Memorandum

Date NOV 15 1996

From Mike Mangano for June Gibbs Brown
Inspector General

Subject Review of Home Health Claims Submitted by First American Health Care, Inc., Pennsylvania (A-03-95-00011)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Home Health Claims Submitted by First American Health Care, Inc., Pennsylvania." This Office of Inspector General (OIG) report provides you with the results of our review of Medicare home health claims submitted by First American Health Care, Inc., Pennsylvania (FAP), which is a home health agency (HHA) under First American Health Care, Inc., Brunswick, Georgia. The objective of our review was to determine whether home health services claimed by FAP were in accordance with Medicare coverage and reimbursement requirements. Preliminary results of this audit, which was performed at the specific request of Health Care Financing Administration (HCFA) program officials, were provided to HCFA in a memorandum dated February 28, 1996.

We randomly selected for review 100 claims submitted by FAP for Medicare reimbursement during the period January 1, 1995 through April 30, 1995. These claims were for 1,731 home health services provided to 99 Medicare beneficiaries. Our review disclosed that 324 services (18.7 percent of the services in our sample) contained in 28 claims (28 percent of our sample claims) were ineligible for Medicare reimbursement. These services included:

- 223 services (12.9 percent) which were provided to beneficiaries who did not require the care needed to qualify for home health benefits (skilled nursing care on an intermittent basis, or physical or speech therapy), or were not homebound, another prerequisite for home health benefits.

- 101 home health services (5.8 percent) which, although provided to eligible beneficiaries, were ineligible for Medicare reimbursement because they were determined by intermediary medical experts to be medically unnecessary or excessive based on the medical condition of the beneficiaries, or not supported by medical documentation maintained by FAP.

During the period January 1, 1995 through April 30, 1995, FAP submitted to its Medicare intermediary 15,959 claims for home health services totaling an allowed amount of $22,641,822. Based on the results of our review, we estimate that at least $2,471,047 is ineligible for Medicare reimbursement and using the 90 percent confidence interval, we believe the overpayment is between $2,471,047 and $5,148,243.

We are not making any procedural recommendations directed to FAP because, at the time of our review, it was in the process of being sold and would no longer participate in the Medicare program under its present ownership. We had recommended that HCFA incorporate the recovery of the overpayments into the Fiscal Year 1995 year-end periodic interim payments (PIP) reconciliation. The FAP was reimbursed under the PIP method in level biweekly amounts.

After First American was convicted of Medicare-related offenses and HCFA suspended the PIP to its subsidiaries, First American and its subsidiaries filed for bankruptcy protection. The Bankruptcy Court enjoined the suspension and ordered HCFA to renew the PIP. First American and HCFA then began negotiations regarding all alleged overpayments to First American and its subsidiaries from 1989 through 1996.

On August 14, 1996, HCFA responded to a draft of this report. In its comments HCFA concurred with our recommendation but indicated that it could not take administrative action regarding the overpayments because of the bankruptcy proceeding.

On October 4, 1996, First American entered into a civil settlement agreement with the United States which provided for the payment of approximately $232 million to HCFA over the course of several years. The settlement amount reflects the estimated overpayments to all First American subsidiaries over the cost report years 1989 through 1996, including those identified in this report. The settlement agreement releases First American from any further liability for Medicare overpayments from the period reflected in this audit 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 call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-03-95-00011 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF HOME HEALTH CLAIMS SUBMITTED BY FIRST AMERICAN HEALTH CARE, INC., PENNSYLVANIA

JUNE GIBBS BROWN
Inspector General

NOVEMBER 1996
A-03-95-00011

Memorandum

Date NOV 15 1996

From for June Gibbs Brown
Inspector General

Subject Review of Home Health Claims Submitted by First American Health Care, Inc., Pennsylvania (A-03-95-00011)

To
Bruce C. Vladeck
Administrator
Health Care Financing Administration

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- 101 home health services (5.8 percent) which, although provided to eligible beneficiaries, were ineligible for Medicare reimbursement because they were determined by intermediary medical experts to be medically unnecessary or excessive based on the medical condition of the beneficiaries, or not supported by medical documentation maintained by FAP.

