claims associated with inappropriate payments and the HHAs with questionable billing that we identified.

AGENCY COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In its comments on the draft report, CMS concurred with all five recommendations. CMS acknowledges that home health services have historically been vulnerable to fraud, waste, and abuse. For this reason, CMS is taking additional steps to address vulnerabilities in the enrollment and claims payment process for HHAs and is building reliable models in its Fraud Prevention System that can detect and generate alerts for suspicious billing by all major provider types, including HHAs.

While concurring with our first recommendation, CMS disagreed with the inappropriate payment amount the report associates with home health claims that inappropriately overlapped with claims for inpatient hospital stays and skilled nursing facility stays. CMS noted that in the absence of individual claims analysis, it is difficult to determine whether there was any financial impact from the submission of overlapping claims. Additionally, CMS noted that when this overlap occurs, the home health claim is rejected and nothing is paid on that initial claim submission. The HHA is able to remove the overlapping visit(s) from the rejected claim and then resubmit the claim for Medicare payment. However, we found that CMS paid for home health claims with visits that inappropriately overlapped with claims for inpatient hospital stays and skilled nursing facility stays. Therefore, we continue to consider the entire Medicare payment amounts as inappropriate as these claims should not have been paid. CMS also stated that it will identify and correct any loopholes in its current enforcement after receiving OIG's specific claims examples.

With regard to our second recommendation, CMS will provide ZPICs with a copy of this report. CMS will also review the measures of questionable billing in this report and consider incorporating them into its Fraud Prevention System models.

With regard to the third recommendation, CMS has taken action to fully enforce the 10-percent outlier cap. In early 2011, CMS identified a problem involving the calculation used to enforce the cap and has since corrected this problem. Additionally, CMS plans to continue evaluating home health outlier policy, including analysis surrounding the current 10-percent threshold, while considering the impact of lowering the cap on legitimate providers.

With regard to our fourth recommendation, CMS is assessing a variety of provider types for suitability for moratoria, including HHAs. CMS is also carefully assessing the geographic areas to which moratoria would apply and is evaluating issues relative to beneficiary access to care.

With regard to our fifth recommendation, CMS will determine the most appropriate administrative actions to take on claims containing inappropriate payments identified in this report. Additionally, CMS will share the HHAs with questionable billing identified in this report with MACs to consider as they prioritize their work and with Recovery Auditors to consider as they decide what claims to review. Recovery Auditors conduct postpayment reviews of claims to identify and correct improper payments.

We support CMS's efforts to address these issues and encourage continued progress. For the full text of CMS's comments, see Appendix B. We made minor changes to the report based on CMS's comments.

APPENDIX A

Number and Percentage of Home Health Agencies With Questionable Billing by State, 2010

- States shaded in black had percentages of home health agencies (HHA) with questionable billing four times or greater than the national average.
- States shaded in dark gray had percentages of HHAs with questionable billing three times the national average.
- States shaded in light gray had percentages of HHAs with questionable billing two times the national average.

State	Number of HHAs With Questionable Billing in State	Total Number of HHAs in State	Percentage of HHAs With Questionable Billing in State	Number of Times the National Average
Florida	652	1251	52%	5.8
Texas	1,000	2212	45%	5.0
Utah	33	82	40%	4.5
California	281	847	33%	3.7
Oklahoma	76	240	32%	3.5
Michigan	130	553	24%	2.6
Louisiana	51	217	24%	2.6
Ohio	83	462	18%	2.0
Massachusetts	21	135	16%	1.7
Nevada	15	99	15%	1.7
Colorado	19	128	15%	1.6
New York	25	173	14%	1.6
Tennessee	20	154	13%	1.4
Wisconsin	13	102	13%	1.4
Nebraska	8	70	11%	1.3
Indiana	19	187	10%	1.1
Mississippi	5	52	10%	1.1
Kansas	11	115	10%	1.1
Rhode Island	2	21	10%	1.1
Illinois	57	625	9%	1.0
Connecticut	7	81	9%	1.0
Idaho	3	44	7%	0.8
New Hampshire	2	32	6%	0.7
Vermont	1	16	6%	0.7
Delaware	1	18	6%	0.6
Missouri	9	172	5%	0.6
North Dakota	1	21	5%	0.5
Kentucky	5	105	5%	0.5

(continued)

APPENDIX A (CONTINUED)

