Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF HOME HEALTH AGENCY COSTS CLAIMED BY NIAGARA COUNTY HEALTH DEPARTMENT FOR CALENDAR YEAR 1997

JUNE GIBBS BROWN
Inspector General

DECEMBER 1999
A-02-98-01040

Office Of Inspector General
Office Of Audit Services

DEPARTMENT OF HEALTH & HUMAN SERVICES

Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

December 1, 1999

Our Reference: Common Identification Number A-02-98-01040

Ms. Joanne Houillon
Manager, Fraud and Abuse
United Government Services
1515 North Rivercenter Drive
Milwaukee, Wisconsin 53212

Dear Ms. Houillon:

This final report provides you with the results of our audit of home health agency services claimed by the Niagara County Health Department (NCHD) in Lockport, New York (Medicare provider number 33-7001). Our audit was performed under the auspices of Operation Restore Trust (ORT) and included working closely with and receiving considerable assistance from United Government Services (UGS), our ORT partner.

OBJECTIVE

The audit objective was to determine whether the home health care visits claimed by NCHD met Medicare reimbursement guidelines.

SUMMARY OF FINDINGS

We estimate that, of the $2.5 million claimed by NCHD for calendar year (CY) 1997, at least $807,679 was for services which did not meet Medicare guidelines. Using the 90 percent confidence interval, we believe the overpayment is between $807,679 and $1,358,319. We found that 70 of 100 home health claims reviewed, containing 780 of 1,562 services, were not reimbursable under Medicare. The 780 services were found to be unallowable for the following reasons:

- 455 services did not have valid physician orders;
- 249 services which were not, in the opinion of medical experts, reasonable and necessary;
- 58 services which were rendered to beneficiaries who, in the opinion of medical experts, were not homebound;
- 13 services which we determined had not been rendered; and
- 5 services where there was no evidence that a medical service was performed.

We believe our findings clearly indicate a serious lack of compliance by this provider with Medicare regulations and controls. The reasons why NCHD submitted inappropriate claims to UGS, the regional home health intermediary (RHHI), which were ultimately approved for payment included:

- Inadequate controls related to determining the eligibility of beneficiaries and services for Medicare coverage, the obtaining of proper physician authorizations, and the billing of services to the Medicare program.
- Inadequate monitoring by NCHD of its subcontractors to ensure that submitted claims were for services that met Medicare reimbursement requirements.
- The lack of active physician involvement in reviewing and authorizing home health services and lack of physician knowledge of Medicare regulations regarding home health services.

We are recommending that UGS:

- Recover the estimated overpayment of $807,679.
- Take steps to ensure that home health services billed to Medicare by NCHD have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include monitoring more closely the claims submitted by NCHD and conducting subsequent periodic in-depth reviews of its claims.
- Instruct NCHD in its responsibilities to properly monitor subcontractors for compliance with the Medicare regulations.

In its written comments to our draft report, UGS concurred with our findings and recommendations. The complete text of UGS's response is presented as Appendix B to this report.

BACKGROUND

Niagara County Health Department

The NCHD is a Medicare certified home health agency (HHA) with its principal office in Lockport, New York and an additional office located in Niagara Falls, New York. As such, it employs or subcontracts with nurses, home health aides, and therapists.

A Medicare certified agency, such as NCHD, can either provide home health services itself or make arrangements with other medical providers to render home health services. Such services are rendered to Medicare beneficiaries during visits to their residences. Although some of the services claimed by NCHD, specifically nursing, were provided by its own employees, most of the sample services were provided under subcontracts with other medical providers.

For CY 1997, NCHD provided 88,897 home health services to both Medicare and non-Medicare patients. Of this total, 41,284 (46 percent) were Medicare services. The NCHD was reimbursed by the RHHI for services to Medicare beneficiaries based upon submitted claims. For CY 1997, NCHD received reimbursement from Medicare for actual claimed costs totaling $2.5 million.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in sections 1814, 1835, and 1861 of the Social Security Act; governing regulations are found in Title 42 Code of Federal Regulations (CFR), and the Health Care Financing Administration (HCFA) coverage guidelines are found in the Medicare HHA Manual.

Regional Home Health Intermediary Responsibilities

The HCFA contracts with RHHIs, usually large insurance companies, to assist in administering the home health benefits program. The RHHI for NCHD was UGS of Milwaukee, Wisconsin.

