DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

FEB 24 2004

TO: Dennis G. Smith
Acting Administrator
Centers for Medicare & Medicaid Services

FROM: Dara Corrigan
Acting Principal Deputy Inspector General

SUBJECT: Review of Payments Made by United Government Services for Home Health Services Preceded by a Hospital Discharge (A-09-03-00042)

We are alerting you to the issuance of the subject report within 5 business days from the date of this memorandum. A copy of the report is attached.

The objective of the audit was to determine whether home health agencies (HHA) properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001 (fiscal year 2001).

Home health intermediaries process claims and conduct audits of cost reports submitted by HHAs. United Government Services, one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by HHAs in 12 States.

We identified 18,134 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 200 of these claims, we identified overpayments to HHAs totaling $55,762. The claims should have been paid at a lower rate, but were not primarily because HHAs did not accurately complete the required Outcome and Assessment Information Set (OASIS) for these beneficiaries.

Under the prospective payment system for home health services in effect since 2000, each HHA must, as a condition of participation in Medicare, provide every patient a comprehensive assessment of his or her health status. This assessment must incorporate OASIS data (42 CFR § 484.55). Information reported on OASIS is used to compute a payment group, which in turn, determines the amount of Medicare reimbursement.

One data element required by OASIS is whether a beneficiary has been discharged from an acute care inpatient facility within the last 14 days. The Centers for Medicare & Medicaid Services (CMS) ascertained that an acute care hospital discharge (without followup postacute inpatient stay) within the 14 days immediately preceding admission to home care is associated with the lowest costs during the 60-day episode. Accordingly, CMS designed the Home Health Resource Groups to provide for a lower payment for HHA services rendered to beneficiaries discharged from an acute care hospital within the 14 days immediately preceding admission to home health care.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, United Government Services did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that United Government Services made approximately $5.3 million in overpayments for 18,134 claims.

We recommended that United Government Services:

- recover the $55,762 in overpayments for the claims in the sample,

- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $5,306,825),

- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and

- provide education to HHAs to ensure that beneficiary discharge data is completed accurately on the patient assessment instruments.

In a letter dated July 22, 2003, United Government Services generally concurred with our findings and recommendations. Details of United Government Services's comments are discussed after the Recommendations section of this report and included in their entirety in Appendix C.

Since submission of United Government Services's comments, CMS published a transmittal specifically to address the home health "payment vulnerability that [the] OIG has identified" in recent reports (Transmittal 13 (Publication 100-04 – Medicare Claims Processing), Change Request 2928, dated October 24, 2003). The transmittal sets forth payment safeguards (both prepayment and postpayment) to be instituted by CMS and its regional home health intermediaries to detect prior hospital stays and ensure that Medicare pays at the correct payment level.

If you have any questions or comments about this report, please do not hesitate to call me or have your staff call George M. Reeb, Assistant Inspector General for the Centers for Medicare & Medicaid Audits, at (410) 786-7104 or Lori A. Ahlstrand, Regional Inspector General for Audit Services, at (415) 437-8360. To facilitate identification, please refer to report number A-09-03-00042 in all correspondence.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

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

FEB 27 2004

Report Number: A-09-03-00042

Ms. Sandy Coston, CPA
Chairman and President
United Government Services, LLA
401 West Michigan Street
Milwaukee, Wisconsin 53203-2804

Dear Ms. Coston:

Enclosed are two copies of the Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report entitled "Review of Payments Made by United Government Services for Home Health Services Preceded by a Hospital Discharge." A copy of this report will be forwarded to the action official noted below for review and any action deemed necessary.

Final determination as to actions taken on all matters reported will be made by the HHS action official. 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.

In accordance with the principles of the Freedom of Information Act, 5 U.S.C. § 552, as amended by Public Law 104-231, OIG reports issued to the Department's grantees and contractors are made available to members of the press and 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).

To facilitate identification, please refer to report number A-09-03-00042 in all correspondence.

