DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Offices of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

JAN 0 9 2006

Report Number: A-07-04-01010

Ms. Karen Thomas, President
Oxford Healthcare
P. O. Box 10939
Springfield, Missouri 65808-0939

Dear Ms. Thomas:

Enclosed are two copies of the U.S. Department of Health and Human Services, Office of Inspector General (OIG) report entitled "Review of Billing Under the Home Health Prospective Payment System for Therapy Services." A copy of this report will be forwarded to the HHS action official noted on the following page for his review and any action deemed necessary.

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

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If you have any questions or comments about this report, please do not hesitate to call me at (816) 426-3591, ext. 274, or your staff may contact Chris Bresette, Audit Manager, at (816) 426-3591, ext. 228, or via e-mail at chris.bresette@oig.hhs.gov. To facilitate identification, please refer to report number A-07-04-01010 in all correspondence.

Sincerely yours,

Patrick J. Cogley
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Thomas W. Lenz
Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
Richard Bolling Federal Building
601 East 12th Street, Room 227
Kansas City, Missouri 64106-2808

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF BILLING UNDER THE HOME HEALTH PROSPECTIVE PAYMENT SYSTEM FOR THERAPY SERVICES

Daniel R. Levinson
Inspector General

JANUARY 2006
A-07-04-01010

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed as well as other conclusions and recommendations in this report represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the awarding agency will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

A home health agency (HHA) provides home visits for skilled nursing care; home health aid services; occupational, physical, and speech therapy; and medical social services.

Under the home health prospective payment system (PPS), Medicare makes one payment for all home health services performed during a 60-day period called an episode. The payment is based upon the beneficiary's health condition (i.e. diagnosis) and level of care needed during the episode. The payment rate varies for claims with 9 or fewer therapy visits and for claims with 10 or more therapy visits. When a claim includes 10 or more visits, the payment increases by approximately $1,800. To qualify for Medicare payment, therapy services must be medically necessary, properly documented, and properly authorized by a physician.

Oxford Healthcare (Oxford) is an HHA in Springfield, MO. Oxford received $3,021,489 in Medicare payments for 851 claims with 10-12 therapy visits. The visits occurred during episodes that began in fiscal year (FY) 2003.

OBJECTIVE

Our objective was to determine if Oxford's claims with 10-12 therapy visits complied with Federal regulations and guidance.

SUMMARY OF FINDINGS

Oxford's claims with 10-12 therapy visits did not always comply with Federal regulations and guidance. Of 100 statistically sampled claims reviewed by medical professionals, 50 claims had errors (6 claims had 2 errors) that caused the Medicare payment amounts to be incorrect.[1]

For 41 claims, Oxford included medically unnecessary therapy services. As a result, the number of allowable therapy visits fell below the 10-visit threshold for increased payment, and the payment amount decreased by approximately $1,800 per claim.

In addition, four of the claims included improperly authorized therapy services, which caused all or a portion of the claims and associated payments to be unallowable. Oxford also incorrectly assessed the beneficiary's health status for 11 claims, which caused a small portion of the claim payment amount to be unallowable.

Oxford had inadequate quality assurance procedures to ensure that the claims were for medically necessary services and properly authorized therapy services, and that it correctly assessed the beneficiary's health status. As a result, we estimate that $685,406, of the $3,021,489 that Oxford received for the 851 therapy claims, is unallowable.

[1]Each claim and its associated errors are listed on Appendix A.

RECOMMENDATIONS

We recommend that Oxford:

- refund $685,406 to the Medicare program;

- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and

- strengthen controls to ensure that all claims are for medically necessary services and properly authorized therapy services, and that it correctly assesses the beneficiary's health status.

AUDITEE'S COMMENTS

In its response, Oxford stated that it "respectfully disagrees with many of the determinations made by OIG [Office of Inspector General] auditors discussed in the Report and continues to stand behind the claims it has submitted." Oxford appealed most of the claims that Cahaba's medical reviewers identified as errors in the draft report; it successfully appealed five of the claims.

