Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

MEDICARE HOME HEALTH AGENCY PROVIDER COMPLIANCE AUDIT: TENDER TOUCH HEALTH CARE SERVICES

Inquiries about this report may be addressed to the Office of Public Affairs at Public.Affairs@oig.hhs.gov.

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Office of Inspector General

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Report in Brief
Date: December 2020
Report No. A-04-18-07077

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

Medicare Home Health Agency Provider Compliance Audit: Tender Touch Health Care Services

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 Tender Touch Health Care Services (Tender Touch) complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Audit

Our audit covered $7.2 million in Medicare payments to Tender Touch for 1,981 claims. These claims were for home health services provided in calendar years 2016 and 2017 (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

Tender Touch did not comply with Medicare billing requirements for 21 of the 100 home health claims that we reviewed. For these claims, Tender Touch received net overpayments of $42,229 for services provided during our audit period. Specifically, Tender Touch incorrectly billed Medicare for services provided to beneficiaries who were not homebound and services provided to beneficiaries who did not require skilled services. These errors occurred primarily because Tender Touch did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas. On the basis of our sample results, we estimated that Tender Touch received overpayments of at least $478,780 for the audit period.

What OIG Recommends and Tender Touch Comments

We made several recommendations to Tender Touch, including that it: (1) refund to the Medicare program the portion of the estimated $478,780 overpayment for claims incorrectly billed that are within the 4-year reopening period; (2) 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; and (3) strengthen its procedures.

In written comments on our draft report, Tender Touch disagreed with our findings and did not address any of our recommendations. Tender Touch disputed our independent medical review contractor's determinations, maintaining that it billed all of the sampled claims correctly. To address Tender Touch's concerns related to the medical review decisions, we had our medical review contractor review Tender Touch's written comments on our draft report and reconsider each of the 27 claims that we questioned in our draft report.

Based on the results of this review, we revised our determinations, reducing the total number of sampled claims originally found to be in error in our draft report from 27 to 21, and adjusted the findings for an additional 12 claims. With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge Tender Touch's right to appeal the findings.

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INTRODUCTION

WHY WE DID THIS AUDIT

For calendar year (CY) 2016, Medicare paid home health agencies (HHAs) about $18 billion for home health services. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing program that the 2016 improper payment error rate for home health claims was 42 percent, or about $7.7 billion. Although Medicare spending for home health care accounts for only about 5 percent of fee-for-service spending, improper payments to HHAs account for more than 18 percent of the total 2016 fee-for-service improper payments ($41 billion). This audit is part of a series of audits of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Tender Touch Health Care Services (Tender Touch) was one of those HHAs.

OBJECTIVE

Our objective was to determine whether Tender Touch complied with Medicare requirements for billing home health services on selected types of claims.

BACKGROUND

The Medicare Program and Payments for Home Health Services

Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers part-time or intermittent skilled nursing care and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments using a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcomes and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS)

codes[1] and represent specific sets of patient characteristics.[2] CMS requires HHAs to submit OASIS data as a condition of payment.[3]

CMS administers the Medicare program and contracts with four of its Medicare administrative contractors to process and pay claims submitted by HHAs.

Home Health Agency Claims at Risk for Incorrect Billing

In prior years, our audits at other HHAs identified findings in the following areas:

- beneficiaries did not always meet the definition of "confined to the home,"
- beneficiaries were not always in need of skilled services,
- HHAs did not always submit the OASIS data in a timely fashion, and
- services were not always adequately documented.

For the purposes of this report, we refer to these areas of incorrect billing as "risk areas."

Medicare Requirements for Home Health Agency Claims and Payments

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (Social Security Act (the Act) § 1862(a)(1)(A)). Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR section 409.42 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician; and

[1] HIPPS codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies.

[2] The final payment is determined at the conclusion of the episode of care using the OASIS information but also factoring in the number and type of home health services provided during the episode of care.

[3] 42 CFR §§ 484.20, 484.55, 484.210(e), and 484.250(a)(1); 74 Fed. Reg. 58077, 58110-58111 (Nov. 10, 2009); and CMS's *Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1.

- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition for payment, a physician must certify that a face-to-face encounter occurred no more than 90 days prior to the home health start-of-care date or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

The determination of "whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR § 484.55 or a medical record of the individual patient" (*Medicare Benefit Policy Manual* (the Manual), chapter 7, § 20.1.2). Coverage determination is not made solely on the basis of general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary's individual need for care (42 CFR § 409.44(a)).

Appendix B contains the details of selected Medicare coverage and payment requirements for HHAs.

Medicare Requirements for Providers to Identify and Return Overpayments

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.[4]

The 6-year lookback period is not limited by OIG's audit period or restrictions on the Government's ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.[5]

Tender Touch Health Care Services

Tender Touch is a proprietary for-profit home health care provider located in Panama City, Florida. Palmetto Government Benefits Administrator, LLC, its Medicare contractor, paid

[4] The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

[5] 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual—Part 1, Pub. No. 15-1, § 2931.2; and 81 Fed. Reg. at 7670.

