DEPARTMENT OF HEALTH & HUMAN SERVICES Office of Inspector General

Washington, D.C. 20201

MAR 12 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 Cahaba Government Benefit Administrators for Home Health Services Preceded by a Hospital Discharge (A-07-03-04021)

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. Cahaba Government Benefit Administrators (Cahaba), one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by HHAs in 15 States and the District of Columbia.

We identified 18,230 improperly billed 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 $55,607. The claims should have been paid at a lower rate, but were not 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) determined that an acute care hospital discharge (without a followup postacute inpatient stay) within the 14 days immediately preceding admission to home care is associated with the lowest costs during a 60-day service period. 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, Cahaba did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that Cahaba made approximately $5.6 million in overpayments for 18,230 claims.

We recommended that Cahaba:

- recover the $55,607 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 $5,620,054),

- 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 its initial response to our draft report (see Appendix C), Cahaba said that it was advised by CMS to refrain from making any claim adjustments until further review of the issue. In a later e-mail, Cahaba advised us that CMS agreed with our recommendations to pursue recovery of all overpayments.

Since submission of Cahaba's comments, CMS published a transmittal specifically to address the home health "payment vulnerability that [the] OIG has identified" in this and three companion 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 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 James P. Aasmundstad, Regional Inspector General for Audit Services, at (816) 426-3591. To facilitate identification, please refer to report number A-07-03-04021 in all correspondence relating to this report.

Attachment

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General
Office of Audit Services

Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

MAR 17 2004

Report Number: A-07-03-04021

Ms. Susan Pretnar
Executive Director
Cahaba Government Benefit Administrators
400 East Court Avenue
Des Moines, Iowa 50309-2017

Dear Ms. Pretnar:

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 Cahaba Government Benefit Administrators for Home Health Services Preceded by a Hospital Discharge." A copy of this report will be forwarded to the action official 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-07-03-04021 in all correspondence.

Sincerely,

James P. Aasmundstad
Regional Inspector General
for Audit Services

Enclosures

Direct Reply to HHS Action Official:

Mr. Joe Tilghman
Regional Administrator, Region VII
Centers for Medicare & Medicaid Services
601 East 12th Street, Room 235
Kansas City, Missouri 64106

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF PAYMENTS MADE BY CAHABA GOVERNMENT BENEFIT ADMINISTRATORS FOR HOME HEALTH SERVICES PRECEDED BY A HOSPITAL DISCHARGE

MARCH 2004
A-07-03-04021

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 18,230 improperly billed 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 $55,607. The claims should have been paid at a lower rate, but were not 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, Cahaba Government Benefit Administrators (Cahaba) did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that Cahaba made approximately $5.6 million in overpayments for the 18,230 claims.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $55,607 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 $5,620,054),

- 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 its initial response to our draft report (see Appendix C), Cahaba said that it was advised by CMS to refrain from making any claim adjustments until further review of the issue. In a later e-mail, Cahaba advised us that CMS agreed with our recommendations to pursue recovery of all overpayments.

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 . . . identified" in this and companion 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.

Cahaba

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. Cahaba, one of four regional home health intermediaries, processes Medicare claims and conducts audits of cost reports submitted by the HHAs in 15 States (Iowa, Nebraska, Kansas, Missouri, South Dakota, North Dakota, Montana, Wyoming, Colorado, Utah, Delaware, Maryland, Pennsylvania, Virginia, and West Virginia) and the District of Columbia. 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-30	HCE**K**1	6/5/2001	$1,720.31	6/6/2001	HCE**J**1	$1,561.69	$158.62
M-36	HCI**M**1	1/20/2001	$4,954.38	1/19/2001	HCI**L**1	$4,437.05	$517.33

***** 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 Cahaba payments for HHA claims with dates of service from October 1, 2000 through September 30, 2001. During this period, there were 18,230 K and M claims that had total payments of $51,607,087 for which there was an inpatient hospital discharge within 14 days prior to the start of the HHA episode—6,621 K claims valued at $12,460,035 and 11,609 M claims valued at $39,147,052. 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 our objective, we:

- reviewed applicable Medicare laws and regulations;

- extracted the Cahaba paid claims 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 18,230 claims totaling $51,607,087;

- 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;

- requested Cahaba to compute an overpayment calculation for each sample claim and compared our overpayment calculation with Cahaba's calculation;

- contacted representatives of six selected HHAs[1] to validate billing errors and determine the underlying cause of noncompliance with Medicare billing requirements;

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

- discussed the results of our review with Cahaba officials and provided them with a file containing the population of claims with overpayments for recovery.

