Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

CMS COULD HAVE SAVED $192 MILLION BY TARGETING HOME HEALTH CLAIMS FOR REVIEW WITH VISITS SLIGHTLY ABOVE THE THRESHOLD THAT TRIGGERS A HIGHER MEDICARE PAYMENT

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Office of Inspector General

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

CMS Could Have Saved $192 Million by Targeting Home Health Claims for Review With Visits Slightly Above the Threshold That Triggers a Higher Medicare Payment

Why OIG Did This Audit

Under the prospective payment system (PPS), Medicare pays home health agencies (HHAs) for each 60-day episode of care that beneficiary receives, called a payment episode. During our audit period, if an HHA provided four or fewer visits in a payment episode, Medicare paid the HHA a standardized per-visit payment. Claims for these types of payments are called Low Utilization Payment Adjustment (LUPA) claims. Once a fifth visit was provided during the payment episode (i.e., above the LUPA threshold), Medicare paid an amount for the services provided that was, in general, substantially higher than the per-visit payment amount. Because of the large payment increase starting with the fifth visit, HHAs have an incentive to improperly bill claims with visits slightly above the LUPA threshold.

Our objective was to determine whether payments for home health services with five to seven visits in a payment episode complied with Medicare requirements.

How OIG Did This Audit

Our audit covered $1.25 billion in Medicare payments to HHAs for claims for home health services provided in 2017 (audit period). We selected a stratified random sample of 120 HHA claims with 5, 6, or 7 visits in a payment episode. An independent medical review contractor determined whether the services met medical necessity and coding requirements.

What OIG Found

Not all payments to HHAs for home health services with five to seven visits in a payment episode complied with Medicare requirements. Of the 120 sampled claims we reviewed, 91 complied with requirements, and for 4 claims there was no documentation available to make a compliance determination. However, the remaining 25 claims did not comply with requirements. As a result, Medicare improperly paid HHAs for a portion of the payment episode (14 claims) and for the full payment episode (11 claims), totaling $41,613. These improper payments occurred because the Medicare administrative contractors (MACs) did not analyze claim data or perform risk assessments to target for additional review those claims with visits slightly above the LUPA threshold of four visits. On the basis of our sample results, we estimated that Medicare overpaid HHAs nationwide $191.8 million for our audit period.

In November 2018 (after our audit period), the Centers for Medicare & Medicaid Services (CMS) finalized a new home health PPS methodology, effective for home health periods of care beginning on or after January 1, 2020. This new methodology revised the LUPA threshold from four visits to a threshold varying from two to six visits. The majority of the claims in our sample (20 of 25) that did not comply with Medicare requirements under the previous PPS methodology would also have not complied with those requirements under the new methodology.

What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the MACs to recover the $41,613 in identified overpayments made to HHAs for the sampled claims; (2) require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review; and (3) instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold, which could have saved Medicare as much as $191.8 million during our audit period.

CMS concurred with our recommendations and described actions that it had taken or planned to take to address the recommendations.

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INTRODUCTION

WHY WE DID THIS AUDIT

Medicare pays home health agencies (HHAs) for each 60-day episode of care that a beneficiary receives. (We refer to this as a "payment episode.") During our audit period,[1] if an HHA provided four or fewer visits in a payment episode, Medicare paid the HHA a standardized per-visit payment based on the types of services (e.g., home health aide services or physical therapy services) provided during each visit. Claims for these types of payments are called Low Utilization Payment Adjustment (LUPA) claims. Once a fifth visit was provided during the payment episode (i.e., above the LUPA threshold), and for all later visits, Medicare paid the HHA an amount for the services provided that was, in general, substantially higher than the per-visit payment amount.

Previous Office of Inspector General (OIG) audits of individual HHA providers determined that HHAs did not always comply with Medicare requirements for billing home health claims. (Appendix E lists related OIG reports.) Because of the large payment increase starting with the fifth visit, HHAs have an incentive to improperly bill claims with visits slightly above the LUPA threshold of four visits. Using computer matching, data mining, and data analysis techniques, we identified HHA claims with five, six, or seven visits, which were at an increased risk of noncompliance with Medicare requirements because of the larger payment for these claims.

