

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOME HEALTH AGENCY  
PROVIDER COMPLIANCE AUDIT:  
CONDADO HOME CARE  
PROGRAM, INC.**

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# *Office of Inspector General*

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## Report in Brief

Date: August 2020

Report No. A-02-17-01022

U.S. DEPARTMENT OF HEALTH & HUMAN SERVICES  
**OFFICE OF INSPECTOR GENERAL**



### Why OIG Did This Audit

Under the Medicare home health prospective payment system (PPS), the Centers for Medicare & Medicaid Services pays home health agencies (HHAs) a standardized payment for each 60-day episode of care that a beneficiary receives. The PPS payment covers intermittent skilled nursing and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies.

Prior reviews of home health services identified significant overpayments to HHAs. These overpayments were largely the result of HHAs improperly billing for services to beneficiaries who were not confined to the home (homebound) or not in need of skilled services.

Our objective was to determine whether Condado Home Care Program, Inc. (Condado), complied with Medicare requirements for billing home health services on selected types of claims.

### How OIG Did This Audit

Our audit covered \$2.4 million in Medicare payments made to Condado for 1,418 claims provided during the period October 1, 2015, through September 30, 2017 (audit period). We selected a simple random sample of 100 claims for audit and submitted these claims to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

## Medicare Home Health Agency Provider Compliance Audit: Condado Home Care Program, Inc.

### What OIG Found

Condado did not comply with Medicare billing requirements for 14 of the 100 home health claims that we audited. Specifically, Condado incorrectly billed Medicare for (1) services provided to beneficiaries who were not homebound, (2) services provided to beneficiaries who did not require skilled services, (3) incorrect Health Insurance Prospective Payment System payment codes, or (4) services provided under a plan of care that did not meet Medicare requirements.

These errors occurred because Condado did not have adequate procedures in place to prevent the incorrect billing of Medicare claims within selected risk areas.

On the basis of our sample results, we estimated that Condado received overpayments of at least \$97,210 for the audit period.

### What OIG Recommends and Condado Comments

We made several recommendations to Condado, including that it (1) refund to the Medicare program the portion of the estimated \$97,210 in overpayments for claims incorrectly billed that are within the 4-year claim reopening period; (2) exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule; and (3) exercise reasonable diligence to identify and return any additional similar overpayments outside the reopening period. We also made several procedural recommendations.

In written comments on our draft report, Condado did not specifically indicate concurrence or nonconcurrence with our findings or recommendations; however, it described corrective actions it has taken to address our procedural recommendations. After reviewing Condado's comments, we maintain that our findings and recommendations are valid. We commend Condado for taking corrective actions to address our findings and continue to encourage Condado to take the necessary steps to address our financial recommendations and identify, report, and return overpayments accordingly.

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## INTRODUCTION

### WHY WE DID THIS AUDIT

For calendar year (CY) 2016, Medicare paid home health agencies (HHAs) about \$18 billion for home health services. The Centers for Medicare & Medicaid Services (CMS) determined through its Comprehensive Error Rate Testing (CERT) program that the 2016 improper payment error rate for home health claims was 42 percent, or about \$7.7 billion. Although Medicare spending for home health care accounts only for about 5 percent of fee-for-service spending, improper payments to HHAs account for more than 18 percent of the total 2016 fee-for-service improper payments (\$41 billion). This audit is part of a series of audits of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk for noncompliance with Medicare billing requirements. Condado Home Care Program, Inc., (Condado) was one of those HHAs.

### OBJECTIVE

Our objective was to determine whether Condado complied with Medicare requirements for billing home health services on selected types of claims.

### BACKGROUND

#### **The Medicare Program and Payments for Home Health Services**

Medicare Parts A and B cover eligible home health services under a prospective payment system (PPS). The PPS covers part-time or intermittent skilled nursing care and home health aide visits, therapy (physical, occupational, and speech-language pathology), medical social services, and medical supplies. Under the home health PPS, CMS pays HHAs for each 60-day episode of care that a beneficiary receives.

CMS adjusts the 60-day episode payments using a case-mix methodology based on data elements from the Outcome and Assessment Information Set (OASIS). The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical severity, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcomes and to determine whether adjustments to the case-mix groups are warranted. The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS)

payment codes<sup>1</sup> and represent specific sets of patient characteristics.<sup>2</sup> CMS requires HHAs to submit OASIS data as a condition of payment.<sup>3</sup>

CMS administers the Medicare program and contracts with four of its Medicare administrative contractors to process and pay claims submitted by HHAs.

### **Home Health Agency Claims at Risk for Incorrect Billing**

In prior years, our audits at other HHAs identified findings in the following areas:

- beneficiaries did not always meet the definition of “confined to the home,”
- beneficiaries were not always in need of skilled services,
- HHAs did not always submit OASIS data in a timely fashion, and
- services were not always adequately documented.

For the purposes of this report, we refer to these areas of incorrect billing as “risk areas.”

### **Medicare Requirements for Home Health Agency Claims and Payments**

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (Social Security Act (the Act) § 1862(a)(1)(A)). Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR § 409.42 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is:

- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis or physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician; and

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<sup>1</sup> HIPPS payment codes represent specific sets of patient characteristics (or case-mix groups) on which payment determinations are made under several Medicare prospective payment systems, including those for skilled nursing facilities, inpatient rehabilitation facilities, and home health agencies.

<sup>2</sup> The final payment is determined at the conclusion of the episode of care using the OASIS information but also factoring in the number and type of home health services provided during the episode of care.

<sup>3</sup> 42 CFR §§ 484.20, 484.55, 484.210(e), and 484.250(a)(1); 74 Fed. Reg. 58077, 58110-58111 (Nov. 10, 2009); and CMS’s *Medicare Program Integrity Manual*, Pub. No. 100-08, chapter 3, § 3.2.3.1.



- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition of payment, a physician must certify that a face-to-face encounter occurred no more than 90 days prior to the home health start-of-care or within 30 days of the start of care (42 CFR § 424.22(a)(1)(v)). In addition, the Act precludes payment to any provider of services or other person without information necessary to determine the amount due the provider (§ 1833(e)).

