DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Office of Audit Services
Region IX
50 United Nations Plaza, Room 171
San Francisco, CA 94102

July 8, 2005

Report Number: A-09-04-00050

Ms. Inga Tamazova
Administrative Director
Red Oak Home Health Services
4855 Santa Monica Boulevard, Suite 114
Los Angeles, California 90029

Dear Ms. Tamazova:

Enclosed are two copies of the Department of Health and Human Services, Office of Inspector General final report entitled "Review of Selected Paid Claims With Therapy Services Submitted to Medicare by Red Oak Home Health Services for the Period October 1, 2002, Through September 30, 2003." A copy of this report will be forwarded to the HHS action official noted below for review and any action deemed necessary.

The HHS action official will make final determination as to actions taken on all matters reported. 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.

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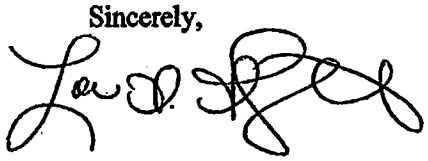
Please refer to report number A-09-04-00050 in all correspondence.

Sincerely,



Lori A. Ahlstrand
Regional Inspector General
for Audit Services

2 Enclosures

Direct Reply to HHS Action Official:

Mr. Jeff Flick
Regional Administrator
Centers for Medicare & Medicaid Services, Region IX
Department of Health and Human Services
75 Hawthorne Street, Fourth Floor
San Francisco, California 94105

Department of Health and Human Services

OFFICE OF
INSPECTOR GENERAL

REVIEW OF SELECTED PAID CLAIMS WITH THERAPY SERVICES SUBMITTED TO MEDICARE BY RED OAK HOME HEALTH SERVICES FOR THE PERIOD OCTOBER 1, 2002, THROUGH SEPTEMBER 30, 2003

Daniel R. Levinson
Inspector General

JULY 2005
A-09-04-00050

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

The designation of financial or management practices as questionable or a recommendation for the disallowance of costs incurred or claimed, as well as other conclusions and recommendations in this report, represent the findings and opinions of the HHS/OIG/OAS. Authorized officials of the HHS divisions will make final determination on these matters.

EXECUTIVE SUMMARY

BACKGROUND

A home health agency (HHA) provides home visits for skilled nursing care; occupational, physical and speech therapy; and home health aide and medical social services.

Under the home health prospective payment system (PPS), Medicare pays for home health services based on a national standardized 60-day service period called an episode. The payment is based upon the beneficiary's health condition and level of care needed during the episode. To establish a level of care, including the expected therapy needs (i.e., physical, speech, or occupational), HHAs use an Outcome and Assessment Information Set (OASIS) instrument. The OASIS instrument is used to determine the appropriate Medicare reimbursement amount.

One item on the OASIS instrument indicates the need for home health therapies totaling 10 or more visits during the episode. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. When the 10-visit threshold is met, the HHA receives a payment increase of about $2,500 more than what the HHA would have received for a similar claim with 9 or fewer therapy visits. To qualify for Medicare reimbursement, therapy services must be medically necessary, properly documented, and properly authorized by a physician.

Red Oak Home Health Services (Red Oak) is an HHA in Los Angeles, CA. With the assistance of medical professionals, we reviewed selected claims submitted by Red Oak and paid by Medicare. The claims selected for review included home health episodes with 10, 11, or 12 therapy visits with dates of service from October 1, 2002, through September 30, 2003. For that period, there were 74 claims billed by Red Oak with 10, 11, or 12 therapy visits and paid by Medicare at the higher rate, totaling $401,154.

OBJECTIVE

Our objective was to determine whether selected home health claims that included therapy services provided by Red Oak to Medicare beneficiaries met Federal requirements and were appropriately paid.

SUMMARY OF FINDINGS

During the period October 1, 2002, through September 30, 2003, 65 of the 74 selected paid claims submitted by Red Oak for home health episodes with therapy services did not meet the Federal requirements and were not appropriately paid:

- 64 claims included therapy services, and in some cases skilled nursing services, that were not reasonable or medically necessary; and

- 1 claim included therapy and skilled nursing services that were not properly authorized by a physician.

As a result, Red Oak was overpaid $187,627 by Medicare for the 65 claims. We based our conclusions on a medical review of Red Oak's medical record documentation performed by United Government Services, the Medicare fiscal intermediary. The overpayments occurred because Red Oak did not have effective quality assurance procedures to ensure that all therapy services provided were reasonable and medically necessary for the beneficiaries' conditions and properly authorized by a physician.