Sincerely,

Lori A. Ahlstrand
Regional Inspector General
for Audit Services

Enclosures – as stated

Direct Reply to HHS Action Official:

Ms. Jackie Garner
Regional Administrator
Centers for Medicare & Medicaid Services
Department of Health and Human Services
233 North Michigan Ave, Suite 600
Chicago, Illinois 60601-5519

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PAYMENTS MADE BY UNITED GOVERNMENT SERVICES FOR HOME HEALTH SERVICES PRECEDED BY A HOSPITAL DISCHARGE

FEBRUARY 2004
A-09-03-00042

EXECUTIVE SUMMARY

OBJECTIVE

The objective of the audit was to determine whether home health agencies (HHA) properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001 (fiscal year (FY) 2001).

SUMMARY OF FINDINGS

We identified 18,134 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 200 of these claims, we identified overpayments to HHAs totaling $55,762. The claims should have been paid at a lower rate, but were not primarily because HHAs did not accurately complete the Outcome and Assessment Information Set (OASIS) for these beneficiaries in accordance with 42 CFR § 484.

As a condition of Medicare participation, HHAs are required to complete a comprehensive assessment for each patient. As part of the assessment, the HHA must accurately complete OASIS using the language and groupings as specified by the Secretary (42 CFR § 484.55). OASIS includes a data element requiring the HHA to identify all inpatient facilities from which the patient was discharged in the 14 days prior to starting home care. As published in the Federal Register on July 3, 2000, the Centers for Medicare & Medicaid Services (CMS) explained that "Our data indicate that an acute care hospital discharge (without follow up post-acute inpatient stay) within the 14 days immediately preceding admission to home care is associated with the lowest costs during the 60-day episode." Accordingly, CMS designed the Home Health Resource Groups to provide for a lower payment for HHA services rendered to beneficiaries discharged from an acute care hospital within the 14 days immediately preceding admission to home health care.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, United Government Services did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that United Government Services paid approximately $5.3 million in overpayments for 18,134 claims.

RECOMMENDATIONS

We recommend that United Government Services:

- recover the $55,762 in overpayments for the claims in the sample,

- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $5,306,825),

- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and

- provide education to HHAs to ensure that beneficiary discharge data is completed accurately on the patient assessment instruments.

In a letter dated July 22, 2003, United Government Services generally concurred with our findings and recommendations. Details of United Government Services's comments are discussed after the Recommendations section of this report and included in their entirety in Appendix C.

On October 24, 2003, subsequent to the issuance of our draft report, CMS published Transmittal 13 (Publication 100-04—Medicare Claims Processing), Change Request 2928, which announced payment safeguards specifically designed to address the "payment vulnerability that [the] OIG has identified" in recent reports. This transmittal also gives additional instructions to regional home health intermediaries regarding the treatment of claims with a prior hospital stay.

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INTRODUCTION

BACKGROUND

Law

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, mandated CMS to implement a prospective payment system for Medicare HHA services. Accordingly, CMS implemented a prospective payment system for HHAs effective October 1, 2000.

Home Health Resource Groups

The HHA prospective payment system utilizes a classification system that groups home health services into 80 mutually exclusive groups called Home Health Resource Groups. Each Home Health Resource Group forms the basis for a five-character Health Insurance Prospective Payment System code that represents the beneficiary's needs over a 60-day service period, called an episode.

The Outcome and Assessment Information Set, referred to as "OASIS," is a lengthy group of standardized data elements used to assess the needs of each home health patient. The OASIS is, in large part, the basis for determining which Home Health Resource Group a particular claim falls into and, as a result, what payment is ultimately warranted for the services provided. Data elements taken almost entirely from OASIS are organized into three dimensions: clinical severity, functional status, and service utilization. The service utilization dimension includes the patient's use of inpatient services in the 14 days preceding admission to home care. A patient's "scores" within each of these dimensions are totaled, and a Home Health Resource Group is assigned.

