Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

METROPOLITAN JEWISH HOME CARE, INC., BILLED FOR HOME HEALTH SERVICES THAT DID NOT COMPLY WITH MEDICARE REQUIREMENTS

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

The designation of financial or management practices as questionable, a recommendation for the disallowance of costs incurred or claimed, and any other conclusions and recommendations in this report represent the findings and opinions of OAS. Authorized officials of the HHS operating divisions will make final determination on these matters.

Report in Brief
Date: May 2019
Report No. A-02-16-01001

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Metropolitan Jewish Home Care, Inc., Billed for Home Health Services That Did Not Comply With Medicare Requirements

Why OIG Did This Review

Under the home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies.

Our prior reviews of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

Metropolitan Jewish Home Care, Inc., (Metropolitan) located in Brooklyn, New York, received Medicare reimbursement of $500 or more for 18,318 claims for home health services provided during calendar years (CYs) 2013 and 2014, totaling $62.8 million.

Our objective was to determine whether Metropolitan complied with Medicare requirements for billing home health services on claims.

How OIG Did This Review

We reviewed a stratified random sample of 100 of Metropolitan's home health claims. We evaluated the claims for compliance with selected billing requirements and submitted them to medical review.

What OIG Found

Metropolitan did not comply with Medicare billing requirements for 11 of the 100 home health claims that we reviewed. For these claims, Metropolitan received overpayments of $34,514 for services provided during CYs 2013 and 2014. Specifically, Metropolitan incorrectly billed Medicare for beneficiaries that were not homebound or did not require skilled services. In addition, Metropolitan received reimbursement for claims for which the services were not supported by documentation. On the basis of our sample results, we estimated that Metropolitan received overpayments of at least $2.9 million for the audit period. All of the incorrectly billed claims are now outside of the Medicare reopening period; therefore, we are not recommending recovery of the overpayments.

What OIG Recommends and Metropolitan Comments

We recommend that Metropolitan exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with our recommendations. We also recommend that Metropolitan strengthen its procedures to ensure that (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented (2) beneficiaries are receiving only reasonable and necessary skilled services and (3) reimbursement for services comply with Medicare documentation requirements.

In written comments on our draft report, Metropolitan generally disagreed with our findings and recommendations and stated that nearly all of its claims for home health services complied with Medicare payment requirements. After reviewing Metropolitan's comments and additional documentation provided, we revised our findings and related recommendations for 19 claims that we questioned in our draft report and eliminated 2 findings. We maintain our findings and determinations, as revised, are valid.

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INTRODUCTION

WHY WE DID THIS REVIEW

For calendar year (CY) 2016, Medicare paid home health agencies (HHAs) about $18 billion for home health services. The Centers for Medicare & Medicaid Services' (CMS) Comprehensive Error Rate Testing program determined that the 2016 improper payment error rate for home health claims was 42 percent, or about $7.7 billion. Although Medicare spending for home health care accounts only for about 5 percent of fee-for-service spending, improper payments to HHAs account for more than 18 percent of the total 2016 fee-for-service improper payments ($41 billion). This review is part of a series of reviews of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Metropolitan Jewish Home Care and Hospice, Inc., (Metropolitan) was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Metropolitan complied with Medicare requirements for billing home health services.

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers part-time or intermittent skilled nursing care and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments using a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcomes and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS)

payment codes[1] and represent specific sets of patient characteristics.[2] CMS requires HHAs to submit OASIS data as a condition of payment.[3]

CMS administers the Medicare program and contracts with four of its Medicare Administrative Contractors (MACs) to process and pay claims submitted by HHAs.

Home Health Agency Claims at Risk for Incorrect Billing

In prior years, our reviews at other HHAs identified findings in the following areas:

- beneficiaries did not always meet the definition of "confined to the home,"
- beneficiaries were not always in need of skilled services,
- HHAs did not always submit the OASIS in a timely fashion, and
- services were not always adequately documented.

For the purposes of this report, we refer to these areas of incorrect billing as "risk areas."

Medicare Requirements for Home Health Agency Claims and Payments

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 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis, needs physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician; and

[1] HIPPS payment codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and HHAs.

[2] The final payment is determined at the conclusion of the episode of care using the OASIS information but also factoring in the number and type of home health services provided during the episode of care.

[3] 42 CFR §§ 484.20, 484.55, 484.210(e), and 484.250(a)(1); 74 Fed. Reg. 58077, 58110-58111 (Nov. 10, 2009); and CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1.

- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition for payment, a physician must certify that a face-to-face 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)). 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 reflected in the home health plan of care, the OASIS as required by 42 CFR § 484.55, or a medical record of the individual patient" (*Medicare Benefit Policy Manual* (the Manual), chapter 7, § 20.1.2). Coverage determination is not made solely on the basis of general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care (42 CFR § 409.44(a)).

OIG believes that this audit report constitutes credible information of potential overpayments. Providers that receive notification of these potential overpayments must (1) exercise reasonable diligence to investigate the potential overpayment, (2) quantify any overpayment amount over a 6-year lookback period, and (3) report and return any overpayments within 60 days of identifying those overpayments (60-day rule).[4]

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

Metropolitan Jewish Home Care, Inc.