The RHHI is responsible for:

- processing claims for HHA services,

- performing liaison activities between HCFA and the HHAs,
- making interim payments to HHAs, and
- conducting audits of cost reports submitted by HHAs.

SCOPE AND METHODOLOGY

The objective of our audit was to determine whether the home health care visits claimed by NCHD met Medicare reimbursement guidelines. This audit was performed under ORT, in partnership with UGS.

For CY 1997, NCHD claimed reimbursement for 41,284 services on 2,253 claims. We reviewed a statistical sample of 100 claims totaling 1,562 services and $99,015 in covered charges for 92 different individuals (7 individuals appeared more than once in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. Appendix A contains the details of our sampling methodology. We used applicable laws, regulations, and Medicare guidelines to determine whether the visits claimed met the reimbursement guidelines.

As part of our review, we attempted to interview the beneficiary or a knowledgeable acquaintance to determine whether they received the services in question and what their medical condition was at the time they were receiving home health services. Interviews were conducted with the beneficiaries or knowledgeable acquaintances associated with 96 of the 100 sample claims; 4 beneficiaries could not be located. In addition, we reviewed and made copies of pertinent supporting medical records maintained by NCHD for all 100 claims in our sample. The beneficiary interview forms and copied medical records were also reviewed by UGS medical personnel to determine if the beneficiary was homebound, whether all services provided were reasonable and necessary and covered by the proper authorization, and whether there was adequate medical documentation for services billed.

Once the medical review of the records was completed, we interviewed only those physicians who had authorized services determined to be unallowable by UGS for the following reasons: (1) the services were provided without valid physician orders, (2) the services were not reasonable and necessary, and (3) the beneficiary was not homebound. We believed these physicians would be able to provide valid information about why the improper services were authorized and ultimately billed to Medicare. We did not, however, interview the physicians authorizing services found to be not rendered or not documented, because, in our opinion, they would not be able to provide insight into why these errors occurred. In total there were 65 claims (762 services) for which authorizing physician interviews were to be conducted.

However, we were able to interview the physicians associated with only 62 claims; the physicians associated with 2 claims had retired and 1 physician could not be located.

Our audit was conducted in accordance with generally accepted government auditing standards. We conducted a limited review of NCHD internal controls over determining the eligibility of beneficiaries and services for Medicare coverage, the authorization of services by physicians, the billing of services to Medicare and the monitoring of services provided by its subcontractors. These controls were further evaluated through our substantive testing. We did not discuss the results of the review with NCHD representatives.

Our field work was performed at NCHD offices in Lockport and Niagara Falls, New York. Interviews were conducted in the beneficiaries' residences and physicians' offices when appropriate, otherwise via the telephone. Copied beneficiary records were reviewed by UGS personnel at their headquarters in Milwaukee, Wisconsin. Our field work was completed in June 1999.

DETAILED RESULTS OF REVIEW

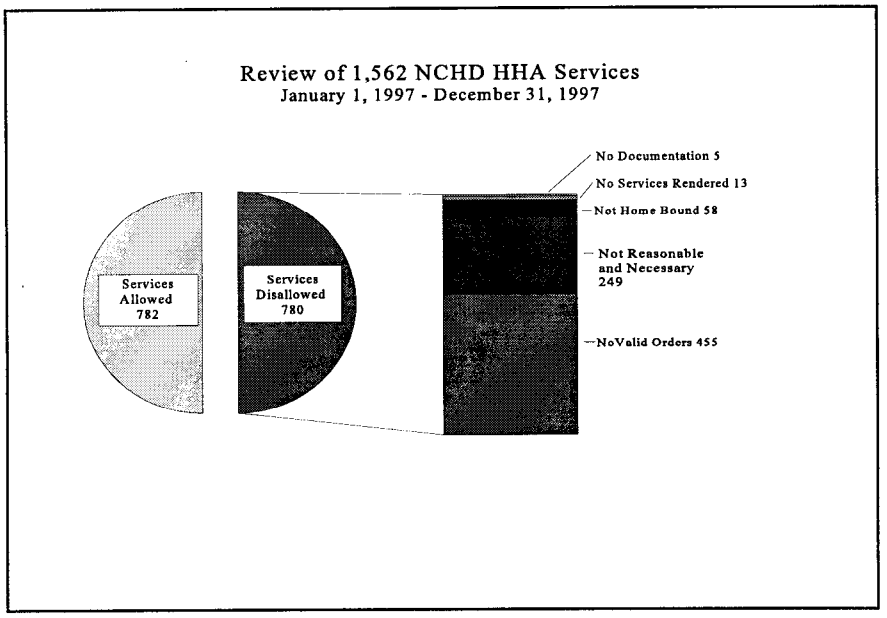
Seventy of the 100 claims in our random sample, containing 780 services and $48,069 of $99,015 tested, did not meet the Medicare reimbursement requirements. Based on these results, we estimate NCHD claimed between $807,679 and $1,358,319 for services that were unallowable for Medicare reimbursement. The midpoint of the confidence interval amounted to $1,082,999. Our tests were based on simple random sampling techniques and the ranges shown have a 90 percent level of confidence with a sampling precision as a percentage of the midpoint of 25.42.

