Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

EHS HOME HEALTH CARE SERVICE, INC., BILLED FOR HOME HEALTH SERVICES THAT DID NOT COMPLY WITH MEDICARE COVERAGE AND PAYMENT REQUIREMENTS

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Office of Inspector General

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

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.

Our objective was to determine whether EHS Home Health Care Service, Inc. (EHS), complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Review

We selected a stratified random sample of 100 home health claims and submitted these claims to independent medical review.

EHS Home Health Care Service, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements

What OIG Found

EHS did not comply with Medicare billing requirements for 35 of the 100 home health claims that we reviewed. For these claims, EHS received overpayments of $55,303 for services provided in calendar years (CYs) 2014 and 2015. Specifically, EHS incorrectly billed Medicare for beneficiaries who (1) were not homebound or (2) did not require skilled services. On the basis of our sample results, we estimated that EHS received overpayments of at least $7.5 million in CYs 2014 and 2015.

What OIG Recommends and EHS Comments

We made several recommendations to EHS, including that it (1) refund to the Medicare program the portion of the estimated $7.5 million in overpayments for claims incorrectly billed for the reopening period; (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period; and (4) strengthen its procedures.

In written comments on our draft report, EHS generally disagreed with all of our findings and recommendations. EHS retained a health care consultant to review all claims we questioned and submitted to us a report prepared by their consultant. EHS challenged the Office of Inspector General's selection of EHS as well as the medical review decisions maintaining that virtually all of the sample claims were billed correctly. To address EHS's concerns related to the medical review decisions, we requested that our medical reviewer review EHS's written comments on our draft report as well as the report by EHS's consultant.

Based on the results of this review, we removed 6 of the 41 claims originally found to be in error in our draft report and adjusted the finding for an additional 9 claims. With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge EHS's rights to appeal the findings.

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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 for only 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.

OBJECTIVE

Our objective was to determine whether EHS Home Health Care Service, Inc., (EHS) complied with Medicare requirements for billing home health services on selected types of claims.

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 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 OASIS data 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 home health agencies.

[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.

EHS Home Health Care Service, Inc.

EHS is a not-for-profit HHA located in Downers Grove, Illinois. CGS Administrators, LLC., its MAC, paid EHS approximately $72 million for 27,075 claims for services in CYs 2014 and 2015 (audit period) on the basis of CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS REVIEW

Our audit covered $66,481,572 in Medicare payments to EHS for 21,141 claims.[5] These claims were for home health services provided during the most recent timeframe for which data was

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[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] In developing this sampling frame, we excluded from our review home health claim payments for low utilization payment adjustments, partial episode payments, and requests for anticipated payments.

available at the start of the audit (CYs 2014 and 2015).[6] We selected a stratified random sample of 100 claims with payments totaling $360,761 for review. We evaluated compliance with selected billing requirements and sent the 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 incorrectly billed sample item.[7]

FINDINGS

EHS did not comply with Medicare billing requirements for 35 of the 100 home health claims that we reviewed. For these claims, EHS received overpayments of $55,303 for services provided in CYs 2014 and 2015. Specifically, EHS incorrectly billed Medicare for services provided to beneficiaries who:

- were not homebound and
- did not require skilled services.

These errors occurred primarily because EHS did not have adequate controls to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that EHS received overpayments of at least $7,563,552 for the audit period.[8]

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[6] CYs were determined by the home health agency claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary.

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

[8] 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 will be less than the actual overpayment total 95 percent of the time.

EHS HOME HEALTH CARE SERVICE, INC., BILLING ERRORS

EHS incorrectly billed Medicare for 35 of the 100 sampled claims, which resulted in overpayments of $55,303.

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, § 30.1.1). Revision 172 of § 30.1.1 (effective November 19, 2013) and Revision 208 of § 30.1.1 (effective January 1, 2015) covered different parts of our audit period.[9]

Revisions 172 and 208 state that for a patient to be eligible to receive covered home health services under both Part 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.

[9] Coverage guidance is identical in both versions of § 30.1.1 in effect during our audit period. The only difference are minor revisions to a few examples.

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.

EHS Did Not Always Meet Federal Requirements for Home Health Services

For 31 of the sampled claims, EHS incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements for being homebound for the full episode (8 claims) or for a portion thereof (23 claims).[10]

Example 1: Beneficiary Not Homebound – Entire Episode

> The beneficiary was not homebound at the start of care or during the episode. She had undergone an uncomplicated pacemaker placement and had been independent in terms of transfers, ambulation, and self-care. She was living in an apartment without barriers, and she declined physical therapy. Leaving the home would not have required a considerable or taxing effort.

Example 2: Beneficiary Not Homebound – Partial Episode

> For another beneficiary, records showed that the patient was initially homebound after being treated for congestive heart failure and a hip fracture. He had some post-hospitalization debility in addition to his normal debility, had pressure ulcers on both heels, was limited to ambulating 20 feet with a rolling walker, and his residence had steps. The beneficiary's condition improved over time and by a later date in the episode, the beneficiary was outside when the physical therapist arrived and had already wheeled himself to the corner of his street two times. At that point, leaving the home did not require a considerable or taxing effort.

EHS stated that the errors were isolated and occurred because documentation was insufficient to support qualifying the beneficiaries as homebound.

[10] Of these 31 claims with homebound errors, 3 claims were also billed with skilled services that were not medically necessary. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

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).[11] 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).

EHS Did Not Always Meet Federal Requirements for Skilled Services

For seven of the sampled claims, EHS incorrectly billed Medicare for an entire home health episode (one claim) or a portion of an episode (six claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.[12]

Example 3: Beneficiary Did Not Require Skilled Services

A recertified beneficiary in his second episode of care with significant comorbid medical conditions was homebound. Skilled nursing, however, was not needed throughout the episode of care. The patient's medical conditions were unchanged, this was the second episode of care for this patient, and basic education had already been provided. He had caregiver assistance available for processing information with respect to education regarding his medical condition. The patient verbalized understanding of medication management, and his wife had assisted with this in the past.

[11] 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, administration of medications, among other things. Manual, chapter 7, § 40.1.2.

[12] Of these seven claims with skilled need services that were not medically necessary, EHS billed three of the claims for beneficiaries with homebound errors. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

EHS stated that the errors were isolated and occurred because documentation was insufficient to verify that beneficiaries required skilled services.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that EHS received overpayments totaling at least $7,563,552 for the audit period.

