DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

MAY 24 1996

Memorandum

Date

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Visiting Nurses Association of Dade County, Inc. (A-04-95-01103)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, *Review of Costs Claimed by Visiting Nurses Association of Dade County, Inc.* The audit objective was to determine whether the home health care services claimed by the Visiting Nurses Association of Dade County Inc. (VNA) in Miami, Florida, met Medicare reimbursement guidelines.

We randomly selected for review 100 claims submitted by VNA for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,856 home health services. Our review showed that 32 claims or 32 percent of our sample contained 403 services (22 percent of the total services) that did not meet Medicare guidelines, as follows:

- 9 percent of the claims were for 129 services provided to beneficiaries who, in their own opinion, or in the opinion of medical experts were not homebound;
- 16 percent of the claims were for 208 services which, in the opinion of medical experts, were not reasonable or necessary;
- 4 percent of the claims were for 18 services not provided; and
- 3 percent of the claims were for 48 services which physicians either denied authorizing, or authorized improperly.

Cases in the latter two categories concern us and should be closely reviewed by the Medicare fiscal intermediary (FI).

During the FY ended December 31, 1993, VNA claimed $11.1 million in 8,606 claims representing 187,197 services. Based on our review, we estimate that at least $1.3 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between $1.3 million and $2.6 million.

Although we found documentation that VNA monitored its own employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as VNA, responsible for the actions of their subcontractors.

We recommend that the Health Care Financing Administration (HCFA) require the FI to instruct VNA on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FI and VNA to ensure that corrective actions are effectively implemented, and recover all overpayments. We also recommend that HCFA direct the FI to investigate all cases of possible fraud and refer them as necessary to the Office of Inspector General's Office of Investigations.

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E 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) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-04-95-01103.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF COSTS CLAIMED BY VISITING NURSES ASSOCIATION OF DADE COUNTY, INC.

JUNE GIBBS BROWN
Inspector General

MAY 1996
A-04-95-01103

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From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Visiting Nurses Association of Dade County, Inc. (A-04-95-01103)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Visiting Nurses Association of Dade County Inc. (VNA) in Miami, Florida.

OBJECTIVE

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

SUMMARY OF FINDINGS

We randomly selected for review 100 claims submitted by VNA for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,856 home health services. Our review showed that 32 claims or 32 percent of our sample contained 403 services (22 percent of the total services) that did not meet Medicare guidelines, as follows:

- 9 percent of the claims were for 129 services provided to beneficiaries who, in their own opinion, or in the opinion of medical experts were not homebound;
- 16 percent of the claims were for 208 services which, in the opinion of medical experts, were not reasonable or necessary;
- 4 percent of the claims were for 18 services not provided; and
- 3 percent of the claims were for 48 services which physicians either denied authorizing, or authorized improperly.

Cases in the latter two categories concern us and should be closely reviewed by the Medicare fiscal intermediary (FI).

During the FY ended December 31, 1993 VNA claimed $11.1 million in 8,606 claims representing 187,197 services. Based on our review, we estimate that at least $1.3 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between $1.3 million and $2.6 million.

Although we found documentation that VNA monitored its own employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as VNA, responsible for the actions of their subcontractors.

We recommend that the Health Care Financing Administration (HCFA) require the FI to instruct VNA on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FI and VNA to ensure that corrective actions are effectively implemented, and recover all overpayments. We also recommend that HCFA direct the FI to investigate all cases of possible fraud and refer them as necessary to the Office of Inspector General's (OIG) Office of Investigations (01).

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

BACKGROUND

Visiting Nurses Association of Dade County Inc.

The VNA is a Medicare certified home health agency (HHA) with a principal place of business in Miami, Florida. The VNA is a voluntary nonprofit Florida corporation that directly and indirectly employs nurses, aides, therapists, and administrative personnel in Dade County.

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

During FY 1993, VNA was reimbursed under the periodic interim payment (PIP) method. Payments under PIP approximate the cost of covered services rendered by the provider. Interim reimbursement from Medicare totaled $10.9 million. Interim payments

are adjusted to actual costs based on annual cost reports. The VNA submitted a cost report for FY 1993 claiming costs totaling $11.1 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 Medicare HHA Manual.