Requirements for Provision of Home Health Services

The Medicare home health benefit allows people with restricted mobility to remain noninstitutionalized and receive needed care at home. To qualify for home health benefits a beneficiary must be:

- confined to home except for infrequent or short absences or trips for medical care;
- under the care of a physician who is a doctor of medicine, osteopathy, or podiatric medicine; and
- in need of one or more of the following qualifying services: skilled nursing, physical therapy, or speech pathology.

The results of our review are summarized below and discussed in detail thereafter.



Services Without Valid Physician Orders

Our review showed 455 services that were rendered and billed without valid physician orders.

Regulations at 42 CFR 424.22 state, in part: "Medicare Part A or 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...." The plan of care must be established and certified by a physician initially and the certification must be updated every 2 months. The plan of care must specify the type and frequency of services to be provided and must be signed and dated by a physician before the bill is submitted to the RHHI for payment.

This error category included instances where the plans of care covering rendered and billed services were not signed and/or dated prior to the submission of the claim to Medicare. There were also cases where services rendered exceeded the physician's orders or the orders were not specific as to the duration of the services or the discipline responsible for rendering them. Finally, other services were not specified in a plan of care nor were they covered by a verbal order.

Services Not Reasonable and Necessary

Our review disclosed 249 services which were not, in the opinion of the RHHI's medical experts, reasonable and necessary.

Regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy...." Section 203.1 of the Medicare HHA Manual states the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary.

As stated above, medical personnel at UGS made the determinations concerning the reasonableness and necessity of services included on each claim. We provided them with our beneficiary interview data and the information copied from the case files for each of the 100 sample claims and they reviewed this material to make their determinations.
Services in this category were deemed unreasonable and unnecessary for the following reasons:

- Medical documentation did not support the need for and/or the actual provision of skilled services.
- No personal care, as defined in Medicare guidelines, was provided during the visit.
- The beneficiary's medical condition did not justify the need for an aide.
- The qualifying skilled service was determined to be unnecessary.

Services to Beneficiaries Who Were Not Homebound

Fifty-eight services were provided to beneficiaries who were not homebound at the time the services were provided. The determinations in all these cases were made by RHHI medical experts based on their review of the beneficiaries' case records, and information gathered during our interviews with the beneficiaries.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." Title 42 CFR 424.22 states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA manual at section 204.1 contains guidance regarding the "homebound" requirement. In general, this section indicates the condition of the beneficiary should be such that there exists a normal inability to leave the home and consequently leaving the home would require a considerable and taxing effort. Furthermore, if the beneficiary does leave the home, he/she may still be considered homebound if the absences are infrequent or for periods of relatively short duration, or are attributable to the need to receive medical treatment.

Beneficiaries or their families, when interviewed, or NCHD records indicated the beneficiaries could leave their homes without considerable effort at the time the home health services were provided. For example:

- One beneficiary, who appeared twice in our sample, was, according to a cousin, able to ambulate without the use of any supportive devices, going for unaccompanied walks five times a day, and working at a vocational training job two days per week. Also, NCHD records did not substantiate that this beneficiary was homebound as there were notes stating the beneficiary was leaving the home frequently for non-medical reasons. Moreover, when interviewed subsequent to UGS review of the medical records, the authorizing physician did not consider the beneficiary to be homebound during the period of time she was receiving home health services.

- Another beneficiary did not consider herself to be homebound as she was able to go out by herself either via a bus or taxi at the time home health services were provided. In addition, NCHD records indicated that the beneficiary was going out to attend family functions and was receiving physical therapy services at her doctor's office three times a week. Finally, when interviewed, the authorizing physician concurred with the beneficiary's belief that she was not confined to the home.

