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Medicare Home Health Agency Provider Compliance Audit: Alternate Solutions Homecare of Dayton

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 Alternate Solutions Homecare of Dayton (Alternate Solutions) complied with Medicare requirements.

What OIG Found

For the audit period (calendar years 2022 and 2023), Alternate Solutions complied with Medicare billing requirements for 96 of the 100 sampled home health claims we reviewed. For the remaining four claims, Alternate Solutions incorrectly billed Medicare for services that did not meet billing and coding requirements and comprehensive assessment reporting requirements. Alternate Solutions stated that as a result of staffing shortages and human error, their internal system safeguards failed to detect the errors.

Alternate Solutions received overpayments totaling $940 for the claims in the sample.

What OIG Recommends

We made two recommendations to Alternate Solutions, including that it (1) refund the $940 in overpayments to the Medicare program, and (2) consider conducting one or more internal audits or investigations for claims after our audit period to identify any similar overpayments and return any identified overpayments to the Medicare program.

Alternate Solutions concurred with our recommendations and provided detailed corrective actions it has taken to address and prevent the types of billing and comprehensive assessment errors 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. Alternate Solutions Homecare of Dayton (Alternate Solutions) was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Alternate Solutions 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 health care 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).

[1] See Appendix B for a list of related Office of Inspector General reports on Medicare home health compliance. For more information, see Work Plan Summary, accessed on Oct. 2, 2025.

[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, Notices of Admission, 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.

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 receive or continue 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]

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.[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

[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 December 22, 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.

- 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 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.

Alternate Solutions Homecare of Dayton

Alternate Solutions is a for-profit HHA headquartered in Dayton, Ohio. Palmetto GBA, LLC, its MAC, paid Alternate Solutions approximately $34 million for 20,026 claims for services provided to enrollees during CYs 2022 and 2023 (audit period), identified in CMS's Integrated Data Repository (IDR) data.[10]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $32,160,982 in Medicare payments to Alternate Solutions for 17,411 claims for services provided during the audit period.[11] We selected a simple random sample of 100 claims with payments totaling $197,254 for review. We evaluated these claims for compliance

[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 dates of service from January 1, 2022, through December 31, 2023, 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(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.

with selected billing requirements and submitted these claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

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

FINDINGS

Alternate Solutions complied with Medicare billing requirements for 96 of the 100 home health claims that we reviewed. For the remaining four claims, Alternate Solutions incorrectly billed Medicare for services that did not meet billing and coding requirements (two claims) and did not meet comprehensive assessment reporting requirements (two claims). For three of these claims, the errors did not result in overpayments.[12] For the remaining claim, Alternate Solutions received overpayments of $940.[13, 14]

According to Alternate Solutions, these errors occurred because its system's safeguards, which include structured internal pre-payment review, failed to detect these errors. Alternate Solutions stated that the errors regarding the billing and coding requirements were inadvertent errors not detected by this process. Alternate Solutions attributed the comprehensive assessment reporting errors to temporary staffing shortages that impacted its ability to meet required timeframes.

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

[12] Although 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 Alternate Solutions' compliance with Medicare requirements for billing home health services.

[13] The claim qualified for partial Medicare reimbursement. We determined the difference between what was originally reimbursed and what was eligible for reimbursement.

[14] 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.

adjusting payment under the PDGM.[15] 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).[16]

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 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).

Alternate Solutions submitted two claims that did not meet billing and coding requirements. For one claim, Alternate Solutions included unsupported secondary diagnosis codes. Although these codes were listed on the claim, there was no documentation in the medical record to support them. This error did not result in an overpayment because the HIPPS code remained unchanged. For the second claim, Alternate Solutions used an incorrect admission source code.[17] The claim was submitted as an institutional admission, but documentation showed the patient was admitted to home health from the community following an emergency room visit, with no inpatient stay. Since institutional admissions typically result in higher payments due to the expectation of more intensive services, this incorrect coding led to an overpayment. Correcting the admission source from institutional to community changed the HIPPS code and resulted in an overpayment of $940.

SERVICES DID NOT MEET COMPREHENSIVE ASSESSMENT REQUIREMENTS

Each enrollee must receive, and the 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

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

[16] 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); 87 Fed. Reg. 66790, 66794-66797 (Nov. 4, 2022); CMS | Home Health PPS, accessed on December 22, 2025.

