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OFFICE OF INSPECTOR GENERAL

DOCUMENTATION OF COVERAGE REQUIREMENTS FOR MEDICARE HOME HEALTH CLAIMS

Daniel R. Levinson
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EXECUTIVE SUMMARY: DOCUMENTATION OF COVERAGE REQUIREMENTS FOR HOME HEALTH CLAIMS
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WHY WE DID THIS STUDY

From 2002 to 2008, the number of home health agencies (HHA) grew by 39 percent from 7,052 to 9,801. Medicare spending on home health increased 84 percent from $8.5 billion in 2000 to $15.7 billion in 2007. The rise of home health spending leads to concerns about the potential for improper payments due to fraud and abuse.

HOW WE DID THIS STUDY

We reviewed medical records of home health care for a sample of 495 beneficiaries to determine whether Medicare coverage requirements were met. We also analyzed Medicare claims to document the extent to which patients were under the care of the physician ordering home health services. We calculated the proportion of claims that had a corresponding billing from a physician for visits with that beneficiary at any time 3 months before and 3 months after the episode of care.

WHAT WE FOUND

Our medical record review showed that in 2008, 98 percent of beneficiaries met the homebound requirement and needed skilled nursing care or therapy services and that beneficiaries were under the care of a physician. HHAs submitted 22 percent of claims in error because services were not medically necessary or claims were coded inaccurately, resulting in $432 million in improper Medicare payments. Also, HHAs upcoded (i.e., billed at a level higher than warranted) about 10 percent ($278 million) of claims and downcoded (i.e., billed at a level lower than warranted) about 10 percent ($184 million) of claims.

WHAT WE CONCLUDED

Identifying home health fraud and abuse is a significant challenge that requires concentrated and sustained efforts using a variety of methods. Given the general concern about risks to the Medicare program in the home health area, further investigations beyond the medical record are needed to determine whether beneficiaries are eligible, services are furnished, and Medicare requirements for payment are met. The Office of Inspector General will continue to monitor Medicare home health claims to determine whether the services are appropriate and merit payment.

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OBJECTIVES

1. To determine the extent to which home health medical records document compliance with Medicare coverage requirements.
2. To determine the appropriateness of payments for Medicare home health claims.

BACKGROUND

Medicare beneficiaries who are generally confined to their homes are eligible to receive certain medical services at home.[1] Home health services include part-time or intermittent skilled nursing care; physical, occupational, and speech therapy; medical social work; and home health aide services.[2] Home health provides treatment for an illness or injury and helps beneficiaries regain their independence and become as self-sufficient as possible.

Medicare Requirements for Home Health Services

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care or physical, speech, or occupational therapy; (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician.[3] For a home health agency (HHA) to receive payment from Medicare, a physician must certify the beneficiary's need for home health services and must recertify the need at least every 60 days.[4]

Homebound Status

Medicare considers beneficiaries homebound if, because of illness or injury, they have conditions that restrict their ability to leave their places of residence. Homebound beneficiaries do not have to be bedridden, but should be able to leave their residences only infrequently with "considerable and taxing effort" for short durations or for health care treatment.[5]

Intermittent Skilled Nursing or Therapy Services

The Social Security 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 the combined services are less than 8 hours each day and

[1] Social Security Act, § 1835(a)(2)(A).

[2] Social Security Act, § 1861(m); Centers for Medicare & Medicaid Services (CMS), *Medicare Benefits Policy Manual (MBPM)*, Pub. No. 100-02, ch. 7, § 40.

[3] 42 CFR § 424.22.

[4] Ibid.

[5] *MBPM*, ch. 7, § 30.1.1.

28 or fewer hours per week.[6] A registered nurse or licensed vocational nurse must provide the skilled nursing care.[7] Home health aide services include personal care, such as bathing and dressing, feeding, and simple dressing changes that do not require the skills of a licensed nurse.[8] Therapy services must be performed by a qualified therapist or therapy assistant under the supervision of a qualified therapist.[9]

Requirement To Be Under the Care of a Physician
Medicare requires that beneficiaries be under the care of a doctor of medicine, osteopathy, or podiatric medicine.[10] CMS expects the physician who signs the plan of care to see the beneficiary;[11] however, prior to April 2011, CMS did not require the ordering physician to see the beneficiary in person as a condition of payment for home health care.[12]

Established Plan of Care
Medicare pays for home health services only if they are provided under a plan of care that a physician establishes, approves, and periodically reviews.[13] A plan of care should list 12 items, including all pertinent diagnoses, functional limitations, frequency of visits to be made, and the types of services required.[14] The physician establishes the plan of care and must review, sign, and date it at least once every 60 days. If a beneficiary does not receive at least one covered home health visit within the 60-day episode, CMS considers the plan to be terminated.[15] Medicare reimburses physicians for establishing and reviewing the plan of care.