During the period January 1, 1995 through April 30, 1995, FAP submitted to its Medicare intermediary 15,959 claims for home health services totaling an allowed amount of $22,641,822. Based on the results of our review, we estimate that at least $2,471,047 is ineligible for Medicare reimbursement and using the 90 percent confidence interval, we believe the overpayment is between $2,471,047 and $5,148,243.

We are not making any procedural recommendations directed to FAP because, at the time of our review, it was in the process of being sold and would no longer participate in the Medicare program under its present ownership. We had recommended that HCFA incorporate the recovery of the overpayments into the Fiscal Year (FY) 1995 year-end periodic interim payments (PIP) reconciliation. The FAP was reimbursed under the PIP method in level biweekly amounts. After First American was convicted of Medicare-related offenses and HCFA suspended the PIP to its subsidiaries, First American and its subsidiaries filed for bankruptcy protection. The Bankruptcy Court enjoined the suspension and ordered HCFA to renew the PIP. First American and HCFA then began negotiations regarding all alleged overpayments to First American and its subsidiaries from 1989 through 1996.

On August 14, 1996, HCFA responded to a draft of this report. In its comments HCFA concurred with our recommendation but indicated that it could not take administrative action regarding the overpayments because of the bankruptcy proceeding. We have summarized HCFA's comments in this report and have included these comments in their entirety as Appendix C.

On October 4, 1996, First American entered into a civil settlement agreement with the United States which provided for the payment of approximately $232 million to HCFA over the course of several years. The settlement amount reflects the estimated overpayments to all First American subsidiaries over the cost report years 1989 through 1996, including those identified in this report. The settlement agreement releases First American from any further liability for Medicare overpayments from the period reflected in this audit report.

BACKGROUND

Home health services allow people with limited mobility to live independently while still receiving professional health care. A 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. The First American Health Care, Inc. (formerly ABC Home Health Services, Inc.) is a Medicare certified HHA. It is a chain organization that included a holding company, home office, 5 senior regional offices, 16 regional offices, and 32 individual providers at 189 separate locations. The FAP was one of the 32 individual providers.

Title XVIII of the Social Security Act, sections 1814 and 1861, authorizes Medicare payments for home health services. Program regulations governing reimbursement for

home health benefits are contained in title 42 of the Code of Federal Regulations (CFR); and the HCFA Medicare Intermediary Manual (MIM). The HCFA contracts with intermediaries, usually large insurance companies, to assist them in administering the home health benefits program. The Iowa South Dakota Health Services Corp. (IASD) was the intermediary designated by HCFA to service FAP.

Among its several functions, IASD was responsible for processing claims submitted by FAP and making interim payments to FAP under the PIP method in level biweekly amounts. The interim payments were determined by estimating the reimbursable amount for the year based on the previous year's experience, as reflected on the cost report, and on information for the current year. For the period January 1, 1995 through June 30, 1995, FAP received interim payments totaling about $36.1 million for Medicare home health care benefits.

SCOPE OF REVIEW

Our audit, which was requested by HCFA, was made in accordance with generally accepted government auditing standards, except that we neither visited FAP nor discussed the results of our review with FAP representatives. The objective of our audit was to determine whether Medicare payments to FAP met Medicare coverage and reimbursement requirements. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by FAP met Medicare coverage and reimbursement requirements.

For the 4-month period ended April 30, 1995, IASD approved payment of 15,959 FAP claims totaling about $23 million in allowed charges. We reviewed a statistical sample of 100 claims totaling 1,731 services for 99 different Medicare beneficiaries. Appendix A contains the details on our sampling methodology. Appendix B contains the details of the results of the projection.

Generally, for each of the 100 claims we:

- interviewed the beneficiary or a knowledgeable acquaintance, primarily to observe their homebound condition;
- obtained beneficiaries payment histories, and supporting medical records maintained by HCFA and FAP, respectively; and
- attempted to contact 85 of the 92 primary and/or prescribing physicians of the 99 beneficiaries whose claims were included in our sample. We could not locate seven physicians and were, therefore, unable to attempt contact.