Intermediary Responsibilities

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

The FI 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

The objective of the audit was to determine whether the home health care services claimed by VNA met Medicare reimbursement guidelines. The audit was performed under the auspices of Operation Restore Trust and was initiated by a request from HCFA'S Atlanta regional office and its regional home health intermediary. The individuals who participated in this audit are shown on Appendix D.

The VNA claimed 187,197 services on 8,606 claims for FY 1993. We reviewed a statistical sample of 100 claims totaling 1,856 services for 99 different individuals (1 individual appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims were submitted by VNA during the period January 1, 1993 through December 31, 1993. Appendix A contains the details on our sampling methodology. Appendix C

contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by VNA 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. Appendix B contains the details of the results of these projections.

Generally, for each of the 100 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 when necessary.

We interviewed 86 of the 99 beneficiaries. We were unable to interview 13 of the beneficiaries or a close acquaintance because they were either deceased or had moved out of the area. We were not able to interview 21 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 VNA for all of the claims in our sample. The records were also reviewed by AEtna medical personnel to determine whether the medical records for the claimed services met the reimbursement requirements.

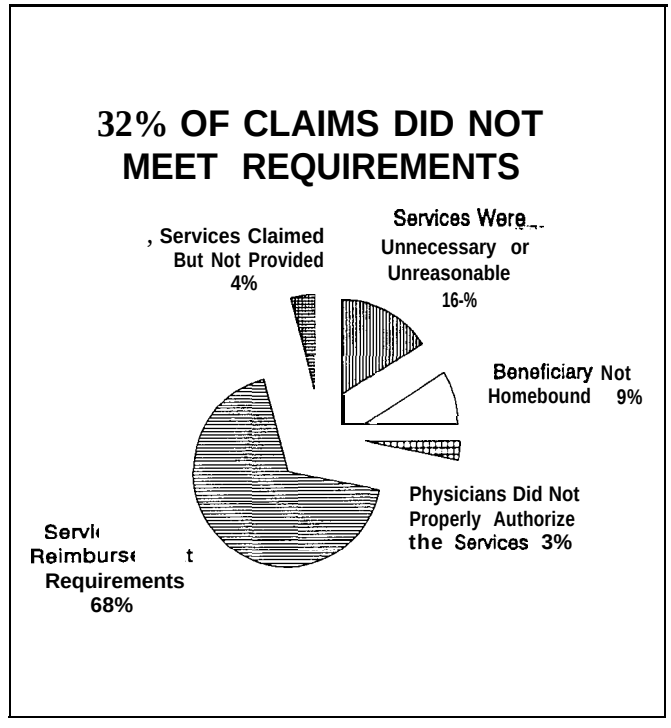
We conducted a review of VNA'S internal controls, but we did not place reliance on them. Specifically, we reviewed quality control work performed by VNA to monitor services provided either by their own staff or subcontractors.

Our field work was performed at the VNA'S administrative office in Miami, 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 January 1995 and completed in October 1995. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

Our audit showed that 32 percent of the claims submitted by VNA during FY 1993 did not meet the Medicare reimbursement requirements.

Based ona statistical sample, we estimate that VNA received overpayments totaling at least $1.3 million and using the 90 percent confidence interval, we believe the overpayment is between $1.3 million and $2.6 million. Although we found documentation that VNA monitored its employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines.



The regulations and guidelines clearly hold the HHA responsible for payments made for services performed by either their own staff or by subcontractors.

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 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. " 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.

Services ***to Beneficiaries Who Were Not Homebound***

Our review showed that 9 of the 100 claims were for 129 services 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, VNA 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 contains guidance regarding the "homebound" requirement.

The AEtna medical review personnel reviewed the records for the nine beneficiaries that we determined did not meet the homebound requirement. They concluded that the medical records did not support a homebound determination for two of the beneficiaries, had questionable documentation for two of the beneficiaries, and did not support the need or reasonableness of the services for two of the beneficiaries. We determined that the three beneficiaries whose records AEtna concluded supported a homebound status were not homebound because the beneficiaries or their personal physicians said they were not homebound.

