DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 19 1999

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Staff Builders Home Health Care, Inc. (A-04-97-01166)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, *Review of Costs Claimed by Staff Builders Home Health Care, Inc.* The objective of our review was to determine whether the home health care services claimed by Staff Builders Home Health Care, Inc. (Staff Builders) in Miami Lakes, Florida met Medicare reimbursement guidelines.

We statistically selected 100 claims for review of which 32 were found to involve services that did not meet Medicare reimbursement requirements. The 100 claims involved 1,930 services of which 429 were unallowable. Our sample of 100 claims was randomly selected from the claims approved for payment by the fiscal intermediary (FI) for services provided during the Calendar Year ended December 31, 1996. These services did not meet Medicare reimbursement requirements because:

- 267 services included in 16 claims were not reasonable or necessary in the opinion of medical personnel.
- 92 services included in 10 claims were provided to beneficiaries who were not homebound. According to medical personnel, the beneficiaries, or their families, these beneficiaries could leave home without considerable effort.
- 70 services included in 6 claims were for home health aide services provided to beneficiaries who had contracted with private agencies to receive similar type services; therefore, the aide services were unnecessary.

Based on our review, we estimate that at least $2.3 million of the $21.8 million claimed by Staff Builders did not meet the reimbursement requirements. Using the 90 percent confidence interval, we believe the overpayment was between $2.3 million and $4.7 million.

Although we found documentation that indicated Staff Builders monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement

requirements. The monitoring did not properly address homebound status, the medical necessity of services, or duplication of services. Nevertheless, the home health agency (HHA) guidelines issued by the Health Care Financing Administration (HCFA) make contractors, such as Staff Builders, responsible for the actions of their subcontractors.

We recommend that HCFA: (1) instruct the FI to recover overpayments of $2.3 million, (2) require the FI to instruct Staff Builders on its responsibilities to properly monitor subcontractors for compliance with the Medicare regulations, and (3) monitor the FI and Staff Builders to ensure that corrective actions are effectively implemented.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as APPENDIX D to this report.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-97-01166 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COSTS CLAIMED BY STAFF BUILDERS HOME HEALTH CARE, INC.

JUNE GIBBS BROWN
Inspector General

APRIL 1999
A-04-97-01166

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 19 1999

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Staff Builders Home Health Care, Inc. (A-04-97-01166)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Staff Builders Home Health Care, Inc. (Staff Builders) in Miami Lakes, Florida.

OBJECTIVE

The audit objective was to determine whether the home health care services claimed by Staff Builders met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

We statistically selected 100 claims for review of which 32 were found to involve services that did not meet Medicare reimbursement requirements. The 100 claims involved 1,930 services of which 429 were unallowable. Our sample of 100 claims was randomly selected from the claims approved for payment by the fiscal intermediary (FI) for services provided during the Calendar Year (CY) ended December 31, 1996. These services did not meet Medicare reimbursement requirements because:

- 267 services included in 16 claims were not reasonable or necessary in the opinion of medical personnel.
- 92 services included in 10 claims were provided to beneficiaries who were not homebound. According to medical personnel, the beneficiaries, or their families, these beneficiaries could leave home without considerable effort.
- 70 services included in 6 claims were for home health aide services provided to beneficiaries who had contracted with private agencies to receive similar type services; therefore, the aide services were unnecessary.

Based on our review, we estimate that at least $2.3 million of the $21.8 million claimed by Staff Builders did not meet the reimbursement requirements. Using the 90 percent confidence interval, we believe the overpayment was between $2.3 million and $4.7 million.

Although we found documentation that indicated Staff Builders monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. The monitoring did not properly address homebound status, the medical necessity of services, or duplication of services. Nevertheless, the home health agency (HHA) guidelines issued by the Health Care Financing Administration (HCFA) make contractors, such as Staff Builders, responsible for the actions of their subcontractors.

