DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF AUDIT SERVICES
233 NORTH MICHIGAN AVENUE
CHICAGO, ILLINOIS 60601

REGION V
OFFICE OF
INSPECTOR GENERAL

September 29, 2006

Report Number: A-05-04-00103

Ms. Leticia Jimenez
Administrator
Pacific Home Health Care, Inc.
4136 North Kedzie Avenue
Chicago, Illinois 60618

Dear Ms. Jimenez:

Enclosed are two copies of the U.S. Department of Health and Human Services (HHS), Office of Inspector General (OIG) final report, entitled "Review of Compliance with Billing Provisions Under the Prospective Payment System for Home Health Agencies' Therapy Services at Pacific Home Health Care, Inc." 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 named below. We request that you respond to the HHS action official within 30 days from the date of this letter. Your response should present any comments or additional information that you believe may have a bearing on the final determination.

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To facilitate identification, please refer to report number A-05-04-00103 in all correspondence relating to this report.

Sincerely,

Paul Swanson

Paul Swanson
Regional Inspector General
for Audit Services

Enclosures – as stated

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Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COMPLIANCE WITH BILLING PROVISIONS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH AGENCIES' THERAPY SERVICES

PACIFIC HOME HEALTH CARE, INC.

Daniel R. Levinson
Inspector General

SEPTEMBER 2006
A-05-04-00103

Office of Inspector General

http://oig.hhs.gov

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OAS FINDINGS AND OPINIONS

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

EXECUTIVE SUMMARY

BACKGROUND

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

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

One item on the OASIS instrument indicates the need for home health therapies totaling 10 or more visits during the episode. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. When the 10 visit threshold is met, the HHA receives a payment increase of about $2,200 more than what the HHA would received for a similar claim with 9 or fewer therapy visits. To qualify for Medicare reimbursement, therapy services must be medically necessary, properly documented, and properly authorized by a physician.

Pacific Home Health Care (Pacific) is an HHA, located in Chicago, Illinois. With the assistance of a Center for Medicare and Medicaid Services (CMS) program safeguard contractor (PSC), we reviewed selected claims submitted by Pacific and paid by Medicare. The claims included home health episodes with 10 or more therapy visits with dates of service between October 1, 2002, and September 30, 2003. For that period, there were 100 claims billed by Pacific totaling $456,637.

OBJECTIVE

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

SUMMARY OF FINDINGS

Pacific was overpaid $108,849 for therapy and skilled nursing services claims that did not comply with Federal requirements. A medical record review performed by the PSC determined that 51 of 100 sampled claims with 10 or more therapy services were inappropriately paid because they were:

- not reasonable and medically necessary;
- not provided as ordered by the physician;
- not supported by documentation in the medical record; and
- based on incorrect payment codes, which resulted in lower allowable reimbursement.

The overpayments occurred because Pacific did not have effective quality assurance and control policies and procedures to identify whether the claims including therapy visits were appropriately billed.

RECOMMENDATIONS

We recommend that Pacific:

- work with Palmetto to reimburse the Medicare program $108,849 for unallowable therapy and skilled nursing services;

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

- establish quality assurance procedures to ensure that patient needs are properly assessed and the level of care is adjusted to meet the requirement for medical necessity and correct payment coding; and

- strengthen controls to ensure that claims for final payment are reasonable and medically necessary, properly authorized by a physician, and supported by medical record documentation.

PACIFIC COMMENTS

Pacific did not directly comment on the recommendations for reimbursement of the costs questioned or adjustment of their Medicare claims after the audit period. Pacific stated that the physical therapists were following the plan of care as prescribed by each patient's physician and independently determining the appropriateness of care and disagreed that 21 claims were not reasonable and medically necessary. Pacific also stated that 13 claims should be accepted because its computer program had erroneously calculated the 60-day episode on the plans of care, which caused the medical reviewers to deny services for being ordered outside the allowable period.

Pacific stated that they have established better controls by employing quality assurance staff, upgrading their software, doing their own Medicare billing, changing key personnel and attending training.

Pacific's written comments to the draft report are included in the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that Pacific refund the overpayments for unallowable claims and review and adjust subsequent claims for similar findings. Although physician orders are the basis for the plan of care, the allowability of the claims are subject to medical review and payment adjustment as set forth in the Social Security Act and Federal regulations. We have

revised the final report to accept 13 claims, based on additional information received from Pacific.

We commend Pacific for making improvements since the audit period, as described in their response.