Home Health Prospective Payment System

In October 2000, CMS implemented the home health prospective payment system (PPS). Under PPS, a standardized payment is made for each 60-day episode of care that a beneficiary receives from an HHA. The PPS payment covers skilled nursing and home health aide visits, as well as covered therapy, medical social services, and routine medical supplies.[16]

HHAs use certain elements from the Outcome and Assessment Information Set (OASIS) to determine the payment amount for each 60-day episode of

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[6] Social Security Act § 1861(m).
[7] *MBPM*, ch.7, § 40.1.1.
[8] *MBPM*, ch.7, § 50.2.
[9] *MBPM*, ch.7, § 40.1.1.
[10] 42 CFR § 424.22(a)(iv).
[11] *MBPM*, ch.7, § 30.3.
[12] Patient Protection and Affordable Care Act (P.L. 111-148) (ACA), § 6407; CMS notice accessed at http://www.cms.gov on August 29, 2011.
[13] 42 CFR § 424.22(a)(iii).
[14] 42 CFR § 484.18; *MBPM*, ch.7, § 30.2.1.
[15] *MBPM*, ch.7, § 30.2.9.
[16] 65 Fed. Reg. 41128 (July 3, 2000).

care for each beneficiary. OASIS evaluates beneficiaries and measures outcomes using demographic, clinical, and functional data items. Elements of OASIS contribute to a score that the HHAs use to assign the individual to a Home Health Resource Group (HHRG). The HHRGs reflect beneficiaries' health conditions and their needs for care in three distinct areas: clinical severity, functional severity, and service utilization. The assignment to a given HHRG represents the amount of care that the HHA expects a beneficiary to need. A change in the group assignment can change the payment that the HHA receives for care of that individual. The HHA assigns the beneficiary to a Health Insurance Prospective Payment System (HIPPS) code that is based on the HHRG level.

2008 Changes to Home Health PPS

For home health care episodes paid prior to 2008, CMS adjusted the home health base payment by assigning beneficiaries to 1 of 80 HHRGs.[17] As of January 1, 2008, CMS significantly refined the home health payment method with the goal of reducing overpayments. Although HHAs continue to assign individuals to an HHRG using OASIS, the score now depends on the timing of the episode. CMS created a case-mix model that differentiates payment based on whether the beneficiary is in an early episode (i.e., a first or second episode) or a late episode (i.e., third episode and beyond), as well as whether the beneficiary has received more than 20 therapy visits. CMS also expanded the number of HHRGs from 80 to 153 to better capture the actual cost of care.

Home Health Fraud

In 2011, CMS assigned newly enrolling HHAs to the high-risk screening level because of program vulnerabilities that these entities pose to Medicare.[18] As early as 1997, the Office of Inspector General (OIG) reported on fraud in HHAs. OIG found that 40 percent of total services in HHA claims reviewed did not meet Medicare reimbursement requirements.[19] As part of its review, OIG interviewed beneficiaries or beneficiaries' family members, as well as the physicians who certified the plans of care. OIG also requested medical records to determine whether beneficiaries were homebound and whether the home health services were medically necessary.

Since that time, the Department of Health and Human Services (HHS) has changed Medicare payment requirements, suspended payments to some HHAs, and investigated and pursued criminal actions in its efforts to combat increasing Medicare fraud, waste, and abuse by HHAs.

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[17] 72 Fed. Reg. 49762 (Aug. 29, 2007).

[18] 76 Fed. Reg. 5862, 5870 (Feb. 2, 2011).

[19] OIG, *Review of Medicare Home Health Services in California, Illinois, New York, and Texas*, A-04-96-02121, July 1997.

Recent Changes in Medicare Home Health Payment Requirements

CMS makes additional payments, known as outlier payments, to compensate HHAs that supply services to beneficiaries who incur unusually large costs. However, in 2008 a number of HHAs in Miami-Dade County accounted for more outlier payments than did HHAs in the rest of the Nation combined.[20] In an attempt to mitigate vulnerabilities associated with outlier payments, in 2010 CMS capped outlier payments to individual HHAs at 10 percent of each HHA's total home health payments.[21]