Metropolitan is a not-for-profit HHA located in Brooklyn, New York. National Government Services, its MAC, paid Metropolitan $63.2 million for 19,558 claims for services provided during CYs[5] 2013 and 2014 (audit period)[6] on the basis of CMS's National Claims History (NCH) data.

[4] The Act § 1128J(d); 42 CFR part 401 subpart D; 42 CFR §§ 401.305(a)(2) and (f); and 81 Fed. Reg. 7654, 7663 (Feb. 12, 2016).

[5] CYs were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary. We selected these "through" dates falling within CYs 2013 and 2014, therefore claims subjected to audit could include dates of service prior to CY 2013.

[6] This timeframe represented the most recent data available at the start of our audit.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $62,818,762 in Medicare payments to Metropolitan for 18,318 claims with payments of $500 or more.[7] These claims were for home health services provided during the most recent timeframe for which data was available at the start of the audit (CYs 2013 and 2014). We selected a stratified random sample of 100 claims with payments totaling $332,259 for review. We evaluated compliance with selected billing requirements and submitted these claims to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

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

Appendix A contains the details of our audit scope and methodology. Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the types of errors for each sample item.[8]

FINDINGS

Metropolitan did not comply with Medicare billing requirements for 11 of the 100 home health claims that we reviewed. For these claims, Metropolitan received overpayments of $34,514 for services provided in CYs 2013 and 2014. Specifically, Metropolitan incorrectly billed Medicare for:

- services provided to beneficiaries were not homebound (2 claims),
- services provided to beneficiaries who did not require skilled services (3 claims), and
- services for which the documentation from the certifying physician was not provided or did not support the services provided (7 claims).

Of the 11 claims that did not comply with Medicare requirements, 1 claim contained more than 1 deficiency. These errors occurred primarily because Metropolitan did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

[7] A claim is defined as an episode of care received during a 60-day period. An HHA submits a claim for Medicare payment for each episode of care.

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

On the basis of our sample results, we estimated that Metropolitan received overpayments of at least $2,979,377 for the audit period.[9]

METROPOLITAN BILLING ERRORS

Metropolitan incorrectly billed Medicare for 11 of the 100 sampled claims, which resulted in overpayments of $34,514.

Beneficiaries Were Not Homebound

Federal Requirements for Home Health Services

For the reimbursement of home health services, the beneficiary must be "confined to the home" (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42)). According to section 1814(a) of the Act:

> [A]n individual shall be considered to be "confined to his home" if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 20.1.2). Revision 1 of § 30.1.1 (effective October 1, 2003) and Revision 172 of § 30.1.1 (effective November 19, 2013) covered different parts of our audit period.

Revision 1 states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. Generally speaking, patients will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

[9] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

Revision 172 states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home and an individual will be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria 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 Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Metropolitan Did Not Always Meet Federal Requirements for Home Health Services

For two of the sampled claims, Metropolitan incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements[10] for being homebound or Metropolitan did not document the specific factors that qualified the beneficiaries as homebound.[11]

Example 1: Beneficiary Not Homebound

The documentation for one beneficiary did not support that the beneficiary was homebound, as her ability to leave the home was not limited due to a cognitive impairment, impaired vision or hearing, weight-bearing restrictions, or shortness of breath. In addition, the beneficiary did not require use of an assistive device or special transportation and did not have a condition such that leaving home was medically contraindicated. Further, leaving the home would not require a considerable or taxing effort.

[10] The two claims had dates of service during the period covered by the Revision 172 of § 30.1.1.

[11] Of these two claims with homebound errors, one claim was also billed with skilled services that were not medically necessary. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

These errors occurred because Metropolitan did not have adequate oversight procedures to ensure that it verified and continually monitored the homebound status of Medicare beneficiaries under its care and properly documented the specific factors that qualified the beneficiaries as homebound.

Beneficiaries Did Not Require Skilled Services

Federal Requirements for Skilled Services

A Medicare beneficiary must be in need of skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy (The Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42(c))). In addition, skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).[12] Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2.1). Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patients 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 (the Manual, chapter 7, § 20.1.2).

Metropolitan Did Not Always Meet Federal Requirements for Skilled Services

For three of the sampled claims, Metropolitan incorrectly billed Medicare for a beneficiary who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.[13]

Example 2: Beneficiary Did Not Require Skilled Services

One beneficiary did not have a new event or an exacerbation of an existing event that would require the skills of home care professionals. While the patient may have benefitted from skilled services, there was no clear indication that the patient benefitted from home care services in a way that would have prevented further deterioration or lessen the degree of pain.

[12] Skilled nursing services can include observation and assessment of a patient's condition, management and evaluation of a patient plan of care, teaching and training activities, and administration of medications, among other things (the Manual, chapter 7, § 40.1.2).