The determination of “whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS as required by 42 CFR § 484.55, or a medical record of the individual patient” (*Medicare Benefit Policy Manual* (the Manual), chapter 7, § 20.1.2). Coverage determination is not made solely on the basis of general inferences about patients with similar diagnoses or on data related to utilization generally but is based upon objective clinical evidence regarding the beneficiary’s individual need for care (42 CFR § 409.44(a)).

Appendix B contains the details of selected Medicare coverage and payment requirements for HHAs.

### **Medicare Requirements for Providers to Identify and Return Overpayments**

The Office of Inspector General (OIG) believes that this audit report constitutes credible information of potential overpayments. Upon receiving credible information of potential overpayments, providers must exercise reasonable diligence to identify overpayments (i.e., determine receipt of and quantify any overpayments) during a 6-year lookback period. Providers must report and return any identified overpayments by the later of (1) 60 days after identifying those overpayments or (2) the date that any corresponding cost report is due (if applicable). This is known as the 60-day rule.<sup>4</sup>

The 6-year lookback period is not limited by OIG’s audit period or restrictions on the Government’s ability to reopen claims or cost reports. To report and return overpayments under the 60-day rule, providers can request the reopening of initial claims determinations, submit amended cost reports, or use any other appropriate reporting process.<sup>5</sup>

### **Condado Home Care Program, Inc.**

Condado is a for-profit HHA located in San Juan, Puerto Rico. National Government Services, its Medicare administrative contractor, paid Condado approximately \$2.7 million for 1,657 claims

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<sup>4</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

<sup>5</sup> 42 CFR §§ 401.305(d), 405.980(c)(4), and 413.24(f); CMS, Provider Reimbursement Manual, Pub. No. 15-1, part 1, § 2931.2; 81 Fed. Reg. at 7670.

for services provided from October 1, 2015, through September 30, 2017 (audit period) according to CMS's National Claims History (NCH) data.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered \$2,410,919 in Medicare payments made to Condado for 1,418 claims provided during the audit period.<sup>6</sup> We selected a simple random sample of 100 claims with payments totaling \$169,234 for audit. We evaluated compliance with selected billing requirements and submitted these claims to an independent medical review contractor to determine whether the services met coverage, medical necessity, and coding requirements.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

Appendix A contains the details of our scope and methodology, Appendix C contains our statistical sampling methodology, Appendix D contains our sample results and estimates, and Appendix E contains the types of errors for each sample claim.

## **FINDINGS**

Condado did not comply with Medicare billing requirements for 14 of the 100 home health claims that we audited. For these claims, Condado received overpayments of \$13,771 for services provided during our audit period. Specifically, Condado incorrectly billed Medicare for:

- services provided to beneficiaries who were not homebound,
- services provided to beneficiaries who did not require skilled services,
- incorrect HIPPS payment codes, and
- services provided under a plan of care that did not meet Medicare requirements.

These errors occurred because Condado did not have adequate procedures in place to prevent the incorrect billing of Medicare claims within selected risk areas. On the basis of our sample results, we estimated that Condado received overpayments of at least \$97,210 for the audit

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<sup>6</sup> In developing this sampling frame, we excluded from our audit, home health claims that were identified in the Recovery Audit Contractor (RAC) data warehouse and requests for anticipated payment.

period.<sup>7</sup> As of the publication of this report, this amount includes claims outside of the 4-year claim reopening period.<sup>8</sup>

## **CONDADO HOME CARE PROGRAM, INC., BILLING ERRORS**

Condado incorrectly billed Medicare for 14 of the 100 sampled claims, which resulted in overpayments of \$13,771.<sup>9</sup>

### **Beneficiaries Were Not Homebound**

#### *Federal Requirements for Home Health Services*

For the reimbursement of home health services, the beneficiary must be “confined to the home” (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42)). According to section 1814(a) of the Act:

[A]n individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7 § 30.1.1).<sup>10</sup> The Manual states that for a patient to be eligible to receive covered home health services under both Parts A and B, the law requires that a physician certify in all cases that the patient is

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<sup>7</sup> To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits calculated in this manner are designed to be less than the actual overpayment total 95 percent of the time.

<sup>8</sup> See 42 CFR § 405.980(b)(2) (permitting a contractor to reopen an initial determination within 4 years for good cause) and 42 CFR § 405.980(c)(2) (permitting a provider to request that a contractor reopen within 4 years for good cause). Notwithstanding, a provider can request that a contractor reopen an initial determination for the purpose of reporting and returning overpayments under the 60-day rule without being limited by the 4-year reopening period. 42 CFR § 405.980(c)(4).

<sup>9</sup> The total number of errors exceeds 14 because 6 claims contained more than 1 type of error.

<sup>10</sup> Revision 208 of § 30.1.1 (effective January 1, 2015) and Revision 233 of § 30.1.1 (effective January 1, 2017) covered all of our audit period. Coverage guidance is substantively identical in both versions of § 30.1.1 in effect during our audit period. The only difference is that Revision 233 provides further clarification of existing policies for clinicians who must decide whether to certify that a patient is homebound.

confined to his or her home and that an individual will be considered “confined to the home” (homebound) if the following two criteria are met:

#### *Criteria One*

The patient must either:

- because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave his or her place of residence; or
- have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

#### *Criteria Two*

There must exist a normal inability to leave home, and leaving home must require a considerable and taxing effort.

#### *Condado Did Not Always Meet Federal Requirements for Home Health Services*

For 9 of the 100 sampled claims, Condado incorrectly billed Medicare for home health episodes for beneficiaries who did not meet the above requirements for being homebound for the full episode (5 claims) or a portion of an episode (4 claims).<sup>11</sup>

#### **Example 1: Beneficiary Not Homebound – Entire Episode**

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The beneficiary was not homebound at the start of care or during the episode. The beneficiary had a medical history that included speech and language deficits following cerebrovascular disease, type II diabetes, and tonsillectomy; and difficulty walking. The beneficiary was evaluated for physical therapy at the start of care and it was determined that physical therapy was not needed because the beneficiary was able to walk within his home. There were no defined barriers for the beneficiary to leave the home and no evidence that leaving his home would have required a considerable and taxing effort.

