

Department of Health and Human Services

**OFFICE OF
INSPECTOR GENERAL**

**REVIEW OF HOME HEALTH SERVICES
BILLED DURING AN INPATIENT STAY**

**HOME HEALTH & HOSPICE CARE OF
WHIDDEN MEMORIAL HOSPITAL**



**JUNE GIBBS BROWN
Inspector General**

**JUNE 1996
A-01-96-00517**



Office of Audit Services
Region I
John F. Kennedy Federal Building
Boston, MA 02203
(617) 565-2684

June 20, 1996

CIN: A-01-96-00517

Mrs. Diane Farragher-Smith
Executive Director & Administrator
Home Health & Hospice Care of Whidden Memorial Hospital
103 Garland Street
Everett, Massachusetts 02149

Dear Mrs. Farragher-Smith:

The purpose of this final report is to provide you with the results of our review of home health services billed by Home Health & Hospice Care of Whidden Memorial Hospital (Whidden HHA) under the Medicare program. The objective of our review was to determine whether procedures were established to ensure that home health agency (HHA) services were not billed to Medicare while a beneficiary was an inpatient at a hospital.

Under current Medicare regulations, Medicare does not cover home health services furnished while a patient is an inpatient at a hospital. Moreover, to be covered, home health services must be properly supported. The Whidden HHA generally has adequate controls in place to ensure that services billed are rendered, properly documented, and supported in the medical records.

A computer match of the calendar year (CY) 1994 inpatient and home health agency paid claims data identified 519 home health claims submitted by Whidden HHA in which the home health dates of service overlapped an inpatient stay. Our review of a random sample of 100 claims representing 1,717 home health visits, identified that only 27 home health visits were billed in error (1.6%). We found that 4 home health visits were billed while the beneficiary was an inpatient at a hospital and 23 home health visits did not have supporting documentation in the medical records to show if the services were rendered. As a result of reviewing a random sample of claims, we estimate that the Medicare program visits and costs reported in Whidden HHA's fiscal year (FY) 1994 cost report may be overstated by 140 home health visits at a cost of approximately \$9,000. In addition, we noted isolated instances in which the physician did not authorize home health aide services, yet, the home health aide services were billed to Medicare contrary to Medicare regulations.

To improve the documenting and supporting of home health visits in the medical records, Whidden HHA developed policies and procedures for tracking the flow of home health aide paperwork. We recommend that Whidden HHA continue to strengthen procedures to ensure that services are rendered and supported in the medical records. A listing of the claims with these

errors was provided to Whidden HHA during our review. We will also forward the results of our review to Associated Hospital Services of Maine (the fiscal intermediary) so that it can determine whether adjustments to Whidden HHA's FY 1994 cost report are warranted.

In response to the draft report, the Whidden HHA stated in its letter dated June 14, 1996 that "We are not in dispute with any of the stated findings and continue the improvement practices described by the agency that are in place to eliminate any error".

BACKGROUND

For home health services provided to Medicare beneficiaries, Medicare regulations state that:

- ✓ Medicare coverage of home health services includes skilled nursing services, physical, occupational, or speech therapy services, and home health aide services. It does not, however, include housekeeping services. [Title 42 Code of Federal Regulation, §409.42, §409.45, §409.49(d) and Home Health Agency Manual, §230.]
- ✓ Medicare home health services are provided under a plan of care established and approved by a physician. The plan of care must contain all pertinent diagnoses, including the beneficiary's mental status, the types of services ordered, the frequency of the visits to be made, etc. [Home Health Agency Manual, §204.2(A).]
- ✓ HCFA requires HHAs to obtain a signed certification as soon as practicable after the start of care and prior to submitting a claim to the intermediary. The HHA may provide services prior to obtaining the physician's written plan of care based on documented verbal orders. If care continues beyond the certification period, the HHA must obtain a recertification from the physician. [Home Health Agency Manual, §234.6.]
- ✓ The plan of care must be reviewed and signed by a physician no less frequently than every two months. A beneficiary is expected to be under the care of the physician who signs the plan of care and the physician certification. [Home Health Agency Manual, §§204.2(F) and 204.3].
- ✓ A beneficiary's residence is wherever he makes his home. However, an institution may not be considered a beneficiary's residence if the institution is a hospital. Medicare does not reimburse HHAs for services rendered while a patient is an inpatient in a hospital. [Title 42 Code of Federal Regulations, §409.42(a) and Medicare Intermediary Manual, §3117.1(B).]