Tender Touch approximately $8 million for 2,371 claims for services provided in calendar years (CYs) 2016 and 2017 (audit period) on the basis of CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS AUDIT

Our audit covered $7,207,960 in Medicare payments to Tender Touch for 1,981 claims.[6] These claims were for home health services provided in CYs 2016 and 2017.[7] We selected a stratified random sample of 100 claims with payments totaling $403,277 for review. We evaluated compliance with selected billing requirements and submitted these claims to independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the types of errors by sample item.[8]

FINDINGS

Tender Touch did not comply with Medicare billing requirements for 21 of the 100 home health claims that we reviewed. For these claims, Tender Touch received net overpayments of $42,229 for services provided during the audit period. Specifically, Tender Touch incorrectly billed Medicare for:

- services provided to beneficiaries who were not homebound and
- services provided to beneficiaries who did not require skilled services.

These errors occurred primarily because Tender Touch did not have adequate controls to prevent the incorrect billing of Medicare claims within the selected risk areas.

[6] In developing this sampling frame, we excluded from our audit home health claim payments that were (a) identified in the Recovery Audit Contractor (RAC) Data Warehouse as previously excluded or under review, (b) less than $1,000, (c) low utilization payment adjustments, (d) partial episode payments associated with HHA transfers, and (e) requests for anticipated payments.

[7] CYs were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary.

[8] Sample items may have more than one type of error.

On the basis of our sample results, we estimated that Tender Touch received overpayments of at least $478,780 for the audit period.[9] As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.

TENDER TOUCH DID NOT ALWAYS COMPLY WITH MEDICARE BILLING REQUIREMENTS

Tender Touch did not comply with Medicare billing requirements for 21 of the 100 sampled claims, which resulted in net overpayments of $42,229.

Beneficiaries Were Not Homebound

Federal Requirements for Home Health Services

For the reimbursement of home health services, the beneficiary must be "confined to his home" (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42)). According to section 1814(a) of the Act:

> [A]n individual shall be considered "confined to his home" if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 30.1.1). Revision 208 of section 30.1.1 (effective January 1, 2015) and Revision 233 of section 30.1.1 (effective January 1, 2017) covered different parts of our audit period.[10] Revisions 208 and 233 state that, for a patient to be eligible to receive covered home health services under both Part A and B, the law requires that a physician certify in all cases that the patient is confined to his or her home and an individual will be considered "confined to the home" (homebound) if the following two criteria are met:

[9] To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

[10] Coverage guidance is substantively identical in both versions of § 30.1.1 in effect during our audit period. The only difference is Revision 233, effective January 1, 2017, provides further clarification of existing policies for clinicians who must decide whether to certify that a patient is homebound.

Criteria One

The patient must either:

- because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or

- have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Tender Touch Did Not Always Meet Federal Requirements for Being Homebound

For 19 of the sampled claims, Tender Touch incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements for being homebound for the full episode (6 claims) or for a partial episode (13 claims).[11]

Example 1: Beneficiary Not Homebound—Entire Episode

From the start of the episode, when assessed for continued physical therapy, the beneficiary was able to transfer independently and ambulated 200 feet without an assistive device. The patient had no pain and no mobility limitations. There were no medical reasons the patient could not leave home. For the entire period, leaving the home did not require a considerable or taxing effort.

Example 2: Beneficiary Not Homebound—Partial Episode

In another episode, the patient was homebound at the start of care because he had two medical conditions expected to impair his mobility. Namely, he had heart disease and fluid around his lungs, which caused shortness of breath. Additionally, he could walk only 50 feet with minimum assistance. Leaving home would have required a considerable and taxing effort. However, he improved over time and did not remain homebound. Later in the episode, he was independent in transfers, walking 200 feet, and independent with a home

[11] Of these 19 claims with homebound errors, Tender Touch also billed 4 claims with skilled services that were not medically necessary. Appendix E provides details on the extent of errors, if any, per claim reviewed.

> exercise program. He was able to complete all exercises with less breaks. The patient denied pain and was alert and oriented. At that point, the beneficiary was no longer homebound because leaving the home did not require a considerable or taxing effort.

These errors occurred because Tender Touch did not have adequate oversight procedures to ensure that it verified and continually monitored the homebound status of Medicare beneficiaries under its care and properly documented the specific factors that qualified the beneficiaries as homebound.

Beneficiaries Did Not Require Skilled Services

Federal Requirements for Skilled Services

A Medicare beneficiary must need skilled nursing care on an intermittent basis, physical therapy, or speech-language pathology; or the beneficiary must have a continuing need for occupational therapy (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42(c)). In addition, skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury, and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).[12] Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2.1).

Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement, but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition (the Manual, chapter 7, § 20.1.2).

Tender Touch Did Not Always Meet Federal Requirements for Skilled Services

For six of the sampled claims, Tender Touch incorrectly billed Medicare for an entire home health episode (3 claims) or a partial episode (3 claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.[13]

[12] Skilled nursing services can include observation and assessment of a patient's condition, management and evaluation of a patient plan of care, teaching and training activities, and administration of medications, among other things (Manual, chapter 7, § 40.1.2).