We recommend that HCFA: (1) instruct the FI to recover overpayments of $2.3 million, (2) require the FI to instruct Staff Builders on its responsibilities to properly monitor subcontractors for compliance with the Medicare regulations, and (3) monitor the FI and Staff Builders to ensure that corrective actions are effectively implemented.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as APPENDIX D to this report.

BACKGROUND

Staff Builders Home Health Care, Inc.

Staff Builders is a Medicare certified HHA with a principal place of business in Miami Lakes, Florida. Staff Builders is a for profit corporation and provides home health services to Dade County residents.

A Medicare certified HHA, such as Staff Builders, can either provide home health services itself or make arrangements with other certified or non-certified providers for home health services. Staff Builders directly and indirectly employs nurses, aides, therapists, and administrative personnel in Dade County.

During the period of our review, Staff Builders 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 $21.8 million. Interim payments are adjusted to actual costs based on annual cost reports. Staff Builders submitted a cost report for 1996 claiming costs totaling $21.8 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 CFR, and HCFA coverage guidelines are found in the Medicare HHA Manual.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist in administering the home health benefits program. The FI for Staff Builders is United Government Services of Milwaukee, Wisconsin. 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 Staff Builders met Medicare reimbursement requirements. The audit was performed in partnership with the HCFA Miami Satellite Office under Operation Restore Trust.

Staff Builders claimed 300,302 services on 14,405 claims for CY 1996. We reviewed a statistical sample of 100 claims which included 1,930 services for 100 different beneficiaries. We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims submitted by Staff Builders were for services provided during the period January 1, 1996 through December 31, 1996. APPENDIX A contains the details of 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 Staff Builders met the Medicare reimbursement requirements.

We also used the sample to project 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 71 of the 100 beneficiaries. We were unable to interview 29 of the beneficiaries or a close acquaintance because 19 could not be located, 8 were deceased, and 2 were in the hospital.

We interviewed the prescribing physicians for 94 of the claims in our sample. Of the physicians not interviewed, two had suspended licenses, one was deceased, one retired, and another physician, who was the prescribing physician for two claims, could not be located.

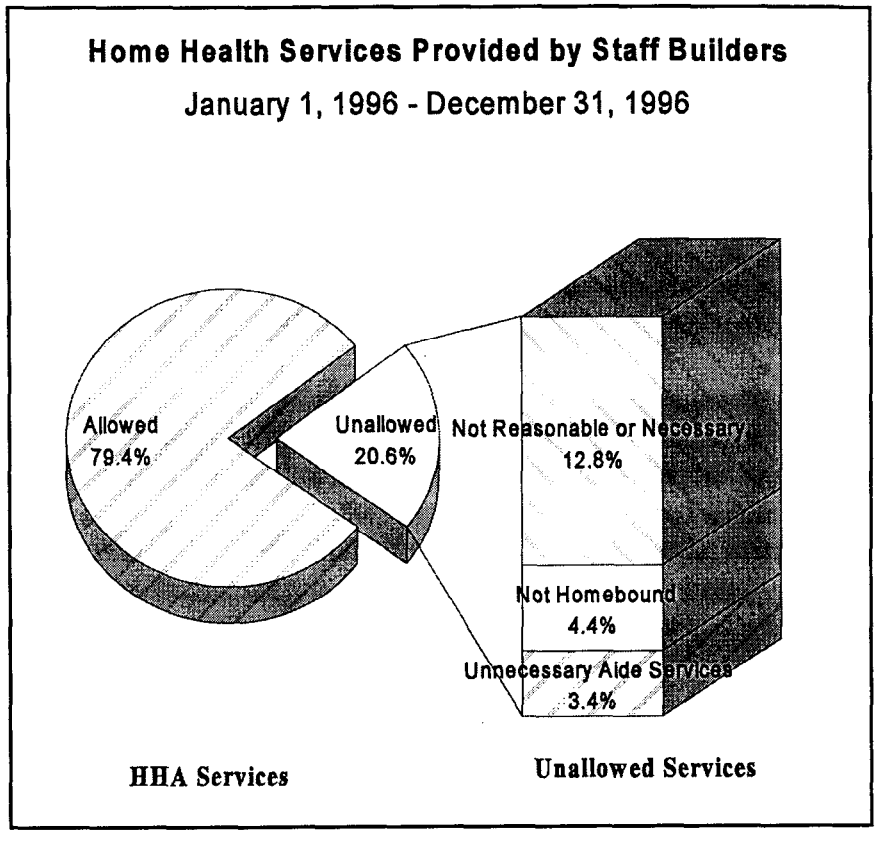
In cooperation with HCFA, we had the medical records reviewed by medical personnel to determine whether the claimed services met Medicare reimbursement requirements for homebound status and medical necessity.