Services Not Rendered

We found evidence that 13 services were not rendered to the beneficiary for a date billed. This determination was made by comparing time documentation (i.e., time sheets) to detailed billing summaries, case notes, Part A inpatient hospitalization records, and other information deemed necessary. Two examples of cases where we determined services were not rendered are as follows:

- On one date of service, NCHD billed a home health aide visit on a date when the beneficiary was hospitalized. Information found in the medical record indicated the beneficiary was admitted to the hospital the day prior to the date billed; however, the aide was not notified. A note on the aide activity sheet stated that when the aide arrived at the beneficiary's home, she found the beneficiary was in the hospital.

- On another claim, NCHD billed a total of 23 home health aide services. Supporting medical and time documentation was found for only 22 of the billed visits. Upon further investigation, we were told by NCHD billing officials that an error occurred when the total number of services to be billed were counted; one visit was actually never made to the beneficiary, yet still billed to Medicare.

Services Not Documented

Evidence, in the form of a progress note or activity sheet, that a medical service had been rendered was missing for 5 services. Section 484.48 of Title 42 CFR states: "A clinical record containing pertinent past and current findings in accordance with accepted professional standards is maintained for every patient receiving home health services. In addition to the plan of care, the record contains ...activity orders; signed and dated clinical and progress notes...."

For each service date billed, we checked to ensure that an activity sheet (for aide services) or skilled note (for all other visits) existed to support that a medical service had been provided. If a note or activity sheet was not found, the service was considered ineligible for Medicare reimbursement.

Effect

In summary, our review of a sample of 100 home health claims, representing a total of 1,562 services, showed that 70, containing 780 services, were not reimbursable under Medicare. We estimate with 95 percent confidence that NCHD was overpaid by at least $807,679 for CY 1997.

Causes

The unallowable home health services disclosed by our review occurred because of the inadequacy of both NCHD and existing Medicare program controls. We found that NCHD controls related to determining the eligibility of beneficiaries and services for Medicare coverage, the obtaining of proper physician authorizations, and the billing of services to the Medicare program were not sufficient to ensure claims submitted for payment were for allowable services. In addition, NCHD monitoring of its subcontractors was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. Finally, HCFA relies on the treating physicians to ensure services are provided only to eligible beneficiaries, i.e., to act as "gatekeepers". However, we found the physicians in our review were not fulfilling this responsibility and depended primarily on NCHD personnel to make these determinations.

Inadequate NCHD Controls--As the result of our (and UGS personnel) review, 780 services, of a total of 1,562 in the sample, were determined to be unallowable. In our opinion, one cause of this significant level of errors was the lack of adequate NCHD controls over the authorization, provision, and billing of home health services.

The majority of the unallowable sample services were denied either due to the lack of a valid physician order or because UGS medical experts determined they were not reasonable and necessary or the receiving beneficiary was not homebound. Finally, billing problems were

noted which included submitting claims for services that were either not supported by medical documentation or were not rendered at all.

During our site visit, we were informed by NCHD officials that there were policies and procedures in effect to ensure the proper physician authorization of services, the provision of services only to homebound beneficiaries who needed them, and the appropriate billing of services to Medicare. However, based on our review and the significance of our findings, it is apparent these controls were not sufficient to ensure NCHD's compliance with Medicare program requirements.

Inadequate Monitoring by NCHD--Sixty-four percent of the 780 services deemed unallowable were provided under subcontracts with other medical providers and not by employees of NCHD. These services included all visits other than skilled nursing services.

Medicare regulations stipulate that home health services must be furnished by, or under arrangements made by a participating HHA. In this regard, Section 200.2 A of the Medicare HHA Manual states that "In permitting home health agencies to furnish services under arrangements it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the agency must exercise professional responsibility over the arranged-for services."

The NCHD officials stated they had policies and procedures in place to monitor the quality and allowability of services provided under arrangement with other providers. In addition, our review of selected contractual agreements between NCHD and other medical providers disclosed clauses citing NCHD's responsibility for ensuring any service provided pursuant to the contract complied with all Federal regulations and adhered to the plan of care established for the patient. We were able to find evidence in the medical records of the implementation of these policies and procedures in the form of supervisory visits, case conference notes and clinical updates. However, these procedures were inadequate, in our opinion, as they failed to prevent the submission of claims for unallowable services.