[13] Of these six claims with skilled services that were not medically necessary, Tender Touch also billed four claims for beneficiaries with homebound errors. Appendix E provides details on the extent of the errors, if any, per claim reviewed.

Example 3: Beneficiary Did Not Require Skilled Services

A beneficiary with poor endurance and walking capacity was homebound throughout the episode of care. The beneficiary had controlled pain but had declined in function. However, the medical records did not support that the beneficiary required physical therapy services for this episode. The patient was independent with bed mobility, transfers, and ambulation with a straight cane. Her lower extremity strength was good, and she was not at risk for falls. She was able to do home exercise program exercises without skilled intervention. Skilled nursing care, speech-language pathology, or occupational therapy services were not ordered for this patient.

These errors occurred because Tender Touch did not always provide sufficient clinical review to verify that beneficiaries initially required or continued to require skilled services.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that Tender Touch received overpayments totaling at least $478,780 for the audit period. As of the publication of this report, this amount included claims outside of the Medicare 4-year claim-reopening period.

RECOMMENDATIONS

We recommend that Tender Touch Health Care Services:

- refund to the Medicare program the portion of the estimated $478,780 overpayment for claims incorrectly billed that are within the 4-year reopening period;[14]

- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule[15] and identify any of those returned overpayments as having been made in accordance with this recommendation; and

[14] OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

[15] This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.

- strengthen its procedures to ensure that:

    - the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented and

    - beneficiaries are receiving only reasonable and necessary skilled services.

OTHER MATTERS: PLANS OF CARE SIGNED AFTER CERTIFICATION PERIOD

The Medicare program will pay a request for anticipated payment (RAP) even though the physician has not signed the plan of care (42 CFR § 409.43(c)).[16] Moreover, the Medicare program will make final percentage payment as long as the physician signs and dates the plan of care before the claim for the episode of service is submitted, even if the physician does not sign and date the plan of care during the episode of service (42 CFR § 409.43(c)(3)). Nevertheless, Federal law and regulations require, as conditions of payment, coverage, and participation, that physicians *establish* plans of care for home health services.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is receiving services under a plan of care that has been *established* and periodically reviewed by a physician. Federal regulations (42 CFR § 409.42(b)) require, as a condition of coverage for home health services, that a beneficiary be under the care of a physician who *establishes* the plan of care. Moreover, Federal regulations (42 CFR § 484.18[17]) require, as a condition of participation, that a plan of care be *established* and periodically reviewed by a physician at least once every 60 days.

Fifty-five of the one hundred claims in our sample had plans of care that were signed by a physician after the 60-day certification period, but prior to submission of claims for final percentage payment. These plans of care documented the verbal start of care orders signed by a nurse or other medical professional, not by a physician, which were dated on the first day of the 60-day episode. Part B claims for evaluation and management (E/M) services submitted by the physicians during the 60-day certification period accounted for 24 of these 55 claims. For these 24 claims, the E/M services occurred while the beneficiaries were receiving HHA services.

The physicians' signatures on plans of care after the 60-day certification period may indicate an absence of physician participation in establishing and reviewing plans of care. Without a

[16] Federal regulations (42 CFR § 409.43(c)(1)(i)(D)) require that, as a condition of payment for a RAP, if the physician has not signed the plan of care by the time the home health agency submits the RAP, the physician verbal order be copied into the plan of care, which is *immediately* submitted to the physician. This suggests the urgency of physician involvement in reviewing and establishing the plan of care.

[17] This requirement was moved to 42 CFR § 424.60(a) effective July 13, 2017 (82 Fed. Reg. 4504 (Jan. 13, 2017)).

physician's signature at the time the plan of care is established, it may not be clear from the medical record that the Medicare requirements listed above are met. While there is no specific requirement that the plan of care be signed by the physician at the time it is established, such a signature may be an effective way to document that the Medicare requirements are met. CMS has told us that, from a survey and certification standpoint, Medicare requires a physician's signature as soon as a home health plan of care is written, and the failure to obtain a physician's signature at that point on a scale we found for Tender Touch (55 of 100 claims) would be cause for CMS to require corrective action under Medicare Conditions of Participation. We suggest that Tender Touch review this matter and take steps as necessary to ensure compliance with Medicare requirements associated with the physician establishment of the plan of care.

TENDER TOUCH COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Tender Touch disagreed with our findings and did not address any of our recommendations.

Tender Touch questioned its selection for audit and disputed our medical review determinations, maintaining that it billed the sample claims correctly. To address Tender Touch's concerns related to the medical review decisions, we had our independent medical review contractor review Tender Touch's written comments on our draft report and reconsider each of the 27 claims that we questioned in our draft report. We have included at Appendix F Tender Touch's comments, from which we removed in excess of 140 pages because of their volume and content (viz., personally identifiable information).[18] We are providing Tender Touch's comments in their entirety to CMS.

Based on Tender Touch's comments on our draft report and the additional medical review that our medical review contractor conducted, we revised our determinations, reducing the total number of sampled claims originally found to be in error in our draft report from 27 to 21, and adjusted the findings for an additional 12 claims.[19] With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge Tender Touch's right to appeal the findings. Below is a summary of the reasons Tender Touch did not agree with our findings and our responses to those disagreements.

