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

December 2025 | A-07-24-05146

# Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC

December 2025 | A-07-24-05146

# Medicare Home Health Agency Provider Compliance Audit: Guardian Home Care, LLC

## 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 Guardian Home Care, LLC, complied with Medicare requirements for billing home health services provided to enrollees from July 1, 2021, through June 30, 2023 (audit period).

## What OIG Found

Guardian Home Care complied with Medicare billing requirements for 97 of the 100 home health claims we reviewed. For the remaining three claims, Guardian Home Care incorrectly billed Medicare for claims with unsupported codes or for a skilled service that did not meet a plan of care requirement.

- Two claims did not meet billing and coding requirements, resulting in overpayments totaling $123.
- One claim did not meet a plan of care requirement, resulting in an overpayment of $1,567.

Guardian Home Care received overpayments totaling $1,690 for the claims in the sample.

## What OIG Recommends

We recommend that Guardian Home Care: (1) refund the $1,690 in overpayments to the Medicare program and (2) consider conducting one or more internal audits or investigations for claims after our audit period, based on the risks identified by this audit, to identify any similar overpayments that Guardian Home Care might have received and return any identified overpayments to the Medicare program.

Guardian Home Care did not specifically indicate concurrence or nonconcurrence with our first recommendation and described corrective actions it planned to take. Guardian Home Care concurred with our second recommendation.

**TABLE OF CONTENTS**


INTRODUCTION ..... 1

Why We Did This Audit ..... 1

Objective ..... 1

Background ..... 1

The Medicare Program and Payments for Home Health Services ..... 1

Medicare Requirements for Home Health Services and Claims ..... 2

Guardian Home Care, LLC ..... 3

How We Conducted This Audit ..... 3

FINDINGS ..... 4

Services Did Not Meet Billing and Coding Requirements ..... 4

Service Billed Did Not Meet a Plan of Care Requirement ..... 6

Causes for the Noncompliance With Medicare Billing Requirements ..... 6

RECOMMENDATIONS ..... 6

GUARDIAN HOME CARE, LLC, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE ..... 7

APPENDICES

A: Audit Scope and Methodology ..... 8

B: Related Office of Inspector General Reports ..... 10

C: Medicare Requirements for Coverage and Payment of Claims for Home Health Services ..... 11

D: Statistical Sampling Methodology ..... 16

E: Sample Results ..... 17

F: Types of Errors by Sample Item ..... 18

G: Guardian Home Care, LLC, Comments ..... 21

# INTRODUCTION

## WHY WE DID THIS AUDIT

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

## OBJECTIVE

Our objective was to determine whether Guardian Home Care 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)[4] 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 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),

[1] See Appendix B for a list of related Office of Inspector General (OIG) audits. For more information, see Work Plan Summary, accessed on July 28, 2025.

[2] We did not include the following types of claims in our review 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 was effective January 1, 2020.

Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue to, receive home health services. CMS requires HHAs to submit OASIS data as a condition of payment.[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; and

[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 July 28, 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 of payment, a practitioner must certify that a face-to-face (F2F) encounter occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)).[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 on objective clinical evidence regarding the enrollee's individual need for care (42 CFR § 409.44(a)).

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

**Guardian Home Care, LLC**

Guardian Home Care is a for-profit HHA headquartered in Dallas, Texas. Palmetto GBA, LLC, its Medicare administrative contractor, paid Guardian Home Care approximately $36 million for 17,439 claims for services provided to enrollees from July 1, 2021, through June 30, 2023 (audit period), based on CMS's Integrated Data Repository (IDR) data.[10]

## HOW WE CONDUCTED THIS AUDIT

Our audit covered $35,645,778 in Medicare payments to Guardian Home Care for 17,402 claims for services provided during the audit period.[11] We selected a simple random sample of 100 claims with payments totaling $208,670 for review. We evaluated these claims for compliance with selected billing requirements and submitted the 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 by 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 claim 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 within our audit period, 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.

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

Guardian Home Care complied with Medicare billing requirements for 97 of the 100 home health claims that we reviewed. For the remaining three claims, Guardian Home Care incorrectly billed Medicare for services that did not meet billing and coding requirements (two claims) or that did not meet a plan of care requirement (one claim). For one of these claims, the error did not result in an overpayment.[12] For two of these claims, Guardian Home Care received overpayments of $1,690.[13, 14]

According to Guardian Home Care staff, these errors occurred because Guardian Home Care's internal review processes did not detect them.

### 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.[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

[12] Although this claim billing error may not always result in an overpayment, a finding such as this can and does result in an overpayment. Therefore, this type of finding is relevant to our objective of determining Guardian Home Care's compliance with Medicare requirements for billing home health services.

[13] One of the two claims qualified for partial Medicare reimbursement. For this claim, we questioned 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.

