Memorandum

Date JUN 4 1996

From June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by American Health Care Services (A-04-95-01104)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, *Review of Costs Claimed by American Health Care Services*. The objective of our review was to determine whether the home health care services claimed by American Health Care Services (American) in Miami Lakes, Florida, met Medicare reimbursement guidelines.

We randomly selected for review 100 claims submitted by American for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,445 home health services. Our review showed that 24 claims or 24 percent of our sample contained 346 services (24 percent of the total services) that did not meet Medicare guidelines, as follows:

- 11 percent of the claims were for 145 services which, in the opinion of medical experts, were not reasonable or necessary;
- 4 percent of the claims were for 24 services not provided; and
- 9 percent of the claims were for 177 services which physicians either denied authorizing, or authorized improperly.

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

During the FY ended December 31, 1993, American claimed $8.5 million in 9,391 claims representing 126,386 services. Based on our review, we estimate that at least $1.2 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between $1.2 million and $2.9 million.

Although we found documentation that American monitored its own employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as American, responsible for the actions of their subcontractors.

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

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

We would appreciate your views and the status of any further action taken or contemplated on our recommendations within the next 60 days. If you have any questions, please call me or have your staff contact George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104. Copies of this report are being sent to other interested Department officials.

To facilitate identification, please refer to Common Identification Number A-04-95-01104.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF COSTS CLAIMED BY AMERICAN HEALTH CARE SERVICES

JUNE GIBBS BROWN
Inspector General

MAY 1996
A-04-95-01104

Memorandum

Date JUN 4 1996

From June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by American Health Care Services (A-04-95-01104)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of American Health Care Services (American) in Miami Lakes, Florida.

OBJECTIVE

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

SUMMARY OF FINDINGS

We randomly selected for review 100 claims submitted by American for Medicare reimbursement during the fiscal year (FY) ended December 31, 1993. These claims represent 1,445 home health services. Our review showed that 24 claims or 24 percent of our sample contained 346 services (24 percent of the total services) that did not meet Medicare guidelines, as follows:

- 11 percent of the claims were for 145 services which, in the opinion of medical experts, were not reasonable or necessary;
- 4 percent of the claims were for 24 services not provided; and
- 9 percent of the claims were for 177 services which physicians either denied authorizing, or authorized improperly.

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

During the FY ended December 31, 1993, American claimed $8.5 million in 9,391 claims representing 126,386 services. Based on our review, we estimate that at least $1.2 million did not meet the reimbursement guidelines and using the 90 percent confidence interval, we believe the overpayment is between $1.2 million and $2.9 million.

Although we found documentation that American monitored its own employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines. Nevertheless, the guidelines make contractors, such as American, responsible for the actions of their subcontractors.

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

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

BACKGROUND

American Health Care Services

American is a Medicare certified home health agency (HHA) with a principal place of business in Miami Lakes, Florida. American is a proprietary Florida corporation that directly and indirectly employs nurses, aides, therapists, and administrative personnel in Dade County.

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

During FY 1993, American was reimbursed under the periodic interim payment (PIP) method. Payments under PIP approximate the cost of covered services rendered by the provider. Interim reimbursement from Medicare totaled $8.4 million. Interim payments are adjusted to actual costs based on annual cost reports. American submitted a cost report for FY 1993 claiming costs totaling $8.5 million.

Authority and Requirements for Home Health Services

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

Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist them in administering the home health benefits program. The FI for American is AEtna in Clearwater, Florida. The FI is responsible for:

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

SCOPE

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

American claimed 126,386 services on 9,391 claims for FY 1993. We reviewed a statistical sample of 100 claims totaling 1,445 services for 99 different individuals (1 individual appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims were submitted by American during the period January 1, 1993 through December 31, 1993. Appendix A contains the details on our sampling methodology. Appendix C contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by American met the reimbursement guidelines.

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

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

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

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

We interviewed 74 of the 99 beneficiaries. We were unable to interview 25 of the beneficiaries or a close acquaintance because they were either deceased or had moved out of the area. We were not able to interview two physicians because they had moved out of the area.

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

We did not conduct a review of American's internal controls. Specifically, we did not review quality control work performed by American to monitor services provided either by their own staff or subcontractors, because American's legal counsel advised them not to discuss internal controls with us until legal counsel reviewed the questions we intended to ask. We provided legal counsel with a copy of the questions, but they did not respond to us.

