

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOME HEALTH AGENCY
PROVIDER COMPLIANCE AUDIT:
CARETENDERS OF JACKSONVILLE, LLC**

*Inquiries about this report may be addressed to the Office of Public Affairs at
Public.Affairs@oig.hhs.gov.*



Amy J. Frontz
Deputy Inspector General
for Audit Services

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Office of Inspector General

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Report in Brief

Date: May 2021

Report No. A-04-16-06195

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



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 either were not confined to home (homebound) or were not in need of skilled services.

Our objective was to determine whether Caretenders of Jacksonville, LLC (Caretenders), 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 an independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

Medicare Home Health Agency Provider Compliance Audit: Caretenders of Jacksonville, LLC

What OIG Found

Caretenders did not comply with Medicare billing requirements for 39 of the 100 home health claims that we reviewed. For these claims, Caretenders received overpayments of \$92,345 for services provided during our audit period. Specifically, Caretenders incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that were assigned with incorrect Health Insurance Prospective Payment System (HIPPS) payment codes. These errors occurred primarily because Caretenders did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas. On the basis of our sample results, we estimated that Caretenders received overpayments of approximately \$4.4 million for the audit period. All 100 claims in our sample are outside of the Medicare 4-year claim-reopening period.

What OIG Recommends and Caretenders Comments

We recommend that Caretenders exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation. We also recommend that Caretenders ensure that: (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, (2) beneficiaries are receiving only reasonable and necessary skilled services, and (3) the correct HIPPS payment codes are billed.

In written comments on our draft report, Caretenders agreed that one of the 55 claims we found to have been improperly billed was paid in error. Caretenders disagreed with our remaining findings and our two recommendations. Caretenders reviewed the claims we questioned and challenged our independent medical review contractor's decisions, maintaining that nearly all of the sampled claims were billed correctly. To address these concerns, we asked our medical review contractor to review Caretenders' written comments and claim rebuttals. Based on the results of that review and our review of additional documentation that Caretenders provided, we reduced the number of sampled claims incorrectly billed from 55 to 39 and revised the related findings and recommendations. We maintain that our remaining findings and recommendations, as revised are valid.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2016, Medicare paid home health agencies (HHAs) about \$18 billion for home health services. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2016 improper payment error rate for home health claims was 42 percent, or about \$7.7 billion. Although Medicare spending for home health care accounts for only about 5 percent of fee-for-service spending, improper payments to HHAs account for more than 18 percent of the total 2016 fee-for-service improper payments (\$41 billion). This audit is part of a series of audits of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Caretenders of Jacksonville, LLC (Caretenders), was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Caretenders complied with Medicare requirements for billing home health services on selected types of claims.

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers part-time or intermittent skilled nursing care and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments using a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups,¹ to monitor the effects of treatment on patient care and outcomes, and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS)

¹ A case-mix group is used in a patient classification system to group together patients with similar characteristics. These groups provide a basis for describing the types of patients to which a provider renders service.

codes² and represent specific sets of patient characteristics.³ CMS requires HHAs to submit OASIS data as a condition of payment.⁴

CMS administers the Medicare program and contracts with four of its Medicare administrative contractors to process and pay claims submitted by HHAs.

Home Health Agency Claims at Risk for Incorrect Billing

In prior years, our reviews at other HHAs identified findings in the following areas:

- beneficiaries did not always meet the definition of “confined to the home,”
- beneficiaries were not always in need of skilled services,
- HHAs did not always submit the OASIS data in a timely fashion,
- services were not always adequately documented, and
- HIPPS billing codes were incorrectly billed.

For the purposes of this report, we refer to these areas of incorrect billing as “risk areas.”

Medicare Requirements for Home Health Agency Claims and Payments

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (Social Security Act (the Act) § 1862(a)(1)(A)). Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR § 409.42 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);

² HIPPS payment codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies.

³ The final payment is determined at the conclusion of the episode of care using the OASIS information but also factoring in the number and type of home health services provided during the episode of care.

⁴ 42 CFR §§ 484.20, 484.55, 484.210(e), and 484.250(a)(1); 74 Fed. Reg. 58077, 58110-58111 (Nov. 10, 2009); and CMS’s *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1.

- in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician; and
- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition for payment, a physician must certify that a face-to-face encounter occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

The determination of “whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR § 484.55 or a medical record of the individual patient” (*Medicare Benefit Policy Manual* (the Manual), chapter 7, § 20.1.2). Coverage determination is not made solely on the basis of general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care (42 CFR § 409.44(a)).

Appendix B contains the details of selected Medicare coverage and payment requirements for HHAs.

Medicare Requirements for Providers To Identify and Return Overpayments

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.⁵

The 6-year lookback period is not limited by OIG’s audit period or restrictions on the Government’s ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.⁶

⁵ The Act § 1128J(d); 42 CFR §§ 401.301-401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

⁶ 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

Caretenders of Jacksonville, LLC

Caretenders⁷ is a limited liability home health care provider with headquarters in Kentucky and a local provider office in Jacksonville, Florida. Palmetto Government Benefits Administrator, LLC, its Medicare contractor, paid this specific Caretenders provider approximately \$25 million for 8,570 claims for services provided in CYs 2014 and 2015 (audit period) on the basis of CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$22,622,193 in Medicare payments to Caretenders for 7,175 claims.⁸ These claims were for home health services provided during our audit period.⁹ We selected a stratified random sample of 100 claims with payments totaling \$379,264 for review. We evaluated compliance with selected billing requirements and submitted these claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

Appendix A contains the details of our scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the types of errors by sample item.¹⁰

⁷ Caretenders also conducts business under the name Apex Home Healthcare. Both Caretenders and Apex Home Healthcare are under the parent company Almost Family.

