

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**MEDICARE HOME HEALTH AGENCY
PROVIDER COMPLIANCE AUDIT: THE
PALACE AT HOME**

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Office of Inspector General

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OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS

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Report in Brief

Date: November 2020

Report No. A-04-17-07067

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



Why OIG Did This Audit

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

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

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

How OIG Did This Audit

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

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

What OIG Found

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

What OIG Recommends and The Palace Comments

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

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

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

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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 only for 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. The Palace at Home (The Palace) was one of those HHAs.

OBJECTIVE

Our objective was to determine whether The Palace 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)

payment codes¹ 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 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 regulations at 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;

¹ HIPPS payment 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 Federal Register 58077, 58110-58111 (Nov. 10, 2009); and CMS’s *Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1.

- under the care of a physician; and
- 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

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, Pub. No. 15-1, part 1, § 2931.2; 81 Fed. Reg. at 7670.

The Palace at Home

Home Nurse Corporation, doing business as The Palace at Home, is a proprietary for-profit home health care provider located in Miami, Florida. Palmetto GBA, its Medicare contractor, paid The Palace approximately \$19 million for 5,548 claims for services provided in CYs 2015 and 2016 (audit period) on the basis of CMS's National Claims History (NCH) data.

HOW WE CONDUCTED THIS AUDIT

Our audit covered \$14,098,696 in Medicare payments to The Palace for 3,851 claims.⁶ These claims were for home health services provided in CYs 2015 and 2016.⁷ We selected a stratified random sample of 100 claims with payments totaling \$441,248 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

The Palace did not comply with Medicare billing requirements for 20 of the 100 home health claims that we reviewed. For these claims, The Palace received overpayments of \$30,387 for services provided in CYs 2015 and 2016. Specifically, The Palace incorrectly billed Medicare for:

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

⁶ In developing this sampling frame, we excluded from our review home health claim payments for low utilization payment adjustments, partial episode payments, and 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.

- claims that it assigned with incorrect HIPPS payment codes.

These errors occurred primarily because The Palace 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 The Palace received overpayments of at least \$731,304 for the audit period.⁹ As of the publication of this report, all incorrectly billed claims in the sample are outside of the 4-year reopening period.

THE PALACE BILLING ERRORS

The Palace incorrectly billed Medicare for 20 of the 100 sampled claims, which resulted in overpayments of \$30,387.

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).¹⁰ The Manual states 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 will be less than the actual overpayment total 95 percent of the time.

¹⁰ Revision 208 of § 30.1.1 was in effect during our audit period.

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.

The Palace Did Not Always Meet Federal Requirements for Home Health Services

For 15 of the sampled claims, The Palace incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirement for being homebound for the full episode (1 claim) or for a portion thereof (14 claims).¹¹

Example 1: Beneficiary Not Homebound – Entire Episode

The medical information for one beneficiary showed that, from the start of the episode, the patient was able to ambulate with a cane and perform higher level gait activities, including ambulating on stairs without hands-on assistance. The patient had no history of recent fall or fall-related injury and no new impairing condition. There were no medical contraindications to leaving the home. For the entire period, leaving the home did not require a considerable or taxing effort.

Example 2: Beneficiary Not Homebound – Partial Episode

For another beneficiary, records showed that the patient was homebound at the start of care because she had multiple comorbidities, including lumbar spinal stenosis and osteoarthritis, that affected her mobility and had fallen and suffered a left leg injury. Leaving the home would have required a considerable

¹¹ Included in these 15 claims with homebound errors, The Palace also billed 3 claims with skilled services that were not medically necessary and assigned 4 claims with an incorrect HIPPS billing code. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

and taxing effort. The patient received home health services to increase range of motion, decrease pain, and provide gait and balance training. These services helped her improve over time, and, consequently, she did not remain homebound. By a later date in the episode, her mobility had improved with care, she was ambulating 300 feet, and she had progressed to higher level gait activities and endurance training. Additionally, she was able to ambulate on and off the bus ramp and elevator. 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 The Palace 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 be in need of skilled nursing care on an intermittent basis, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) 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 depend on the presence or absence of a patient's potential for improvement but rather on a patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain a patient's current condition, or to prevent or slow further deterioration of a patient's condition (the Manual, chapter 7, § 20.1.2).

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, administration of medications, and other things (Manual, chapter 7, § 40.1.2).

