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

EHS Home Health Care Service, Inc., Billed for Home Health Services That Did Not Comply With Medicare Coverage and Payment Requirements

Why OIG Did This Review

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 reviews 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 EHS Home Health Care Service, Inc. (EHS), complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Review

We selected a stratified random sample of 100 home health claims and submitted these claims to independent medical review.

What OIG Found

EHS did not comply with Medicare billing requirements for 35 of the 100 home health claims that we reviewed. For these claims, EHS received overpayments of $55,303 for services provided in calendar years (CYs) 2014 and 2015. Specifically, EHS incorrectly billed Medicare for beneficiaries who (1) were not homebound or (2) did not require skilled services. On the basis of our sample results, we estimated that EHS received overpayments of at least $7.5 million in CYs 2014 and 2015.

What OIG Recommends and EHS Comments

We made several recommendations to EHS, including that it (1) refund to the Medicare program the portion of the estimated $7.5 million in overpayments for claims incorrectly billed for the reopening period; (2) exercise reasonable diligence to identify and return overpayments, in accordance with the 60-day rule, for claims that are outside the reopening period; (3) exercise reasonable diligence to identify and return any additional similar overpayments outside of our audit period; and (4) strengthen its procedures.

In written comments on our draft report, EHS generally disagreed with all of our findings and recommendations. EHS retained a health care consultant to review all claims we questioned and submitted to us a report prepared by their consultant. EHS challenged the Office of Inspector General's selection of EHS as well as the medical review decisions maintaining that virtually all of the sample claims were billed correctly. To address EHS's concerns related to the medical review decisions, we requested that our medical reviewer review EHS's written comments on our draft report as well as the report by EHS's consultant.

Based on the results of this review, we removed 6 of the 41 claims originally found to be in error in our draft report and adjusted the finding for an additional 9 claims. With these actions taken, we maintain that our remaining findings and recommendations are valid, although we acknowledge EHS's rights to appeal the findings.