

**Memorandum**

Date MAR 14 2001
From Michael F. Mangano
Acting Inspector General

Subject Review of Medicare Home Health Services in Florida (A-04-99-01195)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

Attached are two copies of the U.S. Department of Health and Human Services, Office of Inspector General's final report entitled, "Review of Medicare Home Health Services in Florida."

This report compares the results to an earlier audit reported as "*Results of the Audit of Medicare Home Health Services in Florida*" (A-04-94-02087). Our current review found the error rate in home health claims in Florida is still significant. In our current review, we estimate 20.5 percent of the claims (10.4 percent of the services) in Florida during the 9-month period ended September 30, 1998 were improper and did not meet Medicare reimbursement requirements. This compares to our prior audit in Florida in which we estimated 26 percent of the claims in Florida during the month of February 1993 did not meet Medicare reimbursement requirements.

This report is also a companion report to our report, "*Review of Medicare Home Health Services in California, Illinois, New York, and Texas*" (A-04-99-01194). In that review we estimated that 19 percent of the services in those four States during the 9-month period ended September 30, 1998 were improper or highly questionable and did not meet Medicare reimbursement requirements.

As indicated in our audits of home health services in Florida and the four States, the error rate of unallowable services provided by home health agencies (HHA) is still significant. We continue to believe that the majority of the unallowable services were provided because of inadequate physician involvement. In addition, we believe a future study will be required to determine the error rate under the new prospective payment system (PPS) for HHAs.

Therefore, we are recommending the Health Care Financing Administration (HCFA):

- (1) revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days;
- (2) compute an HHA error rate in the future to measure the impact of the new PPS with the accompanying behavioral changes; and
- (3) instruct the intermediaries to collect the overpayments identified in our current review sample.

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In response to our draft report, HCFA noted that although the error rate of 20.5 percent is significant, the rate is a reduction from our previous review in 1993 in which we estimated the error rate to be 26 percent. The HCFA concurred with our recommendations to compute an HHA error rate for services subsequent to the October 2000 implementation of PPS and to instruct the fiscal intermediaries to collect the overpayment identified in the sample. However, HCFA did not agree with our recommendation to revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days. Since we have identified the lack of physician involvement as a long-standing problem, we are continuing to recommend physician contact. The HCFA's response is included as APPENDIX E of our report.

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please contact me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-99-01195 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF MEDICARE HOME
HEALTH SERVICES IN FLORIDA**



**MARCH 2001
A-04-99-01195**

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From *Michael Mangano*
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Acting Inspector General

Subject Review of Medicare Home Health Services in Florida (A-04-99-01195)

To Michael McMullan
Acting Principal Deputy Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of 1998 Medicare home health services in Florida and compares the results to an earlier audit reported as "*Results of the Audit of Medicare Home Health Services in Florida*" (A-04-94-02087). This is a companion report to our report "*Review of Medicare Home Health Services in California, Illinois, New York, and Texas*" (A-04-99-01194) in which we also compared results to an earlier audit of home health services in those four States.

OBJECTIVE

The objectives of this current audit were to determine whether Medicare payments to home health agencies (HHA) in Florida during the 9-month period ended September 1998 met Medicare reimbursement requirements and, in conjunction with the findings in our review of home health services in the four above-mentioned States, to evaluate the implications of our results on future HHA payments.

SUMMARY OF FINDINGS

Our current review found the error rate in home health claims in Florida is still significant. In our current review, we estimate 20.5 percent of the claims in Florida during the 9-month period ended September 30, 1998 were improper and did not meet Medicare reimbursement requirements. We estimate during that period the intermediaries approved unallowable or highly questionable claims with charges totaling about \$78.6 million out of the Florida universe of \$649.8 million in charges. This compares to our prior audit in Florida in which we estimated 26 percent of the claims in Florida during the month of February 1993 did not meet Medicare reimbursement requirements. Since our prior review covered a 1-month

period and our current review covered a 9-month period, the projections of total dollar amounts of overpayments are not comparable.

In addition to determining the error rate on the basis of claims for comparison purposes, we computed the error rate on the basis of services provided. In our current review, we found 10.4 percent of services were improper or highly questionable and did not meet Medicare reimbursement requirements. In our prior review, we did not calculate an error rate on the basis of services provided. Our recent four-State HHA review estimated that 19 percent of the services during the 9-month period ended September 30, 1998 were improper or highly questionable and did not meet Medicare reimbursement requirements.