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<sup>11</sup> Three of these claims were also billed with skilled services that were not medically necessary, two claims contained incorrect billing codes, and one claim contained skilled services not medically necessary and a plan of care error. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

## Example 2: Beneficiary Not Homebound – Partial Episode

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For another beneficiary, records indicated that home health services were ordered to treat decreased mobility, intractable pain, and decreased ambulation. The beneficiary also had a surgical wound that had not healed. She lived alone at home, was dependent on someone else to dress her, and could only walk with another person present. Leaving the home would have required a considerable and taxing effort at the start of care. However, during the episode of care that started on October 24, 2015, her mobility status improved. Specifically, by November 20, 2015, she was able to walk 100 feet on all types of surfaces using a cane with supervision and could tolerate sitting and standing for up to 30 minutes. In addition, there was no evidence in the records that leaving the home required a considerable or taxing effort after November 20, 2015. The medical information does not support that she remained homebound after this date nor that physical therapy services were still needed.

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These errors occurred because Condado did not have adequate oversight procedures in place to ensure that it verified and continually monitored the homebound status of Medicare beneficiaries under its care and did not always properly document the specific factors that qualified the beneficiaries as homebound.

### Beneficiaries Did Not Require Skilled Services

#### *Federal Requirements for Skilled Services*

A Medicare beneficiary must need skilled nursing care intermittently, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A)) and Federal regulations (42 CFR § 409.42(c)). In addition, skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).<sup>12</sup> Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2.1). Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition (the Manual, chapter 7, § 20.1.2).

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<sup>12</sup> Skilled nursing services can include observation and assessment of a patient's condition, management and evaluation of a patient plan of care, teaching and training activities, and administration of medications, among other things (the Manual, chapter 7, § 40.1.2).

## *Condado Did Not Always Meet Federal Requirements for Skilled Services*

For 8 of the 100 sampled claims, Condado incorrectly billed Medicare for an entire home health episode (4 claims) or a portion of an episode (4 claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.<sup>13</sup>

### **Example 3: Beneficiary Did Not Require Skilled Services – Entire Episode**

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A beneficiary in her first episode of care with a medical history including cognitive and memory deficits, hemiplegia,<sup>14</sup> and dysarthria,<sup>15</sup> was referred to speech therapy for cognitive training, minimizing her speech disorder, and improving her ability to swallow. The speech therapy assessment noted that the beneficiary had minimal cognitive deterioration, a mild swallowing disorder where she was able to eat a normal diet and a speech disorder that did not require a lot of help. Accordingly, speech therapy services were not needed.

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### **Example 4: Beneficiary Did Not Require Skilled Services – Partial Episode**

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For another beneficiary, records showed a medical history including left hip fracture, falls, age-related osteoporosis, osteoarthritis, and general muscle weakness. Physical therapy services were ordered to treat the beneficiary's decreased strength, balance, mobility, and increased pain. At the start of care (March 20, 2016), she required supervision or an assistive device for walking around and transferring. However, by March 22, 2016, she was able to walk 70 feet on all types of surfaces and was independent with bed mobility and transfers. As of that date, the only physical therapy services being provided were repetitive gait training exercises, which is not a skilled service. As a result, there was no need for continued therapy after March 22, 2016.

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These errors occurred because Condado's procedures were not adequate to ensure that sufficient clinical review was provided to verify that beneficiaries required skilled services.

## **Condado Billed Home Health Services Using An Incorrect Payment Code**

### *Federal Requirements for Billing Medicare Home Health Services*

For reimbursement of home health services, a Medicare claim must be completed accurately (*Medicare Claims Processing Manual*, chapter 1, § 80.3.2.2). This includes assigning the

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<sup>13</sup> Three of these claims also contained homebound errors and one claim contained a homebound error and a plan of care error. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

<sup>14</sup> Paralysis of one side of the body.

<sup>15</sup> Unclear or slurred speech.

appropriate HIPPS payment code as it relates to the data elements reported in the beneficiaries' OASIS data.

#### *Condado Did Not Always Meet Federal Requirements for Billing Medicare Home Health Services*

For 3 of the 100 sampled claims, Condado did not bill Medicare for home health episodes using the appropriate HIPPS payment code.<sup>16</sup> Specifically, OASIS data did not support the HIPPS code Condado used. For all of these claims, the error resulted in overstated levels of functional and/or supply severity.

These errors occurred because Condado did not have adequate oversight procedures to ensure that it used the appropriate HIPPS code when billing Medicare for the services provided.

#### **Plan of Care Did Not Meet Medicare Requirements**

##### *Federal Requirements for Home Health Services Plans of Care*

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR § 409.42 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is receiving services under a plan of care that has been established and periodically reviewed by a physician. The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

##### *Condado Did Not Always Meet Federal Requirements for Home Health Services Plans of Care*

For 1 of the 100 sampled claims, Condado billed Medicare for a home health episode that did not meet Medicare plan of care requirements.<sup>17</sup> Specifically, the plan of care did not contain the date that the physician reviewed it.

This error occurred because Condado did not have procedures in place to ensure that physicians always included the date of review when signing the plan of care.

#### **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that Condado received overpayments of at least \$97,210 for the audit period.

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<sup>16</sup> Two of these claims also contained homebound errors. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

<sup>17</sup> This claim also contained a homebound error and skilled services not medically necessary error. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

## RECOMMENDATIONS

We recommend that Condado Home Care Program, Inc.:

- refund to the Medicare program the portion of the estimated \$97,210 in overpayments for claims incorrectly billed that are within the 4-year claim reopening period;<sup>18</sup>
- based upon the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule,<sup>19</sup> and identify any of those returned overpayments as having been made in accordance with this recommendation;
- for the remaining portion of the estimated \$97,210 in overpayments that are outside of the Medicare reopening period, exercise reasonable diligence to identify and return overpayments in accordance with the 60-day rule and identify any returned overpayments as having been made in accordance with this recommendation; and
- strengthen its procedures to ensure that:
  - the homebound status of Medicare beneficiaries is verified and continually monitored and the specific factors qualifying beneficiaries as homebound are documented;
  - beneficiaries are receiving only reasonable and necessary skilled services;
  - home health episodes are billed correctly; and
  - plans of care comply with Medicare requirements.

