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Medicare Home Health Agency Provider Compliance Audit: VNS Health

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REPORT HIGHLIGHTS

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Medicare Home Health Agency Provider Compliance Audit: VNS Health

Why OIG Did This Audit

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether VNS Health complied with Medicare billing requirements.

What OIG Found

For the audit period (July 1, 2020, through June 30, 2022), VNS Health complied with Medicare billing requirements for 84 of the 100 sampled home health claims we reviewed. For the remaining 16 claims, VNS Health incorrectly billed Medicare. Specifically:

- Twelve claims did not meet billing and coding requirements.
- Four claims did not meet face-to-face encounter requirements.
- Two claims did not meet plan of care requirements.

The total exceeds 16 because 2 claims contained more than 1 error.

Based on our sample results, we estimate that, of the $191,954,445 in Medicare payments covered by our audit, VNS Health received overpayments of at least $2,965,484 for the audit period.

What OIG Recommends

We made three recommendations to VNS Health, including that it (1) refund the $2,965,484 in overpayments to the Medicare program, (2) consider conducting one or more internal audits or investigations for claims after our audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program, and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

VNS Health did not concur with any of our recommendations, but it agreed to repay a portion of $12,606 in actual overpayments associated with five claims that resulted in errors.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare (enrollees). In that year, nearly 10,000 HHAs participated in Medicare. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims (which is calculated based on July 1, 2021 – June 30, 2022, payments) was 7.7 percent, or about $1.2 billion. This audit is part of a series of audits of HHAs.[1] Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. VNS Health, formerly known as Visiting Nurse Service of New York, was one of those HHAs.[2]

OBJECTIVE

Our objective was to determine whether VNS Health complied with Medicare requirements for billing home health services on selected types of claims.[3]

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare (Parts A and B) covers eligible home health services such as intermittent skilled nursing and home aide visits, covered therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health Prospective Payment System (PPS), CMS pays HHAs a national, standardized 30-day period payment rate.[4] This standardized payment rate is adjusted by using variables in the Patient-Driven Groupings Model (PDGM) that account for the enrollee's condition and health care needs.[5] For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called Home Health Resource Groups (HHRGs).

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[1] See Appendix B for a list of related OIG reports on Medicare home health compliance audits. For more information, see Work Plan Summary, accessed on Oct. 7, 2025.

[2] During our audit period, Visiting Nurse Service of New York changed its organization name to VNS Health.

[3] We did not include the following types of claims in our audit that we judged as low risk for waste and abuse: Requests for Anticipated Payment, Notices of Admission, Low Utilization Payment Adjustments, and Partial Episode Payments.

[4] Adjustments are made for geographic differences in wage levels.

[5] The PDGM became effective Jan. 1, 2020.

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue to, receive home health services. CMS requires HHAs to submit OASIS data as a condition of payment.[6] CMS uses the HHRGs as the basis for the Health Insurance Prospective Payment System (HIPPS) codes, which determine payment.[7]

Although home health PPS payment is made for each 30-day period, patient eligibility is determined based on a 60-day certification period. Medicare permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications as long as the enrollee meets eligibility requirements. Each 60-day certification can include two 30-day payment periods.

CMS administers the Medicare program and contracts with Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs in four jurisdictions.[8]

Medicare Requirements for Home Health Services and Claims

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 and 424.22 require, as a condition of payment for home health services, that a physician or other allowed practitioner[9] certify and recertify that the Medicare enrollee 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 or allowed practitioner; and

[6] 42 CFR §§ 484.45, 484.205(c), and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

[7] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and HHAs. For more information, see CMS | HIPPS Codes, accessed on Oct. 21, 2025.

[8] The MACs are National Government Services, Inc. (two jurisdictions); CGS Administrators, LLC (one jurisdiction); and Palmetto GBA, LLC (one jurisdiction).

[9] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

- receiving services under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner.

Furthermore, as a condition of payment, a practitioner must certify that a face-to-face (F2F) 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)).[10] 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 provided on the forms and in the medical record (e.g., plan of care, certification or recertification statement, the OASIS, progress notes) concerning the unique medical condition of the individual. 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 on objective clinical evidence regarding the enrollee's individual need for care (42 CFR § 409.44(a)).

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

Limitation on Recovery of Overpayments

Medicare contractors may reopen a claim for good cause within 4 years from the date of the initial determination or redetermination.[11] National Government Services, Inc. (NGS), VNS Health's Medicare contractor, reopened all claims in our audit sample frame within 4 years from the date of the initial determination of each of those claims.

Section 1870 of the Act prohibits the recovery of Medicare fee-for-service overpayments if the provider was without fault with respect to the overpayment.[12] A provider is presumed to be without fault for Medicare fee-for-service overpayments if the overpayment determination is made by the Medicare program after the fifth year following the year in which notice of such payment was sent to the provider.[13] MACs typically waive recovery in accordance with this

[10] The F2F encounter can be performed by the certifying physician or allowed practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

[11] 42 CFR § 405.980(b)(2).

[12] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); Medicare Financial Management Manual, ch. 3, §§ 70.3 and 80.

[13] Section 1870; 78 Fed. Reg. 74230, 74445 (Dec. 10, 2013); Medicare Financial Management Manual, ch. 3, §§ 70.3 and 80.

presumption, but have the authority to determine whether there is sufficient evidence to rebut the presumption.

VNS Health

VNS Health is one of the Nation's largest not-for-profit home and community-based health care organizations and is headquartered in New York, New York. NGS paid VNS Health approximately $200 million for 71,893 claims for services provided to enrollees from July 1, 2020, through June 30, 2022 (audit period), based on CMS's Integrated Data Repository (IDR) data.[14]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $191,954,445 in Medicare payments to VNS Health for 68,702 claims for services provided during the audit period.[15] We selected a simple random sample of 100 claims with payments totaling $278,147 for review. We evaluated these claims for compliance with selected billing requirements and submitted them for 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 objectives.

Appendix A contains the details of our audit scope and methodology, Appendix D contains our statistical sampling methodology, Appendix E contains our sample results and estimates, and Appendix F contains the types of errors, if any, for each sample item.[16]

FINDINGS

VNS Health complied with selected Medicare billing requirements for 84 of the 100 sampled home health claims that we reviewed. For the remaining 16 claims, VNS Health incorrectly billed Medicare for services that did not meet billing and coding requirements (12 claims), did not meet F2F encounter requirements (4 claims), or did not meet plan of care requirements

[14] This was the most recent timeframe for which claim data were available at the start of the audit.

[15] Our sampling frame included home health claim payments for 30-day billing periods with dates of service within our audit period that had not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse. We did not include Requests for Anticipated Payment (42 CFR §§ 484.205(h) and (i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[16] Some sample items have more than one type of error.

(2 claims).[17] For eight of these claims, the errors did not result in overpayments.[18] For eight other claims, VNS Health received overpayments of $12,606.[19]

According to the provider, these errors occurred because of the impact of the COVID-19 public health emergency (PHE) on its operations. We determined that these errors occurred because VNS Health did not always review medical record documentation to prevent the incorrect billing of Medicare claims. On the basis of our sample results, we estimated that VNS Health received at least $2,965,484 in overpayments for the audit period.[20]

SERVICES DID NOT MEET BILLING AND CODING REQUIREMENTS

Effective January 1, 2020, Medicare pays HHAs for home health services under the Home Health PPS by means of a national, standardized 30-day payment rate calculated using the PDGM. Each 30-day billing period is categorized into 1 of 432 HHRGs for the purpose of adjusting payment under the PDGM.[21] In particular, 30-day billing periods are placed into different subgroups for each of the following broad categories: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses).[22]

CMS's home health PPS Grouper software automatically draws information from the home health claim and submitted OASIS assessment to group the 30-day billing period into an HHRG and assigns a corresponding HIPPS code. The HIPPS code is a distinct five-position alphanumeric code that represents the case mix on which payment determinations are made.