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INTRODUCTION

BACKGROUND

Home Health Agency

An HHA provides home visits for skilled nursing care, physical therapy, occupational therapy, speech therapy, home health aide and medical social services.

Home Health Legislation

As required by law, CMS implemented the home health Prospective Payment System (PPS), effective October 1, 2000. The new system was established pursuant to the Balanced Budget Act of 1997, as amended by the Medicare, Medicaid, and State Children's Health Insurance Program (SCHIP) Balanced Budget Refinement Act of 1999 and the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000.

Home Health Prospective Payment System

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

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

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

HHAs submit claims for reimbursement using the designated Medicare payment codes. These codes determine the reimbursement amount. Episodes with 10 or more therapy visits are referred to as having met the 10-visit therapy threshold. When an HHA claim meets the threshold, Medicare reimburses the HHA with an enhanced payment of approximately $2,200.

Regional Home Health Intermediary Responsibility

CMS contracts with regional home health intermediaries (RHHI) nationwide to process claims, assist in applying safeguards against unnecessary utilization of services, resolve disputes, and audit cost reports submitted by HHAs. Pacific's RHHI is Palmetto Government Benefits Administrator (Palmetto), located in Columbia, South Carolina.

Pacific Home Health Care

Pacific Home Health Care (Pacific), located in Chicago, Illinois, was incorporated in the State of Illinois as an HHA in October 2001 and received its Medicare provider number on April 8, 2002.

OBJECTIVE, SCOPE, AND METHODOLOGY

Objective

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

Scope

We reviewed Palmetto's Medicare payments, made to Pacific for home health claims that included therapy visits, with dates of service from October 1, 2002, through September 30, 2003. For that period, Pacific submitted and was paid for 123 home health claims that included one or more therapy visits. Based on a risk analysis, we limited our review to claims that included 10 or more therapy visits. During the audit period, Pacific submitted 100 claims that met the therapy threshold totaling $456,637.

To assist with the review of the 100 claims, we contracted with medical reviewers employed by TriCenturion, a Program Safeguard Contractor (PSC) under contract with the CMS to perform selected program integrity functions. The medical records were sent to medical reviewers, who examined the documentation and provided us with their results and conclusions.

We limited our review of internal controls at Pacific to those controls over the preparation and submission of Medicare HHA claims. Our objective did not require us to review Pacific's complete internal control structure.

We conducted the audit from August 2004 through May 2005 and October 2005 through July 2006. Our audit fieldwork included visits to Pacific's office in Chicago, Illinois.

Methodology

To accomplish our objective, we:

- reviewed applicable Medicare laws and regulations;

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

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

- obtained Pacific's medical records for each claim selected and provided those records to the PSC medical review team;

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

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

- interviewed one of Pacific's physical therapy employees;

- obtained the results and conclusions of the medical review, including the allowable payment code and amount reimbursable; and

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

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

FINDINGS AND RECOMMENDATIONS

Pacific was overpaid $108,849 for 51 claims that were not appropriately billed and did not meet Federal requirements. The PSC medical reviewers determined that therapy and skilled nursing services should be denied or adjusted to a lower reimbursement level because they were:

- not reasonable and medically necessary;
- not provided as ordered by the physician;
- not supported by documentation in the medical record; and
- based on incorrect payment codes, which resulted in lower allowable reimbursement.

The overpayments occurred because Pacific did not have effective quality assurance or control policies and procedures to identify whether the claims including therapy visits were appropriately billed.

SERVICES NOT REASONABLE AND MEDICALLY NECESSARY

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

Section 205.2 of the HHA Manual states, "The skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury within the context of the patient's unique medical condition." In addition, " . . . the amount, frequency and duration of the services must be reasonable."

Pacific was overpaid $59,325 for 21 claims with therapy and skilled nursing services that were not reasonable and medically necessary for the documented medical condition of the beneficiary. The overpaid therapy claims amounted to $55,647, while associated skilled nursing overpayments amounted to $3,678.

For example, in one episode Pacific billed 10 physical therapy services and received the higher threshold payment. But, medical records indicated that the beneficiary had met her goals at the end of the episode that preceded the dates of service of the episode under review. The PSC medical reviewers noted that Pacific did not document any decline in the beneficiary's condition that would support the need for continued therapy. Consequently, the medical reviewer denied the 10 therapy services and changed the claim's payment code to represent a lower service utilization level. The lower service utilization level reduced the allowable Medicare reimbursement by $2,311.