We conducted a limited review of Staff Builders internal controls. Specifically, we reviewed the policies and procedures in place to monitor the work performed by its own staff and subcontractors.

Our field work was performed at Staff Builder's administrative office in Miami Lakes, Florida. Interviews were conducted in the beneficiaries' residences and the physicians' offices. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

Our audit disclosed 429 of the 1,930 services included in 32 of the 100 claims submitted by Staff Builders during CY 1996 did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the FI we estimate 20.6 percent of the services contained in the claims did not meet Medicare reimbursement requirements. The percentage was computed using a stratified cluster sampling methodology, considering each claim to be a cluster of services.



Based on a statistical sample, we estimate that Staff Builders received overpayments totaling at least $2.3 million and using the 90 percent confidence interval, we believe the overpayment was between $2.3 million and $4.7 million.

Although we found documentation that Staff Builders monitored its employees and subcontractors, this monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. The monitoring did not properly address homebound status, the medical necessity of services, or the need for aide services when the beneficiaries had access to similar services. The regulations clearly hold Staff Builders responsible for payments made for services performed by either its own staff or by subcontractors.

Criteria for Services Provided by Subcontractors

Section 409.42(e) of Title 42 CFR states that "...home health services must be furnished by, or under arrangements made by a participating HHA." 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." 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 That Were Not Reasonable or Necessary

Our review disclosed 267 services contained in 16 of the 100 claims were not considered reasonable or necessary by the HCFA medical personnel.

The regulations at 42 CFR 409.42 (1) 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.B 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; and section 205.1.B.1 states "Observation and assessment of the beneficiary's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the beneficiary's treatment regime is essentially stabilized."

Of the 100 claims reviewed, the HCFA medical personnel concluded that medical records for 16 beneficiaries did not support the reasonableness and necessity of 267 services. In the 16 claims, there were various reasons for the services being unreasonable and unnecessary.

- In seven claims, reviews showed a lack of medical documentation to support medical need.

- In another five claims, the beneficiaries were in stable condition; therefore, services were unnecessary and considered excessive.

- In another two claims, the beneficiaries had chronic conditions. In both cases, the beneficiary was a psychiatric patient living in an assisted living

facility (ALF). Both beneficiaries in these cases were not homebound and had agreements with the ALF to receive aide services.

- The remaining two claims were for unnecessary medical reasons.

Services to Beneficiaries Who Were Not Homebound

Our review disclosed 92 services contained in 10 of the 100 claims were for beneficiaries who were not homebound at the time the services were provided. The review of medical records, or the interview of the beneficiary or a close acquaintance of the beneficiary, indicated the beneficiaries, by their own assessment or that of the medical reviewer, were not homebound at the time the services were provided. In all cases, Staff Builders 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 (a) 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 (a) (1) 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 review of the HHA medical records indicated that the beneficiaries were not homebound. The interviews of the beneficiary or a close acquaintance of the beneficiary, in most cases, confirmed the beneficiaries could leave their homes without considerable effort at the time HHA services were provided. For example:

- In one case, the interviewer found the beneficiary fully ambulatory. She stated that a friend told her if she went to the HHA and asked the physician to prescribe services, she could obtain home health services. Within a week, the beneficiary was receiving home health services.