[18] Tender Touch's comments on our draft report contained a claim-by-claim rebuttal of the findings in our draft report. We provided the entirety of Tender Touch's comments to our independent medical review contractor as part of our request for an additional review of claims identified as having errors.

[19] The overpayment amount decreased for five claims, increased for four claims, and remained unchanged for three claims.

SELECTION OF TENDER TOUCH FOR AUDIT

Tender Touch Comments

Tender Touch expressed concern that we selected it randomly for audit from among thousands of home health agencies nationwide.

Office of Inspector General Response

We selected Tender Touch using computer matching, data mining, and data analysis techniques. Specifically, we selected Tender Touch for audit based on a risk analysis that considered the number of claims that fell into one or more risk categories for compliance with home health billing and the volume of claims and Medicare payments compared with Tender Touch's peers.

BENEFICIARY HOMEBOUND STATUS

Tender Touch Comments

Tender Touch disagreed with each of our findings and disputed all of our independent medical review contractor's decisions in a claim-by-claim rebuttal of the findings that it included in its response to our draft report. However, because Tender Touch focused most of its response on addressing errors associated with the patient's homebound status, we address those concerns, only.

Tender Touch asserted that the medical reviewers[20] applied their own measures inconsistently throughout the audit to determine ambulating distances and did not follow any specific criteria. Tender Touch also stated that the medical reviewers did not always consider the use of an assistive device or the assistance provided by the therapist when making homebound determinations. Additionally, Tender Touch commented that the reviewers did not consider the mental status or cognitive function of patients, which could further limit the patient's ability to leave the home. Lastly, Tender Touch stated that the medical reviewers often denied claims based on the availability of a caregiver or family member to assist the beneficiary.

Office of Inspector General Response

We disagree with Tender Touch's assertion that our medical reviewers did not consider relevant clinical evidence when determining homebound status. Our medical reviewers prepared detailed medical review determination reports documenting relevant clinical evidence and its analysis. We provided these reports to Tender Touch before we issued our draft report. Each determination letter included a detailed set of facts based on a thorough

[20] Tender Touch referred to our independent medical reviewers as auditors throughout its response to our draft report.

review of the entire medical record. In all cases, our medical reviewers considered the entire record and relied upon the relevant facts necessary to determine homebound status in accordance with CMS's homebound definition.

Ambulation distance is one factor among others that our medical reviewers considered in making homebound determinations. As shown in each medical review determination report, our medical reviewers documented in detail and reviewed for each beneficiary the relevant medical history including diagnoses, skilled nursing or therapy assessments, cognitive function, and mobility. In terms of meeting CMS homebound criteria, medical review determinations must be based on each patient's individual characteristics as reflected in the available record. Our medical reviewers carefully considered the ability to ambulate in conjunction with the individual characteristics noted in each patient's medical record. Ambulation distance was not noted in all decisions, and when it was, it was simply one factor the reviewer considered in making the homebound determination. These considerations are apparent from the relevant facts and discussions included in the individual determinations.

With respect to Tender Touch's comment regarding the denials of claims that included patients who were homebound because of their mental inability to leave the home without assistance, we agree that cognitive impairment must be considered in making a homebound determination. Our medical review contractor carefully considered the patient's cognitive function in conjunction with the individual characteristics noted in each patient's medical record. As can be seen in the medical reviewers' determination letters, cognitive impairment is one factor among others that our medical review contractor considered in making homebound determinations.

To determine whether Tender Touch billed the claims in compliance with selected billing requirements, the medical review contractor carefully considered all of the material in those records along with the report and documentation that Tender Touch submitted. The contractor did not, as Tender Touch has asserted, focus on only one aspect of homebound status and ignore the context of the beneficiaries' overall condition conveyed in their medical records.

Our independent medical review contractor considered Tender Touch's comments regarding caregiver assistance when performing its additional medical review and revised some of the determinations accordingly.

Accordingly, having revised our findings and the associated recommendation for 6 of the 27 claims identified in our draft report, we maintain that our findings for the remaining 21 claims, and the revised recommendation, are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered $7,207,960 in Medicare payments to Tender Touch for 1,981 claims for home health services in CYs 2016 and 2017 (audit period). From this sampling frame, we selected for review a stratified random sample of 100 home health claims with payments totaling $403,277.

We evaluated compliance with selected coverage and billing requirements and submitted the sampled claims to an independent medical review to determine whether the services met coverage, medical necessity, and coding requirements.