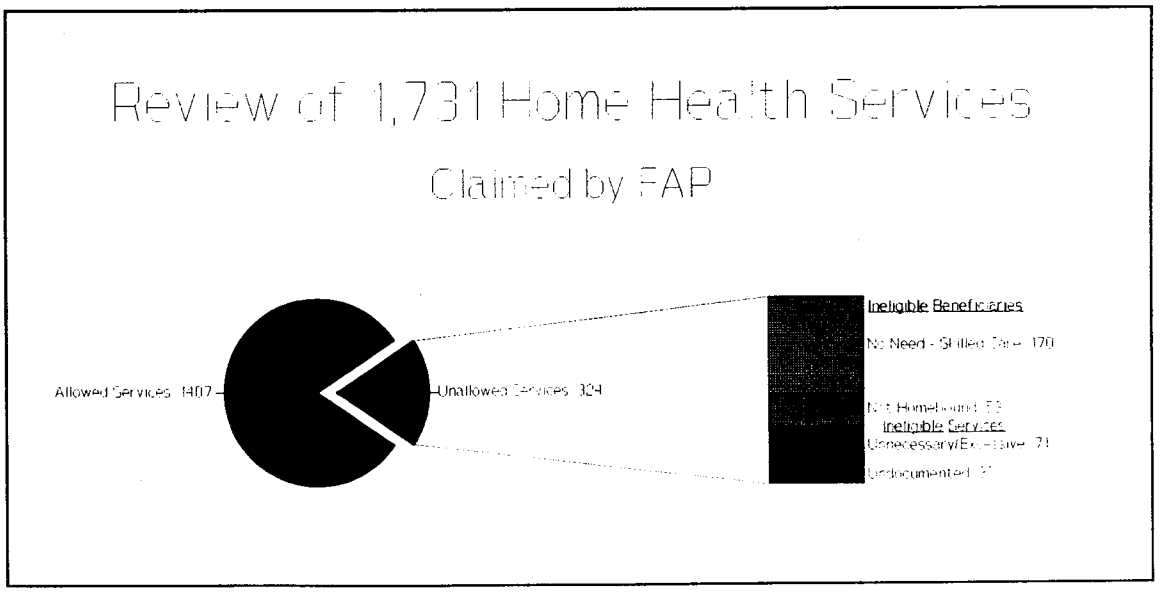
Because we did not have the medical expertise required to make determinations of medical necessity for the home health services included in our sample, we requested the assistance

of IASD medical review personnel. The IASD staff reviewed the medical records of the 99 beneficiaries to determine the reasonableness and medical necessity of the services claimed. They also reviewed our preliminary conclusions relative to whether or not the beneficiaries were homebound. The IASD medical review staff agreed that the 324 home health services identified in this report as being ineligible for Medicare reimbursement are indeed ineligible.

Our field work was performed throughout the Commonwealth of Pennsylvania at the homes (or other nearby sites agreed to by the recipients) of the selected 99 beneficiaries, physician offices, and the office of IASD, Des Moines, Iowa from September 1995 to November 1995. By memorandum dated February 28, 1996, we provided HCFA with the preliminary results of our review.

RESULTS OF AUDIT

Our review showed that 324 of the 1,731 home health services (18.7 percent) included on 28 of the 100 claims in our random sample were ineligible for Medicare reimbursement. As shown in the chart, the services were ineligible for Medicare reimbursement because (1) the beneficiaries who received them were ineligible for home health benefits in that they did not require skilled nursing care or physical or speech therapy, or were not homebound, both prerequisites for home health benefits; and (2) the services, although provided to eligible beneficiaries, were medically unnecessary or excessive or were undocumented. Based on our random sample, we estimate that FAP claims totaling at least $2,471,047 were ineligible for Medicare reimbursement and using the 90 percent confidence interval, we believe the overpayment is between $2,471,047 and $5,148,243.



Beneficiaries Ineligible for Home Health Benefits

Sixteen of the 100 claims included in our statistical sample were totally ineligible for Medicare reimbursement because the beneficiaries on whose behalf the claims were submitted were ineligible for home health benefits. The 16 claims included a total of 223 home health services (12.9 percent).

Prerequisites for Home Health Benefits

Home health benefits are not automatically made available to all Medicare beneficiaries. Specific requirements must be met by a beneficiary before Medicare will reimburse for home health services. A beneficiary must (1) be in need of skilled nursing services on an intermittent basis, or in need of physical or speech therapy, and (2) be homebound. These prerequisites for home health benefits are found in 42 CFR sections 409.42 and 424.22, and the MIM.

