Department of Health and Human Services
Office of Inspector General
Office of Audit Services

October 2025 | A-05-22-00016

Medicare Home Health Agency Provider Compliance Audit: VNA Care Network

REPORT HIGHLIGHTS

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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 VNA Care Network complied with Medicare requirements.

What OIG Found

VNA Care Network complied with Medicare billing requirements for 85 of the 100 home health claims we reviewed. For the remaining 15 claims, VNA Care Network incorrectly billed Medicare for claims with unsupported codes, services that did not meet plan of care requirements, invalid face-to-face encounters, skilled services that did not meet medical necessity requirements, and services that did not meet comprehensive assessment requirements.

VNA Care Network received overpayments totaling $6,171 for the claims in the sample.

What OIG Recommends

We made three recommendations to VNA Care Network, including that it: refund the $6,171 in overpayments to the Medicare program, consider conducting additional audits or investigations to identify any similar overpayments and return any identified overpayments to the Medicare program, and strengthen its review processes for identification of inaccuracies in medical record documentation to improve compliance with Medicare billing requirements.

VNA Care Network concurred with our recommendations and provided detailed corrective actions it has taken to address and prevent the types of findings identified during our audit.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 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 HHA compliance audits.[1] Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. VNA Care Network was one of those HHAs.

OBJECTIVE

Our objective was to determine whether VNA Care Network complied with Medicare requirements for billing home health services on selected types of claims.[2]

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.[3] This standardized payment rate is adjusted by using variables in the Patient-Driven Groupings Model (PDGM) that account for the enrollee's condition and healthcare needs.[4] 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).

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

[1] See Appendix B for a list of related Office of Inspector General reports on Medicare home health compliance.

[2] 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, Low Utilization Payment Adjustments, and Partial Episode Payments.

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

[4] The PDGM became effective January 1, 2020.

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.[5] CMS uses the HHRGs as the basis for the Health Insurance Prospective Payment System (HIPPS) codes, which determine payment.[6]

While 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.[7]

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[8] 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
- receiving services under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner.

[5] 42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

[6] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on June 24, 2025.

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

[8] 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.

Furthermore, as a condition for 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)).[9] 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 upon 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.

VNA Care Network

VNA Care Network is a for-profit HHA headquartered in Worcester, Massachusetts. Palmetto GBA, its MAC, paid VNA Care Network approximately $55 million for 28,001 claims for services provided to enrollees during CYs 2020 and 2021 (audit period), identified in CMS's National Claims History (NCH) data.[10]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $48,730,726 in Medicare payments to VNA Care Network for 20,960 claims provided during the audit period.[11] We selected a simple random sample of 100 claims with payments totaling $227,626 for review. We evaluated these claims for compliance with selected billing requirements and submitted these claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

[9] 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)).

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

[11] Our sampling frame included home health claim payments for 30-day billing periods with beginning dates of service from January 1, 2020, through December 31, 2021, that have 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)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

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 Appendix F contains the types of errors for each sample item.[12]

FINDINGS

VNA Care Network complied with Medicare billing requirements for 85 of the 100 home health claims that we reviewed. For the remaining 15 claims, VNA Care Network incorrectly billed Medicare for services that did not meet billing and coding requirements (9 claims), did not meet plan of care requirements (4 claims), did not meet F2F requirements (2 claims), did not meet skilled need requirements (1 claim), and did not meet comprehensive assessment requirements (1 claim).[13] For 11 of these claims, the errors did not result in overpayments.[14] For four claims, VNA Care Network received overpayments of $6,171.[15,16]

According to VNA Care Network staff, these errors occurred because their review processes failed to detect these errors, leaving the claims at risk for being improperly paid. These review processes included pre- and post-payment audits, conducted internally and externally. VNA Care Network staff also stated that these errors were a result of mis-keyed information and human error by the coding vendor and/or VNA Care Network staff.

[12] Sample items may have more than one type of error.

[13] Two claims had more than 1 type of error, for a total of 17 errors. Specifically, one claim did not meet billing and coding requirements and did not meet the F2F requirements. Another claim did not meet multiple billing and coding requirements.

[14] 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 VNA Care Network's compliance with Medicare requirements for billing home health services.

[15] Two of the four claims qualified for partial Medicare reimbursement. For these two claims, we determined the difference between what was originally reimbursed and what was eligible for reimbursement.

[16] We have chosen not to report any estimates of overpayments in the sampling frame (i.e., extrapolated overpayments) because the lower limit of the two-sided 90-percent confidence interval was less than the known overpayment amount in the sample.

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.[17] 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).[18]

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 a 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 (83 Fed. Reg. 56406, 56461 (Nov. 13, 2018); ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.14; Medicare Program Integrity Manual, ch. 6, § 6.2.4).

