Report in Brief
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U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES
OFFICE OF INSPECTOR GENERAL

Medicare Home Health Agency Provider Compliance Audit: The Palace at Home

Why OIG Did This Audit

Under the home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies.

Our prior audits of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or were not in need of skilled services.

Our objective was to determine whether The Palace at Home (The Palace) complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Audit

Our audit covered $14.1 million in Medicare payments to The Palace for 3,851 claims. These claims were for home health services provided in calendar years (CYs) 2015 and 2016 (audit period). We selected a stratified random sample of 100 home health claims and submitted those claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

What OIG Found

The Palace did not comply with Medicare billing requirements for 20 of the 100 home health claims that we reviewed. For these claims, The Palace received overpayments of $30,387 for services provided in CYs 2015 and 2016. Specifically, The Palace incorrectly billed Medicare for: (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, and (3) claims that it assigned with incorrect Health Insurance Prospective Payment System codes. These errors occurred primarily because The Palace did not have adequate controls to prevent the incorrect billing of Medicare claims. On the basis of our sample results, we estimated that The Palace received overpayments of at least $731,304 for CYs 2015 and 2016. All of the incorrectly billed claims are outside of the 4-year reopening period.

What OIG Recommends and The Palace Comments

We recommend that The Palace, based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation. We also recommend that The Palace strengthen its procedures to ensure full compliance with requirements for billing home health services.

In written comments on our draft report, The Palace disagreed with our findings. Regarding our recommendations, The Palace stated that it plans to appeal our findings. The Palace retained a health care consultant to review the claims that we considered to be in error and submitted to us a report prepared by that consultant. The Palace maintained that it billed the sample claims correctly. To address The Palace's concerns related to the medical review decisions, we had our medical review contractor review both The Palace's written comments on our draft report and the report that its consultant prepared.

Based on the results of this review, we removed 12 of the 32 claims originally found to be in error in our draft report and adjusted the findings for an additional 5 claims. With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge The Palace's rights to appeal the findings.