

**Department of Health and Human Services**

**OFFICE OF  
INSPECTOR GENERAL**

**RESULTS OF THE AUDIT OF  
MEDICARE HOME HEALTH SERVICES  
IN FLORIDA**



**JUNE GIBBS BROWN  
Inspector General**

**JUNE 1995  
A-04-94-02087**



## Memorandum

Date JUN 16 1995  
From June Gibbs Brown  
Inspector General  
Subject Results of the Audit of Medicare Home Health Services in Florida  
(A-04-94-02087)  
To Bruce C. Vladeck  
Administrator  
Health Care Financing Administration

This final report provides you with the results of our audit of Medicare Home Health Services in Florida.

### OBJECTIVE

The audit objective was to determine whether Medicare payments to home health agencies (HHA) in Florida met Medicare reimbursement requirements.

### SUMMARY OF FINDINGS

We estimate that 26 percent of Florida HHA claims approved for payment by fiscal intermediaries in February 1993 did not meet Medicare reimbursement requirements. The claims did not meet Medicare reimbursement requirements because:

- Eight percent of the claims were for visits to beneficiaries who were not homebound. These beneficiaries or their families told us that, at the time the services were provided, these beneficiaries could leave home without considerable effort. One beneficiary told us she was walking 2 miles a day at the time services were provided.
- Thirteen percent of the claims were for unnecessary services. The unnecessary services included (1) home aide visits that were not necessary because a caregiver was willing and able to provide the services and (2) skilled services that, in the opinion of the intermediaries' medical personnel we consulted, were not needed by the beneficiaries.
- Five percent of the claims were for visits that were either not documented, not provided, or provided less frequently than actually claimed.

We estimate that during the month of February 1993 the intermediaries approved unallowable claims with charges totaling \$16.6 million out of a universe of \$78 million.

In order for home health services to be covered by Medicare beneficiaries must be:

- confined to their homes,
- under the care of a physician, and
- in need of skilled nursing services on an intermittent basis or skilled physical, speech, or occupational therapy.

We believe there are several reasons why inappropriate HHA claims are being approved by intermediaries. These reasons are:

- Physicians did not always review or actively participate in developing the plans of care that they signed. They relied heavily on HHAs to develop the plans of care for home health services. Medicare regulations do not require physicians to personally examine beneficiaries or review medical records before signing certifications that beneficiaries need home health care.
- Beneficiaries were not aware that HHAs were claiming reimbursement for services that were not necessary or not provided.
- Intermediary reviews of HHA claims are not sufficient to detect unallowable claims.

We are recommending that the Health Care Financing Administration (HCFA):

- Revise Medicare regulations to require that the treating physician, who is responsible for the patient's care and has knowledge of the patient's condition and medical needs, establish the plan of care and specifically prescribe the type and frequency of home health services needed.
- Require intermediaries reviewing Florida claims to notify beneficiaries when HHA claims are paid on their behalf.
- Require intermediaries to perform more in-depth reviews of claims of Florida HHAs.

In response to our draft report, HCFA generally agreed with our recommendations. The HCFA's comments are presented as Appendix C to this report.

## BACKGROUND

### *Home Health Services*

Home health services allow people with limited mobility to live independently while still receiving professional health care services. An HHA is a public or private organization that is primarily engaged in providing skilled nursing care and other therapeutic services in the home on a visiting basis.

### *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 Intermediary Manual.

Home health services is one of the fastest growing segments of health care. In 1992 Medicare paid \$7.8 billion for home health services nationwide. The Office of the Actuary of HCFA estimates that expenditures will rise dramatically, to \$18.1 billion, in 1996.