Fieldwork was performed at the OIG regional office in Kansas City, Missouri; at Cahaba in Des Moines, Iowa; and at selected HHAs. Fieldwork was conducted from January 2003 through March 2003.

[1] The six HHAs were selected to represent a diverse group of providers. We used the following attributes to select them: urban versus rural, for-profit versus nonprofit, and freestanding versus hospital based.

We issued a draft report to Cahaba on June 26, 2003 and received Cahaba's comments on July 25 and September 18, 2003.

The review of internal controls at Cahaba 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. We conducted our review in accordance with generally accepted government auditing standards.

FINDINGS AND RECOMMENDATIONS

We identified 18,230 improperly billed HHA claims for which there were inpatient hospital discharges within 14 days preceding the home health services. From a statistically valid sample of 200 of these claims, we identified overpayments to HHAs totaling $55,607. The claims should have been paid at a lower rate, but were not because the HHAs did not complete the OASIS for these beneficiaries 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, Cahaba did not initiate recovery because it had not established adequate postpayment controls to detect HHA claims that were billed incorrectly.

We estimate that Cahaba made approximately $5.6 million in overpayments for the 18,230 claims.

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 Cahaba 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 Cahaba 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 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 18,230 claims totaling $51,607,087. 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.

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.[2]

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 preceding the HHA episode. Furthermore, we determined that Cahaba 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 met with officials from 6 selected HHAs to validate the payment errors for 30 of the 200 sample claims and identify specific control weaknesses contributing to noncompliance with Medicare payment provisions. We found that the HHAs did not accurately complete the OASIS form primarily because:

[2] For 1 of the 200 claims, the HHA subsequently resubmitted the claim with coding that indicated that an acute care hospital discharge had occurred within the preceding 14 days. Cahaba corrected the reimbursement amount. Accordingly, this claim was not considered an error for the purposes of our statistical projection.

- the HHA clinicians mistakenly identified only the most recent facility discharge during the 14 days preceding the home health episode, rather than all discharges, including the discharge from the inpatient hospital, and

- the HHA clinicians miscounted the 14 days within the period preceding the start of the home health episode.

Most of these billing errors could have been prevented had the HHA established quality control checks of the completed OASIS forms. Specifically, in 28 of the 30 claims reviewed, the beneficiary's medical file maintained by the HHA indicated that an inpatient hospital discharge occurred within the 14 days preceding the HHA episode.

Cahaba 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 the 200 claims in the stratified random sample resulted in overpayments of $16,749 for 99 K claims and $38,858 for 100 M claims, or total overpayments of $55,607. 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 Cahaba made $5.6 million in overpayments to HHAs for services during FY 2001.

RECOMMENDATIONS

We recommend that Cahaba:

- recover the $55,607 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 $5,620,054),

- 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.

CAHABA COMMENTS AND OIG RESPONSE

Cahaba Comments

In its July 25, 2003 response to our draft report (see Appendix C), Cahaba said that it was advised by CMS to refrain from making any claim adjustments based on the audit until further review of the issue. On September 18, 2003, Cahaba advised us via e-mail that CMS agreed with our findings and recommendations to recover all outstanding overpayments. Cahaba will comply with this decision. CMS and its contractors are currently discussing the technical aspects of making these recoveries and adjusting the claims on the history file. They are exploring whether this process can be automated rather than making manual adjustments.

OIG Response

We commend Cahaba for taking necessary recovery actions.

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 Cahaba 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	6,621	$12,460,035
2	M	11,609	39,147,052
	Total	18,230	$51,607,087

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 sizes are 100 K paid claims and 100 M paid claims.

