DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date FEB 2 1995

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by St. Johns Home Health Agency (A-04-94-02078)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Costs Claimed by St. Johns Home Health Agency." The objective of our review was to determine whether the home health care visits claimed by St. Johns Home Health Agency (St. Johns) in Miami Lakes, Florida met Medicare reimbursement guidelines.

Our review of home health claims submitted by St. Johns during the fiscal year (FY) ended June 30, 1993 showed that 75.5 percent of the claims did not meet Medicare guidelines, as follows:

- 21.5 percent were for visits not made;
- 29 percent were for visits made to individuals who, in their own opinion, or in the opinion of medical experts were not homebound;
- 23.5 percent were for visits which physicians denied authorizing; and
- 1.5 percent were for visits which the beneficiary did not want or were not adequately documented.

Of the $45.4 million claimed by St. Johns for FY ended June 1993, we estimate that $25.9 million did not meet the reimbursement guidelines.

The St. Johns' officials blamed subcontractors for submitting claims for visits that did not meet Medicare reimbursement guidelines. Nevertheless, the guidelines, as well as general principles of contract law, make contractors, such as St. Johns, responsible for the actions of their subcontractors.

The Health Care Financing Administration (HCFA) used interim information we provided as a basis for offsetting the estimated overpayment against periodic interim

payments (PIP) made to St. Johns. While we understand that St. Johns is currently in bankruptcy proceedings, we recommend that HCFA, to the extent possible, recover any remaining overpayment as part of those proceedings.

In response to our draft report, HCFA agreed with our recommendation. The HCFA's comments are presented as Appendix D to this 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) 966-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-04-94-02078 in all correspondence relating to this report.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COSTS CLAIMED BY ST. JOHNS HOME HEALTH AGENCY

JUNE GIBBS BROWN
Inspector General

FEBRUARY 1995
A-04-94-02078

Memorandum

Date FEB 2 1995

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by St. Johns Home Health Agency (A-04-94-02078)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of St. Johns Home Health Agency (St. Johns) in Miami Lakes, Florida.

OBJECTIVE

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

SUMMARY OF FINDINGS

Our review of home health claims submitted by St. Johns during the fiscal year (FY) ended June 30, 1993 showed that 75.5 percent of the claims did not meet Medicare guidelines, as follows:

- 21.5 percent were for visits not made;
- 29 percent were for visits made to individuals who, in their own opinion, or in the opinion of medical experts were not homebound;
- 23.5 percent were for visits which physicians denied authorizing; and
- 1.5 percent were for visits which the beneficiary did not want or were not adequately documented.

Of the $45.4 million claimed by St. Johns for FY ended June 1993, we estimate that $25.9 million did not meet the reimbursement guidelines.

The St. Johns' officials blamed subcontractors for submitting claims for visits that did not meet Medicare reimbursement guidelines. Nevertheless, the guidelines, as well as

general principles of contract law, make contractors, such as St. Johns, responsible for the actions of their subcontractors.

The Health Care Financing Administration (HCFA) used interim information we provided as a basis for offsetting the estimated overpayment against periodic interim payments (PIP) made to St. Johns. While we understand that St. Johns is currently in bankruptcy proceedings, we recommend that HCFA, to the extent possible, recover any remaining overpayment as part of those proceedings.

In response to our draft report, HCFA agreed with our recommendation. The HCFA's comments are presented as Appendix D to this report.

BACKGROUND

St. Johns Home Health Care Agency

The St. Johns is a Medicare certified home health agency (HHA) with a principal place of business in Miami Lakes, Florida. The St. Johns is a not-for-profit Florida corporation that directly and indirectly employs medical doctors, nurses, aides, therapists, and administrative personnel in Dade county.

A Medicare certified HHA, such as St. Johns, can either provide home health services itself or make arrangements with other certified or non-certified providers for home health services. Most of the visits claimed by St. Johns were provided under contract with non-Medicare certified nursing groups.

During FY 1993, St. Johns received over 99 percent of its income from the Medicare program. The St. Johns was reimbursed under the PIP method. Payments under PIP approximate the cost of covered visits rendered by the provider. Interim reimbursement from Medicare totaled $41.4 million. Interim payments are adjusted to actual costs based on annual cost reports. The St. Johns submitted a cost report for FY 1993 claiming costs totaling $45.4 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 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Intermediary Manual.

