

Department of Health and Human Services

**OFFICE OF  
INSPECTOR GENERAL**

**MEDICARE HOME HEALTH AGENCY  
PROVIDER COMPLIANCE AUDIT:  
CATHOLIC HOME CARE**

*Inquiries about this report may be addressed to the Office of Public Affairs at  
[Public.Affairs@oig.hhs.gov](mailto:Public.Affairs@oig.hhs.gov).*



**Amy J. Frontz**  
Deputy Inspector General  
for Audit Services

August 2021  
A-02-19-01013

# ***Office of Inspector General***

<https://oig.hhs.gov>

---

The mission of the Office of Inspector General (OIG), as mandated by Public Law 95-452, as amended, is to protect the integrity of the Department of Health and Human Services (HHS) programs, as well as the health and welfare of beneficiaries served by those programs. This statutory mission is carried out through a nationwide network of audits, investigations, and inspections conducted by the following operating components:

## ***Office of Audit Services***

The Office of Audit Services (OAS) provides auditing services for HHS, either by conducting audits with its own audit resources or by overseeing audit work done by others. Audits examine the performance of HHS programs and/or its grantees and contractors in carrying out their respective responsibilities and are intended to provide independent assessments of HHS programs and operations. These audits help reduce waste, abuse, and mismanagement and promote economy and efficiency throughout HHS.

## ***Office of Evaluation and Inspections***

The Office of Evaluation and Inspections (OEI) conducts national evaluations to provide HHS, Congress, and the public with timely, useful, and reliable information on significant issues. These evaluations focus on preventing fraud, waste, or abuse and promoting economy, efficiency, and effectiveness of departmental programs. To promote impact, OEI reports also present practical recommendations for improving program operations.

## ***Office of Investigations***

The Office of Investigations (OI) conducts criminal, civil, and administrative investigations of fraud and misconduct related to HHS programs, operations, and beneficiaries. With investigators working in all 50 States and the District of Columbia, OI utilizes its resources by actively coordinating with the Department of Justice and other Federal, State, and local law enforcement authorities. The investigative efforts of OI often lead to criminal convictions, administrative sanctions, and/or civil monetary penalties.

## ***Office of Counsel to the Inspector General***

The Office of Counsel to the Inspector General (OCIG) provides general legal services to OIG, rendering advice and opinions on HHS programs and operations and providing all legal support for OIG's internal operations. OCIG represents OIG in all civil and administrative fraud and abuse cases involving HHS programs, including False Claims Act, program exclusion, and civil monetary penalty cases. In connection with these cases, OCIG also negotiates and monitors corporate integrity agreements. OCIG renders advisory opinions, issues compliance program guidance, publishes fraud alerts, and provides other guidance to the health care industry concerning the anti-kickback statute and other OIG enforcement authorities.

# *Notices*

---

**THIS REPORT IS AVAILABLE TO THE PUBLIC**  
at <https://oig.hhs.gov>

Section 8M of the Inspector General Act, 5 U.S.C. App., requires that OIG post its publicly available reports on the OIG website.

## **OFFICE OF AUDIT SERVICES FINDINGS AND OPINIONS**

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

## Report in Brief

Date: August 2021  
Report No. A-02-19-01013

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



### Why OIG Did This Audit

Under the 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.

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

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

### How OIG Did This Audit

Our audit covered over \$103 million in Medicare payments to Catholic Home Care for 28,645 claims for home health services provided in calendar years 2017 and 2018 (audit period). We selected a simple random sample of 100 claims and submitted records associated with them 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: Catholic Home Care

### What OIG Found

Catholic Home Care did not comply with Medicare billing requirements for 17 of the 100 home health claims that we reviewed. For these claims, Catholic Home Care received overpayments of \$25,742 for services provided during our audit period. Specifically, Catholic Home Care incorrectly billed Medicare for services provided to beneficiaries who did not require skilled services and for some dependent services that did not meet coverage requirements. On the basis of our sample results, we estimated that Catholic Home Care received overpayments of at least \$4.2 million for the audit period.

### What OIG Recommends and Catholic Home Care Comments

We recommend that Catholic Home Care: (1) refund to the Medicare program the portion of the estimated \$4.2 million overpayment for claims incorrectly billed that are within the reopening period; (2) exercise reasonable diligence to identify, report, and return overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation; and (3) strengthen its procedures for billing home health services.

In written comments on our draft report, Catholic Home Care did not indicate concurrence or nonconcurrence with our recommendations; however, it disagreed with our findings. Specifically, Catholic Home Care stated that OIG's determinations did not conform with current case law, Medicare standards and guidelines, or clinical facts set forth in Catholic Home Care's records. As part of its comments, Catholic Home Care also provided summary rebuttals for each of the sampled claims questioned in our draft report and submitted a report prepared by a home health care consultant. The consultant reviewed all the questioned claims and determined that they met applicable Medicare coverage requirements. Catholic Home Care also submitted additional medical documentation for two sampled claims.

Based on our review of the additional documentation provided by Catholic Home Care, we revised our determinations for two sampled claims and our related findings and recommendations. We maintain that our findings and recommendations, as revised, are valid, although we acknowledge Catholic Home Care's right to appeal the findings.

## TABLE OF CONTENTS

|  |    |
|--|----|
| INTRODUCTION.....  | 1  |
| Why We Did This Audit.....   | 1  |
| Objective.....   | 1  |
| Background.....  | 1  |
| The Medicare Program and Payments for Home Health Services.....                              | 1  |
| Home Health Agency Claims at Risk for Incorrect Billing.....                                 | 2  |
| Medicare Requirements for Home Health Agency Claims and Payments.....                        | 2  |
| Medicare Requirements for Providers to Identify and Return Overpayments....                  | 3  |
| Catholic Home Care.....  | 4  |
| How We Conducted This Audit.....   | 4  |
| FINDINGS.....  | 5  |
| Catholic Home Care Billing Errors.....   | 5  |
| Beneficiaries Did Not Require Skilled Services.....  | 5  |
| Dependent Services Did Not Meet Coverage Requirements.....                                   | 7  |
| Overall Estimate of Overpayments.....  | 7  |
| RECOMMENDATIONS.....   | 8  |
| CATHOLIC HOME CARE COMMENTS<br>AND OFFICE OF INSPECTOR GENERAL RESPONSE.....                 | 8  |
| Beneficiaries Did Not Require Skilled Services.....  | 9  |
| Catholic Home Care Comments.....   | 9  |
| Office of Inspector General Response.....  | 9  |
| Dependent Services Did Not Meet Coverage Requirements.....                                   | 10 |
| Catholic Home Care Comments.....   | 10 |
| Office of Inspector General Response.....  | 10 |
| APPENDICES   |    |
| A: Audit Scope and Methodology.....  | 12 |
| B: Medicare Requirements for Coverage and Payment of Claims for<br>Home Health Services..... | 14 |

|   |    |
|---|----|
| C: Statistical Sampling Methodology ..... | 19 |
| D: Sample Results and Estimates .....     | 21 |
| E: Types of Errors by Sample Item .....   | 22 |
| F: Catholic Home Care Comments .....      | 26 |