Oxford did not concur with the amount recommended to refund as shown in the draft report. Oxford requested that we amend the content of our final report and the extrapolated refund amount to reflect the appeal decisions. In addition, Oxford stated that it would examine a sample of claims for therapy services provided subsequent to the audit period and submit adjusted home health claims as appropriate once the appeals process is completed. Oxford stated it has implemented corrective steps to strengthen its existing control processes.

Oxford's comments are included in their entirety as Appendix C.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We amended our final report to remove the 5 claims that Oxford successfully appealed; therefore, the final report includes 50 claims that medical reviewers identified as errors. We based our estimate of $685,406 in overpayments according to these revisions. We commend Oxford for steps it stated it would take to identify incorrectly paid claims for therapy services and to strengthen its existing control processes.

TABLE OF CONTENTS

INTRODUCTION

BACKGROUND

Home Health Prospective Payment System

A home health agency (HHA) provides home visits for skilled nursing care; home health aid services; occupational, physical, and speech therapy; and medical social services.

The Centers for Medicare & Medicaid Services (CMS) was required to implement a prospective payment system (PPS) for Medicare HHA services pursuant to the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999. Accordingly, CMS implemented a PPS for HHAs effective October 1, 2000.

Under the home health PPS, Medicare makes one payment for all home health services performed during a 60-day period called an episode. The payment is based upon the beneficiary's clinical severity (health condition and risk factors), functional status (daily living activities), and service utilization (number of services).

One item under the service utilization category indicates if the beneficiary received therapy services. According to the CMS Policy Manual for Home Health Agencies, the payment rate varies for claims with 9 or fewer therapy visits and for claims with 10 or more therapy visits. In Missouri, when a claim includes 10 or more visits, the payment increases by approximately $1,800. For visits to qualify for Medicare payment, therapy services must be medically necessary, properly documented, and properly authorized by a physician.

Oxford Healthcare and Medicare Intermediary

Oxford Healthcare (Oxford) is an HHA located in Springfield, MO. Oxford received $3,021,489 in Medicare payments for 851 claims with 10-12 therapy visits. The visits occurred during episodes that began in fiscal year (FY) 2003. The regional home health intermediary for Oxford is Cahaba Government Benefit Administrators (Cahaba). The intermediary processes claims, assists in applying safeguards against unnecessary utilization of services, resolves disputes, and audits cost reports submitted by HHAs.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine if Oxford's claims with 10-12 therapy visits complied with Federal regulations and guidance.

Scope

We randomly selected a sample of 100 claims in order to review the $3,021,489 Oxford received in Medicare payments. Appendix B presents details of our sampling methodology.

We limited our review of internal controls at Oxford to those controls over the preparation and submission of Medicare HHA claims. Cahaba medical professionals performed a medical review of the sampled claims to determine if the services provided were medically necessary, adequately supported, and properly authorized. All overpayments identified are the results of the medical reviews.

We conducted fieldwork from November 2004 through January 2005, which included a visit to Oxford's office in Springfield, MO.

Methodology

To accomplish our objective, we:

- reviewed applicable Federal laws and regulations, and the HHA Manual;

- interviewed Oxford officials and reviewed Oxford's policies and procedures to obtain an understanding of how it prepared and submitted HHA therapy claims;

- analyzed the Medicare National Claims History File to identify Oxford's home health PPS paid claims with at least 1 therapy visit, which occurred during episodes that began during FY 2003, and selected for review paid claims with 10-12 therapy visits;

- obtained Oxford's medical records for each claim selected, provided those records to Cahaba for medical review, and reviewed the results (determination of medical necessity, adequate supporting documentation, and proper authorization of services billed) identified by the medical professionals; and

- verified the amount of the Medicare overpayments identified by the medical professionals for unallowable services billed by Oxford and projected the results of the statistical sample over the population using standard statistical methods. (See Appendix B.)

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

Oxford's claims with 10-12 therapy visits did not always comply with Federal regulations and guidance. Of 100 statistically sampled claims reviewed by medical professionals, 50 claims had errors (6 claims had 2 errors) that caused the Medicare payment amounts to be incorrect.[2]

For 41 claims, Oxford included medically unnecessary therapy services. As a result, the number of allowable therapy visits fell below the 10-visit threshold for increased payment, and the payment amount decreased by approximately $1,800 per claim.