For another claim, Pacific billed for 10 physical therapy services. The PSC medical reviewers found that the medical records did not support the number of therapies billed. The therapist's progress note for the third visit indicated that the beneficiary would be discharged after the next visit to use a home exercise program. The PSC medical reviewers denied the next six therapy services because the physical therapy visits were not medically necessary. As a result, the claim's payment code was reduced because the claim no longer met the 10-visit threshold and Medicare reimbursement was lowered by $2,237.

The PSC medical reviewers determined that two of the 21 claims for unnecessary therapy services also included skilled nursing visits, which were not considered reasonable and medically necessary. The medical reviewers disallowed the entire skilled nursing service amount for these two claims.

SERVICES NOT PROVIDED AS ORDERED

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

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

Pacific was overpaid $19,045 for seven claims with therapy services that were not provided as ordered. The claims are denied or adjusted because the physicians' orders were incomplete or Pacific did not provide the services, did not complete the services within the timeframes ordered, or provided the services after the patient was to be discharged.

As an example, one medical record included five instances where the therapist prepared the top portion of a progress note but also wrote that the patient cancelled the visit for personal reasons. The Pacific employee that provided claim information to the contracted billing agency did not look at the full note, just the date and times at the top of the progress note and claimed the services in error. Because therapy was not rendered for these five visits, the denied services resulted in a reduced service utilization payment code.

The PSC medical reviewers did not allow any therapy services that did not follow the physicians' plan of care.

SERVICES NOT DOCUMENTED

With respect to medical record documentation, Federal regulations (42 CFR § 484.48) require that:

> A clinical record . . . [be] maintained for every patient receiving home health services. In addition to the plan of care, the record contains appropriate identifying information; name of physician; drug, dietary, treatment, and activity orders; signed and dated clinical and progress notes; copies of summary reports sent to the attending physician; and a discharge summary.

Pacific was overpaid $13,425 for six claims with therapy services that were not adequately documented in the beneficiary medical records. For four of the claims, progress notes were not available for at least one service. Another claim had two services billed per day on two different dates but only one progress note for each day in the medical record. The sixth claim for speech therapy was disallowed in its entirety because the therapist's progress notes were illegible.

Because the PSC medical reviewers denied undocumented therapy services, the number of allowable Medicare services fell below the 10-visit threshold and reimbursement for each claim was lowered by approximately $2,200.

INACCURATE PAYMENT CODES

The CMS Home Health Agency Manual for billing procedures classifies home health services into 80 home health resource groups. Each home health resource group is assigned a five-

character payment code, which represents the case mix as defined by Federal regulation 42 CFR § 484.202. The OASIS instrument is used to assess the level of care needed by each home health patient. It is the basis for determining the home health resource group for a particular claim and the payment made for the services provided.

As part of the OASIS assessment, the beneficiary's diagnosis is used to determine part of the clinical severity portion of the payment code. Because CMS recognizes that a diabetes diagnosis and certain neurological and orthopedic diagnoses account for significantly higher care costs than other diagnostic categories, these groups receive additional weight in determining the payment code.

Pacific was overpaid a total of $17,054 for therapy claims where the primary diagnosis was not supported or key information on the OASIS was contradicted, resulting in reduced payment codes for reimbursement. The PSC medical reviewers determined that nine claims were overstated by $6,569 because the primary diagnosis was not supported by other information on the OASIS or in the medical record. The medical reviewers also determined that 22 claims were overstated by $10,485 because key information on the OASIS forms, used to determine the payment code, was contradicted elsewhere in the OASIS form or within the medical record. Of the 31 claims, 14 claims had also been reduced in the prior findings related to the 10-visit threshold not being met after services were denied.

With regard to payment codes where the primary diagnosis was not supported, one claim showed the beneficiary's primary diagnosis was a stroke (neurological category) but the stroke had occurred many years earlier. The correct diagnosis should have been related to the abdominal surgery that the beneficiary had immediately before the episode with physical therapy.

With regard to information conflicting with payment code decisions, in one case, the OASIS showed the beneficiary's vision was partially impaired but another part recorded that the beneficiary had adaptive equipment and could independently read labels to take medications and perform diabetic testing. The same beneficiary was shown as having memory deficit on one part of the OASIS and yet able to express complex ideas easily in all situations on another part.

The PSC medical reviewers determined that payment codes for these claims were not supported by OASIS and medical record information and that overpayments occurred.