[13] Of these three claims with skilled need services that were not medically necessary, one claim was also billed for a beneficiary with a homebound error. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

These errors occurred because Metropolitan did not always provide sufficient clinical review to verify that beneficiaries initially required skilled services.

Missing or Insufficient Documentation

Federal Documentation Requirements

Medicare pays for home health services only if a physician certifies that the beneficiary meets the coverage requirements specified in the statute and regulations (sections 1814(a)(2) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)). Prior to certifying a patient's eligibility for home health services, the certifying physician must document that he or she (or an allowed nonphysician practitioner) had a face-to-face patient encounter related to the primary reason the patient requires home health services. In addition, the certifying physician must document the encounter either on the certification, which the physician signs and dates, or in a signed addendum to the certification (42 CFR § 424.22(a) and the Manual chapter 7, § 30.5.1.1).

Federal regulations (42 CFR § 484.210(e) and CMS's *Medicare Program Integrity Manual*, chapter 3, § 3.2.3.1) state that HHAs are required to submit OASIS data as a condition of payment and instruct the Medicare contractors not to pay claims that lack OASIS data. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the HIPPS rate codes and represent specific sets of patient characteristics.

Metropolitan Did Not Always Meet Federal Documentation Requirements

For seven of the sampled claims, Metropolitan incorrectly billed Medicare for home health episodes that did not meet the Medicare documentation requirements for physicians' certifications or service delivery. These claims contained the following types of errors:

- the face-to-face encounter was not documented in the medical record (one claim);
- OASIS data were not submitted or were submitted after the claim was paid (five claims); and
- the delivery of home health services was not adequately documented (one claim).

These errors occurred primarily because Metropolitan did not have sufficient procedures to always ensure that the physician's certification complied with Medicare documentation requirements and that it maintained records that supported the services Metropolitan provided.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Metropolitan received overpayments totaling at least $2,979,377 for the audit period.

RECOMMENDATIONS

We recommend that Metropolitan:

- for the estimated $2,979,377 overpayment for all claims outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation;

- exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period, in accordance with the 60-day rule, and identify any returned overpayments as having been made in accordance with this recommendation; and

- strengthen its procedures to ensure that:

    - the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented,

    - beneficiaries are receiving only reasonable and necessary skilled services, and

    - physicians' certifications comply with Medicare documentation requirements and its records support the services Metropolitan provided.

METROPOLITAN COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Metropolitan generally disagreed with our findings and recommendations. (The draft report had four recommendations which we have revised to three.) For the first recommendation, to refund overpayments for incorrectly billed claims,[14] Metropolitan stated that nearly all of its claims for home health services complied with Medicare payment requirements. Specifically, Metropolitan disagreed with our determinations for 28 of the 30 claims questioned in our draft report and, under separate cover, provided

[14] The first recommendation in the draft report was to refund to the Medicare program the portion of the estimated overpayment for claims incorrectly billed that are within the reopening period. We have since removed this recommendation because all of the incorrectly billed claims will be outside of the reopening period when this report is issued.

additional documentation related to these claims.[15] Metropolitan's comments are included as Appendix F.[16]

After reviewing Metropolitan's comments and the additional documentation provided, we revised our findings (including one example) and related recommendations for 19 claims that we questioned in our draft report. Specifically, we are no longer questioning nine claims for noncompliance with Medicare homebound requirements and five claims with missing documentation. In addition, we eliminated two findings: one finding related to nine claims with an incorrect HIPPS billing code and a second finding related to one claim for services not provided in accordance with the plan of care.[17] We maintain that our findings and recommendations, as revised, are valid.

BENEFICIARIES WERE NOT HOMEBOUND

Metropolitan Comments

Metropolitan disagreed with our determination that, for 11 claims identified in our draft report, the associated beneficiary did not meet the Medicare requirement for being homebound. Metropolitan stated that we inappropriately applied Medicare requirements set forth in the 2013 version of the Manual, which became effective on November 19, 2013, for claims for services provided prior to the effective date. Metropolitan stated that we should redetermine claims for services provided prior to the effective date using requirements under the 2003 version of the Manual.

Office of Inspector General Response

After reviewing Metropolitan's comments and the 2003 version of the Manual, we reversed our determinations for nine claims identified in the draft report as not complying with Medicare homebound requirements. For the remaining two claims, the independent medical review contractor determined that the associated beneficiary still did not meet the Medicare requirement for being homebound using requirements under the 2003 version of the Manual.

[15] The determinations for 21 of these claims were based on focused medical review by an independent medical review contractor. The medical reviewers determined whether the services billed met medical necessity and coding requirements. The determinations for 10 claims were based on our review of Metropolitan's billing records. The total exceeds 28 because the determinations for 3 claims were based on both medical review and our review of Metropolitan's billing records.

[16] We did not include exhibits submitted as attachments to Metropolitan's comments because they contained personally identifiable information.

[17] The total exceeds 19 because 5 claims contained more than 1 deficiency.