⁸ In developing this sampling frame, we excluded from our audit of home health claims: low utilization payment adjustments, partial episode payments, Recovery Audit Contractor (RAC) reviewed claims, claims less than \$1,000, and requests for anticipated payments.

⁹ We determined the CYs by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary.

¹⁰ Sample items may have more than one type of error.

FINDINGS

Caretenders did not comply with Medicare billing requirements for 39 of the 100 home health claims that we reviewed. For these claims, Caretenders received overpayments of \$92,345 for services provided in CYs 2014 and 2015. Specifically, Caretenders incorrectly billed Medicare for:

- services provided to beneficiaries who were not homebound,
- services provided to beneficiaries who did not require skilled services, and
- claims that were assigned incorrect HIPPS codes.

These errors occurred primarily because Caretenders did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas. On the basis of our sample results, we estimated that Caretenders received overpayments of at least \$4.4 million for the audit period.¹¹ As of the publication of this report, all of these overpayments are outside of the 4-year reopening period.

CARETENDERS DID NOT ALWAYS COMPLY WITH MEDICARE BILLING REQUIREMENTS

Caretenders incorrectly billed Medicare for 39 of the 100 sampled claims, which resulted in overpayments of \$92,345.

Beneficiaries Were Not Homebound

Federal Requirements for Home Health Services

For the reimbursement of home health services, the beneficiary must be “confined to the home” (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). According to section 1814(a) of the Act:

[A]n individual shall be considered to be “confined to his home” if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

¹¹ Caretenders received overpayments of at least \$4,390,162. To be conservative, we estimated overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 30.1.1). Revision 172 of section 30.1.1 (effective November 19, 2013) and Revision 208 of section 30.1.1 (effective January 1, 2015) covered different parts of our audit period.¹² Revisions 172 and 208 state that for a patient to be eligible to receive covered home health services under both Part A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home and an individual will be considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One

Patients must either:

- because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their places of residence or
- have a condition such that leaving their homes is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Caretenders Did Not Always Meet Federal Requirements for Home Health Services

For 33 of the sampled claims, Caretenders incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements¹³ for being homebound for the full episode (16 claims) or for a portion thereof (17 claims).¹⁴

¹² Coverage guidance is substantively identical in both versions of section 30.1.1 in effect during our audit period. The only difference are minor revisions to a few examples.

¹³ All 33 claims had dates of service during the period covered by Revisions 172 and 208 of section 30.1.1.

¹⁴ Of these 33 claims with homebound errors, 10 claims were also billed with skilled services that were not medically necessary and two claims were billed for having an incorrect HIPPS code. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

Example 1: Beneficiary Not Homebound—Entire Episode

The physical therapy assessment documentation for one beneficiary showed that, from the start of the episode, the patient was able to ambulate without an assistive device. During the episode of care, it was documented the beneficiary had no shortness of breath, was not at risk of falling, and had been cleaning over several days which is consistent with a level of mobility beyond that needed for basic activities of daily living. Therefore, leaving the home did not require a considerable or taxing effort.

Example 2: Beneficiary Not Homebound—Partial Episode

For another beneficiary, records showed that, from the start of the episode, the beneficiary was initially homebound, limited to ambulating 50-75 feet due to dyspnea and pain. The beneficiary had an unsteady gait, the need of an assistive device and help from another person to leave the home. However, later in the episode, the beneficiary was ambulating 175 feet without an assistive device, exhibited increase in activity, and showed improvement in pain management and balance. At that point, leaving the home no longer would have entailed a considerable or taxing effort.

These errors occurred because Caretenders did not have adequate oversight procedures to ensure that it verified and continually monitored the homebound status of Medicare beneficiaries under its care and properly documented the specific factors that qualified the beneficiaries as homebound.

Beneficiaries Did Not Require Skilled Services

Federal Requirements for Skilled Services

A Medicare beneficiary must need skilled nursing care on an intermittent basis; physical therapy, or speech-language pathology; or the beneficiary must have a continuing need for occupational therapy (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42(c)). In addition, skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).¹⁵ Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the

¹⁵ Skilled nursing services can include, among other things, observation and assessment of a patient's condition, management and evaluation of a patient plan of care, teaching and training activities, or administration of medications (the Manual, chapter 7, § 40.1.2).

patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2.1). Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition (the Manual, chapter 7, § 20.1.2).

Caretenders Did Not Always Meet Federal Requirements for Skilled Services

For 14 of the sampled claims, Caretenders incorrectly billed Medicare for an entire home health episode (3 claims) or a portion of an episode (11 claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.¹⁶

Example 3: Beneficiary Did Not Require Skilled Services

A physician's plan of care ordered skilled nursing and physical therapy services for the treatment of unspecified asthma, obesity, abnormality of gait and generalized muscle weakness.

The beneficiary was not homebound as they were ambulating independently in and out of the home. The beneficiary missed two nursing visits for being out of the residence with friends, indicating she was not homebound. Caretenders provided skilled nursing services to the beneficiary, however, the beneficiary did not have skilled nursing needs.

The initial physical therapy (PT) assessment documented that the beneficiary had no complaints and the current level of safe function was consistent with the beneficiary's prior level of function. The beneficiary's range of motion of bilateral lower extremities and strength were within functional limits. The beneficiary ambulated at a modified independence level with a cane and without loss of balance, at their residence including a flight of stairs with railings. The PT assessment documented that the patient was at maximum functional potential.