We interviewed the personal physician of five of the nine beneficiaries. The remaining four beneficiaries did not have a personal physician different from the physician who signed the plan of treatment. The personal physicians stated that the beneficiaries were not homebound at the time the services were claimed as 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 nine 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.

Services That Were Not Reasonable Or Necessary€

Our review showed that 16 of the 100 claims were for 208 services which were not considered reasonable or necessary by the intermediary's medical review personnel.

The ***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 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.

The Aetna medical review personnel reviewed the records for the 16 beneficiaries and concluded that the medical records did not support the reasonableness or necessity of the services.

Services Claimed But Not Provided€

Ourreview showed that 40fthe 100 claims were for 18 services that were not provided. The medical records maintained by VNA contained the required documentation including signatures of the beneficiaries indicating that the services were provided. However, the physicians who purportedly signed certifications for two of these claims did not have any records to support the homebound status for the beneficiary, and did not know of the homebound requirements for home health services.

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 three of the four beneficiaries and showed them the signatures on the visit logs and one beneficiary stated that her signature was forged; a second beneficiary said that some of the signatures appeared to be hers, however she insisted that she did not receive the services; the third beneficiary refused to validate her signature. The fourth beneficiary died before we could validate her signature.

We also interviewed the four physicians who signed the plans of care for the four claims. Two of the physicians had no record to support the homebound status of the beneficiaries, and were not familiar with the homebound requirements for home health services.

Physicians Did Not Properly Authorize The Services

Our review showed that 3 of the 100 claims were for 48 services not properly authorized by a physician. Two of the claims were for services where the physicians said their signatures were forged. We interviewed the two physicians who purportedly signed the plans of care for the claims. The physicians advised us that they did not sign the plans of care. Furthermore, one physician told us that she did not know the beneficiary or have any medical records indicating that the beneficiary had been seen by her. The second physician recognized the beneficiary as his patient, but stated that she was not homebound. The third claim was for services where the physician did not sign the plan of care until after the bill was submitted to the intermediary for payment.

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 424.22 require all care to follow a physician's

plan of care. The Medicare HHA 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, and that the plan of care must be signed by the physician before the bill is submitted to the intermediary for payment.

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

Effect€

Our audit showed that 32 percent of the FY 1993 claims submitted by VNA were overstated. We projected the sample overpayment amounts to the sampling frame. The **90** percent confidence interval is $1,325,105-to $2,629,965 with a midpoint of $1,977,535. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that VNA was overpaid by at least $1,325,105 for unallowed home health services.

VNA Did Not Properly Monitor Subcontractors€

The VNA did not follow its own policies and procedures to monitor its subcontractors. The VNA stated that the subcontractors provided documentation which indicated visits were made and services were provided.

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

The HHA coverage guidelines issued by HCFA, 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 VNA did monitor subcontractors. However, in two instances, the documentation showed that the services were no longer reasonable or necessary, yet no action was taken to discontinue the services. In another instance the physician's signature was not obtained until after the claims had been submitted to the FI for payment.

RECOMMENDATIONS

We recommend that HCFA:

- Require the FI to instruct VNAonits responsibilities to properly monitor its subcontractors for compliance with Medicare regulations and HCFA guidelines.
- Monitor the FI and VNA to ensure that corrective actions are effectively implemented.
- Recover all overpayments.
- Direct the FI to investigate all cases of possible fraud and refer them as necessary to the OIG's 01.

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

APPENDICES

AUDIT OF VNA OF DADE COUNTY 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 VNA during the FY ended December 31, 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 VNA during the FY ended December 31, 1993.

POPULATION:

The universe consisted of 8,606 HHA claims representing $10,874,816 in benefits paid by the FI to VNA during the FY ended December 31, 1993.

SAMPLING UNIT:

The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple services 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 VNA in the unaudited cost report for FY ended December 31, 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 VNA in the unaudited cost report for FY ended December 31, 1993.