BENEFICIARY DID NOT REQUIRE SKILLED SERVICES

Metropolitan Comments

Metropolitan disagreed with our determination that, for three claims, the associated beneficiary did not meet the Medicare requirements for coverage of skilled nursing or therapy services. Metropolitan stated that we applied excessive documentation standards for establishing a skilled need beyond that of the 2003 version of the Manual or the Federal Medicare statute.[18]

Office of Inspector General Response

We maintain that the beneficiaries associated with the three claims did not meet Medicare requirements for coverage of skilled nursing or therapy services. The independent medical review contractor determined that the documentation provided for these claims did not indicate sufficient clinical review to verify that the associated beneficiaries required skilled services.

MISSING OR INSUFFICIENT DOCUMENTATION

Metropolitan Comments

Metropolitan disagreed with our determinations for 9 of the 12 claims identified in our draft report as not meeting Medicare documentation requirements for physicians' certifications or service delivery. Metropolitan provided additional documentation related to five of the claims[19] and, for four others, attested that it appropriately submitted OASIS data to CMS. Specifically, Metropolitan attested that for two claims, it inadvertently overwrote the original OASIS submission date when updating OASIS data and, for two other claims, stated that we should have been able to locate evidence of the OASIS data submission to make a determination.

Office of Inspector General Response

After reviewing the additional documentation provided by Metropolitan, we revised our determinations for five claims. We maintain that our findings related to the claims for which Metropolitan did not appropriately submit OASIS data are valid. We verified with CMS that OASIS data were not submitted in accordance with Medicare requirements.

[18] 42 U.S.C. § 1395f(a).

[19] The additional documentation consisted of notes related to the delivery of home health services (four claims) and the reassessment of a beneficiary (one claim).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $62,818,762 in Medicare payments to Metropolitan for 18,318 home health claims with episode-of-care through dates in CYs 2013 and 2014. From this sample frame, we selected for review a stratified random sample of 100 home health claims with payments totaling $332,259. These claims for home health services had dates of service primarily in CYs 2013 or 2014.

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

We limited our review of Metropolitan's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

We conducted our fieldwork at Metropolitan from January 2015 through March 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Metropolitan's paid claims data from CMS's NCH file, a database of all home health claims for services provided by Metropolitan during CYs 2013 and 2014, and removed claims with paid amounts less than $500;
- created a sample frame of 18,318 claims totaling $62,818,762;
- selected a stratified random sample of 100 claims totaling $332,259 for detailed review (Appendix C);
- used computer matching, data mining, and analysis techniques to identify claims at risk for noncompliance with selected Medicare billing requirements;
- 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 Metropolitan to support the sampled claims;

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

- reviewed Metropolitan's procedures for billing and submitting Medicare claims;

- verified State licensure information for selected medical personnel providing services to the patients in our sample;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample to estimate the total Medicare overpayments to Metropolitan for our audit period (Appendix D);

- discussed the results of our review with Metropolitan officials; and

- requested our medical reviewer re-review the additional documentation provided by Metropolitan in its comments to our draft report.

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

GENERAL MEDICARE 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 that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcomes; and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes Medicare uses in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify patients who are similar clinically in terms of resources used.

CMS requires the submission of OASIS data as a condition of payment as of January 1, 2010 (42 CFR § 484.210(e); 74 Fed. Reg. 58078, 58110 (Nov. 10, 2009); and CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1).

COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (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 therapy;[20] (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 (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 CFR § 409.42, and the Manual, chapter 7, § 30).

[20] 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)).

Per the Manual, chapter 7, § 20.1.2, whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS, or a medical record of the individual patient.

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

Section 6407(a) of the Affordable Care Act[21] added a requirement to §§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Act stating that the physician must have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient 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 by including the date of the encounter.[22]

Confined to the Home

For the reimbursement of home health services, the beneficiary must be "confined to the home" (The Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42)). According to section 1814(a) of the Act:

> [A]n individual shall be considered to be "confined to his home" if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 20.1.2). Revision 1 of § 30.1.1 (effective October 1, 2003) and Revision 172 of § 30.1.1 (effective November 19, 2013) covered different parts of our audit period.

[21] The Patient Protection and Affordable Care Act, P.L.No. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

[22] See 42 CFR § 424.22(a)(1)(v) and the Manual, chapter. 7, § 30.5. The initial effective date for the face-to-face requirement was January 1, 2011. However, on December 23, 2010, CMS granted HHAs additional time to establish protocols for newly required face-to-face encounters. Therefore, documentation regarding these encounters must be present on certifications for patients with starts-of-care on or after April 1, 2011.

Revision 1 states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home. An individual does not have to be bedridden to be considered confined to the home. However, the condition of these patients should be such that there exists a normal inability to leave home and, consequently, leaving home would require a considerable and taxing effort. Generally speaking, patients will be considered to be homebound if they have a condition due to an illness or injury that restricts their ability to leave their place of residence except with the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person; or if leaving home is medically contraindicated.

Revision 172 states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home and an individual will be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria 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 Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria 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) and the Manual, chapter 7, § 40.1).

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) (the Act § 1861(m) and the Manual, chapter 7, § 50.7).

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 beneficiary, 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 may not be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary'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.