[17] 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.

need for home care and medical, nursing, rehabilitative, social, and discharge planning needs (42 CFR § 484.55).

The OASIS is a group of standard data elements home health agencies integrate into their comprehensive assessment, to collect and report quality data to CMS. As a condition of payment and participation, HHAs are required to electronically transmit each completed OASIS assessment to CMS within 30 days of completing the comprehensive assessment (42 CFR §§ 484.45 and 484.205(c)).[18]

For two of the sampled claims, Alternate Solutions submitted claims that did not meet OASIS reporting requirements. For both claims, the OASIS data was not transmitted to CMS within 30 days of completing the Comprehensive Assessment. These errors did not result in overpayments because the minimum visit threshold to receive full payment was met, and there was no change to the HIPPS.

RECOMMENDATIONS

- We recommend that Alternate Solutions refund the $940 overpayment to the Medicare program.[19]

- We recommend that Alternate Solutions 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.

ALTERNATE SOLUTIONS COMMENTS

Alternate Solutions 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. In addition, Alternate Solutions stated that the identified errors in our report were due to human error and temporary staffing shortages. Corrective actions include implementing a structured internal claim review process and adding system safeguards to ensure compliance and accuracy. Alternate Solutions affirmed its commitment to ongoing monitoring and continuous compliance improvements.

Alternate Solutions' comments appear in their entirety as Appendix G.

[18] The Act §§ 1895(b)(3)(B)(v)(IV)(bb) and (cc) and 1899B(b)(1).

[19] 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 $32,160,982 in Medicare payments to Alternate Solutions for 17,411 home health claims with service dates in CYs 2022 and 2023.[20, 21] From this sampling frame, we selected for review a simple random sample of 100 home health claims with payments totaling $197,254.

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 Alternate Solutions' internal controls and compliance with laws and regulations to the extent necessary to satisfy the audit objective. Our review of internal controls focused on Alternate Solutions' procedures when providing and billing home health services. Specifically, we assessed whether Alternate Solutions 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 July 2024 through December 2025.

METHODOLOGY

We took the following steps to accomplish our objective:

- Reviewed applicable Federal laws, regulations, and guidance

[20] We did not include Requests for Anticipated Payment (42 CFR § 484.205(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.

[21] CYs were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the enrollee. We selected claims with "through" dates falling within CYs 2022 and 2023; therefore, claims subjected to audit could include services that began prior to January 1, 2022.

- Extracted Alternate Solutions' paid claim data from CMS's IDR for the audit period
- Identified a sampling frame of 17,411 claims totaling $32,160,982[22]
- 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 Alternate Solutions provided 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 Alternate Solutions' 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[23]
- Calculated the correct payments for those claims requiring adjustments
- Discussed the results of our audit with Alternate Solutions 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.

[22] Our sampling frame included home health claim payments for 30-day billing periods with ending dates of service from January 1, 2022, through December 31, 2023, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[23] 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: 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	7/09/2025
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" (ch. 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.[24] This standardized payment rate is adjusted by using variables in the PDGM that account for the enrollee's condition and health care 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.[25]

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

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

[25] 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 December 22, 2025.

of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy,[26] (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).[27]

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 (§§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Act 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:

[26] 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)).

[27] 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

- 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) of the Act).

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

- 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).[28]

[28] For additional information, see CMS | Jimmo Settlement, accessed on December 22, 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
- 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 17,411 claims for home health services provided by Alternate Solutions with ending dates of service from January 1, 2022, through December 31, 2023. Medicare payments for those claims totaled $32,160,982.

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[29] 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.

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

APPENDIX E: SAMPLE RESULTS

Table: 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
17,411	$32,160,982	100	$197,254	4[30]	$940

[30] For 3 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 Comprehensive Assessment Requirements	Overpayment
1			-
2			-
3		X	-
4			-
5			-
6			-
7			-
8			-
9			-
10			-
11			-
12			-
13			-
14			-
15			-
16			-
17			-
18			-
19			-
20			-
21			-
22			-
23			-
24			-
25			-
26			-
27			-
28			-
29			-
30			-
31			-
32		X	-
33			-
34			-
35			-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Comprehensive Assessment Requirements	Overpayment
36			-
37			-
38			-
39			-
40			-
41			-
42			-
43	**X**		-
44			-
45			-
46			-
47			-
48			-
49			-
50			-
51			-
52			-
53			-
54			-
55			-
56			-
57			-
58			-
59			-
60			-
61			-
62			-
63			-
64			-
65			-
66			-
67			-
68			-
69			-
70			-
71			-
72			-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Comprehensive Assessment Requirements	Overpayment
73			-
74			-
75			-
76			-
77			-
78			-
79			-
80			-
81			-
82			-
83			-
84			-
85			-
86			-
87			-
88			-
89			-
90			-
91			-
92			-
93	**X**		$940
94			-
95			-
96			-
97			-
98			-
99			-
100			-
Totals	**2**	**2**	**$940**

