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Client Alert

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OIG Report Finds 22 Percent Error Rate in Home Health Agency Claims

On March 12, 2012, the Office of Inspector General of the U.S. Department of Health and Human Services (OIG) issued a report detailing its review of a sample of claims submitted by home health agencies (HHAs) in 2008.[1] The report notes that the number of HHAs grew by 39 percent from 2002 to 2008, and Medicare spending on home health increased 84 percent between 2000 and 2007, leading to concerns regarding the potential for fraud and abuse. In light of these concerns, the OIG conducted a review of HHA claims submitted in calendar year 2008 for 489 Medicare beneficiaries. This review found that 22 percent of the reviewed claims were submitted in error because the services either were not medically necessary or were coded inaccurately, resulting in $432 million in improper Medicare payments.

OIG's Findings

OIG's medical record review determined the following:

1. 98 percent of beneficiaries were homebound (OIG could not determine whether the remaining 2 percent were homebound);
2. All beneficiaries needed intermittent skilled nursing care, physical therapy or speech therapy, or had a continuing need for occupational therapy; and
3. 98 percent of the beneficiaries were under the care of a physician.

OIG determined that only 11 percent of the records documented at least one face-to-face visit with the ordering physician. OIG acknowledged that Medicare did not require face-to-face meetings in 2008 but stated that the Centers for Medicare & Medicaid Services (CMS) expected HHAs to document face-to-face meetings as of April 1, 2011.

OIG also determined that all medical records reviewed included a plan of care, but 36 percent lacked at least one required item. The most common care plan deficiencies were failure to address discharge planning (18 percent), lack of information about rehabilitation potential (9 percent), lack of instructions for timely discharge or referral (7 percent) and frequency of visits to be made (6 percent). The report also indicated that in 2008 state surveyors cited 12 percent of HHAs for not following a written plan of care established and periodically reviewed by a physician and also cited 9 percent of all HHAs because of missing items in their plans of care.

1 HHS, OIG, *Documentation of Coverage Requirements for Medicare Home Health Claims*, OEI-01-08-00390, March 2012.

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OIG's medical record review further determined that 22 percent of the reviewed claims were in error because the services either were unnecessary or were coded inaccurately. Medically unnecessary services accounted for 2 percent of all claims ($328 million), while upcoded and downcoded claims each accounted for about 10 percent of all claims ($278 million in estimated overpayments for upcoded claims, and $184 million in estimated underpayments for downcoded claims). Upcoding was often the result of inappropriate diagnosis codes. The report explains that, "[a]lthough a beneficiary may be accurately diagnosed with a disease, it is appropriate to list it for payment purposes only when the plan of care addresses the condition."[2] As an example, the report states that if a beneficiary has gastroesophegeal reflux disease (GERD), it is appropriate to list this diagnosis "in cases that included documentation on diet and medication education along with an assessment that specifically addressed the GERD diagnosis," but it would be inappropriate to list the diagnosis "with no further documentation related to this diagnosis other than listing the GERD medication that the beneficiary was taking."[3]

Conclusion

OIG concluded that, although its review demonstrated that "HHAs nearly always document the information necessary to demonstrate compliance with Medicare coverage and payment requirements,"[4] "other OIG studies and investigations, as well as joint efforts between HHS and DOJ, have demonstrated that home health is an area at increased risk for fraud."[5] OIG noted that because it did not look behind the medical records to determine their accuracy, the eligibility of the beneficiaries, or whether the documented services were actually provided, it could not determine the extent to which any claims were properly paid. Because of these limitations of the medical record review and the remaining concerns regarding the potential for fraud and abuse, OIG concluded "that further investigations beyond the medical records are needed to determine whether beneficiaries are eligible, services are furnished, and Medicare requirements for payment are met."[6]

For a copy of the OIG's March 12, 2012, report, please click here.[7]

2 *Id*. at 11.
3 *Id.*
4 *Id.*
5 *Id.* at 11-12.
6 *Id.* at 12.
7 http://oig.hhs.gov/oei/reports/oei-01-08-00390.pdf