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<sup>18</sup> OIG audit recommendations do not represent final determinations by Medicare. CMS, acting through a MAC or other contractor, will determine whether overpayments exist and will recoup any overpayments consistent with its policies and procedures. Providers have the right to appeal those determinations and should familiarize themselves with the rules pertaining to when overpayments must be returned or are subject to offset while an appeal is pending. The Medicare Part A and Part B appeals process has five levels (42 CFR § 405.904(a)(2)), and if a provider exercises its right to an appeal, the provider does not need to return overpayments until after the second level of appeal. Potential overpayments identified in OIG reports that are based on extrapolation may be re-estimated depending on CMS determinations and the outcome of appeals.

<sup>19</sup> This recommendation does not apply to any overpayments that are both within our sampling frame (i.e., the population from which we selected our statistical sample) and refunded based upon the extrapolated overpayment amount. Those overpayments are already covered in the previous recommendation.



## OTHER MATTERS: PLANS OF CARE SIGNED AFTER CERTIFICATION PERIOD

The Medicare program will pay a request for anticipated payment even though the physician has not signed the plan of care (42 CFR § 409.43(c)).<sup>20</sup> Moreover, the Medicare program will make final percentage payment as long as the physician signs and dates the plan of care before the claim for the episode of service is submitted, even if the physician does not sign and date the plan of care during the episode of service (42 CFR § 409.43(c)(3)). Nevertheless, Federal law and regulations require, as conditions of payment, coverage, and participation, that physicians *establish* plans of care for home health services.

Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is receiving services under a plan of care that has been *established* and periodically reviewed by a physician. Federal regulations (42 CFR § 409.42(b)) require, as a condition of coverage for home health services, that a beneficiary be under the care of a physician who *establishes* the plan of care. Moreover, 42 CFR § 484.18<sup>21</sup> requires, as a condition of participation, that a plan of care be *established* and periodically reviewed by a physician at least once every 60 days.

Forty of the one hundred claims in our sample had plans of care that were signed by a physician after the 60-day certification period, but prior to submission of claims for final percentage payment. These plans of care documented the verbal start of care orders signed by a nurse or other medical professional, not by a physician, and they were dated on the first day of the 60-day episode. Part B claims for evaluation and management (E/M) services submitted by the physicians during the 60-day certification period accounted for 10 of these 40 claims. For 6 of these 10 claims, the E/M services occurred while the beneficiaries were receiving HHA services.

The physicians' signature on plans of care after the 60-day certification period may indicate an absence of physician participation in establishing and reviewing plans of care. Without a physician's signature contemporaneous with the establishment of the plan of care, it may not be clear from the medical record that Medicare requirements listed above were met. While there is no specific requirement that the plan of care be signed by the physician at the time it was established, such a signature may be an effective way to document that the Medicare requirements were met. Condado had policies and procedures indicating that physicians sign plans of care "as soon as possible" but those policies did not include a specific timeframe for when Condado should verify that physicians signed the plans of care. CMS's Center for Clinical Standards and Quality told us that, from a survey and certification vantage point, Medicare requires a physician's signature as soon as a home health plan of care has been written, and

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<sup>20</sup> Federal regulations (42 CFR § 409.43(c)(1)(i)(D)) require that, as a condition of payment for a RAP, if the physician has not signed the plan of care by the time the home health agency submits the RAP, the physician verbal order be copied into the plan of care, which is *immediately* submitted to the physician. This suggests the urgency of physician involvement in reviewing and establishing the plan of care.

<sup>21</sup> This requirement was moved to 42 CFR § 484.60(a) effective January 13, 2018 (82 Fed. Reg. 4504 (Jan. 13, 2017)); 82 Fed. Reg. 31729 (July 10, 2017).

failure to obtain a physician's signature at that point in time on a scale we found for Condado (40 of 100 claims) would be cause for CMS to require corrective action under Medicare Conditions of Participation. We suggest that Condado review this matter and take the necessary steps to ensure there is clear evidence that Medicare requirements associated with physician establishment of the plan of care have been met.

### **CONDADO HOME CARE PROGRAM, INC., COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE**

In written comments on our draft report, Condado did not specifically indicate concurrence or nonconcurrence with our findings or recommendations; however, it described corrective actions it has taken to address our procedural recommendations. Specifically, Condado stated that it has developed new or revised policies and procedures to: (1) reinforce and continuously monitor compliance with home health requirements related to homebound status and the need for skilled services, and (2) ensure home health services are adequately documented and billed with the correct HIPPS code. Additionally, Condado stated that it trained its staff on these policies and procedures. Condado's comments are included as Appendix F.<sup>22</sup>

After reviewing Condado's comments, we maintain that our findings and recommendations are valid. We commend Condado for taking corrective actions to address our findings and continue to encourage Condado to take the necessary steps to address our financial recommendations and identify, report, and return overpayments accordingly.

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<sup>22</sup> We redacted portions of Condado's comments that contained personally identifiable information.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$2,410,919 in Medicare payments made to Condado for 1,418 claims for home health services provided to beneficiaries during the period October 1, 2015, through September 30, 2017 (audit period). From this sampling frame, we selected for audit a simple random sample of 100 home health claims with payments totaling \$169,234.

We evaluated compliance with selected billing requirements and submitted the sampled claims to an independent medical review to determine whether the services met coverage, medical necessity and coding requirements.

We limited our audit of Condado's internal controls to those applicable to specific Medicare billing procedures because our objective did not require an understanding of all internal controls over the submission and processing of claims. We established reasonable assurance of the authenticity and accuracy of the data obtained from CMS's NCH file, but we did not assess the completeness of the file.

