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Medicare Home Health Agency Provider Compliance Audit: HRS Home Health

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REPORT HIGHLIGHTS

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Why OIG Did This Audit

- In calendar year 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare. In that year, nearly 10,000 HHAs participated in Medicare.
- CMS determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims was 7.7 percent, or about $1.2 billion.
- This audit report, part of a nationwide series of home health audits, examined whether HRS Home Health complied with Medicare requirements.

What OIG Found

HRS Home Health complied with Medicare billing requirements for 80 of the 100 home health claims we reviewed. For the remaining 20 claims, HRS Home Health incorrectly billed Medicare for claims with unsupported codes and for skilled services that did not meet requirements, including plan of care requirements.

- Fifteen claims did not meet billing and coding requirements, resulting in overpayments totaling $2,291.
- Four claims did not meet plan of care requirements but did not result in an overpayment.
- One claim did not meet skilled need requirements but did not result in an overpayment.

Based on our sample results, we estimate that HRS Home Health received overpayments of at least $100,696 for the audit period.

What OIG Recommends

We recommend that HRS Home Health: (1) refund the $100,696 in estimated overpayments to the Medicare program; (2) consider conducting one or more internal audits or investigations for claims after our audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program; and (3) strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

In written comments on our draft report, HRS Home Health did not fully concur with our first recommendation to refund the estimated overpayment and responded to our second and third recommendations with actions it has taken or will take to address and prevent the types of findings identified in our audit.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2023, Medicare paid home health agencies (HHAs) about $16 billion for home health services provided to about 2.8 million people enrolled in traditional Medicare (enrollees). In that year, nearly 10,000 HHAs participated in Medicare. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2023 improper payment error rate for home health claims (which is calculated based on July 1, 2021 – June 30, 2022, payments) was 7.7 percent, or about $1.2 billion. This audit is the second to be published of a new series of audits of HHAs.[1] Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. HRS Home Health was one of those HHAs.

OBJECTIVE

Our objective was to determine whether HRS Home Health complied with Medicare requirements for billing home health services on selected types of claims.[2]

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare (Parts A and B) covers eligible home health services such as intermittent skilled nursing and home aide visits, covered therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health Prospective Payment System (PPS), CMS pays HHAs a national, standardized 30-day period payment rate.[3] This standardized payment rate is adjusted by using variables in the Patient-Driven Groupings Model (PDGM) that account for the enrollee's condition and healthcare needs.[4] For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called Home Health Resource Groups (HHRGs).

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The

[1] *Medicare Home Health Agency Provider Compliance Audit: Bridge Home Health (A-05-23-00017),* Dec. 19, 2024; For more information, see Work Plan Summary, accessed on June 9, 2025.

[2] We did not include the following types of claims in our audit that we judged as low risk for waste and abuse: Requests for Anticipated Payment, Low Utilization Payment Adjustments, and Partial Episode Payments.

[3] Adjustments are made for geographic differences in wage levels.

[4] The PDGM became effective January 1, 2020.

patient-specific data for these variables are derived from Medicare claims and the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue to, receive home health services. CMS requires HHAs to submit OASIS data as a condition of payment.[5] CMS uses the HHRGs as the basis for the Health Insurance Prospective Payment System (HIPPS) codes, which determine payment.[6]

While home health PPS payment is made for each 30-day period, patient eligibility is determined based on a 60-day certification period. Medicare permits continuous 60-day recertifications for patients who continue to be eligible for the home health benefit. Medicare does not limit the number of continuous 60-day recertifications as long as the enrollee meets eligibility requirements. Each 60-day certification can include two 30-day payment periods.

CMS administers the Medicare program and contracts with four Medicare administrative contractors (MACs) to process and pay claims submitted by HHAs.

Medicare Requirements for Home Health Services and Claims

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (Social Security Act (the Act) § 1862(a)(1)(A)). Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR §§ 409.42 and 424.22 require, as a condition of payment for home health services, that a physician or other allowed practitioner[7] certify and recertify that the Medicare enrollee is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician or allowed practitioner; and
- receiving services under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner.

[5] 42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019).

[6] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on Mar. 20, 2025.