We limited our review of Tender Touch's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

We conducted our audit from June 2018 through September 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Tender Touch's paid claims data from CMS's NCH file for the audit period;
- removed payments for low utilization payment adjustments, partial episode payments, and requests for anticipated payments from the population to develop our sampling frame;
- selected a stratified random sample of 100 home health claims totaling $403,277 for detailed review (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by Tender Touch to support the claims sampled;
- reviewed sampled claims for compliance with known risk areas;

- used an independent medical review contractor to determine whether the 100 claims contained in the sample were reasonable and necessary and met Medicare coverage and coding requirements;

- reviewed Tender Touch's procedures for billing and submitting Medicare claims;

- verified State licensure information for selected medical personnel providing services to the patients in our sample;

- calculated the correct payments for those claims requiring adjustments;

- used the results of the sample to estimate the total Medicare overpayments to Tender Touch for our audit period (Appendix D);

- discussed the results of our audit with Tender Touch officials; and

- after receiving Tender Touch's written comments on our draft report, had the independent medical review contractor review Tender Touch's written comments and perform an additional medical review of all of the claims that our draft report had questioned, and incorporated those results into our own analysis and determination of the allowability of the claims in light of Tender Touch's comments.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

APPENDIX B: MEDICARE REQUIREMENTS FOR COVERAGE AND PAYMENT OF CLAIMS FOR HOME HEALTH SERVICES

GENERAL MEDICARE REQUIREMENTS

Medicare payments may not be made for items and services that "are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member" (the Act § 1862(a)(1)(A)).

CMS's *Medicare Claims Processing Manual,* Pub. No. 100-04, states: "In order to be processed correctly and promptly, a bill must be completed accurately" (chapter 1, § 80.3.2.2).

OUTCOME AND ASSESSMENT INFORMATION SET DATA

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups; to monitor the effects of treatment on patient care and outcome; and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS rate codes Medicare uses in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify patients who are similar clinically in terms of resources used.

CMS requires the submission of OASIS data as a condition of payment as of January 1, 2010 (42 CFR § 484.210(e); 74 Fed. Reg. 58078, 58110 (Nov. 10, 2009); and CMS's *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1).

COVERAGE AND PAYMENT REQUIREMENTS

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose of obtaining a blood sample) or physical therapy or speech-language pathology, or occupational therapy;[21] (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; 42 CFR § 409.42; and the Manual, chapter 7, § 30).

[21] Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, Medicare covers the first occupational therapy service, which is a dependent service, only when followed by an intermittent skilled nursing care service, physical therapy service, or speech language pathology service as required by law. Once that requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes) (76 Fed. Reg. 68526, 68590 (Nov. 4, 2011)).

Per the Manual, chapter 7, section 20.1.2, whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS, or a medical record of the individual patient.

The Act and Federal regulations state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the above coverage requirements (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 424.22(a)).

Section 6407(a) of the Affordable Care Act[22] added a requirement to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act that the physician have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days prior to the home health start of care date or within 30 days of the start of the home health care by including the date of the encounter.[23]

Confined to the Home

For the reimbursement of home health services, the beneficiary must be "confined to his home" (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 42 CFR § 409.42). According to section 1814(a) of the Act:

> [A]n individual shall be considered "confined to his home" if the individual has a condition, due to illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered "confined to his home," the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7, § 30.1.1). The Manual states that, for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is

[22] The Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

[23] See 42 CFR § 424.22(a) and the Manual, chapter 7, § 30.5. The initial effective date for the face-to-face requirement was January 1, 2011. However, on December 23, 2010, CMS granted HHAs additional time to establish protocols for newly required face-to-face encounters. Therefore, documentation regarding these encounters must be present on certifications for patients with starts of care on or after April 1, 2011.

confined to his or her home. For purposes of the statute, an individual shall be considered "confined to the home" (homebound) if the following two criteria are met:

Criteria One

The patient must either:

- because of illness or injury, need the aid of supportive devices such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave their place of residence; or

- have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

Criteria Two

There must exist a normal inability to leave home and leaving home must require a considerable and taxing effort.

Need for Skilled Services

Intermittent Skilled Nursing Care

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse; must be reasonable and necessary to the treatment of the patient's illness or injury; and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).

The Act defines "part-time or intermittent services" as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day and 35 or fewer hours each week) (the Act § 1861(m) and the Manual, chapter 7, § 50.7).

Requiring Skills of a Licensed Nurse

Federal regulations (42 CFR § 409.44(b)) state that in determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice. If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed nurse, the service may not be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary's family or friends does not negate the skilled aspect of the service when performed by the nurse. If the service could be performed by the average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service.

General Principles Governing Reasonable and Necessary Skilled Nursing Care

Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed practical (vocational) nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service even though a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a nonskilled service does not make it a skilled service when a nurse provides the service.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable (the Manual, chapter 7, § 40.1.1).

Reasonable and Necessary Therapy Services

Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury, the therapy services must be:

- inherently complex, which means that they can be performed safely and effectively only by or under the general supervision of a skilled therapist;

- consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and

- considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

Documentation Requirements

Face-to-Face Encounter

Federal regulations (42 CFR § 424.22(a)) and the Manual (chapter 7, § 30.5.1) state that, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed nonphysician practitioner, had a face-to-face encounter with the patient that is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1) states that the certifying physician must document the encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

Plan of Care

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services (the Manual, chapter 7, § 30.2.2). The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

APPENDIX C: SAMPLE DESIGN AND METHODOLOGY

SAMPLING FRAME

The sampling frame consisted of a database of 1,981 home health claims,[24] valued at $7,207,960 from CMS's NCH file.

SAMPLE UNIT

The sample unit was a home health claim.