RECOMMENDATIONS

We recommend that EHS:

- refund to the Medicare program the portion of the estimated $7,563,552 overpayment for claims incorrectly billed that are within the reopening period;[13]

- for the remaining portion of the estimated $7,563,552 overpayment for claims that are 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 and

    - beneficiaries are receiving only reasonable and necessary skilled services.

[13] OIG audit recommendations do not represent final determinations by the Medicare program but are recommendations to HHS action officials. Action officials at CMS, acting through a MAC or other contractor, will determine whether a potential overpayment exists and will recoup any overpayments consistent with its policies and procedures. If a disallowance is taken, providers have the right to appeal the determination that a payment for a claim was improper (42 CFR § 405.904(a)(2)). The Medicare Part A/B appeals process has five levels, including a contractor redetermination, a reconsideration by a Qualified Independent Contractor, and a hearing before an Administrative Law Judge. If a provider exercises its right to an appeal, it does not need to return funds paid by Medicare until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

EHS HOME HEALTH CARE SERVICE, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, EHS generally disagreed with all of our findings and recommendations. EHS retained a health care consultant to review all claims we questioned and submitted to us a report prepared by their consultant. EHS challenged the Office of Inspector General's (OIG's) selection of EHS as well as the medical review decisions maintaining that virtually all of the sample claims were billed correctly. To address EHS's concerns related to the medical review decisions, we requested that our medical reviewer review EHS's written comments on our draft report as well as the report by EHS's consultant. We have included EHS's comments in their entirety as Appendix F.[14]

Based on the results of this review, we removed 6 of the 41 claims originally found to be in error in our draft report and adjusted the finding for an additional 9 claims.[15] With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge EHS's rights to appeal the findings. Below is a summary of the reasons EHS did not agree with our findings and recommendations and our responses.

SELECTION OF EHS HOME HEALTH CARE SERVICE, INC.

EHS Comments

EHS expressed concerns about why they were selected for review stating that the OIG unfairly targeted them due to EHS's size and overall Medicare reimbursement.

Office of Inspector General Response

The OIG strongly believes that conducting provider specific reviews is an essential part of its role in conducting oversight work of the Medicare program. These reviews frequently identify broader vulnerabilities and lead to nationwide reviews which are designed to inform CMS about potential issues and opportunities for strengthening the Medicare program.

EHS was selected based on data analysis, computer matching, and a high volume of claims that fall into one or more compliance risk categories that we identified during our risk analysis for noncompliance with Medicare requirements. In addition, larger providers like EHS can be selected for review because of a higher volume of claims and Medicare payments in a given risk area or in several risk areas. However, we may also select smaller providers for review based on our assessment of high risk in one or more areas. For example, a small hospital may be selected for review because, although it has relatively low Medicare reimbursement, it has a

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[14] EHS's consultant's report contains considerable personally identifiable information, so we excluded it for inclusion in this report.

[15] The overpayment amount for eight of the nine claims decreased and the overpayment amount for the ninth claim remained unchanged.

high percentage of patient readmissions. OIG considers many factors when selecting a provider for review including analysis of the Comprehensive Error Rate Testing program data and input from CMS or its Medicare contractors.

BENEFICIARY HOMEBOUND STATUS

EHS Comments

EHS said that it believed that our medical reviewer allowed individual clinical factors to determine homebound status and, therefore, failed to view the medical record as a whole. EHS cited examples throughout its consultant's report they believed showed that our medical reviewer used technical measurements, such as the number of feet a patient can ambulate, to determine homebound status (S2-43) or used the beneficiary's residence, caregiver availability, and ability to demonstrate safe ambulation with a rolling walker or cane to determine homebound status (S2-12).

Office of Inspector General Response

We disagree with EHS's assertion that our medical reviewer allowed individual clinical factors to determine homebound status and, therefore, failed to consider the entire medical record. Our medical reviewer prepared detailed medical review determination reports documenting relevant facts and their analysis. These were provided to EHS prior to issuing our draft report. Each determination letter included a detailed set of facts based on a thorough review of the entire medical record. In the case of S2-43, the same facts cited in EHS's consultant report are included in the "Facts" section of our medical reviewer's determination letter and were considered in making the homebound determination. In all cases, our medical reviewer considered the entire record and relied on the relevant and salient facts necessary to determine homebound status in accordance with CMS's homebound definition.

Ambulation distance is one factor among others that our medical reviewer considered in making homebound determinations. As shown in each medical review determination report, our medical reviewer documented in detail and reviewed the relevant medical history, including diagnoses, skilled nursing or therapy assessments, cognitive function, and mobility for each beneficiary. In terms of meeting CMS homebound criteria, medical review determinations must be based on each patient's individual characteristics as reflected in the available record. Our medical reviewer carefully considered ability to ambulate in conjunction with the individual characteristics noted in each patient's medical record. Ambulation distance is not noted in all decisions, and when it is, it is simply one factor the reviewer considered in making the homebound determination. This is evident from the relevant facts and discussion included in the individual decisions.

EHS asserted that living in a barrier-free residence is not a valid criterion for Medicare payment, but did not cite to any law, regulation, or CMS guidance stating that the physical characteristics of a patient's home may not be considered in determining homebound status. Moreover, our

medical reviewer did not consider beneficiaries' residences to be a dispositive factor, but one of many they deliberated upon when analyzing the unique circumstances of each beneficiary.

As set forth in the Manual, chapter 7, § 30.1.1, the second requirement for being homebound is that there must exist a normal inability to leave home and that leaving the home must require a considerable and taxing effort. CMS guidance provides the following example of a homebound patient, which references the physical characteristics of the living environment:

> Some examples of homebound patients that illustrate the factors used to determine whether a homebound condition exists would be . . . . 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 (the Manual, chapter 7, § 30.1.1).