In addition, four of the claims included improperly authorized therapy services, which caused all or a portion of the claims and associated payments to be unallowable. Oxford also incorrectly assessed the beneficiary's health status for 11 claims, which caused a small portion of the claim payment amount to be unallowable.

Oxford had inadequate quality assurance procedures to ensure that the claims were for medically necessary services and properly authorized therapy services, and that it correctly assessed the beneficiary's health status. As a result, we estimate that $685,406, of the $3,021,489 that Oxford received for the 851 therapy claims, is unallowable.

MEDICAL NECESSITY OF THERAPY SERVICES

Therapy Services Must Be Medically Necessary

Pursuant to 42 CFR § 409.44(2), Medicare payment is allowable only for those services that are considered reasonable and medically necessary. Further, section 205.2 of the HHA Manual states: "The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition." In addition, "the amount, frequency and duration of the services must be reasonable."

Medically Unnecessary Therapy Services

For 41 claims, Oxford included medically unnecessary therapy services. As a result, the number of allowable therapy visits fell below the 10-visit threshold for increased payment, and the payment amount decreased by approximately $1,800 per claim.

For example, 1 claim included 11 visits for physical therapy services. Cahaba determined that five visits were unallowable because the services provided were medically unnecessary. Another claim included 10 visits for physical therapy services. Cahaba determined that the goals of the therapy were met by the ninth visit. Therefore, the 10th visit was unnecessary. Because the number of allowable therapy visits on each claim fell below the 10-visit threshold, Oxford was overpaid approximately $1,800 per claim.

[2]Each claim and its associated errors are listed on Appendix A.

AUTHORIZED SERVICES

Services Must Be Authorized by a Physician

Federal regulations (42 CFR § 409.43(c)(3)(ii)) require the plan of care to be signed and dated by a physician before the claim for each episode for services is submitted for final payment. "The physician's orders for services in the plan of care must specify the medical treatments to be furnished as well as the type of home health discipline that will furnish the ordered services and at what frequency the services will be furnished."

Services Were Not Authorized Properly

Four of the claims included improperly authorized therapy services, which caused all or a portion of the claims and associated payments to be unallowable. For three claims, the physician signed the plan of care after the claim was submitted for final payment. For the other claim, the physician did not authorize the therapy services.

For example, on one claim, a physician signed and dated the plan of care after the services were performed and Oxford submitted the claim for final payment. As a result, the entire claim was unallowable and Oxford was overpaid by $3,211.

PATIENT ASSESSMENTS

Assessments Must Be Accurate

Federal regulations (42 CFR § 484.55) state that the HHA must provide a "patient-specific, comprehensive assessment that accurately reflects the patient's current health status and includes information that may be used to demonstrate the patient's progress toward achievement of desired outcomes." Health status includes the beneficiary's clinical severity (health condition and risk factors) and functional status (daily living activities).

Assessments Were Not Correct

Oxford incorrectly assessed the beneficiary's health status for 11 claims. The beneficiary's medical records indicated that either the clinical severity or functional status identified in the assessment was wrong. As a result, a small portion of the claim payment amount was unallowable.

For example, medical professionals found that the primary diagnosis of an unspecified muscle disorder on one assessment was incorrect. The medical records indicated that the correct primary diagnosis was general weakness. Oxford was overpaid $779 for the claim.

INADEQUATE PROCEDURES CAUSED UNALLOWABLE PAYMENTS

Oxford had inadequate quality assurance procedures to ensure that the claims were for medically necessary services and properly authorized therapy services, and that it correctly assessed the beneficiary's health status.

Of the 100 claims in our statistical sample, 50 claims had errors that caused the Medicare payment amounts to be incorrect. We estimate that $685,406, of the $3,021,489 that Oxford received for the 851 therapy claims with 10-12 therapy visits, is unallowable.

RECOMMENDATIONS

We recommend that Oxford:

- refund $685,406 to the Medicare program;
- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and
- strengthen controls to ensure that all claims are for medically necessary services and properly authorized therapy services, and that it correctly assesses the beneficiary's health status.

