

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

OPERATION RESTORE TRUST

**REVIEW OF COSTS
CLAIMED BY
HOME HEALTH SERVICES OF
SOUTH FLORIDA INC., d/b/a USA HOME
HEALTH SERVICES**



JUNE GIBBS BROWN
Inspector General

SEPTEMBER 1996
A-04-95-01105



SEP 30 1996

Memorandum

Date

From

June Gibbs Brown
Inspector General

Subject

Review of Costs Claimed by Home Health Services of South Florida Inc., d/b/a USA Home Health Services (A-04-95-01105)

To

Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Home Health Services of South Florida Inc., d/b/a USA Home Health Services (USA) in Hialeah, Florida.

OBJECTIVE

The audit objective was to determine whether the home health care services claimed by USA met Medicare reimbursement guidelines.

SUMMARY OF FINDINGS

We randomly selected for review 100 claims submitted by USA for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,784 home health services. Our review showed that 32 claims or 32 percent of our sample contained 353 services (20 percent of the total services) that did not meet Medicare guidelines, as follows:

- ▶ 23 percent of the claims were for 262 services which, in the opinion of medical experts, were not reasonable or necessary;
- ▶ 5 percent of the claims were for 69 services provided to beneficiaries who, in their own opinion, or in the opinion of medical experts, were not homebound;
- ▶ 3 percent of the claims were for 17 services which physicians did not authorize; and
- ▶ 1 percent of the claims were for 5 services not provided.

Cases in the latter two categories concern us and should be closely reviewed by the Medicare fiscal intermediary (FI).

During the FY ended December 31, 1993, USA claimed \$12 million in 8,700 claims representing 151,015 services. Based on our review, we estimate that at least \$1.7 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between \$1.7 million and \$3.2 million.

Although we found documentation that indicated USA monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as USA, responsible for the actions of their subcontractors.

We recommend that the Health Care Financing Administration (HCFA) require the FI to instruct USA on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FI and USA to ensure that corrective actions are effectively implemented, direct the FI to investigate all cases of possible fraud and refer them as necessary to the Office of Inspector General's (OIG) Office of Investigations (OI), and recover all overpayments.

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

BACKGROUND

Home Health Services of South Florida Inc., d/b/a USA Home Health Services

The USA is a Medicare certified home health agency (HHA) with a principal place of business in Hialeah, Florida. The USA is a proprietary Florida corporation owned and managed by South Eastern Health Management Associates Inc. The USA directly and indirectly employs nurses, aides, therapists, and administrative personnel in Dade County.

A Medicare certified HHA, such as USA, can either provide home health services itself or make arrangements with other certified or non-certified providers for home health services. Most of the services claimed by USA were provided under contract with non-Medicare certified nursing groups.

During FY 1993, USA was reimbursed under the periodic interim payment (PIP) method. Payments under PIP approximate the cost of covered services rendered by the provider. Interim reimbursement from Medicare totaled \$12.3 million. Interim payments are adjusted to actual costs based on annual cost reports. The USA submitted a cost report for FY 1993 claiming costs totaling \$12 million.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in sections 1814, 1835, and 1861 of the Social Security Act; governing regulations are found in title 42 of the Code of Federal Regulations (CFR); and HCFA coverage guidelines are found in the Medicare HHA Manual.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the home health benefits program. The FI for USA is Aetna Life and Casualty. The FI is responsible for:

- ▶ processing claims for HHA services,
- ▶ performing liaison activities between HCFA and the HHAs,
- ▶ making interim payments to HHAs, and
- ▶ conducting audits of cost reports submitted by HHAs.

SCOPE

The objective of the audit was to determine whether the home health care services claimed by USA met Medicare reimbursement guidelines. The audit was performed under the auspices of Operation Restore Trust and was initiated by a request from HCFA's Atlanta Regional Office and its regional home health intermediary. The individuals who participated in this audit are shown on Appendix D.

The USA claimed 151,015 services on 8,700 claims for FY 1993. We reviewed a statistical sample of 100 claims totaling 1,784 services for 96 different individuals (4 individuals appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims were submitted by USA during the period January 1, 1993 through December 31, 1993. Appendix A contains the details on our sampling methodology. Appendix C contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by USA met the reimbursement guidelines.

In addition to using the sample to determine the amount of overpayment, we used the sample to determine the percentage of certain characteristics. Appendix B contains the details of the results of these projections.

Generally, for each of the 100 claims, we interviewed:

- ▶ the beneficiary or a knowledgeable acquaintance,
- ▶ the physician who certified the plan of care, and
- ▶ the beneficiary's personal physician.

Our interviews included validation of beneficiaries' and physicians' signatures when necessary.