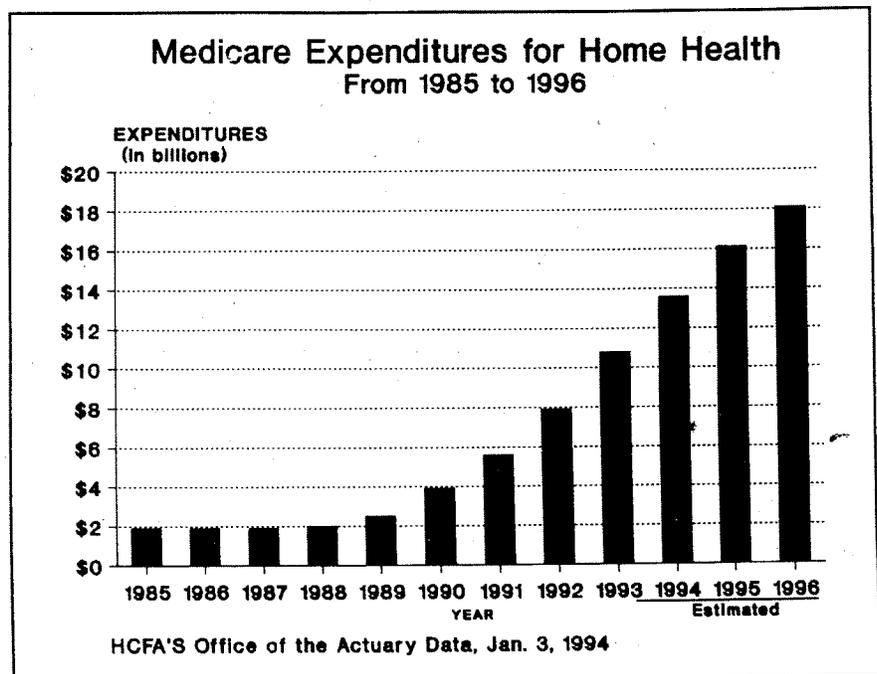
According to data provided by HCFA, in 1992

approximately

10.7 percent of all home health visits nationwide were rendered by HHAs to people living in Florida.

### *Intermediary Responsibility*

The HCFA contracts with intermediaries, usually large insurance companies, to assist them in administering the home health benefits program. The intermediaries for HHAs



in Florida are Aetna Life and Casualty Insurance, and the Blue Cross and Blue Shield (BCBS) companies of Iowa, South Carolina, and Wisconsin. The intermediaries are responsible for:

- processing claims for HHA visits,
- 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 our audit was to determine whether Medicare payments to Florida HHAs met Medicare reimbursement requirements.

During February 1993, the 4 fiscal intermediaries approved for payment 50,202 claims from Florida HHAs with about \$78 million in charges. We reviewed a statistical sample of 200 claims with about \$300,000 in charges. Claims were randomly selected using a stratified sampling design. Details on our sampling methodology and attributes projection are presented in Appendices A and B. We used applicable laws, regulations, and Medicare guidelines to determine whether the visits claimed by the HHAs in Florida met the reimbursement requirements.

Generally, for each of the 200 claims, we interviewed the beneficiary or a knowledgeable acquaintance. We obtained supporting medical records maintained by the HHAs for the 200 claims and requested the intermediary's medical personnel to determine the medical need for services in 25 of the 200 claims. We also reviewed Medicare Parts A and B payment histories for 194 beneficiaries. Finally, we interviewed 58 physicians who certified the plan of care of 59 beneficiaries in our sample whose claims, according to our analysis, did not meet Medicare reimbursement requirements.

We did not review the overall internal control structure of the intermediaries or of the Medicare program. Our internal control review was limited to obtaining an understanding of each intermediary's claims processing system such as pre and post-payment reviews of claims and provider audit activities at the four intermediaries. We did not test the intermediaries' internal controls because the objective of our review was accomplished through substantive testing.