Physical barriers in the home environment are relevant to the homebound assessment under the "normal inability" and "considerable and taxing effort" requirement ("Criteria Two"). Although the patient is the focus of the homebound requirement, the lack of physical access barriers in an ALF or private residence are factors in determining whether a beneficiary is homebound under Criteria Two. For example, a patient residing in a walk-up but who no longer can negotiate steps or stairs has a "normal inability" to leave home and leaving a home with that physical characteristic would require a "considerable and taxing effort." This may not be the case for the same patient in a residence without steps or stairs. The physical characteristics of the home environment, however, are always considered along with the patient's condition.[16]

Indeed, CMS guidance mentions that a patient may have multiple residences and states that homebound status must be met at each residence (the Manual, chapter 7, § 30.1.2). CMS states the following (emphasis added):

> A patient may have more than one home and the Medicare rules do not prohibit a patient from having one or more places of residence. A patient, under a Medicare home health plan of care, who resides in more than one place of residence during an episode of Medicare covered home health services will not disqualify the patient's homebound status for purposes of eligibility. For example, a person may reside in a principal home and also a second vacation home, mobile home, or the home of a caretaker relative. The fact that the patient resides in more than one home and, as a

[16] Regarding physical environment characteristics beneficiaries may encounter once they leave the home, Title III of the Americans with Disabilities Act of 1990 (ADA), as amended (codified at 42 U.S.C. §§ 12181-12189), and its implementing regulations (28 CFR part 36), prohibits discrimination on the basis of disability in the activities of places of public accommodation (businesses that are generally open to the public and that fall into one of 12 categories listed in the ADA, such as restaurants, movie theaters, schools, day care facilities, recreation facilities, and doctors' offices) and requires newly constructed or altered places of public accommodation—as well as commercial facilities (privately owned, nonresidential facilities)—to comply with the ADA Standards.

> result, must transit from one to the other, is not in itself, an indication that the patient is not homebound. **The requirements of homebound must be met at each location (e.g., considerable taxing effort etc).**

CMS anticipated that the physical characteristics of a patient's residence could impact the homebound determination under Criteria Two. Accordingly, it can be reasonably inferred that CMS expects the physical characteristics of a given residence to impact the homebound analysis under Criteria Two. Thus, contrary to EHS's assertions, it was not an error for our medical reviewer to consider the physical characteristics of the home environment as one of many factors in making homebound determinations.

We continue to stand by our medical reviewer's homebound decisions.[17]

MEDICAL NECESSITY

EHS Comments

EHS stated that our medical reviewer demonstrated a faulty understanding of the Medicare criteria as it relates to the medical necessity of skilled services. Specifically, EHS said that it appeared that our medical reviewer misunderstood the difference between the professional services provided by a physical therapist and an occupational therapist. EHS cited examples throughout its consultant's report in which our medical reviewer denied occupational therapy services because they were not medically necessary and duplicated physical therapy.

EHS also stated that our medical reviewer failed to recognize the medical necessity of skilled nursing for observation and assessment when a beneficiary exhibited a high risk of complications.

Office of Inspector General Response

CMS addresses Medicare coverage of skilled physical therapy services and skilled occupational therapy services in the Manual, chapter 7, §§ 40.2.1, 40.2.2 and 40.2.4. We agree that physical therapy and occupational therapy are individual disciplines with differing goals. Upon further consideration, we elected to modify our findings related to occupational therapy that were originally deemed duplicative of physical therapy services in our draft report. We adjusted our findings related to 11 claims accordingly.[18]

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[17] Although we stand by our original homebound findings in our draft report, we removed two claims (S2-26 and S2-38) that no longer had an overpayment after modifying our findings related to certain skilled therapy services.

[18] The 11 claims were S1-20, S1-46, S2-7, S2-10,* S2-17,* S2-26,* S2-27, S2-30, S2-38,* S2-45, and S2-47. After removing the findings related to occupational therapy, we removed four claims (denoted with an *) because they no longer had an overpayment. An overpayment amount remained on the other seven claims due to either homebound errors or other skilled needs errors.

Our medical reviewer's determinations of the medical necessity of skilled therapy services were made in accordance with the Manual, chapter 7, section 40.2. Per these CMS guidelines, it is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed. The guidelines also state: While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition.

Skilled nursing services can include observation and assessment of a patient's condition (the Manual, chapter 7, § 40.1.2). In determining the medical necessity of skilled nursing for observation and assessment, our medical reviewer considered the reasonable potential of a change in condition, complication, or further acute episode (e.g., high risk of complications) pursuant to the Manual, chapter 7, § 40.1.2.1.

HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM CODING

EHS Comments

EHS stated that four claims identified by the medical reviewers with HIPPS coding discrepancies had the proper HIPPS code on the original claim and, therefore, received appropriate payments in all four cases.

Office of Inspector General Response

We requested that our medical reviewer re-review determinations for claims identified in our draft report with HIPPS coding errors. Our medical reviewer identified a software error in its home health grouper program, and we reversed all four HIPPS coding errors originally identified in our draft report.[19]

OFFICE OF INSPECTOR GENERAL'S OVERPAYMENT PROJECTION WAS INAPPROPRIATE

EHS Comments

EHS objected to our use of extrapolation to estimate our overpayment amount. EHS stated that extrapolation is inappropriate unless there is a "sustained or high level of payment error."

[19] Although we reversed our HIPPS finding related to all four claims, two claims (S2-29 and S2-33) remained as errors because of a homebound denial.

Office of Inspector General Response

Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[20]

The legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[21] We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

EHS's argument that our extrapolation was inappropriate because our error rate did not support a "sustained or high level of payment error," according to guidelines prescribed for CMS and its contractors, is not applicable because OIG is not a Medicare contractor.[22]

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[20] *See Yorktown Med. Lab., Inc. v. Perales, 948 F.2d 84 (2d Cir. 1991); Illinois Physicians Union v. Miller, 675 F.2d 151 (7th Cir. 1982); Momentum EMS, Inc. v. Sebelius, 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); Anghel v. Sebelius, 912 F. Supp. 2d 4 (E.D.N.Y. 2012); Miniet v. Sebelius, 2012 U.S. Dist. LEXIS 99517 (S.D. Fla. 2012); Bend v. Sebelius, 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).*

[21] *See John Balko & Assoc. v. Sebelius, 2012 WL 6738246 at *12 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); Maxmed Healthcare, Inc., v. Burwell, 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); Anghel v. Sebelius*, 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Transyd Enter., LLC, v. Sebelius*, 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[22] The Act § 1893(f)(3); CMS *Medicare Program Integrity Manual*, chapter 8.4.1.4 (effective June 28, 2011).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $66,481,572 in Medicare payments to EHS for 21,141 home health claims with episodes of care through dates in CYs 2014 and 2015. From this sample frame, we selected for review a stratified random sample of 100 home health claims with payments totaling $360,761.