We interviewed 72 of the 96 beneficiaries. We were unable to interview 24 of the beneficiaries or a close acquaintance because they were either deceased or had moved out of the area. We were not able to interview five physicians because they had moved out of the area. Two of these physicians certified the plan of care for two beneficiaries who appeared twice in the sample.

We reviewed supporting medical records maintained by USA for all of the claims in our sample. The records were also reviewed by the FI's medical personnel to determine whether the medical records for the claimed services met the reimbursement requirements.

We did not conduct a review of USA's internal controls. Specifically, we did not review USA's policies and procedures to monitor the work performed either by their own staff or subcontractors. However, during our review of medical records, we found documentation that indicated USA did monitor its own employees and subcontractors.

Our field work was performed at USA's administrative office in Hialeah, Florida and the FI's office in Clearwater, Florida. Interviews were conducted in the beneficiaries' residences and the physicians' offices. Our field work was started in January 1995 and completed in December 1995. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW

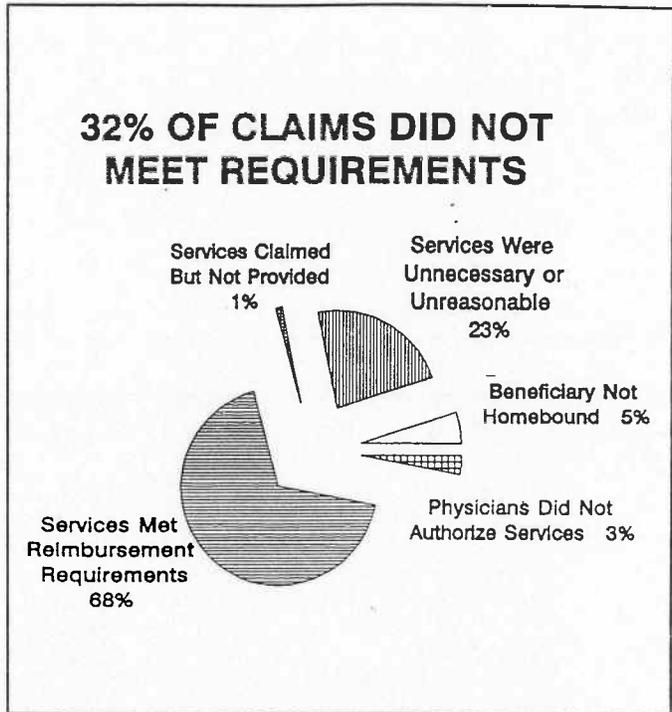
Our audit showed that 32 percent of the claims submitted by USA during FY 1993 did not meet the Medicare reimbursement requirements.

Based on a statistical sample, we estimate that USA received overpayments totaling at least \$1.7 million and using the 90 percent confidence interval, we believe the overpayment is between \$1.7 million and \$3.2 million. Although we found documentation that USA monitored its employees and subcontractors, this monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement guidelines.

The regulations and guidelines clearly hold the HHA responsible for payments made for services performed by either their own staff or by subcontractors.

Criteria for Services Provided by Subcontractors

Section 409.42(g) of title 42 CFR states that "...home health services must be furnished by, or under arrangements made by a participating HHA." Section 200.2 of the Medicare HHA Manual states that "In permitting home health agencies to furnish services under arrangements it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the agency must exercise professional responsibility over the arranged-for services." In addition, the Medicare HHA conditions of participation at 42 CFR 484.14(h) set forth the requirements governing home health services furnished under arrangements.



Services That Were Not Reasonable or Necessary

Our review showed that 23 of the 100 claims were for 262 services which were not considered reasonable or necessary by the intermediary's medical review personnel.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy...." Section 203.1 of the Medicare HHA Manual states that the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary; and section 205.1.B.1 states that "Observation and assessment of the beneficiary's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the beneficiary's treatment regime is essentially stabilized."

The Aetna medical review personnel reviewed the records for the 23 beneficiaries and concluded that the medical records did not support the reasonableness or necessity of the services. The records for nine of the beneficiaries showed that the skilled services provided were not consistent with the nature and severity of the documented illness or injury; the records for three of the beneficiaries did not show any instabilities, physician intervention, or changes in the plan of treatment which would require skilled nursing services; the records for four of the beneficiaries did not show objective comparative data to establish that the condition of the beneficiary will improve, or that the services were necessary to the establishment of a maintenance program; the records for four of the beneficiaries showed that they received psychiatric care from nurses who did not have the proper credentials to provide psychiatric care; the records for two beneficiaries did not document skilled services to support the aide services provided; and one beneficiary received medical social services that did not address specific problems.