[7] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

Furthermore, as a condition for payment, a practitioner must certify that a face-to-face (F2F) encounter occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)).[8] In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

The determination of whether care is reasonable and necessary is based on information provided on the forms and in the medical record (e.g., plan of care, certification or recertification statement, the OASIS, progress notes) concerning the unique medical condition of the individual. 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 enrollee's individual need for care (42 CFR § 409.44(a)).

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

HRS Home Health

HRS Home Health is a for-profit HHA headquartered in Lombard, Illinois. Palmetto GBA, its Medicare contractor, paid HRS Home Health approximately $35 million for 18,422 claims for services provided to enrollees during CYs 2020 and 2021 (audit period) based on CMS's Integrated Data Repository data.[9]

HOW WE CONDUCTED THIS AUDIT

Our audit covered $31,063,154 in Medicare payments to HRS Home Health for 13,830 claims provided during the audit period.[10] We selected a simple random sample of 100 claims with payments totaling $227,528 for review. We evaluated these claims for compliance with selected billing requirements and submitted these claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

[8] The F2F encounter can be performed by the certifying physician or allowed practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health (42 CFR § 424.22(a)(1)(v)).

[9] This was the most recent timeframe for which claim data were available at the start of the audit.

[10] Our sampling frame included home health claim payments for 30-day billing periods with beginning dates of service from January 1, 2020, through December 31, 2021, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse. We did not include Requests for Anticipated Payment (42 CFR § 484.205(h) and (i)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

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

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

FINDINGS

HRS Home Health complied with Medicare billing requirements for 80 of the 100 home health claims that we reviewed. For the remaining 20 claims, HRS Home Health incorrectly billed Medicare for services that did not meet billing and coding requirements (15 claims), did not meet plan of care requirements (4 claims), and did not meet skilled need requirements (1 claim). For 13 of these claims, the errors did not result in overpayments.[11] For seven claims, HRS Home Health received overpayments of $2,291.[12]

These errors occurred because HRS Home Health did not always adequately review medical record documentation to prevent the incorrect billing of Medicare claims.

SERVICES DID NOT MEET BILLING AND CODING REQUIREMENTS

Effective January 1, 2020, Medicare pays HHAs for home health services under the Home Health PPS by means of a national, standardized 30-day payment rate calculated using the PDGM. Each 30-day billing period is categorized into 1 of 432 HHRGs for the purpose of adjusting payment under the PDGM.[13] In particular, 30-day billing periods are placed into different subgroups for each of the following broad categories: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses).[14]

[11] While these claim billing errors may not always result in overpayments, findings such as these can and do result in overpayments. Therefore, these findings are relevant to our objective of determining HRS Home Health's compliance with Medicare requirements for billing home health services.

[12] These seven claims qualified for partial Medicare reimbursement. For these seven claims, we determined the difference between what was originally reimbursed and what was eligible for reimbursement.

[13] Adjustments are also made for geographic differences in wage levels.

[14] 84 Fed. Reg. 60478, 60485-60495 (Nov. 8, 2019); 85 Fed. Reg. 70298, 70302-70305 (Nov. 4, 2020); 86 Fed. Reg. 62240, 62245-62246 (Nov. 9, 2021); CMS | Home Health PPS, accessed on Mar. 20, 2025.

The home health PPS Grouper automatically draws information from the home health claim and submitted OASIS assessment to group the 30-day billing period into a HHRG and assigns a corresponding HIPPS code. The HIPPS code is a distinct five-position alphanumeric code that represents the case mix on which payment determinations are made.

The principal and secondary diagnoses reported on the home health claim, which are used to determine the HHRG and resulting HIPPS code, must be supported by information in the certifying practitioner's and/or the acute or post-acute facility's medical record (83 Fed. Reg. 56406, 56461 (Nov. 13, 2018); ICD-10-CM Official Guidelines for Coding and Reporting, section I.B.14; Medicare Program Integrity Manual, ch. 6, § 6.2.4).

For 15 of the sampled claims, HRS Home Health submitted claims for services that did not meet billing and coding requirements. Specifically, HRS Home Health submitted claims with unsupported or incorrect codes. For eight of these claims, the errors did not result in overpayments. For the remaining seven claims, the errors resulted in overpayments of $2,291.