State	Number of HHAs With Questionable Billing in State	Total Number of HHAs in State	Percentage of HHAs With Questionable Billing in State	Number of Times the National Average
Pennsylvania	12	301	4%	0.4
Georgia	4	113	4%	0.4
Wyoming	1	29	3%	0.4
Minnesota	5	151	3%	0.4
Virginia	6	183	3%	0.4
South Dakota	1	31	3%	0.4
Iowa	5	157	3%	0.4
New Mexico	2	71	3%	0.3
Alabama	4	153	3%	0.3
Arizona	2	102	2%	0.2
West Virginia	1	57	2%	0.2
Washington	1	60	2%	0.2
Arkansas	2	161	1%	0.1
Alaska	0	12	0%	--
District of Columbia	0	21	0%	--
Hawaii	0	11	0%	--
Maine	0	27	0%	--
Maryland	0	53	0%	--
Montana	0	32	0%	--
New Jersey	0	52	0%	--
North Carolina	0	182	0%	--
Oregon	0	58	0%	--
Puerto Rico	0	40	0%	--
South Carolina	0	68	0%	--
U.S. Virgin Islands	0	1	0%	--
Guam	0	4	0%	--
Saipan***	0	2	0%	--
Total	2,594*	10,341*	9%**	--

*Certain HHAs had two different provider States listed on claims and are counted twice.

**This national average is unweighted and is calculated by summing all States' percentages of HHAs with questionable billing and dividing by the total number of States. The weighted national average is 25 percent and is calculated by dividing the total number of HHAs with questionable billing nationwide by the total number of HHAs nationwide.

***Saipan is the largest island of the Northern Mariana Islands, a U.S. territory.

Source: Office of Inspector General analysis of Part A data for home health services, 2012.

APPENDIX B

Agency Comments



DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JUN 27 2012

TO: Daniel R. Levinson
Inspector General

FROM: Marilyn Taveqner /S/
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: Inappropriate and Questionable Billing by Medicare Home Health Agencies (OEI-04-11-00240)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on OIG Draft Report entitled, "Inappropriate and Questionable Billing by Medicare Home Health Agencies" (OEI-04-11-00240). The objectives of this study are to determine the extent to which home health agencies (HHAs) submitted Medicare claims that inappropriately overlapped with an inpatient hospital stay, overlapped with a skilled nursing facility (SNF) stay, or were billed after a beneficiary's death and to identify and describe HHAs that exhibited questionable billing.

HHAs have historically been vulnerable to fraud, waste, and abuse. As such, CMS is taking additional steps to address potential vulnerabilities in the enrollment and claims payment process for this supplier group using the authorities granted under the Affordable Care Act¹. Under the new screening provisions of CMS 6028-FC² all newly enrolling HHAs are considered a high risk provider/supplier and are, therefore, subject to unannounced site visits. The Affordable Care Act also enhanced CMS' authority to suspend payments for credible allegations of fraud. In February, CMS announced the suspension of payments to 78 HHAs involved in an alleged fraud scheme in Dallas that was part of the February 28, 2012 Health Care Prevention Action Team Strike Force takedown.

As part of CMS revalidation efforts, all HHAs were sent revalidation notices prior to December 31, 2011 and are currently in process. In addition, all HHAs are subject to an unannounced physical site visit as part of the revalidation process.

In addition, CMS implemented the Fraud Prevention System (FPS) in June of 2011 which applies predictive analytic technology on claims prior to payment to identify aberrant and suspicious billing patterns. The FPS has been running predictive algorithms and other

¹ Section 6401 of the Affordable Care Act provided the Secretary with authority to perform categorical risk-based screening on providers and suppliers at enrollment and upon revalidation.

² CMS 6028-FC entitled, "Medicare, Medicaid and Children's Health Insurance Programs; Additional Screening Requirements, Application Fees, Temporary Enrollment Moratoria, Payment Suspensions and Compliance Plans for Providers and Suppliers" was published in the *Federal Register* on February 2, 2011.

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sophisticated analytics nationwide against all Medicare fee-for-service, including HHA, and durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) claims prior to payment. CMS uses the FPS to target investigative resources to suspect claims and providers, and swiftly impose administrative action when warranted. CMS is building reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by all major provider types, including HHAs. CMS will review the measures of questionable billing identified by OIG and consider incorporating them into models as appropriate.

In addition, Medicare contractors are instructed to monitor billing patterns of providers for home health services. Their efforts are focused on identified areas where services billed have a significant potential risk of inappropriate payment, overutilization or abusive billing. CMS will issue guidance with instruction to the A/B Medicare Administrative Contractors (MACs) to intensify its monitoring of HH providers on a prepay targeted basis; especially for home health providers where data analysis identifies outliers for high billing, high utilization, and high therapy usage.