In our opinion, our reviews have demonstrated that the majority of the unallowable services continue to be provided because of inadequate physician involvement. In both reviews, we found physicians did not always review or actively participate in developing the plans of care they signed.

We are concerned that the rate of improper or highly questionable services in our current reviews, i.e., 10.4 percent in our Florida review and 19 percent rate in our four-State review, is significant. We believe there is a continued need to monitor the error rate under the new prospective payment system (PPS) for HHAs to determine the effect of the new system on behavioral changes and future error rates.

Therefore, we are recommending the Health Care Financing Administration (HCFA):

- ▶ Revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.
- ▶ Compute an HHA error rate in the future to measure the impact of the new PPS with the accompanying behavioral changes.
- ▶ Instruct the intermediaries to collect the overpayments identified in our sample.

In its written response to our draft report, HCFA concurred with our last two recommendations but did not concur with our recommendation to require that certifying physicians examine the patient before ordering home health services and see the patient at least once every 60 days. The Office of Inspector General (OIG) has identified the lack of physician involvement as a long-standing problem and, therefore, we continue to recommend physician contact. The HCFA response is presented as APPENDIX E to this report. The HCFA also made some technical comments which we have incorporated into the final report.

BACKGROUND

Home Health Services

Home health services allow people with limited mobility to live independently while still receiving professional health care services. In order for home health services to be covered by Medicare, beneficiaries generally must be confined to their home; under the care of a physician; and in need of skilled nursing services on an intermittent basis, physical therapy, or speech pathology services, or have a continued need for occupational therapy in those cases where skilled nursing or physical or speech therapy services had previously been provided under the home health benefit but are no longer needed. An HHA is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis.

During the period of our review, January 1998 through September 1998, HHAs were reimbursed under the Interim Payment System (IPS). Under IPS, HHAs were paid the lesser of (1) actual costs, (2) per-visit limits, or (3) per-beneficiary limits. The IPS was used to pay HHAs prior to the October 2000 implementation of the PPS.

Intermediary Responsibility

The HCFA contracts with intermediaries, usually large insurance companies, to assist them in administering the home health benefits program. During our audit period, the intermediaries for most HHAs in Florida were either Palmetto Government Benefits Administrators (Palmetto GBA), United Government Services (UGS), or Wellmark, Inc.

The intermediaries are responsible for:

- processing claims for HHA services;
- administering payment safeguard activities;
- performing liaison activities between HCFA and HHAs;
- making interim payments to HHAs; and
- conducting audits of cost reports submitted by HHAs.

Prior and Current Audits

In 1995, we completed a review entitled, "*Results of the Audit of Medicare Home Health Services in Florida*" (A-04-94-02087) which examined Florida HHA claims approved by the fiscal intermediaries (FI) during February 1993. That review disclosed 26 percent of the claims did not meet Medicare reimbursement requirements.

As a result of that review, we initiated the "*Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*" (A-04-96-02121). In that review we examined home health claims paid during the 15-month period ended March 31, 1996. That report, issued in July 1997, disclosed that 40 percent of the services contained in 146 of 250 HHA claims reviewed did not meet Medicare reimbursement requirements.

Subsequent to those reports, several changes have been made to Medicare's HHA program. In order to determine whether these changes improved the program by reducing the substantial errors uncovered and reported in the earlier audit, the HCFA Administrator requested us to replicate our earlier four-State HHA review using a more current period specified by HCFA. We decided to also replicate our earlier Florida HHA review using the same period specified by HCFA for the four-State HHA review.

Our replicated four-State HHA review estimated 19 percent of the services in the four States during the 9-month period ended September 30, 1998 were improper or highly questionable and did not meet Medicare reimbursement requirements. Our report, "*Review of Medicare Home Health Services in California, Illinois, New York, and Texas*" (A-04-99-01194) was issued in November 1999.

Home Health Legislation

Prior to the Balanced Budget Act of 1997 (BBA), Medicare reimbursed participating HHAs on the basis of reasonable costs, up to specific per-visit limits. The BBA mandated a number of changes in the way Medicare pays for home health services, including the creation of an IPS and a PPS for home health services. Section 4602 of the BBA required implementation of the IPS until the PPS is implemented. The IPS imposed two sets of cost constraints on HHAs--it reduced the existing home health per-visit cost limit and subjected HHAs to an aggregate per-beneficiary cost limit. Under IPS, HHAs are paid the lesser of (1) actual costs, (2) the per-visit limits, or (3) the per-beneficiary limit.