Claims Billed With Unsupported Principal or Secondary Diagnosis Codes

For 14 of the 15 claims in error, HRS Home Health incorrectly billed Medicare for unsupported principal or secondary diagnosis codes. For eight of these claims, removal of the unsupported principal or secondary diagnosis codes did not result in overpayments because the HIPPS code did not change. For the remaining six claims, removal of the unsupported principal diagnosis codes changed the clinical grouping portion of the HIPPS code and resulted in an overpayment of $1,944.[15]

Example: Principal Diagnosis Not Supported

A patient was referred to HRS Home Health for physical therapy by an inpatient rehabilitation physician after suffering a stroke. Skilled nursing was added for medication/disease management and teaching regarding diabetes. The patient's skilled nursing goals for diabetes were initially met; however, physical therapy services were recertified to continue for pain management, gait and balance training, and strength training related to the stroke. Medical review found that the documentation did not support that diabetes was the primary reason for home health services. The documentation supported the stroke as the primary reason for home health services. The change in principal diagnosis code resulted in an overpayment.

[15] The clinical grouping is based on the principal diagnosis reported on the claim and represents 1 of 12 clinical categories that the enrollee's condition falls into. The principal diagnosis must be the primary reason that the enrollee received home health care during the 30-day billing period.

Incorrectly Billed Admission Source Code

For 1 of the 15 claims in error, HRS Home Health billed Medicare for an incorrect admission source code.[16] Specifically, HRS Home Health incorrectly billed for an institutional admission when the documentation showed a community admission. The patient was admitted to home health after a physician encounter, and no inpatient stay occurred. Patients who are admitted to home health after an inpatient stay generally have higher needs and receive more intensive services, so higher payments are given to claims with an institutional admission source. Adjustment of the claim admission source from institutional to community changed the HIPPS code and resulted in an overpayment of $347.

SERVICES BILLED DID NOT MEET PLAN OF CARE REQUIREMENTS

For HHA services to be covered, the individualized plan of care must specify the services necessary to meet the patient-specific needs identified in the comprehensive assessment (42 CFR § 409.43(a)(2)). The plan of care must include the identification of the responsible discipline(s) and the frequency and duration of all visits. All care provided must be in accordance with the plan of care (42 CFR § 409.43(a)(3)).

The plan of care and any changes to the plan of care (including verbal orders) must be signed and dated by a physician or allowed practitioner before the claim for each 30-day period is submitted (42 CFR § 409.43(c)(2) and (3) and 42 CFR § 409.43(d)).

For four of the sampled claims, HRS Home Health submitted claims that did not meet plan of care requirements. For three of the claims, there was a plan of care verbal order that was signed and dated by the physician after the claim was submitted to CMS for payment. For the remaining claim, multiple skilled visits were billed that were not ordered in the plan of care. These errors did not result in overpayments because the minimum visit threshold to receive full payment was met.

SERVICES DID NOT MEET SKILLED NEED REQUIREMENTS

The need for skilled services must be substantiated by supporting documentation ((SSA §§ 1814(a)(2)(C) and (a)(concluding paragraph), and 1835(a)(2)(A) and (a)(concluding paragraph); 42 CFR § 424.22(c); 42 CFR § 409.42(c); 42 CFR § 409.44; Medicare National Coverage Determinations Manual, chapter 1, part 3, § 170.1)).

To qualify for home health services, a Medicare enrollee must need skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or have a continuing need

[16] The admission source can be either community or institutional and is categorized based on the setting from which the patient was admitted to home health. If the enrollee was discharged from an acute or post-acute facility within 14 days prior to the home health claim start date, the admission source is institutional. If the enrollee does not meet the definition of an institutional admission, the admission source is community.

for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42(c)). Skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR § 409.44(b) and the Medicare Benefit Policy Manual, chapter 7, § 40).[17]

For one of the sampled claims, HRS Home Health incorrectly billed Medicare for skilled services that did not meet Medicare requirements. Specifically, HRS Home Health incorrectly billed skilled nursing services for a portion of a home health billing period that were not reasonable and necessary for the treatment of the patient's condition. Removal of the unallowable visits did not result in an overpayment because the minimum visit threshold to receive full payment was met.