SAMPLE DESIGN AND SAMPLE SIZE

We used a stratified random sample.

Table 1: Claims by Stratum

Stratum	Amount Range of Claims Paid	Number of Claims	Total Dollar Value of Claims	Sample Size
1	$1,229.21 to $3,460.07	907	$2,277,559.51	32
2	$3,469.50 to $4,715.24	616	2,490,857.86	34
3	$4,715.67 to $15,640.61	458	2,439,542.48	34
Total		**1,981**	**$7,207,959.85**	**100**

SOURCE OF RANDOM NUMBERS

We generated the random numbers using the Office of Inspector General, Office of Audit Services (OAS), statistical software.

METHOD OF SELECTING SAMPLE ITEMS

We consecutively numbered the sample units in each stratum, and after generating the random numbers, we selected the corresponding frame items for review.

[24] We excluded from the frame claims that were (a) identified in the RAC Data Warehouse as previously excluded or under review, (b) less than $1,000, (c) low utilization payment adjustments, (d) partial episode payments associated with HHA transfers, and (e) requests for anticipated payments.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of overpayments in the sampling frame paid to Tender Touch during the audit period. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total in the sampling frame 95 percent of the time.

APPENDIX D: SAMPLE RESULTS AND ESTIMATES

Table 2: Sample Results

Stratum	Frame Size	Value of Frame	Sample Size	Value of Sample	Number of Incorrectly Billed Sample Items	Value of Overpayments for Incorrectly Billed Sample Items
1	907	$2,277,560	32	$79,160	4	$5,000
2	616	2,490,858	34	134,700	12	29,183
3	458	2,439,542	34	189,417	5	8,046
Total	**1,981**	**$7,207,960**	**100**	**$403,277**	**21**	**$42,229**

ESTIMATES

Table 3: Estimated Overpayments in the Sampling Frame for the Audit Period
(Limits Calculated for a 90-Percent Confidence Interval)

Point estimate	$778,823
Lower limit	478,780
Upper limit	$1,078,867

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1 (Samples 1–32)

Sample	Not Homebound	Did Not Require Skilled Services	Overpayment
1	-	-	-
2	-	-	-
3	-	-	-
4	-	-	-
5	-	-	-
6	-	-	-
7	-	-	-
8	X	-	$1,640
9	X	-	(126)
10	-	-	-
11	-	-	-
12	-	-	-
13	-	-	-
14	-	-	-
15	-	-	-
16	-	-	-
17	-	-	-
18	X	-	2,765
19	-	-	-
20	-	-	-
21	-	-	-
22	-	-	-
23	-	-	-
24	-	-	-
25	X	-	721
26	-	-	-
27	-	-	-
28	-	-	-
29	-	-	-
30	-	-	-
31	-	-	-
32	-	-	-

STRATUM 2 (Samples 33-66)

Sample	Not Homebound	Did Not Require Skilled Services	Overpayment
33	-	-	-
34	-	-	-
35	X	-	1,958
36	-	-	-
37	-	-	-
38	X	-	3,668
39	-	-	-
40	X	-	1,174
41	X	-	683
42	-	-	-
43	-	-	-
44	-	-	-
45	X	-	3,749
46	-	-	-
47	-	-	-
48	-	-	-
49	X	-	1,232
50	-	-	-
51	-	-	-
52	-	-	-
53	-	-	-
54	-	-	-
55	-	-	-
56	X	-	556
57	X	X	3,661
58	X	-	893
59	-	-	-
60	X	-	3,558
61	-	-	-
62	-	-	-
63	-	X	4,250
64	X	X	3,801
65	-	-	-
66	-	-	-

STRATUM 3 (Samples 67–100)

Sample	Not Homebound	Did Not Require Skilled Services	Overpayment
67	-	-	-
68	-	-	-
69	-	-	-
70	X	-	1,661
71	-	-	-
72	-	-	-
73	-	-	-
74	-	-	-
75	-	-	-
76	-	-	-
77	-	-	-
78	-	-	-
79	-	-	-
80	-	-	-
81	-	-	-
82	-	-	-
83	-	-	-
84	-	X	1,538
85	-	-	-
86	X	-	1,146
87	X	X	84
88	-	-	-
89	-	-	-
90	X	X	3,616
91	-	-	-
92	-	-	-
93	-	-	-
94	-	-	-
95	-	-	-
96	-	-	-
97	-	-	-
98	-	-	-
99	-	-	-
100	-	-	-
Total	**19**	**6**	**$42,229**

		OIG Audit #A-04-18-07077B		

Tender Touch Health Care Services Response to the OIG Audit

We feel it is very important to clarify a few things. Tender Touch Health Care Services has been a part of this community for 18 years, we work hard to provide the best services to our clients, and we have very robust referral sources; the physicians in the community along with the hospitals. Our excellence shows in the care of our patients, the caliber of our clinicians and the recognition of the healthcare industry along with the AHCA surveyors themselves. As of January 30th, 2020, we have just completed our most recent ACHA survey with Zero Deficiencies for the 8th time in a row. As part of the survey, the officers do several home visits with randomly picked patients. We would've been cited by the surveyors should the patient does not qualify to receive home health services. This is, again a testament to our patients we serve, and our clinicians, their knowledge acquired from our weekly education in-services provided by our management team and/or physicians in the community.