The BBA, as amended by the Omnibus Consolidated and Emergency Supplemental Appropriations Act for Fiscal Year 1999, Public Law 105-277, required the Secretary to develop and implement a PPS for home health services effective on or after October 1, 2000.

The HCFA began implementing the HHA PPS on October 1, 2000. The final rule establishing the requirements for the HHA PPS was published in the Federal Register on July 3, 2000.

SCOPE

The objectives of our audit were to determine whether Medicare payments to HHAs in Florida met Medicare reimbursement requirements and, in conjunction with the findings in our recent four-State review, to evaluate the implications of our results on future HHA payments.

Our sample was selected from the claims processed by three of the four FIs included in the prior Florida review: Palmetto GBA, Wellmark, and UGS. The claims processed by Aetna Life and Casualty Insurance Company (the fourth intermediary included in the prior review), who has since left the Medicare business, were absorbed by Palmetto GBA. During the 9-month period ended September 30, 1998, the 3 FIs approved for payment 522,184 HHA claims from Florida totaling about \$649.8 million in charges. We reviewed a statistical sample of 150 claims. APPENDIX A contains the details on our sampling methodology. APPENDIX B contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by the HHAs met the reimbursement requirements.

We determined the percentage of claims that was in error by using a stratified approach. See APPENDIX C for details. We determined the percent of services that were improper or highly questionable by using a stratified cluster approach. See APPENDIX D for details.

During our current review, we projected the result based on services. In addition, we projected the result based on claims for comparison with the prior audit.

Generally, for each of the 150 claims, we:

- interviewed the beneficiary, family member, or a knowledgeable acquaintance;
- interviewed the physician who certified the plan of care;
- obtained supporting medical records maintained by the HHAs; and
- requested the intermediaries' medical review personnel to determine whether the beneficiaries were homebound and the services were medically necessary.

We did not review the overall internal control structure of the intermediaries or of the Medicare program. We did not test the internal controls because the objective of our review was accomplished through substantive testing.

The methodologies used in the current audit regarding statistical sampling, sample testing, interviews of beneficiaries, interviews of physicians, review of intermediary HHA records, and use of intermediary medical review personnel were, to the maximum extent possible, identical to those methodologies used in the prior audit.

Our audit was made in accordance with generally accepted government auditing standards. Field work was performed in Florida and included visiting the HHAs' administrative offices, physicians' offices, and beneficiaries' residences. The field work was completed in June 2000.

DETAILED RESULTS OF REVIEW

Our current audit showed 55 of the 150 claims included in our random sample contained services that were improper or highly questionable and did not meet the Medicare reimbursement requirements. In our sample of 150 claims, 548 of the 2,526 services did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the three intermediaries for Florida during the 9-month period ended September 1998, we estimate 10.4 percent of the services (20.5 percent of the claims) were improper or highly questionable. The percentage of services in error was computed using a stratified cluster sampling methodology. The percentage of claims in error was determined using a stratified approach. See APPENDICES C and D for the details on our sampling results.

The results of our current review of claims are somewhat comparable with our prior audit results. In our current review, we estimate 20.5 percent of the claims contained services which did not meet Medicare reimbursement requirements. For the population of HHA claims processed by the same intermediaries for Florida during February 1993, we estimated 26 percent of the claims contained services that did not meet Medicare reimbursement requirements.

We believe the majority of unallowable HHA services continues to be provided because of inadequate physician involvement. In our current review, we found physicians did not always review or actively participate in developing the plans of care they signed. They relied heavily on HHA staffs to make homebound determinations and develop the plans of care for home health services. Medicare regulations do not require physicians to personally examine beneficiaries or review medical records before signing certifications stating beneficiaries need home health care. The HCFA has issued guidance stating that "...a patient

is expected to be under the care of the physician who signs the plan of care and the physician certification..." (HCFA's HHA Manual section 204.3).

In our previous reviews, we found inadequate physician involvement, lack of knowledge of beneficiaries of the claims being submitted, and limited medical reviews were the underlying causes of the unallowable services being claimed. Currently, HCFA informs the beneficiaries that a Medicare claim was filed for services by sending them a detailed Medicare Summary Notice form for all services. In addition, HCFA has resumed funding of medical reviews at the intermediaries. However, the lack of inadequate physician involvement has never been completely addressed.