APPENDIX G: ALTERNATE SOLUTIONS COMMENTS

ALTERNATE SOLUTIONS
Health Network

January 7, 2026

Department of Health and Human Services
Office Inspector General
Office of Audit Services, Region V
233 North Michigan Avenue, Suite 802
Chicago, IL 60601
Attn: Sheri Fulcher

Dear Ms. Fulcher

Alternate Solutions Homecare of Dayton acknowledges the receipt of the Department of Health and Human Services, Office of Inspector General (OIG) draft report title *Medicare Home Health Agency Provider Compliance Audit: Alternate Solutions Homecare of Dayton.* We understand that this draft report is subject to further review and revision and will safeguard it against unauthorized use and disclosure in accordance with your instructions.

We appreciate the opportunity to review the draft report and to provide written comments regarding the facts presented and the reasonableness of the recommendations. After careful review, our agency concurs with the findings and recommendations outlined in the report.

The identified errors were related to inadvertent human error and temporary staffing shortages, which impacted certain operational processes during the audit period and not the result of intentional misconduct or systemic noncompliance. Our agency took prompt action to address the contributing factors by:

- Ensuring all claims undergo a structured internal review process prior to submission. This process includes manual review by qualified staff to verify supporting documentation, medical necessity, and alignment with applicable Centers for Medicare & Medicaid Services (CMS) and payer regulations. Documentation is reviewed and compared against plan of care requirements, visit documentation, and OASIS assessments to confirm accuracy and consistency. Any discrepancies identified during this review are returned to the originating assessing clinician for correction prior to claim submission, ensuring claims are appropriately supported and compliant
- In addition to manual review, system safeguards have been implemented within the Agency's billing and electronic health record platforms to further support compliance and accuracy. These safeguards include automated edits and validation rules designed to identify incomplete, inconsistent, or noncompliant data prior to claim processing. The

ALTERNATE SOLUTIONS
Health Network

system is configured to prevent the submission of claims with missing documentation, incorrect coding, or timing errors, thereby reinforcing the manual review process.

We believe these corrective actions appropriately address the findings and demonstrate our commitment to compliance, accountability, and continuous improvement. We will continue to monitor these processes to ensure sustained adherence to all applicable regulatory requirements.

Sincerely,

Jilyan Kramer

Jilyan Kramer
Vice President, Compliance
Alternate Solutions Homecare of Dayton
[redacted]

Report Fraud, Waste, and Abuse

OIG Hotline Operations accepts tips and complaints from all sources about potential fraud, waste, abuse, and mismanagement in HHS programs. Hotline tips are incredibly valuable, and we appreciate your efforts to help us stamp out fraud, waste, and abuse.

TIPS.HHS.GOV

Phone: 1-800-447-8477

TTY: 1-800-377-4950

Who Can Report?

Anyone who suspects fraud, waste, and abuse should report their concerns to the OIG Hotline. OIG addresses complaints about misconduct and mismanagement in HHS programs, fraudulent claims submitted to Federal health care programs such as Medicare, abuse or neglect in nursing homes, and many more. Learn more about complaints OIG investigates.

How Does It Help?

Every complaint helps OIG carry out its mission of overseeing HHS programs and protecting the individuals they serve. By reporting your concerns to the OIG Hotline, you help us safeguard taxpayer dollars and ensure the success of our oversight efforts.

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Anyone may request confidentiality. The Privacy Act, the Inspector General Act of 1978, and other applicable laws protect complainants. The Inspector General Act states that the Inspector General shall not disclose the identity of an HHS employee who reports an allegation or provides information without the employee's consent, unless the Inspector General determines that disclosure is unavoidable during the investigation. By law, Federal employees may not take or threaten to take a personnel action because of whistleblowing or the exercise of a lawful appeal, complaint, or grievance right. Non-HHS employees who report allegations may also specifically request confidentiality.

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