OBJECTIVE

Our objective was to determine whether payments to HHAs for home health services with five to seven visits in a payment episode complied with Medicare requirements.

BACKGROUND

Medicare Payments for Home Health Services

Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers skilled services, such as 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 in effect during our audit period, the Centers for Medicare & Medicaid Services (CMS) paid HHAs for each 60-day episode of care that a beneficiary received.

CMS adjusts the episode payment 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

[1] Our audit period covered claims for home health services provided in calendar year 2017.

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. During our audit period, the OASIS classified HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS) payment codes[2] and represent specific sets of patient characteristics.[3] CMS requires HHAs to submit OASIS data as a condition of payment.[4]

Low Utilization Payment Adjustments and Changes to the Home Health Prospective Payment System

During our audit period, if an HHA provided four or fewer visits in a payment episode, the HHA was paid a standardized per-visit payment instead of an episode payment for a 60-day period. Claims for these types of payments are called LUPA claims.[5]

In November 2018 (which was after our audit period), CMS finalized a new PPS methodology, the Patient-Driven Groupings Model (PDGM), effective for home health periods of care beginning on or after January 1, 2020.[6] Table 1 shows a comparison of the previous home health PPS methodology and the new PPS methodology using the PDGM.

Table 1: Comparison of Home Health PPS Methodologies

Previous PPS Methodology	PPS Methodology Using the PDGM
Effective October 1, 2000	Effective January 1, 2020
Unit of payment based on 60-day episode	Unit of payment based on 30-day episode
153 potential HIPPS payment codes	432 potential HIPPS payment codes
Fixed LUPA threshold of four visits regardless of HIPPS payment code billed	Variable LUPA threshold from two to six visits for calendar year (CY) 2020 based on HIPPS payment code billed
Episode payment is increased if one of the therapy thresholds (6, 14, or 20 visits) is met	Episode payment is no longer adjusted for therapy visits; therapy thresholds eliminated

[2] 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.

[3] The final payment is determined at the end 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.

[4] 42 CFR § 484.250.

[5] 42 CFR § 484.230.

[6] 83 Fed. Reg. 56406 (Nov. 13, 2018).

Medicare Administrative Contractors' Processing and Payment of Claims

CMS, which administers the Medicare program, contracts with three Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs.[7] MACs must establish and maintain efficient and effective internal controls, which include system edits. An edit is programming within the standard claim processing system that selects certain claims; evaluates or compares information on the selected claims or other accessible sources; and, depending on the evaluation, takes action on the claims, such as paying them in full, paying them in part, denying payment for them, or suspending them for manual review.

CMS requires the MACs to annually provide assurance that internal controls are in place and to identify and correct any areas of weakness in their operations.[8]

Previous Audits of Home Health Agencies

Previous audits of individual HHAs identified claims with deficiencies in the following areas:

- Some beneficiaries did not meet the definition of "confined to the home."[9]
- Some beneficiaries were not in need of skilled services.
- Some HHAs did not submit some OASIS data in a timely fashion.
- Some home health services were not adequately documented.

Medicare Requirements for Home Health Agency Claims and Payments

Medical Necessity of Home Health Services

Medicare requires that services, including home health services, be medically necessary. Specifically, 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)).

[7] The MACs are Palmetto GBA, LLC; CGS Administrators, LLC; and National Government Services, Inc.

[8] CMS's *Medicare Financial Management Manual*, Pub. No. 100-06, chapter 7, § 10.

[9] An 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. Although 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 (Social Security Act §§ 1814(a) and 1835(a)).

The determination of whether care is reasonable and necessary is "based on information provided on the forms and in the medical record concerning the unique medical condition of the individual beneficiary." The 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)).

Conditions of Payment for Home Health Services

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and Federal regulations (42 CFR §§ 409.41(b) and (c) and 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 or in need of physical therapy or speech-language pathology or has a continuing need for occupational therapy,
- under the care of a physician, and
- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition of payment, a physician must sign and date the plan of care before the claim is submitted for final payment (42 CFR § 409.43(c)(3)(i)).[10] 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)).

Appendix B contains the details of selected Medicare coverage and payment requirements for home health services.