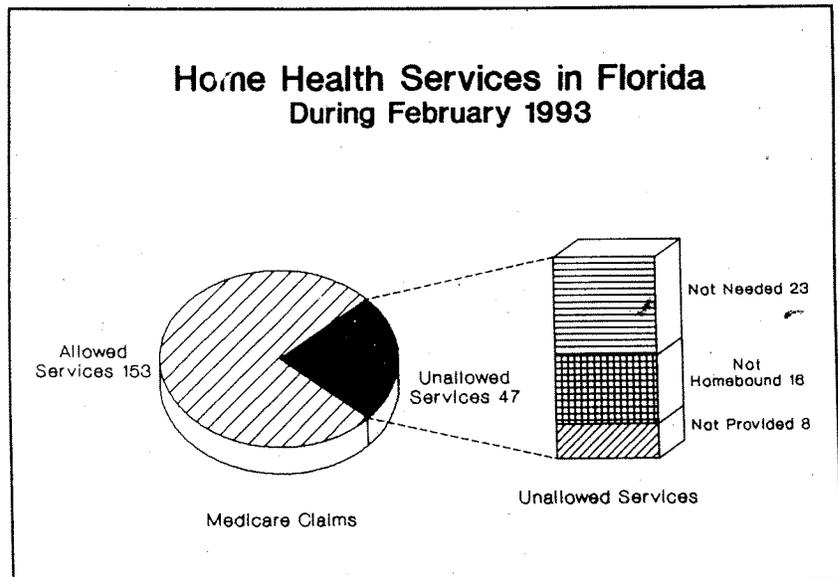
We discussed the objectives of our review with HCFA regional officials to identify requirements placed on the intermediaries by HCFA to ensure that payments were for

eligible services. We also prepared an early alert memorandum to HCFA regarding the physicians' role in the delivery of home health services. The HCFA's comments to our early alert are considered in this report.

Our audit was made in accordance with generally accepted government auditing standards. Field work was performed at the HCFA Regional Office in Atlanta, Georgia, the intermediaries' offices in Florida, South Carolina, Wisconsin, and Iowa, and the HHA's administrative offices throughout Florida. Interviews were conducted at the physicians' offices and beneficiaries' residences. The field work was conducted intermittently from July 1993 to January 1995. The field work was temporarily suspended to respond to an urgent HCFA request to focus on one particular HHA. Also, during our field work, we identified claims for services that, according to the beneficiary, were not made. We referred these claims to the Office of Inspector General's Office of Investigations for further review.

### DETAILED RESULTS OF REVIEW

Our audit showed that 47 of the 200 claims in our random sample did not meet the Medicare reimbursement requirements. For the population of Florida HHA claims processed by the four intermediaries during February 1993, we estimate that 26 percent did not meet Medicare reimbursement requirements. The percentage was computed using a stratified sampling methodology. See Appendices A and B.



Based on a stratified random sample, we estimate that the 4 intermediaries approved claims for payment with charges totaling \$16.6 million that did not meet Medicare reimbursement requirements.

We believe there are several reasons why inappropriate HHA claims are being approved by intermediaries. These reasons are:

- Physicians did not always review or actively participate in developing the plans of care that they signed. They relied heavily on HHAs to develop the plans of care for home health services. Medicare regulations do not require physicians to personally examine beneficiaries or review medical records before signing certifications that beneficiaries need home health care.
- Beneficiaries were not aware that HHAs were claiming reimbursement for services that were not necessary or not provided.
- Intermediary reviews of HHA claims are not sufficient to detect unallowable claims.

#### *Criteria for Certification of Home Health Services*

Section 424.22 of Title 42 CFR states that: "Medicare Part A or Part B pays for home health services only if a physician certifies and recertified..." that "(iii) A plan for furnishing the services has been established and is periodically reviewed by a physician who is a doctor of medicine..." and "(iv) the services were furnished while the individual was under the care of a physician...." The regulations require that a plan of care and a certification of medical necessity be signed by the same physician and that the individual receiving the care be under the care of a physician. However the regulations do not require that the same physician perform all the responsibilities nor do they provide guidance to determine the meaning of "under the care of a physician."

In court decisions, the U.S. District Court has relied heavily on the physician's certifications under the "treating physician rule." This rule has been the turning point in court cases where home services, previously disallowed by the intermediaries and administrative law judges, were allowed by the court. The rule places a significant reliance on the informed opinion of a treating physician, even if contradicted by substantial evidence because the treating physician is considered to be more familiar with the patient's medical condition than other sources.