Intermediary Responsibilities

The HCFA contracts with fiscal intermediaries (FI), usually large insurance companies, to assist them in administering the home health benefits program. The FI for St. Johns is AEtna Life Insurance Company (AEtna) in Clearwater, Florida. The FI is responsible for:

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

SCOPE

The objective of the audit was to determine whether the home health care visits claimed by St. Johns met Medicare reimbursement guidelines. The audit was requested by the HCFA's Atlanta regional office. We provided interim results to the HCFA Administrator on August 11, 1994.

The St. Johns claimed 1,180,429 visits on 56,507 claims for FY 1993. We reviewed a statistical sample of 200 claims totaling 3,612 visits for 199 different individuals. We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims were submitted by St. Johns during the period July 1, 1992 through June 30, 1993. Appendix A contains the details on our sampling methodology. We used applicable laws, regulations, and Medicare guidelines to determine whether the visits claimed by St. Johns met the reimbursement guidelines.

In addition to using the sample to determine the amount of overpayment, we used the sample to determine the percentage of certain characteristics. Appendices B and C contain the details of the results of these projections.

Generally, for each of the 200 claims, we interviewed:

- the beneficiary or a knowledgeable acquaintance,
- the physician who certified the plan of care, and
- the beneficiary's personal physician.

Our interviews included validation of beneficiaries' and physicians' signatures.

We interviewed 194 of the 199 beneficiaries. We were unable to interview five of the beneficiaries or a close acquaintance because they had either moved or were deceased. We were not able to interview some physicians because they were either deceased, had moved out of the area, or refused to talk to us.

We reviewed supporting medical records maintained by St. Johns for all of the claims in our sample except two that they were not able to locate. The records were also reviewed by AEtna and HCFA medical personnel to determine whether the medical records for the claimed visits met the reimbursement requirements.

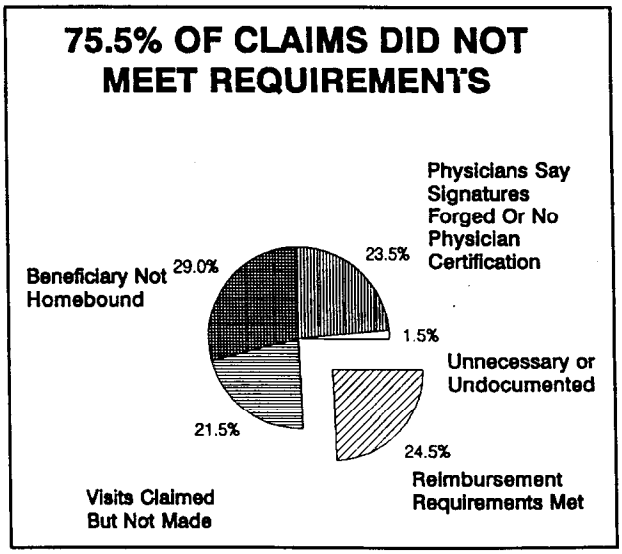
We did not conduct a review of St. Johns' internal controls nor did we place reliance on their internal controls. Specifically, we did not review quality control work performed by St. Johns to monitor subcontracted services. We requested, but were not provided, copies of St. Johns' policies and procedures for monitoring subcontractors.

Our field work was performed at the St. Johns' administrative office in Miami Lakes, Florida, and the FI's office in Clearwater, Florida. Interviews were conducted in the beneficiaries' residences and the physicians' offices. Our field work was started in May 1994 and completed in September 1994. Our audit was conducted in accordance with generally accepted government auditing standards.

The Office of Inspector General (OIG), Office of Investigations opened a criminal complaint of St. Johns and their subcontractors on October 7, 1994.

DETAILED RESULTS OF REVIEW

Our audit showed that over 75 percent of the claims submitted by St. Johns during FY 1993 did not meet the Medicare reimbursement requirements.



Based on a statistical sample, we estimate that St. Johns received overpayments totaling $25.9 million. St. Johns blamed the subcontractors for submitting claims that did not qualify for Medicare reimbursement and, therefore, believed they should not be held accountable for the overpayments. However, the regulations and guidelines, as well as general principles of contract law, clearly hold the HHA

responsible for payments made for services performed by subcontractors. While we understand that St. Johns is currently in bankruptcy proceedings, we recommend that HCFA, to the extent possible, recover any remaining overpayment as part of those proceedings.