We evaluated compliance with selected coverage and billing requirements and subjected the sampled claims to medical review.

We limited our review of EHS'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 EHS from December 2016 through August 2017.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted EHS's paid claims data from CMS's NCH file for the audit period;
- removed payments for low utilization payment adjustments,[23] partial episode payments,[24] and requests for anticipated payments[25] from the population to develop our sampling frame;
- selected a stratified random sample of 100 claims totaling $360,761 for detailed review (Appendix C);

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[23] If fewer than five visits are delivered during a 60-day episode, the home health agency is paid per visit, by visit type, with a low utilization payment adjustment, rather than by the episode payment method.

[24] A partial episode payment is made when a beneficiary elects to transfer to another home health agency or is discharged and readmitted to the same home health agency during the 60-day episode.

[25] Episode payments are split between a request for anticipated payment (RAP), submitted by the home health agency as soon as an episode begins, and a home health claim, submitted after the end of the episode. For all episode payments, the home health claim payment amount will show the total payment for the episode, and the RAP will be canceled.

- 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 EHS to support the sampled claims;

- reviewed sampled claims for compliance with known risk areas;

- 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 EHS'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 EHS for our audit period (Appendix D);

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

- requested our medical reviewer re-review the additional documentation provided by EHS 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 may be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes used by Medicare 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. 58077, 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;[26] (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).

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[26] Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, physical therapy service, or speech-language pathology service, as required by law. Once the requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes) (76 Fed. Reg. 68525, 68590 (Nov. 4, 2011)).

Per the Manual, chapter 7, section 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[27] 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 care date or within 30 days of the start of the home health care by including the date of the encounter.[28]

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, § 30.1.1). Revision 172 of § 30.1.1 (effective November 19, 2013) and Revision 208 of § 30.1.1 (effective January 1, 2015) covered different parts of our audit period.[29]

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[27] 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.

[28] 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.

[29] Coverage guidance is identical in both versions of § 30.1.1 in effect during our audit period. The only difference are minor revisions to a few examples.

Revisions 172 and 208 state that for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is confined to his or her home. For purposes of the statute, an individual shall 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: SAMPLE DESIGN AND METHODOLOGY

TARGET POPULATION

The population consisted of EHS's claims for home health services that it provided to Medicare beneficiaries with episodes of care that ended in CYs 2014 and 2015.

SAMPLING FRAME

The sampling frame consisted of an Excel spreadsheet containing 21,141 home health claims, valued at $66,481,572, from CMS's NCH file.[30]

SAMPLE UNIT

The sample unit was a Medicare home health paid claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used the following stratified random sample:

Stratum	Frame Information			Sample Size
	Payment Range	Count Total	Dollar Total	
1	<=$3,330	13,820	$33,663,345	50
2	>$3,330	7,321	32,818,227	50
Total		**21,141**	**$66,481,572**	**100**

SOURCE OF RANDOM NUMBERS

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

METHOD FOR SELECTING SAMPLE UNITS

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

[30] Our sampling frame excluded home health claim payments for low utilization payment adjustments, partial episode payments, and requests for anticipated payments. We also excluded claims that resulted in error code 534 when matched against the Recovery Audit Contractor Data Warehouse. This code represents claims that have already been marked for exclusion by an OIG audit, investigation, or similar review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to EHS during the audit period. 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 will be less than the actual overpayment total in the sampling frame 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

SAMPLE RESULTS

Stratum	Frame Size	Value of Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Over-payments in Sample
1	13,820	$33,663,345	50	$123,992	15	$21,544
2	7,321	32,818,227	50	236,769	20	33,759
Total	**21,141**	**$66,481,572**	**100**	**$360,761**	**35**	**$55,303**

ESTIMATES

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

Point estimate	$10,897,721
Lower limit	7,563,552
Upper limit	14,231,890

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1 (Samples 1-25)

Stratum and Sample Number	Not Homebound	Did Not Require Skilled Services	Overpayment
S1-1	-	-	-
S1-2	-	-	-
S1-3	-	-	-
S1-4	X	-	$375
S1-5	-	-	-
S1-6	-	-	-
S1-7			
S1-8	X	-	1,883
S1-9	X	-	2,305
S1-10	-	-	-
S1-11	-	-	-
S1-12	X	-	2,530
S1-13	X	-	2,370
S1-14	-	-	-
S1-15	X	-	1,971
S1-16	-	-	-
S1-17	X	-	1,379
S1-18	-	-	-
S1-19	-	-	-
S1-20	X	-	404
S1-21	-	-	-
S1-22	-	-	-
S1-23	-	-	-
S1-24	-	-	-
S1-25	-	-	-

STRATUM 1 (Samples 26-50)

Stratum and Sample Number	Not Homebound	Did Not Require Skilled Services	Overpayment
S1-26	-	-	-
S1-27	-	-	-
S1-28	-	-	-
S1-29	-	-	-
S1-30	-	-	-
S1-31	-	-	-
S1-32	X	-	$699
S1-33	X	-	699
S1-34	-	-	-
S1-35	-	X	2,347
S1-36	X	-	1,923
S1-37	-	-	-
S1-38	-	-	-
S1-39	X	X	1,808
S1-40	-	-	-
S1-41	-	-	-
S1-42	-	-	-
S1-43	-	-	-
S1-44	-	X	447
S1-45	-	-	-
S1-46	X	X	404
S1-47	-	-	-
S1-48	-	-	-
S1-49	-	-	-
S1-50	-	-	-

STRATUM 2 (Samples 1-25)

Stratum and Sample Number	Not Homebound	Did Not Require Skilled Services	Overpayment
S2-1	-	-	-
S2-2	X	-	$1,415
S2-3	-	-	-
S2-4	-	-	-
S2-5	-	-	-
S2-6	X	-	1,695
S2-7	X	-	1,770
S2-8	-	-	-
S2-9	-	-	-
S2-10	-	-	-
S2-11	-	-	-
S2-12	X	-	859
S2-13	-	-	-
S2-14	X	-	1,693
S2-15	-	-	-
S2-16	-	-	-
S2-17	-	-	-
S2-18	-	-	-
S2-19	X	-	3,281
S2-20	-	-	-
S2-21	-	-	-
S2-22	-	-	-
S2-23	-	-	-
S2-24	X	-	791
S2-25	X	-	350

STRATUM 2 (Samples 26-50)