The Palace Did Not Always Meet Federal Requirements for Skilled Services

For seven of the sampled claims, The Palace incorrectly billed Medicare for an entire home health episode (two claims) or a portion of an episode (five claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.¹³

Example 3: Beneficiary Did Not Require Skilled Services

A beneficiary with an unsteady gait, some visual impairment, and pain due to multi-joint osteoarthritis that affected the shoulders, was homebound throughout the episode of care. The patient ambulated with a walker, but the shoulder pain was expected to limit her ability to effectively use an assistive device. The beneficiary received nursing services, but not physical therapy, occupational therapy, or speech therapy. However, the beneficiary did not need skilled services, as evidenced in the documentation. The patient was stable, had received education on medication management, and had on-going needs that included custodial care.

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

Incorrectly Billed Health Insurance Prospective Payment System Codes

Federal Requirements for Billing Medicare Claims

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).

The Palace Did Not Always Meet Federal Requirements for Billing Medicare Claims

For 7 sampled claims, The Palace assigned incorrect HIPPS billing codes to the Medicare claims.¹⁴ The OASIS and other supporting medical records did not support the billing codes that The Palace used. Using the correct HIPPS billing codes, we computed the payment amount in

¹³ Of these seven claims with skilled services that were not medically necessary, The Palace also billed three claims for beneficiaries with homebound errors and assigned three claims with incorrect HIPPS billing codes. Appendix E provides details on the extent of errors, if any, per claim reviewed.

¹⁴ Of these seven claims assigned with incorrect HIPPS billing codes, The Palace also billed four claims for beneficiaries with homebound errors and three claims with skilled services that were not medically necessary. Appendix E provides details on the extent of errors, if any, per claim reviewed.

error by subtracting the correct payment amount from the original payment. We attributed these errors in HIPPS coding to clerical errors.

OVERALL ESTIMATE OF OVERPAYMENTS

On the basis of our sample results, we estimated that The Palace received overpayments totaling at least \$731,304 for the audit period. As of the publication of this report, all incorrectly billed claims in the sample are outside of the 4-year reopening period.

RECOMMENDATIONS

We recommend that The Palace at Home:¹⁵

- 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
- 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,
 - beneficiaries are receiving only reasonable and necessary skilled services, and
 - the correct HIPPS billing codes are assigned.

THE PALACE AT HOME COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, The Palace disagreed with our findings. Regarding our recommendations, The Palace stated that it would appeal our findings.

The Palace retained a health care consultant to review the claims that we considered to be in error and submitted to us a report prepared by that consultant. The Palace maintained that it billed the sample claims correctly. We have included The Palace's comments, excluding its

¹⁵ Our draft report contained a recommendation that The Palace refund to the Medicare program the portion of the estimated overpayment for claims incorrectly billed that were within the reopening period. As of the date of issuance of this final report, all estimated overpayments are beyond the reopening period, so we have removed the recommendation to refund them. We also consolidated our two 60-day rule recommendations that appeared in our draft report into one that appears in this final report.

consultant's report, as Appendix F.¹⁶ We are providing The Palace's comments in their entirety to CMS.

To address The Palace's concerns related to the medical review decisions, we had our independent medical review contractor review both The Palace's written comments on our draft report and the report that its consultant prepared. Based on the results of this review, we removed 12 of the 32 claims originally found to be in error in our draft report and adjusted the findings for an additional five claims.¹⁷ With these actions taken, we maintain that our remaining findings and recommendations are valid, and we acknowledge The Palace's rights to appeal the findings. Below is a summary of the reasons The Palace did not agree with our findings and our responses thereto.

BENEFICIARIES WERE NOT HOMEBOUND

The Palace Comments

The Palace disagreed with all 25 of our findings related to the beneficiaries' homebound status, indicating that homebound status documentation should be reviewed based on a wholistic review of the patient's health record. The Palace stated that, although some ambulating distances would appear to put homebound status in question, most of The Palace's patients lived in some type of congregate living facility, which required them to ambulate significantly longer distances to get to an exit and other areas. Regarding the partially denied claims, The Palace stated that the medical records documented the homebound status throughout the episode of care and that the discharge reflected that the patient still had issues that would have continued to constitute homebound status. The Palace also stated that other errors pertaining to homebound status included patients that were homebound due to their mental inability to leave the home without assistance.