We are concerned that the error rates found in our current Florida review as well as in the four-State review are very significant.

Criteria for Certification of Home Health Services

Regulations at 42 CFR 424.22, state: "Medicare Part A or Part B pays for home health services only if a physician certifies and recertifies..." that "(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine..." and "(iv) the services were furnished while the individual was under the care of a physician...." The regulations require a physician to sign a plan of care that serves as a certification that the services are medically necessary and the beneficiary is homebound. Although HCFA regulations do not provide guidance regarding the meaning of "under the care of a physician," such guidance is provided in HCFA's HHA Manual, section 204.3 which states, "A patient is expected to be under the care of the physician who signs the plan of care and the physician certification. It is expected, but not required for coverage, that the physician who signs the plan of care will see the patient, but there is no specified interval of time within which the patient must be seen."

Services Not Properly Authorized by Physicians or Not Reasonable and Necessary

Our current review disclosed 28 out of 150 claims contained services that were not properly authorized by physicians or not reasonable and necessary. In these 28 claims, we found 251 services for skilled and aide services that were determined to be either not properly authorized by physicians or medically unnecessary by the intermediaries' medical review personnel. This compares with 23 out of 200 claims with services that were found to be not properly authorized by physicians or not reasonable or necessary in our prior review. We did not determine the number of services in error in our prior review.

Many of the physicians who certified home health services on the claims that included services not reasonable and necessary stated the HHAs determined the type and frequency of home care for the beneficiaries. The physician involvement in the preparation of plans of care was limited to merely signing the forms prepared by the HHAs' staffs.

In some instances, the plans of care were signed and dated after the services were performed and after the claims were submitted for payment. In other instances, the plans of care were signed by a nurse, an office manager, a physician's assistant, or a doctor's secretary in the name of the physician.

Medicare regulations require a plan of care and a certification of medical necessity be signed by the same physician and the individual receiving the care be under the care of a physician.

Services to Beneficiaries Who Were Not Homebound

Our current review disclosed 8 out of 150 claims contained services that were provided to beneficiaries who were not homebound. In these 8 claims, we found 100 services did not meet Medicare reimbursement criteria regarding the homebound status for the beneficiaries. This compares with our prior review which found that 16 out of 200 claims included services provided to beneficiaries who were not homebound. We did not determine the number of services in error in our prior review.

During our interviews, the beneficiaries, their families, or HHA records indicated the beneficiaries could leave their homes without considerable effort at the time HHA services were provided. In our review, the determination on the homebound status of the beneficiary was made by the intermediaries' medical review personnel.

Services Not Documented

Our current review disclosed 19 out of 150 claims contained services that were either not documented or not available for our review. In these 19 claims, we found 197 services for which the HHA records showed no evidence the home health services were performed. This compares with our prior review which showed that 8 out of 200 claims were not documented. We did not determine the number of services in error in our prior review.

One of the 19 claims containing 19 services was not available for our review. This claim was at an HHA that had terminated its Medicare contract and had gone out of business. Numerous attempts were made to locate the records. Examples of our efforts include:

- inquiries with neighboring businesses, landlord, and/or property manager;
- contacts with the FI for possible reported forwarding address; and
- contacts with the new HHA that acquired the HHA identified in our sample.

Since the medical records for this HHA could not be located, we recorded these highly questionable services contained in this claim as unallowable.

Effect

We estimate during the 9-month period ended September 30, 1998, the intermediaries approved unallowable and highly questionable claims with charges totaling about \$78.6 million out of the universe of \$649.8 million in charges.

Causes

We believe the unallowable home health services disclosed by our review occurred because of the inadequacy of existing controls to ensure claims approved for payment were for allowable services. The HCFA relied on the treating physicians to ensure services were provided only to eligible beneficiaries. However, the physicians in many cases did not fulfill their responsibility to Medicare, its beneficiaries, or the HHAs.

Additional causes identified in our prior HHA reviews included funding constraints HCFA had imposed on the intermediaries' medical review requirements for home health claims and that beneficiaries did not receive notice of Medicare benefits for home health services, and thus, did not provide the intermediary with feedback regarding services claimed by providers. We believe subsequent actions taken by HCFA have lessened the impact of these causes.

Inadequate Physician Involvement

The Medicare program recognized the physician would have an important role in determining utilization of services. The law requires payment can be made only if a physician certifies the need for services and establishes a plan of care.