CAUSES FOR THE NONCOMPLIANCE WITH MEDICARE BILLING REQUIREMENTS

The errors occurred because HRS Home Health did not always sufficiently review: (1) medical records from the certifying practitioner or the inpatient facility to ensure that all codes billed were supported by documentation, (2) plan of care documentation from the certifying practitioner or the inpatient facility to ensure that the encounter met all plan of care requirements, and (3) the documentation of the patient's condition and the services ordered to ensure that skilled services met Medicare requirements.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that HRS Home Health received at least $100,696 in overpayments for the audit period.[18]

[17] Skilled nursing services can include, among other things, overall management and evaluation of a care plan, observation and assessment of a patient's condition, and patient education services (42 CFR §§ 409.44(b) and 409.33).

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

RECOMMENDATIONS

We recommend that HRS Home Health:

- refund the $100,696 in estimated overpayments to the Medicare program,[19]

- consider conducting one or more internal audits or investigations for claims after our audit period based on the risks identified by this audit to identify any similar overpayments the provider might have received and return any identified overpayments to the Medicare program, and

- strengthen its review of medical record documentation to ensure compliance with Medicare billing requirements.

HRS HOME HEALTH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, HRS Home Health did not fully concur with our first recommendation to refund the estimated overpayment and responded to our second and third recommendations with actions it has taken or will take to address and prevent the types of findings identified in our audit. These actions include periodic internal audits as part of HRS Home Health's compliance program, continued enrollment in CMS's Review Choice Demonstration for Home Health Services, and requiring all Medicare claims be reviewed for compliance prior to releasing the claim.

Regarding our first recommendation, HRS Home Health intends to make repayment for the seven claims that we identified as having a $2,291 overpayment. However, HRS Home Health did not concur with the recommendation to repay the estimated overpayment amount of $100,696. HRS Home Health disputed our decision to extrapolate because it believes that: (1) "the 1 percent payment error rate derived from the OIG's review cannot reasonably be characterized as the 'sustained or high level of payment error' necessary to justify extrapolation" and (2) "the OIG's extrapolated overpayment amount is statistically invalid because [our] precision percentage of 68.22% exceeds the maximum precision percentage found by federal courts to be acceptable."

HRS Home Health's comments appear in their entirety as Appendix F.

[19] OIG audit recommendations do not represent final determinations. CMS, acting through a Medicare contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. An overpayment based on extrapolation is re-estimated depending on the result of the appeal.

We maintain that our findings and recommendations are valid, although we acknowledge HRS Home Health's rights to appeal the findings. HRS Home Health's argument that our extrapolation was inappropriate because our error rate did not support a "sustained or high level of payment error," according to guidelines prescribed for CMS and its contractors, is not applicable because OIG is not a Medicare contractor.[20] Federal courts have consistently upheld statistical sampling and extrapolation as a valid means to determine overpayment amounts in Medicare and Medicaid.[21]

Regarding HRS Home Health's argument that OIG's extrapolated overpayment amount is statistically invalid because the precision percentage exceeds the maximum precision percentage found by Federal courts to be acceptable, the legal standard for use of sampling and extrapolation is that it must be based on a statistically valid methodology, not the most precise methodology.[22] Because absolute precision is not required,[23] any imprecision in the sample may be remedied by recommending recovery at the lower limit, which was done in this audit. This approach results in an estimate that is lower than the actual overpayment amount 95 percent of the time, and thus it generally favors the provider.

We properly executed our statistical sampling methodology in that we defined our sampling frame and sampling unit, randomly selected our sample, applied relevant criteria in evaluating the sample, and used statistical sampling software (i.e., RAT-STATS) to apply the correct formulas for the extrapolation.

[20] The Act § 1893(f)(3); Medicare Program Integrity Manual, Pub. No. 100-08, chapter 8, §8.4.1.4.