These errors occurred because Caretenders did not always provide sufficient clinical review to verify that beneficiaries initially required skilled services or continued to require skilled services.

¹⁶ Of these 14 claims with skilled need services that were not medically necessary, 10 claims were also billed for beneficiaries with homebound errors and 1 claim was billed for having an incorrect HIPPS code. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

Incorrectly Billed Health Insurance Prospective Payment System Codes

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)). CMS’s *Medicare Claims Processing Manual*, Pub. No. 100-04, states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

For five sampled claims, Caretenders assigned an incorrect HIPPS billing code to the Medicare claim.¹⁷ The OASIS and other supporting medical records did not support the billing code that Caretenders used. Using the correct HIPPS billing code, we computed the payment amount in error by subtracting the correct payment amount from the original payment. We attributed these incorrect HIPPS codes to clerical errors.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Caretenders received overpayments totaling at least \$4,390,162 for the audit period. As of the publication of this report, all incorrectly billed claims in the sample are outside of the reopening period.

RECOMMENDATIONS

We recommend that Caretenders:¹⁸

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation and
- strengthen its procedures to ensure that:
 - the homebound status of Medicare beneficiaries is verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented,
 - beneficiaries are receiving only reasonable and necessary skilled services, and
 - HIPPS codes are billed correctly.

¹⁷ Of these five claims with an incorrectly billed HIPPS code, two claims were also billed for beneficiaries with homebound errors and one claim was billed for skilled services that were not medically necessary.

¹⁸ Our draft report contained a recommendation that Caretenders refund to the Medicare program the portion of the estimated overpayment for claims incorrectly billed that were within the reopening period. As of the date of issuance of this final report, all estimated overpayments are beyond the reopening period. Therefore, we have removed the recommendation to refund them.

CARETENDERS COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

CARETENDERS COMMENTS

In written comments on our draft report, Caretenders agreed that it was paid in error 1 of the 55 claims identified in our draft report findings as improperly billed. Caretenders disagreed with our remaining findings and recommendations. To address these concerns, we asked our medical review contractor to review Caretenders's written comments and claim rebuttals. Based on the results of that review and our review of additional documentation that Caretenders provided, we reduced the number of sampled claims incorrectly billed from 55 to 39 and revised the related findings and recommendations.

With respect to our first recommendation, to refund to the Medicare program the portion of the estimated overpayment for claims incorrectly billed that were within the reopening period, Caretenders alleged that our medical review contractor erroneously found that beneficiaries were not homebound, beneficiaries did not require skilled services, and HIPPS coding was incorrect. Caretenders disagreed with our independent medical reviewer's determinations and maintained that all of its sampled claims were billed correctly, apart from one claim that contained a coding error. Caretenders stated that the medical reviewers (1) misconstrued the applicable Medicare Benefit Policy Manual provisions and (2) failed to perform a complete review of the patient's entire medical record.

Regarding our second recommendation, to exercise reasonable diligence to identify and return overpayments in accordance with the 60-Day Rule, Caretenders did not concur because it disagreed with all but one of our findings, a single coding error.

Regarding our third recommendation, Caretenders disagreed that it should strengthen its procedures to ensure full compliance with Medicare billing requirements because it believes that it has effective policies and procedures in place to ensure full compliance with Medicare requirements.

Caretenders' written comments, which summarized its position on our findings, conclusions, and recommendations are included as Appendix F.¹⁹

¹⁹ Caretenders included over 60 pages of rebuttals to our findings. Due to their content (namely, personally identifiable information) we have not included their entire response in Appendix F. While the rebuttals have not been included as appendices in our final report, we have considered these documents in preparing our final report and will provide Caretenders' comments in their entirety to CMS.

OFFICE OF INSPECTOR GENERAL RESPONSE

To address Caretenders' concerns related to the medical review decisions, we had our independent medical review contractor review Caretenders' written comments on our draft report, including the claim-by-claim responses. Based on the results of that additional medical review, we revised some findings related to homebound status, skilled services, HIPPS coding, and the associated overpayments. We reduced the number of sampled claims incorrectly billed from 55 to 39 and revised the related findings and recommendations. We maintain that our remaining findings are valid. Below is a summary of Caretenders' comments and our responses.

BENEFICIARY HOMEBOUND STATUS

Caretenders Comments

Caretenders stated that our determinations pertaining to noncompliance with homebound requirements were flawed because medical reviewers did not correctly apply Medicare coverage criteria and failed to perform a complete review of each beneficiary's entire medical record.

Office of Inspector General Response

After reviewing Caretenders' comments, including additional documentation, and based on the conclusions of our independent medical review contractor's additional medical review, we revised our findings related to homebound status to specify that 33, rather than 46, sampled claims were associated with beneficiaries who did not meet the criteria for being homebound (16 claims for the full episode of care and 17 claims for part of the episode of care).

We disagree with Caretenders' assertion that our medical reviewers did not correctly apply Medicare coverage criteria or did not review the entire medical record when determining homebound status. Our medical reviewer prepared detailed medical review determination letters documenting its thorough analysis of relevant clinical evidence. Each determination letter included a detailed set of facts based on a thorough review of the entire medical record. In all cases, our medical reviewer considered the entire record as provided and relied upon the relevant facts necessary to determine homebound status in accordance with CMS's homebound definition.