To increase physician involvement with Medicare home health beneficiaries, as well as to provide additional clinical oversight for HHA-provided care, the ACA requires that physicians (or certain practitioners working with the physician) who certify beneficiaries as eligible for Medicare home health services have face-to-face encounters with those beneficiaries.[22] Such encounters must occur within a 120-day window: either within the 90 days before beneficiaries start home health care or up to 30 days after they start care. The signing practitioner must document who saw the patient and the date of the encounter; the practitioner must also describe how clinical findings support the beneficiary's eligibility for home health services.[23] CMS gave HHAs until April 1, 2011, to comply with this requirement.[24]

Health Care Fraud Prevention and Enforcement Action Team

In 2007, HHS and the Department of Justice (DOJ) established the joint Medicare Fraud Strike Force, which was designed to combat fraud through the use of Medicare data analysis and an increased focus on community policing.[25] Building on the success of the Strike Force, in 2009 HHS and DOJ established an interagency Health Care Fraud Prevention and Enforcement Action Team to combat health care fraud nationwide.[26] Now operating in 9 cities, Strike Force efforts have resulted in charges against 213 individuals or entities, 107 convictions, and $63.9 million in investigative receivables.[27]

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[20] OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, December 2009.

[21] 74 Fed. Reg. 58078 (Nov. 10, 2009).

[22] P.L. 111-148, § 6407.

[23] 42 CFR § 424.22(a)(1)(v); 75 Fed. Reg. 70372, 70464 (Nov. 17, 2010).

[24] CMS notice accessed at http://www.cms.gov on August 29, 2011.

[25] HHS, *Medicare Fraud Strike Force Operations Lead to Charges Against 53 Doctors, Health Care Executives and Beneficiaries for More than $50 Million in Alleged False Billing in Detroit* (news release), June 24, 2009. Accessed at http://www.hhs.gov/ on June 25, 2009.

[26] HHS, *Attorney General Holder and HHS Secretary Sebelius Announce New Interagency Health Care Fraud Prevention and Enforcement Action Team* (news release), May 20, 2009. Accessed at http://www.hhs.gov/ on June 19, 2009.

[27] HHS, *Semiannual Report to Congress*, Spring 2011.

For example, on July 13, 2011, a manager and a registered nurse from an HHA pleaded guilty to participating in an alleged $25 million Medicare billing scheme.[28] The two individuals falsified patient records to make it appear as though beneficiaries qualified for home health care and therapy services.

CMS Anti-Fraud Activities

In an evaluation of CMS-imposed Medicare payment suspensions in 2007 and 2008, OIG found that the great majority of suspended providers exhibited characteristics that suggested fraud.[29] Some of these suspensions were supported by information from beneficiaries. For example, beneficiaries told law enforcement or Government contractors that they received home health services even though they were not homebound.

Beginning in 2009, CMS and Zone Program Integrity Contractors (ZPIC) conducted a 2-year study regarding home health outlier payments.[30] The study consisted of interviewing beneficiaries to verify that they meet home health coverage requirements and visiting HHAs to review medical records to ensure that a physician who has some sort of relationship with the beneficiary signed a plan of care.

Overall, CMS and ZPICs found that not all beneficiaries were, in fact, homebound. Many were not at home when site visits were conducted. CMS and ZPICs also found that the physicians who signed the beneficiaries' plans of care were not the beneficiaries' regular physicians. These findings, among other factors, prompted CMS to suspend 32 home health providers from the Medicare program.

METHODOLOGY

Scope

Through review of the medical records, this evaluation determined the extent to which individual beneficiaries met Medicare coverage requirements for home health care. It also determined whether Medicare home health claims submitted and paid in 2008 were appropriate and whether higher rates of inappropriate payments existed among HHAs in geographical areas with patterns of aberrant billing than among HHAs in other areas. This study excluded episodes with four or fewer visits because they are reimbursed on a per-visit basis, as well as any claim with a reimbursement of less than $25.

[28] United States v. Nunez, S.D. Fla., No. 11-CR-20113.

[29] OIG, *The Use of Payment Suspensions To Prevent Inappropriate Medicare Payments*, OEI-01-09-00180, November 2010.

[30] Through CMS-awarded task orders, ZPICs detect and deter fraud, waste, and abuse of Medicare dollars by conducting investigations; referring cases to law enforcement; and taking administrative actions, such as referring overpayments to claims processors.

Data Sources

We used the following three data sources to analyze Medicare home health claims and payments: (1) the National Claims History File (NCH), (2) the Online Survey Certification and Reporting System (OSCAR), and (3) a medical record review of home health claims.

NCH. We used the NCH to select a sample for our medical record review. We calculated the proportion of claims that had corresponding billing from a physician for that beneficiary at any time 3 months before and 3 months after the episode of care. We also calculated the proportion of claims in our sample that documented whether the beneficiaries were under the care of the ordering physician.

