Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOME HEALTH AGENCY PROVIDER COMPLIANCE AUDIT: PALOS COMMUNITY HOSPITAL HOME HEALTH AGENCY

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Report in Brief
Date: December 2019
Report No. A-05-17-00022

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

Medicare Home Health Agency Provider Compliance Audit: Palos Community Hospital Home Health Agency

Why OIG Did This Audit

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

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

Our objective was to determine whether Palos Community Hospital Home Health Agency (Palos) 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 medical review.

What OIG Found

Palos did not comply with Medicare billing requirements for 16 of the 100 home health claims that we reviewed. For these claims, Palos received overpayments of $22,428 for services provided in calendar years (CYs) 2015 and 2016. Specifically, Palos incorrectly billed Medicare for (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries that did not require skilled services, or (3) incorrect Health Insurance Prospective Payment System payment codes. On the basis of our sample results, we estimated that Palos received overpayments of at least $680,884 for CYs 2015 and 2016.

What OIG Recommends and Palos Comments

We made several recommendations to Palos, including that it (1) refund to the Medicare program the portion of the estimated $680,884 in overpayments for claims incorrectly billed that are within the reopening period; (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period; and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period. We also made several procedural recommendations.

In written comments on our draft report, Palos concurred with all of our findings and recommendations and stated that they have implemented an action plan which includes monitoring clinical documentation.

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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 (CERT) 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. Palos Community Hospital Home Health Agency (Palos) was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Palos 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, 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)

payment codes[1] and represent specific sets of patient characteristics.[2] CMS requires HHAs to submit OASIS data as a condition of payment.[3]

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 audits 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 OASIS data in a timely fashion, and
- services were not always adequately documented.

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);
- 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

[1] HIPPS rate 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.

[2] 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.

[3] 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.

- 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)).

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Providers that receive credible information of a potential overpayment must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify the overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[4]

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

Palos Community Hospital Home Health Agency

Palos is a not-for-profit HHA located in Lemont, Illinois. Palmetto GBA, LLC, its Medicare administrative contractor, paid Palos approximately $24 million for 9,049 claims for services provided in CYs 2015 and 2016 (audit period) according to CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $21,421,164 in Medicare payments to Palos for 7,241 claims.[5] These claims

[4] The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

[5] In developing this sampling frame, we excluded from our audit home health claim payments for low utilization payment adjustments, partial episode payments, and requests for anticipated payments.

were for home health services provided in CYs 2015 and 2016.[6] We selected a stratified random sample of 100 claims with payments totaling $321,168 for audit. We evaluated compliance with selected billing requirements and submitted these claims to an independent medical review contractor 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 (GAGAS). 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 A contains the details of our audit 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 for each sample item.

FINDINGS

Palos did not comply with Medicare billing requirements for 16 of the 100 home health claims that we audited. For these claims, Palos received net overpayments of $22,428 for services provided in CYs 2015 and 2016. Specifically, Palos incorrectly billed Medicare for:

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

These errors occurred primarily because Palos did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas. On the basis of our sample results, we estimated that Palos received overpayments of at least $680,884 for the audit period.[7]

PALOS COMMUNITY HOSPITAL HOME HEALTH AGENCY BILLING ERRORS

Palos incorrectly billed Medicare for 16 of the 100 sampled claims, which resulted in net overpayments of $22,428.

[6] CYs were determined 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.

[7] To be conservative, we recommend recovery of 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.

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" (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (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.

CMS provided further guidance and specific examples in the Manual (chapter 7 § 30.1.1).[8] The Manual states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home and that an individual will be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One

The patient 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 his or her place of residence; or

- have a condition such that leaving his or her home 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.

[8] Revision 208 of § 30.1.1 (effective January 1, 2015) covered all of our audit period.

Palos Did Not Always Meet Federal Requirements for Home Health Services

For 12 of the sampled claims, Palos incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements for being homebound for the full episode (4 claims) or for a portion of one (8 claims).

