Memorandum

Date MAR 22 1996

From Michael Mangano for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Pro-Med Home Health, Inc. (A-04-95-01106)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

Attached are two copies of our final report entitled, "Review of Costs Claimed by Pro-Med Home Health Inc." The objective of our review was to determine whether the home health care services claimed by Pro-Med Home Health, Inc. (Pro-Med) in Miami, Florida met Medicare reimbursement guidelines.

We randomly selected for review 100 claims submitted by Pro-Med for Medicare reimbursement during the Fiscal Year (FY) ended December 31, 1993. These claims represent 2,068 home health services. Our review showed that 40 claims, or 40 percent of our sample, contained 846 services that did not meet Medicare guidelines, as follows:

- 25 percent of the claims were for 466 services made to individuals who, in their own opinion, or in the opinion of medical experts were not homebound;
- 8 percent of the claims were for 200 services which in the opinion of medical experts were not reasonable or necessary;
- 5 percent of the claims were for 127 services not provided; and
- 2 percent of the claims were for 53 services which physicians denied authorizing.

During the FY ended December 31, 1993, Pro-Med claimed $3.6 million on 2,922 claims representing 54,545 services. Based on our review, we estimate that $1.2 million did not meet the reimbursement guidelines.

Although we found documentation that Pro-Med monitored its subcontractors, it did not follow its own policies and procedures to ensure that claims submitted by its subcontractors were for services that met Medicare reimbursement guidelines.

Nevertheless, the guidelines make contractors, such as Pro-Med, responsible for the actions of their subcontractors.

We recommend that the Health Care Financing Administration (HCFA) require the fiscal intermediary (FI) to instruct Pro-Med on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations, monitor the FI and Pro-Med to ensure that corrective actions are effectively implemented, and recover all overpayments.

In its written response to our draft report, HCFA agreed with our recommendations. The complete text of HCFA's response is presented as Appendix D 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-04-95-01106.

Attachments

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

OPERATION RESTORE TRUST

REVIEW OF COSTS CLAIMED BY PRO-MED HOME HEALTH, INC.

JUNE GIBBS BROWN
Inspector General

MARCH 1996
A-04-95-01106

Memorandum

Date MAR 22 1996

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Pro-Med Home Health, Inc. (A-04-95-01106)

To Bruce C. Vladeck
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Pro-Med Home Health Inc. (Pro-Med) in Miami, Florida.

OBJECTIVE

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

SUMMARY OF FINDINGS

We randomly selected for review 100 claims submitted by Pro-Med for Medicare reimbursement during the Fiscal Year (FY) ended December 31, 1993. These claims represent 2,068 home health services. Our review showed that 40 claims, or 40 percent of our sample, contained 846 services that did not meet Medicare guidelines, as follows:

- 25 percent of the claims were for 466 services made to individuals who, in their own opinion, or in the opinion of medical experts were not homebound;
- 8 percent of the claims were for 200 services which in the opinion of medical experts were not reasonable or necessary;
- 5 percent of the claims were for 127 services not provided; and
- 2 percent of the claims were for 53 services which physicians denied authorizing.

During the FY ended December 31, 1993, Pro-Med claimed $3.6 million on 2,922 claims representing 54,545 services. Based on our review, we estimate that $1.2 million did not meet the reimbursement guidelines.

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

We recommend that the Health Care Financing Administration (HCFA) require the fiscal intermediary (FI) to instruct Pro-Med on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations and HCFA guidelines, monitor the FI and Pro-Med to ensure that corrective actions are effectively implemented, and recover all overpayments.

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

BACKGROUND

Pro-Med Home Health, Inc.

The Pro-Med is a Medicare certified home health agency (HHA) with a principal place of business in Miami, Florida. The Pro-Med 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 Pro-Med, can either provide home health services itself or make arrangements with other certified or noncertified providers for home health services. Most of the services claimed by Pro-Med were provided under contract with non-Medicare certified nursing groups.