#### *Visits Not Needed*

Our review showed that 23 of the 200 claims were for services that were not needed. Of the 23 claims, 14 were for home aide services that were not needed by the beneficiary because a caregiver was available and was willing to provide the services, 8 claims were for skilled services that were determined to be medically unnecessary by the intermediaries' medical review personnel, and 1 claim was for aide services not authorized by the physician.

Section 3116.1 of the Medicare Intermediary Manual (MIM) 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.

The HCFA Publication 11, Section 206.2 states that in order to be considered for coverage, home health aide services must be: medically reasonable and necessary, provided to a homebound beneficiary, rendered under the supervision of a registered health professional, in conjunction with skilled services, and rendered when there is no family member or support system able, available or willing to provide these services.

One of the claims reviewed showed that skilled nursing was authorized and supported by the physician's records. However, aide services claimed by the provider were not prescribed by the physician because he did not consider that the service was necessary. The physician told us that although he prescribed nursing visits, the HHA determined the frequency of the visits. Also, the HHA included unnecessary aide visits in the plan of care and the physician signed it without noticing the inclusion. The physician explained that he did not review the plan of care prepared by the HHA before authorizing the services.

In another case, a beneficiary refused aide services but aide visits continued and were strictly of a social nature. During our interview, the beneficiary told us that she did not like or need help with personal care such as bathing and dressing, and that she had informed the home health aide accordingly during the first visit. The beneficiary's daughter lived with the beneficiary and took care of her mother's daily living activities such as laundry, cleaning, meal preparation, assistance with grooming, and supervision of self administered medications. However, the beneficiary allowed aide visits because she liked to chat with the aide. The authorizing physician advised us that he was not aware of the type or frequency of the home services or the homebound requirement for home health visits. The physician authorized the services without reviewing the plan of care prepared by the HHA.

Our review also showed that aide services were provided to 12 beneficiaries who resided in facilities that offered assistance with daily living activities. These beneficiaries lived in Adult Congregate Living Facilities (ACLF) and in federally subsidized housing for the disabled and aged. The ACLF contracts with residents provide for support services such as assistance with bathing, dressing, walking, eating, and grooming when necessary. Similarly, residents in one federally subsidized housing facility received personal care services from a volunteer nonprofit organization. Four of the physicians related to these 12 claims told us that they were not familiar with the living environment of the beneficiaries before they authorized the home services.

Providing aide services to persons who already receive similar services from a different source is contrary to the intent of the regulation which states that it would not be reasonable for HHA personnel to render services when there is a support system willing and able to provide the services.

The unallowable claims included eight claims for skilled nursing services not considered reasonable or medically necessary by the intermediaries' medical experts. For example, one beneficiary received one nursing visit a month for diabetes and hypertension. However, the intermediary's medical review staff determined that the visit wasn't necessary because the patient's blood sugar was stable and no other health complications were documented.

In another case, the intermediary medical staff concluded that nursing notes from the HHA did not substantiate the patient's need for blood work every other month. No other skilled service was provided to the patient. Also, nursing notes revealed that the procedure was reduced from once a month to once every two months at the beneficiary's request. The physician who authorized the services was not available for comments.

The physicians who certified home services on five of these eight cases that included claims for unnecessary skilled nursing services stated that the HHAs determined the type and frequency of home care for the beneficiaries. The physician involvement in the preparation of plans of care was limited to signing the forms prepared by the HHAs. Three of the eight physicians were not available for comments.

#### *Visits To Beneficiaries Who Were Not Homebound*

Our review showed that 16 of the 200 claims were for visits to beneficiaries who were not homebound. We found that Medicare reimbursement criteria regarding the homebound status of the beneficiaries was not always met because physicians did not make this determination.

Title XVIII of the Social Security Act, Section 1861(m) established that home health services could be provided to beneficiaries who are confined to their home (homebound). Section 3117.1 of the MIM states that a beneficiary will be considered homebound:

- (a) if a health condition restricts his ability to leave his place of residence except with the aide of supporting devices (i.e. crutches, canes, wheelchairs, special transitional equipment, or the assistance of another person), or
- (b) if he has a condition which makes leaving his home medically contraindicated. An individual does not have to be bedridden to be considered homebound. However, a normal inability to leave home requiring a considerable and taxing effort from the beneficiary must exist.