We conducted our fieldwork at Condado from March 2018 through February 2020.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Condado's paid claims data from CMS's NCH file for the audit period;
- removed payments for home health claims that were identified in the RAC data warehouse and requests for anticipated payment;
- selected a simple random sample of 100 claims totaling \$169,234 for detailed review (Appendix C);
- reviewed available data from CMS's Common Working File for the sampled claims to determine whether the claims had been cancelled or adjusted;
- obtained and reviewed billing and medical record documentation provided by Condado to support the claims sampled;
- reviewed sampled claims for compliance with known risk areas;

- used an independent medical review contractor to determine whether the 100 claims contained in the sample were reasonable and necessary and met Medicare coverage and coding requirements;
- reviewed Condado’s procedures for billing and submitting Medicare claims;
- verified Commonwealth licensure information for selected medical personnel providing services to the patients in our sample;
- calculated the correct payments for those claims requiring adjustments;
- used the results of the sample to estimate the total Medicare net overpayments to Condado for our audit period (Appendix D); and
- discussed the results of our audit with Condado officials.

We conducted this performance audit in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objectives.

## **APPENDIX B: MEDICARE REQUIREMENTS FOR COVERAGE AND PAYMENT OF CLAIMS FOR HOME HEALTH SERVICES**

### **GENERAL MEDICARE REQUIREMENTS**

Medicare payments may not be made for items and services that “are not reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member” (the Act § 1862(a)(1)(A)).

*CMS’s Medicare Claims Processing Manual*, Pub. No. 100-04, states: “In order to be processed correctly and promptly, a bill must be completed accurately” (chapter 1, § 80.3.2.2).

### **OUTCOME AND ASSESSMENT INFORMATION SET DATA**

The OASIS is a standard set of data elements that HHA clinicians use to assess the clinical needs, functional status, and service utilization of a beneficiary receiving home health services. CMS uses OASIS data to assign beneficiaries to the appropriate categories, called case-mix groups, to monitor the effects of treatment on patient care and outcome, and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries can be classified into 153 case-mix groups that are used as the basis for the HIPPS payment codes used by Medicare in its prospective payment systems. Case-mix groups represent specific sets of patient characteristics and are designed to classify patients who are similar clinically in terms of resources used.

CMS requires the submission of OASIS data as a condition of payment as of January 1, 2010 (42 CFR § 484.210(e); 74 Fed. Reg. 58078, 58110 (Nov. 10, 2009); and *CMS’s Medicare Program Integrity Manual*, Pub. No. 100-08. chapter 3, § 3.2.3.1).

### **COVERAGE AND PAYMENT REQUIREMENTS**

To qualify for home health services, Medicare beneficiaries must (1) be homebound; (2) need intermittent skilled nursing care (other than solely for venipuncture for the purpose of obtaining a blood sample) or physical therapy, speech-language pathology, or occupational therapy;<sup>23</sup> (3) be under the care of a physician; and (4) be under a plan of care that has been established and periodically reviewed by a physician (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A), 42 CFR § 409.42 and the Manual, chapter 7, § 30).

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<sup>23</sup> Effective January 1, 2012, CMS clarified the status of occupational therapy to reflect when it becomes a qualifying service rather than a dependent service. Specifically, the first occupational therapy service, which is a dependent service, is covered only when followed by an intermittent skilled nursing care service, a physical therapy service, or a speech language pathology service as required by law. Once that requirement for covered occupational therapy has been met, however, all subsequent occupational therapy services that continue to meet the reasonable and necessary statutory requirements are considered qualifying services in both the current and subsequent certification periods (subsequent adjacent episodes) (76 Fed. Reg. 68526, 68590 (Nov. 4, 2011)).

Per the Manual, chapter 7, § 20.1.2, whether care is reasonable and necessary is based on information reflected in the home health plan of care, the OASIS, or a medical record of the individual patient.

The Act and Federal regulations state that Medicare pays for home health services only if a physician certifies that the beneficiary meets the above coverage requirements (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and 42 CFR § 424.22(a)).

Section 6407(a) of the Affordable Care Act<sup>24</sup> added a requirement to sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act that the physician have a face-to-face encounter with the beneficiary. In addition, the physician responsible for performing the initial certification must document that the face-to-face patient encounter, which is related to the primary reason the patient requires home health services, has occurred no more than 90 days before the home health start-of-care date or within 30 days of the start of the home health care by including the date of the encounter.<sup>25</sup>

### **Confined to the Home**

For reimbursement of home health services, the beneficiary must be “confined to the home” (the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42). According to section 1814(a) of the Act:

[A]n individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home,” the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.

CMS provided further guidance and specific examples in the Manual (chapter 7 § 30.1.1). The Manual states that for a patient to be eligible to receive covered home health services under both Part A and Part B, the law requires that a physician certify in all cases that the patient is

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<sup>24</sup> The Patient Protection and Affordable Care Act, P.L. No. 111-148 (March 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. No. 111-152 (March 30, 2010), collectively known as the Affordable Care Act.

<sup>25</sup> See 42 CFR § 424.22(a)(1)(v) and the Manual, chapter 7, § 30.5. The initial effective date for the face-to-face requirement was January 1, 2011. However, on December 23, 2010, CMS granted HHAs additional time to establish protocols for newly required face-to-face encounters. Therefore, documentation regarding these encounters must be present of certifications for patients with starts of care on or after April 1, 2011.

confined to his or her home. For purposes of the statute, an individual must be considered “confined to the home” (homebound) if the following two criteria are met:

#### *Criteria One*

The patient must either:

- because of illness or injury, need the aid of supportive devices, such as crutches, canes, wheelchairs, and walkers; the use of special transportation; or the assistance of another person in order to leave his or her place of residence; or
- have a condition such that leaving his or her home is medically contraindicated.

If the patient meets one of the Criteria One conditions, then the patient must also meet two additional requirements defined in Criteria Two below.

#### *Criteria Two*

There must exist a normal inability to leave home, and leaving home must require a considerable and taxing effort.

### **Need for Skilled Services**

#### *Intermittent Skilled Nursing Care*

To be covered as skilled nursing services, the services must require the skills of a registered nurse, or a licensed practical (vocational) nurse under the supervision of a registered nurse; must be reasonable and necessary to the treatment of the patient’s illness or injury; and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).

The Act defines “part-time or intermittent services” as skilled nursing and home health aide services furnished any number of days per week as long as they are furnished (combined) less than 8 hours each day and 28 or fewer hours each week (or, subject to review on a case-by-case basis as to the need for care, less than 8 hours each day, and 35 or fewer hours each week) (the Act § 1861(m) and the Manual, chapter 7, § 50.7).