United Government Services

CMS contracts with four regional home health intermediaries nationwide to assist in administering the home health benefits program. Home health intermediaries process claims and conduct audits of cost reports submitted by HHAs. United Government Services, one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by HHAs in 12 States (Wisconsin, Michigan, New York, New Jersey, Minnesota, Alaska, California, Nevada, Oregon, Washington, Idaho, and Arizona) and 5 territories (Puerto Rico, Virgin Islands, American Samoa, Guam, and Northern Mariana Islands). Claims processed by the other three home health intermediaries are the subject of similar Office of Inspector General (OIG) audits.

Payment for HHA Services

HHAs submit claims for reimbursement using OASIS codes that are designed to match the reimbursement amount to the amount of services required to treat the patient. For example,

a K claim represents an HHA claim with low service utilization and an M claim represents an HHA claim with high service utilization. CMS has determined that patients who were inpatients in a hospital within 14 days prior to HHA treatment generally require fewer services and thus, the HHA should code those claims at a lower utilization level. The reduced service utilization level would therefore result in a lower reimbursement to the HHA as shown in the examples that follow.

EXAMPLES OF INCORRECTLY BILLED K AND M CLAIMS

Sample Number	HHA-Billed HIPPS* Code	HHA Service Start Date	Original Payment Amount	Hospital Discharge Date	HIPPS Code Revised per OIG	OIG Revised Payment Amount	Amount Overpaid
K-39	HBG**K**1	07/05/01	$2,118.65	06/26/01	HBG**J**1	$1,928.50	$190.15
M-4	HAG**M**1	10/22/00	$4,226.82	10/09/00	HAG**L**1	$3,676.95	$549.87

***** Health Insurance Prospective Payment System.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

The objective of the audit was to determine whether HHAs properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals.

Scope

The audit included United Government Services payments for HHA claims with dates of service from October 1, 2000 through September 30, 2001. During this period, there were 18,134 K and M claims that had total payments of $53,694,685 for which there was an inpatient hospital discharge within 14 days prior to the start of the HHA episode—7,656 K claims valued at $16,174,442 and 10,478 M claims valued at $37,520,243. K and M claims were the only categories of HHA claims that would have been affected by erroneous coding of previous hospital stays. Our audit period covered paid claims with HHA dates of service from October 1, 2000 through September 30, 2001.

Methodology

To accomplish the objective, we:

- reviewed applicable Medicare laws and regulations;

- extracted United Government Services's paid claims data from the National Claims History file for FY 2001 and identified claims that HHAs submitted with codes designating no hospital discharge within 14 days prior to the home health admission;

- performed a computer match of these data to the beneficiaries' inpatient hospital data in the National Claims History file in order to obtain a data file of K and M claims with a hospital discharge within 14 days prior to the HHA episode; this computer match identified 18,134 claims totaling $53,694,685;

- selected a stratified random sample of 100 K and 100 M paid claims (see Appendix A for sampling methodology);

- obtained the common working file data for the sample HHA claims and the corresponding inpatient hospital claims and recalculated the correct payment for the sample claims to determine overpayment amounts;

- contacted representatives of selected HHAs to validate billing errors and determine the underlying cause of noncompliance with Medicare billing requirements (we reviewed the five HHAs having at least two claims in our sample);

- contacted four rehabilitation and two skilled nursing facility providers to determine how these referral providers could facilitate HHA compliance in completing the OASIS; and

- utilized a stratified variable appraisal program to estimate the overpayments to HHAs under the payment jurisdiction of United Government Services (see Appendix B for sample results and projections).

Fieldwork was performed at the OIG field office in Los Angeles, California, and selected HHA sites in California. Fieldwork was conducted from January 2003 through May 2003.

We issued a draft report to United Government Services on June 23, 2003, and received United Government Services's comments on July 25, 2003.

The review of internal controls at United Government Services was limited to obtaining an understanding of its claims processing system edits and procedures to detect improperly billed Medicare HHA claims and to identify and recover overpayments. In addition, the internal control review of selected HHAs was limited to those controls concerning the creation and submission of Medicare HHA claims.