During FY 1993, Pro-Med 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 $3.3 million. Interim payments are adjusted to actual costs based on annual cost reports. The Pro-Med submitted a cost report for FY 1993 claiming costs totaling $3.6 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 Pro-Med is AEtna Life and Casualty Insurance Company (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 Pro-Med 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 E.

The Pro-Med claimed 54,545 services on 2,922 claims for FY 1993. We reviewed a statistical sample of 100 claims totaling 2,068 services for 92 different individuals (8 individuals 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 Pro-Med 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 Pro-Med 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 81 of the 92 beneficiaries. We were unable to interview 11 of the beneficiaries or a close acquaintance because they had either moved or were deceased. We were not able to interview 19 physicians because they were either deceased, had moved out of the area, or refused to talk to us.

We reviewed supporting medical records maintained by Pro-Med 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 conducted a review of Pro-Med's internal controls, but we did not place reliance on the internal controls. Specifically, we reviewed quality control work performed by Pro-Med to monitor subcontracted services.

Our field work was performed at Pro-Med's administrative office in Miami, 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 July 1995. Our audit was conducted in accordance with generally accepted government auditing standards.

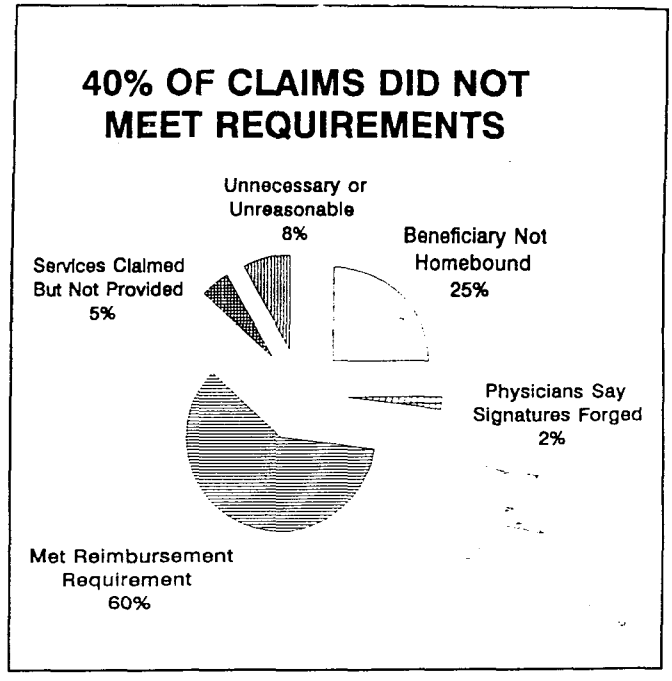
DETAILED RESULTS OF REVIEW

Our audit showed that 40 percent of the claims submitted by Pro-Med during FY 1993 did not meet the Medicare reimbursement requirements.

Based on a statistical sample, we estimate that Pro-Med received overpayments totaling $1.2 million. Although we found documentation that Pro-Med monitored its subcontractors, it did not follow its own policies and procedures to ensure that claims submitted by its subcontractors were for services that met Medicare reimbursement guidelines.

However, the regulations and guidelines clearly hold the HHA responsible for payments made for services performed 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 to Beneficiaries Who Were Not Homebound

Our review showed that 25 of the 100 claims were for 466 services to beneficiaries who were not homebound at the time the services were provided. The interviews of the beneficiary or a close acquaintance of the beneficiary, the certifying physician, and the personal physician indicated that the beneficiaries by their own assessment, or that of the physicians, were not homebound at the time the services were provided. In all cases, Pro-Med had documentation, such as the plan of care that indicated the individual needed skilled care and was homebound.

The regulations at 42 CFR 409.42 provide that the individual receiving home health benefits must be "... confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." Title 42 CFR 424.22 states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA manual at section 204.1 contains guidance regarding the "homebound" requirement.