BENEFICIARY NEED FOR SKILLED NURSING SERVICES

Caretenders Comments

Caretenders stated that our determinations that skilled nursing services were medically unnecessary pertaining to 27 claims were incorrect because the medical reviewers failed to perform a complete review of each beneficiary's entire medical record.

Office of Inspector General Response

After reviewing Caretenders' comments, including additional documentation, and based on the conclusions of our independent medical review contractor's additional medical review, we revised our findings related to the need for skilled nursing services to specify that 14, rather than 27, sampled claims were associated with beneficiaries who did not meet Medicare requirements for coverage of skilled nursing or therapy services (3 claims for an entire home health episode and 11 claims for a portion of an episode).

Our medical reviewer determined the medical necessity of skilled therapy services in accordance with the Manual, chapter 7, section 40.2. Per these CMS guidelines, it is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed. The guidelines also state: "While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled." The key issues are whether the skills of a therapist are needed to treat the illness or injury and whether the services can be carried out by unskilled personnel. The skilled therapy services must be reasonable and necessary for the treatment of a patient's illness or injury within the context of a patient's unique medical condition. In all cases, our medical reviewer considered the entire record as provided and relied upon the relevant facts necessary to determine the medical necessity of skilled therapy services in accordance with CMS's criteria.

Our medical reviewer determined the medical necessity of skilled nursing services in accordance with the Manual, chapter 7, section 40.1. Per these CMS guidelines, skilled nursing services are covered when the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse are necessary. In determining the medical necessity of skilled nursing services, our medical reviewer considered the patient's clinical condition and whether skilled services were necessary to safely and effectively maintain the patient's current condition or to slow further deterioration. When the services provided could be safely and effectively performed by the patient or unskilled caregivers, our medical reviewer determined that such services were not covered under the home health benefit. Pursuant to CMS requirements, our medical reviewer considered whether skilled nursing services were reasonable and necessary to the diagnosis and treatment of each patient's illness or injury within the context of the patient's unique medical condition. In all cases, our medical reviewer considered the entire record as provided and relied upon the relevant facts necessary to determine the medical necessity of skilled nursing services in accordance with CMS's criteria.

INCORRECTLY BILLED HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM CODE

Caretenders Comments

Caretenders concurred that it coded one claim incorrectly, and it is returning the resulting overpayment to Medicare. For the remaining claims with HIPPS coding errors, Caretenders

disagreed that it assigned an incorrect HIPPS payment code. Caretenders stated that our determinations were incorrect because the medical review did not account for changes to the beneficiary OASIS forms.

Office of Inspector General Response

Based on our medical reviewer's additional medical review, we revised our findings related to incorrect HIPPS coding.

The medical reviewer examined all of the material in the beneficiaries' medical records and carefully considered this information to determine whether Caretenders billed the claims in compliance with selected billing requirements. For both the initial and subsequent medical reviews, the medical reviewer reached carefully considered conclusions as to whether the services met coverage, medical necessity, and coding requirements. We revised our draft report finding of six claims with incorrect HIPPS codings to five on the basis of this subsequent medical review.

Accordingly, we maintain that our remaining findings are valid. We maintain that these errors occurred primarily because Caretenders did not have adequate procedures to ensure that the correct HIPPS payment code was billed.

60-DAY RULE RECOMMENDATION

Caretenders Comments

Caretenders disagreed with our recommendation to exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule because it disagreed with the audit findings that were overpayments other than a single coding error.

Office of Inspector General Response

We maintain that our findings are valid, for the reasons stated above, and we therefore maintain our belief that this audit report constitutes credible information of potential overpayments and maintain that our recommendation, to exercise reasonable diligence in accordance with the 60-day rule, is valid.

STRENGTHEN PROCEDURES RECOMMENDATION

Caretenders Comments

Caretenders disagreed with our recommendation to strengthen its procedures because it believes it has strong controls that ensure full compliance with Medicare requirements.

Office of Inspector General Response

Caretenders agreed that 1 of the 100 sampled claims was incorrect and stated that it had plans to refund the overpayment. We believe that our medical reviewers' initial and additional medical determinations of 39 errors is material evidence that the compliance procedures at Caretenders are not sufficient to prevent overpayments, regardless of Caretenders' nonconcurrence with the other potential overpayments.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$22,622,193 in Medicare payments to Caretenders for 7,175 home health claims with episode-of-care through dates in CYs 2014 and 2015 (audit period). From this sample frame, we selected for review a stratified random sample of 100 home health claims with payments totaling \$379,264.

We evaluated compliance with selected billing requirements and submitted the sampled claims to an independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

We limited our audit of Caretenders' internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

We conducted our fieldwork from August 2016 through August 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Caretenders' paid claim data from CMS's NCH file for the audit period;
- removed from the population low utilization payment adjustments, partial episode payments, RAC reviewed claims, claims less than \$1,000, and requests for anticipated payments to develop our sampling frame;
- selected a stratified random sample of 100 home health claims totaling \$379,264 for detailed review (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by Caretenders to support the claims sampled;
- reviewed sampled claims for compliance with known risk areas;

- used an independent medical review contractor to determine whether the 100 claims contained in the sample were reasonable and necessary and met coverage and coding requirements;
- reviewed Caretenders' procedures for billing and submitting Medicare claims;
- verified State licensure information for selected medical personnel providing services to the patients in our sample;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample to estimate the total Medicare overpayments to Caretenders for our audit period (Appendix D);
- discussed the results of our audit with Caretenders officials; and
- used an independent medical review contractor to perform an additional review of the 55 claims identified as improperly billed in our draft report to provide further assurance that the claims determinations were accurate and based on the entire medical record.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: MEDICARE REQUIREMENTS FOR COVERAGE AND PAYMENT OF CLAIMS FOR HOME HEALTH SERVICES

GENERAL MEDICARE REQUIREMENTS

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)).