CMS appreciates OIG's efforts in working with CMS to help identify home health agencies with questionable billing. Our response to each of OIG recommendations follows.

OIG Recommendation 1

CMS should implement claims processing edits or improve existing edits to prevent inappropriate payments.

CMS Response

CMS concurs with this recommendation, although we disagree with the \$4.8 million inappropriate payment amount the report associates with this problem. In the absence of individual claim analysis, it is difficult to determine whether there was any financial impact from the submission of overlapping claims.

Moreover, when a home health claim is found to overlap an inpatient hospital or skilled nursing facility (SNF) claim, the home health claim is rejected and nothing is paid based on that initial claim submission. However, the home health agency is able to remove the overlapping visit(s) from the rejected claim, which could have resulted from a data entry error. They may then resubmit the claim.

CMS also has safeguards in place for home health claims overlapping inpatient stays as the Medicare's Common Working File (CWF) contains edits to identify these situations. The edits have been in place since the advent of the home health prospective payment system (HH PPS) in 2000. In our experience, they are effective in the majority of cases, however, the overlap situations identified in this report, even though relatively small in number, are not acceptable. CMS looks forward to receiving OIG's specific claim examples so we can identify and correct any loopholes in our current enforcement.

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Regarding home health claims paid after the beneficiary's date of death, CMS has already taken action. In the fall of 2010, CMS discovered an error in our process that tracks a beneficiary's date of death. Typically, when an institutional claim is processed with a patient discharge status code of '20 (expired),' the CWF records the "Through" date of the claim as the beneficiary's date of death. We found that home health claims were not causing the date of death to be recorded. CMS believes the 2010 claims identified in this report were paid as a result of this error. In November 2010, we issued Publication 100-20, Transmittal 804 (Change Request 7123) to correct the problem, effective April 1, 2011.

OIG Recommendation 2

CMS should increase monitoring of billing for home health services.

CMS Response

CMS concurs with this recommendation. CMS will provide the Zone Program Integrity Contractors a copy of this report so that they may incorporate it into their business and investigative processes as appropriate. In addition to its more traditional ways of monitoring a variety of providers and claims, CMS is also utilizing the FPS to identify suspicious billing patterns. The FPS uses a series of algorithms to identify potentially fraudulent claims and prioritize the most egregious situations. As each claim streams through the predictive modeling system, the system builds profiles of providers, networks, and billing patterns. Using these profiles, CMS estimates a claim's likelihood of fraud and prioritizes providers with billing behavior that seem to pose an elevated risk to Medicare for a closer review.

CMS is building reliable models in the FPS that can detect and generate alerts for suspicious billing behavior by all major provider types, including HHAs. CMS will review the measures of questionable billing identified by OIG and consider incorporating them into models as appropriate.

OIG Recommendation 3

CMS should enforce and consider lowering the 10 percent cap on the total outlier payments an HHA may receive annually.

CMS Response

CMS concurs with this recommendation and has taken action to fully enforce the 10 percent outlier cap. In early 2011, CMS identified a problem involving the calculation of the year-to-date totals in daily batch claims used to enforce the outlier cap. In May 2011, CMS issued Publication 100-04, Transmittal 2209 (Change Request 7395) directing Medicare contractors to correct the problem effective October 3, 2011. This Transmittal also required Medicare contractors to adjust any claim dating back to January 1, 2010 to recover overpayments. These adjustments will be completed by the end of 2012 and we plan to begin recoupment of overpayments at that time as well.

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We also plan to continue evaluating home health outlier policy, including analysis surrounding the current 10 percent threshold. In the fall of 2012, CMS will be conducting a home health study required by section 3131(d) of the Affordable Care Act, to examine ways to accurately capture the costs of treating Medicare beneficiaries with high levels of severity of illness while minimizing patient vulnerabilities.

In considering OIG's recommendation to lower the 10 percent outlier cap, CMS will also consider the impact of doing so on legitimate providers. Small businesses, which might have normal variation from year to year in the severity of illness of patients served, could be adversely impacted by lowering the 10 percent outlier cap, potentially causing providers to avoid more costlier patients if their payments are reduced. In concluding that HHAs had unusually high outlier payments per beneficiary, OIG established a threshold of outlier payments above \$403 per beneficiary. However, based on our experience, using an average outlier payment amount per beneficiary as a measure of questionable billing does not take into account the size of the HHA and could skew the analytical results. For example, dividing total outlier payments by the number of patients treated by a small HHA could cause the HHA to exceed OIG's measure of questionable billing simply because the HHA provided services to few more costly patients and had a lower number of total patients over which those costs could be spread.