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

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 an HHRG and assigns a corresponding HIPPS code. The HIPPS code is a distinct five-position alphanumeric code that represents the case mix on which payment determinations are made.

The primary and secondary diagnoses reported on the home health claim, which are used to determine the HHRG and resulting HIPPS code, must be supported by information in the certifying practitioner's and/or the acute or post-acute facility's medical record (83 Fed. Reg. 56406, 56461 (Nov. 13, 2018); International Classification of Diseases (ICD), Clinical Modification (CM), ICD-10-CM *Official Guidelines for Coding and Reporting*, Section I.B.14; *Medicare Program Integrity Manual*, ch. 6, § 6.2.4).

For two of the sampled claims, Guardian Home Care submitted claims for services that did not meet billing and coding requirements. Specifically, Guardian Home Care submitted claims with unsupported secondary diagnosis codes. For one of these claims, the error did not result in an overpayment. For the remaining claim, removal of the unsupported secondary diagnosis code changed the comorbidity adjustment portion of the HIPPS code, and the error resulted in an overpayment of $123.[17]

**Example: Secondary Diagnosis Not Supported**

A physician referred a patient to Guardian Home Care for skilled nursing to help manage kidney failure. Occupational therapy and physical therapy were provided for a rehabilitation encounter because of nontraumatic ventricular tachycardia.[18] The HIPPS code initially assigned to the claim reflected the secondary diagnosis of paroxysmal atrial fibrillation.[19] Medical review found that the documentation supported ventricular tachycardia, rather than paroxysmal atrial fibrillation, as a secondary diagnosis. The change in secondary diagnosis resulted in an overpayment totaling $123.

[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 July 28, 2025.

[17] The comorbidity adjustment reflects medical conditions that coexist in addition to the principal diagnosis and is based on the presence of certain secondary diagnoses billed on the claim. The comorbidity adjustment is categorized as none, low, or high.

[18] Nontraumatic ventricular tachycardia occurs when a heart has 3 or more consecutive beats at a rate of more than 100 beats per minute, arising from the ventricle, which is not caused by, or associated with, trauma.

[19] Paroxysmal atrial fibrillation is defined as irregular heart rhythms that are intermittent in nature and terminate either spontaneously or within 7 days of treatment.

## SERVICE BILLED DID NOT MEET A PLAN OF CARE REQUIREMENT

As a condition of coverage of home health services under Medicare, a physician or allowed practitioner must establish and periodically review an individualized plan of care. Specifically, the plan of care must be signed and dated before the claim for each episode is submitted (42 CFR § 409.43(c)(2)(ii)).

For one of the sampled claims, Guardian Home Care submitted a claim that did not meet a plan of care requirement, resulting in an overpayment of $1,567. For this claim, the plan of care was signed by the physician and physician assistant after the claim had been submitted to CMS for payment.

## CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

According to Guardian Home Care staff, these errors occurred because Guardian Home Care's internal review processes did not detect them. For the two sampled claims that were related to billing and coding, Guardian Home Care staff stated that the diagnosis codes used were incorrectly keyed into the claim information. For the claim involving the plan of care that was signed after the claim had been submitted for reimbursement, Guardian Home Care staff told us that once they realized that the physician assistant had signed the plan of care, they returned it to the practitioner for signature. However, the physician assistant (rather than the physician) again signed the plan of care. At this point, the claim had already been submitted to CMS for payment.

## RECOMMENDATIONS

We recommend that Guardian Home Care, LLC:

- refund the $1,690 in overpayments to the Medicare program[20] and

- 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 that Guardian Home Care might have received and return any identified overpayments to the Medicare program.

[20] 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.

## GUARDIAN HOME CARE, LLC, COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Guardian Home Care did not specifically indicate concurrence or nonconcurrence with our first recommendation to refund the $1,690 in overpayments, but stated that it would "voluntarily refund the estimated overpayments of $1,690."[21] Guardian Home Care stated that it concurred with our second recommendation "insofar as it conducts periodic internal audits as part of its standard compliance program and will continue to do so."

Regarding our first recommendation, Guardian Home Care said that the issue with the plan of care finding (i.e., our second finding) was the result of a timing error and acknowledged that it should have submitted an amended claim after obtaining the physician's signature. Guardian Home Care further stated that "the solution results in Guardian retaining payment for the services provided after resubmission of an amended claim."

After reviewing Guardian Home Care's written comments, we maintain that our findings and recommendations are valid. With respect to Guardian Home Care's comments on our first recommendation, we point out that Federal regulations state that a provider must return an overpayment within 60 days after the date on which the overpayment is identified (42 CFR § 401.305(b)). Moreover, Federal regulations establish time limits for filing Medicare claims (42 CFR § 424.44).