HOW WE CONDUCTED THIS AUDIT

Our audit covered approximately $1.25 billion in Medicare payments to HHAs for 549,768 claims. These claims were for home health services provided in CY 2017.[11] Because of the large increase in payment starting with the fifth visit, we focused our audit on claims for home health services with five, six, or seven visits in a payment episode. We selected for review a stratified random sample of 120 claims with payments totaling $279,035.

[10] After our audit period, 42 CFR § 409.43(c)(3) was redesignated as 42 CFR § 409.43(c)(2) and revised. See 83 Fed. Reg. 56406, 56627 (Nov. 13, 2018) (effective Jan. 1, 2019).

[11] The CY was determined by the home health claims with episode-of-care "through" dates in CY 2017. The "through" date is the last day on the billing statement covering services provided to the beneficiary.

We evaluated compliance with billing requirements for home health claims with five, six, or seven visits and submitted the sampled claims to an independent medical review contractor to determine whether the services met medical necessity and coding requirements. If the requirements were not met, the contractor determined whether the requirements were not met for some of the visits provided during the payment episode (i.e., for a portion of the payment episode) or for all the visits provided during the episode (i.e., the full payment episode).

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 describes our audit scope and methodology, Appendix C describes our statistical sampling methodology, and Appendix D contains our sample results and estimates.

FINDINGS

Not all payments to HHAs for home health services with five to seven visits in a payment episode complied with Medicare requirements. Of the 120 sampled claims we reviewed, 91 complied with requirements, and for 4 claims there was no documentation available to make a compliance determination.[12] However, the remaining 25 claims did not comply with requirements. As a result, Medicare improperly paid HHAs for a portion of the payment episode (14 claims) and for the full payment episode (11 claims), totaling $41,613. These improper payments occurred because the MACs did not analyze claim data or perform risk assessments to target for additional review those claims with visits slightly above the LUPA threshold of four visits.

On the basis of our sample results, we estimated that Medicare overpaid HHAs nationwide $191.8 million for our audit period.[13] The majority of the claims in our sample (20 of 25) that did not comply with Medicare requirements under the previous PPS methodology would also not have met Medicare requirements under the new PPS methodology using the PDGM, which was effective January 1, 2020.

MEDICARE REQUIREMENTS

For the reimbursement of home health services, the beneficiary must be "confined to the home" (homebound) (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and 42 CFR §§ 409.41(c) and

[12] We did not receive documentation for four sampled claims because the HHAs had gone out of business or were under investigation. We did not include these claims in our estimated overpayments.

[13] The estimated overpayment amount was $191,773,995.

409.42). The beneficiary must: (1) be in need of skilled nursing care on an intermittent basis or (2) be in need of physical therapy or speech-language pathology or (3) have a continuing need for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and 42 CFR § 409.42(c)).

The physician's orders for services in the plan of care must indicate the type of services to be provided, 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 (42 CFR § 409.43(b)). 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 beneficiary's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e)).

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).

PAYMENTS FOR HOME HEALTH SERVICES DID NOT COMPLY WITH MEDICARE REQUIREMENTS

Medicare improperly paid HHAs for 25 sampled claims that did not meet 1 or more Medicare requirements.[14] Specifically, services were provided to beneficiaries who were not confined to the home (21 claims), services were provided to beneficiaries who did not require skilled services (4 claims), incorrect HIPPS payment codes were assigned (2 claims), and documentation was inadequate to support the service provided (1 claim).[15]

Of these payments, Medicare improperly paid HHAs for a portion of the payment episode for 14 claims and for the full payment episode for 11 claims, totaling $41,613.

- Of the 14 home health claims for which Medicare improperly paid HHAs for a portion of the payment episode, 12 claims should have been billed as LUPA claims.[16] For example, for one claim that was paid $3,131, five of the seven visits did not meet Medicare requirements. Therefore, the claim should have been billed as a LUPA claim because the two allowable visits were below the LUPA threshold of four visits. Based on the standardized per-visit payment rate, the HHA should have been paid $389, resulting in

[14] The total number of deficiencies is greater than 25, because 3 sampled claims had more than 1 deficiency.