## INTRODUCTION

### WHY WE DID THIS AUDIT

For calendar year (CY) 2018, 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 program that the 2018 improper payment error rate for home health claims was 18 percent, or about \$3.2 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 10 percent of the total 2018 fee-for-service improper payments (\$32 billion). This review is part of a series of audits of HHAs. Using computer matching, data mining, and data analysis techniques, we identified HHAs at risk of noncompliance with Medicare billing requirements. Catholic Home Care was one of those HHAs.

### OBJECTIVE

Our objective was to determine whether Catholic Home Care 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.<sup>1</sup>

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.<sup>2</sup> The OASIS classifies HHA beneficiaries into 153 case-mix groups that are used as the basis for the Health Insurance Prospective Payment System (HIPPS)

---

<sup>1</sup> The Bipartisan Budget Act of 2018 (BBA of 2018), Division E, Title X, § 51001, changed the unit of payment from a 60-day unit of payment to a 30-day period payment effective January 1, 2020. The effective date is after our audit period.

<sup>2</sup> A case-mix group is used in a patient classification system to group together patients with similar characteristics. These groups provide a basis for describing the types of patients to which a provider renders service.

codes and represent specific sets of patient characteristics.<sup>3, 4</sup> CMS requires HHAs to submit OASIS data as a condition of payment.<sup>5</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 reviews 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 the OASIS 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:

---

<sup>3</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 HHAs. As directed by Congress in the BBA of 2018, Division E, Title X, § 51001, CMS implement the Patient-Division Groupings Model with 432 case-mix groups effective January 1, 2020 (83 Fed. Reg. 56406 (Nov. 13, 2018), 84 Fed. Reg. 60478 (Nov. 8, 2019)). The effective date is after our audit period.

<sup>4</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>5</sup> **Prior to July 13, 2018:** 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*, chapter 3, § 3.2.3.1. **On or after July 13, 2018:** 45 CFR §§ 484.45, 484.55, 484.210(e), and 484.250(a)(1); 82 Fed. Reg. 4504, 4514 (Jan. 13, 2017); 82 Fed. Reg. 31729 (July 10, 2017). **After our audit period:** 42 CFR § 424.210 was deleted and the OASIS submission requirement moved to 42 CFR § 484.205(c) effective January 1, 2019 (83 Fed. Reg. 56406 (Nov. 13, 2018)). 42 CFR § 484.250 was amended effective January 1, 2020, but still required the submission of OASIS data to CMS (84 Fed. Reg. 60478 (Nov. 8, 2019)).



- confined to the home (homebound);
- in need of skilled nursing care on an intermittent basis, needs physical therapy or speech-language pathology, or has a continuing need for occupational therapy;
- under the care of a physician; and
- receiving services under a plan of care that has been established and periodically reviewed by a physician.

Furthermore, as a condition for 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 date 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>6</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

---

<sup>6</sup> The Act § 1128J(d); 42 CFR §§ 401.301–401.305; and 81 Fed. Reg. 7654 (Feb. 12, 2016).

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>7</sup>

## **Catholic Home Care**

Catholic Home Care is a not-for-profit HHA located in Farmingdale, New York. National Government Services, its Medicare contractor, paid Catholic Home Care approximately \$112 million for 36,665 claims for services provided to beneficiaries during CYs 2017 and 2018 (audit period) based on CMS's National Claims History (NCH) data.<sup>8</sup> During the audit period, Catholic Home Care placed in the top 1 percent of home health providers in Medicare payments received.

## **HOW WE CONDUCTED THIS AUDIT**

Our audit covered \$103,123,790 in Medicare payments to Catholic Home Care for 28,645 claims.<sup>9</sup> These claims were for home health services provided during the most recent timeframe for which data was available at the start of the audit (CYs 2017 and 2018). We selected a simple random sample of 100 claims with payments totaling \$358,540 for review. We evaluated these claims for compliance with selected billing requirements and submitted them 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 audit 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 item.<sup>10</sup>

---

<sup>7</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.

<sup>8</sup> CYs were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary. We selected these "through" dates falling within CYs 2017 and 2018, therefore claims subjected to audit could include dates of service prior to CY 2017.

<sup>9</sup> Our sampling frame included home health claim payments for 60-day episodes of care with dates of service within our audit period valued at \$500 or more that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

<sup>10</sup> Sample items may have more than one type of error.

## FINDINGS

Catholic Home Care did not comply with Medicare billing requirements for 17 of the 100 home health claims that we reviewed.<sup>11</sup> For these claims, Catholic Home Care received overpayments of \$25,742 for services provided in CYs 2017 and 2018. Specifically, Catholic Home Care incorrectly billed Medicare for services provided to beneficiaries who did not require skilled services (17 claims) and for some dependent services that did not meet coverage requirements (3 claims). The total exceeds 17 claims because 3 claims contained both deficiencies.

These errors occurred primarily because Catholic Home Care did not have adequate controls to prevent the incorrect billing of Medicare claims. On the basis of our sample results, we estimated that Catholic Home Care received overpayments of at least \$4,232,959 for the audit period.<sup>12</sup> As of the publication of this report, this amount included claims outside of the 4-year claim reopening period.

### CATHOLIC HOME CARE BILLING ERRORS

Catholic Home Care incorrectly billed Medicare for 17 of the 100 sampled claims, which resulted in overpayments of \$25,742.