Stratum and Sample Number	Not Homebound	Did Not Require Skilled Services	Overpayment
S2-26	-	-	-
S2-27	X	-	$1,212
S2-28	-	-	-
S2-29	X	-	2,664
S2-30	X	-	1,819
S2-31	X	-	5,207
S2-32	X	-	566
S2-33	X	-	592
S2-34	-	-	-
S2-35	-	-	-
S2-36	-	-	-
S2-37	X	-	702
S2-38	-	-	-
S2-39	-	X	184
S2-40	-	-	-
S2-41	-	-	-
S2-42	-	-	-
S2-43	X	-	5,598
S2-44	-	-	-
S2-45	X	X	1,724
S2-46	-	-	-
S2-47	X	-	404
S2-48	-	-	-
S2-49	-	X	1,233
S2-50	-	-	-
Total	**31**	**7**	**$55,303**

APPENDIX F: EHS HOME HEALTH CARE SERVICE, INC., COMMENTS

BASS BERRY + SIMS PLC

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March 16, 2018

Ms. Sheri L. Fulcher
Regional Inspector General for Audit Services
Department of Health and Human Services Office of Inspector General
Office of Audit Services, Region V
233 North Michigan Ave., Suite 1360
Chicago, Illinois 60601

Re: Office of Audit Services Audit A-05-16-00055

Dear Ms. Fulcher:

EHS Home Health Care Service Inc. ("EHS") appreciates the opportunity to comment on the validity of the facts and reasonableness of the recommendations outlined in the Office of Inspector General, Office of Audit Services ("OIG") draft report dated November 3, 2017, and has authorized me to provide a response on its behalf. EHS understands and takes seriously its obligations to bill Medicare appropriately for home health services rendered to program beneficiaries, and acknowledges the important role the OIG plays in enforcing these obligations.

Per your letter dated February 15, 2018, EHS also understands that OIG will share the EHS third-party audit report previously sent to OIG in August 2017 with OIG's medical review contractor for consideration. Per your letter, EHS resubmitted its third-party audit report on February 21, 2018. EHS also understands that while OIG's medical review contractor may adjust its initial determinations, OIG will not provide EHS with an updated report for EHS' comment unless there are "new findings or recommendations" by OIG. We understand this to mean that even if the overall denial rate is adjusted, leading to a revised extrapolated overpayment amount, OIG's "findings and recommendations" may stay the same but include different numerical figures.

In light of the above, EHS provides the below comments based on that November 3, 2017 draft report from OIG. Should OIG's findings and recommendations change after its medical review contractor considers the EHS third-party audit report, EHS appreciates being afforded an opportunity to provide an updated response reflecting any changes to overall findings and recommendations made by the OIG.

I. Introduction

EHS is a subsidiary of Advocate Health Care ("Advocate"), a leading faith-based, non-profit health system in the Midwest operating over 450 sites of care, including 12 hospitals, Illinois' largest integrated children's network, five Level 1 trauma centers, and one of the

region's largest medical groups. Along this comprehensive continuum of care, EHS provides high quality home health to patients in the Chicago metropolitan area (Cook, DuPage, Lake, and Will counties) and statewide, and it has done so for over 40 years. EHS makes every effort to serve all patients, regardless of ability to pay, providing more than $712,000 in community benefit in calendar years 2014 and 2015 and investing millions of (unreimbursed) dollars to ensure access to care for the state's low-income, high-risk patient populations by expanding its footprint in and around Chicago. In 2014 and 2015 alone, EHS provided over 26,000 episodes of home health care to nearly 20,000 Medicare beneficiaries.

While quality care is always the top priority, both EHS and Advocate have also proven to be good stewards of the Medicare Trust Fund. CMS recently acknowledged Advocate for its success in saving the Medicare program (and ultimately taxpayers) $60.6 million in 2016 through its participation in an accountable care organization. One primary reason for this success was the reduction in skilled nursing and home health expenditures due to effective and continued partnerships among Advocate's specialty post-acute care network. At the same time, Advocate recorded outstanding scores in the Medicare program's annual quality, experience, and outcome measures.

Given the necessary role that EHS plays in the health care community in this region, and the decades of work put into ensuring access to quality care for the most vulnerable populations, it is all the more important that we take this opportunity to address the OIG's problematic audit process and findings.

II. Concerns Related to the OIG Audit Process

EHS has two main concerns regarding OIG's Audit Process: (1) OIG acknowledged that it selected EHS for audit not based on any concern or allegations of non-compliance, but rather due to the size of EHS and the opportunity for a higher "return on investment" for OIG; and (2) in light of the first concern, OIG's audit process does not truly allow for an opportunity to engage in a substantive discussion on the merits of OIG's findings on purported errors.

A. Selection of EHS

In its 2016 OIG Work Plan, OIG indicated that it would focus on home health billing compliance issues because one in four home health agencies allegedly had "questionable billing" practices, and it purports to have engaged in this audit of EHS because prior reviews of *other* home health agencies had uncovered "significant overpayments" related to improper billing. However, there is no evidence of questionable or improper billing by EHS. In fact, the PEPPER reports—which aggregate national and state comparative data and help providers identify if they may be a compliance outlier—issued to EHS for calendar years overlapping OIG's audit (2014, 2015, and 2016) show that EHS is not at risk for improper Medicare payments in the PEPPER target areas: (i) average case mix; (ii) average number of episodes; (iii) episodes with five to six visits; (iv) non-LUPA payments; (v) high therapy utilization; and (vi) outlier payments. EHS also

exhibits none of the five characteristics common to home health agencies engaged in fraud, as identified by OIG.[1]

In light of the above, EHS better understands OIG's statements indicating that it did not select EHS based on its propensity for improper billing or allegations of fraud or non- compliance. Specifically, OIG personnel acknowledged on two separate occasions that OIG selected EHS because it presented the "biggest bang for the buck" and a potential for "high return on investment" due to its size and the overall Medicare reimbursement received. In our view, this selection process belies the purpose of the audits, which is to uncover true outliers in billing non-compliance, and suggests that large providers like EHS are unfairly and unnecessarily targeted, and publicly scrutinized.

B. OIG Medical Reviewer Engagement and Accessibility

Importantly, even though EHS provided specific rebuttals to OIG's medical review contractor findings very early on in the process, including in response to two different iterations of "preliminary findings" that did not change from one version to the next, it was not until after EHS provided its official comments to OIG's November 3, 2017 draft report (the third iteration of the same findings) raising concerns about the closed audit process that OIG then reconsidered its position – that its contracted medical reviewers would be provided EHS' third-party audit report to consider whether its determinations on certain errors were actually based on the entirety of the medical records and applicable Medicare reimbursement criteria.