[15] For the one claim with inadequate documentation, the HHA refunded the overpayment during our audit because it determined that the claim should not have been billed. Therefore, we did not submit this claim to the independent medical review contractor.

[16] For two claims, seven visits were provided during the payment episode, and only one visit did not meet Medicare requirements. Because the six allowable visits were slightly above the LUPA threshold of four visits, the HHAs would still have received the full episode payment.

an improper payment of $2,742 for this claim. Because the 12 claims should have been billed as LUPA claims, Medicare should have used the standardized per-visit payment rate, which would have resulted in lower payments to the HHAs.

- Of the 11 home health claims for which Medicare improperly paid HHAs for the full payment episode, all of the visits provided during the episode of care did not meet Medicare requirements. Therefore, Medicare should not have paid for any of the claims.

MEDICARE ADMINISTRATIVE CONTRACTORS DID NOT PERFORM DATA ANALYSIS OR RISK ASSESSMENTS TO TARGET CLAIMS WITH VISITS SLIGHTLY ABOVE THE LOW UTILIZATION PAYMENT ADJUSTMENT THRESHOLD

The improper payments occurred because the MACs did not analyze claim data or perform risk assessments to target for additional review those claims with visits slightly above the LUPA threshold of four visits. Before our audit period, one MAC had an edit that reviewed claims with five to nine visits in a payment episode. However, CMS discontinued this edit and instructed the MACs to focus on "targeted probe and educate" reviews of HHAs.[17] The remaining two MACs did not have an edit, before or after our audit period, to review claims with visits slightly above the LUPA threshold.

Based on the results of our audit, we concluded that the targeted probe-and-educate reviews were not sufficient to prevent improper payments for claims with visits slightly above the LUPA threshold. As part of these reviews, the MACs had the ability to select topics of review based on their own data analysis (e.g., face-to-face encounter requirements). Data analysis and risk assessments to target these claims for additional review could have identified improperly billed claims during our audit period.

IMPROPER PAYMENTS WERE MADE FOR CLAIMS WITH VISITS SLIGHTLY ABOVE THE LOW UTILIZATION PAYMENT ADJUSTMENT THRESHOLD, AND THESE TYPES OF CLAIMS ARE STILL AT RISK UNDER THE NEW PAYMENT METHODOLOGY

The results of our audit show that there were improper payments under the PPS for home health claims with visits slightly above the LUPA threshold. On the basis of our sample results, we estimated that Medicare overpaid HHAs nationwide $191.8 million for our audit period for home health services with five to seven visits in a payment episode.

The majority of these improper payments would still be improper under the home health PPS methodology that uses the PDGM, effective January 1, 2020, which revised the LUPA threshold

[17] For these reviews, CMS directed each MAC to focus on specific HHAs that had been identified through data analysis as being a potential risk to Medicare. The MAC reviewed 20 to 40 claims per round of review, for a total of up to 3 rounds of review. After each round, providers were offered individualized education based on the results of the reviews. MACs may also educate HHAs throughout the review process, when easily resolved errors are identified, helping providers to avoid similar errors later.

from four visits to a threshold varying from two to six visits based on the HIPPS payment code billed. Specifically, 20 of the 25 sampled claims that we found did not comply with Medicare requirements under the previous PPS methodology would not comply with requirements under the new PPS methodology, which uses the PDGM. Of these 20 claims, 9 would still be billed as LUPA claims, which would result in lower payment amounts.[18] In conclusion, even with the new payment methodology, there is still a significant risk of improper payments for HHA claims with visits slightly above the applicable LUPA threshold.

RECOMMENDATIONS

We recommend that the Centers for Medicare & Medicaid Services:

- direct the MACs to recover the $41,613 in identified overpayments made to HHAs for the sampled claims;

- require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review; and

- instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold, which could have saved Medicare as much as $191,773,995 during our audit period.

CMS COMMENTS

In written comments on our draft report, CMS concurred with our recommendations and described actions that it had taken or planned to take to address the recommendations. CMS's comments are included in their entirety as Appendix F.

CMS's comments on our recommendations are summarized below:

- Regarding our first recommendation, CMS stated that it will instruct its MACs to review the 25 sampled claims to verify our findings and recover any overpayments.