The primary and secondary diagnoses reported on the home health claim, which are used to determine the HHRG and resulting HIPPS code, must be supported by information in the certifying practitioner's and/or the acute or post-acute facility's medical record (84 Fed. Reg. 60478, 60514 (Nov. 8, 2019); International Classification of Diseases (ICD), Clinical

[17] The total exceeds 16 claims because 2 claims have more than 1 type of error.

[18] While these claim billing errors may not always result in overpayments, findings such as these can and do result in overpayments. Therefore, these findings are relevant to our objective of determining VNS Health's compliance with Medicare requirements for billing home health services.

[19] Three of these eight claims qualified for partial Medicare reimbursement. For these three claims, we determined the difference between what was originally reimbursed and what was eligible for reimbursement. The remaining five claims were full denials.

[20] 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.

[21] Adjustments are also made for geographic differences in wage levels.

[22] 84 Fed. Reg. 60478, 60485-60495 (Nov. 8, 2019); 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); CMS | Home Health PPS, accessed on Oct. 21, 2025.

Modification (CM), ICD-10-CM *Official Guidelines for Coding and Reporting*, section I.B.14; Medicare Program Integrity Manual, ch. 6, § 6.2.4).

For 12 of the sampled claims, VNS Health submitted claims for services that did not meet billing and coding requirements. Specifically, VNS Health submitted claims with unsupported primary or secondary diagnosis codes. For seven of these claims, the removal of the unsupported secondary diagnosis codes did not result in overpayments. For three claims, the removal of the unsupported primary or secondary diagnosis codes changed the clinical grouping portion of the HIPPS code and resulted in overpayments totaling $1,818.[23] For each of the remaining two claims, there were multiple errors identified on the claims, and the overpayments were assigned to another error category.

Example: Primary Diagnosis Not Supported

VNS Health submitted a claim for a patient that indicated pressure ulcer as the primary reason for home health services. However, the documentation supported the primary diagnosis of small bowel obstruction (SBO). The patient required skilled services to help prevent an SBO episode and pain control. The patient received skilled nursing services to assess general condition, provide health and medication teaching, and provide wound care. Our medical review contractor found that the documentation did not support that the pressure ulcer reported on the claim was the primary reason for home health services. The change in primary diagnosis code resulted in an overpayment totaling $632.

SERVICES BILLED DID NOT MEET FACE-TO-FACE ENCOUNTER REQUIREMENTS

As a condition for payment of home health services under Medicare, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- be related to the primary reason the patient requires home health services;
- occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date; and
- be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

[23] The clinical grouping is based on the primary diagnosis reported on the claim and represents 1 of 12 clinical categories that the enrollee's condition falls into. The primary diagnosis must be the primary reason that the beneficiary received home health care during the 30-day billing period.

For four of the sampled claims, VNS Health submitted claims that did not meet F2F encounter requirements, resulting in overpayments of $8,983. Specifically, for two claims, the F2F encounter was not related to the primary reason the patient required home health services. For one claim, the F2F encounter was performed 39 days after the start-of-care date. For the remaining claim, documentation of the F2F encounter was not provided.

Example: Face-to-Face Encounter Not Related to Primary Reason for Home Health Services

VNS Health submitted a claim for a patient whose F2F encounter note showed that the F2F encounter was related to a Transient Ischemic Attack (mini-stroke). Our medical review contractor found that the F2F encounter was not related to the primary reason the patient required home health services: Malignant Neoplasm of Unspecified Site of Left Female Breast.

SERVICES BILLED DID NOT MEET PLAN OF CARE REQUIREMENTS

For HHA services to be covered, a physician or allowed practitioner must establish and periodically review an individualized plan of care. The plan of care and any changes to the plan of care (including verbal orders) must be signed and dated by a physician or allowed practitioner before the claim for each 30-day period is submitted (42 CFR §§ 409.43(c)(2) and (3) and 42 CFR § 409.43(d)).

For two of the sampled claims, VNS Health submitted claims that did not meet plan of care requirements. For each of these claims, the plan of care or changes to the plan of care were signed and dated by the physician after the claim was submitted to CMS for payment. Any skilled services related to the untimely plan of care or changes in the plan of care were unallowable. For one claim, the removal of the unallowable visits did not result in an overpayment because the minimum threshold[24] to receive full payment was met. For the remaining claim, the minimum threshold was not met after removal of the unallowable visits, resulting in an overpayment of $1,805.

CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

We determined that these errors occurred because VNS Health did not always review: (1) medical records from the certifying practitioner or the inpatient facility to verify that all codes billed were supported by documentation, (2) plan of care documentation from the certifying practitioner or the inpatient facility to ensure that the encounter met all plan of care requirements, or (3) the documentation of the patient's condition and the services ordered to ensure that skilled services met Medicare requirements.

[24] CMS pays home health providers on a per-visit basis if the number of visits does not meet the minimum low utilization payment adjustment threshold during a 30-day payment period (42 CFR § 484.230).

According to VNS Health officials, these errors occurred because of the impact of the COVID-19 PHE.[25] Specifically, VNS Health stated that its operations, including its administrative and coding staff, were affected due to mandatory office shutdowns, restrained resources, and increased difficulty with contacting ordering physicians and institutions regarding documentation. VNS Health stated that its coding staff were also impacted in their ability to adopt and adjust to a new methodology by which Medicare home health care services are coded, billed, and paid.[26, 27] According to VNS Health officials, ordering practitioners were largely inaccessible due to COVID-19-related patient care demands and related office closures. VNS Health also stated that the PHE impacted patients' ability to receive timely F2F encounter visits. Even when patients were able to participate in a timely F2F visit, limited physician availability, restricted office hours, and office closures made it difficult for VNS Health to obtain supporting documentation related to the reason the patient was referred to home care.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that VNS Health received at least $2,965,484 in overpayments for the audit period.[28]

RECOMMENDATIONS

- We recommend that VNS Health refund the $2,965,484 in estimated overpayments to the Medicare program, excluding amounts presumed to be unrecoverable under the Section 1870 waiver of liability provision.[29, 30]

[25] The PHE was declared on Jan. 31, 2020, and was in effect during our entire audit period. We considered all relevant waiver provisions in place during our audit period. The audit report does not reference CMS's waiver provisions in place during the COVID-19 PHE because none of the deficiencies we identified were associated with these provisions.

[26] The updates to the home health prospective payment system (HH PPS) marked a significant change in how home health services are reimbursed by Medicare.

[27] The change to the HH PPS system was implemented less than 30 days prior to the PHE declaration.

[28] See Footnote 20.

[29] OIG audit recommendations do not represent final determinations. CMS, acting through a Medicare contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

[30] NGS retains the authority to determine whether there is sufficient evidence to rebut the Section 1870 "fifth year following" "without fault" presumption that might limit the recovery of any of these overpayments.

- We recommend that VNS Health consider conducting one or more internal audits or investigations for claims after our audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program.