In court decisions, the United States District Court has relied heavily on the physician's certifications under the "treating physician rule." This rule has been the turning point in court cases where home health services, previously disallowed by the intermediaries and administrative law judges, were allowed by the court. The rule places a significant reliance on the informed opinion of a treating physician, even if contradicted by substantial evidence because the treating physician is considered to be more familiar with the patient's medical condition than other sources.

We interviewed 118 physicians who signed the plans of care for the beneficiaries in our review. Our audit disclosed too often the physicians' involvement in home health care was limited to signing plans of care prepared by the HHAs without proper evaluation of the patients to assess their needs and homebound status. We found HHAs were determining the need, type, and the frequency of home health services without physician participation.

The physicians' interviews disclosed inadequate involvement in the preparation of plans of care or the determination of homebound status. For example:

- In one instance, the physician signed the plan of care without having knowledge of the patient condition. This compares with four instances in our prior review.
- In 34 instances, the physicians were not aware of the homebound requirement for home health services. This compares with 11 instances in our prior review.
- In 79 instances, the physicians relied on the HHA to prepare the plan of care. This compares with 39 instances in our prior review.

Certain physicians fell into more than one of the categories above, therefore, they were counted more than once.

As we found in our prior reviews, Medicare does not require physicians to personally examine their patients before signing certifications for home care. Thus, the failure of physicians to personally examine their patients does not render the home care unallowable. However, we believe the lack of physician involvement in the assessment of their patients' needs and homebound status was a leading cause of the unallowable services disclosed by our review.

The certification signed by the physicians clearly states the physician considered the beneficiary homebound. However, our review showed the physicians deferred to HHAs on the homebound determination.

Need to Determine Error Rate in the New PPS

The findings in our recent audits indicate during the first 9 months of 1998 the rate of incorrect Medicare home health services in Florida is less than the comparable rate in four other large States (California, Illinois, New York, and Texas). Although we have not conducted a thorough cause and effect analysis, we note that both HCFA and OIG, as well as Medicare contractors, State agencies, and other law enforcement agencies have concentrated much attention in Florida over the last 5 years. For example, HCFA established a special satellite office in Miami which has focused much of its attention on home health and has carried out collaborative projects with OIG, the State of Florida, and the Medicare contractors. The OIG conducted numerous audits and investigations of Florida HHAs. It may be that the lower error rate in Florida indicates the success of these efforts.

Our replicated Florida and four-State HHA reviews have shown that the error rates are still significant. We believe it will be important to continue to monitor the error rate under the new PPS for HHAs. As new incentives for behavioral changes under the PPS emerge, additional study will be required to determine future error rates.

CONCLUSIONS AND RECOMMENDATIONS

As indicated in our audits of home health services in Florida and the four States, the error rate of unallowable services provided by HHAs is still significant. We continue to believe that the majority of the unallowable services were provided because of inadequate physician involvement. In addition, we believe a future study will be required to determine the error rate under the new PPS for HHAs.

We are recommending that HCFA:

- ▶ revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days;
- ▶ compute an HHA error rate for services subsequent to the October 2000 implementation of the PPS; and
- ▶ instruct the intermediaries to collect the overpayments identified in our sample.

HCFA's RESPONSE AND OIG COMMENTS

In response to our draft report, HCFA noted that although the error rate of 20.5 percent found in HHA claims during the 9-month period ended September 30, 1998 is significant, the rate is a reduction from our previous review in 1993 in which we estimated the error rate to be 26 percent. The HCFA recognizes the importance of the physician's role and agrees that some errors can be attributed to the lack of adequate physician involvement. However, HCFA disagrees with our recommendation to require the certifying physicians to examine the patient before ordering home health services and to see the patient at least once every 60 days. The HCFA generally agreed with our other recommendations. The HCFA response is included as APPENDIX E of our report. The HCFA also made some technical comments which we have incorporated into the final report.

A summary of HCFA's response to our recommendations and our comments follows.

OIG Recommendation

The HCFA should revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

HCFA Response

The HCFA agrees with OIG's concern of the importance of the physician's role and shares its concerns that some errors can be attributed to the lack of adequate physician involvement. However, HCFA does not concur with this recommendation. According to HCFA, the home health PPS significantly reduces the incentive to provide unnecessary services.