RECOMMENDATIONS

We recommend that Red Oak:

- refund to the Medicare program $187,627 for unallowable therapy and skilled nursing services identified by the medical reviewers;

- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and

- establish quality assurance procedures, including periodic independent review, to confirm that (1) patient needs during the home health episode of care are properly reassessed and (2) the level of care is adjusted accordingly to meet the requirement for medical necessity and is properly authorized by a physician.

RED OAK'S COMMENTS

In its comments on the draft report, Red Oak agreed with our finding that one claim included therapy and skilled nursing services that were not properly authorized by a physician and agreed with the recommendation for a refund of $4,856. Red Oak also agreed with our recommendation to establish quality assurance procedures, stating that, subsequent to our audit, it developed several procedural safeguards to ensure quality patient care, including extensive orientation of skilled personnel and regular update training in home health legal requirements. In addition, Red Oak stated that, before a claim is submitted for final payment, the Quality Assurance Division of Red Oak's Medical Records Section performs a complete chart review, including a review of therapy documentation, and the Clinical Supervisor certifies the appropriateness of the claim.

For the remaining claims, Red Oak disagreed with the medical reviewers' determination that the claims included therapy services, and in some cases skilled nursing services, that were not reasonable or medically necessary. Red Oak believed that its documentation adequately addressed the medical necessity and reasonableness of the services provided. Consequently, Red Oak disagreed with the recommendation for a refund of $182,771.

We included the full text of Red Oak's comments as an appendix to this report. Where appropriate, we made changes to the report to reflect Red Oak's comments. We excluded the appendixes to Red Oak's comments because they included excerpts from the Home Health Agency Manual cited in the comments.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We based our conclusions on a medical review of Red Oak's medical record documentation performed by United Government Services, the fiscal intermediary responsible for processing and paying home health agency claims on behalf of the Centers for Medicare & Medicaid Services. After receiving Red Oak's comments on our draft report, we asked United Government Services medical reviewers to reconsider their conclusions. After evaluating additional information provided by Red Oak in its comments, the medical reviewers reversed their original determination that one claim included $2,382 for therapy services that were not supported by documentation. For the remaining claims, the medical reviewers stated that Red Oak's comments did not provide additional support to warrant reversing their original determinations. Accordingly, we revised the report to allow the $2,382 claimed and reduced the recommended refund from the $190,009 included in the draft report to $187,627.

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INTRODUCTION

BACKGROUND

Home Health Agency

A home health agency (HHA) provides home visits for skilled nursing care; occupational, physical and speech therapy; and home health aide and medical social services.

Home Health Legislation

The Centers for Medicare & Medicaid Services (CMS) was required to implement a prospective payment system (PPS) for Medicare HHA services pursuant to the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000. Accordingly, CMS implemented a PPS for HHAs effective October 1, 2000.

Home Health Prospective Payment System

The home health PPS classifies home health services into 80 mutually exclusive groups called home health resource groups. Each home health resource group is assigned a five-character Health Insurance PPS code (payment code), which represents the beneficiary's needs over a 60-day service period, called an episode.

CMS established a split percentage billing system for each 60-day episode. Under this system, an HHA receives a partial episode payment as soon as it notifies Medicare of an admission and a final percentage payment at the close of the 60-day episode. The HHA's final payment may increase or decrease in response to a difference between the projected services (e.g., therapy) at the start of care and the services received by the patient by the end of the 60-day episode.

The Outcome and Assessment Information Set (OASIS) instrument, which includes a group of standardized data elements, is used to assess the level of care needed by each home health patient. The OASIS instrument is, in large part, the basis for determining which home health resource group a particular claim falls into and, as a result, the amount of the payment made for the services provided. Data elements on the OASIS instrument are organized into three categories: clinical severity, functional status, and service utilization. One item in the service utilization category indicates the need for home health therapies totaling 10 or more visits during the episode. A patient's "scores" for the three categories are totaled, and a home health resource group is assigned.

HHAs submit claims for reimbursement using the designated Medicare payment codes. These codes determine the reimbursement amount. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. Episodes with fewer than 10 therapy visits are referred to as below the therapy threshold. When the 10-visit threshold is met, the

HHA receives a payment increase of about $2,500 more than what the HHA would have received for a similar claim with 9 or fewer therapy visits.