#### Beneficiaries Did Not Require Skilled Services

##### *Federal Requirements for Skilled Services*

A Medicare beneficiary must be in need of skilled nursing care on an intermittent basis, 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).<sup>13</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

---

<sup>11</sup> Sixteen of the seventeen claims qualified for partial Medicare reimbursement. For these sixteen claims, we questioned the difference in Medicare reimbursement between what was billed and what was eligible for reimbursement.

<sup>12</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>13</sup> Skilled nursing services can include, among other things, 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 (the Manual, chapter 7, § 40.1.2).

patient's unique medical condition (42 CFR § 409.44(c) and the Manual, chapter 7, § 40.2). 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).

### *Catholic Home Care Did Not Always Meet Federal Requirements for Skilled Services*

For 17 of the sampled claims, Catholic Home Care incorrectly billed Medicare for an entire home health episode (1 claim) or a portion of an episode (16 claims) for beneficiaries who did not meet the Medicare requirements for coverage of skilled nursing or therapy services.<sup>14</sup>

#### **Example 1: Beneficiary Did Not Require Skilled Services – Partial Episode**

---

A beneficiary recovering from hip replacement surgery and with a history of anxiety and osteoarthritis was homebound. Following the surgery, physical therapy rehabilitation and a skilled services nursing assessment were required. However, the medical records did not support that the beneficiary required skilled nursing services after the initial assessment. The beneficiary was hemodynamically stable (i.e., their blood pressure and heart rate were stable), did not require any dressing changes, and did not have an exacerbation of any chronic or acute illness that required skilled nursing follow-up. Additionally, physical therapy was not needed for the entire episode because a home exercise program had been introduced, expanded, and performed on several visits. Further, the beneficiary was reassessed by an orthopedic surgeon who prescribed outpatient physical therapy.

---

#### **Example 2: Beneficiary Did Not Require Skilled Services – Full Episode**

---

A beneficiary with a history of chronic obstructive pulmonary disease, atrial fibrillation, and hypertension was homebound. Skilled nursing services were ordered following the beneficiary's discharge from an inpatient hospital stay for a urinary tract infection. However, the medical records did not support that skilled nursing services were medically necessary because the beneficiary was independent with wound care and colostomy care and did not require medication and disease management. Further, no issues were identified with their medications during the initial assessment, and subsequent nursing visits

---

<sup>14</sup> Of the 17 claims that did not meet skilled need requirements, 3 claims included dependent services that did not meet coverage requirements. Appendix E provides detail on the extent of errors, if any, per claim reviewed.

consisted mostly of reinforcing instructions from previous visits and reviewing instructions from the physician's visit.

---

These errors occurred because Catholic Home Care did not always provide sufficient clinical review to verify that beneficiaries required skilled services.

### **Dependent Services Did Not Meet Coverage Requirements**

#### *Federal Requirements for Providing Dependent Services*

Medicare will cover certain dependent services only if the beneficiary has a skilled need (42 CFR § 409.45(a)). These dependent services include, but are not limited to, home health aides, medical social services, and durable medical equipment and supplies (42 CFR §§ 409.45(b) through (g)).

#### *Catholic Home Care Did Not Always Meet Federal Requirements for Providing Dependent Services*

For three of the sampled claims, Catholic Home Care incorrectly billed Medicare for home health aide services or social work services that did not meet coverage requirements.<sup>15</sup> Specifically, for these claims, Catholic Home Care billed for home health aide or social work services during a period when the beneficiary was determined to not need skilled services (i.e., need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology, or occupational therapy).

These errors occurred because Catholic Home Care did not have adequate oversight procedures to ensure that dependent services provided to beneficiaries complied with Medicare coverage requirements.

### **OVERALL ESTIMATE OF OVERPAYMENTS**

On the basis of our sample results, we estimated that Catholic Home Care received at least \$4,232,959 in overpayments for the audit period.

---

<sup>15</sup> These claims were also billed with skilled need services that were not required.

## RECOMMENDATIONS

We recommend that Catholic Home Care:

- refund to the Medicare program the portion of the estimated \$4,232,959 overpayment for claims incorrectly billed that are within the 4-year reopening period;<sup>16</sup>
- based on the results of this audit, exercise reasonable diligence to identify, report, and return any overpayments in accordance with the 60-day rule and identify any of those returned overpayments as having been made in accordance with this recommendation;<sup>17</sup> and
- strengthen its procedures to ensure that beneficiaries are receiving only reasonable and necessary skilled and dependent services.

### CATHOLIC HOME CARE COMMENTS AND OFFICE OF INSPECTOR GENERAL RESPONSE

In written comments on our draft report, Catholic Home Care did not indicate concurrence or non-concurrence with our recommendations; however, it disagreed with our findings. Specifically, Catholic Home Care stated that OIG's determinations did not conform with current case law, Medicare standards and guidelines, or clinical facts set forth in Catholic Home Care's records. As part of its comments, Catholic Home Care provided summary rebuttals for each of the sampled claims questioned in our draft report and submitted a report prepared by a home health care consultant. The consultant reviewed all the questioned claims and determined that they met applicable Medicare coverage requirements. Catholic Home Care also provided

---

<sup>16</sup> OIG audit recommendations do not represent final determinations by the Medicare program. CMS, acting through a Medicare 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>17</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.

additional medical documentation for two sampled claims. Catholic Home Care’s comments are included as Appendix F.<sup>18</sup>

After reviewing Catholic Home Care’s comments and the additional documentation provided, we revised our determinations, reducing the total number of sampled claims incorrectly billed from 19 to 17, and revised our related findings and recommendations accordingly. We maintain that our findings and recommendations, as revised, are valid, although we acknowledge Catholic Home Care’s right to appeal the findings.

## **BENEFICIARIES DID NOT REQUIRE SKILLED SERVICES**

### **Catholic Home Care Comments**

Catholic Home Care and its home health care consultant disagreed with all medical review determinations related to sampled claims identified in our draft report as containing skilled services that were not medically necessary. Catholic Home Care also provided additional documentation for two sampled claims. Catholic Home Care stated that the associated medical records clearly documented the beneficiaries’ need for skilled services and that OIG’s medical reviewer relied on the apparent “stability” of a beneficiary on a particular date rather than on the overall condition of the beneficiary and the continuity of care provided. In addition, Catholic Home Care asserted that OIG’s medical reviewers applied incorrect Medicare coverage guidelines or standards, and that the associated clinical records supported Catholic Home Care’s Medicare payment. According to Catholic Home Care, the care ordered for each case was needed and reasonable in light of the beneficiary’s overall condition.