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

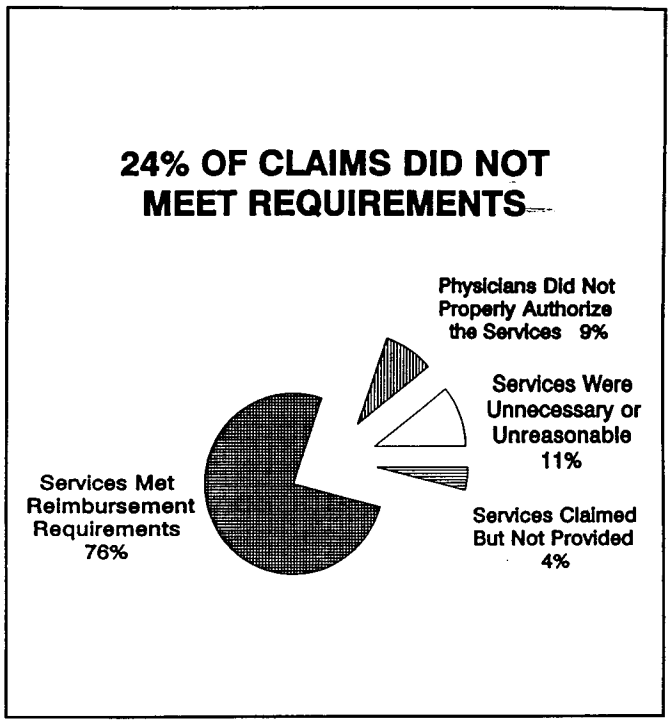
DETAILED RESULTS OF REVIEW

Our audit showed that 24 percent of the claims submitted by American during FY 1993 did not meet the Medicare reimbursement requirements.

Based on a statistical sample, we estimate that American received overpayments totaling at least $1.2 million and using the 90 percent confidence interval, we believe the overpayment is between $1.2 million and $2.9 million. Although we found documentation that American monitored its employees and subcontractors, it did not follow its own policies and procedures to ensure that claims submitted were for services that met Medicare reimbursement guidelines.

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

Criteria for Services Provided by Subcontractors



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

Services That Were Not Reasonable or Necessary

Our review showed that 11 of the 100 claims were for 145 services which were not considered reasonable or necessary by the intermediary's medical review personnel.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "...in need of intermittent skilled nursing care or physical or speech therapy...." Section 203.1 of the Medicare HHA Manual states that the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary.

The Aetna medical review personnel reviewed the records for the 11 beneficiaries and concluded that the medical records did not support the reasonableness or necessity of the services.

Services Claimed but Not Provided

Our review showed that 4 of the 100 claims were for 24 services that were not provided. In three of the four cases, the medical records maintained by American contained the required documentation including nurses notes and signatures of the beneficiaries

indicating that the services provided were less than those claimed. In the fourth case, the beneficiary indicated that she had not received any services, and the review performed by the intermediary's medical personnel of the documentation maintained by American indicated that the services were not reasonable or necessary.

During the initial interview of the beneficiary, she told us that she had not received the services on the dates that were on the sampled claim. A review of the medical records indicated that the beneficiary had signed for the services. We reinterviewed the beneficiary and showed her the signatures on the visit logs. She indicated that the signatures were hers; however, she insisted that she had not received the services.

Physicians Did Not Properly Authorize the Services

Our review showed that 9 of the 100 claims were for 177 services not properly authorized by a physician. One of the claims was for services where the physician said his signature was forged. We interviewed the physician who purportedly signed the plan of care for the claim. The physician advised us that he did not sign the plan of care. In another case, the physician stated that he had not ordered home health services for the period under review. The physician recognized the beneficiary as his patient, but stated that she was not homebound. In another case, the provider rendered and claimed one service in excess of the services authorized by the physician in the plan of care. The other six claims were for services where the physicians did not sign the plan of care until after the bill was submitted to the intermediary for payment.

The laws, regulations and guidelines recognize that the physician plays an important role in determining the utilization of services. The legislation specifies that payment for services may be made only if a physician certifies the services were required because the individual was homebound and needed skilled nursing care. The regulations (42 CFR 424.22) state that Medicare pays only if a physician certifies the services were needed. In addition, the regulations at 42 CFR 424.22 require all care to follow a physician's plan of care. The Medicare HHA Manual states that the patient must be under the care of a physician who is qualified to sign the certification and the plan of care, and that the plan of care must be signed by the physician before the bill is submitted to the intermediary for payment.