Services to Beneficiaries Who Were Not Homebound

Our review showed that 5 of the 100 claims were for 69 services to beneficiaries who were not homebound at the time the services were provided. The interviews of the beneficiary or a close acquaintance of the beneficiary, and the certifying physician indicated that the beneficiaries by their own assessment, or that of the physicians, were not homebound at the time the services were provided. In all cases, USA had documentation, such as the plan of care that indicated the individual needed skilled care and was homebound.

The regulations at 42 CFR 409.42, provide that the individual receiving home health benefits must be "... confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." Title 42 CFR 424.22 states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA manual at section 204.1 contains guidance regarding the "homebound" requirement.

The Aetna medical review personnel reviewed the records for the five beneficiaries that we determined did not meet the homebound requirement. They concluded that the medical records either did not support a homebound determination or were inadequate to help them make the determination. The prescribing physicians for two of the beneficiaries stated that they were not homebound. We did not locate the prescribing physician for the other three beneficiaries.

We did not interview the personal physicians because the five beneficiaries did not have a personal physician different from the physician who signed the plan of treatment. We concluded that the five beneficiaries did not meet the homebound criteria. Our conclusion is based on the opinion of medical professionals, as well as the results of beneficiary interviews which included a description of their daily activities at the time of the services.

Physicians Did Not Authorize the Services

Our review showed that 3 of the 100 claims were for 17 services not authorized by a physician. In one case, the provider rendered and claimed one service in excess of the services authorized by the physician in the plan of care. In the other two cases, there were no plans of care applicable to the periods under review.

The laws, regulations and guidelines recognize that the physician plays an important role in determining the utilization of services. The legislation specifies that payment for services may be made only if a physician certifies the services were required because the individual was homebound and needed skilled nursing care. The regulations (42 CFR 424.22) state that Medicare pays only if a physician certifies the services were needed. In addition, the regulations at 42 CFR 424.22 require all care to follow a physician's plan of care.

We discussed these cases with Aetna officials and they advised that claims not duly authorized should be denied.

Services Claimed but Not Provided

Our review showed that one of the 100 claims was for 5 services that were not provided. The medical records maintained by USA contained the required documentation including signatures of the beneficiary indicating that the services were provided. However, the beneficiary involved with this claim stated that her signatures were forged.

During the initial interview of the beneficiary, she told us that she had not received the services on the dates that were on the sampled claims. A review of the medical records indicated that the beneficiary had signed for the services. We reinterviewed the beneficiary and showed her the signatures on the visit logs and she stated that her signature was forged.

Effect

Our audit showed that 32 percent of the FY 1993 claims submitted by USA were overstated. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval is \$1,656,320 to \$3,173,546 with a midpoint of \$2,414,933. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that USA was overpaid by at least \$1,656,320 for unallowed home health services.

USA Did Not Properly Monitor Subcontractors

Although documentation found in the files indicated that monitoring was being done to ensure that beneficiaries met the homebound and medical necessity criteria to receive HHA services, it failed to disclose the problems that we found.

The HHA coverage guidelines issued by HCFA provide that the HHA has essentially the same responsibilities for services provided by subcontractors as for services provided by their salaried employees. During reviews of the beneficiaries' medical records maintained by the HHA, we found documentation that showed USA did monitor subcontractors. However, in several instances the documentation showed that the beneficiaries were stable after an initial period of covered care, usually 3 weeks, yet no action was taken to discharge them until the certification period was over. In other instances, the services provided were not consistent with the nature and severity of the illness or injury of the beneficiary. We also found one instance where the services claimed were more than what was ordered by the physician, and two other instances where the services were provided without a plan of care signed by a physician. In all these cases, the monitoring visits did not explain the discrepancies.

RECOMMENDATIONS

We recommend that HCFA:

- o Require the FI to instruct USA on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations and HCFA guidelines.
- o Monitor the FI and USA to ensure that corrective actions are effectively implemented.
- o Direct the FI to investigate all cases of possible fraud and refer them as necessary to the OIG's OI.
- o Recover all overpayments.

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix E to this report.

APPENDICES

AUDIT OF USA HOME HEALTH SERVICES
SAMPLING METHODOLOGY

OBJECTIVE:

The sample objective was to estimate overpayments for claims that did not meet Medicare reimbursement requirements. To achieve our objective, we selected a statistical sample of home health claims from a universe of home health claims submitted by USA during the FY ended December 31, 1993. We obtained claim documentation and interviewed beneficiaries and physicians identified in the claim. We used the results to project the overpayments for services that were not reimbursable to USA during the FY ended December 31, 1993.

POPULATION:

The universe consisted of 8,700 HHA claims representing \$12,296,234 in benefits paid by the FI to USA during the FY ended December 31, 1993.