### **Office of Inspector General Response**

After reviewing Catholic Home Care’s comments, including its home health care consultant’s report, we revised our determinations for two sampled claims based on the additional documentation provided. We maintain that the remaining sampled claims are associated with beneficiaries who did not meet Medicare requirements for coverage of skilled nursing or therapy services.<sup>19</sup>

Our medical review contractor’s determinations of the medical necessity of skilled therapy services were made in accordance with the Manual, chapter 7, § 40.2. In accordance with these CMS guidelines, it is necessary to determine whether individual therapy services are

---

<sup>18</sup> Catholic Home Care included several attachments as part of its comments on our draft report. These attachments consisted of claim-by-claim rebuttal of the findings in our draft report prepared by the home health care consultant, which also included clinical records and certifications by Catholic Home Care’s Chief Medical Officer. Although the attachments are not included as appendices in our final report we considered the entirety of these documents in preparing our final report and will provide Catholic Home Care’s comments in their entirety to CMS.

<sup>19</sup> Appendix E provides detail on the extent of errors, if any, per claim reviewed.

skilled and whether, in view of the beneficiary's overall condition, skilled management of the services provided is needed. The guidelines also state that although a beneficiary's particular medical condition is a valid factor in deciding whether skilled therapy services are needed, a beneficiary's diagnosis or prognosis should never be the sole factor in deciding whether a service is or is not skilled. The key issue is whether the skills of a therapist are needed to treat the illness or injury, or whether the services can be carried out by nonskilled personnel. The skilled therapy services must be reasonable and necessary for the treatment of the beneficiary's illness or injury within the context of the beneficiary's unique medical condition.

Skilled nursing services may include observation and assessment of a beneficiary's condition (the Manual, chapter 7, § 40.1.2). To determine the medical necessity of skilled nursing for observation and assessment, our medical review contractor considered the reasonable potential of a change in condition, a complication, or a further acute episode (e.g., a high risk of complications) under the provisions of the Manual, chapter 7, § 40.1.2.1.

The medical review contractor examined all of the material in the medical records and documentation submitted by Catholic Home Care and carefully considered this information to determine whether Catholic Home Care billed the claims in compliance with selected billing requirements. For all medical review, the contractor reached carefully considered conclusions as to whether the services met coverage, medical necessity, and coding requirements.

## **DEPENDENT SERVICES DID NOT MEET COVERAGE REQUIREMENTS**

### **Catholic Home Care Comments**

Catholic Home Care disagreed with our determination that, for three sampled claims, it billed for home health aide or social work services during a period when the beneficiary was determined to not need skilled services. Specifically, Catholic Home Care asserted that these dependent services provided extensive and connected assistance to beneficiaries. According to Catholic Home Care, the services were medically necessary and were provided in accordance with the associated beneficiary's home health plan of care, CMS coverage guidelines, and CMS Conditions of Participation.

### **Office of Inspector General Response**

Catholic Home Care billed for home health aide or social work services during a period when the beneficiary was determined to not need skilled services (i.e., need for skilled nursing care on an intermittent basis, physical therapy, speech-language pathology, or occupational therapy). Medicare will cover certain dependent services only if the beneficiary has a skilled need (42 CFR § 409.45(a)). These dependent services include, but are not limited to, home health aides, medical social services, and durable medical equipment and supplies (42 CFR §§ 409.45(b) through (g)).



Accordingly, we maintain that our findings for the three sampled claims are valid. Catholic Home Care did not have adequate oversight procedures to ensure that dependent services provided to beneficiaries complied with Medicare coverage requirements.

## APPENDIX A: AUDIT SCOPE AND METHODOLOGY

### SCOPE

Our audit covered \$103,123,790 in Medicare payments to Catholic Home Care for 28,645 home health claims with episode-of-care through dates in CYs 2017 and 2018. From this sampling frame, we selected for review a simple random sample of 100 claims with payments totaling \$358,540.

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

We limited our review of Catholic Home Care'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 audit from June 2019 to February 2021.

### METHODOLOGY

To accomplish our objective, we:

- reviewed applicable Federal laws, regulations, and guidance;
- extracted Catholic Home Care's paid claims data from CMS's NCH file for the audit period;
- created a sampling frame of 28,645 claims totaling \$103,123,790;<sup>20</sup>
- selected a simple random sample of 100 claims 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 canceled or adjusted;
- obtained and reviewed billing and medical record documentation provided by Catholic Home Care to support the claims sampled;

---

<sup>20</sup> Our sampling frame included home health claim payments for 60-day episodes of care with dates of service within our audit period valued at \$500 or more that have not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.

- 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 Catholic Home Care’s procedures for billing and submitting Medicare claims;
- verified State licensure information for 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 overpayments to Catholic Home Care for our audit period (Appendix D); and
- discussed the results of our audit with Catholic Home Care 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 outcomes; and to determine whether adjustments to the case-mix groups are warranted. HHA beneficiaries may be classified into 153 case-mix groups that are used as the basis for the HIPPS rate 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 or speech-language pathology, or occupational therapy;<sup>21</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 (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act; 42 CFR § 409.42; and the Manual, chapter 7, § 30).

---

<sup>21</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, physical therapy service, or speech language pathology service as required by law. Once the 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 added a requirement to §§ 1814(a)(2)(C) and 1835(a)(2)(A) of the Act stating that the physician must have a face-to-face encounter with the beneficiary.<sup>22</sup> 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, occurred no more than 90 days prior to 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>23</sup>

### **Confined to the Home**

For the reimbursement of home health services, the beneficiary must be “confined to his home” (sections 1814(a)(2)(C) and 1835(a)(2)(A) of the Act and 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 he or she 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

---

<sup>22</sup> The Patient Protection and Affordable Care Act, P.L. 111-148 (Mar. 23, 2010), as amended by the Health Care and Education Reconciliation Act of 2010, P.L. 111-152 (Mar. 30, 2010), collectively known as the Affordable Care Act.

<sup>23</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 on 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 shall 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 their 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).

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).

