Report in Brief
Date: December 2020
Report No. A-06-16-05005

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

Medicare Home Health Agency Provider Compliance Audit: Total Patient Care Home Health, LLC

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 Total Patient Care Home Health, LLC (TPC), complied with Medicare requirements for billing home health services on selected types of claims.

How OIG Did This Audit

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

What OIG Found

TPC did not comply with Medicare billing requirements for 32 of the 100 home health claims that we reviewed. For these claims, TPC received overpayments of $75,461 for services provided during our audit period, October 1, 2014, through September 30, 2016. Specifically, TPC incorrectly billed Medicare for services provided to beneficiaries who were not homebound or did not require skilled services. On the basis of our sample results, we estimated that TPC received overpayments of at least $1.7 million for our audit period. All 100 claims within our sample are outside of the Medicare 4-year claim-reopening period.

What OIG Recommends and TPC Comments

We recommend that TPC exercise reasonable diligence to identify, report and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with our recommendations. We also recommend that TPC strengthen its procedures to ensure that (1) the homebound statuses of Medicare beneficiaries are verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented and (2) beneficiaries are receiving only reasonable and necessary skilled services.

In written comments on our draft report, TPC disagreed with our findings and recommendations and stated that it intends to contest our findings through the appeals process. To address TPC's concerns for all claims we originally found in error, we had our medical reviewer again review all 38 of the claims originally found in error. Based on the results of that review, we revised our determinations, reducing the total number of sampled claims incorrectly billed from 38 to 32, and adjusted the findings for 13 of the 32 claims. In addition, we eliminated one error category included in the draft report. We revised our related findings and recommendations accordingly. With these actions taken, we maintain that our remaining findings and recommendations, as revised, are valid. We acknowledge TPC's right to appeal the findings.