

REPORT HIGHLIGHTS



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Medicare Home Health Agency Provider Compliance Audit: VNS Health

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 VNS Health complied with Medicare billing requirements.

What OIG Found

For the audit period (July 1, 2020, through June 30, 2022), VNS Health complied with Medicare billing requirements for 84 of the 100 sampled home health claims we reviewed. For the remaining 16 claims, VNS Health incorrectly billed Medicare. Specifically:

- Twelve claims did not meet billing and coding requirements.
- Four claims did not meet face-to-face encounter requirements.
- Two claims did not meet plan of care requirements.

The total exceeds 16 because 2 claims contained more than 1 error.

Based on our sample results, we estimate that, of the \$191,954,445 in Medicare payments covered by our audit, VNS Health received overpayments of at least \$2,965,484 for the audit period.

What OIG Recommends

We made three recommendations to VNS Health, including that it (1) refund the \$2,965,484 in 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.

VNS Health did not concur with any of our recommendations, but it agreed to repay a portion of \$12,606 in actual overpayments associated with five claims that resulted in errors.