General Principles Governing Reasonable and Necessary Skilled Nursing Care

Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed practical (vocational) nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service even though a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a nonskilled service does not make it a skilled service when a nurse provides the service.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable (the Manual, chapter 7, § 40.1.1).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition. 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.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)(1)(v)) and the Manual (chapter 7, § 30.5.1) state that, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed nonphysician practitioner, had a face-to-face encounter with the patient, which is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1) states that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

Plan of Care

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services (the Manual, chapter 7, § 30.2.2). The plan of care must be reviewed and signed by the physician 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 physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

POPULATION

The population consisted of Metropolitan's claims for home health services that it provided to Medicare beneficiaries whose final episodes of care ended in CYs 2013 and 2014.[23]

SAMPLING FRAME

The sampling frame consisted of an Access database of 18,318 home health claims from CMS's NCH file, for services provided by Metropolitan during CYs 2013 and 2014 with paid amounts of $500 or more, totaling $62,818,762.

SAMPLE UNIT

The sample unit was a home health claim.

SAMPLE DESIGN

We used a stratified random sample containing two strata.[24]

Stratum	Dollar Range of Frame Units	Number of Frame Units	Dollar Value of Frame Units
1	$500 to $3,000	8,222	$18,506,427
2	Greater than $3,000	10,096	44,312,335
Totals		**18,318**	**$62,818,762**

SAMPLE SIZE

We selected a sample of 100 claims, consisting of 40 claims from stratum 1 and 60 claims from stratum 2.

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

[23] We excluded claims for home health services with paid amounts less than $500 or claims that were one-day episodes submitted for reimbursement and then cancelled in CMS's common working file.

[24] The claims in the frame were assigned to the strata based on the Medicare payment due to Metropolitan prior to adjustments for sequestration deduction and outlier payments.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units within each stratum, and after generating the random numbers we selected the corresponding sampling frame items for review.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of overpayments paid to Metropolitan during the audit period. To be conservative, we recommend recovery of overpayments at the lower limit of the two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total in the sampling frame 95 percent of the time. We also used this software to calculate the corresponding point estimate and upper limit of the 90-percent confidence interval.

APPENIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE DETAILS AND RESULTS

Stratum	Frame Size	Total Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments In Sample
1	8,222	$18,506,427	40	$97,059	6	$13,803
2	10,096	44,312,335	60	235,200	5	20,711
Total	**18,318**	**$62,818,762**	**100**	**$332,259**	**11**	**$34,514**

ESTIMATES

Estimated Overpayments for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$6,322,116
Lower limit	$2,979,377
Upper limit	$9,664,854

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

Sample Number	Beneficiary Not Homebound	Beneficiary Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
1				$ -
2				-
3				-
4				-
5				-
6		X		2,721
7				-
8				-
9				-
10				-
11				-
12				-
13				-
14				-
15				-
16				-
17				-
18			X	3,907
19				-
20			X	3,752
21				-
22				-
23				-
24				-
25				-
26	X	X		562
27				-
28				-
29				-
30				-
31			X	2,714
32			X	147
33				-
34				-

Sample Number	Beneficiary Not Homebound	Beneficiary Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
35				-
36				-
37				-
38				-
39				-
40				-
41				-
42				-
43				-
44				-
45				-
46				-
47				-
48				-
49				-
50				-
51			X	3,829
52		X		3,198
53				-
54				-
55				-
56				-
57				-
58				-
59				-
60				-
61				-
62				-
63				-
64				-
65			X	5,951
66				-
67				-
68				-
69				-

Sample Number	Beneficiary Not Homebound	Beneficiary Did Not Require Skilled Services	Missing or Insufficient Documentation	Overpayment
70				-
71				-
72				-
73				-
74				-
75				-
76				-
77				-
78				-
79				-
80				-
81				-
82				-
83				-
84	**X**			3,014
85				-
86				-
87				-
88			**X**	4,719
89				-
90				-
91				-
92				-
93				-
94				-
95				-
96				-
97				-
98				-
99				-
100				-
Totals:	**2**	**3**	**7**	**$ 34,514**

APPENDIX F: METROPOLITAN COMMENTS

MJHS

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February 16, 2018

VIA FEDERAL EXPRESS
Brenda M. Tierney
Regional Inspector General for Audit Services
Office of the Inspector General
Department of Health and Human Services
Office of Audit Services, Region II
Jacob K. Javits Federal Building
26 Federal Plaza, Room 3900
New York, NY 10278

Re: Report #: A-02-16-01001

Dear Ms. Tierney:

Enclosed please find Metropolitan Jewish Home Care, Inc.'s ("Provider's") response to the above referenced Draft Audit Report. I have enclosed both a hard copy and an encrypted CD containing Provider's response. I will forward the password for the encrypted CD via email.

I have also enclosed a copy of your spreadsheet with Provider's statement of concurrence/non-concurrence indicated for each claim disallowed within the sample.

Provider's written comments are grouped by the disallowance category. Each response within a disallowance category will set forth: (i) a discussion that addresses the OIG's disallowances within a category generally; and (ii) a specific response to each sample disallowed, including whether Provider agrees or disagrees with the allowance and attachments when applicable.