- Regarding our second recommendation, CMS stated that, since our audit period, the MACs have been analyzing data and performing reviews of home health claims that are slightly above the low volume threshold. CMS also stated that it will continue to encourage the MACs to perform data analysis and risk assessments of claims with visits

[18] We determined the HIPPS codes under the PDGM for the 14 sampled claims that were improperly paid for a portion of the payment episode during our audit period. We identified the applicable LUPA threshold for each of those claims to determine whether the claims would be billed as LUPA claims under the PDGM.

slightly above the applicable LUPA threshold as part of the annual improper payment reduction strategy process and will continue to take any action deemed necessary.

- Regarding our third recommendation, CMS stated that it published a booklet regarding the Medicare home health benefit in November 2019. CMS also stated that MACs provide one-on-one education to providers as part of their review process. Finally, CMS stated that it will continue to educate home health providers on proper billing for home health services.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $1,248,206,959 in Medicare payments to HHAs for 549,768 claims. These claims were for home health services with five, six, or seven visits in a payment episode and episode-of-care "through" dates in CY 2017. We selected for review a stratified random sample of 120 home health claims with payments totaling $279,035.

We evaluated compliance with billing requirements for home health claims with five, six, or seven visits and submitted the sampled claims to an independent medical review contractor to determine whether the services met medical necessity and coding requirements. If the requirements were not met, the contractor determined whether the requirements were not met for some of the visits provided during the payment episode (i.e., for a portion of the payment episode) or for all the visits provided during the episode (i.e., the full payment episode).

We limited our review of CMS's internal controls to those applicable to home health claims for services with five to seven visits in a payment episode 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 National Claims History file, but we did not assess the completeness of the file.

We conducted our fieldwork from August 2018 to May 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;

- interviewed CMS program officials to: (1) determine CMS's oversight of home health claims with visits slightly above the LUPA threshold, (2) discuss program and billing requirements for home health claims, (3) gain an understanding of how LUPA and non-LUPA claims are paid, and (4) discuss potential billing issues (e.g., the billing of incorrect HIPPS payment codes) related to home health claims with 5 to 7 visits in a payment episode;

- interviewed the 3 MACs using a standardized questionnaire to obtain an understanding of the edits in place to review home health claims with visits slightly above the LUPA threshold;

- selected for detailed review a stratified random sample of 120 home health claims totaling $279,035 (Appendix C);

- 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 from the HHAs associated with the sampled claims;

- used an independent medical review contractor to determine whether the sampled claims were for services that complied with medical necessity and coding requirements;

- calculated the correct payments for those claims requiring adjustments;

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

- determined the HIPPS codes under the PDGM for the sampled claims that were improperly paid to HHAs for a portion of the payment episode during our audit period;

- identified the applicable LUPA threshold for each of those claims to determine whether the claims would be billed as LUPA claims under the PDGM; and

- discussed the results of our audit with CMS officials.

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

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 outcome; 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 payment 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, speech-language pathology, or occupational therapy;[19] (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 CMS's *Medicare Benefit Policy Manual* (Benefit Policy Manual), Pub. No. 100-02, chapter 7, § 30).

[19] 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, a physical therapy service, or a speech-language pathology service as required by law. Once that 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)).

According to the Benefit Policy 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[20] added a requirement to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act that the physician 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, has occurred no more than 90 days before 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.[21]

Confined to the Home

For 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 Benefit Policy Manual (chapter 7, § 30.1.1). Revision 233 of section 30.1.1 (effective January 1, 2017) covered our audit period.

[20] 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), is collectively known as the Affordable Care Act.

[21] See Federal regulations (42 CFR § 424.22(a)(1)(v)) and the Benefit Policy Manual, chapter 7, section 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 233 states that for a patient to be eligible to receive covered home health services under both Medicare Parts A and 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 will be considered "confined to the home" (homebound) if the following two criteria are met:

Criterion One

The patient must either:

- because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or

- have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criterion One conditions, the patient must also meet two additional requirements defined in Criterion Two below.