Example 1: Beneficiary Not Homebound – Entire Episode

The beneficiary was not homebound at the start of care or during the episode. He had been hospitalized for approximately 1 week for severe abdominal pain and was treated for a small bowel obstruction and could ambulate 150 feet and negotiate stairs safely without an assistive device. He had good balance and functional endurance and his total Tinetti score[9] was 26/28. Leaving the home would not have required a considerable or taxing effort.

Example 2: Beneficiary Not Homebound – Partial Episode

For another beneficiary, the records showed that the patient was initially homebound after having undergone a left total knee replacement and was limited by pain, decreased knee range of motion, and weakness. She was living in a residence with steps to the entrance. She took medications, including Warfarin, which placed her at risk of fall-related complications related to bleeding. She was limited to ambulating very short distances at the start of care. Leaving the home would have required a considerable and taxing effort at the start of care. However, during the episode of care, which started on February 28, 2015, her mobility status improved. By March 11, 2015, she was able to ambulate 350 feet indoors and 40 feet times two outdoors and had progressed to negotiating stairs without hands-on assistance. Leaving the home did not require a considerable or taxing effort after March 11, 2015. The medical information does not support that she remained homebound after this date.

These errors occurred because Palos did not have sufficient controls in place.

Beneficiaries Did Not Require Skilled Services

Federal Requirements for Skilled Services

A Medicare beneficiary must need skilled nursing care intermittently, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A)) and Federal regulations (42 CFR § 409.42(c)). In addition,

[9] A Tinetti Score is a score used during an assessment of a patient's gait and balance in older adults and the risk of falling. The highest score a patient can reach is 28 which represents a low risk of falls.

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).[10] 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 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).

Palos Did Not Always Meet Federal Requirements for Skilled Services

For three of the sampled claims, Palos incorrectly billed Medicare for a portion of an episode for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.

Example 3: Beneficiary Did Not Require Skilled Services

A beneficiary in her first episode of care with comorbid medical conditions including severe depression, anxiety, and osteoarthritis was homebound. Her conditions were of longstanding and there was no history of recent injury. She had caregiver assistance available for processing information with respect to education regarding her medical conditions. The patient was not consistent with her home exercise program, refused to ambulate with staff by using her wheelchair to attend meals, and refused therapy at times. As a result, ongoing skilled nursing and physical therapy services were excessive and not medically necessary after the third visit.

These errors occurred because Palos lacked quality assurance and clinical staff knowledge of the agency's key internal controls related to OASIS accuracy.

Palos Billed Home Health Services Using An Incorrect Payment Code

Federal Requirements for Billing Medicare Home Health Services

For reimbursement of home health services, a Medicare claim must be completed accurately (The Manual, chapter 1, § 80.3.2.2). This includes assigning the appropriate HIPPS rate code as it relates to the data elements reported in beneficiaries' OASIS data.

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

Palos Did Not Always Meet Federal Requirements for Billing Medicare Home Health Services

Palos did not bill one Medicare home health episode using the appropriate HIPPS payment code or case-mix group. Palos billed the claim using HIPPS rate code 3CHK3, but the home health grouper billed the code to 3CHK5. The discrepancy is related to the Supply Severity Level, which is reflected in the fifth position of the billed code.[11] The code is incorrect because it does not show that the patient required supplies for treating a stasis ulcer; however, the stasis ulcer was reported in the OASIS data.

The error occurred because Palos lacked required documentation relating to the diagnosis of the ulcer and because the home health grouper did not detect an order from Palos for wound care supplies; Palos used supplies they had on-hand instead of ordering and billing for new supplies.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Palos received overpayments totaling at least $680,884 for the audit period.