For example, 42 CFR 409.42 states that an 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 will pay for home health services only if a physician certifies the services are needed and that the individual is homebound. The MIM, section 3117.1, states that to qualify for home health benefits under part A or part B of the program a beneficiary must be confined to his home and in need of skilled nursing services on an intermittent basis or in need of physical or speech therapy.

The MIM section 3118.1 further states that a service is not considered a skilled nursing service merely because it is performed by or under the direct supervision of a licensed nurse. Where a service can be safely and effectively performed (or self-administered) by the average nonmedical person without the direct supervision of a licensed nurse, the service cannot be regarded as a skilled nursing service although a skilled nurse actually provides the service.

Beneficiaries Not Requiring Prerequisite Care

Twelve of the 100 claims in our sample were ineligible for Medicare reimbursement because the beneficiaries on whose behalf the claims were made did not require skilled nursing care, or physical or speech therapy, and were, therefore, ineligible for any home health benefits. The 12 claims contained 170 services.

Since we did not have the medical expertise to determine medical necessity, we requested IASD medical personnel to review the 1,731 services contained on the 100 claims. The medical review personnel identified 12 claims for 11 beneficiaries whose medical conditions did not warrant the prerequisite care. The IASD staff noted that skilled nursing

services were ordered, but not needed, for patient observation and assessment, management and evaluation, and the administration of medication.

- ***Observation and assessment*** of the medical condition of three beneficiaries was ordered although their conditions had stabilized, their diagnoses and medication did not change, and their treatment plans remained the same. Additionally, care was ordered for one of the beneficiaries related to a colostomy that was performed in 1989. Medicare reimburses for ostomy care during the post-operative period and in the presence of associated complications where the need for skilled nursing care is clearly documented. According to the MIM, section 3118.1, observation and assessment by a skilled nurse is not reasonable and necessary to the treatment of the illness or injury where these indications are part of a longstanding pattern of the beneficiary's condition, and there is no attempt to change the treatment to resolve them.

- ***Management and evaluation*** of the plan of care for four beneficiaries was ordered although their conditions were stable and showed no signs of potential serious complications. For example, one beneficiary had received HHA services due to the insistence of the family although her condition was stable. Without the presence of a potential serious problem, the beneficiary's records did not support the need for the skilled nursing services, according to the IASD medical review staff. She was previously denied home health services by one of FAP's competitors.

- ***Administration of medication*** was ordered for four beneficiaries for the prefilling of syringes and medication boxes. In each instance the beneficiary's medical condition was noted as stable. For example, home health care was ordered for a beneficiary whose leg was broken in January 1995. Medical records showed that her condition had stabilized, and there were no new changes in the plan of care. The IASD medical review staff indicated that the skilled nursing visits during the review period mainly concerned the prefilling of the medication box.

  According to the MIM section 3118.1, the prefilling of syringes with insulin (or other medication which is self injected) is not considered to be a skilled nursing service, nor the administration of oral medication, except in specific situations. Prefilling of syringes for self administration of insulin or medications is considered to be assistance with medications which are ordinarily self administered and is an appropriate home health aide service as opposed to skilled nursing care.

The claims for the 11 beneficiaries who were ineligible for home health benefits included 170 home health services--71 skilled nursing, 1 medical social worker, and 98 home health aide visits.

Beneficiaries Not Homebound

Four of the 100 claims in our sample were ineligible for Medicare reimbursement because the 4 beneficiaries on whose behalf the claims were made were not homebound at the time the services were provided and were, therefore, ineligible for any home health benefits. The 4 claims contained 53 services.

Our review of medical records and our observations of and discussions with beneficiaries, revealed that some beneficiaries did not appear to be homebound. We requested IASD medical review personnel to review the records of these beneficiaries. The IASD staff concluded that four beneficiaries were not homebound and, thus, ineligible for any home health benefits. Details concerning the four claims and beneficiaries follow.

- One claim was for a beneficiary who was not sure whether he needed home health services as he did not consider himself homebound. He informed us during the interview that he traveled to a farm twice a week to feed his pets. We noted that this information was also included in the HHA nurse's progress notes. The HHA abruptly discontinued home health services in August 1995 without explanation.

- One claim was for a beneficiary who considered herself homebound only during inclement weather. She stated during our interview that she did not leave home because of inclement weather, but walked every day when the weather was nice. The beneficiary wore a leg brace as a supportive device but was able to walk about 2 1/2 blocks to the location of our interview.