- We recommend that VNS Health strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

VNS HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, VNS Health did not concur with our recommendations. Specifically, VNS Health did not concur with our first recommendation, to refund the $2,965,484 in estimated overpayments to the Medicare program, but agreed to repay a portion of the $12,606 in actual overpayments. VNS Health disputed our findings for three of the eight sampled claims that resulted in overpayments based upon case-specific reasons but did not state whether it agreed with our findings for eight sampled claims where the errors did not result in overpayments. VNS Health also disagreed with our recommendation to refund extrapolated overpayments because (1) the overall financial error rate was less than 5 percent, (2) our statistical sampling design had an unacceptably wide interval of statistical uncertainty, and (3) the total universe of claims incorrectly failed to consider low-risk claims and disproportionately drew from the anomalous period affected by the early months of the COVID-19 PHE. VNS Health stated that it did not concur with our second and third recommendations because any errors we found occurred due to difficulties stemming from the COVID-19 PHE and complications associated with the simultaneous rollout of the new PDGM payment methodology—not structural deficiencies in its broader medical record documentation or compliance processes.

After reviewing VNS Health's written comments, we maintain that our findings and recommendations are valid. A summary of VNS Health's comments and our responses follows. Due to the inclusion of some patient-specific information in its response, VNS Health provided a redacted version of its comments, which are included as Appendix G.

THE COVID-19 PUBLIC HEALTH EMERGENCY AND IMPLEMENTATION OF THE PATIENT-DRIVEN GROUPINGS MODEL

VNS Health Comments

VNS Health stated that any errors we found were due to the combination of the unique and extenuating circumstances of the COVID-19 PHE and the rollout of the PDGM payment methodology. VNS Health further stated that it regularly conducts internal reviews of its home health documentation to ensure compliance and maintains robust policies and procedures that emphasize the importance of appropriate billing and coding, as well as the prompt repayment of any overpayments, as applicable. Accordingly, VNS Health stated that it does not believe that reviewing additional claims outside the audit period and strengthening its review of medical record documentation are necessary at this time.

Office of Inspector General Response

We note that CMS used emergency waiver authorities and various regulatory authorities to enable flexibilities so providers could rapidly respond to people impacted by the COVID-19 pandemic. We worked closely with our independent medical review contractor to ensure that it considered all relevant waiver provisions in place during our audit period. The audit report does not reference CMS's waiver provisions in place during the PHE because none of the deficiencies we identified were associated with these provisions.

In addition, as part of its technical assistance to prepare HHAs and other stakeholders on the implementation of the PDGM, CMS developed educational and training resources as early as February 2019—nearly 1 year prior to the implementation of the PDGM and the start of the COVID-19 PHE.[31]

We recognize that extraordinary conditions were in place during our audit period and that health providers, including HHAs, faced many challenges. However, we maintain that our determinations were accurate. As noted in the report (footnote 29), OIG recommendations do not represent a final determination. Our determinations are transmitted to CMS, which is the agency responsible for determining whether (1) overpayments exist and (2) to recover those funds.

DISPUTED SAMPLE CLAIM FINDINGS

VNS Health Comments

VNS Health disputed our findings for three sampled claims and explained why coding or documentation errors may have occurred for each claim. Specifically:

- For sample claim 21, VNS Health disagreed with OIG's determination that VNS Health did not comply with Medicare F2F requirements because the F2F encounter was not related to the primary reason for home health services. VNS Health stated that while it did not dispute that an isolated coding error occurred for the initial certification period due to a deviation from its standard coding processes, the error took place prior to the audit period. Also, VNS Health stated that it corrected the coding error prior to the associated enrollee's recertification period. It also noted that no rule requires the primary diagnosis on recertification to be related to the primary reason for encounter noted at the start of care.

- For sample claim 49, VNS Health disagreed with OIG's determination that one of the secondary diagnosis codes was unsupported. VNS Health acknowledged that the code (which represents hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease or unspecified chronic kidney disease) was not expressly

[31] CMS, "Home Health Patient-Driven Groupings Model National Provider Call." Accessed on Jan. 28, 2026.

documented on either the encounter note or referral documentation. However, according to VNS Health, chronic kidney disease and hypertension were noted in the anesthesia history included in the referral documentation, and coding guidelines permit the assignment of the code for a patient with a history of both chronic kidney disease and hypertension.

- For sample claim 82, VNS Health disagreed with OIG's determination of an overpayment due to what VNS Health described as extenuating circumstances caused by the PHE. VNS Health stated that although it did not precisely follow CMS documentation requirements for the sample claim, it did so "as part of a considered, deliberate choice to ensure patient health and safety" during the PHE. Specifically, although VNS Health acknowledged that the nurse associated with the sample claim "missed" the F2F visit, it contended that any technical F2F timing deficiency resulted from a severe staffing shortage caused by the PHE. VNS Health also described steps it took to obtain a new referral a "few days" later to certify the associated patient for home health services to continue treatment.

Office of Inspector General Response

For the reasons described below, we maintain our determinations for the three sampled claims for which VNS Health disputed our findings.

- Sample claim 21: As noted in the body of the report, to be eligible for the home health benefit, Medicare requires that a F2F encounter be related to the primary reason the patient *requires* home health services and occur *timely*, either 90 days prior to or within 30 days of the start-of-care date. As VNS Health acknowledged, the F2F visit was not related to the primary reason the patient was admitted to the home health program. Further, as noted in VNS Health's comments, the correction to the patient's primary diagnosis did not occur until 6 months *after* their start-of-care date. Therefore, the F2F visit did not comply with Medicare requirements.

- Sample claim 49: Medicare requires that the primary and secondary diagnoses reported on the home health claim be supported by information in the certifying practitioner's or the acute or post-acute facility's medical record. Additionally, in its response to comments on the PDGM and its instructions for reporting secondary diagnoses on a claim, CMS stated that "…coding instructions state to include any conditions that exist at the time of home health admission… and that affect patient care planning. That is, diagnoses should be reported that affect or potentially affect patient care (and therefore would be addressed in the home health plan of care)…."[32] We maintain that the secondary diagnosis code was unsupported given that it was only mentioned in the anesthesia patient history report, and no other reference in the medical record

[32] 84 Fed. Reg. 60478, 60511 (Nov. 8, 2019).

described how the patient's history of chronic kidney disease and hypertension diagnoses would have affected the plan of care.

- Sample claim 82: Medicare requires a practitioner certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. VNS Health acknowledged that the nurse did not conduct the Medicare required F2F visit. While we recognize the staffing challenges faced by health care providers during the PHE, we note that CMS issued a PHE waiver to address such challenges, which allowed "the required face-to-face encounter for home health [to] be conducted via telehealth…."[33] We would also note that the date of the required visit occurred *over 1 year* after the PHE was declared.

OFFICE OF INSPECTOR GENERAL SAMPLING METHODOLOGY

VNS Health Comments

VNS Health did not concur with our recommendation that it repay the estimated overpayment amount of $2,965,484. VNS Health disputed our decision to extrapolate because it believes that (1) the audit findings did not meet the high error rate criteria in CMS's *Medicare Program Integrity Manual* (MPIM) to justify the use of extrapolation, (2) the small sample size prevented a representative sample across the audit period, (3) our audit precision level did not support extrapolation, and (4) the universe of claims was inappropriate because it excluded unpaid and low-risk claims.