CMS’s Medicare Claims Processing Manual, Pub. No. 100-04, states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

OUTCOME AND ASSESSMENT INFORMATION SET DATA

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups; to monitor the effects of treatment on patient care and outcome; and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes Medicare uses in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify acute-care inpatients who are similar clinically in terms of resources used.

CMS requires the submission of OASIS data as a condition of payment as of January 1, 2010 (42 CFR § 484.210(e); 74 Fed. Reg. 58078, 58110 (Nov. 10, 2009); and *CMS’s Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1).

COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy;²⁰ (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; 42 CFR § 409.42, and the Manual, chapter 7, § 30).

²⁰ Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, Medicare covers the first occupational therapy service, which is a dependent service only when followed by an intermittent skilled nursing care service, physical therapy service, or speech language pathology service as required by law. Once that requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes) (76 Fed. Reg. 68526, 68590 (Nov. 4, 2011)).

Per the Manual, chapter 7, section 20.1.2, the answer to whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS, or a medical record of the individual patient.

The Act and Federal regulations state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the above coverage requirements (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)).

Section 6407(a) of the Affordable Care Act²¹ added a requirement to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act that the physician must have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of the home health care by including the date of the encounter.²²

Confined to the Home

For the reimbursement of home health services, the beneficiary must be “confined to his home” (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR § 409.42)). According to section 1814(a) of the Act:

[A]n individual shall be considered “confined to the home” if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to the home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 30.1.1). The Manual states that, for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is

²¹ The Patient Protection and Affordable Care Act, P.L. No.111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

²² See 42 CFR § 424.22(a)(1)(v) and the Manual, chapter 7, § 30.5. The initial effective date for the face-to-face requirement was January 1, 2011. However, on December 23, 2010, CMS granted HHAs additional time to establish protocols for newly required face-to-face encounters. Therefore, documentation regarding these encounters must be present on certifications for patients with starts-of-care on or after April 1, 2011.

confined to his or her home. For purposes of the statute, an individual shall be considered “confined to the home” (homebound) if the following two criteria are met:

Criteria One

Patients must either:

- need, because of illness or injury, the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their places of residence or
- have a condition such that leaving their homes is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Need for Skilled Services

Intermittent Skilled Nursing Care

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse; must be reasonable and necessary to the treatment of the patient’s illness or injury; and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).

The Act defines “part-time or intermittent services” as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less 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, less than 8 hours each day and 35 or fewer hours each week) (the Act § 1861(m) and the Manual, chapter 7, § 50.7).

Requiring Skills of a Licensed Nurse

Federal regulations (42 CFR § 409.44(b)) state that in determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice. If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed nurse, the service may not be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is

taught to the beneficiary or to the beneficiary's family or friends does not negate the skilled aspect of the service when performed by the nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service.

General Principles Governing Reasonable and Necessary Skilled Nursing Care

Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed practical (vocational) nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service even though a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a nonskilled service does not make it a skilled service when a nurse provides the service.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable (the Manual, chapter 7, § 40.1.1).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury, the therapy services must be:

- inherently complex, which means that they can be performed safely and effectively only by or under the general supervision of a skilled therapist;

- consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and
- considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a) and the Manual (chapter 7, § 30.5.1.1) state that, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed nonphysician practitioner, had a face-to-face encounter with the patient that is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1) states that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

Plan of Care

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services (the Manual, chapter 7, § 30.2.2). The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

APPENDIX C: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of a database of 7,175 home health claims, valued at \$22,622,192.94, from CMS's NCH file. These claims were for select home health services²³ that Caretenders provided to Medicare beneficiaries with episodes of care that ended in CYs 2014 and 2015.

SAMPLE UNIT

The sample unit was a home health claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used the following stratified random sample:

Table 1: Claims by Stratum

Stratum	Frame Information			Sample Size
	Payment Range	Claims in Sample Frame	Dollar Total	
1	\$1,004.06 to \$2,839.54	3,715	\$7,616,884.18	34
2	\$2,839.55 to \$4,604.05	2,098	7,576,901.19	33
3	\$4,604.06 to \$19,360.09	1,362	7,428,407.57	33
Total		7,175	\$22,622,192.94	100

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum, and after generating the random numbers, we selected the corresponding frame items for review.

²³ We excluded home health claims for low utilization payment adjustments, partial episode payments, RAC reviewed claims, claims less than \$1,000, and requests for anticipated payments.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of overpayments paid to Caretenders during the audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Total Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments in Sample
1	3,715	\$7,616,884.18	34	\$69,010	12	\$21,658
2	2,098	7,576,901.19	33	118,020	17	33,813
3	1,362	7,428,407.57	33	192,234	10	36,873
Total	7,175	\$22,622,192.94	100	\$379,264	39	\$92,345*

* The numbers do not add up to the total because of rounding.