Office of Inspector General Response

Based on the information that The Palace provided and the conclusions of our independent medical review contractor's additional medical review, we revised the findings related to homebound status (and the associated recommended disallowance) to specify that 15 claims, rather than 25, involved beneficiaries who did not meet the criteria for being homebound.

¹⁶ The Palace included a comprehensive appendix as part of its comments on our draft report. This appendix, prepared by the health care consultant, contained a claim-by-claim rebuttal of the findings in our draft report. We provided this appendix to the independent medical review contractor as part of our request for an additional review of claims identified as having errors. However, because this appendix was so voluminous, we did not attach it with The Palace's comments at Appendix F.

¹⁷ The overpayment amount for four of the five claims decreased and the overpayment amount for the fifth claim remained unchanged.

We disagree with The Palace's assertion that our medical reviewers did not consider the entire medical record or failed to account for relevant clinical evidence when determining homebound status. Our medical reviewer prepared detailed medical review determination reports documenting relevant clinical evidence and its analysis. Our medical reviewer provided these reports to The Palace before we issued our draft report. Each determination letter included a detailed set of facts based on a thorough review of the entire medical record. In all cases, our medical reviewer considered the entire record and relied upon the relevant and salient facts necessary to determine homebound status in accordance with CMS's homebound definition.

Ambulation distance is one factor among others that our medical reviewer considered in making homebound determinations. As shown in each medical review determination report, our medical reviewer 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 reviewer carefully considered 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. This is evident from the relevant facts and discussions included in the individual decisions.

With respect to The Palace's assertion that some denials included patients that 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. Cognitive impairment is one factor among others that our medical review contractor considered in making homebound determinations.

Rather than focusing on only one aspect of homebound status while ignoring the context of the beneficiaries' overall condition as conveyed in their medical records, the medical review contractor carefully considered all of the material in those records along with the report and documentation that The Palace submitted to determine whether The Palace billed the claims in compliance with selected billing requirements.

Accordingly, having revised our findings and the associated recommendation for 10 of the claims identified in our draft report, we maintain that our findings for the remaining 15 claims, and the revised recommendation, are valid.

BENEFICIARIES DID NOT REQUIRE SKILLED SERVICES

The Palace Comments

The Palace disagreed with all nine of our findings related to skilled services, stating that the care provided to the patients met the skilled need requirements. The Palace cited Medicare regulations in the Manual, chapter 7, section 40.1.2.3, which indicate that teaching and training activities that require skilled training personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen constitute skilled nursing services. The Palace cited section 40.1.2.1, which further states that "observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services when there is a reasonable potential for change in a patient's condition that 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 patient's clinical condition and/or treatment regimen has stabilized." The Palace also stated that our medical reviewers did not consider the patient's baseline and restoration of the patient's function to his pre-illness or injury status (§ 40.2.1).

Office of Inspector General Response

Based on the information that The Palace provided and the conclusions of our independent medical review contractor's additional medical review, we revised our findings related to skilled services (and the associated recommended disallowance) to specify that seven claims, rather than nine, involved beneficiaries who did not meet the criteria for Medicare coverage of skilled nursing or therapy services.

Our medical reviewer made its determinations of the medical necessity of skilled therapy services in accordance with the Manual, chapter 7, section 40.2. Specifically, 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.

The guidelines state that it is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed. The guidelines also state that, although a patient's particular medical condition is a valid factor in deciding whether skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury or whether the services can be carried out by nonskilled personnel. The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition.

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing service when reasonable and necessary to the treatment of the illness or injury (§ 40.1.2.3). In accordance with these CMS guidelines, skilled nursing visits for teaching and

training activities are reasonable and necessary when the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Skilled nursing services can include observation and assessment of a patient's condition (the Manual, chapter 7, § 40.1.2). In determining the medical necessity of skilled nursing for observation and assessment, our medical reviewer considered the reasonable potential of a change in condition, complication, or further acute episode (e.g., high risk of complications) (§ 40.1.2.1).

Accordingly, having revised our findings and the associated recommendation with respect to two of the claims identified in our draft report, we maintain that our findings for the remaining seven claims, and the revised recommendation, are valid.

INCORRECTLY BILLED HEALTH INSURANCE PROSPECTIVE PAYMENT SYSTEM CODES

The Palace Comments

The Palace disagreed with all eight of our findings for billing code errors in our draft report. The Palace stated that, for one error, the reviewer did not appropriately apply the regulations for the processing of HIPPS codes based on the Common Working File content and calculation of adjacent episodes. For the remaining errors, The Palace said the reviewer misapplied the regulations for constructing and processing the non-routine supplies portion of the HIPPS code.