Office of Inspector General Response

We carefully considered VNS Health's comments on our sampling and estimation methods, and we maintain that our statistical approach resulted in a statistically valid and reasonably conservative estimate of the amount Medicare overpaid to VNS Health in the sampling frame. We note that the MPIM requirement cited by VNS Health (that a determination of a sustained or high level of payment error must be made before extrapolation) applies only to Medicare contractors—not OIG.[34] We further note that the statutory provisions upon which the MPIM guidelines are based do not prohibit CMS from accepting and acting upon our monetary recommendation.

Regarding VNS Health's arguments related to sample size, representativeness, and precision, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid

[33] Home Health Agencies: CMS Flexibilities to Fight COVID-19.

[34] See the Act § 1893(f)(3); CMS MPIM, Pub. No. 100-08, ch. 8, §8.4.1.4.

methodology, not the most precise methodology.[35] We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation. To account for the potential differences between the sample and the sampling frame and any imprecision in the sample, we recommend recovery at the statistical 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 in the sampling frame 95 percent of the time. The use of the lower limit accounts for the sample design, sample size, precision, and any differences between the sample and the sampling frame in a manner that favors the auditee. We additionally note that Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid, and small sample sizes, e.g., smaller than 100, have routinely been upheld by the Departmental Appeals Board and Federal courts.[36, 37]

Finally, regarding the argument that excluding claims from the universe of claims was inappropriate, OIG generally may perform a statistical or non-statistical review of a provider without covering all claims from that provider. The "universe" of claims for our estimate of overpayments does not go beyond our sampling frame; OIG only projects to the sampling frame from which the sample was drawn. Therefore, contrary to VNS Health's assertion, a valid sampling frame does not need to include all low-risk or zero-paid claims within the audit period.

[35] See *John Balko & Assoc. v. Sebelius*, 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), *aff'd* 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell*, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), *aff'd*, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius*, 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[36] See *Yorktown Med. Lab., Inc. v. Perales,* 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller,* 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius,* 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Miniet v. Sebelius,* 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius,* 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[37] See *Anghel v. Sebelius*, 912 F. Supp. 2d 4 (E.D.N.Y. 2012) (upholding a sample size of 95 claims); *Transyd Enters*., *LLC v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 (S.D. Tex. 2012) (upholding a sample size of 30 claims).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $191,954,445 in Medicare payments to VNS Health for 68,702 home health claims with service dates from July 1, 2020, through June 30, 2022 (audit period).[38, 39] From this sampling frame, we selected for review a simple random sample of 100 home health claims with payments totaling $278,147.

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

We assessed VNS Health's internal controls and compliance with laws and regulations to the extent necessary to satisfy the audit objective. Our review of internal controls focused on VNS Health's procedures when providing and billing home health services. Specifically, we assessed whether VNS Health had a robust control environment that included establishing and overseeing an internal control system, and control activities that included policies for complying with Medicare regulations. Our internal control review was limited to these areas and may not have disclosed internal control deficiencies that could have existed at the time of this audit.

To assess the reliability of the data obtained from CMS's IDR, we (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 home health claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from October 2022 through November 2025.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance
- Extracted VNS Health's paid claim data from CMS's IDR for the audit period

[38] We did not include Requests for Anticipated Payment (42 CFR §§ 484.205(h) and (i)), Notices of Admission (42 CFR § 484.205(j)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[39] Service dates 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 enrollee. We selected claims with "through" dates falling within the period July 1, 2020, through June 30, 2022; therefore, claims subjected to audit could include services that began prior to July 1, 2020.

- Identified a sampling frame of 68,702 claims totaling $191,954,445[40]

- Selected a simple random sample of 100 claims for detailed review (Appendix D)

- 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 VNS Health to support the claims sampled

- Used an independent medical review contractor to determine whether the 100 claims in the sample were reasonable and necessary and met Medicare coverage and coding requirements

- Reviewed VNS Health's procedures for billing and submitting Medicare claims

- Verified State licensure information for selected medical personnel that provided services to the patients in our sample

- Verified that claims were billed with the appropriate Core Based Statistical Area (CBSA) and Federal Information Processing Standards (FIPS) codes according to the address where the home health services were provided[41]

- Calculated the correct payments for those claims requiring adjustments

- Used the results of the sample to estimate the total Medicare overpayments to VNS Health for our audit period (Appendix E)

- Discussed the results of our audit with VNS Health officials

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.

[40] Our sampling frame included home health claim payments for 30-day billing periods with ending dates of service from July 1, 2020, through June 30, 2022, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[41] CMS requires that claims for home health services include the CBSA and FIPS codes to indicate where the services were provided.

APPENDIX B: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Home Health Agency Provider Compliance Audit: Alternate Solutions Homecare of Dayton	A-05-24-00014	2/19/2026
Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC	A-07-24-05146	12/15/2025
Medicare Home Health Agency Provider Compliance Audit: VNA Care Network	A-05-22-00016	10/23/2025
Medicare Home Health Agency Provider Compliance Audit: Sunflower Home Health	A-05-23-00002	7/9/2025
Medicare Home Health Agency Provider Compliance Audit: HRS Home Health	A-05-22-00017	6/30/2025
Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health	A-05-23-00017	12/19/2024

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

GENERAL MEDICARE BILLING 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, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue, to receive home health services. CMS requires the submission of OASIS data as a condition of payment (42 CFR §§ 484.45, 484.205(c), and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019)).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Under the home health PPS, CMS pays HHAs a national, standardized 30-day period payment rate.[42] This standardized payment rate is adjusted by using variables in the PDGM that account for the enrollee's condition and healthcare needs. For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called HHRGs.

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the OASIS. CMS uses the HHRGs as the basis for the HIPPS codes, which determine payment.[43]

HOME HEALTH COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare enrollees must (1) be confined to the home, (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

[42] Adjustments are made for geographic differences in wage levels.

[43] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and HHAs. For more information, see CMS | HIPPS Codes, accessed on Oct. 21, 2025.

occupational therapy,[44] (3) be under the care of a physician or allowed practitioner, and (4) be under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; and 42 CFR § 409.42).[45]

Whether care is reasonable and necessary is based on information provided on the forms and in the medical record concerning the unique medical condition of the individual patient (42 CFR § 409.44(a)).

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

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)(1)(v) state that the certifying physician or allowed practitioner; or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health; must have a F2F encounter with the enrollee. In addition, the practitioner responsible for the initial certification must document that the date of the F2F patient encounter, and that the encounter, which is related to the primary reason the patient requires home health services, 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 (42 CFR § 424.22(a)(1)(v)).

Confined to the Home

For the reimbursement of home health services, the enrollee must be "confined to his home" (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). Additionally, the law requires that a practitioner certify in all cases that the patient is confined to his or her home (42 CFR § 424.22(a)(1)(ii)). For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

[44] Effective Jan. 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, physical therapy service, or 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)).

[45] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

Criterion 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 their place of residence or

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

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

Criterion 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)).

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) (§ 1861(m)).

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 enrollee, 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 cannot be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the enrollee or to the enrollee'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.

The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time (42 CFR § 409.44(b)(3)(iii)).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) state that skilled services must require the skills of a qualified physical therapist or a qualified physical therapy assistant under the supervision of a qualified physical therapist, a qualified speech-language pathologist, or a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist and must be reasonable and necessary. 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.