While EHS appreciates that OIG has now decided to consider EHS' third-party audit report, EHS has been told that it likely will not receive an updated draft of OIG's report before it is finalized. Therefore, EHS will not truly know whether OIG's findings on the number of denials and extrapolated overpayment amount have been adjusted until OIG's report is finalized and published. A public report based on potentially incorrect findings, and without an opportunity to truly engage with OIG's medical review contractors, will unnecessarily harm the reputation of EHS as a faith-based, non-profit organization furnishing high quality services to an underserved population that even CMS has recently recognized as a good steward of the Medicare program.

III. Concerns Related to OIG Substantive Findings

In its medical review of 100 home health claims, OIG alleges that EHS did not comply with Medicare billing requirements for 41 claims, leading to $64,621 in alleged overpayments for individual claims and an extrapolated overpayment of $8.9 million for calendar years 2014 and 2015. EHS takes these allegations of improper billing seriously. To evaluate OIG's findings objectively, and as indicated above, EHS engaged a reputable third-party auditor with substantial experience in home health care. EHS' third-party auditors come from multiple clinical disciplines, including nursing and therapy, and collectively have 65 years of experience in home health clinical operations and Medicare reimbursement criteria. These professionals were

[1] *See*, OIG Data Brief: Nationwide Analysis of Common Characteristics in OIG Home Health Fraud Cases, OEI-05- 16-00031 (June 2016).

certified in ICD-9 coding during the time EHS rendered the audited services and are currently certified in ICD-10, and they are also trained or certified in OASIS.

EHS' third-party auditor disagreed with OIG in the vast majority of the 41 claims OIG initially found to be in error. There were a handful of instances where EHS' third party auditor agreed with OIG. In its response to OIG's preliminary findings, EHS has offered this information and the full documentation supporting it to OIG. To ensure the public record reflects an accurate picture of the home health services rendered and billed by EHS, we summarize our concerns and EHS' third- party auditor findings below.

A. OIG Alleges Beneficiaries Not Homebound (33 of 41 Claims)

EHS disagrees with OIG's findings, in whole or in part, for a substantial majority of the claims in this category.

To receive payment for home health services, the beneficiary must be homebound.[2] A beneficiary qualifies as homebound if he or she 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, the use of special transportation, or the aid of a supportive device (e.g., crutches, cane, wheelchair, or walker) or if the individual has a condition such that leaving the home is medically contraindicated.[3] A beneficiary need not be bedridden, but the individual must have a normal inability to leave home and doing so must require a considerable and taxing effort.[4] Homebound status is not contingent upon a single clinical factor; in fact, Medicare guidance acknowledges that "longitudinal clinical information about the patient's health status" is typically necessary to evaluate and categorize a patient as homebound.[5] Such information "about the patient's overall health status may include, but is not limited to, such factors as the patient's diagnosis, duration of the patient's condition, clinical course…, prognosis, nature and extent of functional limitations, other therapeutic interventions and results, etc."[6]

Of the 41 allegedly non-compliant claims, OIG alleges that 33 were non-compliant because the beneficiary did not qualify as homebound under the above Medicare standards for all or a portion of the episode of care. Of these 33 cases, EHS' third-party auditor either fully or partially disagreed with a vast majority of the claims OIG found to be in error. Where EHS' third-party auditor agreed with OIG, these were isolated incidents of incomplete documentation and are not indicative of systemic issues at EHS. Where EHS' third-party auditor partially agreed with OIG, EHS' auditor frequently disagreed with the number of visits lacking homebound status. And for these cases, any adjustment related to homebound status either did not affect the overall Medicare reimbursement or EHS' third-party auditor disagreed with the OIG's repricing.

Additionally, the analysis of the OIG reviewers revealed a consistent and problematic theme: OIG's reviewers failed to apply the appropriate Medicare criteria for homebound status.

[2] 42 U.S.C. § 1395f(a)(2)(C); 42 C.F.R. § 409.42.
[3] Medicare Benefit Policy Manual, Ch. 7, § 30.1.1.
[4] *Id.*
[5] *Id.*
[6] *Id*

Specifically, OIG's reviewers repeatedly failed to view the medical record as a whole and appeared to allow individual clinical factors to drive the conclusion that a particular beneficiary was not "homebound." In doing so, OIG's reviewers applied —and appeared to rely exclusively or primarily on—criteria for evaluating homebound status simply not contained in the Medicare regulations and often ignored "longitudinal clinical information" that supported the level of care rendered by EHS. For example:

- **Case S2-43**. The OIG reviewers found this 79-year-old beneficiary was not homebound because (i) on several infrequent occasions of short duration, the beneficiary attended medical appointments for his spouse, and (ii) the beneficiary ambulated 200 feet without an assistive device, suggesting that leaving the home did not present a considerable or taxing effort. Determining homebound status based on these factors alone is wholly incongruous with the Medicare regulation and manual guidance. In fact, the Medicare manual is clear that a beneficiary is not disqualified as being homebound for leaving the home, even for nonmedical purposes, if the trips are "infrequent" and of "short duration."[7] In addition, nothing in the Medicare rules suggests it is permissible to discount homebound status based on technical measurements such as the number of feet a patient can ambulate. In isolation, such a technical fact might suggest that leaving the home is not "taxing," but it cannot be viewed in a vacuum without considering the beneficiary's complete medical record, as it appears OIG reviewers did.

  Here, had the OIG reviewers considered the complete record, they would have seen a 79-year-old beneficiary who, just prior to receiving home health services, was hospitalized with pneumonia and an exacerbation of congestive heart failure. The patient also had multiple co-morbidities, including but not limited to, acute kidney injury, diabetes, and advanced Alzheimer's disease. The Alzheimer's disease itself, without his precipitating acute conditions, severely restricted the beneficiary's cognitive function[8] relative to orientation, memory, attention, problem-solving, and judgment. The combination of the acute medical incidents and his chronic conditions made it not only impossible for the individual to leave the home without his spouse's assistance, but also made it impossible for his spouse to leave him home alone while she attended appointments outside the home. Furthermore, the full scope of his functional limitations, both cognitive and physical limitations (including the numerous comorbid conditions and his high risk for falling based on balance and strength), indicate this beneficiary has a normal inability to leave the home and doing so requires tremendous effort by this beneficiary and his spouse. When considered in its entirety, the medical record supports a finding of homebound status under the Medicare standards.