ESTIMATES

**Table 3: Estimated Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)**

Point estimate	\$6,038,050
Lower limit	4,390,162
Upper limit	7,685,937

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

Table 4: Stratum 1 (Samples 1–25)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
1	-	-	-	-
2	-	-	-	-
3			-	
4	-	-	-	-
5				
6	-	-	-	-
7	X	X	-	\$1,892
8	X	-	-	1,954
9	-	-	-	-
10	X	X	-	2,014
11	-	-	-	-
12	-	-	-	-
13	X	X	-	2,412
14	X	X	-	1,626
15	-	-	X	542
16	-			
17				
18	X	-	-	2,234
19	-	X	X	2,168
20				
21	X	-	-	2,673
22	-	-	-	-
23				
24	-	-	-	-
25	-			

Table 5: Stratum 1 (Samples 26-34)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
26	-	-	-	-
27	-	-	-	-
28	-	-	-	-
29	X	X	-	1,566
30	-	-	-	-
31	-	-	-	-
32	X		-	593
33	-	-	-	-
34	X	-	-	1,984

Table 6: Stratum 2 (Samples 35-67)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
35	X	X	-	\$1,686
36	-	-	-	-
37	X	-	-	229
38	X	-	X	782
39	-	-	-	-
40	-	-	-	-
41	-	-	-	-
42	X	X	-	3,785
43				
44				
45	-	-	-	-
46	X	-	-	666
47	X	-	-	3,346
48	-	-	-	-
49	X	-	-	1,060
50				
51	-	-	-	-
52	X	-	-	3,654
53	X	-	X	970
54				
55	-	-	-	-
56	X	X	-	2,962
57	-	-	-	-
58	X	X	-	4,219
59	X	-	-	715
60	-	-	-	-
61	-	-	-	-
62	X		-	2,476
63	X	X	-	1,248
64	-	-	-	-
65	X	-	-	3,849
66	X	-	-	1,094
67	X		-	1,070

Table 7: Stratum 3 (Samples 68–99)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
68	-	-	-	-
69	-	-	-	-
70	X		-	\$2,197
71	X	-	-	2,560
72	-	X	-	565
73	-	-	-	-
74	X		-	2,345
75	X	-	-	13,734
76				
77	-	-	-	-
78	-	-	-	-
79	-	-	-	-
80	-	-	X	3,959
81	-	-	-	-
82	-	-	-	-
83	-			
84	-	-	-	-
85	-	-	-	-
86				
87	X	-	-	5,249
88	-	-	-	-
89	X		-	836
90	-	-	-	-
91	-	-	-	-
92	-	-	-	-
93				
94	-	-	-	-
95	-	-	-	-
96	-	-	-	-
97	-	X	-	2,394
98	-	-	-	-
99				

Table 8: Stratum 3 (Sample 100 and Totals)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
100	-	X	-	3,033
Totals	33	14	5	\$92,345*

*The numbers do not add up to the total because of rounding.

APPENDIX F: CARETENDERS COMMENTS



Waller Lansden Dortch & Davis, LLP
511 Union Street, Suite 2700
P.O. Box 198966
Nashville, TN 37219-8966
615.244.6380 main
615.244.6804 fax
wallerlaw.com

Jennifer L. Weaver
615.850.8116 direct
jennifer.weaver@wallerlaw.com

February 12, 2020

Lori S. Pilcher
Regional Inspector General for Audit Services
Department of Health and Human Services
Office of the Inspector General
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Report Number: A-04-16-06195, *Caretenders of Jacksonville, LLC*

Dear Ms. Pilcher:

I am counsel for Caretenders of Jacksonville, LLC (“Caretenders”). Thank you for considering this response to the draft report, “*Medicare Home Health Agency Provider Compliance Audit: Caretenders of Jacksonville, LLC*” (“Draft Report”). For the reasons set forth below, Caretenders disagrees with the findings of the independent medical review contractor that the audited claims did not meet Medicare billing requirements. For each of the fifty-five denied claims, Caretenders is submitting detailed responses which demonstrate that the patients at issue were in fact homebound and had skilled needs, and were provided quality care from Caretenders that was reasonable and medically necessary, correctly coded and properly documented. Caretenders contends that the Draft Report is fundamentally flawed because the independent medical review contractor misconstrued the applicable Medicare Benefit Policy Manual provisions and failed to perform a complete review of the patients’ entire medical record. Caretenders welcomes the opportunity to meet with the independent medical review contractor to clear up any confusion and hopefully improve the accuracy of the Final Report.

As discussed below, Caretenders maintains that only a single claim, Sample #19, had a minor coding error resulting from the biller simply checking the wrong box. This minor error should not have resulted in a denial of the entire claim, but rather, a partial denial with a resulting overpayment of approximately \$180. Otherwise, the remaining fifty-four of the fifty-five denied claims in the Draft Report were properly reimbursed by Medicare. Caretenders further denies the contention in the Draft Report that it did not have adequate controls in place to prevent the incorrect billing of Medicare claims. The accuracy and appropriateness of all of the audited claims shows that Caretenders has effective policies and procedures in place to ensure correct Medicare billing. While it continually assesses and seeks to improve upon its billing and compliance policies and procedures, Caretenders presently has strong controls in place to ensure full compliance with Medicare billing requirements. The fact that Caretenders can show that all but one of the 100 audited claims met Medicare billing requirements proves this fact.

4843-5383-8259.1

Caretenders also does not concur with the Draft Report's recommendation that it identify and return "similar overpayments" outside the four-year claim reopening period because it disagrees with the audit finding that there was an overpayment to return, other than the single minor coding error for Sample #19, for which the resulting overpayment of approximately \$180 is being returned to Medicare. Moreover, Caretenders already has effective policies and procedures in place to identify and return overpayments within sixty days in the ordinary course of business. Finally, Caretenders does not concur with the Report's recommendation that it strengthen its controls to ensure full compliance with Medicare billing requirements, as it already has strong and robust controls to ensure full compliance with Medicare billing requirements.