For nine of the sampled claims, VNA Care Network submitted claims for services that did not meet billing and coding requirements. Specifically, VNA Care Network submitted claims with unsupported primary or secondary diagnosis codes. Although these diagnosis codes were reported on the claim, the medical record did not contain any documentation to support the diagnosis. For seven of these claims, the errors did not result in overpayments because the HIPPS code did not change.

For the remaining two claims in error, VNA Care Network submitted claims with an incorrect admission source code.[19] Specifically, VNA Care Network incorrectly submitted claims with an admission source code for an institutional admission when documentation indicated that a community admission should have been coded. The associated patients were each admitted to home health after a 23-hour observation—one for a knee replacement surgery and one for an emergency room visit—with no inpatient stay. Patients admitted to home health after an inpatient stay generally have higher needs and receive more intensive services, so higher payments are given to claims with an institutional admission source. For these two claims, the

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

[18] 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 July 8, 2025.

[19] The admission source can be either community or institutional and is categorized based on the setting from which the patient was admitted to home health. If the enrollee was discharged from an acute or post-acute facility within 14 days prior to the home health claim start date, the admission source is institutional. If the enrollee does not meet the definition of an institutional admission, the admission source is community.

change of the admission source from institutional to community changed the HIPPS code and resulted in an overpayment totaling $772.

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 individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment (42 CFR § 409.43(a)(2)). The plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits. All care provided must be in accordance with the plan of care (42 CFR § 409.43(a)(3)).

The plan of care must include all requirements, including any provision of remote patient monitoring or other services furnished via telecommunications (42 CFR § 409.43(a)).[20] 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 four of the sampled claims, VNA Care Network submitted claims that did not meet plan of care requirements. For three of the claims, which included telehealth services, the plan of care did not include any provision for the use of services furnished via telecommunications (i.e., telehealth services), resulting in services provided that were not supported by the plan of care. The remaining claim contained an addendum order adjusting infusion and frequency for nutritional formula that was not signed or dated by the certifying physician. The errors associated with these four claims did not result in overpayments.

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 (42 CFR § 424.22(a)(1)(v)).

For two of the sampled claims, VNA Care Network submitted claims that did not meet F2F encounter requirements. For both claims, the F2F encounter documented in the records was not related to the primary reason for home health services, resulting in overpayments totaling $5,399.

[20] The requirement to include in the plan of care any provision of remote patient care monitoring or other services furnished via a telecommunications system began on January 27, 2020, and continued through the remainder of our audit period and beyond. 85 Fed. Reg. 19230, 19285 (Apr. 6, 2020); 85 Fed. Reg. 70298, 70354 (Nov. 4, 2020).

SERVICES DID NOT MEET SKILLED NEED REQUIREMENTS

The need for skilled services must be substantiated by supporting documentation ((the Act §§ 1814(a)(2)(C) and (a)(concluding paragraph), and 1835(a)(2)(A) and (a)(concluding paragraph); 42 CFR § 424.22(c); 42 CFR § 409.42(c); 42 CFR § 409.44; Medicare National Coverage Determinations Manual, chapter 1, part 3, § 170.1)).

To qualify for home health services, a Medicare enrollee must need skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42(c)). Skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR § 409.44(b) and the Medicare Benefit Policy Manual, chapter 7, § 40).[21]

For one of the sampled claims, VNA Care Network incorrectly billed Medicare for skilled services that did not meet Medicare requirements. Specifically, VNA Care Network incorrectly billed physical therapy services for a patient that did not meet the medical necessity criteria. Removal of the unallowable visit did not result in an overpayment because the minimum visit threshold to receive full payment was met.

SERVICES DID NOT MEET COMPREHENSIVE ASSESSMENT REQUIREMENTS

Each enrollee must receive, and an HHA must provide, an enrollee-specific comprehensive assessment that accurately reflects the enrollee's current health status and includes information that may be used to demonstrate the enrollee's progress toward achievement of desired outcomes. The comprehensive assessment must identify the enrollee's continuing need for home care and medical, nursing, rehabilitative, social, and discharge planning needs (42 CFR § 484.55).

The comprehensive assessment must be performed by a registered nurse or, under certain circumstances, a qualified clinician such as a physical therapist, occupational therapist, or speech language pathologist, and includes the collection of OASIS items. The comprehensive assessment must include several requirements, including the patient's primary caregiver's willingness and ability to provide care (42 CFR § 484.55).

For one of the sampled claims, VNA Care Network submitted a claim that did not meet comprehensive assessment requirements. The comprehensive assessment included all the required information except for the primary caregiver's willingness and ability to provide care. This error did not result in an overpayment.

[21] Skilled nursing services can include, among other things, overall management and evaluation of a care plan, observation and assessment of a patient's condition, and patient education services (42 CFR §§ 409.44(b) and 409.33).

CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

According to VNA Care Network staff, these errors occurred because their internal and external review processes failed to detect these errors. VNA Care Network staff also stated that these errors were a result of mis-keyed information and human error by the coding vendor and/or VNA Care Network staff.

RECOMMENDATIONS

We recommend that VNA Care Network:

- refund the $6,171 in overpayments to the Medicare program,[22]

- consider conducting one or more internal audits or investigations for claims before and 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

- strengthen its review processes for identification of inaccuracies in medical record documentation to improve compliance with Medicare billing requirements.

VNA CARE NETWORK COMMENTS

VNA Care Network concurred with our recommendations and provided detailed corrective actions it has taken since the audit period to address and prevent the types of findings identified during our audit. These corrective actions include conducting an audit of claims before and after the review period; strengthening its pre-bill audit process; partnering with a new vendor to enhance coding and documentation review; refining its internal processes for documentation; and implementing a comprehensive compliance training and education program for its staff.

VNA Care Network's comments appear in their entirety as Appendix G.

[22] 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.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $48,730,726 in Medicare payments to VNA Care Network for 20,960 home health claims with service dates in CYs 2020 and 2021.[23, 24] From this sampling frame, we selected for review a simple random sample of 100 home health claims with payments totaling $227,626.

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 VNA Care Network'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 VNA Care Network's procedures when providing and billing home health services. Specifically, we assessed whether VNA Care Network 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 NCH file, 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 April 2022 through August 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted VNA Care Network's paid claim data from CMS's NCH file for the audit period;

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

[24] CYs were determined by the HHA claim "from" date of service. The "from" date is the first day on the billing statement covering services provided to the enrollee. We selected claims with "from" dates falling within CYs 2020 and 2021; therefore, claims subjected to audit could include services that ended after CY 2021.

- identified a sampling frame of 20,960 claims totaling $48,730,726;[25]

- 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 VNA Care Network 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 VNA Care Network's procedures for billing and submitting Medicare claims;

- verified State licensure information for selected medical personnel providing 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;[26]

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our audit with VNA Care Network 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.

[25] Our sampling frame included home health claim payments for 30-day billing periods with beginning dates of service from January 1, 2020, through December 31, 2021, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[26] 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: Sunflower Home Health	A-05-23-00002	7/09/2025
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.[27] 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.[28]

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

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

[28] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on July 8, 2025.

of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy,[29] (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).[30]

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 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:

[29] Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, 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)).

[30] 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).[31]

[31] For additional information, see CMS | Jimmo Settlement, accessed on July 8, 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 20,960 claims for home health services provided by VNA Care Network with beginning dates of service from January 1, 2020, through December 31, 2021. Medicare payments for those claims totaled $48,730,726.

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 DSY_VW_REC_LNK_NUM[32] 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 have chosen not to report any estimates of overpayments in the sampling frame because the lower limit of the two-sided 90-percent confidence interval was less than the known overpayment amount in the sample. Therefore, we are recommending recovery of only the overpayment for the items in the sample.

[32] This field uniquely identifies claims in CMS's NCH file.

APPENDIX E: SAMPLE RESULTS

Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Claims in Sample	Value of Claim Overpayments in Sample
20,960	$48,730,726	100	$227,626	15[33]	$6,171

[33] For 11 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 Billed Did Not Meet Plan of Care Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Services Did Not Meet Comprehensive Assessment Requirements	Overpayment
1					X	-
2						-
3						-
4						-
5						-
6						-
7						-
8						-
9						-
10						-
11						-
12						-
13						-
14						-
15		X				-
16						-
17						-
18						-
19						-
20	X					-
21						-
22						-
23						-
24						-
25						-
26						-
27						-
28						-
29						-
30						-
31						-
32	X					375
33						-
34						-
35						-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Billed Did Not Meet Plan of Care Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Services Did Not Meet Comprehensive Assessment Requirements	Overpayment
36						-
37						-
38				X		-
39	X					-
40						-
41						-
42						-
43	X		X			2,442
44						-
45						-
46						-
47						-
48						-
49						-
50	X					-
51						-
52						-
53						-
54	X					-
55						-
56						-
57						-
58						-
59	X[34]					397
60						-
61						-
62						-
63						-
64						-
65						-
66		X				-
67						-
68						-
69						-
70						-

[34] This claim had more than one type of error within billing and coding requirements.