PACIFIC NEEDS TO IMPROVE CONTROLS

These overpayments occurred because Pacific did not have effective (1) quality assurance procedures to ensure that all therapy services provided were reasonable, medically necessary and properly coded for the beneficiaries' conditions and (2) controls to ensure that all therapy services provided were reasonable and necessary, supported by medical record documentation and properly authorized by a physician prior to submitting a claim for final payment.

RECOMMENDATIONS

We recommend that Pacific:

- work with Palmetto to reimburse the Medicare program $108,849 for unallowable therapy and skilled nursing services;

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

- establish quality assurance procedures to ensure that patient needs are properly assessed and the level of care is adjusted to meet the requirement for medical necessity and correct payment coding; and

- strengthen controls to ensure that claims for final payment are reasonable and medically necessary, properly authorized by a physician, and supported by medical record documentation.

PACIFIC COMMENTS

Pacific did not directly comment on the recommendations to work with Palmetto to reimburse Medicare for the costs questioned or to identify and adjust overpayments of Medicare claims subsequent to the audit period.

Pacific provided the following comments on the specific findings reported. Pacific stated that its physical therapists were following the plan of care as prescribed by each patient's physician and that the 21 claims questioned for medical necessity were reasonable and necessary. Pacific disagreed with the medical review determinations, stating that its therapists were independently determining the appropriateness of care in accordance with the Medicare Conditions of Participation and the Medicare regulations.

For the 20 claims with services not provided as ordered, Pacific stated that its computer program had erroneously projected the end date of the episode, starting from the admission date rather than the date of the first service and that the services for these 13 cases were provided within the 60-day episode. For another claim, a new employee erroneously used a hospice form to document the plan of care that was not accepted by the medical reviewers.

Of the seven claims not supported with documentation, Pacific provided legible therapist notes for a speech therapy claim subsequent to our audit and the medical review.

In regard to the inaccurate payment codes, Pacific did not respond to the need for repayment and misstated the number of overpayments related to coding errors.

Pacific felt they had addressed the two recommendations to establish effective controls by employing quality assurance staff, upgrading their software, doing their own Medicare billing, changing key personnel, and attending training.

Pacific's written comments to the draft report are included in the Appendix.

OFFICE OF INSPECTOR GENERAL RESPONSE

We continue to recommend that Pacific refund the overpayments for unallowable claims and review and adjust subsequent claims for similar findings. Our response to comments on specific claim findings follow.

With respect to the claims questioned for medical necessity, the physicians must order therapy and certify plans of care, but Federal regulations [42 CFR 484.205(b)] state that payments may be subject to medical review adjustments for beneficiary eligibility, medical necessity determinations, and payment codes. Section 1862(a)(1)(A) of the Social Security Act further states that Medicare payments may not be made for services that are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve functioning of a malformed body member. To assist providers with determining the allowability of therapy services, Palmetto issued guidance on the coverage of physical therapy services in its Local Coverage Determination L282, effective October 1, 2000. We continue to recommend adjustment for medically unnecessary claims established by medical review.

Based on the additional information received from Pacific, we have revised the final report to accept 13 claims for services not provided as ordered.

In regard to the claim with subsequently provided speech therapist notes and the claim denied in part because the plan of treatment was on a hospice form, we will defer the decisions to the action official.

With respect to the number of claims with inaccurate payment codes, an additional 17 claims had only the coding errors, rather than 14 cited by Pacific.

We do commend Pacific for making improvements since the audit period, as described in their response.

APPENDIX

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VIA FEDERAL EXPRESS

September 13, 2006

Ms. Sheri Fulcher
Audit Manager, Officer of Audit Services
Office of the Inspector General
Department of Health and Human Services
233 N. Michigan Ave Room 1360
Chicago, IL 60601

Re: Pacific Home Health Care
Chicago, IL 60618
Report No.: A-05-04-00103

Dear Ms. Fulcher:

We are in receipt of the U.S. Department of Health and Human Services, Office of Inspector General's ("OIG") August 15, 2006 draft report entitled: "Review of Compliance with Billing Provisions Under the Prospective Payment System for Home Health Agencies' Therapy Services at Pacific Home Health Care, Inc.," ("the Report"). We take this opportunity to respond to the Report.

A. The OIG's Findings and Recommendations

The OIG determined in its draft Report that Pacific was overpaid $140,482 for 62 claims that were inappropriately billed and did not meet Federal Requirements. The medical reviewers from LMPR determined that the claims should be adjusted for the following four (4) reasons: the services for twenty-one (21) sample claims were not reasonable and medically necessary, the services in twenty (20) sample claims were not provided as ordered, for seven (7) claims the services were not documented and fourteen (14) claims had inaccurate payment codes. After explaining its determination, the OIG made the following recommendations: "establish quality assurance procedures to ensure that patient needs are properly assessed and the level of care is adjusted to meet the requirement for medical necessity and correct payment coding.