- ✓ Adequate cost information must be maintained in the provider's records to support payments made for services furnished to beneficiaries. [Title 42 Code of Federal Regulations, §413.24 (c).]
- ✓ Covered home health services are reimbursed on a visiting basis. A visit is a personal contact in the place of residence of a beneficiary made for the purpose of providing a covered service by a health worker on the staff of the HHA. [Social Security Act, §1861(m) and Home Health Agency Manual, §218.1.]
- ✓ Medicare fiscal intermediaries (FI) reimburse HHAs on a reasonable cost basis for the costs related to visits for patient care. As claims are submitted on a periodic basis, i.e., biweekly or monthly, HHAs receive interim payments approximating, on the average, the costs of covered home health services furnished. [Title 42 Code of Federal Regulations, §413.64(a) and (h)(6), and Medicare Intermediary Manual, §3638.]
- ✓ Final reimbursement is made upon settlement of the annual HHA cost report submitted by the HHAs to the FIs. The basis for determining the overall costs of furnishing home health services and the Medicare share of those costs is the HHA cost report. [Title 42 Code of Federal Regulation, §413.64(f), and Provider Reimbursement Manual, §3200.]

The Whidden HHA reported 92,285 Medicare home health visits, valued at a cost of \$6,377,451 in the "as filed" FY 1994 cost report.

SCOPE

Our audit was conducted in accordance with generally accepted government auditing standards. The objective of our review was to determine whether procedures were established to ensure that HHA services were not billed to Medicare while a beneficiary was an inpatient at a hospital. Our audit covered home health services billed in CY 1994.

As part of our examination, we obtained an understanding of the internal control structure as it relates to the audit objective. Specifically, we reviewed controls over the documentation and billing of home health services. Our review did not include a determination of the medical necessity of the home health visits billed.

To accomplish our objective we:

- reviewed the Federal regulations and guidelines provided in the Title 42 Code of Federal Regulations Parts 409 and 413, Social Security Act, Medicare Intermediary Manual, Home Health Agency Manual, and Provider Reimbursement Manual for procedures established for accumulating and reporting HHA visits;

- obtained the "as filed" FY 1994 cost report for Whidden HHA to determine the average cost per discipline;
- conducted a computer match of Health Care Financing Administration's (HCFA) National Claims History CY 1994 inpatient and home health paid claims data, which identified 519 home health claims valued at a cost of approximately \$665,393 in which the home health dates of service overlapped an inpatient stay;
- randomly selected 100 home health claims valued at a cost of \$128,207 from the file of 519 home health claims;
- obtained and reviewed the Medicare remittance advice for the selected 100 home health claims;
- reviewed the medical records for each home health claim to determine when or if the services were actually performed in CY 1994;
- verified the accuracy of the inpatient dates of service with the inpatient provider; and
- used a variable statistical appraisal program to project the overstated Medicare program visits and costs reported in Whidden HHA's FY 1994 cost report.

In completing our review, we established a reasonable assurance on the authenticity and accuracy of the computer generated data. Our audit was not directed toward assessing the completeness of the files from which the data was obtained.

Our work was performed in March 1996 at the Boston Regional Office of the Office of the Inspector General, and Whidden Memorial Hospital, in Everett, Massachusetts.

The draft report was issued on May 3, 1996. The Whidden HHA's response to the draft report, dated June 14, 1996, is appended to this report (see Appendix) and is addressed on page 7.

FINDINGS AND RECOMMENDATION

During our review of a random selection of 100 claims with 1,717 home health visits, we found only 4 home health visits were billed while the beneficiary was an inpatient at a hospital. In addition, we found 23 home health visits were billed which did not have supporting documentation in the medical records to show if the services were rendered. In our opinion, Whidden HHA generally has adequate controls in place to ensure that services billed are rendered, properly documented, and supported in the medical records. To improve the documenting and supporting of home health visits in the medical records, Whidden HHA

developed policies and procedures for tracking the flow of home health aide paperwork. As a result of reviewing a random sample of claims, we estimate that the Medicare program visits and costs reported in Whidden HHA's fiscal year (FY) 1994 cost report may be overstated by 140 home health visits at a cost of \$9,003. In addition, Whidden HHA's FY 1994 cost report is overstated by \$173 for 4 home health aide visits that were rendered without a physician's authorization.