Our second recommendation is for Guardian Home Care to conduct one or more internal audits or investigations for claims after our audit period "based on the risks identified by this audit." Based on Guardian Home Care's comments, it is our expectation that one or more of its "periodic internal audits as part of its standard compliance program" will focus on the risks identified by this audit.

Guardian Home Care's comments appear in their entirety as Appendix G.

[21] To clarify, we found and recommended repayment of $1,690 in actual overpayments. We chose 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.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered $35,645,778 in Medicare payments to Guardian Home Care for 17,402 home health claims for services provided during the audit period.[22, 23] From this sample frame, we selected for review a simple random sample of 100 home health claims with payments totaling $208,670.

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 Guardian Home Care's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. Our review of internal controls focused on Guardian Home Care's procedures when providing and billing home health services. Specifically, we assessed whether Guardian Home Care 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 review showed that Guardian Home Care's controls were logically designed and applied consistently for most of the claims in our sample. 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 this audit from January 2024 through October 2025.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

[22] 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.

[23] Service dates were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the enrollee. We selected claims with "through" dates falling within the period July 1, 2021, through June 30, 2023; therefore, claims subjected to audit could include services that began prior to July 1, 2021.

- extracted Guardian Home Care's paid claim data from CMS's IDR for the audit period;
- identified a sampling frame of 17,402 claims totaling $35,645,778;[24]
- 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 Guardian Home Care 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 Guardian Home Care'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;[25]
- calculated the correct payments for those claims requiring adjustments; and
- discussed the results of our audit with Guardian Home Care 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.

[24] Our sampling frame included home health claim payments for 30-day billing periods with ending dates of service from July 1, 2021, through June 30, 2023, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[25] 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: VNA Care Network* | A-05-22-00016 | 10/23/2025 |
| *Medicare Home Health Agency Provider Compliance Audit: Sunflower Home Health* | A-05-23-00002 | 7/9/2025 |
| *Medicare Home Health Agency Provider Compliance Audit: HRS Home Health* | A-05-22-00017 | 6/30/2025 |
| *Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health* | A-05-23-00017 | 12/19/2024 |

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

### GENERAL MEDICARE BILLING REQUIREMENTS

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

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

### OUTCOME AND ASSESSMENT INFORMATION SET DATA

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

### HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Under the home health PPS, CMS pays HHAs a national, standardized 30-day period payment rate.[26] 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.[27]

### HOME HEALTH COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare enrollees must: (1) be confined to the home; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational

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

[27] 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 28, 2025.

therapy;[28] (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).[29]

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) 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 an F2F encounter with an 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:

[28] 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)).

[29] 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 on 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).[30]

**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 an F2F encounter. The F2F encounter must be documented in the patient's medical record and:

[30] For additional information, CMS | Jimmo Settlement, accessed on July 28, 2025.

- 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 17,402 claims for home health services provided by Guardian Home Care with ending dates of service from July 1, 2021, through June 30, 2023. Medicare payments for those claims totaled $35,645,778.

### 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 HDR_IDR_LINK_NUM[31] 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 our sample.

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

## APPENDIX E: SAMPLE RESULTS

### Sample Details and Results

| Sampling Frame Size | Total Value of Sampling Frame | Sample Size | Total Value of Sample | Incorrectly Billed Sample Items[32] | Value of Overpayments in Sample |
|---|---|---|---|---|---|
| 17,402 | $35,645,778 | 100 | $208,670 | 3 | $1,690 |

[32] For one of these claims, the error did not result in an overpayment.

## APPENDIX F: TYPES OF ERRORS BY SAMPLE ITEM

| Sample Number | Services Did Not Meet Billing and Coding Requirements | Services Did Not Meet Plan of Care Requirements | Overpayment |
|---|---|---|---|
| 1 | | | - |
| 2 | | | - |
| 3 | | | - |
| 4 | | | - |
| 5 | | | - |
| 6 | | | - |
| 7 | | | - |
| 8 | X | | 123 |
| 9 | | X | 1,567 |
| 10 | | | - |
| 11 | | | - |
| 12 | | | - |
| 13 | | | - |
| 14 | | | - |
| 15 | | | - |
| 16 | | | - |
| 17 | X | | - |
| 18 | | | - |
| 19 | | | - |
| 20 | | | - |
| 21 | | | - |
| 22 | | | - |
| 23 | | | - |
| 24 | | | - |
| 25 | | | - |
| 26 | | | - |
| 27 | | | - |
| 28 | | | - |
| 29 | | | - |
| 30 | | | - |
| 31 | | | - |
| 32 | | | - |
| 33 | | | - |
| 34 | | | - |
| 35 | | | - |
| 36 | | | - |

| Sample Number | Services Did Not Meet Billing and Coding Requirements | Services Did Not Meet Plan of Care Requirements | Overpayment |
|---|---|---|---|
| 37 | | | - |
| 38 | | | - |
| 39 | | | - |
| 40 | | | - |
| 41 | | | - |
| 42 | | | - |
| 43 | | | - |
| 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 | | | - |
| 73 | | | - |
| 74 | | | - |