AUDITEE'S COMMENTS

In its response, Oxford stated that it "respectfully disagrees with many of the determinations made by OIG [Office of Inspector General] auditors discussed in the Report and continues to stand behind the claims it has submitted." Oxford's comments are included in their entirety as Appendix C.

According to Oxford's comments, "Since the conclusion of the OIG's audit, . . . Cahaba, has issued denial letters . . . and made a series of adjusted payments to Oxford." Oxford appealed most of the claims that Cahaba's medical reviewers identified as errors in the draft report. After two further reviews, one by Cahaba and the other by the quality improvement contractor, medical reviewers determined that eight claims did meet requirements; however, three of these claims were not included in our draft report as errors. Therefore, Oxford successfully appealed five claims included in our report as errors.

Oxford did not concur with the amount recommended to refund as shown in the draft report. Oxford stated that it continues to pursue the administrative appeals process on many of the claims that it did not successfully appeal. Oxford requested that we amend the content of our final report and the extrapolated refund amount to reflect the appeal decisions. Oxford stated that it will appeal the unfavorable decisions to the Administrative Law Judge level.

Oxford stated that it would examine a sample of claims for therapy services provided subsequent to the audit period and submit adjusted home health claims as appropriate once the appeals process is completed.

Oxford concurred with our recommendation to strengthen its existing control processes and stated it has implemented corrective steps; however, Oxford also stated that its "concurrence with this recommendation should not be construed as an agreement with the allegations contained in the Report." Oxford stated that it provided mandatory education for all Oxford therapists, revised its internal audit process to increase regular reviews of therapy records, and established and implemented processes to ensure increased interdisciplinary communication. In addition, its "therapists have met one-on-one with internal auditors for specialized education regarding documentation issues."

OFFICE OF INSPECTOR GENERAL'S RESPONSE

Medical reviewers have determined after multiple reviews that 50 of the 55 claims we included in our draft report had errors that caused the Medicare payment amounts to be incorrect. We amended our final report to remove the 5 claims that Oxford successfully appealed; therefore, the final report includes 50 claims that medical reviewers identified as errors. As a result of the successful appeals, we adjusted the number of errors for medically unnecessary therapy services, improperly authorized therapy services, and incorrectly assessed beneficiary's health status. We based our estimate of $685,406 in overpayments according to these revisions.

We commend Oxford for steps it stated it would take to identify incorrectly paid claims for therapy services and to strengthen its existing control processes.

APPENDIXES

SAMPLED CLAIMS WITH ERRORS

The table below contains each claim and its associated error(s).

Sample Number	Medical Necessity of Therapy Services	Authorized Services	Patient Assessments
1	X		
2	X		
4	X		X
6	X		
7	X		
10	X		
12	X		
13		X	
14	X		
16	X		
21	X		X
22	X		
23	X		
25	X		
26	X		
28	X		
29	X		
31	X		
32	X		
35	X		
38	X		
41	X		
46	X		
48	X		
50			X
52	X		X
54	X		
55			X
58	X		
60	X		
61	X		
64		X	X
65	X		
66			X
69	X		
72	X		
74			X

Sample Number	Medical Necessity of Therapy Services	Authorized Services	Patient Assessments
77	X		
78	X		
79	X		X
80		X	
82	X		
87	X		X
88	X		
91		X	
95	X		
97	X		
98	X		
99			X
100	X		

Totals	**41**	**4**	**11**

50 claims had 56 errors (41 + 4 + 11) that caused the Medicare payment amounts to be incorrect.

SAMPLING METHODOLOGY

OXFORD HEALTHCARE

POPULATION

The sample population consisted of 851 Medicare Part A home health agency (HHA) claims paid to Oxford Healthcare (Oxford), for which beneficiaries received 10, 11, or 12 therapy services. The beginning dates of service for the 851 claims occurred during 2003.

SAMPLING UNIT

The sampling unit was a claim with 10, 11, or 12 therapy visits in which the beginning date of service occurred during our audit period.

SAMPLE DESIGN

We used a simple random sample design.

SAMPLE SIZE

A simple random sample was used. The frame to be sampled from is 851 HHA claims paid to Oxford with beginning dates services that occurred during FY 2003.