Under current Medicare regulations, Medicare does not cover home health services furnished while a patient is an inpatient in a hospital. Moreover, to be covered, home health services must be properly supported. Medicare home health services are provided under a plan of care established and approved by a physician. Covered home health services are furnished on a visiting basis. In this regard, a visit is a personal contact in the place of residence of a beneficiary made for the purpose of providing a covered service by a health worker on the staff of the HHA. A beneficiary's residence is wherever he makes his home. However, an institution may not be considered a beneficiary's residence if the institution is a hospital.

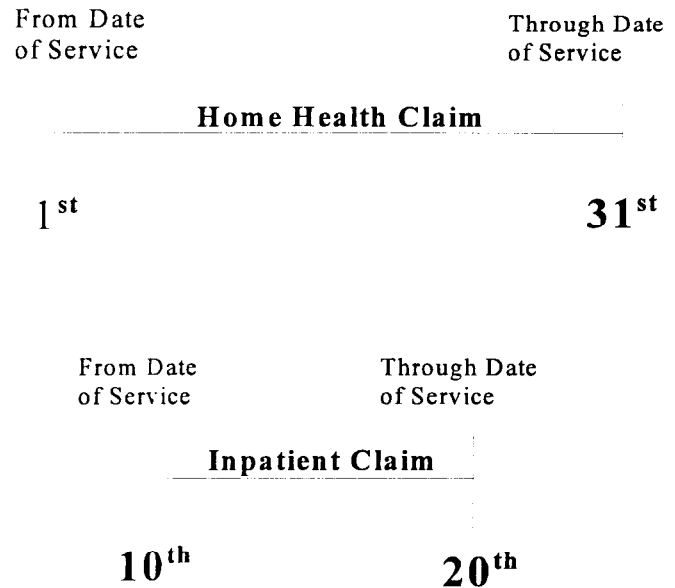


Diagram 1

The Whidden HHA generates home health claims on a monthly basis. Therefore, if a beneficiary becomes an inpatient during the HHA's billing period, an overlap with the inpatient dates of service will occur. As Diagram 1 depicts, Whidden HHA would generate a bill for services provided to a beneficiary from January 1st to January 31st and a hospital would generate a bill for an inpatient stay from January 10th to January 20th for the same beneficiary.

To determine if home health services were billed during an inpatient stay, we performed a computer match of HCFA's National Claims History CY 1994 inpatient and home health agency paid claims data. As a result of these computer applications, we identified 519 home health claims with 9,022 home health visits, valued at an estimated cost of over \$665,000 submitted by Whidden HHA in which the home health dates of service overlapped the dates of service of an inpatient stay.

We randomly selected 100 home health claims, valued at a cost of approximately \$128,000, with 1,717 home health visits. We reviewed the patient's medical records to determine the actual dates of service of the home health visits and compared these dates to the inpatient stay in the hospital. The Whidden HHA reviewed each of the discrepancies noted in our review.

As a result of our review, we identified 27 home health services in which Whidden HHA either billed for services while the beneficiary was an inpatient at a hospital or did not have supporting documentation in the medical records to show if the services were rendered. Specifically, our analysis showed that:

- ✓ four claims contained four home health aide visits billed while the patient was an inpatient at a hospital. For two home health aide visits, the medical records disclosed the beneficiary was “not at home”; for one home health aide visit, Whidden HHA did not have supporting documentation in the medical records indicating when the services were rendered to the beneficiary; therefore, we relied on the detail bill which indicated the dates of service for the visit billed; and for one home health aide visit, the medical records disclosed the home health aide provided services to the beneficiary, i.e., a shower, mouth care, dressed patient, etc. However, these services could not have been rendered since the beneficiary was an inpatient at a hospital. The Whidden HHA attributed the errors found on these claims to data entry/clerical error. As a result, Whidden HHA’s FY 1994 cost report is overstated by four home health aide visits valued at a cost of \$173; and

- ✓ on 12 claims, Whidden HHA did not have supporting documentation in the medical records supporting 6 skilled nursing visits and 17 home health aide visits. According to Whidden HHA, each staff member’s day sheet is the source of the bills submitted to the FI. Therefore, the documentation in the medical records supported fewer home health visits than what was billed to Medicare. For 5 of the claims containing 13 home health visits, Whidden HHA could not find the documentation supporting the services rendered to the patients. Also, Whidden HHA attributed the errors found on 7 of the claims containing 10 home health visits to data entry/clerical error. As such, Whidden HHA’s FY 1994 cost report may be overstated by 23 home health visits valued at a cost of \$1,562.