Regional Home Health Intermediary Responsibility

CMS contracts with four regional home health intermediaries nationwide to process claims, assist in applying safeguards against unnecessary utilization of services, resolve disputes, and audit cost reports submitted by HHAs.

Red Oak

Red Oak Home Health Services (Red Oak), located in Los Angeles, CA, was incorporated in the State of California as an HHA on June 20, 2002. The Medicare fiscal intermediary for Red Oak is United Government Services.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

Our objective was to determine whether selected home health claims that included therapy services provided by Red Oak to Medicare beneficiaries met Federal requirements and were appropriately paid.

Scope

We reviewed United Government Services' Medicare final payments to Red Oak for home health claims that included therapy visits with dates of service from October 1, 2002, through September 30, 2003. For that period, Red Oak submitted 126 home health claims that included 1 or more therapy visits provided to beneficiaries and paid by Medicare. Based on a risk analysis, we limited our review to claims that included 10, 11, or 12 therapy visits. Of the 126 paid claims, 85 claims included 10, 11, or 12 therapy visits, which totaled $432,472. Of those claims, 11 were excluded from review because the claims were either (1) originally paid at lower service utilization amounts (i.e., as if there were fewer than 10 therapy visits) or (2) adjusted to lower service utilization amounts based on prior medical reviews performed by United Government Services. As a result, we reviewed 74 Medicare paid claims with 10, 11, or 12 therapy visits, which totaled $401,154.

We limited our review of internal controls at Red Oak to those controls over the preparation and submission of Medicare HHA claims. Our objective did not require us to review the complete internal control structure at Red Oak. We conducted audit work from July through November 2004, which included visits to Red Oak's office in Los Angeles, CA.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

- identified Red Oak's home health PPS paid claims from the Medicare National Claims History File with dates of service from October 1, 2002, through September 30, 2003, that included episodes with at least one therapy service;

- selected for review paid claims submitted by Red Oak to Medicare for home health episodes with 10, 11, or 12 therapy services during the period October 1, 2002, through September 30, 2003;

- obtained Red Oak's medical records for each claim selected and provided those records to United Government Services for medical review;

- obtained medical review data, which included a determination by medical reviewers of reasonableness, medical necessity, adequate support, and proper authorization of services billed, and summarized the results of the medical review;

- reviewed Red Oak's policies and procedures for providing therapy services and billing Medicare for home health episodes with therapy services;

- interviewed Red Oak's physical therapist and reviewed documentation supporting the therapist's time with selected patients;

- determined, with the assistance of medical reviewers, what the appropriate payment code and amount would have been for claims with unallowable services; and

- quantified the Medicare overpayment for identified unallowable services billed by Red Oak.

We performed our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

During the period October 1, 2002, through September 30, 2003, 65 of the 74 selected paid claims submitted by Red Oak for home health episodes with therapy services did not meet the Federal requirements and were not appropriately paid:

- 64 claims included therapy services, and in some cases skilled nursing services, that were not reasonable or medically necessary; and

- 1 claim included therapy and skilled nursing services that were not properly authorized by a physician.

As a result, Red Oak was overpaid $187,627 by Medicare for the 65 claims. These overpayments occurred because Red Oak did not have effective quality assurance procedures to ensure that all therapy services provided were reasonable and medically necessary for the beneficiaries' conditions and properly authorized by a physician.

SERVICES NOT REASONABLE OR MEDICALLY NECESSARY

Section 1156(a)(1) of the Social Security Act requires all Medicare providers to limit claims only to those that are medically necessary.

Section 205.2 of the HHA Manual states, "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." In addition, "...the amount, frequency and duration of the services must be reasonable."

Based on a review of medical records for selected home health claims, the United Government Services medical reviewers determined that a significant number of therapy and skilled nursing services claimed by Red Oak were not reasonable or medically necessary for the beneficiaries' conditions. As a result, Red Oak was overpaid $182,771 by Medicare for the 64 claims.

Therapy Services

The medical reviewers determined that 64 claims for home health episodes included therapy services that were not reasonable or medically necessary for the documented medical conditions of the beneficiaries.

For example, for 1 of the 64 claims, Red Oak billed 10 physical therapy services with the payment code HCGL1. However, the medical records indicated the need for only 6 physical therapy services to establish a home exercise program. Consequently, the medical reviewer denied 4 therapy services and changed the claim's payment code to HCGJ1, representing a lower service utilization. The lower service utilization level for that claim reduced the allowable Medicare reimbursement to Red Oak by $2,382.