For these reasons, we respectfully request that OIG take into account our defense of each of the fifty-five denied claims and the arguments set forth below, and consider the complete record before issuing its final report.

I. The Independent Medical Review Contractor Incorrectly Concluded that Forty-Six Patients Were Not Homebound

The independent medical review contractor denied forty-six claims on the grounds that the patients were not homebound for all or part of the episode of care. A review of the complete medical record and the applicable law shows that the independent medical review contractor was wrong in each instance.

A patient need not be bedridden to be considered homebound. Rather, the condition of the patient must be such that leaving home is not recommended because of the beneficiary's condition, the beneficiary requires help (e.g., a wheelchair, walker, special transportation, or accompaniment of another person) to leave home, and leaving home requires a considerable and taxing effort. A patient may be homebound and still leave the home for needed medical treatment and short, infrequent non-medical reasons. Homebound status must be determined on a case-by-case basis.

Caretenders is enclosing a detailed argument for each of the forty-six patients showing that they were in fact homebound under the applicable Medicare regulations and guidance governing homebound status. Examples of the errors committed by the independent medical review contractor in concluding the patient was not homebound are set forth below.

For example, the independent medical review contractor determined that Patient #18 was homebound at the start of care but was no longer homebound after 3/26/2015, despite clear indication in the medical record, including his certifying physician determining he still required home care during a 4/9/2015 examination. Based on CMS criteria for homebound status, Patient #18 met the standard throughout the entire episode due to his continued requirement of another

person to safely complete his ADLs. Patient #18 remained very anxious and afraid about touching or caring for his ileostomy. On the physician signed and dated plan of care, Patient #18 was noted to have limitations with endurance and ambulation. Considering the extent of the surgical repair and his hospitalization stay, it was clear Patient #18 was homebound. The medical reviewer's cursory reference to the fact that Patient #18 used to exercise before his very extensive and complicated surgery does not change this fact. There is no documentation in the record that states Patient #18 was leaving the home other than for one physician appointment. The Medicare Benefit Policy Manual specifically states that absence from the home to receive health care treatment shall not disqualify an individual from being considered homebound. (Medicare Benefit Policy Manual, Chapter 7, § 30.1.1.) Again, Patient #18 saw the certifying physician on 4/9/2015 and the physician did not discharge him from services for attending his appointment. Patient #18 was discharged from services appropriately on 5/18/15 with goals met, as he was independent in his ileostomy care.

Throughout, the independent medical reviewer erred by latching on to isolated trips outside the home as the basis for concluding a patient was not homebound. For example, the medical reviewer concludes that Patient #66 was not homebound beginning on 9/17/15 because he ambulated outside with his daughter. This appears to have been a onetime occurrence and other documentation in the record supported that it was likely not safe due to the patient's fall risk. According to the Medicare Benefit Policy Manual, "occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home." (Medicare Benefit Policy Manual, Chapter 7, § 30.1.1.) Clearly, under Medicare's own guidelines, this walk with his daughter outside on one day does not disqualify Patient #66 from being homebound.

If the medical reviewer had carefully reviewed his medical record, Patient #66's homebound status would have been readily apparent. Those records show that Patient #66 had very limited ambulation, and required the use of a cane and walker. His Plan of Care also included a diagnosis of memory loss. He remained homebound and continued to require physician home visits due to memory deficits, increased loss of balance during times of increased anxiety and ongoing assistance required to leave the home. In addition, Patient #66 had cataract surgery on 10/19/15 which further complicated his ability to leave home unattended. Despite one walk with his daughter (an ill-advised one at that given the safety risk), Patient #66 was clearly homebound throughout the entire episode.

II. The Independent Medical Review Contractor Incorrectly Concluded that Twenty-Seven Patients Did Not Need Skilled Nursing or Therapy

The independent medical review contractor denied twenty-seven claims on the basis that the patient did not need skilled nursing or therapy. Again, the error in these conclusions seems to stem from the independent medical review contractor's failure to consider the entirety of the patient's medical record.

The Medicare home health benefit covers skilled nursing care, physical therapy, occupational therapy, and speech-language pathology services, medical social services, and medical supplies that are reasonable and necessary for the treatment of the patient's illness or injury. Skilled nursing can be performed by a registered nurse or a licensed vocational/practice nurse under a registered nurse's supervision. Home health nurses provide direct care (e.g., injections, changing dressings) and also instruct patients and their caregivers about appropriate care (e.g., for diabetes management). Physical and occupational therapy is covered when it is a safe and effective treatment for a beneficiary's condition and can only be provided by qualified therapists and it is expected that the condition for which therapy is ordered will improve over time or therapy is necessary to establish or perform an effective maintenance program. Additionally, home health aide services are covered when given on a part-time or intermittent basis to support skilled nursing care or therapy.

Patient #76 provides a good example of the independent medical review contractor determining there was no skilled need for both physical and occupational therapy without carefully considering the patient's entire medical record. A more careful review of both the Plan of Care for occupational therapy and the Plan of Care for physical therapy shows that both types of therapy were reasonable and medically necessary. The occupational therapy Plan of Care focused on transferring from bed to wheelchair and to the bed side commode using a sliding board. The goal was to increase independence in ADL's, especially toileting, using the sliding board, thereby reducing Patient #76's dependence on her caregiver to assist her on and off the bedpan. The physical therapy Plan of Care had its own distinct goals, overlooked by the medical reviewer. The physical therapy Plan of Care focused on transfers, lower extremity strengthening, static standing, and development of a home exercise program. Physical therapy also worked on strengthening the bilateral lower extremities. The physical therapists performed lower extremity exercises during their visits and advanced them with the use of weights and Thera band. Patient #76 had been capable of ambulating household distances with a walker prior to the fracture for which she was hospitalized. Post-hospitalization, Patient #76 was no longer able to ambulate. Physical therapy worked on sit to stand transfers and static standing using the walker, kitchen sink, and assistance of a caregiver. Due to the skilled physical therapy services provided by Caretenders, Patient #76 was able to advance her standing tolerance from 15 seconds to 2 minutes. This was a significant improvement given the patient's fracture history, morbid obesity, and history of falls. Caretenders' physical therapist was concerned about pressure ulcers related

to the prolonged sitting and was able to assist Patient #76 with standing multiple times a day to relieve pressure. Early in the episode, Patient #76 required the assistance of two people to stand, but with physical therapy, this improved markedly.