| Sample Number | Services Did Not Meet Billing and Coding Requirements | Services Did Not Meet Plan of Care Requirements | Overpayment |
|---|---|---|---|
| 75 | | | - |
| 76 | | | - |
| 77 | | | - |
| 78 | | | - |
| 79 | | | - |
| 80 | | | - |
| 81 | | | - |
| 82 | | | - |
| 83 | | | - |
| 84 | | | - |
| 85 | | | - |
| 86 | | | - |
| 87 | | | - |
| 88 | | | - |
| 89 | | | - |
| 90 | | | - |
| 91 | | | - |
| 92 | | | - |
| 93 | | | - |
| 94 | | | - |
| 95 | | | - |
| 96 | | | - |
| 97 | | | - |
| 98 | | | - |
| 99 | | | - |
| 100 | | | - |
| **Totals** | **2** | **1** | **$1,690** |

James Korn
Regional Inspector General for Audit Services
Office of Audit Services, Region VII
Office of Inspector General
Department of Health and Human Services
1201 Walnut St, Suite 1309
Kansas City, Missouri 64106

Re: Guardian Home Care, LLC
A-07-24-05146

Dear Mr. Korn:

Guardian Home Care ("Guardian") appreciates the opportunity to provide comments in response 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: Guardian Home Care ("Draft Report"). Guardian's comments to the Draft Report, including the report's conclusions and recommendations, are set forth below.

## BACKGROUND INFORMATION ON GUARDIAN

Guardian has served the Roswell, Georgia area for more than twenty (20) years, providing a comprehensive suite of skilled nursing and therapy services for patients with a need for in-home care. Its leadership team has extensive combined home health experience, which is reflected in its high-quality patient care. Guardian has earned Community Health Accreditation Partner ("CHAP") accreditation for meeting the highest performance standards of care, and it performs better than the state or national average on quality metrics reported by Medicare.

As an organization committed to integrity, Guardian has robust policies, procedures, and corporate compliance plans. Notably, the OIG did not identify any flaws in Guardian's compliance program or controls. Guardian believes that its history, leadership, compliance efforts, and culture have resulted in compliant billing practices, which is supported by the Draft Report's conclusions.

## RESPONSE TO THE OIG'S DRAFT REPORT

The Draft Report's conclusions support that Guardian is dedicated to billing compliance. The OIG determined that all patients in the sample had a need for skilled care and received medically necessary home health services. However, the OIG found that 2 of the 100 claims did not have documentation supporting the supplementary diagnosis billed for services, and one of the claims did not meet the plan of care requirements at the time the claim was submitted resulting in a small overpayment to Guardian. These errors alleged by the OIG resulted in less than a one (1) percent overall payment error rate, meaning Guardian's claims were over ninety-

nine (99) percent accurate. This minimal error rate is far better than the 7.7 percent payment error rate that the OIG has identified across the home health industry.

## RESPONSE TO THE OIG'S RECOMMENDATIONS

There are two recommendations in the Draft Report.

A. Response to OIG Recommendation to Refund of The Estimated Overpayments of $1690.

Guardian will voluntarily refund the estimated overpayments of $1690. However, Guardian points out that the plan of care requirement issue was identified by Guardian following submission of the claim. The plan of care was signed by a physician assistant prior to submitting the claim. After checking in the signed plan of care, releasing the claim, Guardian realized the plan of care should have been signed by a physician and later obtained a plan of care signed by the certifying physician. Guardian should have submitted an amended claim following obtaining the physician signature on the plan of care. This is an error in the timing of claim submission, however the solution results in Guardian retaining payment for the services provided after resubmission of an amended claim.

B. Response to OIG Recommendation to Consider Conducting Internal Audits for Claims After the Audit Period.

Guardian concurs with this recommendation insofar as it conducts periodic internal audits as part of its standard compliance program and will continue to do so.

## CONCLUSION

Thank you once again for the opportunity to present these comments to the Draft Report. We appreciate the work that the OIG has put into this effort, and we respectfully request that the OIG consider these comments in reviewing and revising the Draft Report.

Sincerely,

/Marc Bonora/

Marc Bonora - Chief Legal Officer

# 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.

## Who Is Protected?

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.

# Stay In Touch

Follow HHS-OIG for up to date news and publications.

 OIGatHHS

 HHS Office of Inspector General

Subscribe To Our Newsletter

OIG.HHS.GOV

# Contact Us

For specific contact information, please visit us online.

U.S. Department of Health and Human Services
Office of Inspector General
Public Affairs
330 Independence Ave., SW
Washington, DC 20201

Email: Public.Affairs@oig.hhs.gov