For another claim, Red Oak billed 2 occupational therapy services and 10 physical therapy services with the payment code HCGL1. However, the medical records did not indicate the need for physical therapy. Consequently, the medical reviewer denied the 10 physical therapy services and changed the claim's payment code to HCGJ1, which reduced the allowable Medicare reimbursement to Red Oak by $2,382.

By billing therapy services that the medical reviewers determined to be not reasonable or medically necessary, Red Oak was overpaid $150,057 by Medicare for the 64 claims.

Skilled Nursing Services

Of the 64 claims, the medical reviewers determined that 14 claims included not only therapy services but also skilled nursing visits they considered not reasonable or medically necessary.

Of the 14 claims, the medical reviewers did not allow 6 claims in total because all of the therapy services and skilled nursing services were not reasonable or necessary for the documented medical conditions of the beneficiaries. The medical reviewers determined that the remaining 8 claims, in addition to the excessive therapy, included excessive skilled nursing services, which they considered not reasonable or medically necessary. Consequently, the medical reviewers adjusted the payment amounts for these claims to reflect the appropriate level of care.

By billing skilled nursing services that the medical reviewers determined to be not reasonable or medically necessary, Red Oak was overpaid $32,714 by Medicare for the 14 claims.

SERVICES NOT PROPERLY AUTHORIZED

Federal regulations (42 CFR § 424.22(a)(2)) state, "The certification of need for home health services must be obtained at the time the plan of treatment is established or as soon thereafter as possible and must be signed by the physician who establishes the plan." In addition, § 424.22(b)(1) states, "Recertification is required at least every 60 days, preferably at the time the plan is reviewed, and must be signed by the physician who reviews the plan of care."

Also, 42 CFR § 409.43(c)(3) states, "The plan of care must be signed and dated (i) By a physician as described who meets the certification and recertification requirements...and (ii) Before the claim for each episode for services is submitted for the final percentage prospective payment."

One claim for a home health episode, which included therapy services, did not have a proper physician authorization. A physician signed and dated the plan of care after the services were performed and after the HHA submitted the claim for final payment. As a result, the medical reviewer determined that the entire claim was unallowable and denied the $4,856 paid by Medicare: $2,382 for therapy services and $2,474 for skilled nursing services.

LACK OF EFFECTIVE PROCEDURES

The overpayments for the 65 claims occurred because Red Oak did not have effective quality assurance procedures to ensure that all therapy services provided were reasonable and medically necessary for the beneficiaries' conditions and properly authorized by a physician.

RECOMMENDATIONS

We recommend that Red Oak:

- refund to the Medicare program $187,627 for unallowable therapy and skilled nursing services identified by the medical reviewers;

- identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period; and

- establish quality assurance procedures, including periodic independent review, to confirm that (1) patient needs during the home health episode of care are properly reassessed and (2) the level of care is adjusted accordingly to meet the requirement for medical necessity and is properly authorized by a physician.

RED OAK'S COMMENTS

In its comments on the draft report, Red Oak agreed with our finding that one claim included therapy and skilled nursing services that were not properly authorized by a physician and agreed with the recommendation for a refund of $4,856. Red Oak also agreed with our recommendation to establish quality assurance procedures, stating that, subsequent to our audit, it developed several procedural safeguards to ensure quality patient care, including extensive orientation of skilled personnel and regular update training in home health legal requirements. In addition, Red Oak stated that, before a claim is submitted for final payment, the Quality Assurance Division of Red Oak's Medical Records Section performs a complete chart review, including a review of therapy documentation, and the Clinical Supervisor certifies the appropriateness of the claim.

For the remaining claims, Red Oak disagreed with the medical reviewers' determination that the claims included therapy services, and in some cases skilled nursing services, that were not reasonable or medically necessary. Red Oak believed that its documentation adequately addressed the medical necessity and reasonableness of the services provided. Consequently, Red Oak disagreed with the recommendation for a refund of $182,771.

We included the full text of Red Oak's comments as an appendix to this report. Where appropriate, we made changes to the report to reflect Red Oak's comments. We excluded the appendixes to Red Oak's comments because they included excerpts from the Home Health Agency Manual cited in the comments.