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[7] Medicare Benefit Policy Manual, Ch. 7, § 30.1.1.

[8] Certain Medicare Administrative Contractors have stated that a beneficiary "may be considered homebound because of cognitive impairment," including specifically Alzheimer's disease, if all other criteria are met. See, CGS Administrators Home Health & Hospital Coverage Guideline: Cognitive or Psychiatric Conditions, available here: https://www.cgsmedicare.com/hhh/coverage/hh_coverage_guidelines/3b.html (last accessed November 16, 2017).

- **Case S2-12**. The OIG reviewers determined this beneficiary no longer qualified as homebound as of a certain date because she lived in a "residence without barriers and had caregiver assistance available," and "demonstrated safe ambulation with a rolling walker or cane," leading to a conclusion that leaving the home did not entail a considerable or taxing effort. By focusing on the status of the beneficiary's residence, caregiver availability, and "safe" ambulation with a rolling walker or cane, OIG reviewers used a standard for homebound status inconsistent with Medicare's explicit rules. Ambulation with a supportive device actually substantiates the beneficiary's homebound status, rather than negating it. In addition, living in a barrier-free residence is simply not a valid criterion for Medicare payment. Even if it were a relevant factor (among others), OIG reviewers do not seem to appreciate that ambulating safely in a familiar residence differs greatly from ambulating outside the home.

  Perhaps more troubling, OIG reviewers did not consider these factors in the context of the broader medical record, failing to recognize this 88-year-old beneficiary's complex medical history. EHS provided services to this beneficiary following a complicated two-week hospitalization for major surgery, after which she experienced significant post-operative weakness and was prone to falls based on a MAHC-10 score of seven. The beneficiary also had comorbidities of heart failure and arthritis, and exhibited numerous other physical limitations, including unsteady gait and balance, continuous need for an assistive device and ambulating only with assistance, fatigue and weakness, and daily pain. The beneficiary also exhibited cognitive limitations, with the record showing a beneficiary diagnosed with Alzheimer's disease who was disoriented, intermittently confused, and forgetful with a poor short- term memory. Given these limitations — which persisted throughout the entire episode of care — the beneficiary required the assistance of another person to leave the home, had a normal inability to leave the home, and leaving the home required a considerable and taxing effort. Absences were infrequent, of short duration, and primarily to seek medical treatment. Evaluated under the appropriate Medicare standard, this beneficiary clearly met the criteria for homebound status.

These are only two examples among the claims with which EHS' third-party auditor wholly disagreed. OIG reviewers' persistent use of invalid and overly narrow criteria for Medicare home health payment resulted in an error rate that tremendously distorts reality. While EHS could not discuss these discrepancies with OIG reviewers before OIG finalized and publishes this report (due to the process described above), EHS firmly believes the majority of OIG's findings will be overturned on appeal.

B. OIG Alleged Beneficiaries Did Not Require Skilled Services (16 of 41 Claims)[9]

EHS disagrees with OIG's findings, in whole or in part, for almost all of the claims OIG found to be in error in this category.

In addition to homebound status, Medicare payment for home health services is contingent upon the beneficiary requiring at least one of the following skilled services: (i) intermittent skilled nursing services, which must demand the skills of a registered nurse ("RN"), or licensed practical nurse under RN supervision, and must be reasonable and necessary; (ii) physical therapy; (iii) speech-language pathology; or (iv) occupational therapy.[10] Each individual therapy service must comply with certain additional requirements to be covered.[11]

Of the 41 allegedly non-compliant claims, OIG found that 16 were non-compliant because the beneficiary did not require medically necessary skilled nursing or skilled therapy services. Of these 16 cases, EHS' third-party auditor either fully or partially disagreed with the OIG for almost all of the claims found to be in error by OIG. Where EHS' third-party auditor agreed with OIG, the cases represent isolated incidents that are not indicative of systemic issues at EHS. Where EHS' third-party auditor partially agreed with OIG, it repeatedly disagreed with the number of visits for which the beneficiary did not require skilled services, although generally agreed with OIG's minor adjustments in repricing.

Unfortunately, OIG reviewers again demonstrated a faulty understanding of the Medicare criteria and the important clinical distinctions necessary to correctly apply them. In several cases, there were inexplicable findings regarding medical necessity for skilled services based on what appeared to be a lack of understanding of the difference between the scope of the professional services provided, and needs addressed, by a physical therapist ("PT") and an occupational therapist ("OT"). For example:

- **Case S2-17**. This case involved a beneficiary who had been hospitalized for a below-knee amputation and who received an internal jugular PermCath. Among other chronic and comorbid diseases, the beneficiary required dialysis three times per week to treat kidney disease. In denying eight occupational therapy visits for lack of medical necessity, OIG reviewers stated there was "no clear need for occupational therapy as the patient's rehabilitation needs were being addressed through the physical therapy being provided." The OIG reviewers do not appear to question EHS' compliance with any of the relevant conditions of payment within 42 C.F.R. § 409.44(c) for skilled therapy services, other than the general notion that the PT and OT services were duplicative and, therefore, the OT was not medically necessary.

[9] Please note that certain claims allegedly contained errors in multiple categories. For example, OIG reviewers may have determined that a single claim failed to demonstrate homebound status and medically necessary skilled services. As a result, the three categories contain some overlapping claims, and the numbers in each category do not total 41.
[10] 42 C.F.R. § 409.42(c).
[11] *See*, 42 C.F.R. § 409.44(c).

This notion is misguided and inconsistent with the Medicare guidance, which repeatedly recognizes that PT and OT are independent disciplines with unique clinical functions that require the specialized judgment, knowledge, and skills of a qualified PT or OT.[12] The actual record reflects that the beneficiary received skilled OT with distinct clinical goals of improving activities of daily living and self-care such as dressing, preparing meals, and using the wheelchair safely. By contrast, the beneficiary required skilled PT to address the below-knee amputation, focusing on safe transfers and strengthening the remaining limb and stump. These clearly encompass different skilled needs that could not have been addressed by a single therapist. Furthermore, because of the beneficiary's need for dialysis three times per week, it was necessary to divide the therapy care plan between the two specialized disciplines to address the beneficiary's overall goals and limited endurance for exercise.