#### *Requiring Skills of a Licensed Nurse*

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 nonskilled 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) 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 encounter either on the certification, which the physician signs and dates, or a signed addendum to the certification.

### *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, § 30.2.1). 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: STATISTICAL SAMPLING METHODOLOGY**

### **SAMPLING FRAME**

The sampling frame consisted of an Access database of 28,645 home health claims from CMS's NCH file, for services claimed by Catholic Home Care, totaling \$103,123,790. The sampling frame included home health claim payments for 60-day episodes of care with dates of service that ended within CYs 2017 and 2018 valued at \$500 or more that had not been previously reviewed by a CMS contractor or identified as low risk for waste and abuse.<sup>24</sup>

### **SAMPLE UNIT**

The sample unit was a home health claim.

### **SAMPLE DESIGN**

We used a simple random sample.

### **SAMPLE SIZE**

We selected a sample of 100 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 sorted the sample units in the sampling frame first by the beneficiary's health insurance claim number and then by their associated claims' internal control number. We then consecutively numbered them from 1 to 28,645. After generating 100 random numbers, we selected the corresponding frame items.

---

<sup>24</sup> CYs were determined by the HHA claim "through" date of service. The "through" date is the last day on the billing statement covering services provided to the beneficiary. We selected these "through" dates falling within CYs 2017 and 2018, therefore claims subjected to audit could include dates of service prior to CY 2017.

## **ESTIMATION METHODOLOGY**

We used the OAS statistical software to estimate the total amount of overpayments made to Catholic Home Care in the sampling frame. 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.

**APPENIX D: SAMPLE RESULTS AND ESTIMATES**

**Sample Details and Results**

| <b>Sampling Frame Size</b> | <b>Total Value of Sampling Frame</b> | <b>Sample Size</b> | <b>Total Value of Sample</b> | <b>Incorrectly Billed Sample Items</b> | <b>Value of Overpayments in Sample</b> |
|----------------------------|--------------------------------------|--------------------|------------------------------|--|--|
| 28,645                     | \$103,123,790                        | 100                | \$358,540                    | 17                                     | \$25,742                               |

**Estimated Overpayments in the Sampling Frame**  
*(Limits Calculated for a 90-Percent Confidence Interval)*

|                |             |
|----------------|-------------|
| Point estimate | \$7,373,799 |
| Lower limit    | 4,232,959   |
| Upper limit    | 10,514,638  |

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

| <b>Sample Number</b> | <b>Beneficiary Did Not Require Skilled Services</b> | <b>Dependent Services Did Not Meet Coverage Requirements</b> | <b>Overpayment</b> |
|----------------------|---|--|--------------------|
| 1                    |   |  | -                  |
| 2                    | <b>X</b>  | <b>X</b>   | 2,518              |
| 3                    |   |  | -                  |
| 4                    |   |  | -                  |
| 5                    |   |  | -                  |
| 6                    | <b>X</b>  |  | 841                |
| 7                    |   |  | -                  |
| 8                    |   |  | -                  |
| 9                    |   |  | -                  |
| 10                   |   |  | -                  |
| 11                   |   |  | -                  |
| 12                   |   |  | -                  |
| 13                   |   |  | -                  |
| 14                   | <b>X</b>  | <b>X</b>   | 2,041              |
| 15                   |   |  | -                  |
| 16                   | <b>X</b>  |  | 416                |
| 17                   |   |  | -                  |
| 18                   |   |  | -                  |
| 19                   | <b>X</b>  |  | 1,334              |
| 20                   | <b>X</b>  |  | 3,066              |
| 21                   |   |  | -                  |
| 22                   |   |  | -                  |
| 23                   |   |  | -                  |
| 24                   |   |  | -                  |
| 25                   |   |  | -                  |
| 26                   |   |  | -                  |
| 27                   |   |  | -                  |
| 28                   |   |  | -                  |
| 29                   |   |  | -                  |
| 30                   | <b>X</b>  |  | 630                |
| 31                   |   |  | -                  |

| Sample Number | Beneficiary Did Not Require Skilled Services | Dependent Services Did Not Meet Coverage Requirements | Overpayment |
|---------------|--|---|-------------|
| 32            |  |   | -           |
| 33            |  |   | -           |
| 34            |  |   | -           |
| 35            |  |   | -           |
| 36            |  |   | -           |
| 37            |  |   | -           |
| 38            | X  |   | 2,308       |
| 39            |  |   | -           |
| 40            | X  |   | 2,119       |
| 41            |  |   | -           |
| 42            |  |   | -           |
| 43            |  |   | -           |
| 44            |  |   | -           |
| 45            |  |   | -           |
| 46            |  |   | -           |
| 47            |  |   | -           |
| 48            |  |   | -           |
| 49            |  |   | -           |
| 50            | X  |   | 2,186       |
| 51            |  |   | -           |
| 52            |  |   | -           |
| 53            |  |   | -           |
| 54            |  |   | -           |
| 55            |  |   | -           |
| 56            |  |   | -           |
| 57            |  |   | -           |
| 58            |  |   | -           |
| 59            |  |   | -           |
| 60            |  |   | -           |
| 61            |  |   | -           |
| 62            |  |   | -           |
| 63            | X  |   | 1,570       |
| 64            |  |   | -           |

| Sample Number | Beneficiary Did Not Require Skilled Services | Dependent Services Did Not Meet Coverage Requirements | Overpayment |
|---------------|--|---|-------------|
| 65            |  |   | -           |
| 66            |  |   | -           |
| 67            |  |   | -           |
| 68            |  |   | -           |
| 69            |  |   | -           |
| 70            | X  | X   | 1,958       |
| 71            |  |   | -           |
| 72            |  |   | -           |
| 73            | X  |   | 504         |
| 74            |  |   | -           |
| 75            | X  |   | 1,987       |
| 76            |  |   | -           |
| 77            |  |   | -           |
| 78            |  |   | -           |
| 79            |  |   | -           |
| 80            |  |   | -           |
| 81            |  |   | -           |
| 82            |  |   | -           |
| 83            | X  |   | 978         |
| 84            |  |   | -           |
| 85            |  |   | -           |
| 86            | X  |   | 871         |
| 87            |  |   | -           |
| 88            |  |   | -           |
| 89            |  |   | -           |
| 90            |  |   | -           |
| 91            |  |   | -           |
| 92            |  |   | -           |
| 93            |  |   | -           |
| 94            |  |   | -           |
| 95            |  |   | -           |
| 96            |  |   | -           |
| 97            |  |   | -           |

| <b>Sample Number</b> | <b>Beneficiary Did Not Require Skilled Services</b> | <b>Dependent Services Did Not Meet Coverage Requirements</b> | <b>Overpayment</b> |
|----------------------|---|--|--------------------|
| 98                   |   |  | -                  |
| 99                   |   |  | -                  |
| 100                  | <b>X</b>  |  | 414                |
| <b>Totals:</b>       | <b>17</b>   | <b>3</b>   | <b>\$25,742*</b>   |

\*Amounts do not add up exactly due to rounding.