OFFICE OF INSPECTOR GENERAL'S RESPONSE

We based our conclusions on a medical review of Red Oak's medical record documentation performed by United Government Services, the fiscal intermediary responsible for processing and paying home health agency claims on behalf of the Centers for Medicare & Medicaid Services. After receiving Red Oak's comments on our draft report, we asked United Government Services medical reviewers to reconsider their conclusions. After evaluating additional information provided by Red Oak in its comments, the medical reviewers reversed their original determination that one claim included $2,382 for therapy services that were not supported by documentation. For the remaining claims, the medical reviewers stated that Red Oak's comments did not provide additional support to warrant reversing their original determinations. Accordingly, we revised the report to allow the $2,382 claimed and reduced the recommended refund from the $190,009 included in the draft report to $187,627.

APPENDIX

Red Oak
Home Health Services

May 17, 2005

Ms. LORI A. AHLSTRAND
Regional Inspector General
for Audit Services
1055 Corporate Center Drive,
Suite 110, Monterey Park, CA 91754

RE : Report # A-09-04-00050

Dear Ms. Ahlstrand,

Further to our telephone conversation, attached, pleased find a summarized statement, in response to the preliminary findings of your review conducted on selected paid claims with therapy services provided by Red Oak Home Health Services covering the fiscal year October 1, 2002 to September 30, 2003.

A separate detailed explanation of Red Oak Home Health Services' response had been previously forwarded to your offices, which contained patient information. The purpose of this was to ensure that the sample numbers indicated in your findings matched the specific patient to which the findings alluded to.

We are cognizant that our response will be included in your final report and will be made public on your website. We will endeavor to keep our statements brief and concise, however, it will indicate the specific reasons for either concurring or not with your findings.

We hope that, in the final analysis, you will be in agreement with our response. Thank you for your usual judicious action. We remain

Respectfully yours,

Ms. INGA TAMAZOVA
Administrator

ARMEN ADAMYAN, DPCS
Director
Patient Care and Services

4855 Santa Monica Blvd., Suite 114, Los Angeles, CA 90029 • phone (323) 906-9090 • fax (323) 906-9696

May 17, 2005
Report Number A-09-04-00050

The draft findings conducted by the Office of Audit Services on 74 reviewed claims were divided into four (4) main groups:

a) Therapy threshold was met and no adjustments were made on the claims.
b) Services were not properly authorized by the Primary Physician.
c) Services were not documented.
d) Services were not reasonable and medically necessary – this was further subdivided into:
    i. Claims that were denied in total, and
    ii. Claims that were adjusted/ downcoded

We shall tackle each group separately.

THERAPY THRESHOLD MET – NO ADJUSTMENT

Red Oak Home Health Services, Inc. concurs with Medical Reviewer's findings.

SERVICES NOT PROPERLY AUTHORIZED

Medical Reviewer disallowed entire claim payment, as POC was untimely signed by MD. Red Oak Home Health Services, Inc. concurs with the statement, in that POC was unfortunately not timely signed. The amount of USD 4,855.85 billed will be refunded.

SERVICES NOT DOCUMENTED

Medical Reviewer denied the claim as there were no supporting documents filed. The documents were inadvertently missed during the photocopying process. This episode had been previously requested for an Additional Developmental Request (ADR) and was sent to the Fiscal Intermediary (United Government Services) on July 18, 2003. Red Oak Home Health Services has included the missing notes for additional review.

SERVICES NOT REASONABLE AND NECESSARY
Claims denied in total

Medical Reviewer denied entire claims for six (6) patients, as not reasonable and necessary. Red Oak Home Health does not concur with M.R. findings, because as per submitted documentation, we believe that we had adequately addressed the medical necessity and reasonableness of the services provided.

The Home Health Agency Manual (HIM 11) under Section 205 establishes the coverage of services for Skilled Nursing Care (205.1), outlining the General Principles Governing Reasonable and Necessary Skilled Nursing Care (205.1A), which states that the determination of whether patient needs skilled nursing care is based solely upon patient's unique condition and individual needs, without regard to whether the illness or injury is acute, chronic, terminal or continue to be necessary for patients whose condition is stable. Likewise, HIM 11 also establishes coverage for Skilled Therapy Services (205.2A) and the General Principles

Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology and Occupational Therapy. Under Section 205.2B Application of principles to P.T. services, therapeutic exercises performed by or under P.T supervision to ensure safety of patient, and effectiveness of the treatment, and that patient is expected to materially improve, are considered reasonable and necessary. For purposes of information, this portion of the manual is hereby attached, and highlighted for reference. (APPENDIX A)