Online Survey Certification and Reporting System. We downloaded OSCAR survey and deficiency data from the three most recent surveys and analyzed the number and trends of deficiencies associated with plans of care for beneficiaries.[31]

Home Health Medical Record Review. Through a contract with an independent firm, we conducted a medical record review of home health records for a sample of 495 beneficiaries.

Sample Selection

We obtained data on 5,536,018 home health claims from the NCH that were submitted in calendar year 2008. We used these data to select a stratified random sample of 495 home health claims. We divided the universe of home health claims from which we drew our sample into four strata using a set of five payment characteristics established in a previous OIG report that analyzed aberrant home health outlier payments.[32] See Appendix A for details on the sample selection.

Medical Record Collection

We provided the contractor with a list of claims. For each claim, we included the beneficiary's name, dates of services, and the name and address of the HHA. The contractor sent up to three written requests for medical records to each HHA and made additional telephone calls to each HHA, as needed. The contractor received 489 out of the 495 requested medical records, a 98.8-percent response rate. The contractor was unable to obtain six medical records because the HHAs had closed and the contractor was unable to determine the records' current locations; we dropped these medical

[31] CMS oversees compliance with Medicare health and safety standards for HHAs through the survey or inspection process. Performed by States on behalf of CMS, these surveys include conducting investigations, certifying and recertifying that HHAs meet Medicare's Conditions of Participation, and explaining requirements to providers with regard to applicable Federal regulations.

[32] OIG, *Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008*, OEI-04-08-00570, December 2009.

records from our sample. We followed OIG policies to protect personally identifiable information.

Medical Record Review

The contractor reviewed the OASIS assessment and other information in the home health medical record to determine whether HHAs correctly coded and documented each 60-day episode. The contractor used Medicare policy on coverage requirements as well as professional judgment to verify that the beneficiary qualified for home health services and determine whether the HHA had accurately coded the OASIS. Contractor staff provided a payment code based on their review of the medical record, which we then used to compare to the one billed by the HHA.

Based on the medical review, we calculated the proportion of claims that did not meet the Medicare program requirements. We also compared the proportion of inappropriate claims in each of the four strata, looking for differences among them.

Medicare Home Health Cost Analysis

We calculated the total dollar amount of claims that did not meet program requirements. This analysis included only Medicare home health claims that the contractor determined did not meet program requirements. In these situations, contractors reviewed the medical records to identify the appropriate diagnosis and calculated a new HIPPS code based on that information. We then used CMS's fiscal year 2008 Home Health Prospective Payment System PC Pricer software to calculate the resulting Medicare reimbursement amounts. For each claim, we calculated the reimbursement amount using the recalculated HIPPS code submitted by the contractor. To calculate the total dollar amount of claims that did not meet program requirements, we then compared the recalculated dollar amount to the amount paid to the HHA.

Limitations

This review assessed the HHA's medical record for the beneficiary but did not determine whether that record accurately reflected the beneficiary's medical condition. We did not physically confirm that the beneficiary was homebound or determine whether the care provided was medically necessary.

Standards

This study was conducted in accordance with the *Quality Standards for Inspection and Evaluation* issued by the Council of the Inspectors General on Integrity and Efficiency.

FINDINGS

Medical records document that almost all home health beneficiaries met Medicare coverage requirements

To qualify for home health care, a Medicare beneficiary must: (1) be homebound, (2) need skilled nursing care or therapy services, (3) be under the care of a physician, and (4) be under a plan of care that has been established and reviewed by a physician. Our medical record review showed that 98 percent of beneficiaries were homebound and almost all required skilled nursing care and skilled services. Our review also showed that 98 percent of beneficiaries were under the care of a physician. Finally, all medical records included a plan of care, but 36 percent lacked at least one specified element.

Medical records show that 98 percent of beneficiaries were homebound and needed skilled nursing care or therapy services

Our medical record review showed that in 2008, 98 percent of all beneficiaries met the criterion of being homebound. Each medical record stated why the beneficiary was homebound and that the beneficiary continued to be confined to the home. We were unable to determine whether the remaining 2 percent were homebound.

In addition to indicating compliance with the homebound requirement, all medical records indicated that each beneficiary needed intermittent skilled nursing care, physical therapy, or speech therapy or had a continuing need for occupational therapy (see Table 1). Furthermore, our medical record review determined that almost all medical records sufficiently documented that the skilled nursing care and therapy services were reasonable and necessary.