Thank you for your consideration in extending Provider's time to respond to the Draft Report.

Please contact me if you have any questions or need clarification regarding this submission.

Sincerely,

Nancy E. Cohn
Deputy General Counsel

C: Jennifer Webb
Timothy Higgins

UJA Federation of New York

DISCUSSION

Beneficiary Not Homebound

In its review of the sampled claims, the OIG, relying on the 2013 version of CMS Medicare Benefit Policy Manual, misapprehended and misapplied the criteria under the Medicare Act for determining whether a Medicare beneficiary in need of home care is homebound, and as a consequence, mistakenly concluded that x of the sampled patients were ineligible for home care services. On both the law and facts, the OIG's proposed disallowances should be removed.

The OIG applied the 2013 version of the Medicare Benefit Policy (Chapter 7, § 30.1.1), to all of the 2013-14 audited claims, on the assumption that "[a]lthough different in format, the requirements [for homebound status] were the same" in both the 2003 version (no. 1) and the 2013 version (no. 172) of the Manual. The 2013 version of the Manual was made effective November 19, 2013. In fact, the 2013 version of the Manual materially differs from the 2003 version, and imposes requirements for coverage beyond what either the 2003 version or the federal Medicare statute itself, 42 U.S.C. § 1395f(a), imposes. See Caring Hearts Personal Home Services, Inc. v. Burwell, 824 F.3d 968 (10th Cir. 2016); see also 42 U.S.C. §1395n(a)(2).

In Caring Hearts, Judge (now Supreme Court Justice) Neil Gorsuch held that: (1) the revisions made in the 2013 Manual to the definition of "homebound" effected more restrictive criteria for Medicare coverage when compared with the 2003 version and the statute; and (2) applying the more stringent criteria, retroactively to home care claims for services rendered prior to the effective date of the 2013 revisions, was grounds for reversing disallowances made in reliance on the 2013 Manual. According to Judge Gorsuch, the 2013 revisions did not merely "clarify" the homebound definition; they "narrow[ed] the class of persons who qualify as homebound. . ." when compared with the beneficiaries reviewed under the 2003 Manual and statute, by among other things converting "hortatory" language in the statute and 2013 Manual ("should") to mandatory conditions ("must") in the 2013 Manual. Caring Hearts, 824 F.3d at 972, 973. Under the statute, homebound included any "individual [who] has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker)." (Emphasis added). Reading the plain text of the statute, Judge Gorsuch

concluded that any beneficiary requiring support or an assistive device to leave the home qualified as homebound.

The second sentence of the statute goes on to state: "While an individual does not have to be bedridden to be considered 'confined to his home', the condition of the individual should be such that their existing normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual." 42 U.S.C. § 1395f(a); see also 42 U.S.C. § 1395n(a)(2). (Emphasis added.) Reviewing the two sentences in conjunction with each other, Judge Gorsuch opined --

> The first sentence says the patient must suffer from a "condition" that restricts his or her ability to leave home "except with" (but for) the use of a supportive device. . . . [T]he second sentence's use of the term "condition" may be best read as meaning that the patient's condition normally renders him unable to leave without considerable and taxing effort but for his supportive device. (Caring Hearts, 824 F.3d at 973.)

In the 2013 Manual, however, CMS recast key operative language in the first sentence of the statute, making that condition one of two mandatory criteria for homebound status. CMS then converted the language in the second sentence into separate and additional mandatory criteria for homebound status. Now, under the 2013 Manual, the home care patient who relies on a walker or cane or another person to leave the home is no longer qualified as homebound unless he or she also satisfies a second set of mandatory criteria: the "patient must ALSO meet two additional requirements defined in Criteria-Two below." (Emphasis in original.) That is, there "must be" a normal inability to leave "AND Leaving" home now "must" require a considerable and taxing effort. (Emphasis in original.)

The alteration of the statutory language effected by the 2013 Manual revisions was not a mere exercise in semantics. To the contrary, Judge Gorsuch in Caring Hearts found that CMS, when applying the 2013 Manual criteria, had denied coverage to home care patients who would otherwise have qualified as homebound. Referring to one of the patients whose coverage was disallowed by CMS, Judge Gorsuch observed that the individual would qualify under the statute and the 2003 Manual as homebound:

> Under this reading it is the first sentence that does the real work—providing that someone like L.Sm. "shall be considered"

> homebound because he has a condition that restricts his ability to leave home "except with" (but for) a wheelchair or some other form of assistance. Under this reading, the second sentence adds only hortatory guidance about the sorts of people who will generally qualify as homebound under the first sentence, but it doesn't narrow the universe of people encompassed by the first sentence. (Caring Hearts, 824 F.3d at 973.)

In other words, the second sentence cannot be fairly read to restrict qualification for homebound status of anyone who meets the criterion in the first sentence.