Claims Adjusted/ Downcoded

A total of 58 claims were adjusted/ downcoded by Medical Review, generally for services that were considered not reasonable and necessary. A detailed explanation on Red Oak Home Health Agency's non-concurrence by claim has already been forwarded to your good office. We would just like to point out some inconsistencies that were noted when the claims were reviewed by the Medical Reviewers.

a) One claim was reduced to LUPA when M.R. denied all PT, OTR visits and SN visits as not reasonable and necessary. Claims were subsequently reduced to LUPA. Beneficiary was legally blind since age 16, lived alone in a senior complex, and her sister lived next door. Physical Therapy had documented patient to be highly functional. However, being highly functional in the Physical Therapy sense, i.e., no limitation of motion, able to gait/ transfer independently, should not be confused with patient's ability to perform them safely. Due to patient's blindness, Occupational Therapy was required to instruct the patient on how to perform ADLs safely, simplify ADLs, such as keeping clothings within reach; putting on lower body clothing; getting in and out of shower safely, etc., (HIM 11 Sec. 205.2D 2-D – Application of General Principles to Occupational Therapy – Teaching compensatory techniques to improve the level of independence in the activities of daily living. – (APPENDIX B)
b) One claim was downcoded by M.R. when it alleged beneficiary was functional by the 6th visit. However, P.T. notes documented that beneficiary was able to safely move around the house only on the 9th visit, and was also utilizing other modalities (ultrasound), which is considered skilled therapy. SN was necessary to assess patient's co-morbid conditions of DM, and HTN; and had several care coordination with Primary Physician on patient's clinical status.
c) On one claim M.R. denied all SN visits as not reasonable and necessary. In the same breath, a subsequent episode, all SN visits were included for the same beneficiary. SN continued with instructions from the previous episode; the only difference was that in prior episode, SN notes were handwritten, whereas in the subsequent episode, SN shifted to computerized charting.

Clearly, as had been shown in the above samples, Medical Review had arbitrarily and unfairly denied skilled visits, both nursing and therapy, as not reasonable and necessary, contrary to documentations provided. Red Oak Home Health Services strongly believes that all claims were properly submitted. While documentation may not have been of the highest standards, we believe, nonetheless, they have established the propriety of the claim. We therefore hope that after a due diligence

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review, the appropriate revisions will be made to the draft in favor of Red Oak Home Health Services.

RESPONSE TO RECOMMENDATIONS

a) Refund to the Medicare program $190,009 for unallowable therapy and skilled nursing services identified by the medical reviewers.
Red Oak Home Health does not concur with this recommendation for the reasons stated above, and has specifically detailed the reasons on a per claim basis in a previously submitted response.

b) Identify and submit adjusted home health claims for Medicare overpayments received subsequent to our audit period.
Red Oak Home Health acknowledges that one claim was not properly authorized as MD signature on POC was untimely. The amount of USD 4,855.85 billed will be refunded.

c) Establish quality assurance procedures, including periodic independent review, to confirm that the patient's needs during the home health episode of care are properly reassessed and the level of care is adjusted accordingly to meet the requirement for medical necessity.
Red Oak Home Health has developed, subsequent to the audit process, several procedural safeguards to ensure quality patient care, including extensive orientation of skilled personnel and regular update training in home health legal requirements. Ongoing education for clinicians in various aspects are provided, ranging from the basics of home health to complex patient care issues and outcome-based quality initiatives. All OASIS and plans of care are carefully reviewed by supervisory clinicians for accuracy prior to submission to the physicians for signing, case conferences among disciplines involved in patient care are mandatory, and supervisory visits have been strengthened to ensure compliance and adequacy of the plan of care.

d) Strengthen billing controls to ensure that prior to submitting a claim for final payment all therapy services provided were reasonable and medically necessary, supported by medical record documentation, and properly authorized by a physician.
At Red Oak Home Health Services, prior to submission of final claims, a complete chart review is done by the Quality Assurance division of the Medical Records Section; therapy documentations are reviewed for specificity of services provided, as per Physician-authorized Therapy Plan of Care, and the Clinical Supervisor initials a certification as to the appropriateness of the claims. Retrospectively, quarterly utilization reviews analyze adequacy of skilled services provided and corrective measures adopted for prospective implementation.

ACKNOWLEDGMENTS

This report was prepared under the direction of Lori A. Ahlstrand, Regional Inspector General for Audit Services. Other principal Office of Audit Services staff who contributed include:

Jerry McGee, *Audit Manager*
Danuta Biernat, *Senior Auditor*
Bernard Urabe, *Auditor-in-Charge*

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