We feel that we have been treated unfairly at two levels, first, we were told that we are Agency number 18 or 19 that was "randomly" chosen by OIG for this audit. This is out of thousands of agencies nationwide. Second, when the OIG auditor reviewed our records he/she cherry picked phrases and words to deny our claims.

OIG audited a sample of 100 claims over a period of 3 years between 2015-2017. The OIG auditor denied partial or full payments for a total of 27 claims out of the 100. Out of the 27 denied claims, there were 18 claims partially disallowed and 9 claims were fully disallowed. The denied claims were denied due to one of following errors: not homebound, did not require skilled services, or incorrect HIPPS code. Out of the 27 denied claims, 19 claims were denied due to not meeting homebound status only, 2 claims were denied because the patient did not require skilled services, 5 claims were denied due to not meeting homebound AND did not require skilled services, and only 1 claim was denied due to incorrect HIPPS code.

We do not concur with any of the auditor's decisions, we believe that all claims were paid correctly and the remittance should remain the same.

An issue that was extremely troubling was the fact that the auditor continued to make many false or wrong statements that were not reflected in the record and resulted in wrong conclusions. For example, and in several records, the auditor claimed that a patient walked a certain distance on a certain date. This was never seen in the note of any clinician involved in the care of the patient. Which again brought the auditor to the wrong conclusion.

We also observed many other issues and problems with the auditor's review. There were numerous inconsistencies between audited charts. For example, in one chart the auditor states that the patient is not homebound because her son picks her up and takes her to his home for dinner in the evenings. However, in a different chart, the auditor agrees the patient is homebound, despite going to church a few times a week.

There are times when some items form the Outcome Assessment Information Data Set (OASIS) are used by the auditor to support their rationale, but this is not consistent. It is apparent that an OASIS single functional item (i.e., Patient's ability to Transfer) is used only when it supports

their findings without regard to the rest of the functional items. If the OASIS functional items (i.e., ambulation, transferring, toileting, bathing, dressing upper and lower body) taken in totality and not in isolation, it will confirm the need to home care i.e. medical issues, homebound status, but at these times the information is conveniently left out of the report.
The auditor has also been inconsistent throughout the audit using his/her own measures. No specific distance is considered or at least no specific criteria was followed. It must be stated that there is nothing in the CMS guidelines that state a certain distance to support homebound status. The distance that a patient can safely, independently ambulate should be considered based on individual patient needs and functional goals (e.g., to get the mailbox, the bus stop, the community clubhouse, etc). Each distance walked is different for each patient, but studies have shown that 984-1968 feet is the minimum necessary distance a person may need to walk when visiting one place. In fact, when a patient needs to run errands, it is usually more than one place. (see attached article titled "Documenting Homebound Status by Stephanie Miller, PT, MS, CLT)

The use of an assistive device was considered at times and was not at other times. The assistance provided by the therapist to the patient was used to support the claim at times and used to deny the claim for others. Although the auditor always reported some of the recorded test scores such as the Time up and Go (TUG) and Body Mass Index (BMI) values, he/she never took these values and their meaning into account when weighing the homebound status of the patient or the skill need. Other values were rarely mentioned by the auditor such as balance, endurance, and strength scores and were never used in the auditor's determination of either the homebound status or in the skill need. On the other hand, the auditor never reported Missouri Alliance for Home Care's fall risk assessment score (MAHC). All these tests/measures are industry standards and objectively measure the patient's ability to move or ambulate safely. We were told by CMS and the intermediary (Palmetto), that it is crucial to conduct these objective tests and include them in our assessments to formulate an accurate and individualized plan of care for each patient and yet they were never utilized by the OIG auditor when deciding on the "errors" found in their review of our charts. This is again another example of cherry-picking statements, phrases, or words to come to erroneous conclusions. This is also an indication that the auditor is either not knowledgeable of these objective tests and their meanings or he/she understands their value and choose not to include them because they did not support their findings.

Virtually all the claims denied for "not meeting the homebound status" were on distances ambulated with no regard to assistance given but the clinician. These ranged from supervision to stand by assistance to contact guard assistance, etc. The auditor seems to not differentiate between gait quality, gait training, and safe ambulation. There was nothing said about gait quality and gait deviation. Patients were described as having unsteady, shuffling, ataxic, festinating gait. All of these things described have a huge bearing on a patient's ability to move through their environment safely. Just walking 200 feet shouldn't be the criteria for determining the homebound status if the patient is not safe. BUT even these finding were inconsistent from chart to chart.