## APPENDIX F: CATHOLIC HOME CARE COMMENTS



### VIA ELECTRONIC MAIL AND UPS OVERNIGHT

June 11, 2021

Brenda M. Tierney, Regional Inspector General for Audit Services  
Department of Health and Human Services  
Office of the Inspector General  
Office of Audit Services, Region II  
Jacob K. Javits Federal Building  
26 Federal Plaza, Room 3900  
New York, NY 10278

Re: *Catholic Home Care*  
*Medicare Home Health Agency Provider Compliance Audit*  
*Report #: A-02-19-01013*

Dear Inspector Tierney:

On behalf of Catholic Health Care (“CHC”), please accept this letter as the response to the draft “Medicare Home Health Agency Provider Compliance Audit: Catholic Home Care” (“Report”) dated April 2021. We wish to thank you for the extension of time provided to CHC to properly assess the auditors’ findings and provide our response to those findings.

The objective of the audit as set forth in the Report was to “determine whether CHC complied with Medicare requirements for billing home health services on selected types of claims”. The impetus was stated to be that “... prior audits of home health services identified significant overpayments to HHAs.”

CHC has now had the opportunity to review and assess both the audit methodologies employed as well as the preliminary findings of the auditors which identified an alleged overpayment to CHC for a number of sampled claims for the period under review.

After careful review of the individual claims in question as well as the governing Medicare home care service requirements as set out in regulation and the Medicare manuals, we submit the enclosed specific objections to the draft findings for your review and consideration. These are

12623647.1 6/10/2021



submitted in addition to any and all materials, documents and arguments previously provided during the course of this audit.

### **Background**

Catholic Health Home Care (“CHC”) is a New York State certified home health agency based at 110 Bi-County Boulevard, Farmingdale, New York. Founded by The Congregation of the Infant Jesus in 1905, CHC is a non-profit, faith-based home health agency affiliated with the Catholic Health network of facilities and providers, which furnishes healthcare services throughout Long Island. CHC provides care to more than 3,000 patients in their homes each day. The agency consists of more than 700 professionals, paraprofessionals, and support staff, all working to assure that patients continue to have their home care needs met twenty-four hours a day, seven days per week.

Currently covering Suffolk, Nassau and Queens Counties, CHC helps patients following acute illness remain in the setting of choice, their own home. Services offered in the home setting include nursing care, physical therapy, occupational therapy, speech language pathology, medical social work, nutritional counseling, home health aides and pastoral care visits. Providing care to patients of all faiths, CHC also offers specialty programs including pediatric and maternal child home care, home infusion services, remote monitoring through telehealth, post orthopedic surgery care, wound management, behavioral health home care, home-based pulmonary rehabilitation and palliative care.

CHC takes great pride in its over 100 years of service to the Long Island community, as well as its record of quality and compliance during that span. In a continuation of that tradition, CHC takes its home care compliance program very seriously. In none of the cases sampled has there been any draft finding of inappropriate care or services which are not in line with each patient’s full recovery and successful discharge. We are very proud of the overall quality of care provided by our agency to our patients in Long Island.

### **Objections and Bases**

In reviewing the findings contained in the Report, CHC has proceeded on a two-track basis. We have reviewed the course of care for each of the sampled patients with our clinical team as well as engaged an independent consultant to review conformity with Medicare standards. CHC has also been assisted by retained counsel to further review the adequacy of services rendered and documentation associated with Medicare coverage in this matter. The attached submittal includes:

1. Individual rebuttal responses for each of the nineteen (19) sample cases, which address the specific draft determination summaries provided by the OIG contractor.
2. The highlighted areas of the clinical record which support our payment for the episodes of care as billed by CHC. (These include page references to the record previously submitted and in two (2) sample cases, we provided additional documentation.)

12623647.1 6/10/2021

3. Certification of each summary by CHC's Chief Medical Officer.
4. Standards and criteria used by CHC's independent consultant (see the included as Attachment #4).

Our assessment of the substantive findings as to the specific claims submitted and paid for nineteen (19) beneficiaries contained in the Report indicates that the determinations reached by the auditors are not in conformity with either current case law, Medicare standards, guidelines and issuances or the clinical facts set forth in CHC's records.

The OIG's draft findings rely on the apparent "stability" of the patient on a particular date during the care period in question rather than on the overall condition of the patient and continuity of care through discharge. While many of the conditions with which the patients suffered are chronic and subject to periods of "plateauing", that alone does not render home care services either unnecessary or unreasonable.

In this regard, we believe that the appropriate policy to be applied overall is found in the CMS transmittal implementing the settlement reached in the class action litigation titled *Jimmo v. Sebelius* (U.S. District Court, D. of Vermont, Case No. 5:11-cv-17). As a result of the settlement, CMS issued the following statement regarding coverage:

"[coverage]... does not turn on the presence or absence of a beneficiary's potential for improvement, but rather on the beneficiary's need for skilled care. Skilled care may be necessary to improve a patient's condition, to maintain a patient's current condition, or to prevent or slow further deterioration of the patient's condition." (CMS Transmittal 179, Pub 100-02, 1/14/2014).

Under this transmittal it is clear, particularly regarding physical/occupational therapy, that a patient's capacity for improvement is not the deciding factor for coverage determinations. The nature of the services ordered and provided, as determined by the patient's treating physician based upon the overall condition of the patient, must be given substantial weight in the determination of necessity and reasonableness.