The AEtna medical review personnel reviewed the records for the 25 beneficiaries that we determined did not meet the homebound requirement. They concluded that the medical records did not support a homebound determination for 12 of the beneficiaries, had questionable documentation for 8 of the beneficiaries, had insufficient documentation

to make a determination for 3 of the beneficiaries, and did not support the need or reasonableness of the services for one of the beneficiaries. We determined that the beneficiary whose record AEtna concluded supported a homebound status was not homebound because the beneficiary and his personal physician said he was not homebound.

We interviewed the personal physician of 7 of the 25 beneficiaries. The remaining 18 beneficiaries did not have a personal physician different from the physician who signed the plan of treatment. The personal physicians stated that the beneficiaries were not homebound at the time the services were claimed as provided. We used the personal physicians' opinion to confirm our position and to refute the evidence of homebound status in the HHA records. We concluded that the 25 beneficiaries did not meet the homebound criteria. Our conclusion is based on the opinion of medical professionals, as well as the results of beneficiary interviews which included a description of their daily activities at the time of the services.

Services That Were Not Reasonable Or Necessary

Our review showed that 8 of the 100 claims were for 200 services which were not considered reasonable or necessary either by the intermediary's medical review personnel or the beneficiaries' personal physician.

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 provided the basis for determination as to whether services provided are reasonable and necessary.

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

We interviewed the personal physician for four of the eight beneficiaries. The remaining four beneficiaries did not have a personal physician different from the physician who signed the plan of treatment. Three of the four physicians stated that the beneficiaries were either not homebound or did not need the skilled services provided by the HHA.

Services Claimed But Not Provided

Our review showed that 5 of the 100 claims were for 127 services that were not provided. The medical records maintained by Pro-Med contained the required documentation including signatures of the beneficiaries indicating that the services were provided. However, the physicians who purportedly signed certifications for four of these claims did not have any records to support the prescription of home health

services. Two of the five beneficiaries involved with the five claims stated that their signatures were forged. One beneficiary received fewer services than claimed by Pro-Med.

During the initial interview of the beneficiaries, they told us that they had not received the services on the dates that were on the sampled claims. A review of the medical records indicated that the beneficiaries had signed for the services. We re-interviewed three of the four beneficiaries and showed them the signatures on the visit logs and two beneficiaries stated that their signature was forged; the third beneficiary said that some of the signatures appeared to be hers.

We also interviewed the two physicians who signed the plans of care for the four claims. They had no record of ordering the HHA services, and they had no record of ever seeing the beneficiaries.

Physicians Say Signatures Were Forged

Our review showed that 2 of the 100 claims were for 53 services where the physicians said their signatures were forged. We interviewed the two physicians who purportedly signed the plans of care for the claims. The physicians advised us that they did not sign the plans of care. Furthermore, they told us that they did not know the beneficiary or have any medical records indicating that the beneficiary had been seen by them.

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.

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

Effect

Our audit showed that 40 percent of the FY 1993 claims submitted by Pro-Med were overstated. Projecting our sample results, we estimate that Pro-Med was overpaid $1,176,345.

Pro-Med Did Not Properly Monitor Subcontractors

The Pro-Med did not follow its own policies and procedures to monitor its subcontractors. They stated that the subcontractors provided documentation which indicated visits were made and services were provided. The Pro-Med had procedures for monitoring subcontractors to ensure that beneficiaries met the homebound and medical necessity criteria to receive HHA services. However, Pro-Med had no explanation as to why their monitoring did not 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 Pro-Med did monitor subcontractors. However, in one instance the documentation showed that the beneficiary was not homebound, yet no action was taken to discontinue the services. In another instance a beneficiary was discharged because he was not homebound, but was re-admitted the next day by another subcontractor as a new patient, with no explanation for the sudden change in the patient's condition. We also found a case where the documentation showed that the beneficiary refused the home health aide services, yet the services were documented as if provided, and the monitoring visits did not explain the discrepancies.

RECOMMENDATIONS

We recommend that HCFA:

- Require the FI to instruct Pro-Med on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations and HCFA guidelines;

- monitor the FI and Pro-Med to ensure that corrective actions are effectively implemented; and

- recover all overpayments.