OIG Recommendation 4

CMS should consider imposing a temporary moratorium on new HHA enrollments in Florida and Texas.

CMS Response

CMS concurs with this recommendation. CMS, in developing our approach for implementing the new temporary moratorium authority effectively and thoughtfully, is in the process of assessing a variety of provider types for suitability for moratoria, including HHAs, and is also carefully assessing the geographic area to which moratoria will apply. The Center for Program Integrity is also working with the Center for Medicaid and CHIP Services and other appropriate partners within CMS and states to evaluate beneficiary access to care issues that could potentially be triggered by a moratorium on new HHA enrollments in areas such as Florida and Texas.

OIG Recommendation 5

CMS should take appropriate action regarding inappropriate payments and HHAs with questionable billing.

CMS Response

CMS concurs with this recommendation. Once CMS receives the specific claims at issue in this report from OIG, we will determine the most appropriate administrative actions to take, including recouping any payments from claims that should have been denied. Administrative

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actions may also include, but not be limited to, prepayment review, post-payment review, auto-deny edits, payment suspensions and revocations.

In addition, upon receipt of the files from OIG, CMS will share the HHAs with questionable billing as identified by OIG with the A/B MACs. CMS requests OIG furnish the data necessary (Medicare contractor numbers, provider numbers, claims information including the paid date, HIC numbers, etc.). Also, CMS requests that Medicare contractor-specific data be written to separate CD-ROMs or sent to a secure portal to better facilitate the transfer of information to the appropriate contractors. We will instruct the contractors to consider taking the appropriate actions on the suppliers identified in this report and the additional claim information when prioritizing their Medicare review strategies or other interventions.

The Recovery Auditors review Medicare Fee-For-Service claims on a post payment basis and are tasked with identifying overpayments. While CMS does not mandate areas for review, we will share this information with them and encourage them to consider these findings as they decide what claims to review.

Again, we appreciate the opportunity to comment on this draft report and look forward to working with OIG on this and other issues.

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General Comments

1. One of the six measures of questionable billing used in the report is “High average number of visits per beneficiary.” Its justification is that “The payment rate for an episode increases as the number of visits provided increases.” This statement is inaccurate. Other than therapy visits (addressed by one of the other measures) and LUPAs (which are a specific type of episode involving few visits and would barely register in these calculations), payment is made prospectively based on case mix (addressed by yet another measure), and not by number of visits. This is not to deny that episodes with many visits may serve as a proxy for, and are more likely to be driven by, therapy and case mix abuse. But the report’s results showing how many HHAs exceeded however many measures of questionable billing, as outlined in Table 3, are not as meaningful given the inclusion of this measure and its overlap with the others.
2. Regarding another measure in the report, “High average Medicare payment amount per beneficiary,” it appears that OIG did not strip off the wage adjustments based on geographical area, making both this measure and again the combined measures less meaningful.
3. The report mentions that numerous HHAs somehow exceeded the 10 percent provider outlier cap, which obviously contributed towards the finding of a large number of HHAs with unusually high outlier payments per beneficiary. One of OIG recommendations is to “Enforce and consider lowering the 10 percent cap on the total outlier payments an HHA may receive annually”. Regarding enforcing, measures have already been enacted to not only enforce the cap, but also to recoup the overpayments. This helps mitigate the financial impact of OIG’s outlier findings.
4. We note that OIG’s finding of \$5 million in inappropriate payments for overlapping hospital or SNF care or for deceased beneficiaries, as well as its recommendation to “Implement claims processing edits or improve existing edits to prevent inappropriate payments,” \$5 million on essentially 100 percent claims is less than 0.03 percent (or around 1/3900) of expenditures.

ACKNOWLEDGMENTS

This report was prepared under the direction of Dwayne Grant, Regional Inspector General for Evaluation and Inspections in the Atlanta regional office, and Jaime Durley, Deputy Regional Inspector General.

Rachel Daiber served as the lead analyst for this study. Other Office of Evaluation and Inspections staff from the Atlanta regional office who conducted the study include David Samchok. Central office staff who provided support include Kevin Farber, Scott Horning, Scott Manley, and Christine Moritz.

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