- One claim was for a beneficiary who was active in community service according to information included in the HHA nurse's progress notes. The progress notes also stated that the beneficiary cared for herself.

- One claim was for a beneficiary who was able to drive himself to the location of the interview. The HHA nurse's progress reports showed that the beneficiary was able to drive a vehicle to pick up his wife after school. Calls made to the beneficiary's home by the nurse went unanswered.

The 4 claims for the beneficiaries who were ineligible for home health benefits included 53 home health services--23 skilled nursing, 2 occupational therapy, 2 medical social worker, and 26 home health aide visits.

Eligible Beneficiaries Received Services Ineligible for Medicare Reimbursement

Twelve of the 100 claims included in our sample contained 101 services that were, according to IASD medical review personnel that reviewed the claims, ineligible for Medicare reimbursement because the services were either medically unnecessary or excessive, or were not documented in the medical records maintained by FAP.

Services Unnecessary or Excessive

Nine of the 100 claims included in our sample contained 71 services that, although provided to Medicare beneficiaries eligible for home health benefits, were medically unnecessary or excessive.

Section 3116.1 of MIM states that 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 and, therefore, eligible for Medicare reimbursement. The IASD medical review staff reviewed the medical records and the plans of care of the beneficiaries and identified:

- 2 claims containing 16 services which were provided after the beneficiaries' conditions stabilized. Medical records showed that the medical problems treated were chronic and that the care was custodial. Additionally, services provided to one beneficiary to obtain a medic alert bracelet and a handicapped parking card, and to review the home for fire and kitchen safety (in this case) were not medically necessary.

- 7 claims containing 55 services whose frequency did not correspond to the medical data presented in the plan of care. The IASD review showed excessive services for skilled nursing, medical social services, and home health aide. Instances were noted where additional visits were ordered to complete applications for food stamps, and to determine the beneficiaries' health benefits coverage.

The 9 claims contained 71 services--41 skilled nursing, 18 medical social worker, and 12 home health aide visits--that were identified by IASD medical review personnel as being medically unnecessary or excessive.

Insufficient Documentation in Medical Records

Three of the 100 claims included in our sample contained 30 services that were not supported by medical documentation. The medical records maintained by FAP did not contain clinical evidence regarding the beneficiaries' need for the services or documentation that the services were provided.

The beneficiary's health status and medical need as reflected in the home health plan of care and medical record provide the basis for determinations as to whether services provided are reasonable and necessary.

- The medical records for one claim did not include the beneficiary's plan of care (HCFA Form 485) for the period of our review. Without a plan of care, the IASD medical review personnel could not determine the medical treatment plan established by the treating physician.

- The billing records for one beneficiary showed eight aide visits; however, the medical records and notes documented only five visits. Any increase in the frequency of services or addition of new service during a certification period must be authorized by a physician by way of a verbal order or written order prior to the provision of the increased or additional services. The IASD concluded that claims for the undocumented visits should be denied.

- The medical records for one beneficiary included a plan of care (HCFA Form 485) with an invalid date of "certification period."

The 3 claims contained 30 services--13 skilled nursing, 1 occupational therapy, and 16 home health aide visits--that were identified by IASD medical review personnel as being unsupported by medical documentation.

Conclusions and Recommendation

Our audit showed that 28 of the 100 claims reviewed contained one or more services that did not meet Medicare reimbursement requirements. Projecting these results to all FAP claims approved for payment during the period January 1, 1995 through April 30, 1995, we estimate that at least $2,471,047 in allowed amounts was ineligible for Medicare reimbursement. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval is $2,471,047 to $5,148,243 with a midpoint of $3,809,645. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that FAP was overpaid by at least $2,471,047 for unallowed home health services.

We had recommended in our draft report that HCFA incorporate the recovery of the overpayments in the FY 1995 year-end PIP reconciliation. After First American was convicted of Medicare-related offenses and HCFA suspended the PIP to its subsidiaries, First American and its subsidiaries filed for bankruptcy protection. The Bankruptcy Court enjoined the suspension and ordered HCFA to renew the PIP. First American and HCFA then began negotiations regarding all alleged overpayments to First American and its subsidiaries from 1989 through 1996.

On August 14, 1996, HCFA responded to a draft of this report. In its comments HCFA concurred with our recommendation but indicated that it could not take administrative action regarding the overpayments because of the bankruptcy proceeding. The HCFA's comments are included as Appendix C.