In addition, to encourage physician involvement, HCFA will permit physicians to be separately reimbursed for the physician services they render in certifying and recertifying covered home health services. In addition, HCFA has reimbursed physicians since 1995 for care plan oversight services rendered with respect to patients requiring complex home health services. The HCFA believes that additional payment for physician certification and recertification, combined with continued reimbursement for care plan oversight services, will increase physician involvement with their Medicare home health patients which will reduce errors and thus eliminate the need to require physicians to examine all patients.

OIG Comments

The OIG, in a series of 20 reports dating back to 1995, has documented that the lack of physician involvement in the delivery of home health services has been a continuing problem and has recommended that HCFA require physician examination of HHA patients. These reports are available on the OIG web site. The HCFA officials believe that the creation of two new HCPCS codes coupled with increased education efforts will substantially increase adequate physician involvement in the delivery of home health services. However, HCFA officials provide no evidence that these actions would lead to the expected improvements. We believe that a 20.5 percent error rate requires drastic actions. Accordingly, we still believe that requiring the certifying physician to examine the patient before ordering the home health services and to see the patient at least every 60 days is the most effective way to ensure that the home health services ordered meet the Medicare coverage and reimbursement requirement.

OIG Recommendation

The HCFA should compute an HHA error rate for services subsequent to the October 2000 implementation of PPS.

HCFA Response

The HCFA concurred with our recommendation. The HCFA indicated that the standard system changes needed to implement the Comprehensive Error Rate Testing for the regional home health intermediaries (RHHI) are scheduled for July 2001. The HCFA expects to have reliable error rates for home health services by the summer of 2002.

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OIG Recommendation

The HCFA should instruct the FIs to collect the overpayment identified in the OIG sample.

HCFA Response

The HCFA concurred with our recommendation. The OIG will furnish the necessary documentation to HCFA.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE

The objective of this assignment was to determine whether Medicare payments for services provided by HHAs in Florida met the Medicare eligibility and reimbursement requirements.

POPULATION

The population was the claims approved for payment by the principal RHHIs for the State of Florida for the period January 1, 1998 through September 30, 1998.

Each of the three RHHIs provided a computer file of the home health claims approved for payment for the State of Florida during the 9-month period ended September 30, 1998. The number of claims per the computer file was:

<u>Stratum Number</u>	<u>RHHI</u>	<u>State</u>	<u>Number of Claims</u>	<u>Charges</u>
1	Palmetto GBA	Florida	475,428	589,326,735
2	Wellmark	Florida	23,439	27,708,318
3	UGS	Florida	<u>23,317</u>	<u>32,791,328</u>
TOTAL			<u>522,184</u>	<u>\$649,826,381</u>

SAMPLE UNIT

The sample unit was a home health claim approved for payment for a Medicare beneficiary. An approved claim includes multiple visits and items of cost for the home health services provided.

SAMPLE DESIGN

A stratified random sample was used. Each of the three RHHIs that processed claims for Florida was considered as a stratum.

SAMPLE SIZE

A sample of 50 claims from each stratum was selected. There are 3 strata with a total sample size of 150 claims.

ESTIMATION METHODOLOGY

Using the Department of Health and Human Services (HHS)-OIG-Office of Audit Services (OAS) RAT-STATS Variable Appraisal Program for stratified samples, we projected the overpayment for services that either were not reasonable or necessary, not to homebound beneficiaries, did not have valid physician orders, or did not have documentation.

VARIABLES PROJECTIONS

RESULTS OF 1998 SAMPLE:

The results of our review are as follows:

<u>Stratum Number</u>	<u>Number of Claims</u>	<u>Sample Size</u>	<u>Value of Errors</u>	<u>Number of Errors</u>
1	475,428	50	5,748.00	9
2	23,439	50	28,865.00	23
3	<u>23,317</u>	<u>50</u>	<u>22,409.00</u>	<u>23</u>
Total:	<u>522,184</u>	<u>150</u>	<u>\$ 57,022.00</u>	<u>55</u>

Point Estimate \$ 78,636,751

----- 90 percent Confidence level-----

Lower Limit	\$38,309,709
Upper Limit	\$118,963,792
Precision Amount	\$40,327,041
Precision Percent	51.28%

STRATIFIED ATTRIBUTES APPRAISAL OF CLAIMS

For the 9 Months Ended September 30, 1998

We used our random sample of 150 claims, 50 from each of 3 RHHIs servicing Florida, to project the occurrence of certain types of errors. We used the HHS-OIG-OAS RAT-STATS Stratified Attribute Appraisal Program to project the percentage of claims in error. The results of these projections are presented below:

Claims That Did Not Meet Medicare Requirements

Quantity of Claims in Error	55
Point Estimate	20.507%
90% Confidence Level	
Lower Limit	12.255%
Upper Limit	28.759%

Not Properly Authorized by Physicians or Not Reasonable or Medically Necessary

Quantity of Claims in Error	28
Point Estimate	16.358%
90% Confidence Level	
Lower Limit	8.493%
Upper Limit	24.223%

Beneficiary Was Not Homebound

Quantity of Claims in Error	8
Point Estimate	0.717%
90% Confidence Level	
Lower Limit	0.318%
Upper Limit	1.117%

Not Documented

Quantity of Claims in Error	19
Point Estimate	3.432%
90% Confidence Level	
Lower Limit	.383%
Upper Limit	6.481%

ATTRIBUTE PROJECTIONS PRIOR REVIEW

For the Month of February 1993

We used a stratified sample of 200 claims out of the 50,202 claims to project the occurrence of certain types of errors. The results of these projections at the 90 percent confidence level are presented below. The projections were made using a stratified methodology.

Claims That Did Not Meet Medicare Requirements

Quantity of Claims in Error	47
Point Estimate	25.997%
90% confidence Level	
Lower Limit	20.596%
Upper Limit	31.398%

Claims for Visits Not Properly Authorized by Physicians or Not Needed by the Beneficiaries

Quantity of Claims in Error	23
Point Estimate	13.104%
90% Confidence Level	
Lower Limit	8.879%
Upper Limit	17.329%

Claims for Visits Made to Beneficiaries That Were Not Homebound

Quantity of Claims in Error	16
Point Estimate	8.124%
90% Confidence level	
Lower Limit	4.842%
Upper Limit	11.406%

Claims for Visits Not Documented, Not Provided, or Provided Less Frequently Than Actually Claimed

Quantity of Claims in Error	8
Point Estimate	4.769%
90% Confidence Level	
Lower Limit	2.048%
Upper Limit	7.490%

STRATIFIED CLUSTER ATTRIBUTES PROJECTION OF SERVICES

For the 9 Months Ended September 30, 1998

We used our random sample of 150 claims, 50 from each of 3 RHHs servicing Florida, to project the occurrence of certain types of errors. Since the sample was taken of claims, we used the HHS-OIG-OAS RAT-STATS Stratified Cluster Attribute Appraisal Program to project the percentage of services in error. For these appraisals, we considered each claim to be a cluster of services. The results of these projections are presented below:

Services That Did Not Meet Medicare Requirements

Quantity of Services in Error	548
Point Estimate	10.42%
90% Confidence Level	
Lower Limit	7.72%
Upper Limit	13.12%

Services That Were Not Properly Authorized by Physicians or Not Reasonable or Medically Necessary

Quantity of Services in Error	251
Point Estimate	6.09%
90% Confidence Level	
Lower Limit	4.24%
Upper Limit	7.94%

Beneficiary Was Not Homebound

Quantity of Services in Error	100
Point Estimate	0.46%
90% Confidence Level	
Lower Limit	0.25%
Upper Limit	0.66%

Services Not Documented

Quantity of Services in Error	197
Point Estimate	3.87%
90% Confidence Level	
Lower Limit	1.93%
Upper Limit	5.81%



DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

Deputy Administrator
Washington, D.C. 20201

DATE: 10/1/98

TO: Michael F. Mangano
Acting Inspector General

FROM: Robert A. Berenson, M.D. *Robert A. Berenson*
Acting Deputy Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Medicare Home Health Services in Florida," (A-04-99-01195)

Thank you for the opportunity to review and comment on the above-referenced draft report related to Medicare payments to home health agencies (HHAs) in Florida. Your current review found that the error rate in HHA claims in Florida is still significant, estimated at 20.5 percent of the claims during the 9-month period ending September 30, 1998. This rate is, however, a reduction from your prior review in 1993 in which you estimated that 26 percent of the claims in Florida did not meet Medicare reimbursement requirements.

Specific efforts taken by our Medicare contractors to achieve the above reduction are just part of our broader strategy to protect Medicare today and into the future. Since 1993, the Clinton Administration made significant efforts to fight waste, fraud, and abuse of the Medicare program, which pays more than \$200 billion each year for health care for nearly 40 million beneficiaries. The result is a record series of investigations, indictments, and convictions, as well as new management tools to identify improper payments to health care providers. Last year, the Federal Government recovered nearly \$500 million as a result of health care prosecutions. Medicare has also reduced the improper payment rate sharply from 14 percent 4 years ago to less than 8 percent last year. The Health Care Financing Administration (HCFA) is committed to achieving further reductions.