Federal regulations (42 CFR § 409.44(b)) state that, in determining whether a service requires the skill of a licensed nurse, consideration must be given to the inherent complexity of the service, the condition of the beneficiary, and accepted standards of medical and nursing practice. If the nature of a service is such that it can be safely and effectively performed by the average nonmedical person without direct supervision of a licensed nurse, the service may not be regarded as a skilled nursing service. The fact that a skilled nursing service can be or is taught to the beneficiary or to the beneficiary’s family or friends does not negate the skilled aspect of the service when performed by the nurse. If the service could be performed by the

average nonmedical person, the absence of a competent person to perform it does not cause it to be a skilled nursing service.

### *General Principles Governing Reasonable and Necessary Skilled Nursing Care*

Skilled nursing services are covered when an individualized assessment of the patient's clinical condition demonstrates that the specialized judgment, knowledge, and skills of a registered nurse or licensed practical (vocational) nurse are necessary to maintain the patient's current condition or prevent or slow further deterioration so long as the beneficiary requires skilled care for the services to be safely and effectively provided.

Some services may be classified as a skilled nursing service on the basis of complexity alone (e.g., intravenous and intramuscular injections or insertion of catheters) and, if reasonable and necessary to the patient's illness or injury, would be covered on that basis. If a service can be safely and effectively performed (or self-administered) by an unskilled person, without the direct supervision of a nurse, the service cannot be regarded as a skilled nursing service even though a nurse actually provides the service. However, in some cases, the condition of the patient may cause a service that would ordinarily be considered unskilled to be considered a skilled nursing service. This would occur when the patient's condition is such that the service can be safely and effectively provided only by a nurse. A service is not considered a skilled service merely because it is performed by or under the supervision of a nurse. The unavailability of a competent person to provide a non-skilled service does not make it a skilled service when a nurse provides the service.

A patient's overall medical condition, without regard to whether the illness or injury is acute, chronic, terminal, or expected to extend over a long period of time, should be considered in deciding whether skilled services are needed. A patient's diagnosis should never be the sole factor in deciding that a service the patient needs is either skilled or not skilled. Skilled care may, depending on the unique condition of the patient, continue to be necessary for patients whose condition is stable (the Manual, chapter 7, § 40.1.1).

### *Reasonable and Necessary Therapy Services*

Federal regulations (42 CFR § 409.44(c)) and the Manual (chapter 7, § 40.2.1) state that skilled services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition. To be considered reasonable and necessary for the treatment of the illness or injury, the therapy services must be:

- inherently complex, which means that they can be performed safely and effectively only by or under the general supervision of a skilled therapist;



- consistent with the nature and severity of the illness or injury and the patient's particular medical needs, which include services that are reasonable in amount, frequency, and duration; and
- considered specific, safe, and effective treatment for the patient's condition under accepted standards of medical practice.

## **Documentation Requirements**

### *Face-To-Face Encounter*

Federal regulations (42 CFR § 424.22(a)(1)(v)) and the Manual (chapter 7, § 30.5.1) state that, prior to initially certifying the home health patient's eligibility, the certifying physician must document that he or she, or an allowed nonphysician practitioner, had a face-to-face encounter with the patient that is related to the primary reason the patient requires home health services. In addition, the Manual (chapter 7, § 30.5.1) states that the certifying physician must document the date of the encounter.

### *Plan of Care*

The orders on the plan of care must indicate the type of services to be provided to the patient, both with respect to the professional who will provide them and the nature of the individual services, as well as the frequency of the services (the Manual, chapter 7, § 30.2.2). The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6).

## **APPENDIX C: SAMPLE DESIGN AND METHODOLOGY**

### **SAMPLING FRAME**

During the period October 1, 2015, through September 30, 2017 (audit period), Condado received Medicare payments of \$2,676,454 for 1,657 claims<sup>26</sup> for home health services provided to Medicare beneficiaries. We excluded requests for anticipated payments. We also excluded claims identified in the RAC Data Warehouse as previously excluded or under review.<sup>27</sup> The resulting sampling frame consisted of an Access database containing 1,418 claims for home health services, with total Medicare payments of \$2,410,919, from CMS's NCH file.

### **SAMPLE UNIT**

The sample unit was a Medicare home health claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 Medicare home health claims.

### **SOURCE OF RANDOM NUMBERS**

We generated the random numbers using the OIG, Office of Audit Services (OAS), statistical software.

### **METHOD OF SELECTING SAMPLE ITEMS**

We consecutively numbered the home health claims in the sampling frame, and after generating the random numbers, we selected the corresponding frame items for audit.

### **ESTIMATION METHODOLOGY**

We used the OIG/OAS statistical software to estimate the total amount of overpayments paid to Condado during the audit period. To be conservative, we recommend recovery of overpayments at the lower limit of a two-sided 90-percent confidence interval. Lower limits

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<sup>26</sup> We defined a claim as an episode of care received for a 60-day period.

<sup>27</sup> Claims that resulted in error codes 534 or 540 when matched against the RAC Data Warehouse represent claims that have already been marked for exclusion by an OIG audit, investigation, or similar review or claims that were selected for review by another contractor, respectively.

calculated in the manner are designed to be less than the actual overpayment total 95 percent of the time.