RECOMMENDATIONS

We recommend that Palos Community Hospital Home Health Agency:

- refund to the Medicare program the portion of the estimated $680,884 in overpayments for claims incorrectly billed that are within the reopening period;

- for the remaining portion of the estimated $680,884 in overpayments for claims that are outside of the Medicare reopening period, exercise reasonable diligence in identifying and returning overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;

- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and

[11] The fifth position in the HIPPS code indicates a severity group for non-routine supplies (NRS). The home health PPS grouper software will assign each episode into one of six NRS severity levels and create the fifth position of the HIPPS code with the values S through X. If the HHA is aware that supplies were not provided during an episode, they must change the code to the corresponding number 1 through 6 (1 being the least amount of supplies needed) before submitting the claim.

- strengthen its procedures to ensure that:

    - the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented;

    - beneficiaries are receiving only reasonable and necessary skilled services; and

    - home health episodes are billed correctly.

PALOS COMMUNTIY HOSPITAL HOME HEALTH AGENCY COMMENTS

In written comments to our draft report, Palos concurred with all of our findings and recommendations and stated that they have implemented an action plan which includes monitoring clinical documentation. Palos' comments are included in their entirety in Appendix F.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $21,421,164 in Medicare payments to Palos for 7,241 home health claims with episode-of-care through dates in CYs 2015 and 2016. From this sampling frame, we selected for audit a stratified random sample of 100 home health claims with payments totaling $321,168.

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 Palos' 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 at Palos from July 2017 through March 2019.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Palos' paid claims data from CMS's NCH file for the audit period;
- removed payments for low utilization payment adjustments, partial episode payments, and requests for anticipated payments from the population to develop our sampling frame;
- selected a stratified random sample of 100 home health claims totaling $321,168 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 Palos 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 Medicare coverage and coding requirements;

- reviewed Palos' 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 Palos for our audit period (Appendix D); and

- discussed the results of our audit with Palos officials.

We conducted this performance audit in accordance with GAGAS. 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 outcomes; 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 patients 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, speech-language pathology, or occupational therapy;[12] (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 (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 CFR § 409.42, and the Manual, chapter 7, § 30).

[12] 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, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, a physical therapy service, or a speech-language pathology service as required by law. Once the 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, 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 (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and 42 CFR § 424.22(a)).

Section 6407(a) of the Affordable Care Act[13] added a requirement to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act that the physician 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 before 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.[14]

Confined to the Home

For reimbursement of home health services, the beneficiary must be "confined to the home" (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A)) and Federal regulations (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.

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

[13] 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.

[14] 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 must be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One

The patient 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 his or her place of residence; or

- have a condition such that leaving his or her home 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)(1)(v)) and the Manual (chapter 7 § 30.5.1) 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

TARGET POPULATION

The population consisted of Palos' claims for select home health services[15] that it provided to Medicare beneficiaries with episodes of care that ended in CYs 2015 and 2016.

SAMPLE FRAME

The sampling frame consisted of a database of 7,241 home health claims, valued at $21,421,164, from CMS's NCH file.

SAMPLE UNIT

The sample unit was a home health claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample.

Stratum	Frame Information			Sample Size
	Payment Range	Count Total	Dollar Total	
1	<=$3,050.30	4,843	$11,142,350	50
2	>$3,050.31	2,398	10,278,814	50
Total		**7,241**	**$21,421,164**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR 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 audit.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid

[15] We excluded home health payments for low utilization adjustments, partial episode payments, and requests for anticipated payments. We also excluded claims that resulted in error code 534 when matched against the Recovery Audit Contractor Data Warehouse. This code represents claims that have already been marked for exclusion by an OIG audit, investigation, or similar review.

to Palos during the audit period. To be conservative, we recommend recovery of 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.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Stratum	Frame Size	Total Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments In Sample
1	4,843	$11,142,350	50	$115,443	4	$7,055
2	2,398	10,278,814	50	205,725	12	15,373
Total	**7,241**	**$21,421,164**	**100**	**$321,168**	**16**	**$22,428**

ESTIMATES

Estimates of Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$1,420,693
Lower limit	680,884
Upper limit	2,160,502

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1 (Samples 1-25)