[21] See *Yorktown Med. Lab., Inc. v. Perales,* 948 F.2d 84 (2d Cir. 1991); *Illinois Physicians Union v. Miller,* 675 F.2d 151 (7th Cir. 1982); *Momentum EMS, Inc. v. Sebelius,* 2013 U.S. Dist. LEXIS 183591 at *26-28 (S.D. Tex. 2013), adopted by 2014 U.S. Dist. LEXIS 4474 (S.D. Tex. 2014); *Anghel v. Sebelius,* 912 F. Supp. 2d 4 (E.D.N.Y. 2012); *Miniet v. Sebelius,* 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Bend v. Sebelius,* 2010 U.S. Dist. LEXIS 127673 (C.D. Cal. 2010).

[22] See *John Balko & Assoc. v. Sebelius,* 2012 U.S. Dist. LEXIS 183052 at *34-35 (W.D. Pa. 2012), aff'd 555 F. App'x 188 (3d Cir. 2014); *Maxmed Healthcare, Inc. v. Burwell,* 152 F. Supp. 3d 619, 634–37 (W.D. Tex. 2016), aff'd, 860 F.3d 335 (5th Cir. 2017); *Anghel v. Sebelius,* 912 F. Supp. 2d 4, 18 (E.D.N.Y. 2012); *Miniet v. Sebelius,* 2012 U.S. Dist. LEXIS 99517 at *17 (S.D. Fla. 2012); *Transyd Enters., LLC v. Sebelius,* 2012 U.S. Dist. LEXIS 42491 at *13 (S.D. Tex. 2012).

[23] *See Pruchniewski v. Leavitt*, 2006 U.S. Dist. LEXIS 101218 at *51-52 (M.D. Fla. 2006).

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $31,063,154 in Medicare payments to HRS Home Health for 13,830 home health claims with service dates in CYs 2020 and 2021.[24, 25] From this sampling frame, we selected for review a simple random sample of 100 home health claims with payments totaling $227,528.

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

We assessed HRS Home Health's internal controls and compliance with laws and regulations necessary to satisfy the audit objective. Our review of internal controls focused on HRS Home Health's procedures when providing and billing home health services. Specifically, we assessed whether HRS Home Health had a robust control environment that included establishing and overseeing an internal control system, and control activities that included policies for complying with Medicare regulations. Our review showed that HRS Home Health's controls were logically designed and applied consistently for most of the claims in our sample. Our internal control review was limited to these areas and may not have disclosed internal control deficiencies that could have existed at the time of this audit.

To assess the reliability of the data obtained from CMS's National Claims History (NCH) file, we: (1) performed electronic testing for obvious errors in accuracy and completeness, (2) reviewed existing information about the data and the system that produced the data, and (3) traced our random sample of 100 home health claims to source documents. We determined that the data were sufficiently reliable for the purposes of this report.

We conducted our audit from June 2022 through April 2025.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted HRS Home Health's paid claim data from CMS's NCH file for the audit period;

[24] We did not include Requests for Anticipated Payment (42 CFR § 484.205(h) and (i)), Low Utilization Payment Adjustments (42 CFR § 484.230), or Partial Episode Payments (42 CFR § 484.235) in our review of claims.

[25] CYs were determined by the HHA claim "from" date of service. The "from" date is the first day on the billing statement covering services provided to the enrollee. We selected claims with "from" dates falling within CYs 2020 and 2021; therefore, claims subjected to audit could include services that ended after CY 2021.

- identified a sampling frame of 13,830 claims totaling $31,063,154;[26]

- selected a simple random sample of 100 claims for detailed review (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 provided by HRS Home Health to support the claims sampled;

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

- reviewed HRS Home Health's procedures for billing and submitting Medicare claims;

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

- verified that claims were billed with the appropriate Core Based Statistical Area (CBSA) and Federal Information Processing Standards (FIPS) codes according to the address where the home health services were provided;[27]

- calculated the correct payments for those claims requiring adjustments; and

- discussed the results of our audit with HRS Home Health 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.

[26] Our sampling frame included home health claim payments for 30-day billing periods with beginning dates of service from January 1, 2020, through December 31, 2021, that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

[27] CMS requires that claims for home health services include the CBSA and FIPS codes to indicate where the services were provided.

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

GENERAL MEDICARE BILLING 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, including therapy needs and functional impairment, that HHA clinicians use when assessing an enrollee who will, or will continue, to receive home health services. CMS requires the submission of OASIS data as a condition of payment (42 CFR §§ 484.45, 484.205(c) and 484.250; and 84 Fed. Reg. 60478, 60490-60493 (Nov. 8, 2019)).