The audit was conducted in conjunction with other OIG audits of claims processed by each of the four regional home health intermediaries nationwide. The audit was made in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We identified 18,134 HHA claims for which there was an inpatient hospital discharge within 14 days preceding the home health services. From a statistically valid sample of 200 of these claims, we identified overpayments to HHAs totaling $55,762. The claims should have been paid at a lower rate, but were not primarily because the OASIS for these beneficiaries was not completed in accordance with 42 CFR § 484.

Overpayments occurred because HHAs had not established the necessary controls to identify all inpatient stays and so prevent the incorrect billing for services. In addition, United Government Services did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

HHA PROSPECTIVE PAYMENT SYSTEM REGULATIONS

According to 42 CFR § 484.55, HHAs must complete for each HHA patient, a patient-specific comprehensive assessment that accurately reflects the patient's current health status. HHAs use the OASIS to complete the comprehensive patient assessment. Medicare payments to HHAs under the prospective payment system are based on a home health case-mix system that uses selected data elements from the OASIS.

The three areas assessed on the OASIS include the (1) clinical severity of the patient's condition, (2) the patient's ability to carry out activities of daily living such as bathing, and (3) medical services the patient received in the preceding 14 days. When HHAs assess the needs of new home health patients, OASIS requires them to identify all facilities from which the patients have been discharged in the previous 14 days. This response has a direct impact on the amount of Medicare reimbursement. HHAs receive higher payments for providing services that were not preceded by an inpatient hospital discharge within 14 days of the HHA episode.

HHA BILLING ERRORS

HHAs incorrectly billed and United Government Services paid claims for services to beneficiaries who received HHA services. The claims were billed and paid as if the beneficiary had not had an inpatient hospital discharge within 14 days prior to the HHA services when in actuality there was an inpatient hospital discharge within 14 days of receiving the HHA services.

We determined that HHA billing errors existed by extracting the HHA prospective payment system claims data for United Government Services paid claims from the National Claims History file for FY 2001 and identifying claims that HHAs submitted with codes designating no hospital discharge within 14 days prior to the home health admission. We then performed a computer match of these data to the beneficiaries' inpatient hospital data in National Claims History file in order to obtain a data file of K and M claims with a hospital discharge within 14 days prior to the HHA episode.

This computer match identified 18,134 claims totaling $53,694,685. From the computer match, we selected a stratified random sample of 100 K paid claims and 100 M paid claims (see Appendix A for sampling methodology). We obtained the common working file data for the sample HHA claims and the corresponding inpatient hospital claims and, by comparison, verified that the claims history agreed with the match data.

To verify that United Government Services paid the 200 sample claims, we calculated what the claims payment amounts should have been considering a hospital discharge within 14 days prior to the HHA services. Based on our recalculations, we determined that HHAs were overpaid for each of the 200 claims.

BILLING AND PAYMENT CONTROLS NOT ESTABLISHED

The HHAs incorrectly billed services because they had not established the necessary controls to prevent the incorrect billing of claims for which there was an inpatient hospital discharge within the 14 days prior to the HHA episode. Furthermore, we determined that United Government Services had not established adequate postpayment controls to detect HHA claims that were billed incorrectly and recover the overpayments.

To gain a further understanding of the cause(s) for the billing errors, we contacted five HHAs having at least two claims in our sample. We determined that the claims (17 of the 200 sample claims) were billed as if the beneficiary had not had an inpatient hospital discharge within 14 days prior to the HHA services when in actuality there was such a discharge preceding the HHA episode. The HHAs did not always accurately complete the OASIS. For 16 of the 17 claims that were part of our sample of 200 claims, the HHAs mistakenly identified only the most recent post-acute care facility discharge during the 14 days preceding the home health episode and, therefore, did not necessarily capture hospital discharges within the 14-day window. For the remaining claim, the HHA identified the inpatient hospital stay on the OASIS, but billed it as if there was no hospital stay.