Office of Inspector General Response

Based on the information that The Palace provided and the conclusions of our independent medical review contractor's additional medical review, we revised our findings related to billing code errors (and the associated recommended disallowance) to specify that seven claims, rather than eight, involved incorrectly billed HIPPS codes. The medical review contractor carefully considered all of the material included in both the medical record and the report from The Palace's health care consultant to determine whether The Palace billed the claims in compliance with selected billing requirements.

Accordingly, having revised our findings and the associated recommendation with respect to one of the claims identified in our draft report, we maintain that our findings for the remaining seven claims, and the revised recommendation, are valid.

APPENDIX A: AUDIT SCOPE AND METHODOLOGY

SCOPE

Our audit covered \$14,098,696 in Medicare payments to The Palace for 3,851 claims for home health services in CYs 2015 and 2016. From this sampling frame, we selected for review a stratified random sample of 100 home health claims with payments totaling \$441,248.

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 medical necessity and coding requirements.

We limited our review of The Palace'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 December 2016 through September 2020.

METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted The Palace'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 \$441,248 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 The Palace 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 The Palace’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 The Palace for our audit period (Appendix D); and
- discussed the results of our audit with The Palace officials; and
- requested the independent medical review contractor to perform an additional medical review of all of the claims that our draft report had questioned.

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 Federal Register 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;¹⁸ (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 (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A); 42 CFR § 409.42; and the Manual, chapter 7, § 30).

¹⁸ 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)).

In accordance with the Manual, chapter 7, section 20.1.2, the question 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 (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and 42 CFR § 424.22(a)).

Section 6407(a) of the Affordable Care Act¹⁹ 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.²⁰

Confined to the Home

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). 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

¹⁹ 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.

²⁰ 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 3,851 home health claims, valued at \$14,098,696, 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	\$1,358.85 to \$3,186.99	1,605	\$3,615,648.57	30
2	\$3,187.00 to \$5,014.99	1,481	5,686,129.71	35
3	\$5,015.00 to \$19,648.47	765	4,796,917.35	35
Total		3,851	\$14,098,695.63	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.

ESTIMATION METHODOLOGY

We used the OAS statistical software to estimate the total amount of overpayments paid to The Palace 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 Incorrectly Billed Sample Items
1	1,605	\$3,615,649	30	\$65,540	5	\$8,460
2	1,481	5,686,130	35	131,361	11	14,721
3	765	4,796,917	35	244,347	4	7,206
Total	3,851	\$14,098,696	100	\$441,248	20	\$30,387

ESTIMATES

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

Point estimate	\$1,233,045
Lower limit	731,304
Upper limit	1,734,785

APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM

STRATUM 1 (Samples 1–30)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
1	-	-	-	-
2	-	-	-	-
3	-	-	-	-
4	-	-	-	-
5	-	-	-	-
6	-	-	-	-
7	-	-	-	-
8	-	-	-	-
9	-	-	-	-
10	-	-	-	-
11	-	-	-	-
12	-	-	-	-
13	-	X	-	\$1,688
14	-	X	-	1,639
15	-	-	-	-
16	X	X	-	1,348
17	X	X	-	2,796
18	-	-	-	-
19	-	-	-	-
20	-	-	-	-
21	-	-	-	-
22	X	-	-	990
23	-	-	-	-
24	-	-	-	-
25	-	-	-	-
26	-	-	-	-
27	-	-	-	-
28	-	-	-	-
29	-	-	-	-
30	-	-	-	-

STRATUM 2 (Samples 31-65)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
31	-	-	-	-
32	X	-	-	1,921
33	-	-	-	-
34	-	-	-	-
35	-	-	-	-
36	X	-	-	220
37	X	-	-	407
38	-	-	-	-
39	X	-	-	162
40	X	-	-	1,202
41	-	-	-	-
42	-	-	-	-
43	-	-	-	-
44	-	-	-	-
45	-	-	-	-
46	X	-	-	3,196
47	-	-	-	-
48	-	-	-	-
49	-	-	-	-
50	X	-	-	1,309
51	-	-	-	-
52	X	-	-	1,883
53	-	-	-	-
54	-	-	-	-
55	-	-	-	-
56	X	-	X	669
57	-	X	X	3,081
58	-	-	-	-
59	X	-	X	669
60	-	-	-	-
61	-	-	-	-
62	-	-	-	-
63	-	-	-	-
64	-	-	-	-
65	-	-	-	-