As a result of reviewing the 100 claims and extrapolating the results of the statistical sample over the population using standard statistical methods, these errors, both visits billed during the inpatient stay and visits billed with no supporting documentation in the medical records, would mean that Whidden HHA’s FY 1994 cost report may be overstated by 140 home health visits \pm 49.58 percent, at a cost of \$9,003 \pm 47.52 percent, at the 90 percent confidence interval.

To eliminate the data entry/clerical errors, subsequent to CY 1994, Whidden HHA established policies and procedures for tracking the flow of home health aide paperwork. Specifically, the home health aide office staff verifies the accuracy of submitted paperwork by comparing the home health aide’s day sheets and narratives/care plans with the actual scheduled visits. In addition, narratives/care plans are sent to the medical record’s department to be filed in the patient’s permanent record.

In addition, we noted isolated instances in which the physician did not authorize home health aide services, yet, the home health aide services were billed to Medicare contrary to Medicare regulations.

To improve the documenting and supporting of home health visits in the medical records, Whidden HHA developed policies and procedures for tracking the flow of home health aide paperwork. We recommend that Whidden HHA continue to strengthen procedures to ensure that services are rendered and supported in the medical records. A listing of the claims with these errors was provided to Whidden HHA during our review. We will also forward the results of our review to Associated Hospital Services of Maine (the fiscal intermediary) so that it can determine whether adjustments to Whidden HHA's FY 1994 cost report are warranted.

AUDITEE RESPONSE

In response to the draft report, the Whidden HHA stated in its letter dated June 14, 1996 that "We are not in dispute with any of the stated findings and continue the improvement practices described by the agency that are in place to eliminate any error".



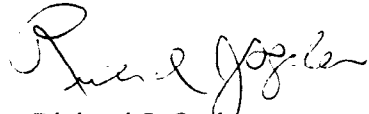
In accordance with the principles of the Freedom of Information Act (Public Law 90-23), Office of Inspector General, Office of Audit Services reports issued to the Department's grantees and contractors are made available, if requested, to members of the press and the general public to the extent information contained therein is not subject to exemptions in the act which the Department chooses to exercise. (See 45 CFR Part 5).

Final determination as to actions taken on all matters reported will be made by the HHS action official named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

Page 8 - Diane Farragher-Smith

Please refer to Common Identification Number A-01-96-00517 in all correspondence relating to this report.

Sincerely yours,

A handwritten signature in black ink, appearing to read "Richard J. Ogden". The signature is written in a cursive style with a large initial "R".

Richard J. Ogden
Regional Inspector General
for Audit Services

Direct Reply to HHS Action Official:
Sidney Kaplan, Regional Administrator
Health Care Financing Administration

cc: Al Harvey, Director of Audit and Reimbursement
Associated Hospital Services of Maine

Mark Humphreys, Audit Supervisor
Associated Hospital Services of Maine

Robert Baroutas, Executive Director of Medicare Reimbursement Audit
Blue Cross and Blue Shield

APPENDIX



HOME HEALTH & HOSPICE CARE

Whidden Memorial Hospital (617) 381-7111
103 Garland Street fax (617) 381-7195
Ereton, MA 02149

June 14, 1996

Richard J. Ogden
Regional Inspector General for Audit Services
Region 1
JFK Federal Building
Boston, MA 02203


CIN: A-01-96-00517

Dear Mr. Ogden,

This letter serves as a validation of the facts and reasonableness of the recommendations described in the draft report dated May 3, 1996. We are not in dispute with any of the stated findings and continue the improvement practices described by the agency that are in place to eliminate any error.

Kindly call me directly at 617-381-7103 if further data is required.

Sincerely,


Diane Farragher-Smith RN, MSN, MBA, CNA
Executive Director and Administrator