The five HHAs we contacted advised that they were not always able to obtain the necessary information to accurately complete the OASIS. Specifically, the information sources available to HHAs--beneficiaries, family members, and recent caregivers--could not always be depended upon for accurate hospital discharge information. However, based on our review of the selected HHAs' files, we determined that prior inpatient hospital stay information was available to the HHAs in most cases. One of the HHAs admitted that its referral data did vaguely indicate hospital stays; however, this information was not used because the clinician's emphasis was more on the patient's immediate prior admission (facilities such as sub-acute, rehabilitation, etc.). Three of the five HHAs responded that it was possible to determine a hospital discharge prior to the skilled nursing or rehabilitation facility stay by reviewing the physician referral and medical records available to them.

Furthermore, the two skilled nursing and four rehabilitation facility providers that we contacted advised that information referred to the HHAs often included the hospital stay, or if not, it could be provided if requested.

Overpayments to HHAs were not recovered because United Government Services had not initiated postpayment data analysis to detect HHA claims vulnerable to this billing error in order to facilitate overpayment identification and recovery.

MEDICARE PROGRAM OVERPAYMENTS

The billing errors for all 200 claims in the stratified random sample resulted in overpayments of $18,992 for the 100 K claims and $36,770 for the 100 M claims, or total payment error of $55,762. Projecting the sample results to the universe of K and M claims with an inpatient hospital discharge within 14 days of the HHA episode, we estimate that United Government Services made $5.3 million in overpayments to HHAs for services during FY 2001.

RECOMMENDATIONS

We recommend that United Government Services:

- recover the $55,762 in overpayments for the claims in the sample,

- review the balance of the universe to identify and recover additional overpayments (we estimate the total overpayments to be $5,306,825),

- conduct postpayment data analysis, subsequent to the period of the audit, to detect improperly paid HHA claims and use the results of that data analysis to recover overpayments and take additional corrective actions as necessary, and

- provide education to HHAs to ensure that beneficiary discharge data is completed accurately on the patient assessment instruments.

UNITED GOVERNMENT SERVICES COMMENTS

In a letter dated July 22, 2003, United Government Services generally concurred with our recommendations, indicating that it will coordinate its efforts with CMS to recover the overpayments related to the 200 sample claims, and the universe of claims provided by OIG. Additionally, United Government Services stated that its Medical Review and Provider Communication Departments provide education to HHAs on billing issues, and United Government Services is in the process of implementing additional measures to ensure accurate billings and payments.

Further, United Government Services indicated that its Data/Statistics Department has developed an ad hoc report, which will be run on a periodic basis and analyzed by medical review. Any claims identified by the medical review as having been processed incorrectly will be adjusted. However, United Government Services indicated that the most effective method of recovering overpayments would be through the common working file automated review, where the HHA claim start date could be cross-referenced to the inpatient facility discharge date. This automated interface with the common working file is not currently available to United Government Services. However, United Government Services stated that it would be willing to work with CMS to provide its feedback and recommendations on this process.

United Government Services expressed a concern that OIG should take under consideration certain factors, presented in its comments to the draft report, regarding United Government Services not having adequate postpayment controls to detect HHA claims that were billed incorrectly. The complete text of United Government Services's comments is included as Appendix C to this report.

APPENDICES

SAMPLING METHODOLOGY

OBJECTIVE

The objective of the audit was to determine whether HHAs properly claimed Medicare reimbursement for services provided to certain beneficiaries who were previously discharged from inpatient hospitals.

POPULATION

The population is HHA claims paid by United Government Services with a date of service during FY 2001 having a K or M in the fourth position of the five-character health insurance prospective payment system code that were preceded by an inpatient hospital discharge within 14 days of the home health episode.

Stratum Number	Type of Claim	Number of Claims	Payment Amount
1	"K"	7,656	$16,174,442
2	"M"	10,478	37,520,243
	Total	18,134	$53,694,685

SAMPLE DESIGN

The audit utilizes a stratified random sample consisting of two strata—one for K paid claims and one for M paid claims with dates of service during FY 2001. Error amounts were determined by subtracting the OIG-calculated, correct payment amount from the original reimbursement amount to the provider.