Criterion Two

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

Revision 208 (effective January 1, 2015) of section 40.2.1, chapter 7, of the Benefit Policy Manual states that for each therapy discipline for which services are provided, a qualified therapist (instead of an assistant) must assess the patient's function using a method that objectively measures activities of daily living, such as, but not limited to, eating, swallowing, bathing, dressing, toileting, walking, climbing stairs, using assistive devices, and mental and cognitive factors. It states that the measurement results must be documented in the clinical record.

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 Benefit Policy 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 Benefit Policy Manual, chapter 7, § 50.7).

Requiring Skills of a Licensed Nurse

Federal regulations (42 CFR § 409.44(b)(1)) 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 (Benefit Policy Manual, chapter 7, § 40.1.1).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) and the Benefit Policy 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 Benefit Policy Manual (chapter 7, § 30.5.1) state that, before 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 that is related to the primary reason the patient requires home health services. In addition, the Benefit Policy 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 in 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 (Benefit Policy 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 Benefit Policy Manual, chapter 7, § 30.2.6).

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

For CY 2017, Medicare paid HHAs $1,250,305,397 for 551,689 claims for home health services with 5, 6, or 7 visits from a skilled service provider.[22] We excluded payments, representing 1,921 claims, that were: (1) less than $500 and (2) associated with 5 HHA providers that were under review by OIG in which the audit scope included CY 2017 claims. We compared the sampled claims with all of the claims in the recovery audit contractor's data warehouse and did not find any claims that the contractor had excluded from future reviews. The resulting sampling frame contained 549,768 home health claims, totaling $1,248,206,959 in Medicare payments to HHAs.

SAMPLE UNIT

The sample unit was a home health claim.

SAMPLE DESIGN

We used a stratified random sample (Table 2).

Table 2: Strata for Our Sample

Stratum	Description	No. of Claims	Value of Claims
1	HHA claims for services with five visits	179,645	$387,887,527
2	HHA claims for services with six visits	186,139	420,821,963
3	HHA claims for services with seven visits	183,984	439,497,469
Total		**549,768**	**$1,248,206,959**

SAMPLE SIZE

We randomly selected 40 claims from stratum 1, 40 claims from stratum 2, and 40 claims from stratum 3. Our total sample size was 120 claims.

[22] We verified that three types of claims were excluded from the target population: (1) Request for Anticipated Payment claims, which, by definition, are not final HHA claims; (2) LUPA claims; and (3) Partial Episode Payment claims associated with HHA transfers.

SOURCE OF RANDOM NUMBERS

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

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum. After generating 40 random numbers for each of the 3 strata, we selected the corresponding frame items.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to HHAs during our audit period.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 3: Sample Results

Stratum	No. of Items in Sampling Frame	Value of Sampling Frame	Sample Size	Value of Sample	No. of Incorrectly Billed Sample Items	Value of Overpayments
1	179,645	$387,887,527	40	$89,080	4	$7,903
2	186,139	420,821,963	40	88,092	13	22,776
3	183,984	439,497,469	40	101,863	8	10,934
Total	**549,768**	**$1,248,206,959**	**120**	**$279,035**	**25**	**$41,613**

Table 4: Estimated Overpayments for Our Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$191,773,995
Lower limit	132,045,387
Upper limit	251,502,603

APPENDIX E: RELATED OFFICE OF INSPECTOR GENERAL REPORTS

Report Title	Report Number	Date Issued
Medicare Home Health Agency Provider Compliance Audit: Residential Home Health	A-05-16-00063	4/9/2020
Medicare Home Health Agency Provider Compliance Audit: Palos Community Hospital Home Health Agency	A-05-17-00022	12/5/2019
Medicare Home Health Agency Provider Compliance Review: Angels Care Home Health	A-07-16-05093	10/30/2019
Mederi Caretenders Home Health Billed for Home Health Services That Did Not Comply With Medicare Billing Requirements	A-07-16-05092	8/20/2019
Great Lakes Home Health Services, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements	A-05-16-00057	5/28/2019
Metropolitan Jewish Home Care, Inc., Billed for Home Health Services That Did Not Comply With Medicare Requirements	A-02-16-01001	5/20/2019
EHS Home Health Care Service, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements	A-05-16-00055	5/13/2019
Excella HomeCare Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements	A-01-16-00500	5/8/2019