Considering the complete record and the applicable Medicare standards, EHS' third-party auditor found strong evidence of medical necessity for the OT visits.

The OIG reviewers' propensity to confuse the disciplines of PT and OT and to find non- compliance based on beneficiaries receiving both types of skilled therapy repeated itself in at least six other cases. These findings entirely contradict Medicare regulations, which recognize and allow for PT and OT to be furnished independently as unique skilled services.

In an equally disconcerting theme, the OIG reviewers ignored the need for skilled nursing services in several cases. Specifically, the OIG reviewers failed to recognize the medical necessity of skilled nursing for observation and assessment when a beneficiary exhibited a high risk of complications, including three cases with unstable PT/INRs requiring instruction for changes in anticoagulant dosages and ongoing monitoring. In doing so, the OIG reviewers again misapplied the Medicare regulatory criteria, which acknowledge that observation and assessment constitutes a medically necessary "skilled service" when the skills of a professional are "required to identify and evaluate the patient's need for modification of treatment," as they are when a case involves unstable PT/INR results.[13]

Based on the analysis of the EHS third-party auditor, the overall error rate related to the need for skilled services is grossly overstated in the OIG report.

C. OIG Alleged Incorrect HIPPS Billing Codes (4 of 41 claims)

EHS disagrees with OIG's findings for all four claims in this category.

Medicare pays for home health services based on a case-mix adjusted payment for each 60-day episode of care. Each episode is assigned to a home health resource group ("HHRG") that is represented on a home health claim using a Health Insurance Prospective Payment System ("HIPPS") code, which ultimately drives the Medicare payment amount. As noted in OIG's

[12] *See*, Medicare Benefit Policy Manual, Ch. 7, §§ 40.2.2, 40.2.4.
[13] 42 C.F.R. § 409.33(a)(2)(i).

report, "a bill must be completed accurately" to be processed and paid correctly and, therefore, a home health agency must use proper HIPPS codes on its claims.

OIG alleges that EHS failed to use the proper HIPPS code on four sampled claims, which resulted in higher reimbursement. EHS' third-party auditor wholly disagreed with these findings. Specifically, EHS' third-party auditor conducted an independent analysis of the claims, which involved validating all Pertinent Diagnoses and OASIS responses and applying the relevant standards from the CMS OASIS Guidance Manual. Ultimately, EHS' third-party auditor concluded that EHS used the proper HIPPS code on the original claims and, therefore, received appropriate payment.

As far as EHS can discern, the reviewers offered no support for their findings. Rather than provide evidence to demonstrate the basis for downgrading the HIPPS codes and reducing the Clinical Severity Levels, the OIG reviewers essentially made conclusory statements with no supporting documentation.

D. Extrapolation of Overpayment Obligations is Inappropriate

EHS objects to the OIG's use of extrapolation to arrive at an estimated overpayment amount. By statute, extrapolation of Medicare overpayments is inappropriate unless there is a "sustained or high level of payment error."[14] EHS strongly believes this is not the case here. Although the OIG reviewers found potential errors in 41 of 100 cases, a legitimate review backed by substantial medical record documentation suggests that the error rate is nominal, not a "sustained or high level of payment error," and not suggestive of a systemic error warranting extrapolation or further investigation.

IV. Response to OIG Recommendations

- ***Recommendation #1*: Refund the Medicare program the portion of the estimated $8,983,655 overpayment for claims incorrectly billed that are within the reopening period.**

  In light of the foregoing, EHS declines to accept this recommendation as written. However, for those claims that EHS has acknowledged contained errors affecting Medicare payment, EHS will make the applicable refund.

- ***Recommendation #2*: For the remaining portion of the estimated $8,983,655 overpayment for claims that are outside 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.**

[14] 42 U.S.C. § 1395ddd(f)(3). We acknowledge that OIG is not bound by this statute because it is not a "Medicare contractor," per se. However, these are Medicare overpayments, and the Medicare contractor that processes any associated overpayment demand letter is subject to this provision.

EHS declines to accept this recommendation as written but, consistent with its robust compliance and internal audit program, EHS will continue to address any overpayments consistent with the 60-day rule.

- ***Recommendation #3**: 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.*

  EHS declines to accept this recommendation as written but, consistent with its robust compliance and internal audit program, EHS will continue to address any overpayments consistent with the 60-day rule.

- ***Recommendation #4**: Strengthen its procedures to ensure that (i) homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented, and (ii) beneficiaries are only receiving reasonable and necessary skilled services.*

  EHS generally disagrees that its procedures failed to assure beneficiaries are homebound and that they receive only reasonable and necessary skilled services. EHS has a thorough process that includes providing education, particularly on homebound status, to its care management team, potential referral sources, New Home Care Liaisons, and new home health staff as part of its orientation and onboarding process. Moreover, at the time a patient is referred to EHS for home care, EHS' RNs screen the patient to ensure s/he meets homebound criteria and collects all required documentation up front. In addition to the initial screening by the RN, EHS also has a second staff member review the required documentation to ensure the patient is eligible for home health care. Throughout the course of care, EHS routinely assesses and monitors each patient's status via weekly case management conferences between the field clinicians and the clinical manager. If the documentation does not support homebound status or the ongoing need for medically necessary skilled care, those patients are appropriately discharged.

  Nonetheless, EHS agrees there is always room for improvement, and it consistently seeks opportunities to strengthen its existing policies and procedures. EHS will continue to work diligently to ensure that it complies with all Medicare payment and coverage rules, and it will reeducate its team members to ensure these rules are clearly understood.

V. Closing

EHS respects OIG's oversight authority and the need to ensure Medicare services are properly furnished and billed. However, from EHS' perspective, the audit process undertaken by the OIG was flawed. OIG reviewers repeatedly misapplied the Medicare conditions of payment for home health, identifying "errors" based on irrelevant criteria and leading to a grossly overstated error rate.

While EHS understands it will have the opportunity to challenge these findings on appeal, EHS hopes OIG considers the potential for reputational harm to EHS, and other providers subject to similar OIG audits, when OIG publicizes a report that includes erroneous findings that will likely not be upheld upon appeal.

On behalf of EHS, thank you for the opportunity to provide this response.

Sincerely,

// Brian D. Bewley //

Brian D.
Bewley
Member

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