

## Report in Brief

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



### Why OIG Did This Audit

Under the prospective payment system (PPS), Medicare pays home health agencies (HHAs) for each 60-day episode of care that beneficiary receives, called a payment episode. During our audit period, if an HHA provided four or fewer visits in a payment episode, Medicare paid the HHA a standardized per-visit payment. Claims for these types of payments are called Low Utilization Payment Adjustment (LUPA) claims. Once a fifth visit was provided during the payment episode (i.e., above the LUPA threshold), Medicare paid an amount for the services provided that was, in general, substantially higher than the per-visit payment amount. Because of the large payment increase starting with the fifth visit, HHAs have an incentive to improperly bill claims with visits slightly above the LUPA threshold.

Our objective was to determine whether payments for home health services with five to seven visits in a payment episode complied with Medicare requirements.

### How OIG Did This Audit

Our audit covered \$1.25 billion in Medicare payments to HHAs for claims for home health services provided in 2017 (audit period). We selected a stratified random sample of 120 HHA claims with 5, 6, or 7 visits in a payment episode. An independent medical review contractor determined whether the services met medical necessity and coding requirements.

## CMS Could Have Saved \$192 Million by Targeting Home Health Claims for Review With Visits Slightly Above the Threshold That Triggers a Higher Medicare Payment

### What OIG Found

Not all payments to HHAs for home health services with five to seven visits in a payment episode complied with Medicare requirements. Of the 120 sampled claims we reviewed, 91 complied with requirements, and for 4 claims there was no documentation available to make a compliance determination. However, the remaining 25 claims did not comply with requirements. As a result, Medicare improperly paid HHAs for a portion of the payment episode (14 claims) and for the full payment episode (11 claims), totaling \$41,613. These improper payments occurred because the Medicare administrative contractors (MACs) did not analyze claim data or perform risk assessments to target for additional review those claims with visits slightly above the LUPA threshold of four visits. On the basis of our sample results, we estimated that Medicare overpaid HHAs nationwide \$191.8 million for our audit period.

In November 2018 (after our audit period), the Centers for Medicare & Medicaid Services (CMS) finalized a new home health PPS methodology, effective for home health periods of care beginning on or after January 1, 2020. This new methodology revised the LUPA threshold from four visits to a threshold varying from two to six visits. The majority of the claims in our sample (20 of 25) that did not comply with Medicare requirements under the previous PPS methodology would also have not complied with those requirements under the new methodology.

### What OIG Recommends and CMS Comments

We recommend that CMS: (1) direct the MACs to recover the \$41,613 in identified overpayments made to HHAs for the sampled claims; (2) require the MACs to perform data analysis and risk assessments of claims with visits slightly above the applicable LUPA threshold and target these claims for additional review; and (3) instruct the MACs to educate HHA providers on properly billing for home health services with visits slightly above the applicable LUPA threshold, which could have saved Medicare as much as \$191.8 million during our audit period.

CMS concurred with our recommendations and described actions that it had taken or planned to take to address the recommendations.