HOME HEALTH PROSPECTIVE PAYMENT SYSTEM

Under the home health PPS, CMS pays HHAs a national, standardized 30-day period payment rate.[28] This standardized payment rate is adjusted by using variables in the PDGM that account for the enrollee's condition and healthcare needs. For the purposes of adjusting payment under the PDGM, each 30-day period is categorized into 1 of 432 case-mix groups, called HHRGs.

HHRGs are different payment groups based on five main case-mix variables under the PDGM: Admission Source, Timing of the Billing Period, Clinical Grouping (from principal diagnosis), Functional Impairment Level, and Comorbidity Adjustment (from other diagnoses). The patient-specific data for these variables are derived from Medicare claims and the OASIS. CMS uses the HHRGs as the basis for the HIPPS codes, which determine payment.[29]

HOME HEALTH COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare enrollees must: (1) be confined to the home; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose

[28] Adjustments are made for geographic differences in wage levels.

[29] HIPPS payment codes are used in several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies. For more information, see CMS | HIPPS Codes, accessed on Mar. 20, 2025.

of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy;[30] (3) be under the care of a physician or allowed practitioner; and (4) be under a plan of care that has been established and periodically reviewed by the certifying physician or allowed practitioner (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; and 42 CFR § 409.42).[31]

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 patient (42 CFR § 409.44(a)).

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

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)(1)(v) state that the certifying physician or allowed practitioner; or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health; must have a F2F encounter with the enrollee. In addition, the practitioner responsible for the initial certification must document the date of the F2F patient encounter and that the encounter, which is related to the primary reason the patient requires home health services, occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of the home health care (42 CFR § 424.22(a)(1)(v)).

Confined to the Home

For the reimbursement of home health services, the enrollee must be "confined to his home" (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). Additionally, the law requires that a practitioner certify in all cases that the patient is confined to his or her home (42 CFR § 424.22(a)(1)(ii)). For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

[30] Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, physical therapy service, or speech language pathology service as required by law. Once the requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes) (76 Fed. Reg. 68526, 68590 (Nov. 4, 2011)).

[31] An allowed practitioner means a nurse practitioner, physician assistant, or clinical nurse specialist. For brevity we will use the term "practitioner" to refer to all allowable practitioner types, including a physician.

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, then 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.

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)).

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)).

Requiring Skills of a Licensed Nurse

Federal regulations (42 CFR § 409.44(b)) state that in determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the enrollee, 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 cannot be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the enrollee or to the enrollee'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.

The determination of whether skilled nursing care is reasonable and necessary must be based solely upon the patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal, or expected to last a long time (42 CFR § 409.44(b)(3)(iii)).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) state that skilled services must require the skills of a qualified physical therapist or a qualified physical therapy assistant under the supervision of a qualified physical therapist, a qualified speech-language pathologist, or a qualified occupational therapist or a qualified occupational therapy assistant under the supervision of a qualified occupational therapist and must be reasonable and necessary. 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.

Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition. To be considered a skilled service, the service must be so inherently complex that it can be safely and effectively performed only by, or under the supervision of, professional or technical personnel (42 CFR § 409.44).[32]

[32] For additional information, see CMS | Jimmo Settlement, accessed on Mar. 20, 2025.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)(1)(v)) state that, a practitioner must certify the patient's eligibility for the home health benefit, including the occurrence of a F2F encounter. The F2F encounter must be documented in the patient's medical record and:

- be related to the primary reason the patient requires home health services;

- occur timely, no more than 90 days prior to the home health start-of-care date or within 30 days of the start-of-care date; and

- be performed by the certifying practitioner, or a physician, nurse practitioner, clinical nurse specialist, certified nurse midwife, or physician assistant who cared for the patient in an acute or post-acute care facility from which the patient was directly admitted to home health.

Plan of Care

The practitioner's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the services and at what frequency the services will be furnished (42 CFR § 409.43(b)). The plan of care must be reviewed and signed by the practitioner 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 practitioner and the date of review (42 CFR § 409.43(e).

