DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 16 1999

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Med Tech Home Health Services, Inc. (A-04-97-01169)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

Attached is a copy of our final report entitled, *Review of Costs Claimed by Med Tech Home Health Services, Inc.* The objective of our review was to determine whether the home health care services claimed by Med Tech Home Health Services, Inc. (Med Tech) in Davie, Florida met Medicare reimbursement guidelines.

We statistically selected 100 claims for review of which 42 were found to involve services that did not meet Medicare reimbursement requirements. The 100 claims involved 2,294 services of which 577 were unallowable. Our sample of 100 claims was randomly selected from the claims approved for payment by the fiscal intermediary (FI) for services provided during the Calendar Year ended December 31, 1996. These services did not meet Medicare reimbursement requirements because:

- 288 services included in 20 claims were provided to beneficiaries who were not homebound. According to medical personnel, the beneficiaries, or their families, these beneficiaries could leave home without considerable effort.

- 233 services included in 16 claims were not reasonable or necessary in the opinion of medical personnel.

- 56 services included in 6 claims were for home health aide services provided to beneficiaries who had contracted with private agencies to receive similar type services; therefore, the aide services were unnecessary.

Based on our review, we estimate that at least $1.9 million of the $8.3 million claimed by Med Tech did not meet the reimbursement requirements. Using the 90 percent confidence interval, we believe the overpayment was between $1.9 million and $3.5 million.

Although we found documentation that indicated Med Tech monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. The monitoring did not properly address homebound status, the medical

necessity of services, or duplication of services. Nevertheless, the home health agency (HHA) guidelines issued by the Health Care Financing Administration (HCFA) make contractors, such as Med Tech, responsible for the actions of their subcontractors.

We recommend that HCFA: (1) instruct the FI to recover overpayments of $1.9 million, (2) require the FI to instruct Med Tech on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations, and (3) monitor the FI and Med Tech to ensure that corrective actions are effectively implemented.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as APPENDIX D to this report.

We would appreciate your views and the status of any action taken or contemplated on our recommendations within the next 60 days. Any questions or further comments on any aspect of the report are welcome. Please address them to George M. Reeb, Assistant Inspector General for Health Care Financing Audits, at (410) 786-7104.

To facilitate identification, please refer to Common Identification Number A-04-97-01169 in all correspondence relating to this report.

Attachment

Department of Health and Human Services

OFFICE OF INSPECTOR GENERAL

REVIEW OF COSTS CLAIMED BY MED TECH HOME HEALTH SERVICES, INC.

JUNE GIBBS BROWN
Inspector General

APRIL 1999
A-04-97-01169

DEPARTMENT OF HEALTH & HUMAN SERVICES

Office of Inspector General

Memorandum

Date APR 16 1999

From for June Gibbs Brown
Inspector General

Subject Review of Costs Claimed by Med Tech Home Health Services, Inc. (A-04-97-01169)

To Nancy-Ann Min DeParle
Administrator
Health Care Financing Administration

This final report provides you with the results of our audit of Med Tech Home Health Services, Inc. (Med Tech) in Davie, Florida.

OBJECTIVE

The audit objective was to determine whether the home health care services claimed by Med Tech met Medicare reimbursement requirements.

SUMMARY OF FINDINGS

We statistically selected 100 claims for review of which 42 were found to involve services that did not meet Medicare reimbursement requirements. The 100 claims involved 2,294 services of which 577 were unallowable. Our sample of 100 claims was randomly selected from the claims approved for payment by the fiscal intermediary (FI) for services provided during the Calendar Year (CY) ended December 31, 1996. These services did not meet Medicare reimbursement requirements because:

- 288 services included in 20 claims were provided to beneficiaries who were not homebound. According to medical personnel, the beneficiaries, or their families, these beneficiaries could leave home without considerable effort.

- 233 services included in 16 claims were not reasonable or necessary in the opinion of medical personnel.

- 56 services included in 6 claims were for home health aide services provided to beneficiaries who had contracted with private agencies to receive similar type services; therefore, the aide services were unnecessary.