**APPENDIX D: SAMPLE RESULTS AND ESTIMATES**

**Sample Details and Results**

<b>Number of Claims in Frame</b>	<b>Value of Frame</b>	<b>Sample Size</b>	<b>Value of Sample</b>	<b>Incorrectly Billed Sample Claims</b>	<b>Value of Overpayments In Sample</b>
1,418	\$2,410,919	100	\$169,234	14	\$13,771

**Estimates of Overpayments for the Audit Period**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

Point Estimate	\$195,268
Lower Limit	97,210
Upper Limit	293,326

**APPENDIX E: TYPES OF ERRORS BY SAMPLE ITEM**

<b>Sample</b>	<b>Not Homebound</b>	<b>Did Not Require Skilled Services</b>	<b>Incorrect HIPPS Code</b>	<b>Plan of Care Did Not Meet Medicare Requirements</b>	<b>Overpayment</b>
1	-	-	-	-	-
2	-	-	-	-	-
3	-	-	-	-	-
4	-	-	-	-	-
5	-	X	-	-	\$282
6	-	-	-	-	-
7	-	-	-	-	-
8	-	-	-	-	-
9	X	-	-	-	419
10	-	-	-	-	-
11	-	-	-	-	-
12	-	-	-	-	-
13	X	X	-	-	1,612
14	-	X	-	-	36
15	-	-	-	-	-
16	X	X	-	-	1,061
17	-	-	-	-	-
18	-	-	-	-	-
19	-	-	-	-	-
20	-	-	-	-	-
21	-	-	-	-	-
22	-	-	-	-	-
23	X	X	-	-	1,323
24	-	-	-	-	-
25	-	-	-	-	-
26	-	-	-	-	-
27	-	-	-	-	-
28	-	-	-	-	-
29	-	-	-	-	-
30	-	-	-	-	-
31	X	-	-	-	696
32	-	-	-	-	-
33	-	-	-	-	-
34	X	X	-	X	2,076
35	-	-	-	-	-

Sample	Not Homebound	Did Not Require Skilled Services	Incorrect HIPPS Code	Plan of Care Did Not Meet Medicare Requirements	Overpayment
36	-	-	-	-	-
37	-	-	-	-	-
38	-	-	-	-	-
39	-	-	-	-	-
40	-	-	-	-	-
41	-	-	X	-	\$180
42	-	-	-	-	-
43	X	-	X	-	1,844
44	-	-	-	-	-
45	-	-	-	-	-
46	-	-	-	-	-
47	-	X	-	-	1,844
48	-	-	-	-	-
49	-	-	-	-	-
50	-	-	-	-	-
51	-	-	-	-	-
52	-	-	-	-	-
53	-	-	-	-	-
54	-	-	-	-	-
55	-	-	-	-	-
56	-	-	-	-	-
57	-	-	-	-	-
58	-	-	-	-	-
59	-	-	-	-	-
60	-	-	-	-	-
61	-	-	-	-	-
62	-	-	-	-	-
63	-	-	-	-	-
64	-	-	-	-	-
65	-	-	-	-	-
66	-	-	-	-	-
67	-	-	-	-	-
68	-	-	-	-	-
69	-	-	-	-	-
70	-	-	-	-	-
71	-	-	-	-	-
72	-	-	-	-	-

<b>Sample</b>	<b>Not Homebound</b>	<b>Did Not Require Skilled Services</b>	<b>Incorrect HIPPS Code</b>	<b>Plan of Care Did Not Meet Medicare Requirements</b>	<b>Overpayment</b>
73	-	-	-	-	-
74	-	-	-	-	-
75	-	-	-	-	-
76	-	-	-	-	-
77	-	-	-	-	-
78	-	-	-	-	-
79	-	-	-	-	-
80	-	-	-	-	-
81	-	-	-	-	-
82	-	-	-	-	-
83	-	-	-	-	-
84	-	-	-	-	-
85	-	-	-	-	-
86	-	-	-	-	-
87	-	-	-	-	-
88	-	-	-	-	-
89	-	-	-	-	-
90	-	-	-	-	-
91	-	-	-	-	-
92	-	-	-	-	-
93	-	-	-	-	-
94	X	-	-	-	\$1,648
95	-	X	-	-	456
96	X	-	X	-	293
97	-	-	-	-	-
98	-	-	-	-	-
99	-	-	-	-	-
100	-	-	-	-	-
<b>Total</b>	<b>9</b>	<b>8</b>	<b>3</b>	<b>1</b>	<b>\$13,771<sup>28</sup></b>

<sup>28</sup> The individual overpayments do not add up to the total amount due to rounding.

## APPENDIX F: CONDADO HOME CARE PROGRAM, INC., COMMENTS



### Condado Home Care

June 18, 2020

Nicholas J. Halko  
Assistant Regional Inspector General for Audit Services

RE: Report Number: A-02-17-01022

Mr. Nicholas Halko, in accordance to the Report in reference received on May 6, 2020, we present our corrective action plan for the findings:

Finding number 1:

- Beneficiaries did not always meet the definition of “confined to the home”
  - the beneficiary must be “confined to the home, in accordance to Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42). According to section 1814(a) of the Act:
    - [A]n individual shall be considered to be “confined to his home” if the individual has a condition, due to an illness or injury, that restricts the ability of the individual to leave his or her home except with the assistance of another individual or the aid of a supportive device (such as crutches, a cane, a wheelchair, or a walker), or if the individual has a condition such that leaving his or her home is medically contraindicated. While an individual does not have to be bedridden to be considered “confined to his home”, the condition of the individual should be such that there exists a normal inability to leave home and that leaving home requires a considerable and taxing effort by the individual.
  - To reinforce compliance with the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42)) we have revised the policy and procedure of Homebound status PC.002, “Sobre el confinamiento del paciente (SHB) al momento de la admisión de los servicios de salud en el hogar”. A written educational session was developed by [REDACTED], PT, DPT, MPH, EdD and Clinical Services Manager, [REDACTED] RN, BSN titled “Documentación del Criterio Homebound”. We also prepared a webinar to educate each of our personnel of the new policy. Documents such as: Clinical notes for nursing, physical therapy, occupational therapy, and speech language pathologist were revised to reinforce the comprehensive assessment and follow up documentation for homebound status.