Sample	Not Homebound	Did Not Require Skilled Services	Billed Inappropriately	Overpayment
1	-	-	-	-
2	-	-	-	-
3	-	-	-	-
4	-	-	-	-
5	-	-	-	-
6	-	-	-	-
7	X	-	-	$645
8	-	-	-	-
9	-	-	-	-
10	-	-	-	-
11	-	-	-	-
12	-	-	-	-
13	-	-	-	-
14	-	-	-	-
15	-	-	-	-
16	-	-	-	-
17	-	-	-	-
18	-	-	-	-
19	-	-	-	-
20	-	-	-	-
21	-	-	-	-
22	-	-	-	-
23	-	-	-	-
24	-	-	-	-
25	-	-	-	-

STRATUM 1 (Samples 26–50)

Sample	Not Homebound	Did Not Require Skilled Services	Billed Inappropriately	Overpayment
26	-	-	-	-
27	X	-	-	$2,525
28	-	-	-	-
29	-	-	-	-
30	-	-	-	-
31	-	-	-	-
32	-	-	-	-
33	-	-	-	-
34	-	-	-	-
35	-	-	-	-
36	-	-	-	-
37	-	-	-	-
38	X	-	-	1,897
39	-	-	-	-
40	-	-	-	-
41	-	-	-	-
42	-	-	-	-
43	-	-	-	-
44	-	-	-	-
45	-	X	-	1,989
46	-	-	-	-
47	-	-	-	-
48	-	-	-	-
49	-	-	-	-
50	-	-	-	-

STRATUM 2 (Samples 51–75)

Sample	Not Homebound	Did Not Require Skilled Services	Billed Inappropriately	Overpayment
51	X	-	-	$699
52	-	-	-	-
53	-	-	-	-
54	-	-	-	-
55	-	-	-	-
56	-	-	-	-
57	-	-	-	-
58	-	-	-	-
59	-	-	-	-
60	-	-	-	-
61	-	-	-	-
62	X	-	-	699
63	-	-	-	-
64	-	X	-	504
65	-	-	-	-
66	-	-	-	-
67	X	-	-	3,162
68	-	-	-	-
69	-	-	-	-
70	-	-	-	-
71	-	-	-	-
72	X	-	-	(39)
73	-	-	-	-
74	-	-	-	-
75	-	X	-	1,399

STRATUM 2 (Samples 76–100)

Sample	Not Homebound	Did Not Require Skilled Services	Billed Inappropriately	Overpayment
76	X	-	-	$1,689
77	-	-	-	-
78	X	-	-	850
79	-	-	-	-
80	-	-	-	-
81	-	-	-	-
82	-	-	-	-
83	-	-	-	-
84	-	-	-	-
85	-	-	-	-
86	-	-	-	-
87	X	-	-	1,700
88	-	-	-	-
89	-	-	-	-
90	-	-	-	-
91	X	-	-	699
92	X	-	-	4,188
93	-	-	-	-
94	-	-	X	(178)
95	-	-	-	-
96	-	-	-	-
97	-	-	-	-
98	-	-	-	-
99	-	-	-	-
100	-	-	-	-
Total	**12**	**3**	**1**	**$22,248**[16]

[16] The sum of the column does not equal the total amount due to rounding.

PALOS HEALTH

PALOS HOSPITAL
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November 26, 2019

Sheri L. Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
233 North Michigan, Suite 1360
Chicago, IL 60601

Re: OIG Audit: A-05-17-0022A

Dear Ms. Fulcher,

Palos Community Hospital Home Health Agency (PCH) reviewed documentation of charts randomly selected for audit by the Office of Inspector General. Palos Community Hospital Home Health Care concurs with the OIG audit findings and recommendations. PCH has implemented an action plan which includes monitoring of PCH Home Health clinical documentation.

Again, we concur with the OIG audit findings and recommendations.

Sincerely,

// Terrence Moisan, MD //

President and Chief Executive Officer
Palos Health
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Palos Heights, IL 60463
(708)923-5000