Table 1: Extent of Documentation for Home Health Skilled Care and Therapy Services

Type of Skilled Care and Therapy Service	Percentage of Claims Documenting That Beneficiary Required Service	Percentage of Claims Documenting That Care/Service Was Reasonable and Necessary
Skilled Nursing Care	92%	99%
Physical Therapy	53%	100%
Occupational Therapy	18%	100%
Speech Therapy	3%	100%

Source: OIG medical record review of home health claims for 2008.

Medical records show that beneficiaries were under the care of a physician

At the time of our review, CMS expected, but did not require, the physician who signed the plan of care to see the beneficiary at an unspecified interval of time. However, CMS did not explain how one might establish the physician-beneficiary relationship. For the purposes of our analysis, we used the signature on the plan of care as evidence of a relationship between the ordering physician and the beneficiary. Our review showed physicians' signatures on 98 percent of the plans of care, but 21 percent of those plans were missing the dates on which the physicians signed them. HHAs can submit a request for advance payment based on verbal orders by the physician; however, the plan of care must be both signed and dated by a physician prior to final payment of the claim.

To gain a better understanding of the relationship between the ordering physician and the beneficiary, we reviewed the home health record. Specifically, we reviewed physician orders, dates of phone calls, and progress notes to determine the extent to which the beneficiary was under the care of the ordering physician. Although 85 percent of the home health records included these items, only 11 percent of the records documented at least one face-to-face visit with the ordering physician.

We also reviewed separate Medicare claims data from any time 3 months before and 3 months after the episodes of care to determine how many beneficiaries had face-to-face visits with the physicians who ordered home health services.[33] We found that only 30 percent of beneficiaries had at least one visit during that 6-month period. Although Medicare did not require such visits at the time of our review, the ACA has since created this requirement, and CMS expected HHAs to comply as of April 1, 2011.

All medical records included a plan of care; however, 36 percent lacked at least one specified item

In particular, 18 percent of plans did not address discharge planning and 9 percent lacked information about rehabilitation potential (see Table 2 for a list of specified items). A plan of care that is truly comprehensive matches beneficiaries' needs with the appropriate level of services to improve their quality of life, maintain their independence, and avoid hospitalization or long-term care. Shortfalls in any area of the plan of care, therefore, can adversely affect beneficiaries' outcomes.

[33] Our analysis of face-to-face encounters with the ordering physician differs from CMS's requirement in two ways. First, we looked at all episodes of care, whereas CMS's requirement is limited to the first episode of care. Second, our review included any visit 3 months before and 3 months after the episode of care, whereas CMS requires the qualifying visit to occur within a shorter period—3 months before or 30 days after the start of home health care.

Table 2: Specified Items Missing From Home Health Plans of Care

Plan of Care Item	Percentage of Plan of Care Item Not Documented
Discharge plan	18%
Rehabilitation potential	9%
Instructions for timely discharge or referral	7%
Frequency of visits to be made	6%
Types of services, supplies, and equipment required	2%
Prognosis	2%
Functional limitations	1%
Mental status	1%
Activities permitted	1%
Nutritional requirements	1%
All medications and treatments	1%
Safety measures to protect against injury	0%

Source: OIG medical record review of home health claims, 2010.

State surveys also show vulnerabilities in care planning. These surveys aim to ensure that HHAs are meeting Medicare's conditions of participation. From 2008 through 2010, State surveyors cited deficiencies related to care planning more often than any other deficiency. In 2008, they cited 12 percent of HHAs for not following a written plan of care established and periodically reviewed by a physician. They also cited 9 percent of all HHAs because the plans of care were missing required items.

Home health agencies submitted 22 percent of claims in error in 2008, resulting in $432 million in improper payment

Our medical record review showed that HHAs submitted 22 percent of claims in error because services were not necessary or claims were coded inaccurately. This $432 million in improper payments represented about 2.5 percent of the total $17 billion in Medicare home health payments in 2008. Two percent ($328 million) of claims were for services that were not medically necessary. The beneficiaries associated with these claims were not homebound, not in need of skilled nursing care, or not under the care of a physician.

Our medical record review also showed that HHAs upcoded about 10 percent of claims, i.e., billed them at a level higher than the beneficiaries'

conditions warranted. HHAs also downcoded about 10 percent of claims, i.e., billed them at a level lower than the beneficiaries' conditions warranted (see Table 3). Although estimated overpayments for upcoded claims were $278 million and estimated underpayments for downcoded claims were $184 million, we cannot reliably estimate the difference. Table 3 shows the error rates.

Table 3: Percentage of Miscoded Home Health Services, 2008

Type of Error	Error Rate
Incorrect code	20.2%
Upcoded	10.4%
Downcoded	9.8%
Medically unnecessary services	2.1%
Insufficient documentation	0%
Total error rate*	**21.8%**

Source: OIG medical record review of home health claims for 2008.