Based on our review, we estimate that at least $1.9 million of the $8.3 million claimed by Med Tech did not meet the reimbursement requirements. Using the 90 percent confidence interval, we believe the overpayment was between $1.9 million and $3.5 million.

Although we found documentation that indicated Med Tech monitored its own employees and subcontractors, the results of our review indicated that the monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. The monitoring did not properly address homebound status, the medical necessity of services, or duplication of services. Nevertheless, the home health agency (HHA) guidelines issued by the Health Care Financing Administration (HCFA) make contractors, such as Med Tech, responsible for the actions of their subcontractors.

We recommend that HCFA: (1) instruct the FI to recover overpayments of $1.9 million, (2) require the FI to instruct Med Tech on its responsibilities to properly monitor its subcontractors for compliance with the Medicare regulations, and (3) monitor the FI and Med Tech to ensure that corrective actions are effectively implemented.

In response to our draft report, HCFA concurred with these recommendations. The HCFA response has been included in its entirety as APPENDIX D to this report.

BACKGROUND

Med Tech Home Health Services, Inc.

Med Tech is a Medicare certified HHA with a principal place of business in Davie, Florida. Med Tech is a for profit corporation and is owned and managed by Cancer Treatment Holdings, Inc.

A Medicare certified HHA, such as Med Tech, can either provide home health services itself or make arrangements with other certified or non-certified providers for home health services. The HCFA guidelines require that an HHA must have at least one direct service; therefore, all services in that specialty must be provided by the HHA's employees, not subcontractors. Medical Social Worker is Med Tech's direct service. Med Tech directly and indirectly employs nurses, aides, therapists, and administrative personnel in Broward County.

During the period of our review, Med Tech was reimbursed under the per diem method. Payments under the per diem method approximate the costs of covered services rendered by the provider. Interim payments are adjusted to actual costs based on annual costs reports. Med Tech submitted a cost report for 1996 claiming costs totaling $8.3 million.

Authority and Requirements for Home Health Services

The legislative authority for coverage of home health services is contained in sections 1814, 1835, and 1861 of the Social Security Act; governing regulations are found in Title 42 of the CFR; and HCFA coverage guidelines are found in the Medicare HHA Manual.

Fiscal Intermediary Responsibilities

The HCFA contracts with FIs, usually large insurance companies, to assist in administering the home health benefits program. The FI for Med Tech is Palmetto Government Benefits Administrators. The FI is responsible for:

- processing claims for HHA services,
- performing liaison activities between HCFA and the HHAs,
- making interim payments to HHAs, and
- conducting audits of cost reports submitted by HHAs.

SCOPE

The objective of the audit was to determine whether the home health care services claimed by Med Tech met Medicare reimbursement requirements. The audit was performed in partnership with the HCFA Miami Satellite Office under Operation Restore Trust.

Med Tech claimed 134,520 services on 5,777 claims for CY 1996. We reviewed a statistical sample of 100 claims which included 2,294 services for 95 different beneficiaries (5 individuals appeared twice in the sample). We are reporting the overpayment projected from this sample at the lower limit of the 90 percent confidence interval. The claims submitted by Med Tech were for services provided during the period January 1, 1996 through December 31, 1996. APPENDIX A contains the details on our sampling methodology. APPENDIX C contains the results and projection of our sample. We used applicable laws, regulations, and Medicare guidelines to determine whether the services claimed by Med Tech met the Medicare reimbursement requirements.

We also used the sample to project the percentage of certain characteristics. APPENDIX B contains the details of the results of these projections.

Generally, for each of the 100 claims, we interviewed:

- the beneficiary or a knowledgeable acquaintance,
- the physician who certified the plan of care, and
- the beneficiary's personal physician.

Our interviews included validation of beneficiaries' and physicians' signatures when necessary.

We interviewed 85 of the 100 beneficiaries. We were unable to interview 15 of the beneficiaries or a close acquaintance because they were deceased, could not be located, or refused to be interviewed. We were not able to interview one physician because he refused to be interviewed.