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Billed Did Not Meet Plan of Care Requirements	Services Billed Did Not Meet Face-to-Face Requirements	Services Did Not Meet Skilled Need Requirements	Services Did Not Meet Comprehensive Assessment Requirements	Overpayment
71						-
72	X					-
73						-
74						-
75						-
76		X				-
77						-
78						-
79						-
80						-
81						-
82						-
83						-
84						-
85						-
86						-
87						-
88						-
89						-
90						-
91						-
92						-
93						-
94						-
95						-
96						-
97		X				-
98			X			2,957
99						-
100						-
Totals	**9**	**4**	**2**	**1**	**1**	**6,171**

APPENDIX G: VNA CARE NETWORK COMMENTS

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Worcester, MA 01606

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By Electronic Filing

September 5, 2025

Sheri Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
Office of Inspector General
Department of Health and Human Services
233 North Michigan Avenue, Suite 802
Chicago, Illinois 60601

Re: VNA Care Network
A-05-22-00016

Dear Ms. Fulcher:

VNA Care Network Foundation, Inc. ("VNA Care Network") appreciates the opportunity to respond to the United States Department of Health and Human Services, Office of Inspector General's ("OIG's") draft report entitled *Medicare Home Health Agency Provider Compliance Audit: VNA Care Network* ("Draft Report"). VNA Care Network's response is set forth below.

BACKGROUND OF VNA CARE NETWORK

VNA Care Network is a non-profit home health care organization offering comprehensive nursing, therapy, hospice, and palliative care services. With roots tracing back over 140 years, it is proud to include some of the earliest visiting nurse associations in the United States. In 2024 alone, VNA Care Network's dedicated team of over 750 clinicians and employees delivered more than 350,000 visits to over 25,000 patients across Massachusetts.

VNA Care Network is dedicated to upholding integrity through comprehensive policies, procedures, and corporate compliance plans. The OIG's review did not reveal any systemic deficiencies within VNA Care Network's compliance program or controls, and acknowledges that its claims review processes include pre- and post-payment audits conducted both internally and externally. VNA Care Network's established history, leadership, compliance initiatives, and organizational culture contributes to its sound billing practices, a position generally corroborated by the conclusions in the Draft Report.

RESPONSE TO THE OIG'S RECOMMENDATIONS

VNA Care Network's responses to each of the three recommendations in the Draft Report are as follows:

1. Response to OIG Recommendation to Refund Overpayments of $6,171

VNA Care Network concurs with the OIG's recommendation to refund $6,171 in overpayments to the Medicare program for the four errors identified by the OIG that resulted in overpayments.

2. Response to OIG Recommendation to Conduct Audits of Claims Before and After Review Period

VNA Care Network agrees with the recommendation to conduct one or more internal audits for claims based on risks identified in the Draft Report. VNA Care Network has already engaged a qualified third-party to audit claims submitted before and after the review period and will diligently review any findings to determine if claims resulted in overpayments.

3. Response to OIG Recommendation to Strengthen Review Processes

VNA Care Network concurs with the recommendation to strengthen its review process for identification of inaccuracies in medical record documentation to improve compliance with Medicare billing requirements. VNA Care Network has strengthened its pre-bill audit activity through processes within its electronic medical record and within various departments of the agency. Jordan Raddish has been named VNA Care Network's Chief Compliance and Quality Officer in an effort to further strengthen its compliance and audit programs.

VNA Care Network recently notified its external coding and review vendor that it would be terminating its contract, and it has partnered with another vendor to enhance the quality and integrity of ICD-10CM coding and documentation review. VNA Care Network has implemented a robust Quality Assurance and Performance Improvement ("QAPI") program that includes quarterly random sampling and auditing of records to ensure compliance with billing and coding, Face-to-Face Encounter, and skilled need requirements. VNA Care Network routinely reviews the results of its QAPI process, analyzes trends, and addresses findings.

Additionally, VNA Care Network has implemented a comprehensive compliance training program and is currently developing targeted training sessions for new employees, as well as annual compliance education for agency leadership, relevant staff, and clinicians. These sessions address key topics such as proper documentation to support both primary and secondary diagnosis codes, provider signature requirements, documentation standards for Face-to-Face encounters in patient records, skilled need criteria, and thorough assessment protocols—including documentation of the caregiver's capacity and willingness to provide care.

VNA Care Network has also refined its internal processes and documentation templates to ensure adherence to these standards. Further, the organization has communicated clear expectations to third-party vendors, emphasizing that diagnosis codes should only be assigned when thoroughly substantiated by clinician or provider documentation.

The organization has introduced updated Face-to-Face encounter requirements at defined intervals during patient care and established real-time monitoring systems to enhance policy compliance.

Lastly, VNA Care has instituted a structured case conferencing process at designated intervals to evaluate and document the continued necessity for skilled care services.

CONCLUSION

Thank you again for the opportunity to present these comments to the Draft Report. VNA Care Network remains steadfast in its commitment to ensuring compliance with Medicare billing and coding requirements. We respectfully request that the OIG consider these responses and incorporate them into its final report.

Sincerely,

Stephen Gut

Stephen Gut
Chief Financial Officer

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