SAMPLING UNIT:

The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple services and items of cost for the home health services provided.

SAMPLING DESIGN:

A simple random sample was used.

SAMPLE SIZE:

A sample of 100 claims.

ESTIMATION METHODOLOGY:

We used the cost per visit for each type of service reported by USA in the unaudited cost report for FY ended December 31, 1993. For the unallowed services on a sample unit, we computed the amount of error by multiplying the number of unallowed services for each type of claim by the cost reported by USA in the unaudited cost report for FY ended December 31, 1993.

Using the Department of Health and Human Services, OIG, Office of Audit Services Variables Appraisal Program, we estimated the overpayments that either did not meet reimbursement requirements, were not authorized, or were not rendered.

AUDIT OF USA HOME HEALTH SERVICES
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 8,700 claims to project the occurrence of certain types of errors. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

Claims That Did Not Meet the Requirements

Quantity Identified in the Sample	32
Point Estimate	32.0%
Lower Limit	24.3%
Upper Limit	40.5%

Services That Were Not Reasonable or Not Necessary

Quantity Identified in the Sample	23
Point Estimate	23.0%
Lower Limit	16.3%
Upper Limit	30.9%

Services to Beneficiaries Who Were Not Homebound

Quantity Identified in the Sample	5
Point Estimate	5.0%
Lower Limit	2.0%
Upper Limit	10.2%

Services That Were Not Properly Authorized by Physicians

Quantity Identified in the Sample	3
Point Estimate	3.0%
Lower Limit	0.8%
Upper Limit	7.6%

AUDIT OF USA HOME HEALTH SERVICES
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

Services Claimed but Not Provided

Quantity Identified in the Sample	1-
Point Estimate	1.0%
Lower Limit	0.0%
Upper Limit	4.6%

AUDIT OF USA HOME HEALTH SERVICES
VARIABLES PROJECTIONS**REPORTING THE RESULTS:**

We used our random sample of 100 claims out of 8,700 claims to project the value of claims that did not meet the requirements. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

Claims That Did Not Meet the Requirements

Identified in the sample	
Number of Claims	32
Value	\$ 27,758
Point Estimate	\$2,414,933
Lower Limit	\$1,656,320
Upper Limit	\$3,173,546

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201



DATE: AUG 14 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by Home Health Services of South Florida Inc., d/b/a USA Home Health Services," (A-04-95-01105)

We reviewed the above-referenced report which discusses claims submitted by USA Home Health Services that did not meet Medicare reimbursement guidelines. Our comments are attached for your consideration.

Thank you for the opportunity to review and comment on this report.

Attachment

IG	_____
EAIG	_____
SAIG	_____
PDIG	_____
DIG-AS	_____
DIG-EC	_____
DIG-EI	_____
DIG-OI	_____
DIG-MP	_____
AIG-LC	_____
OGC/IG	_____
ExecSec	_____
Date Sent	8-20

RECEIVED
AUG 20 1996
GENERAL

Health Care Financing Administration (HCFA) Comment: on
Office Of Inspector General (OIG) Draft Report entitled: "Review of Costs Claimed by
Home Health Services of South Florida Inc., d/b/a USA Home Health Services"
(A-04-95-01105)

OIG Recommendation

HCFA should require Fiscal Intermediaries (FI) to instruct USA Home Health Services on its responsibilities to properly monitor its subcontractor for compliance with Medicare regulations and HCFA guidelines.

HCFA Response

We concur. The HCFA Regional Office (RO) will instruct the FI to conduct focused medical reviews on future claims from USA and instruct USA Home Health Services on its responsibilities to Medicare. The HCFA RO will also instruct the FI to refer USA Home Health Services to the state agency to monitor USA's future compliance with rules of subcontractor supervision.

OIG Recommendation

HCFA should monitor FI and USA to ensure that corrective actions are effectively implemented.

HCFA Response

We concur. The HCFA RO will monitor corrective actions.

OIG Recommendation

HCFA should direct the FI to investigate all cases of possible fraud and refer them as necessary to the OIG, Office of Investigations.

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HCFA Response

We concur. As this is current practice, HCFA will continue to investigate all cases of fraud and refer them to the OIG, Office of Investigations.

OIG Recommendation

HCFA should recover all overpayments.

HCFA Response

We concur. We will take the appropriate actions necessary to instruct Aetna Life and Casualty, the Regional Home Health Intermediary, to recover all overpayments from Home Health Services of South Florida Inc., for home health care services claimed by the provider that did not meet Medicare reimbursement guidelines. To recover the overpayments related to this review, the OIG will need to provide Aetna Life and Casualty with copies of records that support the findings regarding the 32 claims.