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. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel (42 CFR § 409.44).[46]

[46] For additional information, see CMS | Jimmo Settlement, accessed on Oct. 21, 2025.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)(1)(v)) state that, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- be related to the primary reason the patient requires home health services;
- occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date; and
- be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

Plan of Care

The practitioner's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the services and at what frequency the services will be furnished (42 CFR § 409.43(b)). The plan of care must be reviewed and signed by the practitioner 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 practitioner and the date of review (42 CFR § 409.43(e)).

APPENDIX D: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 68,702 claims for home health services provided by VNS Health with ending dates of service from July 1, 2020, through June 30, 2022. Medicare payments for those claims totaled $191,954,445.

SAMPLE UNIT

The sample unit was a Medicare home health claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We randomly selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG/Office of Audit Services (OAS) Statistical Software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in the sampling frame by IDR_LINK_NUM[47] and then consecutively numbered the items in the sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments made to VNS Health in the sampling frame. To be conservative, we recommended 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.

[47] This field uniquely identifies claims in CMS's IDR.

APPENDIX E: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments in Sample
68,702	$191,954,445	100	$278,147	16[48]	$12,606

Table 2: Estimated Overpayments in the Sampling Frame (*Limits Calculated for a 90-Percent Confidence Interval)*

Point estimate	$8,660,615
Lower limit	2,965,484
Upper limit	14,355,747

[48] For 8 of these claims, the errors did not result in overpayments.

APPENDIX F: TYPES OF ERRORS BY SAMPLE ITEM

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Plan of Care Requirements	Overpayment
1				-
2				-
3				-
4				-
5				-
6				-
7				-
8	X			-
9				-
10				-
11				-
12	X			-
13	X			-
14				-
15				-
16				-
17				-
18				-
19				-
20				-
21	X	X		$1,721
22		X		2,707
23				-
24				-
25				-
26				-
27				-
28				-
29	X			-
30				-
31				-
32				-
33			X	-
34				-
35				-
36				-
37				-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Plan of Care Requirements	Overpayment
38				-
39				-
40				-
41	**X**			632
42				-
43				-
44				-
45				-
46				-
47				-
48				-
49	**X**			115
50				-
51				-
52				-
53				-
54				-
55				-
56				-
57				-
58				-
59				-
60				-
61				-
62				-
63				-
64				-
65				-
66				-
67				-
68				-
69				-
70				-
71				-
72				-
73				-
74				-
75				-
76				-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Face-to-Face Requirements	Services Did Not Meet Plan of Care Requirements	Overpayment
77	**X**			-
78				-
79				-
80	**X**			-
81	**X**			-
82		**X**		1,637
83				-
84	**X**			1,071
85			**X**	1,805
86				-
87	**X**	**X**		2,918
88				-
89				-
90				-
91				-
92				-
93				-
94				-
95				-
96				-
97				-
98				-
99				-
100				-
Totals	**12**	**4**	**2**	**$12,606**

APPENDIX G: VNS HEALTH COMMENTS

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* REDACTED

December 19, 2025

HHS/OIG DELIVERY SERVER
Ms. Jennifer Webb
Regional Inspector General for Audit Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Medicare Home Health Agency Provider Compliance Audit A-02-22-01023

Dear Ms. Webb:

I write on behalf of Visiting Nurse Service of New York Home Care II d/b/a VNS Health Home Care ("VNS Health Home Care" or the "Agency") in response to the draft report issued for A-02-22-01023 – Home Health Audit (the "Draft Report"). Thank you for your continued willingness to engage in conversations with VNS Health Home Care regarding the findings made by the Department of Health and Human Services ("HHS") Office of the Inspector General ("OIG") in the Draft Report.

VNS Health Home Care takes great pride in the care that it provides to its patients, as well as in its attention to compliance with all health care laws and regulations, including Medicare's regulatory and sub-regulatory coverage rules. As a result, following receipt of the Draft Report, VNS Health Home Care undertook a detailed review of all of the auditor's findings to assess OIG's recommendations and to determine, where applicable, the root cause of instances in which the auditor found that certain VNS Health Home Care claims did not fully comply with Medicare billing and coding requirements ("Unsupported Claims"). Based on this review, and as set forth in further detail below, VNS Health Home Care respectfully disagrees with certain of OIG's findings and recommendations:

- First, VNS Health Home Care disagrees with OIG's overpayment determinations with respect to three of the alleged "Unsupported Claims," such that none of these three claims should be deemed to result in overpayments, in whole or in part.

- Second, even if certain of the Unsupported Claims contained isolated, unique errors, extrapolation of an estimated overpayment is inappropriate because (a) the Draft Report's overall financial error rate of less than 5% does not warrant extrapolation, (b) the design of the sample itself cannot reliably calculate overpayments through extrapolation due to an unacceptably wide interval of statistical uncertainty, and (c) the total universe applied by OIG is incorrect, as it fails to consider low-risk claims and disproportionately draws from

* **OIG Note:** As described in the report, VNS Health provided a redacted version of its comments to protect patient-specific health information. We will provide an unredacted version of VNS Health's comments to CMS.

the anomalous period affected by early months of the COVID-19 Public Health Emergency ("PHE").

- Finally, the errors cited for the Unsupported Claims arose from difficulties stemming from the PHE and complications associated with the simultaneous rollout of an entirely new Patient-Driven Groupings Model ("PDGM") billing methodology, rather than structural deficiencies with VNS Health Home Care's broader medical record documentation or compliance processes, such that (a) a review of more recent claims is unwarranted, and (b) VNS Health Home Care's medical record documentation process currently ensures compliance with Medicare billing requirements.

Below, we provide background on VNS Health Home Care, including its compliance program, a summary of the applicable regulatory and sub-regulatory requirements for home health billing, the circumstances under which billing requirements were changed in 2020, and then discuss VNS Health Home Care's review and response to the auditor's findings and OIG's recommendations.

A. BACKGROUND

1. VNS Health Background and History

The Visiting Nurse Service of New York d/b/a VNS Health was founded in 1893 by Lillian D. Wald, the originator of American public health nursing, and began by delivering in-home care to immigrant families in Manhattan's densely populated Lower East Side. Today, VNS Health, together with its subsidiaries, is one of the nation's largest not-for-profit, home- and community-based health care organizations in the United States, which carries forward the organization's long-standing mission to improve the health and well-being of New Yorkers through the delivery of high-quality, cost-effective care in both the home and community. VNS Health's home health services are provided by its not-for-profit subsidiary entity VNS Health Home Care, which is licensed by the State of New York pursuant to Article 36 of the New York Public Health Law as a certified home health agency and is accredited by the Community Health Accreditation Program, which was granted deeming authority for home care agencies by the Centers for Medicare and Medicaid Services ("CMS"). The Agency provides skilled nursing services, home health aide services, and other related services to patients in their homes, including but not limited to physical, speech, and occupational therapy, medical social services, and personal care services to some of the New York metropolitan area's most vulnerable and at-risk residents.

2. VNS Health Home Care's Compliance Program

VNS Health Home Care has a well-established corporate compliance program (the "Compliance Program") that provides mandatory annual training to all Agency personnel. The training includes, among other things, the Agency's expectation that coding, billing, and reimbursement practices comply with all applicable laws, regulations, federal health care program requirements, and contractual requirements. It further warns against the creation of any bills or reports containing deliberately or recklessly false or misleading statements or omissions, and that such practices will result in disciplinary action up to and including termination of employment by VNS Health Home Care. The Compliance Program also provides role-specific compliance training, focusing on specific compliance risks each staff member may encounter.