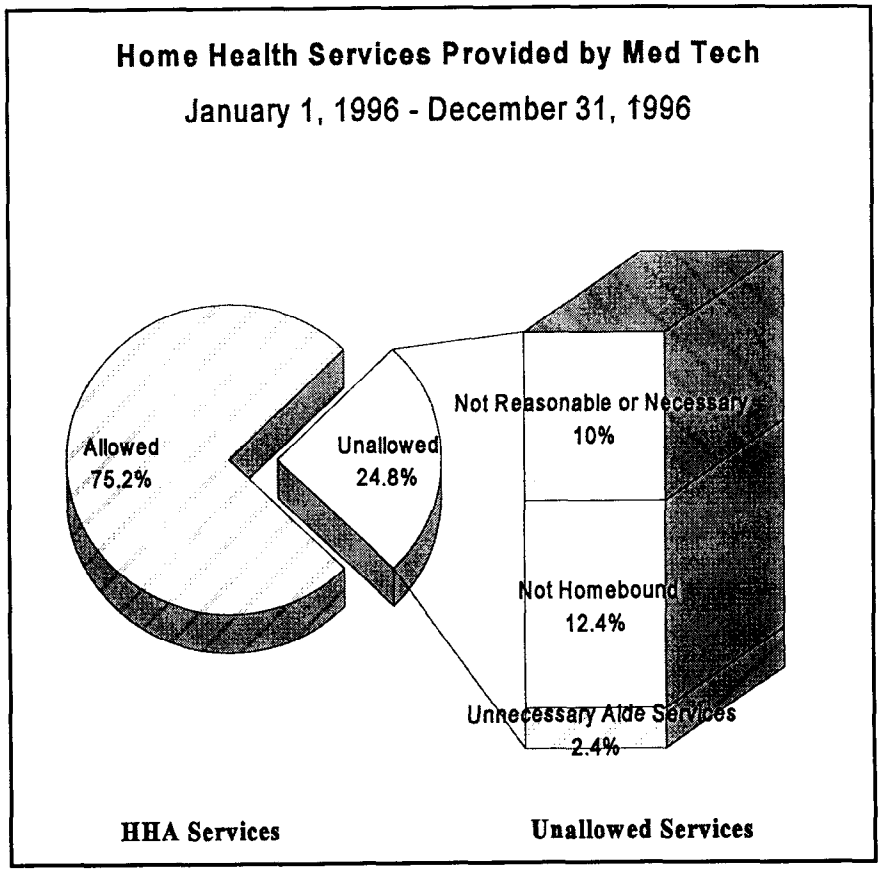
In cooperation with HCFA, we had the medical records reviewed by medical personnel to determine whether the claimed services met Medicare reimbursement requirements for homebound status and medical necessity.

We conducted a limited review of Med Tech's internal controls. Specifically, we reviewed the policies and procedures in place to monitor the work performed by its own staff and subcontractors.

In addition, we reviewed Med Tech's accounts payable to verify that Med Tech's subcontracted costs were actually incurred and paid. During our limited review, we found no reportable conditions.

Our field work was performed at Med Tech's administrative office in Davie, Florida. Interviews were conducted in the beneficiaries' residences and the physicians' offices. Our audit was conducted in accordance with generally accepted government auditing standards.

DETAILED RESULTS OF REVIEW



Our audit disclosed 577 of the 2,294 services included in 42 of the 100 claims submitted by Med Tech during CY 1996 did not meet the Medicare reimbursement requirements. For the population of HHA claims processed by the FI, we estimate 24.8 percent of the services contained in the claims did not meet Medicare reimbursement requirements. The percentage was computed using a stratified cluster sampling methodology, considering each claim to be a cluster of services.

Based on a statistical sample, we estimate Med Tech received overpayments totaling at least $1.9 million. Using the 90 percent confidence interval, we believe the overpayment was between $1.9 million and $3.5 million.

Although we found documentation that Med Tech monitored its employees and subcontractors, this monitoring was not adequate to ensure that claims submitted were for services that met Medicare reimbursement requirements. The monitoring did not properly address homebound status, the medical necessity of services, or the need for aide services when the beneficiaries had access to similar services. The regulations clearly hold Med Tech responsible for payments made for services performed by either its own staff or by subcontractors.