* Total error rate does not equal the combined types of errors because 0.5 percent of claims had overlapping errors.

Upcoding often resulted because HHAs assigned inappropriate diagnosis codes to the beneficiaries. When an HHA adds certain diagnosis codes to a beneficiary's primary diagnosis code, the payment will increase for that beneficiary. Although a beneficiary may be accurately diagnosed with a disease, it is appropriate to list it for payment purposes only when the plan of care addresses the condition. For example, our review found that some HHAs inappropriately listed gastroesophageal reflux disease (GERD) as a diagnosis with no further documentation related to this diagnosis other than listing the GERD medication that the beneficiary was taking. Conversely, the reviewers supported the GERD diagnosis as appropriate in cases that included documentation on diet and medication education along with an assessment that specifically addressed the GERD diagnosis.

Additionally, we did not find different rates of miscoding among HHAs that exhibited aberrant billing patterns in counties that OIG had identified in previous studies.

CONCLUSION

Our medical record review showed that HHAs nearly always document the information necessary to demonstrate compliance with Medicare coverage and payment requirements. Our study identified only 2 percent of claims as being for services that were not medically necessary. However, other OIG studies and investigations, as well as joint efforts between HHS and DOJ,

have demonstrated that home health is an area at increased risk for fraud. In 2011, CMS assigned newly enrolling HHAs to the high risk screening level because of program vulnerabilities that these entities pose to Medicare.

The nature of the Medicare home health benefit relies on an HHA's documentation that a beneficiary is homebound and needs skilled nursing care or therapy. The ACA recognized the need to enhance the physician's responsibility for certifying the need for home health services by requiring face-to-face contact with beneficiaries.

Our review found that providers generally include adequate documentation in the medical record to support their claims for Medicare payment. Because our review did not look further at whether records were accurate, whether beneficiaries were eligible for the benefit, or whether the services were actually furnished, we can make no judgment about the extent to which these claims were properly paid. That determination would require additional investigation, such as site visits and interviews with physicians and beneficiaries.

Identifying home health fraud and abuse is a significant challenge that requires concentrated and sustained efforts using a variety of methods. Given the general concern about risks to the Medicare program in the home health area, we conclude that further investigations beyond the medical record are needed to determine whether beneficiaries are eligible, services are furnished, and Medicare requirements for payment are met. OIG will continue to monitor Medicare home health claims to determine whether the services are appropriate and merit payment.

AGENCY COMMENTS

In its comments on the draft report, CMS stated that it has begun using technologies and analytic tools to prevent fraudulent payments and identify risky providers and claims. The agency also noted the importance of the new requirement for face-to-face interaction between the home health provider and beneficiaries.

For the complete text of CMS's comments, see Appendix C.

APPENDIX A

Detailed Sampling Methodology

In an earlier study—*Aberrant Medicare Home Health Outlier Payment Patterns in Miami-Dade County and Other Geographic Areas in 2008* (OEI-04-08-00570)—the Office of Inspector General (OIG) matched providers' ZIP Codes to the corresponding counties and calculated the total number of home health providers in each county. In this study, OIG calculated the total amount that Medicare paid for the home health claims by county, provider, and beneficiary and calculated the outlier amounts included in those payments. Using this information, OIG calculated the following five payments and rates nationally, as well as that for each county and home health provider listed on the claims:[34]

1. average outlier payment per provider;[35]
2. average outlier payment per beneficiary;[36]
3. average outlier payment per claim;
4. outlier payment rates (i.e., outlier payments as a percentage of total home health payments); and
5. outlier payment rates for claims with a primary diagnosis related to diabetes (i.e., outlier payments for claims with a primary diagnosis related to diabetes as a percentage of total home health payments).[37]

We define payments as aberrant if they are at least twice the national average for three or more of the above five calculations.

The four mutually exclusive strata are:

- Stratum 1: 100 claims with a total reimbursement less than $2,500,
- Stratum 2: 200 claims with a total reimbursement greater than or equal to $2,500,
- Stratum 3: 75 claims from providers not in stratum 1 or 2 and not located in aberrant counties identified in the previous OIG study, and

[34] According to the U.S. Census Bureau, there were 3,141 counties or county equivalents in the United States in 2007. There were 2,158 counties or county equivalents listed on the claims we reviewed.

[35] This value is the equivalent of total outlier payments for an individual home health provider.

[36] Some beneficiaries received services from more than one home health provider. These beneficiaries were counted more than once when calculating the average outlier payment per beneficiary for each home health provider.