Criteria for Services Provided By Subcontractors

Section 409.42(g) of title 42 CFR states that "home health services must be furnished by, or under arrangements made by a participating HHA." Section 200.2 of the Intermediary 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." In addition, the Medicare HHA conditions of participation at 42 CFR 484.14(h) set forth the requirements governing home health services furnished under arrangements.

Visits Claimed But Not Made

Our review showed that 43 of the 200 claims were for visits that were not made. The medical records maintained by St. Johns contained the required documentation including signatures of the beneficiaries indicating that the services were provided. However, the **physicians** who purportedly signed certifications for 29 of these claims have indicated that their **signatures** were **forged**. All of the **beneficiaries** involved with the 43 claims stated that their **signatures** were **forged**.

During the initial interview of the beneficiaries, they told us that they had not received the services on the dates that were on the sampled claims. A review of the medical records indicated that the beneficiaries had signed for the services. We reinterviewed each of the beneficiaries and showed them the signatures on the visit logs and all **43 beneficiaries stated that their signature was forged**; 41 stated that they did not know the physician who ordered the services.

We also interviewed most of the physicians who signed the plans of care. The results were as follows:

- **Eleven physicians who were responsible for 29 claims said their signature was forged**, they did not know the beneficiary, and they had no record of ordering the HHA services;

- Two physicians who ordered the services on four of the claims were not sure whether they signed the plan of care, and they had no record of ordering the services for the beneficiary;

- Two physicians for two claims said they signed the plan of care but the beneficiary said they did not receive the services; and

- Four physicians who signed the plan of care for services on eight of the claims were not interviewed because one could not be located, one was deceased, one was in prison, and one refused to be interviewed.

Visits to Beneficiaries Who Were Not Homebound

Our review showed that 58 of the 200 claims were for visits to beneficiaries who were not homebound at the time the services were provided. The interviews of the beneficiary or a close acquaintance of the beneficiary, the certifying physician, and the personal physician indicated that the beneficiaries by their own assessment, or that of the physicians, were not homebound at the time the services were provided. In all cases, St. Johns had documentation, such as the plan of care that indicated the individual needed skilled care and was homebound.

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 and the Medicare Intermediary Manual at section 3117.1 contain guidance regarding the "homebound" requirement.

AEtna medical review personnel reviewed the records for 57 of the 58 beneficiaries that we determined did not meet the homebound requirement. They concluded that the medical records did not support a homebound determination for 39 of the beneficiaries. One record could not be located by St. Johns. We determined that the 18 records that AEtna concluded supported a homebound status were not homebound because the beneficiaries and their personal physician said they were not homebound.

We interviewed the personal physician of 49 of the 58 beneficiaries. The remaining nine beneficiaries included six who did not have a personal physician, and three whose personal physician could not be located. The personal physicians for 42 of them stated that the beneficiary was not homebound at the time the services were claimed as provided. Five of the beneficiaries' personal physicians were also the certifying physicians, and said the beneficiaries were homebound. However, we determined that they were not homebound because the beneficiaries, AEtna and HCFA medical review personnel all said that they were not homebound in accordance with Medicare requirements. The personal physician for two of the beneficiaries did not know whether the beneficiary met the homebound requirements at the time the services were supposedly provided.

We used the personal physicians' opinion to confirm our position and to refute the evidence of homebound status in the HHA records. We concluded that the 58 beneficiaries did not meet the homebound criteria. Our conclusion is based on the opinion of medical professionals, as well as the results of beneficiary interviews which included a description of their daily activities at the time of the services.

Physicians Say Signatures Were Forged

Our review showed that 47 of the 200 claims were for visits where the physicians said their signatures were forged or where there was no physician certification. We interviewed the 19 physicians who purportedly signed the plans of care for 46 of the 47 claims. **The physicians advised us that they did not sign the plans of care.** Furthermore, they told us that they did not know the beneficiary or have any medical records indicating that the beneficiary had been seen by them. The remaining claim was not supported by a plan of care certified by a physician.