Criteria for Services Provided by Subcontractors

Section 409.42(e) of Title 42 CFR states that "...home health services must be furnished by, or under arrangements made by a participating HHA." Section 200.2.A of the Medicare HHA Manual states that "In permitting home health agencies to furnish services under arrangements it was not intended that the agency merely serve as a billing mechanism for the other party. Accordingly, for services provided under arrangements to be covered the agency must exercise professional responsibility over the arranged-for services." In addition, the Medicare HHA conditions of participation at 42 CFR 484.14(h) set forth the requirements governing home health services furnished under arrangements.

Services to Beneficiaries Who Were Not Homebound

Our review disclosed 288 services contained in 20 of the 100 claims were for beneficiaries who were not homebound at the time the services were provided. The review of medical records, or the interview of the beneficiary or a close acquaintance of the beneficiary, indicated that the beneficiaries, by their own assessment or that of the medical reviewer, were not homebound at the time the services were provided. In all cases, Med Tech had documentation, such as the plan of care, that indicated the individual needed skilled care and was homebound.

The regulations at 42 CFR 409.42 (a) provide that the individual receiving home health benefits must be "... confined to the home or in an institution that is neither a hospital nor primarily engaged in providing skilled nursing or rehabilitation services...." Title 42 CFR 424.22 (a) (1) states that Medicare pays for home health services only if a physician certifies the services are needed and that the individual is homebound. The Medicare HHA Manual at section 204.1 contains guidance regarding the "homebound" requirement.

The review of the HHA medical records indicated the beneficiaries were not homebound. The interview of the beneficiary or a close acquaintance of the beneficiary, in most cases, confirmed the beneficiaries could leave their homes without considerable effort at the time HHA services were provided. For example:

- In one case, the medical reviewer found the beneficiary was independent in transfers and ambulation. The interview revealed that the beneficiary was out of the home every day; he even walked to his mother's home.

- In another case, the medical reviewer found that the beneficiary was independent in all activities of daily living. In addition, during the interview the beneficiary stated he was not homebound at the time of the services.

Services That Were Not Reasonable or Necessary

Our review disclosed 233 services contained in 16 of the 100 claims were not considered reasonable or necessary by the HCFA medical personnel.

The regulations at 42 CFR 409.42 (1) provide that the individual receiving home health benefits must be in need of intermittent skilled nursing care or physical or speech therapy. Section 203.1.B of the Medicare HHA Manual states that the beneficiary's health status and medical need as reflected in the plan of care and medical records provide the basis for determination as to whether services provided are reasonable and necessary; and section 205.1.B.1 states that "Observation and assessment of the beneficiary's condition by a licensed nurse are reasonable and necessary skilled services when the likelihood of change in a patient's condition 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 beneficiary's treatment regime is essentially stabilized."

Of the 100 claims reviewed, HCFA medical personnel concluded that medical records for 16 claims did not support the reasonableness and necessity of 233 services. For example:

- In one claim, the medical review disclosed that the beneficiary had a chronic rather than an acute condition.
- In another claim, the beneficiary required wound care which was simply cleaning with hydrogen peroxide and leaving open to air.
- Another claim revealed that the beneficiary had reached the medical goals set for physical therapy.
- In five claims, the medical reviews showed a lack of medical documentation to support medical need.
- In three claims, the beneficiaries were not responsive to psychiatric nursing services and, therefore, could not benefit from these skilled services.

Duplication of Services

Our review disclosed 56 services contained in 6 of the 100 claims were for home health aide services provided to beneficiaries who had contracted with private agencies to receive similar type services. These beneficiaries resided in adult living facilities (ALF) which were under contract to the beneficiaries to provide assistance with activities of daily living. Although the medical records maintained by Med Tech contained the required documentation including home health aides' notes and signatures of the beneficiaries indicating the services were provided, the beneficiaries had contracted to receive similar services from the ALF; therefore, the aide services provided by Med Tech were unnecessary.