B. Pacific's Response to the OIG's Report Findings

a. Services not reasonably and medically necessary

The Report indicated that medical reviewers from a Program Safeguard Contractor found that Pacific was overpaid for twenty-one (21) claims that the medical reviewers believe were not medically and reasonably necessary based on the documented medical condition of the beneficiary. These 21 claims (Sample numbers 11, 14, 16, 24, 32, 37, 39, 40, 49, 53, 61, 62, 67, 72, 73, 78, 90, 95, 96, 97, 98) aggregated to $55,647 in questioned therapy services and $3,678 in questioned skilled nursing services/HIPPS downcodes.

The CMS Medicare Benefit Policy Manual ("Benefit Policy Manual"), particularly Chapter 7, which deals with Home Health Services, dictates that payment can only be made to a provider if the physician certifies the need for services and establishes a plan of care ("POC"). Furthermore, the decision on whether the care is reasonable and necessary is based on the information in the POC, the OASIS or the medical record of the individual. *See* CMS Medicare Benefit Policy Manual, Ch.7, §20.1.1 -20.1.2. The Benefit Policy Manual also details what needs to be included in the plan of care. Among other requirements, the POC must describe the types of services, supplies and equipment required, as well as the frequency of visits to be made. *See* §30.2.1.

According to the Social Security Act, items and services must be furnished under a plan established and periodically reviewed by a physician. Soc. Sec Act §1861(m), 42 C.F.R. §409.42(d). The same physician must certify the medical necessity of the home health services signing the certification at the time the plan of treatment is established. *See* 42 C.F.R. §424.22.

Recertification is required at least every 60 days when a new episode of care commences. The POC must contain all pertinent diagnoses, including the beneficiary's mental status, types of services, supplies and equipment required; frequency of visits; prognosis; rehabilitation potential; functional limitations; activities permitted, nutritional requirements; safety measures to protect against injury; instructions for all medications and treatments; instructions for timely discharge or referral and any additional items the HHA or physician chooses to include. *See* 42 C.F.R. §484.18(a); Benefit Policy Manual, Ch. 7, §30.2.

The POC must be reviewed and signed by a physician in consultation with a HHA professional personnel no less frequently than every 60 days. In the case of a physical or speech therapy plans, the POC may be signed by the qualified therapist providing the services. In such cases the physician still must review the plan. *See* 42 C.F.R. §409.43(d); Benefit Policy Manual, Ch. 7, §30.2.

For the twenty-one (21) claims that the Report indicated were not medically necessary, it is Pacific's position that its physical therapists were following the POC as prescribed by each individual patient's physician and the therapists were, pursuant to the Medicare Conditions of Participation and the Medicare regulations, independently determining the appropriateness of the care. The PSC reviewers should have contacted the individual physicians or therapists if they had questions about the plan of care Since they did not, and the POC calls for the care rendered, the amount of physical therapy visits for each patient were reasonable and medically necessary as Pacific was following physician's orders.

b. Services not provided as ordered by the physician

Next, the Report found that twenty (20) claims were overpaid because the therapy services were not provided as ordered in that the physician orders were incomplete, services were not provided within the time frames in the POC, or because Pacific did not purportedly follow the ordered treatment frequency per week. (These involve Sample numbers 2, 6, 7, 15, 17, 23, 33, 36, 45, 46, 48, 52, 55, 57, 64, 75, 77, 84, 89, 92) The questioned amount for therapy services involves $48,441.

There were thirteen (13) claims that the Report found were not provided within the time frames in the POC. As discussed at the August 31, 2006 meeting with the OIG, this was a technicality that was caused by the computer program that Pacific was using at the time to create projected visit schedules. The program, called Care Facts, would list the start of care date as the date that the patient was assigned to Pacific, before any assessment of the patient had been completed.

The Benefit Policy Manual indicates that the time frame for a physical therapy episode is sixty (60) days. *See* §10.1. Pursuant to Medicare definitions, the start of care begins when the first visit is rendered, Soc. Sec. Act §1861(a). Pacific did provide physical therapy services as prescribed by the plan of care within the timeframe. It was merely a technical error caused by the Care Facts program that made it appear that services were provided outside of sixty (60) days, but Pacific could not begin the care on the day the referral was received.