However, under the 2013 Manual, CMS improperly determined that this same patient was not homebound:

> And it's surely true that CMS's *current* regulations state that for a patient to qualify as homebound he must "normal[ly]" be unable "to leave home" even with a wheelchair and any attempt to leave home must also "require a considerable and taxing effort." Medicare Benefit Policy Manual (MBPM), Pub. No. 100-02, Ch. 7, § 30.1.1 (Rev. 208, May 11, 2015). (Caring Hearts, 824 F.3d at 971.)
>
> * * *
>
> The trouble is that CMS's current regulations defining who qualifies as homebound look little like the regulations in effect when Caring Hearts provided care to L.Sm. in 2008. Back then, CMS's regulations indicated that, "[g]enerally speaking, a patient will be considered homebound if they [sic] have a condition due to illness or injury that restricts their ability to leave the place of residence except with the aid of: supportive devices such as crutches, canes, wheelchairs, and walkers...." MBPM, Ch. 7, § 30.1.1 (Rev. 1, Oct. 1, 2003). So rather than asking whether a patient could leave home *with* a supportive device, the regulations back then seemed to ask whether a patient ***972** could leave home *without* one. And it seems pretty clear from the record before us that L.Sm. qualified as homebound under this more generous definition. After all, no one disputes that L.Sm. was unable to leave his house without some kind of "supportive device," for he "lived" in his wheelchair and struggled to walk even 20 feet. (Caring Hearts, 824 F.3d at 972.)

Here, too, the OIG's application of both criteria in the 2013 Manual as prerequisites to homebound status, beyond the statutory requirements, was evident in no fewer than four (4) of the sampled cases, in which the OIG determined that the patient failed the "considerable and taxing effort" litmus test (among others). See samples 9, 39, 86, 96. Moreover, the OIG determined nine

(9) patients not to be homebound, even though each required the support of another person, or an assistive device (cane, walker, wheelchair), or both, to ambulate outside of their home. See samples 9, 26, 39, 49, 52, 54, 65, 84, 96. Under Judge Gorsuch's analysis, all of those patients should be considered "homebound" under the statute and the 2003 Manual.

Applying the 2013 Manual, the OIG reversed eight (8) out of eleven (11) sampled claims based on the "homebound" status of the patient even though the services were rendered prior to the November 2013 effective date of the 2013 Manual. See samples 9, 21, 26, 52, 65, 84, 86, 96. Aside from the improper retroactive application of the 2013 Manual, Judge Gorsuch was equally concerned about the application of agency guidance -- for any periods of service -- that imposed requirements above and beyond what the statute calls for. Caring Hearts, 824 F.3d at 974, 975. More recently, the U.S. Department of Justice issued a memorandum to government attorneys barring them from relying on agency guidance, through manuals or otherwise, as a basis for an enforcement action, where the guidance expands upon statutory or regulatory requirements, stating that those agency guidance documents "cannot create any additional legal obligations." See Department of Justice Memorandum, January 25, 2018. This proscription applies with equal force to application of the 2013 Manual revisions imposing criteria for coverage in excess of the statutory requirements.

In any event, as we will show below, the clinical records -- some of which the OIG may not have reviewed or may have overlooked -- show that [1] each of the patients determined not to be homebound suffered from one or multiple conditions that restricted his or her ability to leave the home and [2] leaving the home -- with or without an assistive device or other support -- would require a considerable and taxing effort. For those reasons as well, we respectfully urge that the OIG reconsider each disallowed claim based on the "homebound" status of the patient, under the statute and 2003 Manual; and, upon reconsideration, remove the disallowances from its findings.

In addition to Judge Gorsuch's opinion discussed above, the Manual (both revision #1 and revision #172) sets forth examples of conditions that meet the homebound requirement as well as cautionary language against treating certain absences from the home as support for a disallowance based on homebound requirement. Those examples include:

1. Absences attributable to the need to receive health care treatment include, but are not limited to:

   • Attendance at adult day centers to receive medical care;

   • Ongoing receipt of outpatient kidney dialysis; or

   • The receipt of outpatient chemotherapy or radiation therapy.

2. Any absence of an individual from the home attributable to the need to receive health care treatment, including regular absences for the purpose of participating in therapeutic, psychosocial, or medical treatment in an adult day-care program that is licensed or certified by a state, or accredited to furnish adult day-care services in a state, shall not disqualify an individual from being considered to be confined to his home.

3. Any other absence of an individual from the home shall not so disqualify an individual if the absence is of an infrequent or of relatively short duration. For purposes of the preceding sentence, any absence for the purpose of attending a religious service shall be deemed to be an absence of infrequent or short duration. It is expected that in most instances, absences from the home that occur will be for the purpose of receiving health care treatment. However, occasional absences from the home for nonmedical purposes, e.g., an occasional trip to the barber, a walk around the block or a drive, attendance at a family reunion, funeral, graduation, or other infrequent or unique event would not necessitate a finding that the patient is not homebound if the absences are undertaken on an infrequent basis or are of relatively short duration and do not indicate that the patient has the capacity to obtain the health care provided outside rather than in the home.