Inadequate Physician Involvement--The Medicare program recognized the physician would have an important role in determining utilization of home health services. The law indicates that payment can be made only if a physician certifies the need for services and establishes a plan of care.

We interviewed the authorizing physicians for 62 of the 70 sample claims found to be in error. The interviews disclosed that often the physicians' involvement in home health care was limited to signing plans of care prepared by NCHD without proper evaluation of the patients to assess their needs and homebound status. In many cases, NCHD was determining the need, type, and frequency of home health visits without the physicians' participation.

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

- In only 9 of the 62 cases was the physician familiar with the Medicare criteria that requires a beneficiary to be homebound in order to receive home health services.

- In only four cases did the physician personally make the determination the beneficiary was eligible for services, i.e., the beneficiary was homebound and in need of skilled services.

- None of the physicians interviewed indicated they had personally prepared the plan of care, and in 56 instances, the physician relied on NCHD to prepare it.

Currently, 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 active, informed physician involvement in the assessment of their patients' needs and homebound status was a contributing cause of the unallowable services disclosed by our review. The fact that the physicians did not fulfill the "gatekeeping" responsibilities assigned to them by the Medicare regulations created a vulnerability which worsened the impact of NCHD's lack of adequate controls and monitoring.

Further, our findings related to the lack of physician involvement in the authorization of home health care services are similar to those discussed in our earlier report to HCFA entitled ***Results of the Operation Restore Trust Audit of Medicare Home Health Services in California, Illinois, New York and Texas*** (A-04-96-02121). That review found that too often the physician's 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. It was also found that HHAs were determining the need, type, and frequency of home health services without physician participation.

RECOMMENDATIONS

We recommend that UGS:

- Recover the estimated overpayment of $807,679.

- Take steps to ensure that home health services billed to Medicare by NCHD have the proper authorization, appropriate supporting documentation, and are otherwise allowable for reimbursement. These steps should include UGS monitoring more closely the claims submitted by NCHD and conducting subsequent periodic in-depth reviews of its claims.

- Instruct NCHD in its responsibilities to properly monitor subcontractors for compliance with the Medicare regulations.

UGS's Comments

UGS concurred with our findings and recommendations. However, in its response, UGS also commented that the statistical methodology used by the OAS differed from the methodology HCFA has instructed its Fiscal Intermediaries to utilize when performing FI reviews. In this regard, UGS requested to review copies of our working papers and data files relating to the estimated overpayment identified in our audit, and agreed to pursue collection of the overpayment based on HCFA's directive. The complete text of UGS's response is presented as Appendix B.

OIG's Response

We appreciate UGS's prompt response concurring with our findings and recommendations. In regards to the statistical methodology used by the OAS, we appraised the simple random sample results using the difference estimator, and recommended recovery at the lower limit of the 90 percent two-sided confidence interval. This methodology has been successfully used by the OAS for many years on audits, including home health agency audits involving cost report recoveries. We believe that UGS should recover from the home health agency the statistically valid estimated overpayment identified in our audit. We will make available to UGS working papers and data files to assist them in their recovery efforts.

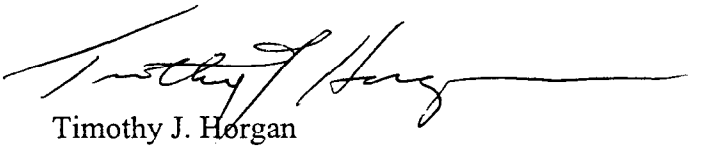
* * * * * * * *

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and general public to the extent the Department chooses to exercise (See 45 CFR Part 5).

To facilitate identification, please refer to Common Identification Number A-02-98-01040 in all correspondence relating to this report.

Sincerely yours,



Timothy J. Horgan
Regional Inspector General
for Audit Services

Direct Reply to Action Official:

Dorothy Collins
Regional Administrator
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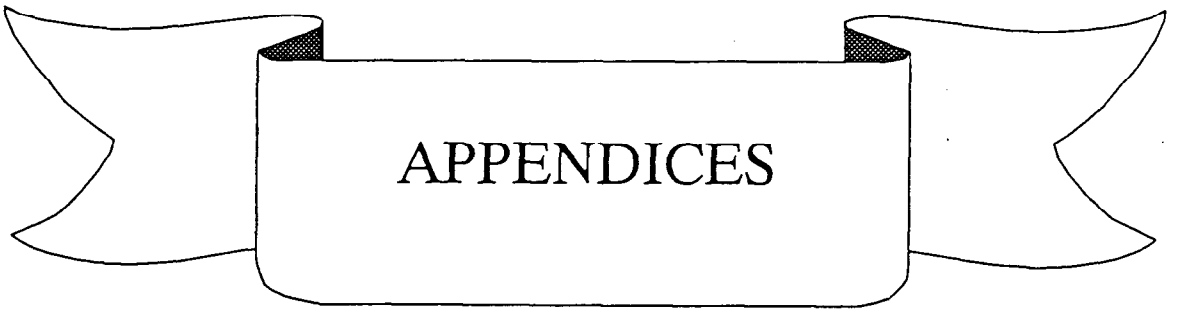
Chicago, Illinois 60601


APPENDICES

SAMPLING METHODOLOGY

Objective:	To determine whether home health services claimed by Niagara County Health Department (NCHD) met Medicare reimbursement guidelines.
Population:	The universe consisted of 2,253 claims for which NCHD reported $2.5 million in costs for calendar year (CY) 1997.
Sampling Unit:	The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple home health service visits.
Sampling Design:	A simple random sample was used.
Sample Size:	A sample of 100 paid claims representing 1,562 services and $99,015.
Source of Random Numbers	Department of Health and Human Services, Office of Inspector General, Office of Audit Services Random Number Generator
Estimation Methodology:	We used the cost per visit for each type of service as contained in NCHD's CY 1997 audited cost report. The amount of error for a sampling unit was computed by multiplying the number of each type of unallowed service by the applicable cost per visit contained in NCHD's CY 1997 audited cost report. Using the Department of Health and Human Services, Office of Inspector General, Office of Audit Services Variables Appraisal Program, we estimated the overpayments on claims for services that either did not meet reimbursement requirements, were not authorized, or were not rendered.

MEDICARE
PART A INTERMEDIARY
NATIONAL FQHC INTERMEDIARY
REGIONAL HOME HEALTH INTERMEDIARY
PHONE 414-226-6075

September 10, 1999

Mr. Timothy J. Horgan
Regional Inspector General for Audit Services
Office of Inspector General/Office of Audit Services
Region II
Jacob K. Javits Federal Building
26 Federal Plaza
New York, NY 10278

RE: Common Identification Number A-02-98-01040
Niagara County Health Department

Dear Mr. Horgan:

This letter is in regard to the draft report entitled "Review of Home Health Agency Costs Claimed by Niagara County Health Department for Calendar Year 1997". United Government Services, LLC. ("UGS") appreciates receiving the draft copy of the report and the opportunity to provide comments. The information was reviewed by Lynda Hunter, the nurse investigator who reviewed the Niagara cases for this report and by Sarah Kleaveland-Kupczak, the Project Manager of the Data and Statistics Unit at UGS..

UGS agrees with the report findings with respect to claim denials and the reasons for those denials. In addition, UGS also reviewed this report focusing on the way in which we might be able to recoup the overpayments identified. The method used by OIG-OAS to estimate the overpayment differs from the method HCFA has instructed its Fiscal Intermediaries to utilize. Rather than using ratio estimators (e.g., percentage denied by service category), it appears that the OIG-OAS instead determined the costs denied per claim, and then calculated the average costs denied per claim to determine the overpayment estimate. While this is a common procedure, it does not allow for the determination of the lower limit of the visits denied per service category. For UGS to recoup the overpayment via the cost report, thus remaining consistent with current practices, this determination must be made.

We may be able to calculate the ratio estimators, but will need to receive the OIG-OAS working papers and data files to do so. If it is approved to recoup the overpayment via a lump sum adjustment, (and not calculate ratio estimators), it is important to note that the OIG-OAS will need to support their methodology if we are challenged on the recoupment of the overpayment amount.

Page 2.
Mr. Timothy J. Horgan

I hope these comments are helpful. UGS enjoyed working with Ms. Hickok and Ms. Griffis of your staff on this project. We would greatly appreciate a copy of the final report upon completion. UGS will pursue collection of the overpayment based on HCFA's directive. If we can be of further assistance in this project, please do not hesitate to contact me. I can be reached at 414-226-6059.

Sincerely,

Joanne Houillon
Manager, Benefit Integrity
United Government Services, LLC.

cc: Sarah Kleaveland Kupczak
Janet Mandel
Lynda Hunter

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