During our interviews, the beneficiaries or their families stated that the beneficiaries could leave their homes without considerable effort at the time of the services. For example:

- o A beneficiary explained she was never homebound and felt that the services she received were not necessary.
- o A 67 year-old beneficiary stated she was walking 2 miles a day. The HHA nurse had documented the beneficiary's walks in her notes; however, the beneficiary was considered homebound and received services for hypertension and diabetes.
- o A beneficiary was approached by a recruiter at a senior citizens' nutrition center; the recruiter arranged for the beneficiary to go to a local clinic where HHA services were prescribed. Five of the 16 beneficiaries who were not homebound were recruited and enrolled for home services by HHA personnel and freelance recruiters.

The interviews of the 58 physicians disclosed that in 15 cases the determination of the homebound status of the beneficiaries was made by the HHA with no input from physicians. Four physicians stated that they signed plans of care including homebound certifications for patients they had never seen. Eleven physicians disclosed that they were not aware of the homebound requirements for HHA services.

***Services Not Documented, Not Provided Or Provided Less Frequently Than Claimed***

Our review showed that 8 of the 200 claims were for services that were either not documented, not provided or provided less frequently than claimed. In these cases, the beneficiaries confirmed they did not receive the services as claimed by the providers.

Title 42 CFR Section 409.42 (g) and (e), state that services must be furnished by a home health agency, or by others under an arrangement with a home health agency on a visiting basis. Title 42 CFR Section 409.43 states that a visit is charged to Medicare each time a health worker furnishes home health services to the beneficiary.

We found one claim that lacked supporting documentation showing that skilled services were provided. A nursing visit and 18 aide visits were claimed. No record of visits documented the services for the skilled nursing visit and for four aide visits. Also, no HHA service lists (itinerary logs) with patient's signature were found. We considered payment of this claim unallowable for lack of documentation.

In another claim, the beneficiary's family stated that the beneficiary received some home visits but no services were provided during the visits. The beneficiary was approached by a freelance recruiter on several occasions, sometimes by telephone and sometimes in person. According to the beneficiary's family, the freelance recruiter arranged a

doctor's visit for the beneficiary in a local clinic and provided the beneficiary with transportation to the clinic. The doctor then authorized home services after seeing the beneficiary only once.

Another beneficiary told us that she only received 12 nursing and 12 aide visits during the month we reviewed. The HHA claimed 23 nursing visits and 19 aide visits during the month. Further, when we showed the beneficiary the service documentation obtained from the HHA, the beneficiary complained that the HHA had used her name on the service logs but that some of the signatures were not hers. The beneficiary noted that signatures on the aide logs were very different from the signatures on the nursing logs, and that her name was misspelled in one case. In this case as well as in the rest of the cases in which the beneficiaries denied receiving services as claimed by the providers, the beneficiaries did not know that HHAs were claiming payment for services on their behalf.

### *Effect*

Our audit showed that 26 percent of the claims approved for payment during February 1993 did not meet the Medicare reimbursement requirements. Projecting the error rate to the universe of claims approved for payment during February 1993, we estimated that the intermediaries approved unallowable claims with charges totaling \$16,551,410.

### *Controls Over Home Health Services*

The unallowable home services disclosed by our review occurred because of the inadequacy of existing controls to insure that claims approved for payment were for allowable services. Existing controls included the treating physicians who certified to the beneficiaries' need and eligibility for home health services, and the fiscal intermediaries' medical review of home health claims. We also found that beneficiaries did not receive notice of Medicare benefits for home health services; and thus, did not provide the intermediary with feedback regarding services claimed by providers but not received.