The regulations at 42 CFR 409.45 (b) (3) state "... services provided by the home health agency must be reasonable and necessary. To be considered reasonable and necessary, services must be of a type that there is no able or willing care giver to provide, or, if there is a potential care giver, the beneficiary is unwilling to use the services of that individual."

Effect

We estimate during CY 1996 Med Tech was paid at least $1.9 million for unallowable home health services. We estimate 24.8 percent of the services in claims paid to Med Tech were unallowable. We projected the sample overpayment amounts to the sampling frame. The 90 percent confidence interval was $1,922,366 to $3,527,955 with a midpoint of $2,725,161. Using the lower limit of the 90 percent confidence interval, we are 95 percent confident that Med Tech was overpaid by at least $1.9 million for unallowable home health services.

Med Tech Did Not Properly Monitor Services

We reviewed Med Tech's policies and procedures to monitor the work performed by its own employees and subcontractors, in the determination and assessment of homebound status and medical necessity criteria to receive HHA services. Although documentation found in the medical records indicated Med Tech conducted supervisory visits, these procedures failed to disclose the problems found during our review.

The HHA coverage guidelines issued by HCFA provide that the HHA has essentially the same responsibilities for services provided by subcontractors as for services provided by their salaried employees.

RECOMMENDATIONS

We recommend that HCFA:

- instruct the FI to recover overpayments of $1.9 million,
- require the FI to instruct Med Tech on its responsibilities to properly monitor its subcontractors for compliance with Medicare regulations, and
- monitor the FI and Med Tech to ensure that corrective actions are effectively implemented.

HCFA's Comments

In response to our draft report, HCFA concurred with our recommendations. In its reply, HCFA posed a technical question of whether the results of a random sample of 100 claims are adequate to recommend a financial recovery. The HCFA response is included in its entirety as APPENDIX D to this report.

OIG Response

Our random sample of 100 claims was adequate to recommend financial recovery. This sample size is consistent with Office of Inspector General (OIG), Office of Audit Services' policy which has been used in similar audits over the last 3 years in which HCFA has concurred with our recommendations to recover funds. We use the lower limit of the 90 percent two-sided confidence interval for recommended recoveries. The larger the sample size used, the more precise our sample results and the greater the lower limit. Thus, a larger sample would result in greater recommended recovery. The size of the sample does not impact the validity of the estimates; it does impact the amount of recovery recommended. Also, except for very small sampling populations, the size of the sampling population does not greatly impact the size of a sample for a given level of precision.

APPENDICES

APPENDIX A

AUDIT OF MED TECH HOME HEALTH SERVICES
SAMPLING METHODOLOGY

OBJECTIVE:

The sample objective was to estimate overpayments for claims that did not meet Medicare reimbursement requirements. To achieve our objective, we selected a statistical sample of home health claims from a universe of home health claims submitted by Med Tech during the CY ended December 31, 1996. We obtained claim documentation and interviewed beneficiaries and physicians identified in the claim. We used the results to project the overpayments for services that were not reimbursable to Med Tech during the CY ended December 31, 1996.

POPULATION:

The universe consisted of 5,777 claims for home health services provided by Med Tech during the period January 1, 1996 to December 31, 1996 which covered cost reporting periods ending May 31, 1996 and May 31, 1997.

SAMPLING UNIT:

The sampling unit was a paid home health claim for a Medicare beneficiary. A paid claim included multiple services and items of cost for the home health services provided.

SAMPLING DESIGN:

An unrestricted random sample was used.

SAMPLE SIZE:

A sample of 100 claims.

ESTIMATION METHODOLOGY:

We used the lower of the cost per visit or the program cost limits for each type of service reported by Med Tech in the unaudited cost reports for fiscal years (FY) ended May 31, 1996 and May 31, 1997. For the unallowed services on a sample unit, we computed the amount of error by multiplying the number of unallowed services for each type of claim by the cost reported by Med Tech in the unaudited cost report for the appropriate FY.