APPENDIX C: STATISTICAL SAMPLING METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of 13,830 claims for home health services provided by HRS Home Health with beginning dates of service from January 1, 2020, through December 31, 2021. Medicare payments for those claims totaled $31,063,154.

SAMPLE UNIT

The sample unit was a Medicare home health claim.

SAMPLE DESIGN

We used a simple random sample.

SAMPLE SIZE

We randomly selected a sample of 100 claims.

SOURCE OF RANDOM NUMBERS

We generated the random numbers with the OIG/Office of Audit Services (OAS) Statistical Software.

METHOD FOR SELECTING SAMPLE ITEMS

We sorted the items in the sampling frame by DSY_VW_REC_LNK_NUM[33] and then consecutively numbered the items in the sampling frame. After generating random numbers according to our sample design, we selected the corresponding frame items for review.

ESTIMATION METHODOLOGY

We used the OIG/OAS statistical software to estimate the total amount of overpayments made to HRS Home Health in the sampling frame. To be conservative, we recommended recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[33] This field uniquely identifies claims in CMS's NCH file.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 1: Sample Details and Results

Sampling Frame Size	Total Value of Sampling Frame	Sample Size	Total Value of Sample	Incorrectly Billed Sample Items	Value of Overpayments in Sample
13,830	$31,063,154	100	$227,528	20[34]	$2,291

Table 2: Estimated Overpayments in the Sampling Frame (*Limits Calculated at the 90-Percent Confidence Level)*

Point estimate	$316,852
Lower limit	100,696
Upper limit	533,008

[34] For 13 of these claims, the errors did not result in overpayments.

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Plan of Care Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment
1	X			-
2				-
3				-
4				-
5				-
6				-
7		X		-
8				-
9				-
10	X			-
11				-
12				-
13				-
14				-
15		X		-
16				-
17				-
18				-
19				-
20				-
21				-
22				-
23				-
24				-
25				-
26	X			$508
27				-
28				-
29				-
30		X		-
31	X			$317
32				-
33				-
34			X	-
35				-

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Plan of Care Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment
36				-
37		X		-
38				-
39				-
40				-
41				-
42				-
43				-
44	X			$156
45				-
46				-
47				-
48				-
49	X			$306
50	X			$577
51				-
52	X			-
53				-
54	X			-
55				-
56				-
57				-
58	X			-
59				-
60				-
61				-
62				-
63				-
64				-
65				-
66				-
67				-
68				-
69				-
70				-
71				-
72	X			$80

Sample Number	Services Did Not Meet Billing and Coding Requirements	Services Did Not Meet Plan of Care Requirements	Services Did Not Meet Skilled Need Requirements	Overpayment
73				-
74				-
75				-
76				-
77				-
78				-
79				-
80				-
81				-
82				-
83	**X**			-
84				-
85				-
86				-
87				-
88				-
89				-
90	**X**			-
91				-
92				-
93				-
94				-
95				-
96				-
97	**X**			$347
98				-
99				-
100	**X**			-
Totals	**15**	**4**	**1**	**$2,291**

APPENDIX F: HRS HOME HEALTH COMMENTS

HUSCH BLACKWELL

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May 7, 2025

VIA ELECTRONIC FILING

Sheri Fulcher
Regional Inspector General for Audit Services
Office of Audit Services, Region V
Office of Inspector General
Department of Health and Human Services
233 North Michigan Avenue, Suite 802
Chicago, Illinois 60601

Re: HRS Home Health
A-05-22-00017

Dear Ms. Fulcher:

HRS Home Health ("HRS") appreciates the opportunity to provide comments in response to the United States Department of Health and Human Services, Office of Inspector General's ("OIG's") draft report entitled *Medicare Home Health Agency Provider Compliance Audit: HRS Home Health* ("Draft Report"). HRS's comments to the Draft Report, including the report's conclusions and recommendations, are set forth below.

BACKGROUND INFORMATION ON HRS

HRS has served the greater Chicagoland area for 20 years, providing a comprehensive suite of skilled nursing and therapy services for patients with a need for in-home care. Its leadership and management team has more than 100 years in combined home health experience, which is reflected in its high-quality patient care. HRS has earned Community Health Accreditation Partner ("CHAP") accreditation for meeting the highest performance standards of care, and it performs better than the state or national average on 16 of 17 quality metrics reported by Medicare.