SAMPLE SIZE

The sample consisted of 100 paid claims for each stratum from the identified population.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	7,656	100	$209,572	100	$18,992
2	10,478	100	341,914	100	36,770
Total	18,134	200	$551,486	200	$55,762

VARIABLE PROJECTIONS

The point estimate of the sample was $5,306,825 with a precision of plus or minus $397,814 at the 90 percent confidence level.

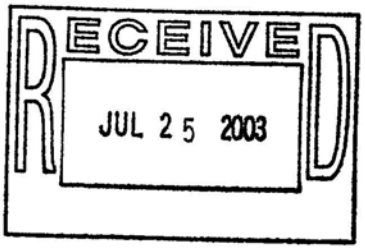
CMS
CENTERS for MEDICARE & MEDICAID SERVICES

PART A INTERMEDIARY NATIONAL FQHC INTERMEDIARY
REGIONAL HOME HEALTH INTERMEDIARY

MEDICARE

PHONE 414-226-5588 ▾ FAX 414-226-2647

SANDY COSTON, CPA
CHAIRMAN AND PRESIDENT



July 22, 2003

Ms. Lori A. Ahlstrand
Regional Inspector General for Audit Services
DHHS-OIG Office of Audit Services
50 United Nations Plaza, Room 171
San Francisco, CA 94102

RE: Common Identification Number A-09-03-00042

Dear Ms. Ahlstrand:

We have reviewed the draft document referenced above detailing the review of home health agencies' compliance with Medicare billing provisions under the prospective payment system. The following are our comments and responses to the findings and recommendations.

Finding – UGS had not established adequate post-payment controls to detect HHA claims that were billed inconsistently.

Comments – The audit period for the sample is from the beginning of the implementation of the Home Health Agency (HHA) Prospective Payment System (PPS). Therefore, this period represents a time that was a learning process for the new system for providers and fiscal intermediaries. There are several factors that should be considered regarding this finding:

- Outcome and Assessment Information Set (OASIS) Training was delivered and managed by the state agencies, not by the fiscal intermediaries. In addition, the Centers for Medicare and Medicaid Services (CMS) – formerly Health Care Financing Administration – established a website for PPS/OASIS Questions and Answers (in approximately August/September 2000).

- During the time period in which the sample was pulled, there was no historical data to help identify billing vulnerabilities to the program.

- During the transition period, a HHA PPS workgroup was created. The workgroup consisted of staff from CMS Central Office, CMS Regional Offices, and Regional Home Health Intermediaries (RHHIs). Issues, concerns, and problems were

discussed within the group. The potential program vulnerabilities of miscoding the OASIS were discussed many times in the workgroup. The initial instructions received from CMS were to accept what the provider had entered on the OASIS unless there was documentation in the medical record that contradicted the OASIS. Later, a joint decision between CMS and the RHHIs was to use the guidelines in the RHHI OASIS Verification (ROVER) manual. These guidelines were, if the reviewer doubted the documentation in the medical record and the accuracy of the HHA OASIS response to any item, then the reviewer would conduct a ROVER review. This could result in a re-coding of the Health Insurance Prospective Payment System (HIPPS) code.

- During a meeting held May 30 and 31, 2001 at the CMS Region VII office in Kansas City, Kansas, a question was raised as to whether RHHI's should be utilizing CWF to double check the hospital or Skilled Nursing Facility (SNF) stays in field MO175 or should rely on the provider's response. CMS responded that bills for SNF/Rehab stays may not be submitted before review of the HHA claim. Therefore, RHHI's were instructed not to check CWF in these instances. This is documented in the minutes from this meeting and is the directive that UGS followed until August of 2002. At that time, Medical Review identified cases in which OASIS item MO175 was incorrectly completed. Staff was then directed to check the claims history file on any case with a HIPPS code of "K" or "M" and down code as appropriate, because the primary goal of Medical Review is to pay claims correctly.