### **Inadequate Physician Involvement**

We interviewed 58 physicians who signed the plans of care associated with the potentially unallowable claims found in our review. Forty of these physicians indicated that they had limited involvement in the preparation of the plan of care or the homebound requirement. More specifically, these 40 physicians signed the plans of care for 27 of the 47 claims in our sample that did not meet Medicare reimbursement requirements. Our audit disclosed that too often the physicians' involvement in home health care was limited to signing plans of care prepared by the HHAs without proper evaluation of the patients to assess their needs and homebound status. We found that HHAs were determining the need, type, and the frequency of home health visits without physician participation.

Of the 58 physicians we interviewed, 40 indicated that they were not fully aware of the contents of the plans of care that they signed or the homebound requirement. Forty of the 58 physicians disclosed one or more characteristics of inadequate involvement in the preparation of plans of care or the homebound requirement. Among the 40 physicians, we found 54 instances of limited physician involvement. For example:

- In 39 instances, the physicians signed the plans of care without determining the type and frequency of the services. The HHAs made the determination. The physicians did not review the HHA determination.
- In 11 instances, the physicians were not aware of the homebound requirement for home services or of the beneficiary's need for skilled services before allowing home aide visits.
- In four instances, the physicians never saw the beneficiary before authorizing home services.

Currently, Medicare does not require physicians to personally examine their patients before signing certifications for home care. Thus, the failure of physicians to personally examine their patients does not render the home care unallowable. However, we believe that the lack of physician involvement in the assessment of their patients' needs was a leading cause of the unallowable services disclosed by our review.

#### **Beneficiaries Not Aware of HHA Services Claimed on Their Behalf**

We also found that the intermediaries do not notify beneficiaries of the claims submitted by the providers. Thus, beneficiaries do not know what the HHAs are claiming on their behalf and do not provide feedback to the intermediaries on unnecessary home services or claims for services that were never received.

For services other than home health, Part A intermediaries and Part B carriers are required to notify beneficiaries of actions taken on their behalf (MIM Sec.3718 and Medicare Carrier Manual Sec. 7000). Medicare Benefit Notices and Explanation of Medicare Benefits are sent by intermediaries and carriers to provide beneficiaries with a record of services claimed to Medicare and information about coinsurance, deductibles, limits of services, and disallowed charges. Currently, the beneficiaries do not receive benefit notices for home health services because there is no Medicare requirement for deductibles, coinsurance, or lifetime limit of services.

To have an idea of the effectiveness of notice of benefits for Medicare services, we asked BCBS of Florida about the public response to Part A and B notices. According to BCBS of Florida data, during Fiscal Year 1994, they received 16,513 complaints from beneficiaries regarding Part A and B charges with over \$7 million in overpayments. Eighty-four percent (or 13,868) of the complaints were related to notice of benefits for services not received as claimed by providers.

In our opinion, providing beneficiaries with a record of services claimed to Medicare and educating them to monitor providers' claims on their behalf could be an effective tool to detect unnecessary services or claims for services that were never received. We believe intermediaries should use this beneficiary feedback to target abusive HHAs and deter unallowable home health claims.

### **Intermediaries' Limited Review of Home Health Claims**

We found that most claim documentation from providers appears to be legitimate and will on the surface withstand medical review. However, most of the problems we found with HHA claims were detected when we interviewed beneficiaries and physicians. In our opinion, HCFA needs to develop procedures for intermediaries to contact beneficiaries to verify that services were provided and to contact physicians to verify that services were ordered.

We also found that HCFA limited the claims reviewed each year by the fiscal intermediaries. For example, in 1988 HCFA required the intermediaries to review 50 percent of all types of claims. By 1993, HCFA had reduced the intermediary's review efforts to approximately 4 percent.

According to documentation obtained from HCFA, the review effort was reduced because:

- It was not cost-effective to review a large number of claims because there were low denial rates. Services on the face of the claims appeared to be covered services.
- The review of claims evolved from general to focused medical review. Focused medical review is where the intermediaries use analysis of billed history data to find aberrancies and target problematic providers.

We believe that focused medical review should be augmented with physician and beneficiary interviews to verify that services were provided and properly prescribed.