[37] Services related to diabetes may constitute a payment vulnerability in the Medicare program. For example, some home health providers received Medicare payments for reportedly providing insulin injections to beneficiaries who did not qualify for home health services because they were not confined to their homes.

- Stratum 4: 120 claims from providers that were not in stratum 1 or 2 and that were located in aberrant counties identified in the previous OIG study. (See Table A-1).

Table A-1: Descriptions of Four Strata

Stratum	Stratum Description	Number of Claims in Population	Sample Size
1	Claims with total reimbursement < $2,500	2,515,212	100
2	Claims with total reimbursement ≥ $2,500	2,111,072	200
3	Claims from providers that were not in stratum 1 or 2 and not located in aberrant counties identified in the previous OIG study	502,356	75
4	Claims from providers that were not in stratum 1 or 2 and were located in aberrant counties identified in the previous OIG study	407,378	120
Total		**5,536,018**	**495**

APPENDIX B

Selected Point Estimates and Confidence Intervals

Table B-1: Estimates Regarding Miscoded Claims and Inappropriate Payments

Type of Estimate	Sample Size	Point Estimate ($ in millions)	95-Percent Confidence Interval ($ in millions)
Percentage of claims that were upcoded in 2008	489	10.4%	7.2%–13.6%
Percentage of claims that were downcoded in 2008	489	9.8%	6.5%–13.1%
Percentage of claims that were appropriately coded	489	79.8%	75.5%–84.1%
Percentage of claims that were inappropriately coded	489	20.2%	15.9%–24.5%
Percentage of claims for services that were medically unnecessary	489	2.1%	0.9%–4.6%
Percentage of claims that had overlapping errors	489	0.5%	0.1%–3.2%
Percentage of claims that did not meet Medicare program requirements	489	21.8%	17.4%–26.3%
Total amount of inappropriate home health payments	489	$431.5	$285.9–$576.5
Amount of inappropriate payments due to upcoding	489	$278.0	$184.1–$371.8
Amount of inappropriate payments due to downcoding	489	$184.3	$109.4–$259.3
Amount of overpayments due to medically unnecessary services	489	$328.0	$83.0–$575.5

Source: Office of Inspector General (OIG) medical record review of home health claims for 2008.

Table B-2: Estimates Regarding Plan of Care Items

Characteristic in Medical Records	Sample Size	Point Estimate	95-Percent Confidence Interval
Contained a plan of care	489	100%	*
Lacked at least one required element	489	35.5%	30.5%–40.9%
Lacked documentation on discharge plan	489	17.9%	14.1%–22.6%
Lacked documentation on rehabilitation potential	489	9.4%	6.7%–12.9%
Lacked documentation on instructions for timely discharge or referral	489	7.0%	4.8%–10.0%
Lacked documentation on frequency of visits to be made	489	6.3%	4.2%–9.3%
Lacked documentation on types of services, supplies, and equipment required	489	1.8%	0.9%–3.5%
Lacked documentation on prognosis	489	2.0%	0.9%–4.6%
Lacked documentation on functional limitations	489	0.6%	0.2%–1.6%
Lacked documentation on mental status	489	0.6%	0.2%–1.8%
Lacked documentation on activities permitted	489	1.1%	0.3%–3.5%
Lacked documentation on nutritional requirements	489	1.1%	0.5%–2.4%
Lacked documentation on all medications and treatments	489	1.1%	0.4%–3.0%
Lacked documentation on safety measures to protect against injury	489	0.2%	0%–1.4%

Source: OIG medical record review of home health claims for 2008.

*We are unable to calculate a confidence interval for this point estimate. We are confident that the point estimate accurately predicts the population value.

Table B-3: Estimates Regarding Requirements for Home Health Coverage

Requirement	Sample Size	Point Estimate	95-Percent Confidence Interval
Beneficiaries were homebound	489	98.3%	96.5%–99.2%
Beneficiaries had an uncertain homebound status	489	1.7%	0.7%–4.22%
Beneficiaries received skilled nursing care	489	92.3%	89.1%–94.6%
Skilled nursing care was reasonable and necessary	489	99.4%	97.5%–99.7%
Beneficiaries received physical therapy	489	53.3%	48.5%–58.1%
Physical therapy was reasonable and necessary	489	100%	*
Beneficiaries received occupational therapy	489	17.8%	14.2%–21.6%
Occupational therapy was reasonable and necessary	489	100%	*
Beneficiaries received speech therapy	489	3.1%	1.96%–4.92%
Speech therapy was reasonable and necessary	489	100%	*

Source: OIG medical record review of home health claims for 2008.