In reading the findings of the auditor, it is apparent that any kind of progress should not be documented for us to keep the patient homebound. Isn't this the result everyone is looking for:

Progress and Improvement? For example, if we progressed a patient from the use of a rolling walker to the use of a standard cane, the auditor would deem the patient not homebound and suggest the patient be abruptly discharged without us ensuring the patient's ability to safely carryover the task. The auditor did not seem to give any consideration to any other factor that influence the patient's ability to safely perform the task at hand.
I think we all agree that we should not be discharging patients abruptly for multiple reasons, but mainly because we need to look at the overall goals (both patient and clinician goals). So, while pain has improved or TUG score improved on that one visit, how does this one-time notation of improvement impact the overall patient's functional improvement and safety and their progress towards the stated goals. This example is a stretch, but let's say we have a patient who is receiving IV antibiotics that has been ordered for 2 weeks. At around day 7 they start to demonstrate improvement and symptoms have dissipated. That does not mean we stop the treatment, but rather we need to continue the full course of the ordered treatment.

How about discharge planning? The auditor did not allow for any planning before discharge. We would refer to instructions when completing the NOMNC – this document needs to be delivered to the beneficiary at least two calendar days before Medicare covered services end or the second to last day of service if care is not being provided daily. We also refer to the argument of what is the patient's usual status 50% of the time or more. Just because they demonstrate a certain level of performance on one visit, as clinicians, we would want to make sure that is their usual status more than 50% of the time before we discharge the patient.

As healthcare providers, it is our responsibility to improve/increase health, functional mobility and safety and document accordingly. This is the unspoken directive from the physician that refer their patients to us. As the patient improves in health and functional mobility, we must always be cognitive of their consistency over the course of the care that is being given. Not only is it our responsibility to improve functional mobility, but to be sure that the increase in functional mobility is long standing and being done in a safe manner.

When considering the homebound status for a patient, we must also consider the mental status of our patients. According to CMS guidelines regarding this issue, ***a patient with a psychiatric illness that is manifested, in part, by a refusal to leave home or is of such a nature that it would not be considered safe for the patient to leave home unattended, even if they have no physical limitations*** *(MLN Matters Number: SE1436, P. 3) See attached.*

The auditor never took into consideration when deciding on the homebound status those patients with diagnoses such as Alzheimer's, Dementia, anxiety, depression, memory deficit, fluctuating mental status, senility, etc. Not only are they declining in health, which in and of itself is a huge worry, but depression is a very real possibility. There are some diagnoses that in and of themselves, limit the ability for persons to leave the home such as Agoraphobia (See attached definition). This is a diagnosis in one of the charts. This, by itself, makes the patient truly homebound.

The auditor should be aware of the areas and demographics covered by the home health agency he or she is auditing. In our case, we cover a very rural area that at times need 4-wheel drive

vehicles to get to some of the homes of our patients. Many roads are sand/dirt and very difficult to navigate and far away from any public transport. Homebound status takes on a new meaning when you live alone, can't drive, and are unable to use the services available. That is a taxing effort by itself to be able to get out of your home. Just picture an 87 -year-old patient attempting to get to the bus stop with her rolling walker in the rain on the muddy roads.

The auditor often used the availability of a caregiver or a family member to deny the claim. Based on the OASIS definition of care giver availability it can either be 24 hours, 12 hours day or night or occasionally. For example, this was seen in the chart were the son picked his mother up in the evening to take her to his home for dinner. Here the son is only available occasionally. In addition, his availability does not constitute willingness to assist in her ADLs. So, if there is a caregiver but they are not willing/able to be taught by the physical therapist on how to supervise the patient while ambulating, or use of compensatory strategies and correct body mechanics, the patient remains unsafe to walk alone or get in the car, for example.

As mandated by CMS new Conditions of Participation (CoPs) effective January 2018, it has become very important to include patients' personal stated goals in the plan of care. Our clinicians began identifying patient's personal goals and including them in the plan of care from 2015 forward. It is obvious that meeting the patients' goals meant nothing to the auditor as he/she wanted the patient to be discharged prior to meeting these goals.

The auditor used patient's stated plans or statements to consider them not homebound especially when it helps his/her decision but ignores these statements when it does not fit the narrative. For example, in one of the audited cases where the patient "wanted" to go to the gym and run on the treadmill". This does not mean he "did go" or even "could go" to the gym. The documentation clearly points to the fact that the patient will not be able to do so because of his safety, level of assistance and it was a considerable and taxing effort.

However, in one area he/she was very consistent. It is apparent that when the auditor reads a statement, a word, or a phrase that is noted to support either 'not homebound' or 'no skill', the review of the chart stops at that statement. The subsequent notes are not checked to ensure that the **ONE** statement, or the one phrase, or the one word is completely accurate, when in fact, another clinician could interpret the information differently. After picking on "the chosen" phrase, the auditor failed to check the rest of the skilled note to at least validate his/her claim that the patient was "not homebound" or there was "no skill". This happened in virtually every claim denied partially or fully by the auditor.

We believe that an auditor at this level should be very knowledgeable and well versed in all aspects of home care as a practicing clinician. Their findings make a huge difference in the moral of the staff, the financial outcome of the audit and the reputation of the entire company. It is very evident that our auditor did not live up to this standard as is seen in all the mistakes made in this audit. We also believe that our clinicians ought to be commended for the outstanding services they provided to our patient. These clinicians kept almost all the patient who were audited in this

sample from hospitalization/ re-hospitalization and free from falls. Instead, we are getting penalized.