STRATUM 3 (Samples 66–100)

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Overpayment
66	-	-	-	-
67	-	-	-	-
68	-	-	-	-
69	-	-	X	(93)
70	X	-	X	1,972
71	-	-	-	-
72	-	-	-	-
73	-	-	-	-
74	-	-	-	-
75	-	-	-	-
76	-	-	-	-
77	-	-	-	-
78	-	-	-	-
79	-	-	-	-
80	-	X	X	3,109
81	-	-	-	-
82	-	-	-	-
83	-	-	-	-
84	-	-	-	-
85	X	X	X	2,219
86	-	-	-	-
87	-	-	-	-
88	-	-	-	-
89	-	-	-	-
90	-	-	-	-
91	-	-	-	-
92	-	-	-	-
93	-	-	-	-
94	-	-	-	-
95	-	-	-	-
96	-	-	-	-
97	-	-	-	-
98	-	-	-	-
99	-	-	-	-
100	-	-	-	-
Total	15	7	7	\$30,387



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July 4, 2019

Ms. Lori S. Pilcher
Regional Inspector General for Audit Services
Office of Inspector General
U. S. Department of Health & Human Services
Office of Audit Services, Region IV
61 Forsyth Street, SW, Suite 3T41
Atlanta, GA 30303

Re: Report No. A-04-17-07067 The Palace at Home

Dear Ms. Pilcher,

I have been engaged by The Palace at Home (the “Provider”) to respond to your letter of June 10, 2019 enclosing the report of the draft audit of the subject Provider. The Provider has requested that I provide its comments herein. We have a number of general comments as well as response to the individual findings made with regard to specific encounters. We ask that these comments be reviewed and that your audit be adjusted accordingly.

General Comments: the following comments are applicable in general to all of the audit findings:

1. Beneficiaries were not Homebound

- a. Homebound status documentation should be reviewed based on a wholistic review of the patient health record and documentation by all disciplines. Below is a Recap of the issues used in denial:
 - i. Ambulation distances – while there are some distances that would appear to a reviewer to put homebound status in question, the documentation goes way beyond that. Most of the patients reviewed live in some type of congregate living facility and must ambulate significantly longer distances to get to food, garage, exit, etc. Example: The 08/05/16 PT note

Re: Report No. A-04-17-07067

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documents the patient remains generally deconditioned and requires rest after DESCENDING stairs; patient ambulated **(50 feet) to stair well, 1st floor stair with rolling walker (100 feet) well-elevator** (required sit/rest), **elevator to 4th floor (75 feet)**. **The patient required rest break supporting taxing effort as well as pain relieved by rest.**

- ii. Other homebound denials include patients that meet the criteria of being homebound **due to their mental inability to leave home alone**. One chart was denied for not homebound and the patient is in a locked down Memory Care unit. It is completely unreasonable to refute this patient's homebound status. Following is **EDUCATION from a CMS Medicare Administrative Contractor** regarding homebound status: *Pay special attention to documentation if the beneficiary is homebound secondary to Alzheimer's disease or other mental illness. Early stages of these disease processes may not support homebound status based solely on the diagnosis code. Therefore, documentation in the certifying physician's medical records and/or the acute/post-acute care facility's medical records should clearly reflect why it is unsafe for the beneficiary to leave the home unsupervised, even if the beneficiary has no physical limitations.* **Example:** The beneficiary is unable to leave home due to psychotic symptomatology (e.g., auditory and visual hallucinations). These symptoms are of such nature and severity that it would be considered unsafe for the beneficiary to leave home without assistance.
- iii. Many of the denials for homebound were partial denials for the patient being no longer homebound at some point during the episode of care. The majority of these charts not only continued to document homebound status, the discharge reflected that the patient still had issues that would have continued to constitute homebound status.