APPENDIX F: CMS COMMENTS

DEPARTMENT OF HEALTH & HUMAN SERVICES

Centers for Medicare & Medicaid Services

Administrator
Washington, DC 20201

DATE: June 24, 2020

TO: Amy J. Frontz
Deputy Inspector General for Audit Services
Office of Inspector General

FROM: Seema Verma
Administrator
Centers for Medicare & Medicaid Services

SUBJECT: Office of Inspector General (OIG) Draft Report: CMS Could Have Saved $192 Million by Targeting Home Health Claims for Review With Visits Slightly Above the Threshold That Triggers a Higher Medicare Payment (A-09-18-03031)

The Centers for Medicare & Medicaid Services (CMS) appreciates the opportunity to review and comment on the Office of Inspector General's (OIG) draft report. CMS is committed to providing Medicare beneficiaries with high quality healthcare while protecting taxpayer dollars by preventing improper payments.

A home health agency is a public agency or private organization primarily engaged in providing skilled nursing services and other therapeutic services. Medicare Parts A and B cover eligible home health services that are paid for under a prospective payment system. The prospective payment system provides payment for: part-time or intermittent skilled nursing care; part-time or intermittent home health aide care; therapy (physical, occupational, and speech-language pathology); medical social services; and medical supplies. For episodes of care that began before January 1, 2020, Medicare paid home health agencies for each 60-day episode of care that a beneficiary received. If a home health agency provided four visits or less in an episode, they were paid a standardized per visit payment instead of an episode payment for the 60-day period. These payment adjustments are called low utilization payment adjustments. In November 2018, CMS finalized a new case-mix classification methodology based on a 30-day period of care. This new methodology revised the low utilization payment adjustment threshold from four visits to a threshold that varies from two to six visits dependent upon the payment group. These changes took effect for periods of care beginning on or after January 1, 2020.

CMS uses a robust program integrity strategy to reduce and prevent Medicare improper payments, including automated system edits within the claims processing system and prepayment and postpayment medical reviews. As part of this strategy, CMS recovers identified overpayments in accordance with relevant law and agency policies and procedures. For example, since the audit period, CMS contractors have been analyzing data and performing reviews of home health claims that are slightly above the low utilization payment adjustment threshold and taken appropriate action where necessary. Further, CMS educates health care providers on appropriate Medicare billing through various channels including the Medicare Learning Network, weekly electronic newsletters, and quarterly compliance newsletters. More specifically, a booklet on the Medicare home health benefit, which includes information on

qualifying for home health services, consolidated billing, therapy services, and physician billing and payment, along with other resources, was published in November 2019.[1]

It is important to note that the estimated overpayments reported by the OIG represent approximately one percent of the total payments made to home health agencies by Medicare Part A and B in 2017.

The OIG's recommendations and CMS' responses are below.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services direct the MACs to recover the $41,613 in identified overpayments made to HHAs for the sampled claims.

CMS Response
CMS concurs with this recommendation. CMS will instruct its Medicare Administrative Contractors to review the 25 sampled claims to verify the OIG's findings and recover any identified overpayments consistent with relevant law and the agency's policies and procedures.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review.

CMS Response
CMS concurs with this recommendation. Since the audit period, the Medicare Administrative Contractors have been analyzing data and performing reviews of home health claims that are slightly above the low volume threshold. CMS will continue to encourage the Medicare Administrative Contractors to perform data analysis and risk assessments of claims with visits slightly above the applicable low utilization payment adjustment threshold as part of the annual improper payment reduction strategy process and to continue to take any action deemed necessary.

OIG Recommendation
The OIG recommends that the Centers for Medicare & Medicaid Services instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold.

CMS Response
CMS concurs with this recommendation. As stated above, CMS published a booklet regarding the Medicare home health benefit in November of 2019. Further, Medicare Administrative Contractors provide one-on-one education to providers as part of their review process. CMS will continue to educate home health providers on proper billing for home health services.

[1] https://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNProducts/Downloads/Home-Health-Benefit-Fact-Sheet-ICN908143.pdf