*We are unable to calculate a confidence interval for this point estimate. We are confident that the point estimate accurately predicts the population value.

Table B-4: Estimates Regarding Physician Involvement With Home Health Beneficiaries

Type of Estimate	Sample Size	Point Estimate	95-Percent Confidence Interval
Percentage of physicians who signed the plans of care	489	98.0%	95.4%–99.1%
Percentage of plans of care that were missing the date on which the physicians signed them	489	21.1%	15.2%–27.1%
Percentage of medical records indicating that the beneficiaries were under the care of the ordering physicians	489	84.6%	80.6%–88.5%
Percentage of medical records that documented at least one visit by the ordering physician	489	10.7%	7.2%–14.1%
Percentage of beneficiaries who did not have face-to-face visits with the ordering physicians during the 3 months before or after their home health episodes of care	489	30.0%	25.1%–34.8%

Source: OIG medical record review of home health claims for 2008.

APPENDIX C

Agency Comments

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: JAN 2 7 2012

TO: Daniel R. Levinson
Inspector General

FROM: /S/
Marilyn Tavenner
Acting Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Documentation of Coverage Requirements for Medicare Home Health Claims" (OEI-01-08-00390)

Thank you for the opportunity to review and comment on the OIG draft report titled, "Documentation of Coverage Requirements for Medicare Home Health Claims" (OEI-01-08-00390). The Centers for Medicare & Medicaid Services (CMS) appreciates the time and resources OIG has invested to review this issue. OIG's audit focused on a medical record review of home health records for a sample of beneficiaries to determine if Medicare coverage requirements were met. The objective of the audit was to determine the extent to which these records document compliance with Medicare coverage requirements and to determine payment accuracy for Medicare home health claims. OIG reported two findings to CMS for consideration. Its major findings stated the following: 1) medical records document that almost all home health beneficiaries met Medicare coverage requirements and 2) home health agencies submitted 22 percent of claims in error in 2008.

The CMS is committed to reducing improper payments in the Medicare Fee-For-Service program. CMS will continue to use its available resources to ensure home health claims are paid in accordance with Medicare coverage requirements and billing policy. CMS considers the return on investment and other workload issues when determining the allocation of these resources to address vulnerabilities. We focus our medical review resources on the most highly vulnerable areas identified through any number of sources, including but not limited to, using internal data analysis tools and OIG reports.

The OIG reported findings on types of errors. OIG found that only 2 percent of claims were not medically necessary and determined that the majority of the estimated $432 million dollars in improper payments were due to coding errors (upcoded overpayments or downcoded underpayments). CMS recognizes the significance of the estimated improper payments in this report. Therefore, we will share this report with our contractors to consider as they determine where to focus resources in the future.

The CMS is committed to using new and innovative approaches to aggressively prevent fraud, waste and abuse. The Agency is implementing a rigorous prevention program that uses advanced analytics and technologies to identify fraud before payment. With the authorities and funding in the Small Business Jobs Act of 2010, CMS launched the Fraud Prevention System (FPS) on June 30, 2011, as part of an end-to-end solution for preventing fraudulent payments.

The CMS has in place an innovative system of predictive analytics and other sophisticated analytic tools that are applied to home health claims along with all Medicare Part A, Part B, and Durable Medical Equipment (DME) claims through the FPS. The providers and associated claims identified in real-time as high risk are prioritized in the FPS. Risky provider behavior is investigated and appropriate administrative actions are administered based on the findings of the investigation. CMS is continuously developing additional analytical models and refining existing models to isolate and prioritize risky behavior.

In addition, beginning April 1, 2011, all patients needing Medicare reimbursed home health care services are required to have a documented face-to-face encounter with an eligible health care provider within the 90-day period before or 30 days after the initiation of needed home health care services. The purpose of this mandate is to assure that the order for home care is based on current knowledge of the patient's condition. Under this new requirement, the provider must document that he or she has had a face-to-face encounter with the patient in this timeframe.

The CMS appreciates OIG's efforts and insight on this report. CMS looks forward to continually working with OIG on issues related to waste, fraud and abuse in the Medicare program.

Attachment

ACKNOWLEDGMENTS

This report was prepared under the direction of Joyce Greenleaf, Regional Inspector General for Evaluation and Inspections in the Boston regional office, and Russell Hereford, Deputy Regional Inspector General.

Danielle Fletcher served as the team leader for this study. Other principal Office of Evaluation and Inspections staff from the Boston regional office who contributed to the report include Tim Chettiath; central office staff who contributed include Clarence Arnold and Sandy Khoury.

Office of Inspector General

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The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These assessments help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

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