- In another case, the interviewer found the beneficiary was independent in all activities of daily living. The beneficiary stated that she was not homebound at the time of services and that she frequently left her home. The skilled services were requested to obtain aide services. The beneficiary conveyed that it was absurd to require skilled services in order to have aides clean her home.

Unnecessary Aide Services

Our review disclosed 70 services contained in 6 of the 100 claims were unnecessary home health aide services. The beneficiaries resided in ALFs which were under contract to the beneficiaries to provide assistance with activities of daily living, similar to the home health

aide services provided by Staff Builders. During our review, a control system was in place at Staff Builders to detect and identify duplication of services. The ALF contracts were filed, cataloged, and were to be used by Staff Builders to identify and compare home health aide services with those provided by ALFs; however, this control failed to prevent unnecessary aide services as evidenced by our finding.

Although the medical records maintained by Staff Builders contained the required documentation including home health aides' notes and signatures of the beneficiaries indicating the services were provided, the beneficiaries had contracted to receive similar services from the ALFs; therefore, the aide services provided by Staff Builders were unnecessary.

The regulations at 42 CFR 409.45 (b) (3) state the "...services provided by the home health agency must be reasonable and necessary, services must be of a type that there is no able or willing care giver to provide, or, if there is a potential care giver, the beneficiary is unwilling to use the services of that individual."

Effect

We estimate during CY 1996, Staff Builders was paid at least $2.3 million for unallowable home health services. We estimate 20.6 percent of the services in claims paid to Staff Builders were unallowable. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval was $2,332,293 to $4,697,658 with a midpoint of $3,514,976. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that Staff Builders was overpaid by at least $2.3 million for unallowable home health services.

Staff Builders Did Not Properly Monitor Services

We reviewed Staff Builder's policies and procedures to monitor the work performed by its own employees and subcontractors, in the determination and assessment of homebound status and medical necessity criteria to receive HHA services. Although documentation found in the medical records indicated Staff Builders conducted supervisory visits, these procedures failed to disclose the problems we found during our review.

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.

RECOMMENDATIONS

We recommend that HCFA:

- instruct the FI to recover overpayments of $2.3 million,
- require the FI to instruct Staff Builders on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations, and
- monitor the FI and Staff Builders to ensure that corrective actions are effectively implemented.

HCFA's Comments

In response to our draft report, HCFA concurred with our recommendations. In its reply, HCFA posed a technical question of whether the results of a random sample of 100 claims are adequate to recommend a financial recovery. The HCFA response is included in its entirety as APPENDIX D to this report.

OIG Response

Our random sample of 100 claims was adequate to recommend financial recovery. This sample size is consistent with Office of Inspector General (OIG), Office of Audit Services' policy which has been used in similar audits over the last 3 years in which HCFA has concurred with our recommendations to recover funds. We use the lower limit of the 90 percent two-sided confidence interval for recommended recoveries. The larger the sample size used, the more precise our sample results and the greater the lower limit. Thus, a larger sample would result in greater recommended recovery. The size of the sample does not impact the validity of the estimates; it does impact the amount of recovery recommended. Also, except for very small sampling populations, the size of the sampling population does not greatly impact the size of a sample for a given level of precision.

APPENDICES

AUDIT OF STAFF BUILDERS HOME HEALTH SERVICES
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 Staff Builders during the CY ended December 31, 1996. 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 Staff Builders during the CY ended December 31, 1996.

POPULATION:

The universe consisted of 14,405 claims for home health services provided by Staff Builders during the period January 1, 1996 to December 31, 1996 which covered cost reporting periods ending February 29, 1996 and February 28, 1997.

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:

An unrestricted random sample was used.

SAMPLE SIZE:

A sample of 100 claims.