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

AUDIT OF VNA OF DADE COUNTY INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 8,606 claims to project the occurrence of certain types of errors. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

CLAIMS THAT DID NOT MEET THE REQUIREMENTS

Quantity Identified in the Sample	32
Point Estimate	32.0%
Lower Limit	24.3%
Upper Limit	40.5%

SERVICES CLAIMED BUT NOT PROVIDED

Quantity Identified in the Sample	4
Point Estimate	4.0%
Lower Limit	1.4%
Upper Limit	8.9%

SERVICES PROVIDED TO BENEFICIARIES THAT WERE NOT HOMEBOUND

Quantity Identified in the Sample	9
Point Estimate	9.0%
Lower Limit	4.8%
Upper Limit	15.2%

SERVICES THAT WERE NOT PROPERLY AUTHORIZED BY PHYSICIANS

Quantity Identified in the Sample	3
Point Estimate	**3.0%**
Lower Limit	0.8%
Upper Limit	7.6%

AUDIT OF VNA OF DADE COUNTY INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

SERVICES THAT WERE NOT REASONABLE OR NOT NECESSARY

Quantity Identified in the Sample	16
Point Estimate	16.0%
Lower Limit	10.3%
Upper Limit	23.3%

APPENDIX C

AUDIT OF VNA OF DADE COUNTY INC.
VARIABLES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 8,606 claims to project the value of claims that did not meet the requirements. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

CLAIMS THAT DID NOT MEET THE REQUIREMENTS

Identified in the sample	
Number of Claims	32
Value	$22,979
Point Estimate	***$1,977,535***
Lower Limit	***$1,325,105***
Upper Limit	***$2,629,965***

APPENDIX D

MAJOR CONTRIBUTORS TO THIS REPORT

From HHS OIG OAS	Roy C. Wainscott, Region IV HCFA Audit Manager (404) 331-2446 ext. 106. Albert Bustillo, Senior Auditor Mario Pelaez, Auditor in Charge Catherine Bumside, Auditor James Duncan, Auditor Maritza Hawrey, Auditor Lourdes Puntonet, Auditor
From HCFA Region IV	Rita Brock-Perini, Nurse Consultant Isabel Frank, Nurse Consultant Jerri Devon, Nurse Consultant
From the Regional Home Health Intermediary	Theresa S. Ginnetti, RN Supervisor Benefit Integrity Jane Dallara, RN Minnie Johnson, RN Veronica Lozado, Analyst Sandi Maitland, RN Karen McCall, LPN Lori Peters, RN Mary Tennies, RN

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE APR 10 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by Visiting Nurses Association of Dade County," (A-04-95-01103)

We have reviewed the above report concerning claims submitted by Visiting Nurses Association of Dade County, Inc. (VNA) which did not meet Medicare reimbursement guidelines.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Health Care Financing Administration (HCFA) Comments
on Office of Inspector General (OIG) Draft Report: "Review of Costs
Claimed by Visiting Nurses Association of Dade County,"
(A-04-95-01103)

OIG Recommendation

HCFA should require Fiscal Intermediaries (FI's) to instruct Visiting Nurses Association (VNA) on its responsibilities to properly monitor its subcontractor for compliance with Medicare regulations and HCFA guidelines.

HCFA Response

We concur. HCFA will instruct the FI to conduct focused medical review on future claims submitted by VNA and ask the Medicare survey and certification agency to review the subcontracting arrangements.

OIG Recommendation

HCFA should monitor the FI and VNA to ensure that corrective actions are effectively implemented.

HCFA Response

We concur. HCFA will monitor Aetna Life and Casualty Insurance Company's compliance with our instructions to review VNA.

OIG Recommendation

HCFA should recover all overpayments.

HCFA Response

We concur. We will take the appropriate actions necessary to recover from VNA those payments made for home health visits failing to meet Medicare reimbursement guidelines. If the OIG, Office of Investigation collects sufficient evidence, we will support the imposition of Civil Monetary Penalties.

OIG Recommendation

HCFA should direct the FI to investigate all cases of possible fraud and refer them as necessary to the OIG's, Office of Investigations.

HCFA Response

We concur. This procedure is already outlined in our contractor manual and is being followed by the FI.