It is evident that the occupational and physical therapy services provided to Patient #76 were not duplicative and both were medically necessary. Patient #76 benefited from receiving both skilled services, making slow but steady progress. Patient #76 was discharged from all therapy when she had reached her maximum functional potential, which she was only able to do because of the high-quality occupational and physical therapy services provided by Caretenders.

The independent medical reviewer also erred in determining that patients no longer needed skilled services after a certain date, when a thorough review of the patient's record disproved that determination. For example, the medical reviewer determined that Patient #83 did not need skilled services after 9/15/2015. However, the Medicare Benefit Policy Manual provides that observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that 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 patient's clinical condition and/or treatment regimen has stabilized. (Medicare Benefit Policy Manual, Chapter 7, § 40.1.2.1.) Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode, but did not develop a further acute episode or complication, the skilled observation services are still covered for three weeks or so long as there remains a reasonable potential for such a complication or further acute episode. (*Id.*) That is exactly the situation with Patient #83.

The skilled nursing documentation in the records supports Patient #83's ongoing need for observation and assessment related to her labile blood sugar readings. On the skilled nursing visit of 9/10/2015, Patient #83's blood sugar readings ranged from 159 to 364. The following week on 9/15/2015, the skilled nurse documented her blood sugar was 118. On the skilled nursing visit of 9/22/2015, the skilled nurse continued to instruct Patient #83 on her diet and eating times and how that affects her blood sugar readings. Patient #83 was discharged from skilled nursing care on 10/13/2015 when her goals were met and she and her caregiver were able to manage blood sugars and diet. Had Caretenders discharged Patient #83 prematurely, the moment her blood sugar readings improved, there is a strong likelihood those improvements would not have been maintained and a reasonable potential Patient #83 could have suffered further complications or another acute episode. The Medicare Benefit Policy Manual explicitly provides the three-week skilled nursing cushion to prevent such an eventuality. (*See* Medicare Benefit Policy Manual, Chapter 7, § 40.1.2.1.)

III. The Independent Medical Review Contractor Incorrectly Determined that Five Claims Were Incorrectly Coded

The independent medical review contractor's conclusions with regard to coding also do not hold up to scrutiny. For example, the contractor determines that claims for Patient #53 are incorrectly coded. However, it is the independent medical review contractor who is incorrect. HIPPS code 1CHP1 (Early Episode, 0-13 therapies, Clinical Severity Level 3, Functional Severity Level 3, Service Severity Level 5, Supply Severity Level 1, supplies not provided) was correctly indicated on the claim form. According to the OASIS correction form along with the OASIS, the above billed HIPPS/HHRG is correct. Changes to the OASIS questions M1400, M1810, M1820, M1840, M1860 and M2200 were made and supported by the OASIS Recommendation Change Form. Billed Home Health grouper was correct.

Similarly, the medical reviewer erred in determining that Sample #80 was incorrectly coded. This claim was correctly billed. CMS has always auto-adjusted the therapy amount in the final claim to the correct number. According to OASIS guidance, this should be the clinician's best estimate of the services needed. It is always difficult to be exact because of exacerbations, re-hospitalizations, or other events that may hinder or speed progress that is unexpected at the time of assessment. M2200 was blank and was not updated on the correction form, but from the 485 and what was entered as projected the number of therapy visits, 9 was correct. Then on 7/23/2015, OT was added. The final result was that the original projected 9 PT with the addition of the 9 OT visits was correct. There were 4 PT visits not covered by orders, making the Final correct billed HHRG as; C3F3S2, case weight 1.8852, supply 26 and revenue as \$4931.17.

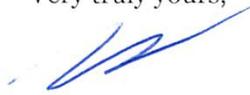
Caretenders concurs with the medical review contractor that sample #19 was incorrectly coded. There is a discrepancy in the functional severity level scoring on Patient #19's admission OASIS documentation. The episode was billed as a F3, M1840 was answered 3. The admission OASIS has the answer to M1840 as a 1 and the answer was not changed on the start of care OASIS change form. When the document was transcribed into the software system, the transcriber inadvertently checked box 3 instead of box 1. Caretenders is correcting this claim which was inadvertently incorrectly coded, and is returning the associated overpayment of approximately \$180 to Medicare.

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Lori S. Pilcher
February 12, 2020
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In closing, Caretenders respectfully requests that OIG take a second look at the findings of the independent medical review contractor in light of the information provided in this response. Caretenders continues to welcome any opportunity to meet with your office and the independent medical review contractor to work through these issues so that the final report issued by OIG is as fair and accurate as possible. We are also enclosing the fifty-five individual patient responses. If there is anything else that we can provide, please do not hesitate to ask.

Very truly yours,



Jennifer L. Weaver

Enclosures

JLW:cwb

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