The laws, regulations and guidelines recognize that the physician plays an important role in determining the utilization of services. The legislation specifies that payment for services may be made only if a physician certifies the services were required because the individual was homebound and needed skilled nursing care. The regulations (42 CFR 424.22) state that Medicare pays only if a physician certifies the services were needed. In addition, the regulations at 42 CFR 484.18 require all care to follow a physician's plan of care. The Intermediary Manual states that the patient must be under the care of a physician who is qualified to sign the certification and the plan of care.

We discussed these cases with AEtna officials and they advised that claims not duly authorized should be denied.

Other

Our review showed that 3 of the 200 claims were for visits that did not meet the reimbursement requirements. One was for home aide visits to a beneficiary who did not want the home aide service because she had a personal aide. Section 203.2 of the Medicare Intermediary Manual says "that where a family member or other caring person is or will be providing services that adequately meet the patients needs, it would not be reasonable and necessary for home health agency personnel to furnish such services. Ordinarily it can be presumed that there is no able and willing person in the home to provide the services being rendered by the home health agency unless the beneficiary or family indicates otherwise, and object to the provision of the services by the home health agency."

Two claims were for visits that were not supported with medical records at the HHA, including a plan of care, treatment records, and signature logs. These services did not

meet the reimbursement requirement that home aide services are authorized when a caregiver is not otherwise available, and claims for services be documented in the HHA medical records.

Effect

Our audit showed that 75 percent of the FY 1993 claims submitted by St. Johns were overstated. Projecting our sample results, we estimate that St. Johns was overpaid $25,877,579.

St. Johns Did Not Properly Monitor Subcontractors

The St. Johns blamed the subcontractors for claiming these visits. They stated that the subcontractors provided documentation which indicated visits were made and services were provided.

The St. Johns stated that they had procedures for monitoring subcontractors to ensure that beneficiaries met the homebound and medical necessity criteria to receive HHA services. However, St. Johns had no explanation as to why their monitoring did not disclose the problems that we found.

The HHA coverage guidelines issued by HCFA, as well as general principles of contract law, provide that the HHA has essentially the same responsibilities for services provided by subcontractors as for services provided by their salaried employees. During reviews of the beneficiaries' medical records maintained by the HHA, we found documentation that showed St. Johns did monitor subcontractors. However, in two instances the documentation showed that the beneficiaries were not homebound, yet no action was taken to discontinue the services. Also, a beneficiary that we interviewed stated that someone from St. Johns contacted her by telephone about services which the beneficiary stated were not provided. The beneficiary advised us that she told the caller she had not received the HHA services. St. Johns continued to bill for the services not provided to this beneficiary.

RECOMMENDATION

While we understand that St. Johns is currently in bankruptcy proceedings, we recommend that HCFA, to the extent possible, recover any remaining overpayment as part of those proceedings.

In response to our draft report, HCFA agreed with our recommendation. The HCFA's comments are presented as Appendix D to this report.

APPENDICES

AUDIT OF ST. JOHNS HOME HEALTH AGENCY INC.
SAMPLING METHODOLOGY

OBJECTIVE:

The sample objective 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 St. Johns during the FY ended June 30, 1993. We obtained claim documentation and interviewed beneficiaries and physicians identified in the claim. We used the results to project the overpayments for services that were not reimbursable to St. Johns during the FY ended June 30, 1993.

POPULATION:

The universe consisted of 56,507 HHA claims representing $41,441,619 in benefits paid by the FI to St. Johns during the FY ended June 30, 1993.

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 single stage random sample was used.

SAMPLE SIZE:

A sample of 200 claims.

ESTIMATION METHODOLOGY:

We used the cost per visit for each type of service reported by St. Johns in the unaudited cost report for FY ended June 30, 1993. 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 claim by the cost reported by St. Johns in the unaudited cost report for FY ended June 30, 1993.

Using the Department of Health and Human Services, OIG, Office of Audit Services (OAS) Variables Appraisal Program, we estimated the overpayments that either did not meet reimbursement requirements, were not authorized, or were not rendered.