2. Beneficiaries Did Not Require Skilled Services

- a. Six of the remaining cases were denied for not requiring a skilled service. With an additional three that included homebound status in the denial. In all 9 cases the care provided to the patient met the skilled need requirements. There appears to have a lack for allowance for skilled care under the following Medicare Guidelines for home health patients: *Medicare Benefit Policy Manual, Chapter 7, Section 40.1.2.3 - When teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Medicare Benefit Policy Manual, Chapter 7, Section 40.1.2.1 - ...reasonable and necessary when observation and assessment of the patient's condition by a nurse is performed when there is a reasonable potential for change in a patient's condition that 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 patient's clinical condition and/or treatment regimen has stabilized..*
- b. In addition, a couple of the above charts were denied for therapy obviously using criteria of ambulation distances. The reality is that there are no ambulation distances in the Medicare regulations and therefore should not be utilized in the

determination of medical necessity when there is clear documentation to support that the patient required contact guard assist, stand by assist, etc. when ambulating the distances in question. There was also lack of consideration for the patient's baseline and restoring the patient's function to pre-illness/injury status. : *Medicare Benefit Policy Manual, Chapter 7, Section 40.2.1 - The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also 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.*

3. Incorrectly Billed Health Insurance Prospective Payment System Code

- a. The content of the draft report, when summarizing this denial on page 8, does not match the detail findings by patient for this error. Page 8 states that the agency assigned an incorrect HIPPS code on the claim and that this is attributed to clerical errors. **Due to the non-reimbursement impact of this adjustment and the fact that it actually is not an error, see support below, we request that the entire error be removed from the final report.**

Following are the issues in the findings of the reviewers and the rebuttal for blatant misapplication of the regulations as it applies to the HIPPS code structure and processing of payment.

- i. One claim adjustment stated that the HIPPS code was incorrect in the 1st position due to the HIPPS code on the claim beginning with a 3, which reflects that the episode is late, 3rd or greater in a series of adjacent episodes. The reviewer states that the OASIS M0110 is marked that the patient episode is early so the HIPPS code first position should be a 1. While that initial analysis is correct, **the HIPPS code is AUTO ADJUSTED FOR THIS BASED, ON THE CONTENT OF THE COMMON WORKING FILE/FISS system at the point of claims processing, which is the reason that the claim reflected a 3 at the point of payment.** This was addressed by the Provider in the first response to findings and remains on the draft report. The patient's record clearly reflects that the episode being reviewed is the 4th episode in a series and is indeed late. The reviewer has not appropriately applied the regulations for the processing of HIPPS codes based on the Common Working File content and calculation of adjacent episodes.
- ii. The remaining errors for the HIPPS code not being correct are also the result of a complete misapplication of the regulations for constructing and processing the Non-Routine Supplies (NRS) portion of the HIPPS code. The NRS portion of the HIPPS code is based SOLELY AND COMPLETELY on responses to the OASIS questions that apply. Once the OASIS responses are final and the points tabulated accordingly the patient is grouped into 1 of six NRS severity ratings and the agency is paid based on these severity levels. S, T, U, V, W or X are the alpha codes and

1-6 the numeric. The alpha is reflected on the Request for Anticipated Payment 100% of the time and the same is reflected on the claim if NRS charges are reflected on the final claim. If NO NRS charges are reflected on the claim then the 5th position of the HIPPS reflects the numeric code. **REGARDLESS of whether the 5th position of the claim is alpha or numeric the reimbursement is the SAME.**

Response to Recommendations: In compliance with the requirements of the letter, we offer more specific comments for each recommendation made by the OIG.

1. The Provider will comply with all audit proceedings and will be appealing all findings and anticipate an extremely high overturn rate based on the findings.
2. The Provider will continue to provide care to home health patients in compliance with Medicare regulations, including homebound status and reasonable and necessary skilled services as they have always done.

In conclusion, the denials that remain from this review were primarily denied citing lack of documentation to support homebound status. While there may be notes or statements that the patient was ambulatory, there is detail, documented proof throughout these patient records that support the homebound status of these patients throughout the episode of care. Skilled need was also a minor error and there is documentation throughout the charts that this requirement was met. The HIPPS code error is completely unfounded. This audit has produced an estimated overpayment that will cause undue hardship and threaten the viability of the Provider. This audit should be adjusted to eliminate any adjustments that were made based on subjective decisions and not on measurable objective data, which is all of the adjustments.

Attached are summarized rebuttals to the individual claims.

We would appreciate the opportunity to discuss this case with you and the appropriate staff.

Sincerely,

Melinda A. Gaboury, CEO

Julio Chacon, Administrator
The Palace at Home