### **RECOMMENDATIONS**

We recommend that HCFA:

- Revise Medicare regulations to require that the treating physician, who is responsible for the patient's care and has knowledge of the patient's condition and medical needs, establish the plan of care and specifically prescribe the type and frequency of home health services needed.

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- Require intermediaries reviewing Florida claims to notify beneficiaries when HHA claims are paid on their behalf and use this information to target abusive HHAs for focused medical review.
- Require intermediaries to perform more in-depth reviews of claims from Florida HHAs that have been targeted as abusive. The reviews should include procedures to verify that physicians ordered the services and that beneficiaries received the services.

In response to our draft report, HCFA generally agreed with our recommendations. The HCFA's comments are presented as Appendix C to this report.

## APPENDICES

## APPENDIX A

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### SAMPLING METHODOLOGY

The following statistical sampling information is presented as required by Section 20-06-120 of the OAS Audit Policies and Procedures Manual. A stratified random sample was used for this review.

#### POPULATION:

We used the universe of home health agency claims approved for payment by each one of the four Regional Home Health Intermediaries (RHHI) servicing Florida providers during February 1993 as follows:

<u>Stratum Number</u>	<u>RHHI</u>	<u>Number of Claims</u>	<u>Charges</u>
1	AETNA-Florida	34,646	\$49,682,549
2	BCBS-South Carolina	3,536	4,674,890
3	BCBS-Iowa	5,681	7,572,253
4	BCBS-Wisconsin	<u>6,339</u>	<u>16,328,891</u>
	Total:	<u>50,202</u>	<u>\$78,258,583</u>

#### SAMPLE DESIGN:

Our sample was stratified by the four RHHIs in Florida during February 1993.

#### RESULTS OF SAMPLE:

The results of our review are as follows:

<u>Stratum Number</u>	<u>Number of Claims</u>	<u>Sample Size</u>	<u>Value of Sample</u>	<u>Number of Errors</u>	<u>Value of Errors</u>
1	34,646	110	\$157,419	32	\$38,462.46
2	3,536	30	46,452	0	0.00 *
3	5,681	30	53,608	9	19,663.30
4	<u>6,339</u>	<u>30</u>	<u>48,830</u>	<u>6</u>	<u>3,377.00</u>
Total:	<u>50,202</u>	<u>200</u>	<u>\$306,309</u>	<u>47</u>	<u>\$61,502.76</u>

## **APPENDIX A**

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The point estimate of the sample was \$16,551,410 with a precision of plus or minus \$4,349,586 at the 90 percent confidence level.

- \* Florida HHAs served by South Carolina were part of a prospective payment system demonstration project that lasted from August 1991 to July 1994. The HHAs participating in this project were monitored closely by the Intermediary. In addition, none of these HHAs were located in South Florida. These two factors explain why no errors were found in the South Carolina stratum.

## **ATTRIBUTES PROJECTION**

We used a stratified sample of 200 claims out of the 50,202 claims to project the occurrence of certain type of errors. The results of these projections at the 90 percent confidence level are presented below. The projections were made using a stratified methodology.

### **CLAIMS THAT DID NOT MEET MEDICARE REQUIREMENTS**

Quantity Identified in the Sample:	47	
Ratio:		25.997%
Precision at 90% Confidence Level:		5.401%

### **CLAIMS FOR VISITS NOT PROPERLY AUTHORIZED BY PHYSICIANS OR NOT NEEDED BY THE BENEFICIARIES**

Quantity Identified in the Sample:	23	
Ratio:		13.104%
Precision at 90% Confidence Level:		4.225%

### **CLAIMS FOR VISITS MADE TO BENEFICIARIES THAT WERE NOT HOMEBOUND**

Quantity Identified in the Sample:	16	
Ratio:		8.124%
Precision at 90% Confidence Level:		3.282%

### **CLAIMS FOR VISITS NOT DOCUMENTED, NOT PROVIDED, OR PROVIDED LESS FREQUENTLY THAN ACTUALLY CLAIMED**

Quantity Identified in the Sample:	8	
Ratio:		4.769%
Precision at 90% Confidence Level:		2.721%



DEPARTMENT OF HEALTH & HUMAN SERVICES

APPENDIX C  
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Health Care Financing Administration

The Administrator  
Washington, D.C. 20201

**DATE** APR 28 1995

**TO** June Gibbs Brown  
Inspector General

**FROM** Bruce C. Vladeck  
Administrator

**SUBJECT** Office of Inspector General (OIG) Draft Report: "Results of the Audit of Medicare Home Health Services in Florida" A-04-94-02087

We reviewed the subject report in which OIG found a significant number of claims approved for payment by fiscal intermediaries did not meet Medicare reimbursement requirements.