On October 4, 1996, First American entered into a civil settlement agreement with the United States which provided for the payment of approximately $232 million to HCFA over the course of several years. The settlement amount reflects the estimated overpayments to all First American subsidiaries over the cost report years 1989 through 1996, including those identified in this report. The settlement agreement releases First American from any further liability for Medicare overpayments from the period reflected in this audit report.

AUDIT OF FAP
SAMPLING METHODOLOGY

OBJECTIVE:

The objective of the sample was to estimate overpayments for claims that did not meet Medicare reimbursement requirements. To achieve our objective, we selected a statistical sample of home health claims from a universe of home health claims submitted by FAP during the period January 1, 1995 through April 30, 1995. We used the results to project the overpayments for services that were not reimbursable to FAP during the review period.

POPULATION:

The universe consisted of 15,959 HHA claims representing $22,641,822 in benefits paid to FAP during the period January 1, 1995 through April 30, 1995.

SAMPLING UNIT:

The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple visits and items of cost for the home health services provided.

SAMPLING DESIGN:

A simple random sample was used.

SAMPLE SIZE:

A sample of 100 claims.

ESTIMATION METHODOLOGY:

We used the cost per visit for each type of service reported by FAP in IASD's Computation of Interim Payment Rate report for the period January 1, 1995 to June 30, 1995. For the unallowed services on a sample unit, we computed the amount of error by multiplying the number of unallowed services for each type of service by the cost per visit computed by IASD in the Computation of Interim Payment Rate report for the above period.

Using the Department of Health and Human Services, OIG, Office of Audit Services Variables Appraisal Program, we estimated the overpayments resulting from claims that did not meet Medicare reimbursement requirements.

APPENDIX B

AUDIT OF FAP
VARIABLE PROJECTIONS

The lower and upper limits of the dollar value of overpayments are shown at the 90 percent confidence level. We used our random sample of 100 claims out of 15,959 claims to project the value of the errors. The result of this projection is presented below.

Claims That Did Not Meet Medicare Requirements for Reimbursement

Value Identified in the Sample	$ 23,871
Point Estimate	$3,809,645
Lower Limit	$2,471,047
Upper Limit	$5,148,243

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: AUG 14 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General Draft Report: "Review of Home Health Claims Submitted by First American Health Care, Inc., Pennsylvania," (A-03-05-00011)

We reviewed the subject draft report which examines claims submitted by First American Health Care, Inc., Pennsylvania, to determine if they were in accordance with Medicare policy.

Our detailed comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report. Please contact us if you would like to discuss our comments further.

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report: "Review of Home Health
Claims Submitted by First American Health Care, Inc., Pennsylvania"
(A-03-95-000111)

OIG Recommendation

HCFA should incorporate the recovery of overpayments in the FY 1995 year-end periodic interim payments (PIP) reconciliation.

HCFA Response

We concur with the OIG's recommendation in principle, however, as the OIG is aware First American Health Care, Inc., is currently bankrupt and operating within the bankruptcy court's "stay" of February 21,1996. As stated in the report, HCFA did order 100 percent suspension for the PIP, however, a Federal ruling overturned the PIP suspension. The court order further directs that there shall be no prospective reduction to the PIP to address prior behavior of the provider. Overpayments prior to February 1996 cannot be collected. Thus, HCFA cannot recoup any overpayments identified for the period January 1, 1995 - April 30, 1995.

Technical/General Comments

We recommend that the discussion of coverage of ostomy care under the Medicare home health benefit (within the discussion of observation and assessment of skilled nursing services on pages 5 and 6) be clarified. The statement is made that "Medicare reimburses for ostomy care during the post-operative period." There is limited coverage under the home health benefit for the observation and assessment of a patient's condition when only the specialized skills of a medical professional can determine the patient's status as discussed under section 3118.1B.1 of the Intermediary Manual. However, Medicare covers ostomy care as a skilled nursing service during the post-operative period **and in the presence of associated complications where the need for skilled nursing care is clearly documented** (section 3118.1B.9). Also, teaching ostomy care remains skilled nursing care regardless of the presence of complications. Teaching care for a recent ostomy **or where reinforcement of ostomy care is needed** can be covered as a skilled nursing service (sections 3118.1B.3 and .9)