As to the standard for skilled nursing services, we believe that the policy referred to above is equally applicable. The recent settlement reached with CMS in *McKee v. Azar* (U.S. District Court, D. of Vermont, Case No.2:19-cv-00114) in July 2020 is pertinent. In that case, the beneficiary had been denied coverage due to the alleged "stability" of her condition at a particular point in time. However, as the settlement makes clear, home health coverage based on skilled observation and assessment as well as patient education services is fully appropriate. Clinically identified risks for complications resulting from the individual patient's overall condition, including diagnoses, comorbidity, medications and emotional/mental status, support the need for the knowledge and judgment of skilled nurses that are vital to identifying when and if additional or modified care is needed.

Brenda M. Tierney, Regional Inspector General for Audit Services  
June 10, 2021  
Page 4

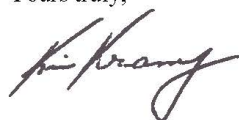
In each of the claims for which draft audit adjustments are proposed, our clinical team has assessed the coverage as appropriate, our independent consultant has found appropriate support for coverage, and CHC's Chief Medical Officer has opined through the certification in each case that the care ordered was needed and reasonable in light of the patient's overall condition. Critically, these rebuttal findings are supported by the clinical records and the evaluations performed and documented by the treating skilled professionals in the home.

CHC engaged the medical review and consulting firm SimiTree Health Care Consulting (f/k/a Simone Consulting) to independently evaluate the necessity and reasonableness of the care ordered and provided under applicable *Medicare Benefit Policy Manual* provisions as well as the documented clinical record. SimiTree Healthcare Consultants ("SimiTree") is a firm that provides comprehensive expertise to support clinical, operational, billing and financial compliance in the home care and hospice industry. The professional consultants at SimiTree have a long track record of successful collaboration with healthcare attorneys and corporate compliance with audit departments, as well as government agencies and contractors. SimiTree has assessed each of the nineteen (19) samples adjusted by the auditors and found that the course of care through discharge by the agency met the Medicare criteria applicable for coverage. Attachment 4 to this letter outlines the criteria used in this assessment.

The Medicare beneficiaries served by CHC received high-quality, appropriate care in accordance with public policy designed to avoid re-hospitalization and ensure that there is a successful discharge. As noted in the benefit manual provisions cited within the rebuttal responses attached to this letter, all aspects of a patient's care needs must be considered in assessing Medicare coverage. We strongly believe that the care we provided is entirely in line with such criteria and ultimately saved the Medicare program additional costs, which would have been applicable if the coverage was cut short. We respectfully request that the draft audit report findings be revised to reflect applicable Medicare standards and medical record evidence.

Thank you in advance for your consideration of this response. If you have any questions, please feel free to contact me.

Yours truly,



Kim Kranz, R.N., M.S., C.H.P.C.A.  
President

Enclosures

12623647.1 6/10/2021



SimiTree Healthcare Consultants (SimiTree) is providing an overall summary of key supporting findings and regulatory references related to documentation that supports eligibility and medical necessity of home health services provided by Catholic Health Home Care (CHC), a member of Catholic Health System of Long Island, Inc. d/b/a Catholic Health. SimiTree reviewed CHC's clinical record documentation and draft appeal letters for 19 patient episodes that were prepared by Catholic Health to evidence the support in the medical record documentation that demonstrates CHC's compliance with Medicare eligibility and applicable clinical, billing, and regulatory requirements for Medicare reimbursement of home health services.

The reviews were completed by SimiTree experts with extensive home health and hospice experience, as well as experience in compliance audits and Medicare appeals, Medicare regulatory and payment requirements. Biography information is available for each auditor on request:

- Beth Noyce, RN, BSJMC, HCS-C, BCHH-C, COQS
- Kimberly Skehan, RN, MSN, HCS-D, COS-C
- Mary Suarez, PT, MPT, MBA, COS-C, CSCS

The key findings and references were previously reviewed with counsel and Catholic Health staff and are included in this summary document, which may be utilized by CHC as a further resource for submittal to the OIG.

#### **Key Findings and Recommendations:**

Clinical documentation to support eligibility and medical necessity is set forth in CHC's patient summaries. Our overall key points are as follows:

- The CHC documentation in each episode was adequate to support medical necessity and eligibility for home health services in accordance with CMS/Medicare coverage guidelines (*Medicare Benefit Policy Manual, Chapter 7*). This includes but is not limited to documentation to support homebound status and face to face encounter documentation requirements.
- Visit frequency and duration appeared very appropriate; there were no patient episodes noted to be excessive in length. CHC provided services in accordance with *Medicare Benefit Policy Manual, Chapter 7, § 40.1.2.1*, which states "skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode."
- CHC documentation supports skilled observation and assessment of comorbid diagnoses and wounds as appropriate to meet the patient's needs.
- Therapists clearly documented the patient's function/ability.



- Patient education and training was well documented by CHC staff. Re-teaching, when necessary, was provided in accordance with ***Medicare Benefit Policy Manual, Chapter 7, § 40.1.2.3.***
- In some instances, clinical documentation was succinct, with minimalist documentation style noted in some areas of some records. However, in each of these cases additional documentation in the clinical record was present to support Medicare coverage criteria.

**Resources and References: *Medicare Benefit Policy Manual***

Clinical documentation reviewed in each of the patient episodes met the following key requirements of the ***Medicare Benefit Policy Manual***, as cited in each appeal letter submitted by CHC (with emphasis supplied as underlined text as applicable).

**Section 40.1 - 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 as discussed in § 40.1.1, below, and must be intermittent as discussed in § 40.1.3. Coverage of skilled nursing care does not turn on the presence or absence of a patient’s potential for improvement from the nursing care, but rather on the patient’s need for skilled care.