4. A patient paralyzed from a stroke who is confined to a wheelchair or requires the aid of crutches in order to walk;

5. A patient who is blind or senile and requires the assistance of another person in leaving their place of residence;

6. A patient who has lost the use of their upper extremities and, therefore, is unable to open doors, use handrails on stairways, etc., and requires the assistance of another individual to leave their place of residence;

7. A patient in the late stages of ALS or neurodegenerative disabilities.

8. A patient who has just returned from a hospital stay involving surgery who may be suffering from resultant weakness and pain and, therefore, their actions may be restricted by their physician to certain specified and limited activities such as getting out of bed only for a specified period of time, walking stairs only once a day, etc.

9. A patient with arteriosclerotic heart disease of such severity that they must avoid all stress and physical activity; and

10. A patient with a psychiatric illness that is manifested in part by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations.

Finally, with the exception of one patient, whose physician corrected his original documentation, every chart contained the statement that the patient was homebound on the Plan of Care, signed by the physician.

DISCUSSION

In the draft report, the OIG cited one example of the sampled claims to illustrate how it determined that X patients lacked a need for skilled nursing or therapy services. This example, however, reveals how OIG apparently applied excessively onerous documentation standards for establishing a skilled need, beyond what it is required under the statute or the Manual:

> One beneficiary did not have a new event or an exacerbation of an existing event that would require the skills of home care professionals. While the patient may have benefited from skilled services, there was no clear indication that the patient benefited from home care services in a way that would have prevented further deterioration or lessened the degree of pain.

What the OIG report omitted from this example was the additional requirement the OIG imposed on Metropolitan. In OIG's view, it was not enough that the agency point to clinical records evidencing how the patient may have benefitted from skilled nursing or therapy. Indeed, in the cited example, OIG does not seriously question that the patient would benefit from skilled services. According to the OIG, however, the agency had to "explicitly document" a skilled need to pass muster. This is so even though the Manual itself cautions against reliance on conclusory assertions of "skilled need," or the absence of such assertions, instead of the clinical records, to support coverage determinations.

Moreover, neither the statute nor Manual limits home care coverage to only those patients who suffered a specific "new event or an exacerbation of an existing condition" as a prerequisite to finding a skilled need. Likewise, home care eligibility is not limited to only cases where there is a "clear indication" that the skilled services "prevent deterioration" or "lessen pain". Rather, so long as the documents show that the patient needs and can benefit from skilled care, including to "maintain current functions," the patient should quality for home care.
Here, too, the clinical records support that the [x] patients who the OIG found no skill need in fact had a need for skilled nursing or therapy services.

DISCUSSION

The Provider submits that it was not overpaid on account of what was essentially a later-occurring clerical error identified by OIG. In each of the disallowances cited in the category of "Claim paid before OASIS submitted", the Provider had submitted the OASIS prior to billing and being paid for the service. However, when the Provider updated the OASIS to reflect additional information it had received, it inadvertently replaced the original OASIS from the electronic claims history with the later updated OASIS on account of a key-stroke error. Specifically, subsequent events (adding a secondary payer) coupled with human error (selecting Key Field Correction instead of Non-Key Field Correction) resulted in the original OASIS being replaced by the revised OASIS. As a result, the electronic claims history reflects, incorrectly, that the Provider had billed before submitting the OASIS.

In any event, even if the key-stroke error had resulted in an overpayment, or an underpayment, to Provider, an error of this nature should not be the basis for a disallowance and extrapolation. Mere clerical errors in the billing process may be cured and corrected, at any time, through a broader reopening claims process specifically mandated by Congress. Medicare Claims Processing Manual, Chapter 34, sec. 10.4 . See also 42 C.F.R. 405.927 and 405.980(a)(3). As such, clerical errors identified in a sample, curable at any time, are hardly representative or evidence of overpayments in the universe of Medicare claims.

The Provider has included evidence of the original OASIS submission to support its objection to the disallowances. In the category of "No OASIS Submitted", the Provider does not know why the OASIS could not be found by the auditors/reviewer and has produced evidence of the OASIS and its submission. Please note that both of these samples involved patients receiving services from Provider's Long Term Home Health Care Program (LTHHCP).

DISCUSSION

Provider does not perform its own coding. All claims are coded by an independent third party – QIRT.

All of the QIRT coders who performed coding services on the claims identified by the auditors/reviewers were certified home care coders. See attached documentation.

Upon receipt of OIG's disallowances, Provider submitted the findings and explanations to QIRT and requested that all claims be "re-coded" and re-scored by a certified QIRT coder who was not involved in coding the original claims.

QIRT assigned its Assistant Director of Quality Operations, a certified home care coder, to perform the re-review, who confirmed the appropriateness of the coding on the claim originally submitted. See CV and Attestation, attached. Her analysis validated the results of the initial QIRT review that support the clinical domain severity score on the bill versus the reviewer's claim that all samples should have been scored C1. Because the reviewer did not provide any detailed information as to how they determined a clinical domain severity rating of C1, it is unclear how the reviewer arrived at the decision to disallow the claim based on an alleged clinical domain severity code discrepancy.