ESTIMATION METHODOLOGY:

We used the lower of the cost per visit or the program cost limits for each type of service reported by Staff Builders in the unaudited cost reports for fiscal years (FY) ended February 29, 1996 and February 28, 1997. 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 Staff Builders in the unaudited cost report for the appropriate FY.

Using the Department of Health and Human Services (HHS), OIG, Office of Audit Services Variables Appraisal Program, we estimated the overpayments that either did not meet reimbursement requirements for homebound, medical reasonableness and necessity, or were a duplication of services.

APPENDIX B

AUDIT OF STAFF BUILDERS HOME HEALTH SERVICES
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 14,405 claims to project the occurrence of certain types of errors. Since the sample was taken of claims, we used the HHS, OIG, RAT-STAT Two-Stage Attribute Appraisal Program to project the percentage of services in error. For this appraisal, we considered each claim to be a cluster of services. The results of these projections are presented below:

Services That Did Not Meet the Requirements	
Quantity of Services in Error	429
Point Estimate	20.6%
Precision at the 90% Confidence Level	+/- 7.0%
Services That Were Not Reasonable or Not Necessary	
Quantity of Services in Error	267
Point Estimate	12.8%
Precision at the 90% Confidence Level	+/- 6.2%
Services to Beneficiaries Who Were Not Homebound	
Quantity of Services in Error	92
Point Estimate	4.4%
Precision at the 90% Confidence Level	+/- 3.0%
Unnecessary Aide Services	
Quantity of Services in Error	70
Point Estimate	3.4%
Precision at the 90% Confidence Level	+/- 2.6%

APPENDIX C

AUDIT OF STAFF BUILDERS HOME HEALTH SERVICES
VARIABLES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims ($119,004) out of 14,405 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	$ 24,401
Point Estimate	$3,514,976
Lower Limit	$2,332,293
Upper Limit	$4,697,658

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JAN 1 1 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle NMD
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Review of Costs Claimed by Staff Builders Home Health Care," (A-04-97-01166); "Review of Costs Claimed by MedTech Home Health Services, Inc." (A-04-97-01169); and, "Review of Costs Claimed by MedCare Home Health Services," (A-04-97-01170)

Thank you for the opportunity to review the above-referenced reports concerning medical review of claims for home health care services in the Florida area. I also want to acknowledge that these audits were performed in partnership with our HCFA Miami Satellite Office under Operation Restore Trust.

HCFA concurs with the three OIG recommendations. Our specific comments follow:

OIG Recommendation
HCFA should instruct the fiscal intermediaries (FI) to recover overpayments.

HCFA Response
We concur and will instruct the FIs to recover overpayments. While HCFA agrees with the recommendation to recover the overpayments from each provider specified, we cannot attest to the exact overpayment figures stated in the reports until the responsible intermediaries receive the audit work papers. Our Atlanta Regional Office will be instructed to review the audit reports and insure that the intermediaries receive the necessary work papers for establishing and recouping the correct overpayment amounts.

OIG Recommendation
HCFA should require the FIs to instruct the home health agencies on their responsibilities to properly monitor their subcontractors for compliance with the Medicare regulations.

HCFA Response
We concur and will instruct our Atlanta Regional Office to work with the intermediaries to assure that the home health agencies have been properly educated to comply with this recommendation.

OIG Recommendation
HCFA should monitor the FIs and home health agencies to ensure that corrective actions are effectively implemented.

HCFA Response
Our Atlanta Regional Office will be instructed to monitor this process.

Technical Comment:
We are concerned about determining such large recoveries from samples as small as 100 claims. The size of the sample reviewed did not vary despite disparities in the annual claims volumes of the agencies. MedCare and MedTech had comparable claims volumes in CY 1996 (5606 and 5777 respectively) while the claims volume for Staff Builders is over two and a half times those amounts (14405). This disparity is not addressed in the methodology.