The OIG acknowledged this technicality and indicated that it would allow the payment for those thirteen (13) claims at the August 31, 2006 meeting. Claim number 84 indicated that it was a hospice visit on the treatment plan, but Pacific is not a hospice agency and never was. The hospice heading was mistakenly checked by new Pacific personnel.

c. Services not supported by documentation in the medical record

In this category, the Report indicated that Pacific was overpaid for seven (7) claims. This category includes Sample number 42, 43, 54, 63, 66, 88 and 99. The questioned therapy amount is $15,662. For one of the claims, the OIG indicated that the patient files were unreadable. This claim was for speech therapy. The Speech Therapist subsequently provided a printed version that was verbatim to what his original notes indicated.

At the August 31, 2006 meeting, the OIG agreed to allow Claim number 43, which involves $2,237. It is Pacific's position that the speech therapy claim should be allowed, as the OIG was provided with legible notes regarding the claim from the therapist.

d. Inaccurate Payment Codes

In the final category, the Report indicated that fourteen (14) claims were questioned because the medical reviewers determined that payment codes for these claims were not supported by OASIS and medical record information. This involves $17,053.

C. Pacific's Response to the OIG's Report Recommendations.

In the report the OIG suggested the Pacific needs to improve controls. Specifically, the report stated that Pacific "did not have effective (1) quality assurance procedures to ensure that all therapy services provided were reasonable, medically necessary and properly coded for the beneficiaries' conditions and (2) controls to ensure that all therapy services provided were reasonable and necessary, supported by medical record documentation and properly authorized by a physician prior to submitting a claim for final payment." The report recommended that Pacific establish quality assurance procedures and strengthen controls.

Quality Assurance Procedures. Since 2002-2003, Pacific has already made such changes as recommended by the Report, among others, to ensure that it is submitting accurate claims for payment to Medicare. First, Pacific now employs Quality Assurance Staff ("Q/A Staff"). The Q/A Staff periodically takes samples of patient cases and reviews the charts to verify that the forms are accurately filled out, the services completed according to the POC and that the services are medically and reasonably necessary.

Care Facts no longer used. Furthermore, Pacific no longer utilizes the Care Facts computer program to organize its therapy visit schedules. Pacific has since upgraded

to the Genie Unit program which is provided by New Tech in California. The Genie computer program provides more of a high tech approach to producing therapy visit schedules than the Care Facts program did.

Billing in-house. Pacific also now does its billing in-house. It has a trained employee in charge of billing to ensure that claims are made accurately and that in the event that a mistake is made, it can be quickly and easily corrected.

Change in key personnel and organizational responsibilities In addition to the recommendations made by the report, Pacific has changed its organizational chart. During the periods audited, there was a different administrator in charge of Pacific. Currently, both Leticia Jimenez and Bernadette Pingue serve as administrators of Pacific, although for reporting purposes Ms. Jimenez is the Administrator and Ms. Pingue is the Director of Nurses. Both are registered nurses who are members of the Board of Directors of Pacific, as well as employees. As such, Ms. Jimenez and Ms. Pingue are more involved in the day to day operations than the previous administrator. Ms. Jimenez and Ms. Pingue take an active role in supervising the assessment of patients and the level of care provided to ensure that the care is medically necessary.

Outside and in-house training Under the administration of Ms. Jimenez and Ms. Pingue, Pacific's entire staff regularly attends CMS endorsed training and education conferences and in-services to keep themselves up to date on the current changes and trends in the health care industry.

Pacific will continue its training and education practices to ensure that controls are in place to monitor and manage its Medicare payment claims.

D. Conclusion

On October 1, 2002, Pacific was a relatively new Medicare Provider, as it became Medicare certified in April of 2002. While Pacific's principals, Ms. Jimenez and Ms. Pingue, were experienced nurses and had worked in other home health agencies, Pacific initially relied heavily on its former administrator, management and computer consultant. Some of the early charting errors were caused merely in the recording of the care rendered. In the last several years, Pacific has continually been rated as a high quality home care provider and its charts today are some of the best in the home care industry. Pacific has already demonstrated to the OIG that much of the $140,482 still being question can be explained to show that the claims were made properly and according to

Federal Requirements. Accordingly, Pacific requests that the OIG minimize the amount of disallowances that have been identified for the sample period.

Thank you for your professionalism and your cooperation. Should you have any questions concerning this matter, please do not hesitate to contact me.

Sincerely,

Charles MacKelvie

Charles F. MacKelvie

cc: Ms. Cynthia Owens