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Finding number 2:

- Beneficiaries were not always in need of skilled services.
  - In accordance with the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42(c)) Medicare beneficiary must need skilled nursing care intermittently, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy. In addition, skilled nursing services must require the skills of a registered nurse or a licensed practical nurse under the supervision of a registered nurse, must be reasonable and necessary to the treatment of the patient's illness or injury and must be intermittent (42 CFR § 409.44(b) and the Manual, chapter 7, § 40.1).<sup>12</sup> Skilled therapy services must be reasonable and necessary to the treatment of the patient's illness or injury or to the restoration or maintenance of function affected by the patient's illness or injury within the context of the patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2.1). Coverage of skilled nursing care or therapy does not turn on the presence or absence of a patient's potential for improvement but rather on the patient's need for skilled care. Skilled care may be necessary to improve a patient's current condition, to maintain the patient's current condition, or to prevent or slow further deterioration of the patient's condition (the Manual, chapter 7, § 20.1.2).
  - To reinforce compliance with the Act §§ 1814(a)(2)(C) and 1835(a)(2)(A) and Federal regulations (42 CFR § 409.42(c)) and the need for reasonable and necessary skilled nursing care intermittently, or physical therapy or speech-language pathology, or have a continuing need for occupational therapy policies and procedures were revised to ensure compliance.
    - A new policy was implemented entitled SD.001 "Sobre los Servicios Necesarios, Diestros y Razonables ofrecidos al paciente" and educational material was developed which include the following:
      1. Skill Nursing Services- developed and written by Clinical Services Manager; [REDACTED] RN, BSN, and [REDACTED] PT, DPT, MPH, EdD.
      2. Skill Speech Language Pathology Services- developed and written by [REDACTED] [REDACTED] PT, DPT, MPH, EdD.
      3. Skill Physical Therapy Services- developed and written by [REDACTED] PT, DPT, MPH, EdD and [REDACTED] RN, BSN.

Clinical personnel were educated and were given written educational material for disciplines such as: RN, PT, PHL, OT, AOT, APT.

Finding number 3:

- HHAs did not always submit OASIS in a timely fashion, incorrect HIPPS payment codes.
  - Under this occurrence, we met with our Software Vendor, [REDACTED] to reinforce the importance of updating the HIPPS Codes when the updates occur. Also, we created a Billing Committee, which main purposes are:
    - Identify incongruencies in HIPPS before billing
    - To monitor compliance with the updates for billing established by CMS on October and January of each year, and whenever necessary.
    - Notify the Board of Directors the incongruencies found and the corrective actions
    - Each member of the Committee has responsibilities to monitor compliance with the billing process
    - The contract between our vendor and our agency has been revised and updated to comply with the new regulations.
    - The duties and responsibilities of the Committee members were revised and updated according to the new regulations.

Finding number 4:

- Services were not always adequately documented
  - Under this nonoccurrence, this incident was 1 out of 100.
  - To comply with Sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and regulations at 42 CFR § 409.42 require, as a condition of payment for home health services, that a physician certify and recertify that the Medicare beneficiary is receiving services under a plan of care that has been established and periodically reviewed by a physician. The plan of care must be reviewed and signed by the physician who established the plan of care, in consultation with HHA professional personnel, at least every 60 days. Each review of a patient's plan of care must contain the signature of the physician and the date of review (42 CFR § 409.43(e) and the Manual, chapter 7, § 30.2.6), we established:
    - We have developed and implemented new policies and procedures, entitled PC.005 "Sobre el cumplimiento con las regulaciones de Medicare y la vigilancia continua en la prestación en los servicios de salud en el hogar en Condado Home Care Program, Inc., en sus diferentes etapas y/o procesos".

This policy allows us to monitor the following aspects at different stages:

- Preadmissions Coordinator
  - Intake and preadmission process triage
  - Status Homebound
  - Face to Face encounter
  - Medical Orders, signed and dated
  - Compliance with 48 hours evaluation process
  - Validates Physician in PECOS and NPI
  - Identifies if the patient is in the correct period (early or late)

- Clinical Services Coordinator and Physical Therapist Supervisor triage
  - Status Homebound
  - Face to Face encounter
  - Medical Orders, signed and dated
  - Coordination of Plan of Care with the referring physician
  - Compliance with 48 hours evaluation process
  - Skilled services are reasonable and necessary
  - Identifies if the patient is in the correct period (early or late)
  - Compliance with documentation to support and monitor homebound status and skilled services
- OASIS Auditor in their different events
  - Medical Orders for Home Health Services, signed and dated by referral physician
  - Validates inform consent and authorization by the primary care giver, patient, and/or legal representative
  - Validates if the patient has Advanced Directives
  - Validates Status Homebound
  - Validates that Face to Face encounter is related to the patient's referral to Home Health Services
  - Validates coordination of Plan of Care with the referring physician and the medical orders and changes in plan of care are documented, signed, and dated.
  - Validates compliance with 48 hours evaluation requirement
  - Validates necessity and reasonability of skilled services
  - Identifies if the patient is in the correct period (early or late)
  - Validates compliance with documentation to support and monitor homebound status and skilled services
  - Audit the OASIS elements and accuracy of coding
  - Audits and codes the clinical diagnoses using the-current ICD-CM.
  - Audits clinical documentation of services to validate necessity and reasonability of skilled services
  - Validates that visits offered, frequency, are consistent with the ones established in the Plan of Care
  - Monitors compliance with the plan of care established.
- Discharge Auditors
  - Medical Orders for Home Health Services, signed and dated by referral physician
  - Monitors and audits that the Plan of Care established in the 485 is signed and dated within 60 days of the episode.
  - Analyzes the accuracy of the OASIS elements from admission to discharge.
  - Validates Status Homebound
  - Audits clinical documentation of services to validate necessity and reasonability of skilled services

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- Validates that visits offered, frequency, are consistent with the ones established in the Plan of Care
- Billing Department
  - Validates that visits offered, frequency, are consistent with the ones established in the Plan of Care and are archived in the medical record
  - Monitors and audits that the Plan of Care established in the 485 is signed and dated within 60 days of the episode and archived in the medical record
  - Validates that the Face to Face encounter and the status Homebound justification is in the medical record
  - Validates Physician in PECOS and NPI
  - Identifies if the patient is in the correct period (early or late)
  - Validates occurrence codes in the UB04
  - Identify incongruencies in HIPPS before billing and coordinates with the Auditor to correct the incongruencies. ‘

The duties and responsibilities of the Committee members had been reviewed and update according to the new regulations to comply with the regulations.

If you have any questions, you can contact me at [REDACTED] or you can email me at [REDACTED] or [REDACTED]

Cordially,



María de L. De León Rosa, MS  
 Administrator  
 Condado Home Care Program, Inc.