SAMPLE RESULTS AND PROJECTIONS

SAMPLE RESULTS

Stratum Number	Number of Claims	Sample Size	Value of Sample	Number of Errors	Value of Errors
1	6,621	100[1]	$193,957	99	$16,749
2	11,609	100	347,673	100	38,858
Total	18,230	200	$541,630	199	$55,607

VARIABLE PROJECTIONS

The point estimate of the sample was $5,620,054 with a precision of plus or minus $350,434 at the 90-percent confidence level.

[1] For 1 of the 200 claims, the HHAs subsequently resubmitted the claim with coding that indicated that an acute care hospital discharge had occurred within the preceding 14 days. Cahaba corrected the reimbursement amount prior to the audit. Accordingly, this claim was not considered an error for the purposes of our statistical projection.

CMS
CENTERS for MEDICARE & MEDICAID SERVICES

MEDICARE PART A INTERMEDIARY
REGIONAL HOME HEALTH INTERMEDIARY

July 25, 2003

James P. Aasmundstad
Regional Inspector General for Audit Services
Region VII
601 East 12th Street
Room 284A
Kansas City, Missouri 64106

Report: A-07-03-04021

Dear Mr. Aasmundstad:

We are in receipt of your draft report entitled: *"Home Health Prospective Payment Systems (PPS)- Preceding Hospital Stays."* Thank you for the opportunity to submit our comments. Please see the information below regarding the findings of this report.

The report indicates the OIG looked at claims from October 1, 2000 to September 30, 2001. The HHPPS payment system, which was a new payment system, was implemented on October 1, 2000. The OIG should recognize during this transition period, home health agencies and the Regional Home Health Intermediaries were addressing many implementation concerns. The volatility of the environment should be considered in any judgments about controls in place during this period.

The report makes a recommendation for a need for education of the home health agencies regarding the proper reporting of OASIS item M0175. Education efforts regarding OASIS have been ongoing during the past two years. This education may impact the extent to which these errors persist. It should also be noted that primary education regarding OASIS is performed by State agencies, not by the RHHI.

The report findings indicate a specific concern that home health agencies have miscounted the 14 days within the period prior to the beginning of a home health episode. However, the report does not indicate the counting rule applied to identify the claims in the study. It is difficult to determine whether the findings are consistent with CMS guidelines in counting the 14 days.

The OIG file of claims data used as a basis for recovery should indicate the date of the inpatient claim so that an independent determination of this guideline is possible. Information about how many cases fall near the 14-day boundary may also help target education.

Adjustments to the claims identified in the OIG files cannot be initiated without research of claims history, since provider adjustments to correct the error may have already occurred. OIG experienced this situation in their review and should recognize this complicates the effort involved. We have been advised by CMS to refrain from making any claim adjustments based on this audit until we can look further into this issue and get more information from your agency regarding the specific method used at arriving at the findings.

It is important to recognize that the institution of post-payment safeguards can never be entirely accurate. Even though the OASIS may be scored to indicate a hospital stay, no system edit implemented by Medicare intermediaries can account for hospital stays paid by other payers.

The ability for an RHHI to perform post-payment data analysis to identify this problem is limited by our restricted access to claims history. We can only identify hospital stays paid at our site. Lacking direct access to CWF or NCH paid claims history, a national process for this analysis at CMS' direction would need to be developed.

In order for post-payment analysis to be complete, there will always be a significant time delay involved. The hospital claim associated with a home health episode has the same 15-27 month timely filing period as any other Medicare claim. This period would need to be fully elapsed before a comprehensive analysis can be done. It is notable that the filing period for the first year of HH PPS was not fully elapsed until December 31, 2002.

It is also important to note that post-payment review funding is limited, and that pursuing research on these cases can only occur within our allotted budget from CMS.

Thank you for your consideration of this response. If you have any questions regarding this information, please feel free to contact me at (515) 471-7273. We look forward to working with you to take appropriate actions based on your agency's findings.

Sincerely,

Richard Sloma
Department Manager, Program Safeguards

CC: Joni Jones/CMS