ESTIMATION METHODOLOGY

We used the Office of Inspector General, Office of Audit Services Statistical Software Variable Appraisal program for random sampling to estimate the amount of unallowable program payments based on the dollar value of the sampled claims determined to be paid in error. The estimate of unallowable program payments was reported using the difference estimator at the lower limit of the 90-percent two-sided confidence interval.

SAMPLE RESULTS

The results of our review are as follows:

Sample Size	Value of Sample	Number of Claims with Unallowable Payments	Unallowable Payments
100	$363,300	50	$98,285

VARIABLE PROJECTIONS

The results of our estimations of unallowable Medicare payments are as follows:

Point Estimate	$836,406
90% Confidence Interval	
Lower Limit	$685,406
Upper Limit	$987,406

Oxford HealthCare

We Set The Standard Of Excellence For Home Care

November 3, 2005

Report Number: A-07-04-01010

Mr. Patrick Cogley
Regional Inspector General of Audit Services
Department of Health and Human Services
Region VII
601 E. 12th Street, Room 284A
Kansas City, MO 64106

Dear Mr. Cogley:

Oxford HealthCare ("Oxford") has received the draft version of the above-referenced audit report ("Report"). As requested, we have reviewed the Report and are now providing written comments as to the content and accuracy of the Report. Our responses to the issues raised in the Report are as follows.

The Report focused on claims submitted by Oxford for patients receiving between ten (10) and twelve (12) therapy visits to determine whether the claims complied with federal regulations and guidance. In the Executive Summary, it states that of the 100 claims reviewed, 55 of the claims contained errors and 10 of the 55 claims contained 2 errors.

By extrapolating the sample to the total number of claims submitted by Oxford where 10-12 therapy visits were provided, the Report states that Oxford has been overpaid approximately $771,239 from the $3,021,489 that Oxford received for 851 therapy claims. The Report concluded by making three specific recommendations: (1) that Oxford refund $771,239 to the Medicare program; (2) that Oxford identify and submit adjusted home health claims for Medicare overpayments received subsequent to the audit period; and (3) that Oxford strengthen controls to ensure that all claims are for medically necessary services, properly authorized therapy services, and that the beneficiary's health status is correctly assessed.

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Since the conclusion of the OIG's audit, Oxford's Regional Home Health Intermediary, Cahaba, has issued denial letters, recouped $209,362.00 (the total dollar amount paid for all of the records at issue) and made a series of adjusted payments to Oxford such that the original dollar amount in question was $117,990.12. Oxford clinical and quality assurance personnel reviewed the patient charts for the 55 claims alleged to contain errors. Oxford personnel feel very strongly that in most cases the services provided within the sampled claims were medically necessary, properly authorized, and the patient's health status was correctly assessed. At the time of this response, Oxford has initiated the Medicare appeals process with regard to all but 11 of the 55 claims alleged to contain errors. Cahaba has paid, or is expected to pay, Oxford for each of the favorable appeal determinations discussed in the paragraph below.

To date, Oxford has received several favorable re-determinations and reconsiderations from Cahaba and the Quality Independent Contractor ("QIC"), respectively. Specifically, Oxford has received the following favorable re-determinations and re-considerations:

- Record #75, in the amount of $2,210.14;
- Record #86, in the amount of $1,839.02;
- Record #73, in the amount of $3,807.98;
- Record # 17, in the amount of $2,173.71;
- Record #5, in the amount of $1,809.08;
- Record #67, in the amount of $2,210.13;
- Record #51, in the amount of $2,138.13; and
- Record # 37, in the amount of $817.72.

Finally, Oxford has received several partially favorable re-determinations and reconsiderations for Records # 35, 100, and 46.

Oxford strives to provide services in accordance with federal regulations and guidance. Oxford respectfully disagrees with many of the determinations made by OIG auditors discussed in the Report and continues to stand behind the claims it has submitted. Currently, most of the claims which have not received favorable determinations on appeal, and those which were found only partially favorable, will be pursued at the Administrative Law Judge level of the Medicare appeals process.

For the 11 claims that were not appealed to Cahaba at the re-determination level of the appeals process, Oxford personnel determined that the documentation in these records did not support Oxford's ability to appeal the claims. Oxford has reviewed both the appealed and non-appealed claims carefully to determine the nature and the source of the alleged errors to ensure that these problems do not recur.