We appreciate the effort that went into this report, and the prior report, and the opportunity to review and comment on the issues raised. Our detailed comments on the OIG recommendations are discussed below.

OIG Recommendation

Recommend that HCFA revise Medicare regulations to require the certifying physician to examine the patient before ordering home health services and see the patient at least once every 60 days.

HCFA Response

While we agree with OIG's concern of the importance of the physician's role and share its concern that some errors can be attributed to the lack of adequate physician involvement, we do not concur with this recommendation. Under the home health prospective payment system

(PPS), the incentives change from overutilization to underutilization. There is a lack of incentives under PPS to provide extra services. We continue to believe that mandating visits for purposes of physician certification are likely to generate unnecessary costs.

The role of the physician is critical to ensure that beneficiaries receive needed, physician-ordered home health services. One strategy that HCFA has developed to encourage physician involvement is the establishment of two new HCFA Common Procedure Coding System (HCPCS) codes for physician certification and recertification of home health services. The new HCPCS codes will permit physicians to be separately reimbursed for the physician services they render in certifying and recertifying covered home health services. In addition, HCFA has reimbursed physicians since 1995 for care plan oversight services rendered with respect to patients requiring complex home health services. We believe that additional payment for physician certification and recertification, combined with the current reimbursement for care plan oversight services, will increase physician involvement with their Medicare home health patients.

As part of our overall educational effort on home health PPS, we have developed educational materials for physicians, and we have revised the Medicare home health care brochure to educate beneficiaries on the potential effects of PPS. Although Medicare home health coverage and eligibility does not change under home health PPS, we believe it is important that beneficiaries are aware that they are admitted to home care based on the physician's plan of care, and they should notify their physician if they do not agree with any changes in their care. We believe the additional physician payment coupled with education efforts will increase the critical physician involvement in Medicare home health care. We will continue to monitor the role of the physician under home health PPS.

OIG Recommendation

Recommend that HCFA compute an HHA error rate for services subsequent to the October 2000 implementation of the PPS.

HCFA Response

We concur with comment. The standard system changes needed to implement the Comprehensive Error Rate Testing (CERT) for the regional home health intermediaries are scheduled for July 2001, and we expect to have reliable error rates for those services by the summer of 2002. In August 2000, we started the CERT program at the contractors that process claims for durable medical equipment, prosthetics, orthotics, and supplies. When fully implemented, the CERT program will allow us to calculate various types of error rates. In addition to national error rates, the expanded CERT program will allow us to calculate contractor-specific error rates, as well as error rates specific to a particular type of benefit (e.g., home health services). While these error rates are based on the dollar amount of improper payments made rather than the number of claims or services paid improperly, this program will give us valuable information that will enable us to focus medical review effort efficiently and effectively.

It is our goal that increased physician involvement will reduce payment errors. We believe that provider education and early intervention is key to ensure proper billing under the new PPS, and can help reduce both denials and errors by increasing compliance to the Medicare billing rules. Review of the 1999 OIG Chief Financial Officer audit findings revealed common errors made on home health claims. A letter detailing this information was sent to all home health providers in the summer of 2000. Failure to document the need for daily skilled visits beyond 21 days and/or document the need for daily skilled visits is finite and predictable and failure to obtain dated physician certifications before billing were the two most common billing errors made on home health claims. HCFA has instructed all regional home health intermediaries to make available educational opportunities about the PPS to home health providers to ensure understanding of the billing rules and requirements.

OIG Recommendation

Recommend that HCFA instruct the intermediaries to collect the overpayments identified in the OIG sample.

HCFA Response

We concur that HCFA should direct the fiscal intermediaries to recover the overpayments identified in the OIG sample. While HCFA agrees with the OIG's findings, it cannot attest to the exact dollar amount until those intermediaries, identified in the draft report, receive the necessary data to determine the overpayment and issue demand letters. The OIG has agreed to furnish these documents to the HCFA regional offices and the fiscal intermediaries participating in the audit. We will forward a copy of the draft audit report to the appropriate regional office advising them to contact the OIG auditor for further information.

OIG NOTE: The HCFA also made technical comments which we incorporated into the final report. We deleted the technical comments since they are no longer relevant.