3. VNS Health Home Care's Implementation of Patient-Driven Groupings Model Amidst the COVID-19 Public Health Emergency

By way of background, payment for home health episodes is made under the Home Health Prospective Payment System ("HH PPS") for each 30-day period.[1] Certifications, however, are for 60 days, such that each certification includes two 30-day payment periods.[2] Medicare does not limit the number of continuous 60-day recertifications for beneficiaries who continue to be eligible for the home health benefit.[3]

Effective January 1, 2020, the HH PPS began using the new PDGM. Unlike the earlier iteration of the HH PPS, which largely conditioned payment based on the volume of services that fell within one of 153 possible case-mix groups, also known as home health resource groups ("HHRGs"), the PDGM system shifted payments toward a more patient-centric model that expanded the number of possible HHRGs to 432. These 432 HHRGs take into account multiple additional factors driven by patient characteristics, many of which are new or different from the previous HH PPS methodology. Specifically, under the PDGM, HHRGs are determined based on admission source, episode timing, clinical grouping, primary diagnosis, functional impairment level, and a comorbidity adjustment (which is determined based on secondary diagnosis codes). HHRGs in turn are represented by Health Insurance Prospective Payment System ("HIPPS") codes.

In preparation for CMS's January 1, 2020 implementation of the PDGM, VNS Health Home Care used CMS guidance to develop broad training curricula for both its administrative and clinical operations staff. The Agency also implemented a pilot of PDGM standards from September 23, 2019 to November 30, 2019, which allowed it to deploy new workflows and systems in advance of the official PDGM rollout, adapt to new PDGM-specific requirements, and simplify and streamline clinician resources. The pilot also facilitated the Agency's refinement of the roles and responsibilities of specific members of administrative and frontline staff directly involved in the collection and documentation of clinical information necessary for accurate HIPPS code development under the PDGM.

Just as the Agency was getting accustomed to the new requirements in the PDGM, however, the PHE was declared.[4] Like nearly all health providers, the Agency suffered immediate and sustained adverse impacts from the PHE; these impacts were particularly acute given the Agency's location in New York City, the epicenter of the PHE. In particular, as community spread of COVID-19 became increasingly prevalent in the New York City metropolitan area, closing physician offices and other essential services, and limiting others, the Agency's ability to obtain timely documentation from providers became severely restricted.

Despite the sudden onset of the PHE and the ensuing mandatory shutdown shortly following the implementation of the new PDGM requirements, VNS Health Home Care continued regular training of its staff on PDGM standards and the Compliance Program guidelines. The Agency

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[1] *See* Medicare Claims Processing Manual Ch. 7 § 10.3.
[2] *Id.*
[3] *Id.*
[4] The new PDGM methodology implementation date occurred just seven months prior to the commencement of the Audit Period, which was also just 30 days prior to HHS's declaration of the COVID-19 federal PHE, and just two months prior to New York State's declaration of a PHE. Significantly, shortly after declaration of the state PHE, New York State issued a state-wide directive to close all non-essential in-office personnel functions and gatherings of individuals of any size, for any reason.

worked diligently to ensure that, to the best of its ability, it complied with all standards, without restricting medically necessary care.

B. Response to the Draft Report

1. Overview of OIG's Draft Audit Findings

OIG selected a sample of 100 claims (the "Sampled Claims") from a sampling frame of 68,702 claims, evaluating each claim for compliance with Medicare's (i) billing and coding requirements, (ii) Face-to-Face ("F2F") encounter requirements, and (iii) Plan of Care ("PoC") requirements. The sampling frame included home health claim payments for 30-day billing periods with dates of service between July 1, 2020 and June 30, 2022 (the "Audit Period"). Significantly, the entirety of the Audit Period was during the PHE, which also coincided with the immediate rollout of the new PDGM requirements.

OIG's Draft Report found that 84 of the 100 Sampled Claims complied with all the assessed Medicare requirements, but 12 claims did not meet all applicable billing and coding requirements, four claims did not meet F2F encounter requirements, and two claims did not meet PoC requirements.[5] Of these 16 Unsupported Claims, OIG determined that eight of the Unsupported Claims resulted in an overpayment, totaling $12,606. Notably, OIG did not identify any issues relating to the quality or need for the skilled care services delivered to VNS Health Home Care patients.

Based on these findings, OIG recommended that the simple overpayment calculation of $12,606 be extrapolated across the sampling frame, such that $2,965,484 would be repaid to the Medicare program. OIG also recommended that VNS Health Home Care (i) conduct one or more internal audits or investigations for claims after the Audit Period, and (ii) strengthen its review of medical record documentation. While VNS Health Home Care agrees to repay simple overpayments assessed for certain of the Unsupported Claims, it disputes all three recommendations.

2. Response to Recommendation to Refund of Estimated Overpayments

VNS Health Home Care respectfully disagrees with OIG's recommendation that it refund an estimated $2,965,484 for alleged overpayments that it received during the Audit Period. As a preliminary matter, VNS Health Home Care does not concur with OIG's calculation of $12,606 in overpayments received by the Agency in connection with the Sampled Claims, as it has determined that three of the Sampled Claims assessed as Unsupported Claims—totaling $3,473.20 in alleged overpayment—should not be deemed to result in overpayment, in whole or in part. Moreover, the calculation of $2,965,484 in overpayments across the full universe included in the sampling frame is unsound, not only because the extremely low error rate fails to establish a "sustained or high level of payment error,"[6] but also because the design of the sample itself does not provide statistically reliable support for an extrapolated calculation of estimated overpayments.

[5] Some sample items were assigned more than one type of error, such that there are 16 Unsupported Claims total.
[6] MPIM, Sec. 8.4.1.4 (Determining When Statistical Sampling May Be Used).

i. Review of Sampled Claims and Overpayment

VNS Health Home Care disputes OIG's assessment that Sampled Claims S-21, S-49, and S-82 were Unsupported Claims resulting in overpayments made to VNS Health Home Care.

a. S-21

VNS Health Home Care disagrees with the OIG's determination for S-21 that it did not comply with Medicare F2F requirements because the F2F encounter was not related to the primary reason for home health services. While VNS Health Home Care does not dispute that an isolated coding error occurred for the initial certification period due to an individual deviation from VNS Health Home Care's standard coding processes, that error took place *prior* to the Audit Period, and the coding was actually corrected in the specific episode under audit. Moreover, such a technical coding error does not undermine the fact that the claim submitted for S-21 satisfied regulatory standards for F2F encounters.

Medicare regulations require an F2F patient encounter, which is related to the primary reason the patient requires home health services, to occur no more than 90 days prior to the patient's home health start of care date or within 30 days of the patient's admission to home care.[7] The F2F encounter must be performed by a physician, or an allowed practitioner, and the F2F encounter must be related to the primary reason the patient necessitates home health services.[8]

For S-21, the patient's F2F encounter occurred on [redacted]. The related visit documentation indicates the active presence and treatment of [redacted] that causes inflammation of blood vessels (i.e., vasculitis), the formation of granulomas, and [redacted][9] The chart summary included in the F2F encounter note lists diagnoses of [redacted]. The physician's F2F encounter note further specifies that the patient: (1) was taking Rituxan, an immunotherapy medication indicated for the treatment of [redacted]; (2) was taking Bactrim, an antibiotic medication, three times weekly for the "[redacted] wounds that are not healing"; and (3) reports ongoing lower extremity lesions. The physician further noted in the F2F encounter note that the patient "should contact rheum re immunotherapy resumption." Finally, the note documents treatment of the ulcers and blisters that arose due to the [redacted] diagnoses—specifically, debridement of wounds (coded as blisters) on her lower right and left legs. In the initial certification period, however, the primary diagnosis was miscoded as ulcerative colitis. Following that initial certification period, but prior to the recertification period reviewed by OIG, the patient was seen on [redacted], for a lower leg wound, consistent with [redacted]. Based on these encounter notes, the recertification PoC was recoded with a primary diagnosis code of [redacted], consistent with both the initial F2F encounter note and the [redacted] encounter note.