Thank you for the opportunity to review and comment on this final report. Our detailed comments on the report findings and recommendations are attached for your consideration. Please contact us if you want to discuss our comments and response.

Attachment

Comments of the Health Care Financing Administration (HCFA)  
on Office of Inspector General Draft Report:  
"Results of the Audit for Medicare Home Health Services in Florida"

Recommendation 1

Revise Medicare regulations to require that the treating physician, who is responsible for the patient's care and has knowledge of the patient's condition and medical needs, establish the plan of care and specifically prescribe the type and frequency of home health services needed.

HCFA Response

Concur. The regulations in effect when this audit was performed did not impose such requirements. However, new regulations that became effective February 21, 1995, require at 42 CFR 409.42(b) that the beneficiary must be under the care of a physician who establishes the plan of care, and at 409.43(b) that the physician's orders for services in the plan of care must specify the medical treatments to be furnished, the discipline to furnish the services, and their frequency. In addition, under physician fee schedule changes effective January 1, 1995, Medicare will make separate payment to the treating physician for oversight of a home health care plan. This is responsive to the frequently voiced complaint from physicians that they are expected to provide oversight but are not separately paid for it.

Recommendation 2

Require intermediaries reviewing Florida claims to notify beneficiaries when home health agency (HHA) claims are paid on their behalf and use this information to target abusive HHAs for focused medical review.

HCFA Response

HCFA concurs in principle with the recommendation. We agree that HCFA can do more to improve beneficiary and provider awareness of home health care services. Beginning April 1, 1995, we will conduct a 4-month pilot of beneficiary notification in four States. In parts of Florida, Georgia, Alabama, and Mississippi, intermediaries will send monthly notices to beneficiaries containing information about home health services provided to them. Beneficiaries will be asked to report any discrepancies concerning those services to the Regional Home Health Intermediary (RHHI) in their area. Also, during this same period, we will test the utility of sending some health utilization notices to ordering physicians in parts of Georgia and Florida. Physicians will be asked to verify that the billed services were necessary and to report any inconsistencies to the RHHI.

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Finally, HCFA through the Medicare home health initiative, is developing a home health pamphlet for beneficiaries which describes the benefit (eligibility, coverage, and payment) and cautions beneficiaries to be cognizant of potential fraudulent activities.

### Recommendation 3

Require intermediaries to perform more indepth reviews of claims from Florida HHAs that have been targeted as abusive. The reviews should include procedures to verify that physicians ordered the services and that beneficiaries received the services.

### HCFA Response

We concur in principle with the recommendation. HCFA, through the Medicare Home Health Initiative, is exploring ways to improve detection and control of overutilization through focused medical review, but our resources are limited and we must employ them in ways that maximize their use. HCFA favors a team approach to indepth reviews, in which audit and reimbursement, fraud, and medical review staff reviews a provider's claims and medical documentation together. Moreover, we support collaboration between the intermediaries and State agencies when conducting these reviews. We are working to include State survey and certification personnel and State Medicaid agencies as partners during reviews. We expect to issue final instructions in May 1995 to RHHIs that direct intermediaries to perform team reviews. Although we concur in principle with OIG's recommendation, HCFA believes we should wait and evaluate the results of these efforts before fully committing to a specific methodology.

### Technical Comments

We are concerned with the report's findings being based on HHA charges. Because Medicare makes payments to HHAs on the basis of reasonable costs, a true basis for determining Medicare payments is intermediary audited reasonable cost payments to HHAs, rather than charges.