As an organization committed to integrity, HRS has robust policies, procedures, and corporate compliance plans. Notably, the OIG did not identify any flaws in HRS's compliance program or controls. In fact, the OIG agreed that HRS's policies and compliance controls were "logically designed" and applied consistently. HRS believes that its history, leadership, compliance efforts, and culture have resulted in compliant billing practices, which is supported by the Draft Report's conclusions.

RESPONSE TO THE OIG'S DRAFT REPORT

The Draft Report's conclusions support that HRS is dedicated to billing compliance. Of the sample of 100 claims reviewed, the OIG determined that all patients had a need for skilled care and received medically necessary home health services.[1] Rather, the OIG alleged that 7 of the 100 claims had the wrong code billed for services, resulting in a small overpayment to HRS (on average, about $300 overpaid per claim). These few coding errors alleged by the OIG resulted in just a 1 percent overall payment error rate, meaning that even if the OIG is correct in its conclusions, HRS's payment was still 99 percent accurate. This is far better than the 7.7 percent payment error rate that the OIG has identified across the home health industry.[2]

HRS disputes the OIG's decision to extrapolate this very small error rate (an alleged overpayment of $2,291) to the entire universe of claims submitted by HRS to Medicare during the two-year time frame for this audit. The extrapolation is unfounded because the 1 percent payment error rate derived from the OIG's review cannot reasonably be characterized as the "sustained or high level of payment error" necessary to justify extrapolation.[3] Moreover, the OIG's extrapolated overpayment amount is statistically invalid because its precision percentage of 68.22% exceeds the maximum precision percentage found by federal courts to be acceptable – somewhat counterintuitively, a higher precision percentage indicates a less precise extrapolation.[4]

RESPONSE TO THE OIG'S RECOMMENDATIONS

There are three recommendations in the Draft Report; HRS's position with respect to these recommendations is set forth below.

A. Response to OIG Recommendation to Refund of The Estimated Overpayments of $100,696

HRS intends to make a repayment for the 7 claims that the OIG reviewed and identified as having a $2,291 overpayment. However, HRS does not concur with the recommendation to extrapolate this overpayment to all 13,830 claims billed by HRS during the audit period, for the reasons described above. If any attempt is made by HRS's Medicare Administrative Contractor ("MAC") to recoup this extrapolated amount, HRS intends to consider all appeal rights available to it.

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[1] While the OIG claimed that, for one claim, HRS billed for skilled nursing services that were not reasonable and necessary, the OIG conceded that this patient received other necessary skilled services from HRS, such that the claim was still supported as billed.
[2] *See* Draft Report at p. 1.
[3] *See* 42 U.S.C. § 1395ddd(f)(3).
[4] *See Central Louisiana Home Health Care, LLC v. Price*, 2018 WL 7888523 (W.D. La. 2018) (in invalidating an extrapolation, the Court found that "[the auditor's] precision level of 32.4% is the highest reflected in the published case law nationwide (the previous highest was 26.17%).")

B. Response to OIG Recommendation to Consider Conducting Internal Audits for Claims After the Audit Period.

HRS will conduct periodic internal audits as part of its compliance program. Additionally, HRS has been enrolled in the CMS Review Choice Demonstration ("RCD") for Home Health Services since 2017. As part of the RCD, HRS's MAC, Palmetto, reviews 100% of billing periods for compliance with Medicare rules prior to HRS's submission of the final claim. In essence, this means that HRS has been continuously audited by Palmetto and has only submitted those claims that were provisionally affirmed by Palmetto. This additional level of review for Medicare compliance further addresses OIG's recommendation.

C. Response to OIG Recommendation to Strengthen Its Review of Medical Record Documentation.

HRS will require all Medicare claims to be reviewed for compliance with Medicare requirements prior to releasing the claim, consistent with HRS policy.

CONCLUSION

Thank you once again for the opportunity to present these comments to the Draft Report. We appreciate the work that the OIG has put into this effort, and we respectfully request that the OIG consider these comments in reviewing and revising the Draft Report.

Sincerely,

Bryan K. Nowicki

BKN/CMP

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