Using the Department of Health and Human Services (HHS), OIG, Office of Audit Services Variables Appraisal Program, we estimated the overpayments that either did not meet reimbursement requirements for homebound, medical reasonableness and necessity, or were a duplication of services.

APPENDIX B

AUDIT OF MED TECH HOME HEALTH SERVICES
ATTRIBUTES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims out of 5,777 claims to project the occurrence of certain types of errors. Since the sample was taken of claims, we used the HHS, OIG, RAT-STAT Two-Stage Attribute Appraisal Program to project the percentage of services in error. For this appraisal, we considered each claim to be a cluster of services. The results of these projections are presented below:

Services That Did Not Meet the Requirements

Quantity of Services in Error	577
Point Estimate	24.8%
Precision at the 90% Confidence Level	+\- 7.1%

Services to Beneficiaries Who Were Not Homebound

Quantity of Services in Error	288
Point Estimate	12.4%
Precision at the 90% Confidence Level	+\- 5.3%

Services That Were Not Reasonable or Not Necessary

Quantity of Services in Error	233
Point Estimate	10.0%
Precision at the 90% Confidence Level	+\- 5.4%

Duplication of Services

Quantity Services in Error	56
Point Estimate	2.4%
Precision at the 90% Confidence Level	+\- 1.8%

AUDIT OF MED TECH HOME HEALTH SERVICES
VARIABLES PROJECTIONS

REPORTING THE RESULTS:

We used our random sample of 100 claims ($196,022) out of 5,777 claims to project the value of claims that did not meet the requirements. The lower and upper limits are shown at the 90 percent confidence level. The results of these projections are presented below:

Claims That Did Not Meet the Requirements

Identified in the sample	
Number of Claims	42
Value	$ 47,173
Point Estimate	$2,725,161
Lower Limit	$1,922,366
Upper Limit	$3,527,955

DEPARTMENT OF HEALTH & HUMAN SERVICES

Health Care Financing Administration

The Administrator
Washington, D.C. 20201

DATE: JAN 1 1 1999

TO: June Gibbs Brown
Inspector General

FROM: Nancy-Ann Min DeParle
Administrator

NMD

SUBJECT: Office of Inspector General (OIG) Draft Reports: "Review of Costs Claimed by Staff Builders Home Health Care," (A-04-97-01166); "Review of Costs Claimed by MedTech Home Health Services, Inc." (A-04-97-01169); and, "Review of Costs Claimed by MedCare Home Health Services," (A-04-97-01170)

Thank you for the opportunity to review the above-referenced reports concerning medical review of claims for home health care services in the Florida area. I also want to acknowledge that these audits were performed in partnership with our HCFA Miami Satellite Office under Operation Restore Trust.

HCFA concurs with the three OIG recommendations. Our specific comments follow:

OIG Recommendation
HCFA should instruct the fiscal intermediaries (FI) to recover overpayments.

HCFA Response
We concur and will instruct the FIs to recover overpayments. While HCFA agrees with the recommendation to recover the overpayments from each provider specified, we cannot attest to the exact overpayment figures stated in the reports until the responsible intermediaries receive the audit work papers. Our Atlanta Regional Office will be instructed to review the audit reports and insure that the intermediaries receive the necessary work papers for establishing and recouping the correct overpayment amounts.

OIG Recommendation
HCFA should require the FIs to instruct the home health agencies on their responsibilities to properly monitor their subcontractors for compliance with the Medicare regulations.

HCFA Response
We concur and will instruct our Atlanta Regional Office to work with the intermediaries to assure that the home health agencies have been properly educated to comply with this recommendation.

OIG Recommendation
HCFA should monitor the FIs and home health agencies to ensure that corrective actions are effectively implemented.

HCFA Response
Our Atlanta Regional Office will be instructed to monitor this process.

Technical Comment:
We are concerned about determining such large recoveries from samples as small as 100 claims. The size of the sample reviewed did not vary despite disparities in the annual claims volumes of the agencies. MedCare and MedTech had comparable claims volumes in CY 1996 (5606 and 5777 respectively) while the claims volume for Staff Builders is over two and a half times those amounts (14405). This disparity is not addressed in the methodology.