AUDIT OF ST. JOHNS HOME HEALTH AGENCY, INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

The lower and upper limits of the number of claims not meeting reimbursement requirements are reported at the 90 percent confidence level. We used our random sample of 200 claims out of the 56,507 claims to project the occurrence of certain types of errors. The results of these projections are presented below:

CLAIMS THAT DID NOT MEET THE REQUIREMENTS

Quantity Identified in the Sample	151
Point Estimate	75.5%
Lower Limit	70.0%
Upper Limit	80.4%

VISITS CLAIMED BUT NOT MADE

Quantity Identified in the Sample	43
Point Estimate	21.5%
Lower Limit	16.8%
Upper Limit	26.82

VISITS MADE TO BENEFICIARIES THAT WERE NOT HOMEBOUND

Quantity Identified in the Sample	58
Point Estimate	29.0%
Lower Limit	23.7%
Upper Limit	34.7%

VISITS THAT WERE NOT PROPERLY AUTHORIZED BY PHYSICIANS

Quantity Identified in the Sample	47
Point Estimate	23.5%
Lower Limit	18.6%
Upper Limit	29.0%

AUDIT OF ST. JOHNS HOME HEALTH AGENCY, INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

VISITS THAT WERE NOT NECESSARY OR NOT DOCUMENTED

Quantity Identified in the Sample	3
Point Estimate	1.5%
Lower Limit	.4%
Upper Limit	3.8%

APPENDIX C

AUDIT OF ST. JOHNS HOME HEALTH AGENCY, INC.
VARIABLES 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 200 claims out of the 56,507 claims to project the value of certain types of errors. The results of these projections are presented below:

CLAIMS THAT DID NOT MEET THE REQUIREMENTS

Value Identified in the Sample	$101,871
Point Estimate	$28,782,236
Lower Limit	$25,877,579
Upper Limit	$31,686,893

VISITS CLAIMED BUT NOT MADE

Value Identified in the Sample	$32,039
Point Estimate	$9,052,153
Lower Limit	$6,730,603
Upper Limit	$11,373,703

VISITS MADE TO BENEFICIARIES THAT WERE NOT HOMEBOUND

Value Identified in the Sample	$41,647
Point Estimate	$11,766,718
Lower Limit	$9,195,371
Upper Limit	$14,338,066

VISITS THAT WERE NOT PROPERLY AUTHORIZED BY PHYSICIANS

Value Identified in the Sample	$26,961
Point Estimate	$7,617,375
Lower Limit	$5,665,005
Upper Limit	$9,569,745

VISITS THAT WERE NOT NECESSARY OR NOT DOCUMENTED

Value Identified in the Sample	$1,225
Point Estimate	$345,990
Lower Limit	-$32,377
Upper Limit	$724,356

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care
Financing Administration

Memorandum

DATE JAN 17 1995

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by St. Johns Home Health Agency" (A-04-94-02078)

TO June Gibbs Brown
Inspector General

We reviewed the subject draft report which examined whether the home health care visits claimed by St. Johns Home Health Agency in Miami Lakes, Florida met Medicare reimbursement guidelines.

The Health Care Financing Administration (HCFA) concurs with the report recommendation to recover, to the extent possible, any remaining overpayment as part of the bankruptcy proceedings. Comments on the status of actions taken with respect to the recommendation are attached.

Thank you for the opportunity to review and comment on this report. This report is an example of the value of cooperation between the OIG, HCFA, and the contractors to our programs. Please advise us if you would like to discuss our comments.

Attachment

Health Care Financing Administration's (HCFA) Comments
on Office of Inspector General (OIG) Draft Report:
Review of Costs Claimed by St. Johns Home Health Agency
A-04-94-02078

Recommendation

HCFA should, to the extent possible, recover any remaining overpayment as part of current St. Johns bankruptcy proceedings.

HCFA Response

We concur with the recommendation and ask that the final report be issued as expeditiously as possible, since a final report is essential to the impending bankruptcy litigation.

Additionally, the following actions have taken place with regard to the recommendation:

- In August 1994, HCFA suspended program payments to St. Johns. Through this effort, HCFA has recovered approximately $1.6 million of the $25.9 million overpayment amount identified by the OIG.

- The fiscal intermediary has been instructed to reopen St. Johns fiscal year 1993 cost report and to revise it to reflect the overpayment identified by the OIG; the intermediary was also directed to promptly issue a demand for payment of the revised amount.

- The Atlanta Regional Office has discussed the OIG's draft report with the Regional Attorney. The Regional Attorney will initiate overpayment recovery procedures applicable to the St. Johns bankruptcy, when the report is issued in final.