As to each of the specific recommendations contained in the Report, Oxford's responses are as follows:

1. **Regarding the recommendation that Oxford refund $771,239**: Oxford does not concur with this recommendation. As outlined above, since the draft Report was issued, Oxford has successfully appealed several of the claims alleged to contain

errors and continues to pursue the administrative appeals process on many of the remaining claims. Therefore, Oxford respectfully requests that the OIG amend the content of the Report and the extrapolated refund amount to reflect these favorable determinations in the final version of the report.

2. **Regarding the recommendation that Oxford identify and submit adjusted claims**: As stated above, Oxford is currently pursuing appeals of many of the claims at issue. The appeals process will serve to define the nature and the scope of the issues addressed in the draft Report. Until the appeals process has been completed, it is premature to perform a further audit. When the appeals process has been completed, and Oxford has more defined parameters regarding these issues, Oxford will endeavor to examine a sample of claims for therapy services provided subsequent to the audit period and submit adjusted home health claims as appropriate.

3. **Regarding the recommendation to strengthen control processes**: In the interest of consistent improvement and the pursuit of quality, Oxford concurs with the recommendation to strengthen existing control processes. However, it should be noted and understood that Oxford continues to stand behind the medical necessity, authorization and assessments contained in many of the claims addressed in the Report and concurrence with this recommendation should not be construed as an agreement with the allegations contained in the Report. Oxford has implemented the following corrective action steps in order to strengthen its processes and controls and ensure that claims are submitted appropriately:

    1. Mandatory education was provided for all Oxford therapists as of June 14, 2005. This educational program focused on:
        a. creation and implementation of a home exercise program;
        b. physician orders and the establishment of goals for therapy patients;
        c. medical necessity and progression toward patients' therapy goals; and
        d. interdisciplinary communication between therapy and nursing professionals.
    2. Oxford's internal audit process has been revised and strengthened to include increased regular reviews of therapy records and claims.
    3. Oxford therapists have met one-on-one with internal auditors for specialized education regarding documentation issues.
    4. Processes have been established and implemented to ensure increased interdisciplinary communication.

Prior to notification of the OIG's intent to audit certain claims, quality initiatives and education were clear priorities at Oxford. For example, in March 2004, months prior to the notification of the OIG's audit, Oxford's quality initiatives focused on education regarding physician referrals for extensions of visits, and the coordination of therapy and nursing disciplines. In May 2004 Oxford engaged a consulting firm to assist in the education of Oxford personnel as to the use of the OASIS tool and

related issues pertaining to documentation and interdisciplinary communication.[1] During the summer of 2004, Oxford took further steps to educate personnel as to the OASIS tool, proper documentation, establishing the utilization and frequency of services based on the patient's needs, and communication between disciplines (including dependent disciplines). Finally, in August of 2004, education programs were developed regarding issues such as documentation of: patients' status and vital signs, balance and strengthening exercises; gait and transfer training; discharge planning; review of the plan of care; and interdisciplinary communication.

In addition to the corrective action steps described above, Oxford continues to utilize a three-pronged audit process which was in place at Oxford prior to the OIG's audit of therapy services. First, all therapy visits are reviewed by supervisory personnel to assure that billable, skilled services were provided. If it is determined that the documentation does not support a certain visit, the claim is adjusted accordingly prior to billing. Second, records in which the evaluating professional indicated ten or more visits were needed are examined throughout the admission time period and the estimation of visits needed is then altered on the assessment if it is later determined that fewer than ten visits were actually necessary. Finally, Oxford's quality assurance personnel audit approximately 8-10% of Oxford's records each month. If it is determined through these audits that a visit should not have been billed, processes are in place to ensure that the error is corrected appropriately.

If you have any questions or comments as to the content of this response you may contact me at (417) 883-7500, ext. 2248 or by email at karen.thomas@oxfordhealthcare.net. Thank you for your time and assistance with this matter.

Sincerely,

Karen Thomas

[1] The same consulting firm was engaged to provide additional OASIS education in May 2005.