We note that there is no rule that requires the primary diagnosis on recertification to be related to the primary reason for encounter note at the start of care. As such, VNS Health Home Care

[7] 42 CFR §424.22(a)(1)(v).
[8] *Id.*
[9] *See* Encounter Note dated [redacted]

respectfully requests that the OIG reverse its finding of deficiency and its overpayment assessment of $1,721.10 for S-21 pursuant to the F2F encounter finding.

VNS Health Home Care does not dispute the error in secondary diagnosis coding (i.e., that gastroesophageal reflux disease without esophagitis was improperly coded), but notes that the error has no financial impact.

b. S-49

VNS Health Home Care disagrees with the OIG's determination for S-49 that the secondary diagnosis of I12.9 was unsupported. The ICD-10-CM code I12.9 represents hypertensive chronic kidney disease with stage 1 through stage 4 chronic kidney disease, or unspecified chronic kidney disease.

The anesthesia history dated [redacted], and included in the referral documentation, records both (1) chronic kidney disease and (2) hypertension as medical conditions affecting perioperative care. While neither hypertensive nor unspecified chronic kidney disease (I12.9) were expressly documented on either the encounter note or referral documentation, coding guidelines permit assignment of this code for a patient with a history of both chronic kidney disease and hypertension. Specifically, the ICD-10-CM Guidelines, Section I(9)(a)(2) state, "Assign codes from category I12, Hypertensive chronic kidney disease, when both hypertension and a condition classifiable to category N18, Chronic kidney disease (CKD), are present."[10] As such, the Agency correctly coded the secondary diagnoses on this claim, and VNS Health Home Care requests that OIG reverse its finding of deficiency and its partial overpayment assessment of $115.18 for S-49 pursuant to diagnosis coding.

c. S-82

VNS Health Home Care disagrees with OIG's determination of an overpayment for S-82. Any technical F2F timing deficiency resulted from an extraordinary circumstance caused by the PHE, during which VNS Health Home Care prioritized the health and safety of a longstanding Agency patient with a well-established and documented need for continuous home care services.

The patient was an [redacted] female with a primary diagnosis of Schizophrenia and secondary diagnoses of Anxiety Disorder and Long-Term Drug Therapy who had been receiving home care from the Agency continuously from [redacted] to [redacted]. Pursuant to physician orders, VNS Health Home Care nurses administered intramuscular injections of Prolixin, an antipsychotic medication most often used in schizophrenic patients that are not compliant with oral medications, to the patient every two weeks for approximately eight years. With the benefit of committed care provided by VNS Health Home Care nurses, the patient was able to live safely in the community for several years without requiring hospitalization. The patient was scheduled for a home health recertification visit on [redacted], but, due to a severe staffing shortage caused by the PHE, the Agency's field nurse missed the visit. For this reason, rather than any issues relating to her care, the patient was automatically discharged from the Agency's home health services on [redacted].

[10] This requirement has been included in the ICD-10-CM Guidelines for the duration of the Audit Period, and remains in effect today.

On the very next day, on [redacted], a VNS Health Home Care nurse called the patient's physician and, when she was unsuccessful in making contact, left a message for him in an attempt to obtain a new referral in order to readmit the patient for home care. The nurse also informed the patient and her caregiver that a new referral was needed. The patient and caregiver indicated that they would continue to try to reach the certifying physician themselves. Ultimately, the patient's caregiver contacted the physician's office later that day and asked for a new referral.

As a result, a few days later, the physician's office sent a signed home health services referral to VNS Health Home Care, dated [redacted], which contained a certification of an encounter with the patient also on [redacted]. The document provided by the physician's office to evidence the encounter was a radiology report from a mammogram ordered by the certifying physician and completed at an affiliated mammography center on [redacted]. The last page of the radiology report indicated communication with VNS Health Home Care regarding certification for home health services, but the certifying physician did not have another encounter with the patient until [redacted]. Despite this technical lapse in receipt of the certifying physician's documentation due to difficulties associated with the PHE, VNS Health Home Care re-admitted the patient on [redacted], in the interest of providing the patient's regular Prolixin injections, and avoiding a scenario that would likely result in acute hospitalization. This decision was not made lightly, but was made to prioritize the patient's well-being given her serious diagnosis, reliance on Prolixin, and the PHE circumstances.

Although VNS Health Home Care did not precisely follow CMS documentation requirements for S-82, it did so as part of a considered, deliberate choice to ensure patient health and safety during a federal and state PHE. Had there not been a pressing medical need, or had the PHE not been occurring such that the patient could have sought treatment in the emergency room, the Agency would have required adherence to the required protocol. This decision was deliberately made by VNS Health Home Care, given the unique circumstances of the patient, the consequences to the patient's health if the patient did not receive the injection, and the risk to the patient of having to go to the emergency room, at a time when the COVID-19 vaccine was not yet widely available and hospital resources were being prioritized for the PHE. This decision was supported by the fact that the patient was known to be clinically eligible for home care services because her clinical needs were unchanged, well-documented, and specified pursuant to a PoC signed by a certifying physician who was actively engaged in her care.

As such, VNS Health Home Care respectfully requests that the OIG approve at least partial payment of this claim for $1,636.92 for care delivered to a patient during extraordinary circumstances. In the alternative, we ask that OIG remove this claim from the extrapolation. Fewer than 0.1% of VNS Health Home Care episodes are coded with a primary diagnosis of Schizophrenia, and only seven unique patients during the Audit Period had such a primary diagnosis. The chances that there is another claim within the sampling frame for which a patient with Schizophrenia did not have a timely encounter with a physician, but for which a home health service was nonetheless provided, are close to zero.

ii. Extrapolation is Inappropriate

a. Error Rate Does Not Support Extrapolation

As a preliminary matter, while we understand that OIG is not strictly bound by the same rules that Medicare Administrative Contractors must follow, we note that *any* Medicare reimbursement

amount extrapolated from a sample—including the sample drawn under the Audit—must ultimately comply with the requirements of the Medicare Program Integrity Manual ("MPIM") before it can be enforced. Here, even if OIG does not agree that S-21, S-49, and S-82 were correctly billed, the Draft Report finds an error rate of only 4.53%,[11] whereas the MPIM instructs that "the contractor shall use statistical sampling when it has been determined that a sustained or high level of payment error exists" and that "[f]or purposes of extrapolation, a sustained or high level of payment error shall be determined to exist through a variety of means, including, but not limited to . . . high error rate determinations by the contractor or by other medical reviews."[12] OIG has not presented any evidence to suggest that there is a sustained or high level of payment error. In fact, the opposite is true—the Agency's alleged error rate is still well below the 7.7% error rate the CMS Comprehensive Error Rate Testing ("CERT") program determined was average in 2023 and which OIG cites in the Draft Report.[13]