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

APPENDICES

APPENDIX A

AUDIT OF PRO-MED HOME HEALTH INC.
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 Pro-Med 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 Pro-Med during the FY ended December 31, 1993.

POPULATION:

The universe consisted of 2,922 HHA claims representing $3,277,970 in benefits paid by the FI to Pro-Med 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 visits 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 Pro-Med 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 Pro-Med in the unaudited cost report for FY ended December 31, 1993.

Using the Department of Health and Human Services, Office of Inspector General, 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.

AUDIT OF PRO-MED HOME HEALTH, INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 2,922 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	40
Point Estimate	40.0%
Lower Limit	31.9%
Upper Limit	48.6%

SERVICES CLAIMED BUT NOT PROVIDED

Quantity Identified in the Sample	5
Point Estimate	5.0%
Lower Limit	2.0%
Upper Limit	10.2%

SERVICES PROVIDED TO BENEFICIARIES THAT WERE NOT HOMEBOUND

Quantity Identified in the Sample	25
Point Estimate	25.0%
Lower Limit	18.1%
Upper Limit	33.0%

SERVICES THAT WERE NOT PROPERLY AUTHORIZED BY PHYSICIANS

Quantity Identified in the Sample	2
Point Estimate	2.0%
Lower Limit	0.3%
Upper Limit	6.1%

AUDIT OF PRO-MED HOME HEALTH, INC.
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

SERVICES THAT WERE NOT REASONABLE OR NOT NECESSARY

Quantity Identified in the Sample	8
Point Estimate	8.0%
Lower Limit	4.1%
Upper Limit	13.9%

APPENDIX C

AUDIT OF PRO-MED HOME HEALTH, INC.
VARIABLES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 2,922 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	40
Value	$ 53,395
Point Estimate	$1,560,206
Lower Limit	$1,176,345
Upper Limit	$1,944,067

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administrati

The Administrator
Washington, D.C. 20201

DATE [illegible] 15 [illegible]95

TO June Gibbs Brown
Inspector General

FROM Bruce C. Vladeck
Administrator

SUBJECT Office of Inspector General Draft Report: " Review of Costs Claimed by Pro-Med Home Health, Inc." (A-04-95-0-1106)

We reviewed the above-referenced report. 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. Please contact us if you would like to discuss our comments.

Attachment

Health Care Financing Administration (HCFA) Comments on
Office of Inspector General Draft Report: "Review of Costs Claimed by Pro-Med Home Health, Inc. (A-04-95-0-1106)

Recommendation 1

HCFA should require the fiscal intermediary (FI) to instruct Pro-Med on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations and HCFA guidelines.

HCFA Response

We concur. HCFA will continue to advise the FI to closely monitor claims submitted by home health agencies. HCFA will instruct the FI to conduct focused medical reviews on future claims from Pro-Med and instruct Pro-Med on its responsibilities to Medicare. HCFA will instruct the FI to refer the facility to the State agency to monitor Pro-Med's future compliance with rules of subcontractor supervision.

Recommendation 2

HCFA should monitor the FI and Pro-Med to ensure that corrective actions are effectively implemented.

HCFA Response

We concur. HCFA will continue to monitor the FI to ensure corrective actions are implemented.

Recommendation 3

HCFA should recover all overpayments.

HCFA Response

We concur. HCFA will take the appropriate action necessary to recover from Pro-Med those payments made for home health visits that do not comply with Medicare reimbursement guidelines.

APPENDIX E

MAJOR CONTRIBUTORS TO THIS REPORT

From HHS OIG OAS:	Roy Wainscott, Region IV HCFA Audit Manager - (404) 331-2446 Albert Bustillo, Senior Auditor Mario Pelaez, Auditor in Charge Catherine Burnside, Auditor James Duncan, Auditor Maritza Hawrey, Auditor Lourdes Puntonet, Auditor
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