- The Progressive Corrective Action (PCA) process mandated by CMS with PM AB-00-72 of August 2000 requires that the selection of providers for Medical Review be performed based on data analysis. To date, our analysis has not identified the use of K or M in the HIPPS code as being aberrant.

With respect to the four recommendations cited in the draft report, we offer the following responses:

1. ***Recover the $55,762 in overpayments related to the 200 claims in our sample –***
   UGS agrees with the need to recover the dollars related to the 200 claims in the sample. Since this review is part of a national review, UGS will coordinate its recovery efforts with CMS.

2. ***Utilize our file containing the population of paid claims with probable billing errors to identify and recover the additional overpayments estimated as $5.25 million –***
   UGS agrees to recover the universe of claims identified in the file provided by the OIG. As stated above, since this is part of a national review, UGS will coordinate its recovery efforts with CMS.

3. ***Direct HHAs to strengthen billing controls, including procedures to ensure their clinicians accurately complete the patient assessment document –***
The UGS Medical Review and Provider Communication Departments provide education to Home Health Agencies on billing and coverage issues through provider specific telephone contacts, Medicare Memos newsletters, quarterly Advisory Meetings, face-to-face meetings, and access to the UGS and CMS internet sites.

   In addition, UGS has the following measures in process:

   - ✓ Every provider that is identified as incorrectly coding a "M" or "K" is telephoned and informed of the error and measures to correct the problem.
   - ✓ The Medical Review staff also down codes the claim, ensuring accurate payment.
   - ✓ Medical Review will develop an article regarding this issue to be published in a Medicare Memo before the end of the fiscal year.
   - ✓ Education on this issue will be presented at the National Home Health Advisory meeting, scheduled for August 19, 2003.
   - ✓ Provider Education and Training staff will include this topic as part of future training presentations.

4. ***Conduct periodic post-payment data analysis to detect improperly billed HHA claims and use the results of that analysis to recover overpayments and take additional corrective action, as necessary –***
UGS routinely conducts post-payment data analysis to identify provider-billing practices that may be aberrant as compared to their peers, national data, and UGS data. This is an ongoing responsibility of the Medical Review and Data/Statistics Departments within UGS. Our policy has been and continues to be the following:

   - ✓ Identification of problematic providers.
   - ✓ Recovery of inappropriate payments.
   - ✓ Performance of educational interventions to correct inappropriate practices.

   In addition, based on this recommendation, the Data/Statistics Department has developed an ad hoc report, which will be run on a periodic basis. Medical Review will analyze the report and adjust any claims identified as having been processed incorrectly for those HIPPS codes having "K" or "M." The first report is currently being analyzed.

   UGS believes that in this particular situation in which the provider incorrectly coded the HIPPS code to a "K" or "M," the most effective method of recovering

overpayments would be through the Common Working File. A utility report would need to be developed to cross-reference the claim's start of care date to the discharge date of any acute inpatient facility admissions. If these two dates fall within 14 days of each other, the home health claims would then need to be down coded to the appropriate HIPPS code.

A determination would have to be made as to how often or when to run the program, as home health claims tend to be received before inpatient claims are submitted and in the system. If this type of utility report could be implemented via CWF, all Home Health claims would then be subject to an automated review and potential down coding. This would be more cost effective and yield a higher return to the Medicare Program than just having Medical Review perform reviews on a sample of claims.

Since UGS does not control or maintain the Common Working File, we cannot implement this process on our own, but would need to rely on CMS and the system maintainer to do this. We would be willing to work with CMS and the system maintainer to provide our feedback and recommendations on this process.

Sincerely,

Sandy Coston

Copy: Daly Vargas, CMS
Ron Bryan, CMS
Rosalie Teran, CMS
Sean Johnson, CMS
Sally Wood, UGS
Steve Holubowicz, UGS
Barb Hensley, UGS
Pat Coleman, UGS
Cheryl Leissring, UGS