The 2023 CERT analysis was based on July 1, 2021 through June 30, 2022 data—this error rate likely increased during the first half of the Audit Period due to the combined impacts of the PHE and PDGM rollout, as we discuss below. Moreover, OIG, in reference to audits pertaining to corporate integrity agreements, has stated that extrapolation is only required if the error rate is greater than 5%.[14] As such, given the low error rate, extrapolation is inappropriate.

b. Precision Level Does Not Support Extrapolation

OIG's own policies historically outlined provider audit procedures under corporate integrity agreements that specified that claims audits must achieve a precision level of 25% at a two-sided 90% confidence level in order to reliably calculate overpayments through extrapolation.[15] While the current audit uses a two-sided 90% confidence level, the resulting statistical uncertainty interval far exceeds this 25% precision level—specifically, the auditor's estimate of overpayments may differ from the true overpayment amount by as much as 65.76% (the calculated precision level). This means the estimate is highly imprecise, with considerable uncertainty about the true value of the overpayment. In practical terms, this means the auditor is 90% confident that the overpayment estimate will lie within 65.76% of the true overpayment value or—because of the symmetry of the distribution of the overpayment estimate with respect to the overpayment value—95% confident that OIG's estimate does not exceed the true overpayment amount by more than 65.76%. This is an extremely wide margin, which is far beyond any level of precision to support a valid extrapolation, and more than *double* what courts have upheld historically.[16]

OIG failed to consider the size of VNS Health Home Care when pulling the sample size. This initial failure taints the precision level, such that extrapolation is wholly inappropriate. Using OIG's own

[11] The error rate is the total dollar amount OIG believes VNS Health Home Care erroneously paid for claims in the sample divided by the total dollar amount paid for claims in the sample.
[12] MPIM, Sec. 8.4.1.4 (Determining When Statistical Sampling May Be Used).
[13] Draft Report at 1.
[14] *See* HHS OIG, Corporate Integrity Agreement FAQs (March 14, 2025), https://oig.hhs.gov/faqs/corporate-integrity-agreement-faq/.
[15] 1998 OIG Provider Self-Disclosure Protocol. The 2021 update to these guidelines loosened this standard, "To avoid unreasonably large sample sizes, the [Self-Disclosure Protocol] does not require a minimum precision level for the review of claims." OIG's Health Care Fraud Self-Disclosure Protocol at 6 (2021). Nonetheless, the 25% provides a benchmark—one that is more than doubled in the present matter.
[16] *See* Central Louisiana Home Health Care, LLC v. Price, 2018 WL 7888523 (W.D. La. 2018) (in invalidating an extrapolation, the Court found that "[the auditor's] precision level of 32.4% is the highest reflected in the published case law nationwide (the previous highest was 26.17%).")

statistical approach and parameters, achieving the 25% precision standard would have required a sample of approximately 686 claims—nearly seven times larger than the actual sample. Given this lack of precision, it is statistically inappropriate to extrapolate the results of this sample to the full sampling frame of claims.

c. Sampled Claims are Not Representative

As a result of the inappropriately small sample size and the fact that OIG used a simple random sample, the sample fails to ensure a representative sample of claims, tainting the extrapolation figure. The small sample size prevents OIG from ensuring a representative sample across all years. The failure to do so is particularly fatal to the extrapolation due to the impact of both (i) the PHE and (ii) the fact that the PDGM was brand new and the Agency's personnel were continuing to learn best practices throughout the Audit Period. This is particularly relevant in a sample this small, as an assessment of even very small incremental overpayments will be disproportionately overstated when extrapolated across the sampling frame, as is evident from the fact that OIG's finding of just $12,606 in overpayments in the sample was extrapolated as an overpayment of $2,965,484 (over 235 times OIG's finding of simple overpayment for the sample).

Notably, 31 of the 100 claims are for dates of services through December 31, 2020—the first six months of the 24-month Audit Period—which coincides with both the first 12 months of the PDGM and the early months of PHE, when access to physician offices was restricted and providers were told not to tell patients to go to the emergency room, and before the COVID-19 vaccine became widely available. In contrast, OIG only reviewed 18 claims from the final six months of the Audit Period. The Agency's billing and coding practices improved as physician offices and hospitals reopened, and as the Agency's staff became accustomed to the PDGM. Yet, OIG's sample overly represented claims from the first quarter of the Audit Period, coinciding with the height of the PHE and the rollout of the PDGM.

d. The Extrapolated Universe is Inappropriate

Notwithstanding the fact that extrapolation is unwarranted in this circumstance, even if the error rate were to be extrapolated, the universe of claims to which extrapolation was applied is inappropriate. As described in the Draft Report, OIG used a simple random sample of 100 Medicare home health claims, from a universe of 68,702 claims for home health services. The Draft Report explains that the sampling frame only includes claims paid by Medicare and further excludes claims "judged as low risk for waste and abuse." OIG's decision to exclude unpaid and "low risk" claims flaws the extrapolation, as it increases the error rate in the sampling frame and fails to account for underpayments that offset the overpayments.

C. Response to Recommendations to Conduct Additional Audits and Strengthen Medical Record Documentation Review Process

The Draft Report recommends that VNS Health Home Care (i) review additional claims outside the Audit Period and identify and return additional similar overpayments, and (ii) review medical record documentation to ensure compliance with Medicare billing requirements. VNS Health Home Care is committed to compliance in its delivery of care to patients, and all documentation and billing related thereto. Accordingly, VNS Health Home Care (i) regularly conducts internal reviews of its home health documentation to ensure compliance, and (ii) maintains robust policies and

procedures that emphasize the importance of appropriate billing and coding, as well as the prompt repayment of any overpayments, as applicable.

The errors identified in the Draft Report are largely attributable to the specific Audit Period, and more specifically, the rollout of the PDGM, and the unique circumstances of the PHE.

D. Conclusion

VNS Health Home Care is committed to ensuring that it submits claims for Medicare reimbursement only for care that is medically necessary, supported by clinical documentation, and allowed by law and governing regulations. Due to the highly unique, extenuating circumstances of the PHE, the Agency was unable to satisfy certain technical billing criteria in certain limited instances. As described above, VNS Health Home Care will repay the overpayments associated with these claims, in whole or in part, in accordance with the findings of the Draft Report. It will not, however, repay the overpayments associated with S-21, S-49, and S-82, as VNS Health Home Care disputes that these claims resulted in overpayments, in whole or in part.

Notwithstanding the foregoing, however, OIG only reviewed a limited sample of claims, finding an error rate of less than 5%, which—far from demonstrating a sustained or high level of payment errors—actually reflects an extraordinarily high level of billing compliance, and one that does not warrant extrapolation, as it does not establish a "sustained or high level of payment error."

Any errors found by OIG in its review are attributable to the combination of the rollout of a new payment methodology—the PDGM—and the unique and extenuating circumstances of the PHE. Putting aside that extrapolation of overpayments for dates of service arising exclusively during a global pandemic is wholly unfair, OIG's statistical sampling is flawed—as demonstrated by the precision level—such that it has no basis for extrapolation. Even if extrapolation were appropriate, OIG failed to calculate the appropriate extrapolation universe, so the recommended overpayment is incorrect, and VNS Health Home Care will not be repaying the extrapolated figure.

Moreover, because the Audit Period encompassed both the launch of the PDGM as well as the PHE, it identified errors caused by those two factors, and the cited errors were isolated to that time period. As such, VNS Health Home Care has no reason to think that errors extended outside the Audit Period such that additional auditing or process changes are necessary at this time.

Thank you for your consideration.

Very truly yours,

Leah Griggs Pauly

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