**Section 40.1.1 - General Principals Governing Skilled Nursing Care**

Skilled nursing care is necessary only when (a) the particular patient’s special medical complications require the skills of a registered nurse or, when provided by regulation, a licensed practical nurse to perform a type of service that would otherwise be considered non-skilled; or (b) the needed services are of such complexity that the skills of a registered nurse or, when provided by regulation, a licensed practical nurse are required to furnish the services. A service that, by its nature, requires the skills of a nurse to be provided safely and effectively continues to be a skilled service even if it is taught to the patient, the patient’s family, or other caregivers. The skilled nursing service must be reasonable and necessary to the diagnosis and treatment of the patient’s illness or injury within the context of the patient’s unique medical condition. To be considered reasonable and necessary for the diagnosis or treatment of the patient’s illness or injury, the services must be consistent with the nature and severity of the illness or injury, the patient’s particular medical needs, and accepted standards of medical and nursing practice. The determination of whether the services are reasonable and necessary should be made in consideration that a physician or allowed practitioner has determined that the services ordered are reasonable and necessary. The services must, therefore, be viewed from the perspective of the condition of the patient when the services were ordered and what was, at that time, reasonably expected to be appropriate treatment for the illness or injury throughout the certification



period. 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

**Section 40.1.2.1 - Observation and Assessment of the Patient's Condition When Only the Specialized Skills of a Medical Professional Can Determine Patient's Status**

Observation and assessment of the patient's condition by a nurse are reasonable and necessary skilled services where there is a reasonable potential for change in a patient's condition that requires skilled nursing personnel to identify and evaluate the patient's need for possible modification of treatment or initiation of additional medical procedures until the patient's clinical condition and/or treatment regimen has stabilized. Where a patient was admitted to home health care for skilled observation because there was a reasonable potential of a complication or further acute episode but did not develop a further acute episode or complication, the skilled observation services are still covered for 3 weeks or so long as there remains a reasonable potential for such a complication or further acute episode. Information from the patient's home health record must document the rationale that demonstrates that there is a reasonable potential for a future complication or acute episode and, therefore, may justify the need for continued skilled observation and assessment beyond the 3-week period.

**Section 40.1.2.3 - Teaching and Training Activities**

Teaching and training activities that require skilled nursing personnel to teach a patient, the patient's family, or caregivers how to manage the treatment regimen would constitute skilled nursing services. Where the teaching or training is reasonable and necessary to the treatment of the illness or injury, skilled nursing visits for teaching would be covered. The test of whether a nursing service is skilled relates to the skill required to teach and not to the nature of what is being taught. Therefore, where skilled nursing services are necessary to teach an unskilled service, the teaching may be covered. Skilled nursing visits for teaching and training activities are reasonable and necessary where the teaching or training is appropriate to the patient's functional loss, illness, or injury.

Re-teaching or retraining for an appropriate period may be considered reasonable and necessary where there is a change in the procedure or the patient's condition that requires re-teaching, or where the patient, family, or caregiver is not properly carrying out the task. The medical record should document the reason that the re-teaching or retraining is required and the patient/caregiver response to the education.



#### **40.1.2.15 - Psychiatric Evaluation, Therapy, and Teaching**

The evaluation, psychotherapy, and teaching needed by a patient suffering from a diagnosed psychiatric disorder that requires active treatment by a psychiatrically trained nurse and the costs of the psychiatric nurse's services may be covered as a skilled nursing service.

Psychiatrically trained nurses are nurses who have special training and/or experience beyond the standard curriculum required for a registered nurse. The services of the psychiatric nurse are to be provided under a plan of care established and reviewed by a physician or allowed practitioner.

#### **40.2 - Skilled Therapy Services**

To be covered as skilled therapy, the services must require the skills of a qualified therapist and must be reasonable and necessary for the treatment of the patient's illness or injury. Coverage does not turn on the presence or absence of an individual's potential for improvement, but rather on the beneficiary's need for skilled care.

#### **40.2.1 - General Principles Governing Reasonable and Necessary Physical Therapy, Speech-Language Pathology Services, and Occupational Therapy**

The service of a physical therapist, speech-language pathologist, or occupational therapist is a skilled therapy service if the inherent complexity of the service is such that it can be performed safely and/or effectively only by or under the general supervision of a skilled therapist. To be covered, assuming all other eligibility and coverage criteria have been met, the skilled services must also 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. It is necessary to determine whether individual therapy services are skilled and whether, in view of the patient's overall condition, skilled management of the services provided is needed. The development, implementation, management, and evaluation of a patient care plan based on the physician or allowed practitioner's orders constitute skilled therapy services when, because of the patient's clinical condition, those activities require the specialized skills, knowledge, and judgment of a qualified therapist to ensure the effectiveness of the treatment goals and ensure medical safety. Where the specialized skills, knowledge, and judgment of a therapist are needed to manage and periodically reevaluate the appropriateness of a maintenance program, such services would be covered, even if the skills of a therapist were not needed to carry out the activities performed as part of the maintenance program.

While a patient's particular medical condition is a valid factor in deciding if skilled therapy services are needed, a patient's diagnosis or prognosis should never be the sole factor in deciding that a service is or is not skilled. The key issue is whether the skills of a therapist



are needed to treat the illness or injury, or whether the services can be carried out by unskilled personnel. A service that is ordinarily considered unskilled could be considered a skilled therapy service in cases where there is clear documentation that, because of special medical complications, skilled rehabilitation personnel are required to perform the service.

Assuming all other eligibility and coverage criteria have been met, 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. To be considered reasonable and necessary for the treatment of the illness or injury:

- a. The services must be consistent with the nature and severity of the illness or injury, the patient's particular medical needs, including the requirement that the amount, frequency, and duration of the services must be reasonable; and
- b. The services must be considered, under accepted standards of medical practice, to be specific, safe, and effective treatment for the patient's condition, meeting the standards noted below. The home health record must specify the purpose of the skilled service provided.

#### **Conclusion**

Based on the review of all patient documentation and appeal letters, Catholic Health and SimiTree assert that CHC furnished medically necessary skilled nursing and therapy services, based on criteria cited in Chapter 7 of the *Medicare Benefit Policy Manual*, and provided services to Medicare beneficiaries in accordance with the patients' home health plan of care and the CMS Conditions of Participation.

SimiTree is appreciative of CHC's request for assistance with this OIG audit and submission process. SimiTree also appreciates the cooperation of CHC and Catholic Health management during the document review and appeal letter review process. SimiTree is grateful for the opportunity to work with CHC, and is available to provide additional assistance to CHC and Catholic Health in connection with any additional OIG clinical record audits and/or assistance with expert rebuttals related to the OIG audits, staff/manager education, and compliance program assessments.

SimiTree discloses that it has no relationship with Catholic Health, other than this retention as an independent contractor to review the draft findings in the OIG audit report as well as CHC's documentation and clinical record in support of Medicare coverage.