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

Effect

Our audit showed that 24 percent of the FY 1993 claims submitted by American were overstated. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval is $1,248,747 to $2,854,140 with a midpoint of

$2,051,443. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that American was overpaid by at least $1,248,747 for unallowed home health services.

American Did Not Properly Monitor Subcontractors

American had procedures for monitoring subcontractors to ensure that beneficiaries met the homebound and medical necessity criteria to receive HHA services. However, these procedures failed to disclose the problems that we found.

The HHA coverage guidelines issued by HCFA, provide that the HHA has essentially the same responsibilities for services provided by subcontractors as for services provided by their salaried employees. During reviews of the beneficiaries' medical records maintained by the HHA, we found documentation that showed American did monitor subcontractors. However, in one instance the documentation showed that the beneficiary was discharged because the services were not reasonable or necessary, yet no action was taken to determine why the services were continued. In another instance, the services were provided without a plan of care signed by a physician, and in several other instances the physician's signature was not obtained until after the claims had been submitted to the FI for payment. We also found several instances where the services claimed were more than those actually provided, and the monitoring visits did not explain the discrepancies.

RECOMMENDATIONS

We recommend that HCFA:

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

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

APPENDICES

AUDIT OF AMERICAN HEALTH CARE SERVICES
SAMPLING METHODOLOGY

OBJECTIVE:

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

POPULATION:

The universe consisted of 9,391 HHA claims representing $8,394,704 in benefits paid by the FI to American during the FY ended December 31, 1993.

SAMPLING UNIT:

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

SAMPLING DESIGN:

A simple random sample was used.

SAMPLE SIZE:

A sample of 100 claims.

ESTIMATION METHODOLOGY:

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

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

APPENDIX B

AUDIT OF AMERICAN HEALTH CARE SERVICES
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 9,391 claims to project the occurrence of certain types of errors. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

Claims That Did Not Meet the Requirements

Quantity Identified in the Sample	24
Point Estimate	24.0%
Lower Limit	17.2%
Upper Limit	32.0%

Services Claimed but Not Provided

Quantity Identified in the Sample	4
Point Estimate	4.0%
Lower Limit	1.4%
Upper Limit	8.9%

Services That Were Not Properly Authorized by Physicians

Quantity Identified in the Sample	9
Point Estimate	9.0%
Lower Limit	4.8%
Upper Limit	15.2%

Services That Were Not Reasonable or Not Necessary

Quantity Identified in the Sample	11
Point Estimate	11.0%
Lower Limit	6.3%
Upper Limit	17.5%

APPENDIX C

AUDIT OF AMERICAN HEALTH CARE SERVICES
VARIABLES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 9,391 claims to project the value of claims that did not meet the requirements. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

Claims That Did Not Meet the Requirements

Identified in the sample	
Number of Claims	24
Value	$ 21,845
Point Estimate	$2,051,443
Lower Limit	$1,248,747
Upper Limit	$2,854,140

APPENDIX D

MAJOR CONTRIBUTORS TO THIS REPORT

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DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE APR 11 1996

TO: June Gibbs Brown
Inspector General

FROM: Bruce C. Vladeck
Administrator

SUBJECT: Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by American Health Care Services," (A-04-95-01104)

We have reviewed the above report concerning improper claims submitted by American Health Care Services for home health care visits that did not meet Medicare reimbursement guidelines.

Our detailed comments on the report findings and recommendations are attached for your consideration. Thank you for the opportunity to review and comment on this report.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General (OIG) Draft Report: "Review of Costs Claimed by American Health Care Services," (A-04-95-01104)

OIG Recommendation

HCFA should require Fiscal Intermediaries (FI's) to instruct American Health Care Services (AMHCS) on its responsibilities to properly monitor its subcontractor for compliance with Medicare regulations and HCFA guidelines.

HCFA Response

We concur. HCFA will instruct the FI to conduct focused medical review on future claims from AMHCS and ask the Medicare survey and certification agency to review the subcontracting arrangements.

OIG Recommendation

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

HCFA Response

We concur. HCFA will monitor the FI's compliance with our instructions to review AMHCS.

OIG Recommendation

HCFA should recover all overpayments.

HCFA Response

We concur. We will take the appropriate actions necessary to recover from AMHCS those payments made for home health visits failing to meet Medicare reimbursement guidelines. If the OIG, Office of Investigations, collects sufficient evidence, we will support the imposition of Civil Monetary Penalties.

OIG Recommendation

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

HCFA Response

We concur. This procedure is already outlined in our contractor manual and is being followed by our FI.